Management of Acute Conjunctivitis in School-Aged Children

Pediatric ophthalmologists participating in presentations or informal discussions with pediatricians and school nurses on the topic of conjunctivitis in children are frequently asked when children diagnosed as having acute conjunctivitis can return to school. Their response to this question impacts the health of these children and their classmates, and may require their parents to juggle their work schedules and childcare arrangements. The *Red Book* (Pickering LK, Baker CJ, Long SS, McMillan JA, eds. *Red Book: 2006 Report of the Committee on Infectious Diseases*, 27th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2006) provides a general guideline, recommending that, “Except when viral or bacterial conjunctivitis is accompanied by systemic signs of illness, infected children should be allowed to remain in school once any indicated therapy is implemented, unless their behavior is such that close contact with other students cannot be avoided.” The latter part of this statement is certainly open to interpretation.

In this issue of the *Journal of Pediatric Ophthalmology & Strabismus*, Ohnsman attempted to use current state health department recommendations to establish uniform criteria for getting children back to school. Unfortunately, she found tremendous variation in state requirements and could not reach a conclusion. On reviewing the epidemiology of acute conjunctivitis in children and the new therapies available, Ohnsman proposes an excellent treatment plan. It is clear that the literature supports excluding children with conjunctivitis from school until they are asymptomatic. Now that clinical cure can be obtained within 24 hours of treatment following the use of a fourth-generation fluoroquinolone, the decision may be easier. If the signs and symptoms disappear, children most likely had bacterial conjunctivitis and can return to school immediately, often within 24 hours of treatment. If the signs and symptoms persist, the infection is most likely viral and return to school should be delayed, as these children are more likely to remain contagious. These proposed guidelines may help to prevent epidemics of acute conjunctivitis among school-aged children.

The article also reviews the literature on the fourth-generation fluoroquinolones, which include gatifloxacin and moxifloxacin. Ohnsman highlights some of the perceived advantages of moxifloxacin for children.

I think this article makes a significant contribution to the decision-making process regarding the treatment of acute conjunctivitis in children. It is now easier to respond about when a child can return to school.

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