Clinical Sub-Group to support the delivery of an Expanded Role for Community Pharmacy

Common Conditions Service Protocol

Acute Infective Conjunctivitis (Final)

V1.2 26/09/2025

This protocol does not impede the sale and supply of medicines 'over the counter' where this legal route of supply is relevant

Table of Contents

1. Critical Elements

1.1 Protocol Version
Version 1.2
1.2 Protocol Authors
Clinical Sub-Group to support the delivery of an Expanded Role for Community Pharmacy (See Appendix A for membership)
• Pharmacists wishing to deliver this service must: 1. Complete the mandatory Common Conditions Service training. Training can be accessed on the Irish Institute of Pharmacy website. 2. Adhere to the information and recommendations included in the Clinical Protocol for this common condition, and always ensure that they are following the current version of the protocol. Current versions of the Clinical Protocols can be accessed on the HSE website. 3. Comply with legislation in place that relates to delivery of the service and any associated guidance from the PSI. • NOTE: Locum pharmacists employed on a temporary basis who have successfully completed the training may be authorised to provide the service. They must be able to produce a record of their training upon request.

2. Clinical Criteria

2.1 Clinical condition for use of the protocol and differential diagnosis

Bacterial/Viral Conjunctivitis

Background

Conjunctivitis is an eye condition characterised by inflammation of the conjunctiva of the eyelid and eye. It can be caused by a number of factors including:

- Infection (bacterial/viral).
- Immune response to allergens e.g. seasonal allergens such as pollen or excipients of eyedrops (especially those with preservatives).
- Irritants e.g. loose eyelash/chemical splash.
- Mechanical abrasion e.g. contact lens wearers.

Conjunctivitis due to infection can be contagious while allergic conjunctivitis is noncontagious.

Managing the Red Eye: Conjunctivitis vs. Eyelid Disease

Individuals may present with red eye due to a variety of conditions. It may affect the eyelid, surface of the eye, or both. It is important that pharmacists are familiar with other conditions which may give rise to a red irritated eye and require differentiation, before a diagnosis of conjunctivitis is achieved. The standard clinical approach is to first examine the lids and lashes before examining the surface of the eye.

Clinical approach to evaluating the Red Eye:

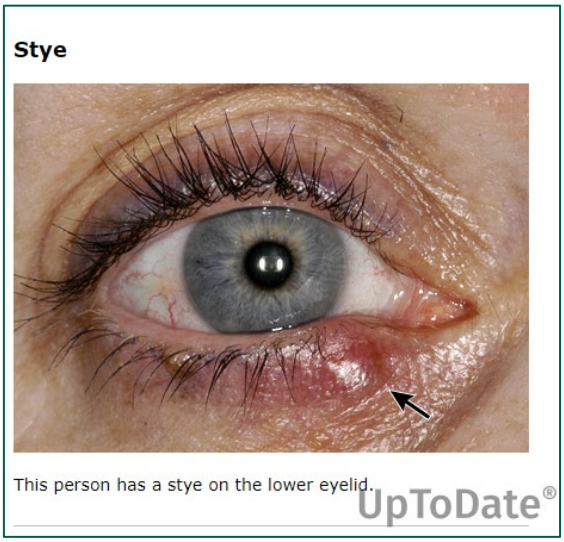
1. Is there generalised redness of either eyelid or both?
2. Is there a localised swelling of the lid?
   a) Is there swelling along the lid margin near the lashes? *Consider Stye (also called hordeolum)*
   b) Is there swelling within the lid, palpable as a small lump? *Consider Meibomian Cyst*
   c) Is the entire lid swollen and dark red around a localised initial lump/swelling? *Consider Meibomian Cyst with localised cellulitis – See Section 2.4 for referral pathway*
3. Are the eyelids pink and mildly swollen but not painful to the touch? (non-localised) *Consider Allergic Conjunctivitis*
4. Is the lid margin swollen around the lashes with or without crusts building up along the lash line? *Consider Blepharitis*
5. Are both upper and lower lid intensely swollen/closed and difficult to open *Consider pre septal or orbital cellulitis – See Section 2.4 for referral pathway*
6. Are both lids swollen and closed with a soft swelling but can be opened easily? No conjunctival hyperaemia. *Consider allergic reaction to a sting/bite/unknown irritant/medication*
7. Is the redness primarily on the eye surface i.e. hyperaemia with or without discharge, as opposed to primarily affecting the eyelids with minimal-no hyperaemia? *Consider Conjunctivitis – see Section 2.2 for Clinical Features of Conjunctivitis*

Differential Diagnosis:
Causes of Red Eye: Eyelid
Stye
A stye, also known as hordeolum, is caused by an infection of an eye gland. It commonly presents as swelling and pain in a localised area and is usually self-limiting. Symptoms should resolve within a week or two. Self-care advice is available from HSE A-Z. Individuals should be advised:

To reduce swelling and help the stye heal:
- Soak a clean face cloth in warm water.
- Hold it against the eye for 5 to 10 minutes.
- Repeat this 3 or 4 times a day.

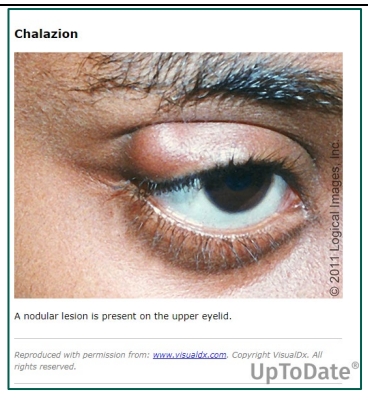
If necessary, the individual should be advised to take simple over-the-counter (OTC) analgesia e.g. paracetamol or ibuprofen to ease the pain.

Individuals should avoid wearing contact lenses and eye make-up until the stye has burst and healed. An individual should see their GP if symptoms deteriorate or persist for longer than three to four weeks.



Stye (UpToDate®)

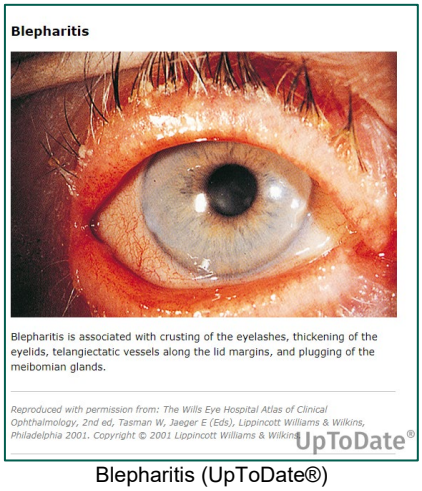
Meibomian cyst (Chalazion)
A meibomian cyst is a chronic inflammatory lesion (lump) that develops due to a blocked meibomian gland duct. The meibomian glands produce meibum, the oily substance in tears. A cyst can present as a tender sore red swelling on the upper or lower eyelid. If the cyst is large, it can distort the individual's vision. The first line of treatment should include hot bathing. This can be done by placing a clean flannel in hot water and placing it over the affected eye, ensuring the eye is closed, until the flannel cools down. This can be repeated about 4-5 times twice daily. This encourages the cyst to discharge its contents, and the cyst may resolve itself. An individual should see their GP if symptoms deteriorate or persist for longer than three to four weeks. A referral to the GP will also be required if:
- the meibomian cyst is discharging and becomes red and inflamed and/or tender
- the lid becomes fully swollen
- the lid closes with localised tissue infection



Chalazion (UpToDate®)

Blepharitis

Blepharitis is a common, inflammatory condition of the eyelids which results in red lids and crusting. It is not contagious, occurs in children and adults and, in most people, is not harmful. It can recur. Signs and symptoms include red eyelid(s), sore eyelid(s), dandruff-like flakes seen at the base of eyelashes, and/ or stinging sensation in the eyes. It is most common in those with eczema, acne and people who suffer with scalp dandruff. Those with sensitivity to a bacteria (*Staphylococcus*) that normally lives on the skin are also more likely to develop blepharitis. The use of a regular lid cleaning regime can alleviate symptoms. It may be associated with mild conjunctival hyperaemia (visible reddening of the white portion of the eye), which is generalised across the eye surface and is secondary to drying of the eye. This can cause the dry eye feelings of sandy, gritty, tired or uncomfortable eyes.



Blepharitis (UpToDate®)

Causes of Red Eye: Conjunctival Redness

Subconjunctival Haemorrhage

Individuals may present with subconjunctival haemorrhage. This is a deep red presentation that obscures the view of the vessels. It is usually localised as a subconjunctival haemorrhage or bleed, often associated with coughing, sneezing, or valsalva manoeuvre. It is more common in individuals on anticoagulants or already using topical drops. It may be associated with minor trauma. An individual should see their GP if symptoms deteriorate or persist for longer than 14 days.

Subconjunctival haemorrhage (UpToDate®)

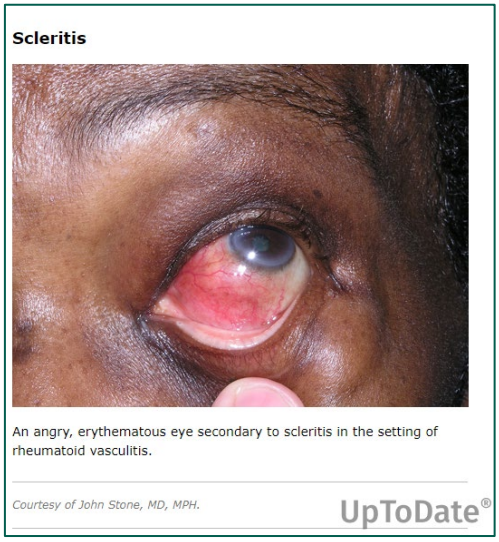
Conjunctival Dilated Vessels

Individuals may present with hyperaemia (conjunctival dilated vessels). This is where the lining of the conjunctiva is irritated and the vessels become more prominent with a pink/angry deep red appearance depending on the severity. The hyperaemia is generalised and involves the entire surface of the conjunctiva over the sclera (white of the eye) and the conjunctiva that covers the inside of the eyelid.

It should not be confused with **episcleritis** where the inflammation is localised to a single sector, usually either the nasal (medial) or temporal (lateral) side of the midpoint of the pupil as seen in the image below. In episcleritis, the inflammation is mild to moderate with little or no pain and is less intense/deep red in colour. This may be associated with autoimmune conditions e.g. rheumatoid arthritis. An individual should see their GP if symptoms deteriorate or persist for longer than 14 days.

Episcleritis (UpToDate®)

Scleritis presents with a deeply red colour with tortuous vessels. It may be localised or generalised and is usually associated with a deep or intense pain (see image below). Individuals with this presentation require emergency referral (see Section 2.4).



Scleritis (UpToDate®)

Dry eye symptoms
In some individuals there is decreased tear production or a reduced quality of tears produced. This may result in ocular discomfort including mild conjunctival hyperaemia with some intermittent blurring which clears on blinking. Individuals may also report excessive blinking and irritation which may lead to eyes watering.

These symptoms may be less when the individual wakes up but get worse as the day goes on. The use of preserved topical drops of gel (hyaluronic acid based) for short term treatment may alleviate symptoms. If long term treatment is required, then preservative free drops are recommended. If the dry eye symptoms include severe discomfort of lids that are stuck at night or upon awakening, then an ocular gel may be beneficial.

There are a number of medications which may predispose individuals to dry eye and should be considered as part of the individual's medical history when completing a differential diagnosis. These include antihistamines, hormonal replacement therapy, oral contraceptives, beta adrenoreceptor blockers, antispasmodics, diuretics, retinoids and related drugs, preservatives in eye drops e.g. benzalkonium chloride.

There are also a number of conditions which may pre-dispose individuals to dry eye and should be considered when reviewing the individual's medical history. These include diabetes mellitus, Parkinson's disease, rheumatoid arthritis, thyroid disorders, blepharitis, and eye surgery.

The use of contact lenses or exposure to environmental factors such as smoking or a dusty environment may also contribute to dry eye.

Impaired Nasolacrimal Duct Function (Blocked Tear Duct)
The most common cause of sticky eye is due to an impaired nasolacrimal duct function. It is a non-infective condition and does not require antibiotic treatment. It is common in newborns and small babies while their tear ducts are developing. The tear ducts will

usually open up themselves in the first few months of life and the baby's eyes will usually get better on their own.

Symptoms may include yellow or white discharge in the eyes, excessive tearing and crusting of the eyelids. Warnings signs which would require referral to a GP include painful swelling near the inside corner of the eye, and recurrent eye infection or inflammation. A change in discharge colour or volume (becomes more copious) or if it is associated with conjunctival hyperaemia, may indicate a secondary bacterial infection or conjunctivitis and antibiotic treatment may be required.

Individuals should be signposted to HSE A-Z “Sticky eyes in babies and toddlers” for guidance on how to clean the baby’s eyes. Individuals should be advised to:

- Wash their hands.
- Wet a sterile cotton ball with saline solution.
- Gently wipe the baby's eye from the inside corner to the outside corner. Use a new cotton ball for each wipe.
- Dry the eye using a different cotton ball, wiping from the inside corner out.
- Wash their hands.

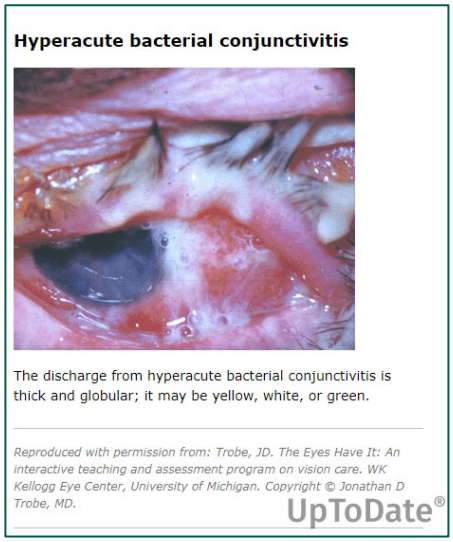
A GP or public health nurse may advise the individual how to massage the baby's tear duct to unblock it. A GP referral to see a specialist may be required if the condition persists after 12 months.

Nasolacrimal duct obstruction (UpToDate®)

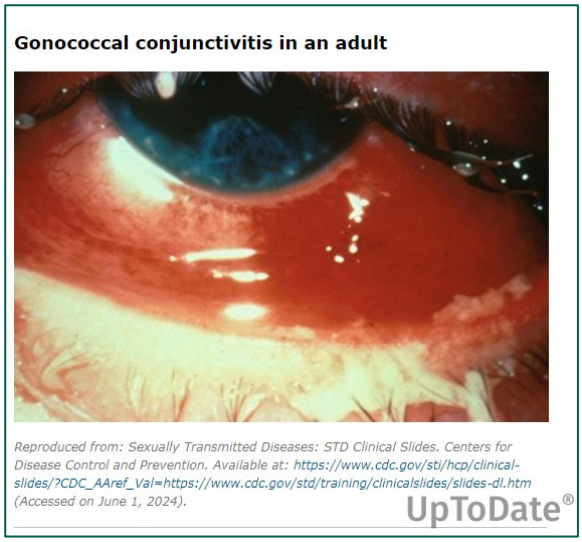
Neisseria gonorrhoeae

Newborn infants in the first week or life, as well as teenagers and adults, may be at risk of *Neisseria gonorrhoeae* eye infection. *Neisseria gonorrhoeae* eye infections present a high risk of complications including uveitis, severe keratitis and corneal perforation. The presence of *Neisseria gonorrhoeae* eye infection should be suspected in cases of hyperacute conjunctivitis (rapid onset within 12-24 hours, severe purulent discharge). Warning signs include the severity in terms of the volume of discharge (the discharge is copious and almost reforms as soon as it has been cleared away), severe conjunctival hyperaemia and discharge, formation of any white membrane on the inside of the eyelid,

blurring vision and pain or lid swelling. An immediate referral is required for diagnosis and systemic treatment (see Section 2.4).



Hyperacute bacterial conjunctivitis (UpToDate®)



Gonococcal conjunctivitis in an adult (UpToDate®)

Chlamydia trachomatis

Haemorrhagic conjunctivitis presenting in the first month of life may be caused by *Chlamydia trachomatis*. This is a serious medical condition in newborns and requires an immediate referral to the appropriate Emergency Department. Teenagers and adults are also at risk of *Chlamydia trachomatis* conjunctivitis, and this should be considered if there is no response to standard topical therapy. Such cases often present with a chronic (longer than 2 weeks) low-grade irritation and mucous discharge in a sexually active person. Pre-auricular lymphadenopathy (swelling of the lymph nodes in front of the ears) may be present. An immediate referral is required for diagnosis and systemic treatment (see Section 2.4).

Neonatal chlamydia conjunctivitis (UpToDate®)

Herpes zoster virus

Herpes zoster ophthalmicus (shingles involving the eye) is a potentially sight threating complication caused by infection of the trigeminal nerve. Symptoms may include:

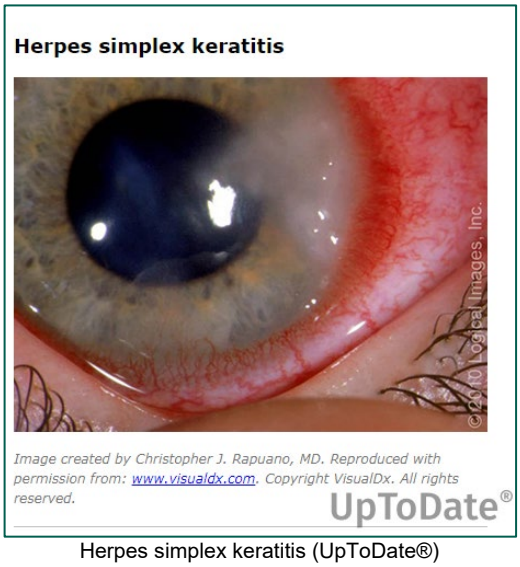
- Blistering rash and/or vesicles around the eye, eyelid or nose
- Pain, swelling and redness around the eye

An immediate referral is required (see Section 2.4).

Herpes zoster ophthalmicus (UpToDate®)

Herpes simplex virus

Ocular herpes is a viral infection of the ocular area caused by the *Herpes simplex* virus. It usually affects one eye, and symptoms may include eye pain, watery discharge, blurred vision, swelling of the eyelid, and light sensitivity. An immediate referral is required (see Section 2.4).



Herpes simplex keratitis (UpToDate®)

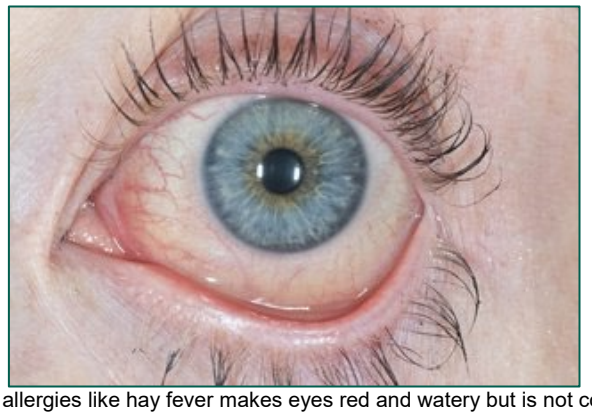
Herpes simplex virus blepharitis (UpToDate®)

Allergic Conjunctivitis

Signs and symptoms of allergic conjunctivitis may include:

- Irritated red eye with dilated/injected vessels (red inflamed blood vessels) on the conjunctival lining of the white of the eye (sclera) across the entire white of the eye
- Pink mild swelling in the eyelid
- Profuse watery or mucoserous, stringy discharge
- Feeling of an itchy eye i.e. needing to rub the eye
- Sensation of grittiness, burning, or irritation
- Crusting on lid margin in morning
- Rhinorrhoea or hay fever-like symptoms

The signs can be unilateral or bilateral but are more often bilateral in allergic conjunctivitis. Blurred vision or pain is not associated with allergic conjunctivitis. Causes of allergic conjunctivitis include seasonal allergens (most common in spring to summer – e.g. high pollen counts, often with rhinitis), irritants (e.g. new cream, cleanser, applying makeup on or close to eyelids), unknown allergens, use of topical drops e.g. glaucoma drops, or long term use of preserved eye drops of any kind due to exposure to benzalkonium chloride (the most commonly used preservative in bottled drops).



Conjunctivitis caused by allergies like hay fever makes eyes red and watery but is not contagious. Credit: DR P. MARAZZI/SCIENCE PHOTO LIBRARY (HSE A-Z)

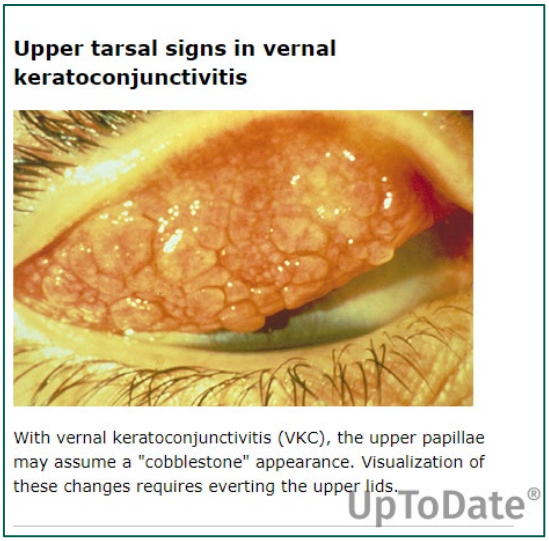
Vernal/Atopic Keratoconjunctivitis

This is a chronic condition caused by an allergic inflammation of the eye. Presentation can be seen at any age – although it more commonly presents early with initial episodes, as opposed to allergic conjunctivitis without atopy that can start at any age. Presentation may occur later if there was a failure to obtain diagnosis and treatment for a previous episode of vernal conjunctivitis.

It is characterised by a lack of response to a topical antihistamine or a mast cell stabiliser. Symptoms include thick swollen lids (papillae – see image below), secondary corneal changes, or blurred vision. Intense eye rubbing is often a feature.

Blurred vision may be an indicator of secondary corneal changes, which may have long term consequences for vision including the risk of corneal scarring and vision loss. As part of the assessment for blurred vision, individuals should be advised to wear any necessary prescription eyewear and evaluate if the blurring continues to be present. The presence of blurred vision is always an indication for referral to a medical practitioner for further assessment.

If signs and symptoms of allergic conjunctivitis are severe or not settling within 14 days of topical antihistamine or a mast cell stabiliser treatment, then referral to a GP is warranted as it may indicate the presence of Vernal/Atopic Keratoconjunctivitis. A subsequent ophthalmological opinion may be required as treatment may include the use of steroids.



Upper tarsal signs in vernal keratoconjunctivitis (UpToDate®)

2.2 Clinical Features

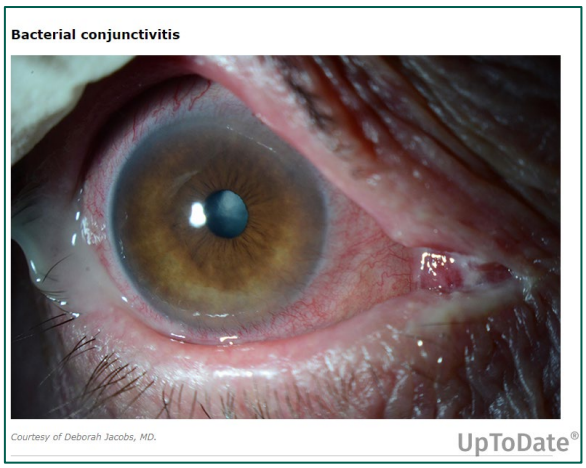
Signs and Symptoms

Bacterial Conjunctivitis

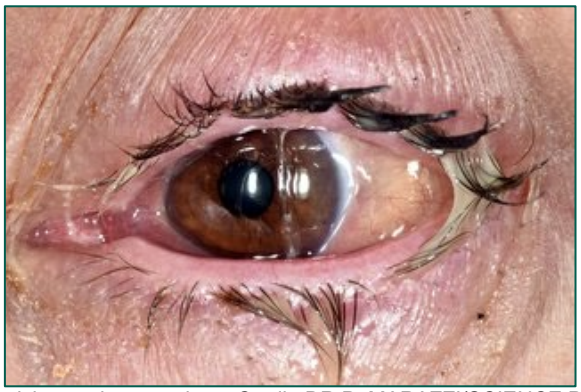
Signs and symptoms of bacterial conjunctivitis may include:

- Irritated red eye with dilated/injected vessels (red inflamed blood vessels) on the conjunctival lining the white of the eye (sclera) across the entire white of the eye
- Pink mild swelling in the eyelid
- Purulent or mucopurulent discharge (typically yellow-white), collected inside the inner eyelid or actively discharging
- Eye often stuck closed in the morning

The signs are more often unilateral in bacteria conjunctivitis and most acute bacterial conjunctivitis infections are self-limiting and do not require topical antibiotics. Symptoms usually resolve within 5-7 days without treatment.



Bacterial conjunctivitis (UpToDate®)



Conjunctivitis that produces sticky pus is contagious. Credit: DR P. MARAZZI/SCIENCE PHOTO LIBRARY (HSE A-Z)

Conjunctivitis in a baby (HSE A-Z)

Infection in contact lens wearers

For contact lens wearers there is a risk is of the bacterial infection getting into the cornea (keratitis) which is a sight threatening condition and requires immediate referral. In some cases, the vision does not recover due to secondary scarring and, in rare cases, spontaneous perforation of an infected corneal ulcer. Individuals should be advised to remove contact lenses while awaiting referral (see Section 2.4).

Viral Conjunctivitis

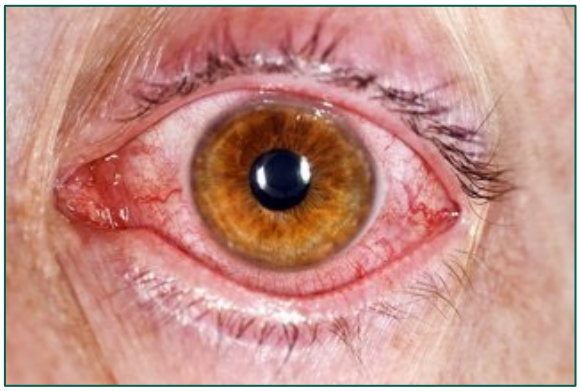
Signs and symptoms of viral conjunctivitis may include:

- Irritated red eye with dilated/injected vessels (red inflamed blood vessels) on the conjunctival lining the white of the eye (sclera) across the entire white of the eye
- Pink mild swelling in the eyelid
- Watery or mucoserous discharge
- Sensation of grittiness, burning, or irritation
- Crusting on lid margin in morning
- Associated viral symptoms e.g. common cold, sore throat

The signs can be unilateral or bilateral, often progressing from unilateral to bilateral within 24 to 48 hours. Viral conjunctivitis accounts for the majority of conjunctivitis cases and usually presents in individuals over 5 years old.

The conjunctiva is usually hyperaemic (vessels are active and red) with a pink lid.

Viral conjunctivitis (UpToDate®)



If eyes are red and feel gritty, the conjunctivitis is also usually contagious. Credit: DR P. MARAZZI/SCIENCE PHOTO LIBRARY (HSE A-Z)

Adenoviral Conjunctivitis
If the conjunctiva is intensely injected (vessels are dilated, active, red) and photophobia is present in a unilateral or bilateral presentation, without mucopurulent discharge, it may be due to adenoviral conjunctivitis. This can take a longer course (two to three weeks) and be associated with severe discomfort and light sensitivity. It is a highly infectious form of conjunctivitis. It often commences first in one eye, followed by second eye involvement a few days later.

If adenoviral conjunctivitis is suspected due to the severity of the hyperaemia, which is often associated with pain and light sensitivity, then immediate referral is recommended (see Section 2.4). If adenoviral conjunctivitis is confirmed then advice about later secondary corneal involvement and further treatment is required, as well as certification of sick leave to avoid spread.

Symptoms not usually associated with acute conjunctivitis include:

- Pain
- Photophobia (apart from the more severe adenoviral conjunctivitis)
    - Red flags include intense sensitivity to bright lights, avoiding light, sitting in a darkened room, pain reading (as pupil constricts), darkening the phone screen etc.
- Blurred vision

2.3 Inclusion criteria

2.3.1 CRITERIA FOR INCLUSION

- Informed consent given by an individual or parent/legal guardian for a child aged under 16 years.
- Individuals aged 6 months and over.
- Diagnosis of bacterial/viral conjunctivitis.

2.4 Exclusion criteria and Referral Pathways

2.4.1 CRITERIA REQUIRING EMERGENCY REFERRAL TO HOSPITAL EMERGENCY DEPARTMENT or EMERGENCY EYE SERVICE

- Suspected scleritis.
- Rash and/or vesicles around eye, eyelid or nose – consider shingles (*Herpes zoster*) assessment.
- *Herpes simplex* viral infection of the ocular area is suspected.
- Suspected *Chlamydia trachomatis* infection in the first month of life.
- Suspected adenoviral conjunctivitis due to the severity of the hyperaemia (and is often associated with pain and light sensitivity).
- Changes/loss in vision/visual acuity (includes blurred vision, seeing halos).
- Severe photophobia and/or severe foreign body sensation (cannot hold eye open).
- Individuals wearing contact lenses (individuals should be advised to remove contact lenses while awaiting referral).
- Irregular pupil(s) (see Appendix B).
- Ciliary flush, especially if unilateral (see Appendix B).
- Moderate to severe eye pain.
- Visible corneal opacity/haze.
- History of recent significant ocular trauma (e.g. recent eye surgery, welding flashes, high velocity power tools etc.).

2.4.2 CRITERIA REQUIRING IMMEDIATE REFERRAL TO GENERAL PRACTITIONER or OTHER RELEVANT MEDICAL PRACTITIONER

Note: Pharmacist prescribing not permitted

- Individuals under 6 months of age.
- Contraindications as specified in the medication Summary of Product Characteristics.
- History of ocular disease e.g. keratitis, scleritis, iritis (individual using topical eye drops for glaucoma is not a reason for referral unless no improvement after 2 days of treatment initiation).
- Hyper-purulent discharge (yellow/green) with very rapid onset (as this may indicate *Neisseria gonorrhoea* eye infection).
- Suspected *Chlamydia trachomatis* infection in individuals aged 1 month and older.
- Both upper and lower lid intensely swollen/closed with no palpable lesion and difficult to open (risk of preseptal or orbital cellulitis).
- Entire lid swollen with a dark red presentation around a localised initial lump/swelling (risk of meibomian cyst with localised cellulitis).
- Minor ocular trauma (e.g. fingernail, branch etc.).
- Severe headache with or without nausea.
- Focal redness not diffuse redness.
- Recent reinfection with relapse within two weeks.
- If treatment initiated and not improving after 2 days.
- Known hypersensitivity or adverse reaction to medication treatment options as included in Section 3.1, or any of the components within the formulation.

2.5 Action to be taken where individual meets exclusion criteria, or treatment is not indicated, or if the individual/parent/legal guardian declines treatment
• If individual meets exclusion criteria, they should be referred or signposted as per the protocol (see Section 2.4). • Advise individual/parent/legal guardian to seek medical advice if symptoms deteriorate. • Signpost to available resources on HSE A-Z and the HSE app if appropriate. • Follow record keeping procedures.

3. Details of medication

3.1 Name of medication, dose, and duration

Treatment Options & Formulary

Management is dependent on:

- determining the likelihood of conjunctivitis
- determining the likely aetiology of conjunctivitis where features are consistent with conjunctivitis.

Bacterial Conjunctivitis

- A topical lubricant may provide relief for the symptoms of conjunctivitis and be applied up to four times a day to the affected eye(s). An agent without preservative is preferable, particularly if the longer-term use of topical lubricant (>1 month) is required.
- For bacterial conjunctivitis, a topical antibiotic should **only be considered** as a treatment option where both conjunctival hyperaemia **AND** a purulent or mucopurulent discharge (typically yellow-white) are present.

If topical antibiotic is required:

- Individual should be informed to seek medical advice if no improvement after 48 hours of treatment. If symptoms persist for more than one week of treatment, then individuals should be advised to see their GP as a referral to ophthalmology may be required.
- Prolonged or recurrent use of any topical antimicrobial agent should be avoided where possible, as it leads to the emergence of antimicrobial resistance.
- Fusidic acid has minimal Gram-negative activity.
- Chloramphenicol is not recommended in pregnancy or breastfeeding.
- The product “Chloromycetin 0.5% w/v Redidrops eye drops, solution” contains boron which has been shown to impair fertility in animals. While the potential for effect on fertility in humans is not known, it should be prescribed with particular caution to a child younger than 2 years, as the exposure to boron may exceed the established safety limit when used in line with the maximum recommended posology in this age group. Prescribers may need to consider the appropriateness of repeated use in this patient population.

Bacterial Conjunctivitis			
Drug	**Dose**	**Duration**	**+/- Notes**
1st choice options			
Chloramphenicol 0.5% w/v eye drops, solution	**Adults and Children:** Apply one or two drops to the infected eye(s) four times daily. Doses should be spaced evenly during waking hours.	Treatment should be continued for 48 hours after resolution of symptoms, in general for a maximum of one week	• Chloramphenicol is not recommended in pregnancy or breastfeeding. • Chloramphenicol eye drops should be used with caution in children <2 years (see note above). **Note:** Minims Chloramphenicol 0.5% Eye Drops, Solution is indicated in adults and children (above 2 years old). • **Note:** Chloromycetin 0.5% w/v Redidrops eye drops, solution contains preservatives. • Chloramphenicol 1% Ointment may be preferred in individuals who find the frequency of drops difficult to comply with. • Presence of ointment on the eye may blur the vision with use during the day.
OR			
Chloramphenicol 1% w/w Ointment *(Unlicensed medication)*	**Adults and Children:** Apply to the infected eye(s) three to four times daily. Doses should be spaced evenly during waking hours.	Treatment should be continued for 48 hours after resolution of symptoms, in general for a maximum of one week	
2nd choice options (if 1st choice option not available or suitable)			
Fusidic Acid 10mg/g Viscous Eye Drops Suspension	**Adults and Children:** Apply one drop to infected eye(s) every 12 hours	Treatment should be continued for 48 hours after resolution of symptoms, in general for a maximum of one week	• Fucithalmic viscous eye drops can be used during pregnancy and breast-feeding. For further details see SPC Section 4.6 for “Fucithalmic 10mg/g Viscous Eye Drops, suspension”. • **Note:** Fusidic acid has minimal Gram-negative activity.

Viral Conjunctivitis
Viral Conjunctivitis is often self-limiting. A topical lubricant may provide relief for the symptoms of conjunctivitis and should be applied up to four times a day to the affected eye(s). An agent without preservative is preferable, particularly if the longer-term use of topical lubricant (>1 month) is required. If necessary, the individual should be advised to take simple over-the-counter (OTC) analgesia e.g. paracetamol or ibuprofen to ease the pain. Escalation to review for suspected adenoviral conjunctivitis may be required if the conjunctival hyperaemia (red eye) is severe.

Allergic Conjunctivitis
Please refer to the Common Conditions Service Protocol for *Allergic Rhinitis & Allergic Conjunctivitis* which includes Treatment Options & Formulary for Allergic Conjunctivitis.

3.2 Summary of Product Characteristics including warnings, cautions, contraindications, interactions and side effects.

Visit the Health Products Regulatory Authority (HPRA) website for detailed drug information (summary of product characteristics and patient information leaflets). Dosing details, contraindications and drug interactions can also be found in the Irish Medicines Formulary (IMF) or other reference sources such as British National Formulary (BNF) / BNF for children (BNFC).

3.3 Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, website: www.hpra.ie

3.4 Procedure for the reporting and documentation of errors and near misses involving the medication including open disclosure.

PSI Advice on Medication Error Management:
https://www.psi.ie/practice-supports/practice-updates-and-learnings/advice-medication-error-management
PSI Open Disclosure:
Open Disclosure | PSI

3.5 Resources and equipment necessary for care under the protocol to be specified. This is dependent on the assessment requirements and best practice guidelines identified for the clinical condition.

- HSE National Consent Policy
- Chaperone Policy
- Patient Consultation Area
- Infection Prevention Control Measures
- Protecting Staff – Occupational Health

4. Patient/service-user care information

4.1 General Advice for Self-Care and Safety Netting

Bacterial/Viral Conjunctivitis
• Individuals should:
  ○ Make sure they wash their hands often with warm soapy water
  ○ Wash their hands immediately if they touch their eyes and after applying eye drops or eye ointment.
  ○ Not touch or rub their eyes
  ○ Wash pillows and face cloths in hot water and detergent
• Individuals should not:
  ○ Wear contact lenses until they have completed the antibiotic treatment course, and all symptoms have resolved
  ○ Share towels and pillows
  ○ Touch or rub their eyes
• Children with conjunctivitis do not need to stay out of school/ childcare if child is well but school/childcare provider should be informed.
 	
Individuals should be informed to seek medical advice if no improvement after 48 hours of treatment. If symptoms persist for more than one week of treatment, then individuals should be advised to see their GP as a referral to ophthalmology may be required.
 	
Allergic Conjunctivitis
Please refer to the Common Conditions Service Protocol for *Allergic Rhinitis & Allergic Conjunctivitis* which includes General Advice for Self-Care for Allergic Conjunctivitis.

4.2 Medication information to be provided to the individual/parent/legal guardian using the authorised patient information leaflet if one is available.
• Signpost to available resources on HSE A-Z and the HSE app. • Medication Patient Information Leaflets (PILs).

Key References

- HPRA https://www.hpra.ie/
- HSE Antibiotic Prescribing https://www.hse.ie/eng/services/list/2/gp/antibiotic-prescribing/
- HSE A-Z https://www2.hse.ie/conditions/
- HSE Blepharitis https://www.hse.ie/eng/services/list/1/lho/dublinse/eyecare/blepharitis.pdf
- UpToDate Infectious Conjunctivitis and related images https://www.uptodate.com/contents/infectious-conjunctivitis

Appendix A – Clinical Sub-Group Membership

Core Membership

- Dr. Siobhán Ní Bhriain - HSE National Clinical Director Integrated Care (Chair)
- Dr. David Hanlon - HSE National Clinical Advisor Primary Care (Vice Chair)
- Ms. Ciara Kirke - HSE Clinical Lead National Medication Safety Programme
- Ms. Linda Fitzharris - HSE PCRS Head of Pharmacy
- Dr. Diarmuid Quinlan - Medical Director ICGP & GP
- Ms. Elaine Dobell - HSE General Manager, Office of National Clinical Director Integrated Care
- Ms. Marie Philbin - AMRIC Chief Pharmacist
- Mr. Jonathon Morrissey - Community Pharmacist
- Ms. Áine McCabe - Community Pharmacist
- Dr. Clíona Murphy – National Women and Infants Health Programme
- Ms. Sarah Clarke - Medicines Management Programme

General Membership as needed

- Ms. Aoife Doyle - HSE National Clinical Lead for Ophthalmology
- Prof. Anne Marie Tobin - HSE National Clinical Lead for Dermatology
- Dr. Eavan Muldoon - HSE National Clinical Lead for Infectious Diseases
- Dr. Seán O'Dowd - HSE National Clinical Lead for National Dementia Office representing National Clinical Programme for Neurology on behalf of Prof. Sinéad Murphy
- Ms. Ruth Hoban - HSE West Assistant Director of Nursing and Midwifery for Nurse Prescribing on behalf of Dr. Geraldine Shaw
- Prof. Fiona Lyons - HSE National Clinical Lead for Sexual Health
- Ms. Caoimhe Gleeson - HSE National Office for Human Rights and Equality Policy
- Dr. Andrew Bolas - Assistant National Oral Health Lead
- Dr. Myra Herlihy - Assistant National Oral Health Lead Special Care and Training

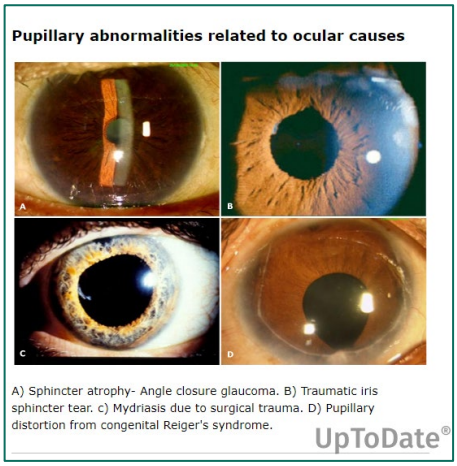
Acute Infective Conjunctivitis CSG Working Group

- Ms. Aoife Doyle - HSE National Clinical Lead for Ophthalmology
- Dr. David Hanlon - HSE National Clinical Advisor Primary Care (Vice Chair)
- Ms. Ciara Kirke - HSE Clinical Lead National Medication Safety Programme
- Ms. Marie Philbin - AMRIC Chief Pharmacist
- Mr. Jonathon Morrissey - Community Pharmacist
- Ms. Áine McCabe - Community Pharmacist

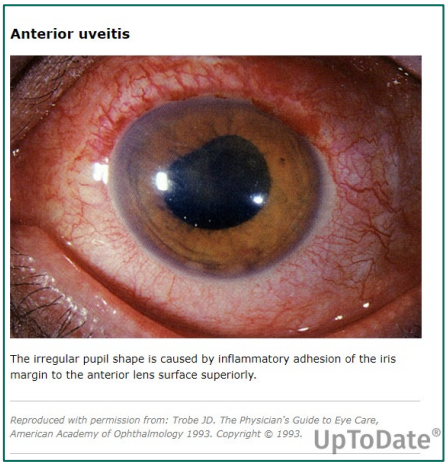
Appendix B

Irregular pupil(s)

Irregular pupils may include pupils which are fixed, smaller, larger, sluggish to light.



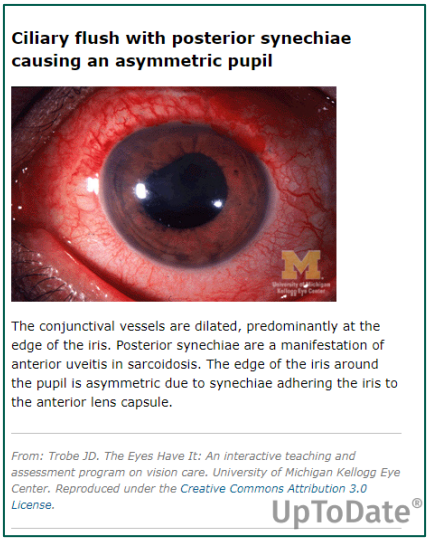
Pupillary abnormalities related to ocular cause (UpToDate®)



Anterior uveitis (UpToDate®)

Ciliary Flush

Ciliary flush can be mild or severe (as seen in the image below). It relates to redness of the conjunctival vessels in a circular pattern over the junction of the cornea and the sclera (i.e. where the coloured part meets the white of the eye). It is a sign of intraocular inflammation/uveitis, and the pupil may be stuck to the lens and therefore irregular or not reacting to light.



Ciliary flush with posterior synechiae causing an asymmetric pupil (UpToDate®)