**Ophthalmology and Visual Sciences** 



# Rosacea

Category(ies): Cornea, External Disease

Rosacea, sometimes referred to as acne rosacea, is a chronic dermatologic condition characterized by sebaceous gland dysfunction of the face, neck, and shoulders. Patients may experience vasomotor lability and facial flushing with consumption of alcohol, hot beverages, spicy foods, or other substances. Rhinophyma is a characteristic sign, but may not be present until late in the disease. Ocular manifestations are present in 50% of cases. They include recalcitrant blepharitis, meibomian gland dysfunction, telangiectasia of the eyelid margin, and recurrent chalazia. Longstanding ocular surface inflammation can result in chronic conjunctivitis, episcleritis, iridocyclitis, keratitis, marginal corneal infiltrates, or corneal ulceration. The keratitis associated with rosacea is most commonly inferior, presumably due to the accumulation of inflammatory cytokines in the tear film above the lower lid. It results in the formation of broad, "spade-shaped" pannus with vessels extending into gray or white peripheral stroma, occasionally with subepithelial infiltrates at the leading edge. Findings are usually bilateral, but may be asymmetric.

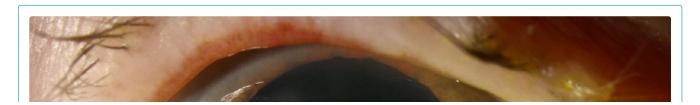


Figure 1a: Bilateral rosacea keratitis with inferior pannus formation and Salzmann-like changes. Also note the irregular lid margins with marked telangectasia and abnormal meibomian gland secretions. There is also prominent anterior blepharitis.

Contributor: <u>Jesse Vislisel, MD</u> Photographer: Carol Chan, CRA







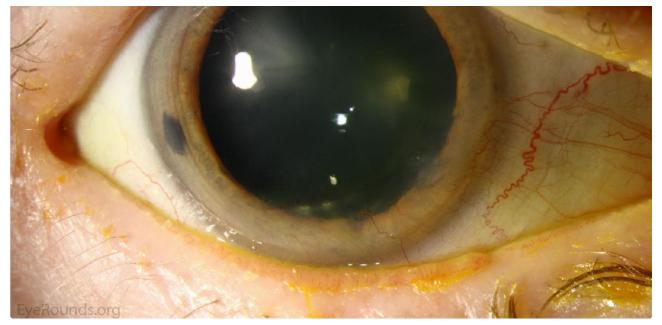


Figure 1b: Bilateral rosacea keratitis with inferior pannus formation and Salzmann-like changes. Also note the irregular lid margins with marked telangectasia and abnormal meibomian gland secretions. There is also prominent anterior blepharitis.

Contributor: <u>Jesse Vislisel, MD</u> Photographer: Carol Chan, CRA

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Figure 2: Corneal ulcer secondary to ocular rosacea

Contributor: Justin Risma, MD

Photographer: Cindy Montague, CRA

This 60-year-old male was referred due to progressive peripheral corneal ulceration. He was noted to have an inferior peripheral corneal epithelial defect with 70% underlying stromal thinning. There was a sterile-appearing infiltrate surrounding the ulcer and peripheral corneal neovascularization. He was also noted to have marked eyelid margin inflammation and telangiectasias, meibomian gland

inspissation, and facial erythema and telangiectasias, consistent with ocular and facial rosacea. He was treated with oral doxycycline, oral fish oil supplements, warm compresses, preservative-free artificial tears every two hours, and a topical fluroquinolone four times daily. His epithelial defect healed and the area scarred without further progression.

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Figure 3: Facial lesions and rhinophyma associated rosacea.

Contributor: William Charles Caccamise, Sr, MD



- Krachmer, Jay H., Mark J. Mannis, and Edward J. Holland. Cornea. St. Louis, Mo: Mosby, 2011.
- Akpek EK, Merchant A, Pinar V, Foster CS. Ocular rosacea: patient characteristics and follow-up. Ophthalmology. 1997 Nov;104(11):1863-7. PubMed PMID: 9373118.

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## Address

University of Iowa Roy J. and Lucille A. Carver College of Medicine Department of Ophthalmology and Visual Sciences 200 Hawkins Drive Iowa City, IA 52242

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