Contact-lens-related microbial keratitis: case report and review

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Submitted 31 May 2011; accepted 26 September 2011

Abstract Bacterial keratitis is a serious, potentially blinding, complication most often involving overnight contact lens wear. This case report reviews the management of a patient with bacterial keratitis and discusses the etiology, differential diagnosis, classification and risk factors associated with the condition.

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Introduction

Bacterial keratitis (corneal ulcer) is a sight-threatening contact lens complication. Either untreated or severe bacterial keratitis may result in perforation and endophthalmitis. Contact lens wear is the main risk factor, and sleeping in contact lenses is the major risk factor among contact lens wearers. Estimates put the number affected annually by bacterial keratitis in the U.S. at 30,000 and higher.

A corneal ulcer is defined by a corneal infiltrate associated with an overlying epithelial defect. Corneal ulcers generally occur when the normal eye’s natural resistance to infection has been compromised from either trauma or...
contact lens wear. Bacterial infection accounts for approximately 90% of microbial keratitis. Microbial keratitis increased in prevalence following the introduction of soft lenses in the 1970s. The most common pathogens implicated are staphylococci and pseudomonas. While most corneal ulcers in North America are bacterial in origin (accounting for approximately 90% of cases of microbial keratitis) and are most often caused by contact lens wear, trauma (often fungal) is the leading cause of ulcers in developing countries.

Case report

A twenty-six-year-old female presented to our clinic on May 21, 2009 with a painful right eye which was swollen shut. The patient had been seen in our clinic for routine eye exams in 2006 and 2007 and was a wearer of contact lenses (O2 Optix –2.75 D OU, BC 8.6 DIA 14.2). She had been referred back to us by her family physician, who believed she had either a foreign body trapped in her right eye or a corneal ulcer. The patient had slept in her contact lenses the previous night. She denied using water either to clean or to store her lenses and claimed to have changed her multipurpose solution fortnightly. There was no history either of swimming with the contact lenses or of injury to the eye involving vegetation.

The young woman’s ocular and medical history was negative, and she denied either taking medication or having allergies. Her presenting visual acuity was 20/20 in each eye with glasses at distance. Slit lamp evaluation revealed diffuse conjunctival injection and a small circular epithelial defect with underlying stromal inflammation. The condition is due to a reactivation of Herpes zoster virus (HZV) and migration to the first division of the trigeminal nerve to the skin and eye. Herpes zoster keratitis is most common in the aged and the immunocompromised.

— Marginal keratitis is a reaction to staphylococcal exotoxins. Marginal keratitis generally occurs with coexisting conditions of either blepharitis or ocular rosacea and is usually accompanied by multiple subepithelial marginal infiltrates separated from the limbus by a clear zone. The condition is often bilateral and recurrent. Corneal staining is also possible. Conjunctival injection is usually localized.

The patient’s skin was clear, and she had neither dendrites nor pseudodendrites on her cornea. There was no history of either “cold sores” or an immunocompromised state. She had not used either tap water or saline instead of multipurpose solution to clean her contacts. The ulcer was round with neither feathery borders nor a ring shape, and the pain seemed proportional to the size of the disturbance. There was no history of either blepharitis, acne rosacea or an eye injury involving vegetation. The patient had slept in her lenses and was exhibiting the classic signs and symptoms of contact-lens-related microbial keratitis (CLMK). The patient was diagnosed with bacterial keratitis.

A drop of Cyclopentolate 1% was instilled in the right eye to help to control pain and to prevent synchiae formation. With a letter explaining her condition, the patient was sent to Western Hospital Emergency Department for treatment.

In the emergency room, the diagnosis of a corneal ulcer was confirmed and Vigamox was prescribed: one drop in the right eye every two hours. A follow-up was scheduled in the ophthalmology department for the next day.

Follow-up #1

The patient was seen by staff at Western Hospital Ophthalmology on May 22, 2009. Her presenting visual acuity with spectacle correction for distance was 20/20 OD and OS. Pupils were equal and reactive to light and accommodation. Slit lamp examination revealed a small corneal infiltrate with mild staining overtop. There was marked improvement in the patient’s condition and the dose of Vigamox was subsequently reduced to one drop four times daily for two days. The small ulcer was attributed to contact lens noncompliance, and she was instructed not to wear contact lenses until her follow-up in one week.

Follow-up #2

The patient returned to Western Hospital Ophthalmologist on June 15, 2009. (Unclear is why, after one week, the patient had not returned as scheduled.) The attending ophthalmologist instructed the patient never to sleep in her contact lenses and informed the patient of the risks of
contact lens noncompliance. The examination was
unremarkable, and “eyes all clear” was written in the
record. Neither was the ulcer present nor were
the symptoms of discharge, redness and pain from the 1st visit.

Discussion

Contact lens-related microbial keratitis (CLMK) is a severe
and potentially blinding condition requiring urgent treatment
to contain damage and to improve prognosis.5,6,10,11 Microbial
keratitis affects approximately 5 in 10,000 wearers.1 (One
2010 study gives data of more than double that.)12 The use
of contact lenses overnight is the single most common risk
factor in the developed world.6,9

There are approximately 125 million contact lens wearers
globally.7 Corneal ulcers are a major cause of vision loss
worldwide.8 Considering the large number of contact lens
wearers, there are important public health consequences
for microbial keratitis and other deceptively rare diseases
with significant morbidity.4

Though the introduction of silicone hydrogels has allowed
physiological levels of oxygen to reach the ocular surface,
the incidence of corneal ulcers has not dramatically
decreased.3,4,9,17,20 In fact, there has been an upward trend
in ulcers in the U.S.4

Mechanism behind ulceration

Although progressive research continues to make inroads
into a fuller understanding of the mechanism of
ulceration,20 several factors play a role in contact-lens-
related keratitis. They include bacterial adherence to the
lens, formation of biofilm on the lens and in the storage
case, resistance of microorganisms to disinfection systems,
stagnation of tear film behind contact lenses and reduced
resistance of the cornea to infection.9,20

In bacterial keratitis, bacteria accessing the corneal
stroma cause damage and an inflammatory response which
result in loss of transparency.3 Although some bacteria can
invade a healthy cornea, most enter through either an
abnormality or a defect in the corneal surface.10

Corneal ulceration is mercifully less common than the
presence of bacteria on ocular surfaces.11,20 Clearly, under
normal conditions, the cornea’s countermeasures are highly
effective against invaders.3,20 Hypoxia may increase bacterial
binding, compromise corneal integrity and impair wound
healing.4 These effects are reduced but not eliminated with
silicone hydrogel lenses.3 Hypoxia, which is unlikely to be
the sole factor in corneal ulceration, is most likely a
contributor.3

Changes to ocular surface biochemistry underneath the
contact lens may be why contact lens wearers are more
susceptible to infection.20 Interaction with contact lenses
can override the cornea’s defence mechanism and increase
the rate at which pathogens adhere to the ocular surface
and allow progression to microbial keratitis.3,9,17,20 The
adhesion of bacteria to contact lenses is considered a major
risk factor for serious corneal problems (particularly
Staphylococcus epidermis and Pseudomonas aeruginosa).17,20
Contact lenses are a suitable surface for bacterial adhesion
and biofilm formation.20 They sustain a large quantity of
organisms in prolonged contact with the cornea.9,17 Pouchier
contact lenses are surfaces are prone to more extensive
bacterial adhesion and microbial colonization from
imperfections in the lens surface, where deposits may
form.17 Gram negative bacteria may survive at the upper inner
rim of the case where, due to the air-liquid interface,
biofilms have a higher likelihood of occurring.7 Therefore, a
patient making contact with that area of the case while
handling a lens before its insertion may be severely
reinfecting the lens.7

Contamination of the contact lens case has been
associated with microbial keratitis.9 The case has been
shown to be more heavily contaminated than either lens
or solution.7 The same strains have been isolated from a
corneal ulcer and the contact lens case.7 Level of
contamination is associated with the age of the lens
case.4 The elimination of “rub and rinse” may decrease the
amount of microorganisms removed in the cleaning process
and create a “carry-over effect” (from lens to case) which
allows the remaining pathogens to form a biofilm in the case
and to increase their virulence and rate of survival.7,9,10,20

Contact lens wear seems to reduce tear exchange; the
mean elimination rate in eyes wearing conventional contact
lenses is about half of that observed in normal non-wearers
of contact lenses.9,20 However, silicone hydrogels may allow
significantly higher levels of tear exchange than conventional
lenses.21 The impact of tear exchange on the risk of
microbial keratitis is not fully understood.3,20,21

Risk of contact lens microbial keratitis varies widely with
the type of contact lens and pattern of wear.19 The rate of
progression of microbial keratitis is dependent on the
virulence of the offending pathogen and host factors.10,11
Pseudomonas aeruginosa, one of the more common
pathogens in CLMK, is highly destructive and difficult to
neutralize because of its virulent structure, adaptability
and high rate of survival under different conditions.3,20
Another highly common pathogen in CLMK, staphylococcus,
may account for 45% of all bacterial keratitis.11,17

The role of laboratory culture

Because no clinical features of microbial keratitis may be
considered pathognomonic, the identification of the
pathogen is critical.1 In the U.S., the most common practice
begins treatment empirically and only investigates the
offending pathogen if initial treatment fails.1,2,10 One U.S.
study has shown that approximately half of American
ophthalmologists routinely culture and only 17.5% of
gram stain.16 The same study showed that only 13% perform
cultures more than fifty per cent of the time.16

A restrained approach to cultures may be justified when
we consider that over 90% of ulcers in the U.S. are bacterial
in nature and respond to antibiotics.2 The policy that all
ulcers be cultured before treatment be initiated is, for
practical reasons of time and cost, not followed by most
specialists.2,22 Before initiating treatment, cultures are
indicated in either sight-threatening or severe keratitis.10
Smears and cultures are indicated either when the infiltrate
is large, when it is central, when there is no response to
broad spectrum antibiotics or when the observation of
atypical clinical features suggest a more exotic pathogen (such as either fungus or acanthamoeba). Cultures can also decrease toxicity by eliminating the use of unhelpful medications. Culture yields can be improved by avoiding anaesthetics with preservatives. Cultures of either the contact lens, its case or the solution may also be helpful. The best approach is to culture and to treat lesions as potentially infective.

Management

CLMK is assumed to be bacterial until proven otherwise. The goal of treatment is the rapid eradication of the pathogen. Currently the “gold standard” of treatment for corneal ulceration is the use of third generation antibiotics: either cefazolin 5% and tobramycin 1.3% or monotherapy with second generation fluoroquinolones (either ciprofloxacin or ofloxacin). Frequency of re-evaluation depends on severity of disease but microbial keratitis should initially be monitored on a daily basis. If pain decreases and the epithelial defect, in irritable size and anterior chamber reaction improve, the treatment may be considered to be effective. Treatment should be re-evaluated after 48 hours if there is no sign of improvement (although pseudomonas and other gram negative bacteria may show increased in ammation despite appropriate therapy within the rst 24 to 48 hours). When ulcers are either atypical or unresponsive to medication, a mixed bacterial and fungal infection should be considered. Ciprofloxacin ointment at bedtime (optionally tobramycin in less severe cases) may be useful. Cycloplegic drugs decrease synchia formation, reduce pain and manage anterior chamber reaction.

While some experts advocate the use of topical corticosteroids in concert with topical antibiotics, the value of topical steroids remains controversial. There is no conclusive evidence that corticosteroids alter clinical outcome. Consequently, the amount of corticosteroids used to achieve control of inflammation should be minimized. Subconjunctival antibiotics may be used in patients with poor compliance with topical treatment. Systemic antibiotics are rarely used but may be considered for severe infections.

Keratoplasty may be considered when aggressive microbial keratitis doesn’t respond to medical therapy. The procedure aims to eliminate the infectious disease process and to establish the integrity of the globe. The procedure offers a microbial cure rate of 90 to 100%. With the emergence of more potent antimicrobial agents, therapeutic keratoplasty is required less often. A recent study in Bahrain found that only 1% of CLMK patients needed therapeutic keratoplasty.

After their introduction in the 1990s, second generation fluoroquinolones quickly became an accepted alternative to third generation antibiotics. Ciprofloxacin was the most frequently prescribed to approximately 90% of patients in the Portsmouth study. Relative ease of dosing and higher potency are among the factors increasing interest in fourth generation fluoroquinolones, which are also without the recent resistance some bacteria have developed to Ciloxan (ciprofloxacin) and Ocuflox (ofloxacin). The suggested initial dose of either Vigamox (moxifloxacin) or Zymar (gatifloxacin) is one drop every one to two hours. In less severe cases, a regime with less frequent dosing is appropriate. Moxifloxacin and gatifloxacin both have improved potency and impede growth of organisms resistant to the second and third generation antibiotics. In a recent study, moxifloxacin and gatifloxacin were found to have lower minimum inhibitory concentrations (MIC) than fortified antibiotics and second generation fluoroquinolones. The inhibitory property of DNA topoisomerase IV reduces the likelihood that pathogens shall develop resistance to moxifloxacin and gatifloxacin. Fourth generation fluoroquinolones require two mutations to establish resistance while the second generation only needs one mutation for resistance to occur. They have better penetration of the cornea and aqueous and therefore may lead to more effective therapeutic levels and better prognosis.

One study by Hsu et al. has found that corneal specialists and comprehensive ophthalmologists by overwhelming majority (76% and 88% respectively) use fourth generation fluoroquinolones as the initial treatment of choice in corneal ulcers. Several studies have found no difference in efficacy between the fourth generation fluoroquinolones and the generally accepted alternatives. Emerging evidence of resistance to fourth generation fluoroquinolones is isolated, and they can therefore be considered just as effective as, if not more effective than, the currently accepted treatments. However, fourth generation fluoroquinolones are not yet FDA-approved for treatment of bacterial keratitis.

Risk factors, prevention and innovations in care

The problem of contact lens care is a common one; studies suggest that 40 to 70% of patients are noncompliant. Healthy contact lens wear depends on many factors. They include age, sex, lens brand, smoking habits, cleaning regime and wearing regime. Higher rates of complications were associated with men, with youth, with smokers, with longer periods of wear and with a lack of hand-washing. (Internet purchase, possibly due to attitudes and behaviours associated with it, was also recently identified as a risk.) Noncompliance with the manufacturer’s recommended frequency of replacement of contact lenses is highest among teenagers and among the wearers of non-silicone hydrogels.

Microbial contamination of contact lens case and poor contact lens hygiene are also associated with microbial keratitis. Recent studies also suggest noncompliance is a factor in corneal infections related to CL solution. Patients using hydrogen peroxide solutions were found to be more compliant with the contact lens replacement schedule, perhaps because the care regime is more complex and demanding. Daily disposables were found to be associated with the lowest rate of complications in general. They also have lower risks for severe CLMK and associated vision loss. Because neither a case nor a cleaning regime is at issue with daily disposables, their use may both reduce the risk of microbial keratitis and decrease its severity.
suggesting that daily wear decreased the risk of microbial keratitis remain controversial.  

Early treatment can limit the scarring and vision loss caused by CLMK. 

Even a slight delay in assessment and treatment can increase the risk of a poorer outcome. Recent studies show that treatment delayed by more than 12 hours increases the risk of vision loss. Therefore, timely recognition and treatment is of paramount importance. This would suggest that countries should follow the American model and expand the scope of practice of optometrists to enable more immediate access to crucial care.

Although the risk to the individual is low, the group at risk is a vital one, including the young, healthy and of working age who are at low risk of infection in the absence of overnight contact lens wear. Though lenses may be approved for overnight wear, informing patients of the associated risks of such use may decrease the incidence of corneal ulcers. Risks include the destructive nature of microbial keratitis and the potential for rapid, painful and permanent vision loss. There is evidence that overnight contact lens wearers are at greater risk of microbial keratitis especially in the early days of their wear experience. Patients should be particularly cautioned never to sleep or to nap in their contact lenses. Teenaged and young adults should be especially educated on proper contact lens procedures and the potential for complications. Demographically common behaviours such as poor hygiene, binge drinking and contact lens overuse put them at higher risk.

Confocal microscopy is a promising tool in the diagnostic arsenal and may be used in the differential diagnosis of infectious keratitis, particularly where it involves acanthamoeba and fungus. Collagen crosslinking (CXL) with riboflavin and ultraviolet-light A, has been used successfully to halt the progression of Keratoconus by increasing the biomechanical strength of the tissue and has shown potential as a treatment for severe cases of bacterial keratitis. Photoactivation of ribo avin is thought to damage the DNA of bacteria, viruses and parasites and to inactivate them. CXL may also increase the collagen defence against enzymatic degradation. This technique could potentially be used as an alternative to keratoplasty when ulcers do not respond to either systemic or topical therapy. A crosslinked cornea is also more resistant to corneal melting. Further investigation is needed to determine the role of corneal crosslinking in the treatment of bacterial keratitis. The use of this technique is not yet widespread. Due to possible cytotoxic effects, CXL should be considered only in keratitis resistant to therapy and not as a first line of treatment.

Better lens storage design, frequent replacement of the case (every 3 to 6 months) and improved hygiene may decrease the incidence of corneal ulceration. Rubbing contact lenses when cleaning should be encouraged because that method may be superior to the "no rub" alternative.

A recent study by Hua Zhu et al. found that "rub and rinse" removed bacteria more effectively than did rinsing alone, without regard to whether the multipurpose solution used or the type of contact lens. Interestingly, with "rinse only" multipurpose disinfection, a regime containing Polyquad solution removed more bacteria than did those with PHMB (polyhexamethylene biguanide), and Gatiflox was more resistant to bacterial adhesion (with rinse only) than were other silicone hydrogel lenses.

A better understanding of the mechanism behind microbial keratitis will help eye care professionals to recommend and ultimately to create better lenses and to suggest ways to decrease the risks. For the present, the taping of patients in silicone hydrogels and daily disposables while absolutely advocating against sleeping in the lenses appears to be the best form of prevention.

Conclusions

This case of bacterial keratitis demonstrated how rapid diagnosis and effective management in the initial stages of the condition resulted in quick resolution and prevented vision loss. Continued research into the pathogenesis of bacterial keratitis as well as patient education on proper contact lens procedures will hopefully decrease the incidence of this potentially devastating infection.

References


