the ocular surface and prevent and treat cicatrization and conjunctival and corneal defects.[282, 283]

Sebaceous Carcinoma

When a diagnosis of sebaceous carcinoma is confirmed by an eyelid biopsy, excision is indicated. The excision should be performed by a surgeon experienced in the treatment of eyelid tumors, and adjunctive therapy should be used as needed for any residual pagetoid component.[284] If uncertainty in labelling, handling, or processing of the specimen exists, prior discussion with the pathologist who is to prepare and read the specimen is beneficial.

Ocular Surface Squamous Neoplasia

When a diagnosis of ocular surface squamous neoplasia is confirmed by biopsy, treatment may consist of local excision with cryotherapy to the edges[285] and/or topical chemotherapeutic agents (mitomycin-C or fluorouracil). Interferon, an effective topical therapy for ocular surface squamous neoplasia, is no longer manufactured.[286] Some studies have indicated that topical chemotherapeutics alone may completely lead to resolution of the malignancy. The optimal treatment should be tailored to the patient/tumor needs and be done by an experienced specialist.[287] Anterior segment optical coherence tomography may facilitate diagnosis and follow-up for patients with ocular surface squamous neoplasia.

Adenoviral Conjunctivitis

The majority of cases of acute, infectious conjunctivitis in the adult population are viral and self-limited; these cases do not require antimicrobial treatment. Patients with adenoviral conjunctivitis need to understand that the condition is highly contagious and that this is a hearty virus that can survive for many weeks on a countertop or similar surface if careful disinfection doesn't occur. Because of its ability to infect multiple members of a family, classmates at school, or staff or clients at work, this infection is often termed epidemic keratoconjunctivitis (EKC).[288] The patient should be educated about measures that will help reduce the spread of this infection[6] and encouraged to make every attempt to minimize contact with other people for 10 to 14 days from the onset of symptoms in the last eye affected.[289]

To minimize spread within the clinic, consider an abbreviated exam in a dedicated exam room with limited physical interaction. Physical exam may include swollen and tender preauricular or submandibular lymph nodes. Slit-lamp exam should focus on identifying membranes or pseudomembranes, corneal epithelial defects, dendrites, filaments, or infiltrates. Depending on exam findings, follow-up might be a couple days to 1 to 2 weeks. The clinician is often asked for advice on how to balance public health concerns and work/school requirements. This can be a particularly difficult issue for patients working in health care, food service, or sales.[290] Some occupations allow for work at home or from the privacy of an individual office or similar setting.

There is no proven effective treatment for eradication of adenovirus infection; however, artificial tears, topical antihistamines, topical steroids, oral analgesics, or cold compresses may be used to mitigate symptoms. The use of antibiotics in the management of this viral infection should be avoided because of potential adverse treatment effects.

Topical corticosteroids are helpful to reduce symptoms and may reduce scarring in severe cases of adenoviral keratoconjunctivitis with marked chemosis or eyelid swelling, epithelial sloughing, or membranous conjunctivitis. Close follow-up is warranted for patients with adenoviral conjunctivitis who are being treated with corticosteroids. In an animal model of adenoviral conjunctivitis, administration of topical corticosteroids led to prolonged viral shedding.[291] It is not known whether this is the case in humans. Because of its broad antimicrobial spectrum, povidone-iodine has been investigated as a treatment consideration.[292] Off-label use of topical ganciclovir 0.15% ophthalmic gel has been investigated for the treatment of EKC and has shown potential benefit against specific adenovirus serotypes, but further efficacy on a larger scale needs to be demonstrated before definitive recommendations can be made.[293] For patients with membranous conjunctivitis, debridement of the membrane can be considered to prevent corneal epithelial abrasions or permanent cicatricial changes (e.g., foreshortening of the conjunctival fornix).