Herpes simplex virus (HSV) blepharoconjunctivitis is characterized by a vesicular rash, tender preauricular adenopathy, and follicular conjunctivitis. It is important to realize that the classic vesicular rash is frequently crusted over by the time the patient is evaluated. The clinical findings may be much more subtle than those seen in Figure 1.

HSV corneal infection most commonly presents as a dendriform epithelial keratitis. Fluorescein dye reveals the extent of the corneal surface affected (Figure 2) whereas Rose Bengal (or lissamine green) identifies actively infected epithelial cells at the leading edge of the infection. Sensation is usually markedly reduced in the affected portion of the cornea.

HSV infection of the corneal stroma (stromal keratitis) is the most common cause of infectious corneal blindness in the United States (Figure 3). Because this disease can present in a number of different patterns and without a prior history of HSV ocular disease, clinicians must have a high index of suspicion that any form of corneal inflammation or scarring may be due to HSV.

Patients with a history of atopy appear to have a greater risk for recurrent and severe herpes simplex virus (HSV) ocular disease, and this severity may manifest in different forms (Figures 4 and 5). Furthermore, these patients often require more aggressive antiviral therapy than do patients without atopic disease.

Antiviral agents are used to treat HSV lid disease, conjunctivitis, and epithelial keratitis. Systemic medications, such as acyclovir (400 mg by mouth, 5 times/day), are as effective as topical agents and are generally better tolerated. Stromal keratitis and iritis also require the use of topical corticosteroids, which should never be used without antiviral coverage.

Because HSV keratitis can lead to blindness, all patients with any manifestation HSV infection in or around the eye should be promptly referred to an ophthalmologist.