Marginal Infiltrative Keratitis

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Etiology
- Staphylococci exotoxin produces an antigen/antibiotic immune reaction
- Sterile-infiltrate ulcer as opposed to live bacteria in ulceration
- Chronic Staphylococcal blepharitis: Mild to severe
- Contact lens patients especially extended wear more prone
- More common in adult life

Symptoms
- Acute or subacute onset with frequent past history of prior attacks, most often unilateral attacks, often worse in AM
- Redness, foreign-body sensation, pain, and photophobia
- Visual acuity rarely affected

Signs
- Blepharoconjunctivitis: May be subclinical, inferior punctate staining
- Marginal intra-epithelial infiltrate: An initial gray-white, round or crescent, raised subepithelial, anterior stromal haze seen near limbus; circumferential with limbus, epithelium intact with superficial staining
- Most vulnerable sites at 2, 4, 10 and 8:00 of peripheral cornea, where lid margin crosses limbus and more toxins present

Differential Diagnosis
- Sterile cultures
- Marginal herpetic keratitis (epithelial first then stroma)
- Phylctenular ulcer, scleritis, vasculitis, CT disease, Mooren’s ulcer are other causes of marginal keratitis
**Treatment**

- Topical solutions of 0.3% Tobrex or Ciloxan or Ocuflox 2 gtt every 2 to 4 hours, plus bacitracin, erythromycin, polysporin ointment at bedtime
- Eyelid hygiene & warm compresses & D/C CL wear
- Cycloplegic if pain & A/C reaction: In office
- Antibiotic/steroid combination treatment: e.g., Tobradex, Blephamide, Zylet or 1% Pred Forte q4-6h with rapid taper; if ulcer formation, no steroids for 24 to 48 hours
  - New steroids: Vexol, Lotemax, Flarex, or Eflone

**Chronic or Recurrent Episodes**

- Oral doxycycline, 100mg bid PO for 1 mo. then qd for 1mo.

**Frequently Results in Nebula Scar Formation and Pannus**

**Staphylococcus Infection**