

BC ICS Dry Eye Prescribing Guidelines for Adults (18+) only

Version	1.4
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Agreed by:	BC ICB JFG
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Target Audience:	Primary & Secondary Care, ICS Medicines Optimisation Teams, Community Pharmacy & Optometrists (Optical Practices)

Date Reviewed	Reviewed by	Comments	Version	Actioned
December 2024	Annabel Smith	Review of former Dudley CCG / DFGFT / Dudley LOC Dry Eye Prescribing Guidelines Published March 2019 Removed discontinued products & checked pricing (Dec 24)	1.1	Discuss with RWT, Sandwell & Walsall Trusts
January -June 2025	Document co-authors	Agreements of eye drops used for each stage of Dry Eye Syndrome. Tables throughout document moved to Appendices to ensure updates can be carried out when required.	1.2	Document sent out for wider consultation (July/August 2025)
September 2025	Document co-authors	Full review of Dry Eye Pathway by LOC & CUES – Updated pathway Black Country Stakeholder engagement carried out for 1 month (primary including	1.3	Document sent to co-authors for final review

		<p>general practice, community pharmacy and optical practices and secondary care)</p> <p><i>Review of comments from:</i></p> <p>*Dr Anna Stone (BC ICB Prescribing Lead)</p> <p>*Navid Iqbal and Hanadi Alkhder (Birmingham and Solihull ICB Medicines Management Team)</p> <p>*Shamina Asif (Dudley Local Optical Committee Chair)</p> <p>*Wasim Sarwar (Clinical Lead and Head of Professional Development, Primary Eyecare Services)</p> <p>*Birmingham and Midlands Eye Centre (BMEC)</p>		and send to BC JFG.
November 2025	Document co-authors		1.4	To go to JFG January 2026

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Dry Eye Syndrome

'Dry eye is a multifactorial disease of the ocular surface characterised by a loss of homeostasis of the tear film, and accompanied by ocular symptoms, in which tear film instability and hyperosmolarity, ocular surface inflammation and damage, and neurosensory abnormalities play etiological roles¹.

It is accompanied by increased osmolarity of the tear film and inflammation of the ocular surface causing a range of symptoms from mild, moderate, severe to sight threatening.

There are two types of dry eye syndrome that often overlap and coexist, they are:

Aqueous Deficient - reduced aqueous secretion from lacrimal glands causing a reduced tear volume
Evaporative Dry Eye (more common) - increased tear evaporation, most often due to a deficient lipid layer in the tear film².

The key features of dry eye syndrome are:



Symptoms patients typically present with:



- Feelings of dryness, grittiness, foreign body sensation, burning and stinging sensation, red eyes, staining of cornea with fluorescein, or soreness in both eyes, which get worse throughout the day



- Eyes water, particularly when exposed to wind, and reflex tearing or blurring whilst reading or driving



- Eyelids stuck together on waking or difficulty opening eyes
- Excess mucous or stringy clear or white discharge

See [Appendix 4](#) for further information on symptoms as this list is not exhaustive.

Common Causes of Dry Eye

It is an extremely common eye condition and has a wide range of causes, including:



Dry eye syndrome prevalence: 8.4% of participants younger than 60 years have dry eyes and 19% of those aged more than 80 years²; it is 50% more common in women than in men and a frequent complaint in post-menopausal women and rheumatoid patients.

For a full list of underlying conditions associated with aqueous dry eye syndrome see [Appendix 6](#) and evaporative dry eye syndrome see [Appendix 7](#).

General Management in Primary Care at presentation:

BC ICB has a designated pathway of care for those who have dry eye symptoms. This includes when patients visit the GP, pharmacy, or via self-care by signposting to the [Community Urgent Eye Care Service \(CUES\)](#)³.

The patient can be seen in the community for dry eyes through two avenues:

Dry Eye Pathway 1- Standard eye test at Optical Practice

If during the sight test the patient has been diagnosed with dry eyes using the oxford grading scale, the optometrist can recommend self-care. If the dry eyes, are moderate to severe, they can complete a request to the GP requesting that treatment is continued as specified in [Appendix 2](#).

Dry Eye Pathway 2- If a patient has acute eye related symptoms, they can be signposted to the Community Urgent Eye Care Service (CUES) which is a symptom-based service. After the consultation, the patient may be diagnosed with dry eyes from the presenting symptoms.



Figure 1: Primary Eyecare - Urgent Eyecare Service

What (acute) symptoms can be treated by the Community Urgent Eyecare Service?

- Red or painful eye or eyelids
- Foreign body in the eye
- Gritty eyes
- Recently occurring flashes and floaters
- Recent and sudden loss of vision

This is an NHS service provided by accredited optometrists (in community- optical practices).

If the patient is diagnosed with dry eyes, the practitioner will then follow the dry eye pathway outlined below.

Please be advised that this service does not include eye or sight testing for glasses and is not available as a walk-in service.

CUES is a symptom-led health check that must have an appointment booked in advance.

Protocol for issuing an NHS written order from CUES

For eligible patients who have moderate or severe dry eyes:

1. The diagnostic work up must be noted under the comments section of the NHS written order (see below), i.e. the severity of dry eye along with the Oxford grading (of corneal and conjunctival staining) score.
2. Ensure the drops are prescribed in line with treatments listed in [Appendix 2](#).

The patient doesn't have to pay because he / she

is under 16 years of age

Any additional information or comments to be added to either the written order or the private prescription

Please read instructions carefully, dispose of your used medication responsibly and do not share your eye medication with anyone else. Consult your optician or GP if you have any questions.

How should we send the prescription / written order? The order will be available for download following submission of assessment.

I will print it out Send to Patient Email or NHS NET

Back Next

Figure 2: Additional information required on an NHS written order

3- The patient is to take the NHS written order to a participating community pharmacy so the initial treatment can be dispensed.

CUES Written Order

Private & Confidential

2025-09-25

TO THE PHARMACIST

GP Practice Name GREAT BRIDGE P/SHIP FOR HEALTH
SAI SURGERY10 SLATER
ST.GREAT BRIDGETIPTONWEST
MIDLANDSDY4 7EY

Patient First Name SANDWELL
Patient Surname XXTEST
Patient Date of Birth 01-01-1900
Patient Address 599 BEAROOWD ROAD
Waiting for population
Waiting for population
B66 4BJ
NHS Number Waiting for population
Patient Telephone 00000000000

Drug name	Dose	Duration	Eye(s) to treat	Frequency
Carbomer 980 Eye Gel 10g	One drop	7 days	Both Eyes	Four Times a day

Treating Clinician WASIM SARWAR
Clinician GOC 01-00026

Practice Address PRIMARY EYECARE SERVICES LTD. UNIT 2.3. WAULK MILL, AFW

Comments: Add in here about the severity of dry eye along with the Oxford grading (of corneal and conjunctival staining) score and other relevant findings linked to the dry eye.

Electronic signature:
WASIM SARWAR

Wet ink signature:

This document has been produced electronically from within an NHS approved patient management system. If you require further details please contact the named clinician above.
Written Order in accordance with Section 5 of Schedule 5, article 11(1)(a) of Statutory Instrument 1997 No 1830 as amended by Section 8 of Statutory Instrument 2005 No. 78.

The medication prescribed on this form may be supplied under the NHS from pharmacies participating in the NHS Community Pharmacy Dispensing Service for Community Optometry Minor Eye Conditions Service.
This is free of charge except where a patient pays a prescription charge.

The patient doesnt have to pay because he / she is 60 years of age or over

Pharmacy Use Only

Evidence not seen

I declare the information I have given on this form is correct and complete. I understand that if it is not, appropriate action maybe taken. I confirm proper entitlement to exemption.

To enable the NHS to check if I have a valid exemption and to prevent and detect fraud and incorrectness. I consent to the disclosure of relevant information from this form to and by the NHS Business Services Authority, the Department of Work and Pensions and relevant Local Authorities.

Part 2: I have paid	£	I am:	The Patient	The Patient's Guardian
Signature		Date:		
Address if different from that above				

Figure 3: Example NHS written order from CUES

Protocol for requesting a repeat prescription for the patient from a CUES or sight test.

When writing to a GP to request a repeat prescription for lubricants for eligible patients with moderate or severe dry eyes, please specify the above findings to justify your request.

General Management including Secondary Care:

Dry eye is graded according to the Oxford grading scale as Mild, Moderate and Severe. In cases that are so severe, it is recommended to refer an ophthalmologist in secondary care.

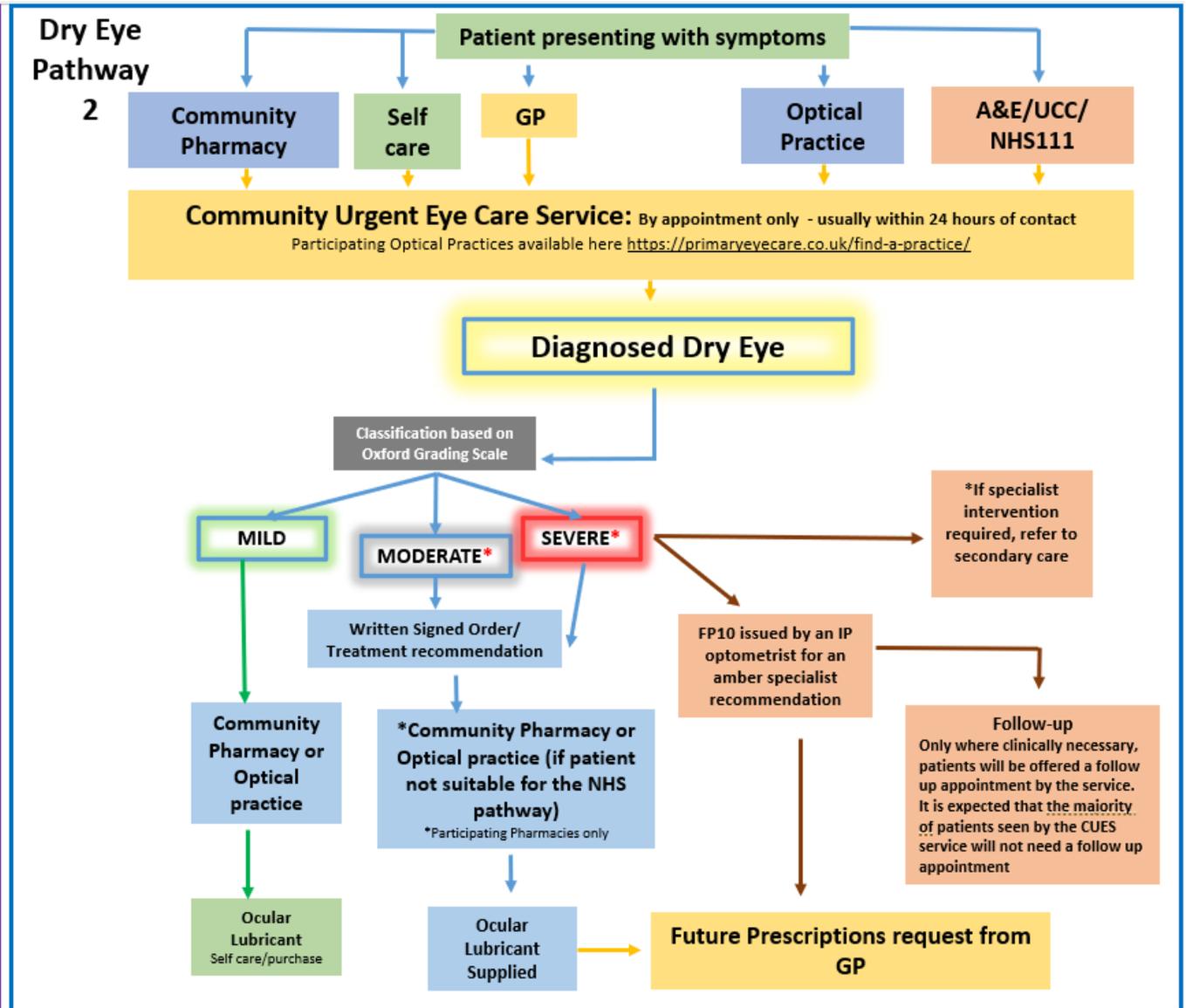
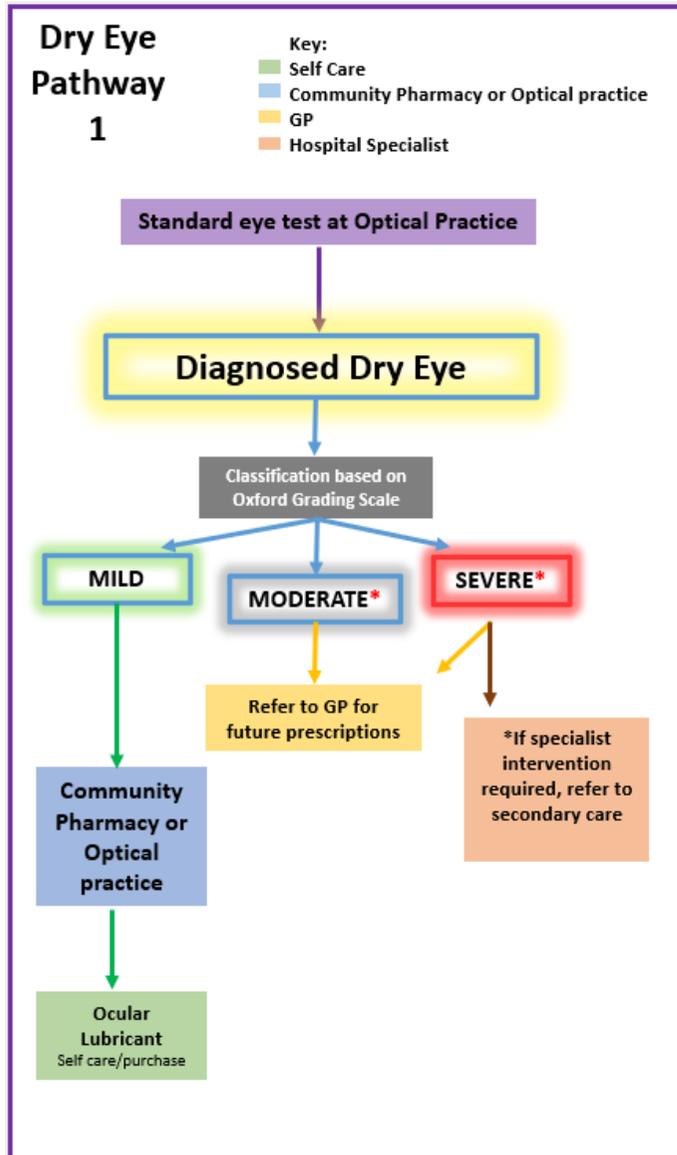
Recommendations are based on current national guidelines and relevant evidence-base. This guideline helps inform clinicians clinical judgement. However, clinicians will consider the trade-off between the benefits and harms of an intervention before making a clinical decision.

Please note: Independent Prescribing (IP) Optoms can prescribe drops that are **AMBER** recommendation (AR) on Formulary.

A full comparable chart is located in [Appendix 1](#) with treatment guidelines in [Appendix 2](#).

Type/ Severity	Mild (self-care) Refer patient to purchase over-the-counter	Moderate (signpost to CUES) If treatment failed with drops used for Mild dry eye	Severe (signpost to CUES) If treatment failed with drops used for Moderate dry eye	Ophthalmologist (secondary care) Initiation/ recommendation only
Aqueous deficient				
Evaporative (Meibomian Gland Dysfunction and lipid / tear film instability)				
Mixed Dry Eye Disease				

NHS Greener Agenda: Since 2008, the NHS has tracked and reported its carbon footprint, regularly improving its methods and monitoring our progress in meeting the commitments of the Climate Change Act⁴. NHS Black Country ICB is helping to work towards these targets set by reducing the carbon footprint for all drug therapies where possible. Unit dose vials will no longer be prescribed where there is a suitable preservative-free alternative unless clinically appropriate.



BC ICB Dry Eye Pathway

Self-care treatments for over-the-counter purchase:



• Lid hygiene measures wipe away bacteria and deposits from lid margins, mechanically express the lid glands and lead to improved signs and symptoms in the majority of individuals



- Lid hygiene -consisting of warm compresses or microwaveable blepharitis mask (e.g. MeiboPatch®, Optase™, EyeBag® or similar are commercial products available for self-purchase **if desired**), lid massage and lid scrubs) is the first line of management regardless of type of blepharitis.
- Warm compresses to loosen collarettes and crusts in anterior blepharitis and to melt meibum in posterior blepharitis (once or twice daily for 5-to-10-minute intervals)

Alternative lid hygiene methods:



- Clean eyelids using a cotton pad.
- Gently wipe along the edge of your eyelids to remove any flakes or crusts.

Carry out twice daily at first; reduce to once daily as condition improves.



- Commercial products can be purchased if desired (not on NHS prescription)

e.g. dedicated lid cleaning solutions or impregnated wipes (e.g. Blephaclean®, Blephasol® Ilast®, Ocusoft®, Optase™ etc)



- Advise the avoidance of cosmetics, especially eye liner and mascara
- Advise patient to return/seek further help if symptoms persist

Dry eye drops such as Optive Plus®, Systane Balance® or Cationorm® can be used if there is considerable staining with patients who have posterior marginal blepharitis (MGD) or anterior marginal blepharitis (Ophthalmologist recommendation only). However, first line treatment is regular lid hygiene. These drops may be more helpful for significant tear film instability than standard eye drops.

Other special agents (monitored in corneal and external diseases clinic) **Secondary care ophthalmology initiation/recommendation only**

Acetylcysteine 5% eye drops (Ilube®) *

Preservative free topical steroids drops**

Ciclosporin topical drops**

Oral tetracyclines**

**(approved by NICE for treating severe keratitis in adult patients with dry eye disease that has not improved despite treatment with tear substitutes)*

*** Duration of use to be clearly stipulated*

*** Different strengths available, % to be clearly stipulated*

Manual dexterity

If patient has difficulty administering drops due to reduced manual dexterity, consider carbomer gel. **ClinOptic®** (sodium hyaluronate 0.21%) is supplied in a pump action that some patients may find easier to use such as those with rheumatoid arthritis. Alternatively, universal eye drop aids are available for purchase to assist those individuals with reduced manual dexterity e.g. **AutoDrop®** and **AutoSqueeze™**.

Environment and other measures (See [Appendix 7](#) for more information)

Advise patients to minimise environmental and other factors that aggravate dry eye syndrome:

If smokers, try to stop as it exacerbates symptoms

Avoid air conditioning

Take regular breaks if use computer for long periods/avoid staring at the screen for long periods

Wear wrap-around glasses outside.

Omega 3 fatty acid supplements may be of anecdotal help in blepharitis (*self-purchase supplements*)⁺

Review patient's medication history
Topical and systemic antihistamines, HRT, TCAs and SSRIs can aggravate ocular symptoms.

⁺*patient should be advised that evidence of benefit is inconclusive⁵.*

Appendix 1: Dry eye syndrome comparators

Aqueous Deficiency Dry Eyes				Evaporative*
Stage	Mild	Moderate	Severe	
Discomfort	Mild	Moderate	Severe	Moderate
Frequency of discomfort:	Episodic	Episodic or chronic	Constant / disabling	Episodic or chronic
Visual symptoms	Nil/mild	Episodic / limiting activity	Constant, activity limiting & disabling	Episodic or chronic
Corneal staining with fluorescein:	Nil/mild	Variable	Marked severe punctate erosions	Variable
Conjunctival staining	Nil/mild	Variable	Moderate to marked	Variable
Oxford Grades	0-II	III	IV or greater	II or greater
TBUT (Tear break up time):	Variable	< 10 seconds	< 5 seconds	< 5 seconds
Schirmer test	Variable	10mm at 5 mins	5mm at 5 mins	Any
Tear Meniscus Height	Normal	Normal/reduced	Low	Normal or Low
Other information			Mucous filaments or clumping, increased tear debris, corneal ulceration	Signs of Meibomian gland dysfunction Lipid layer quality or quantity abnormality predominating

*Evaporative Dry Eye: Same as Aqueous Deficiency except the tear meniscus height is abnormal. The TBUT will be moderate or severely low in evaporative dry eyes. Less than 5 seconds in moderate or severe. For mild the TBUT will be variable usually greater than 10 seconds.

Appendix 2: Dry Eye Syndrome Treatments

Type/ Severity	Mild (self-care) <i>(refer patient to purchase Over-the-Counter)</i>	Moderate Signpost to the <u>Community Urgent Eye Care Service (CUES)</u> If treatment failed with drops used for Mild dry eye	Severe Signpost to the <u>Community Urgent Eye Care Service (CUES)</u> If treatment failed with drops used for Moderate dry eye	Ophthalmologist (secondary care) Initiation/ recommendation only
Aqueous deficient	<p>1st Line: Carmellose 0.5% eye drops</p> <p>2nd Line: <i>(In addition to or replacement of)</i> Carbomer 980 gel /drops</p> <p>Nighttime use options available: Xailin Night[®] eye ointment</p> <p>HydraMed Night[®] (lanolin free – for sensitive patients)</p> <p>Artelac Nighttime Gel[®] (non-ointment option)</p>	<p>1st Line: Sodium Hyaluronate 0.2% eye drops: Hy-Opti[®] 0.2% (Pump action dispenser bottle) Eyeaze[®] 0.2% (Standard squeeze bottle), or Occufresh Everyday[®] 0.2% (standard squeeze bottle with blue tip to support dose administration) <small>≠ contains phosphate buffers</small></p> <p>or Carmellose 1% eye drops</p> <p>2nd Line: <i>(In addition to or replacement of)</i> Carbomer 980 gel /drops or Systane Ultra[®]</p> <p>Nighttime use options available: Xailin Night[®] eye ointment or Hylo-Night[®]</p> <p>Hylo Night[®]</p> <p>HydraMed Night Sensitive[®] (lanolin free – for sensitive patients)</p> <p>Artelac Nighttime Gel[®] (non-ointment option)</p>	<p>1st Line: Sodium Hyaluronate 0.4% eye drops (Eyeaze[®]0.4% or ClinOptic[®]0.4%)</p> <p>Nighttime use options available: Xailin Night[®] eye ointment</p> <p>Hylo Night[®]</p> <p>HydraMed Night Sensitive[®] (lanolin free – for sensitive patients)</p> <p>Artelac Nighttime Gel[®] (non-ointment option)</p>	<p>Options available:</p> <p>HydraMed[®] TS 0.4%</p> <p>Evolve HA 0.2%* (*under active ophthalmologist only)</p>

Type/ Severity	Mild (self-care) (refer patient to purchase Over-the-Counter)	Moderate Signpost to the <u>Community Urgent Eye Care Service (CUES)</u> If treatment failed with drops used for Mild dry eye	Severe Signpost to the <u>Community Urgent Eye Care Service (CUES)</u> If treatment failed with drops used for Moderate dry eye	Ophthalmologist (secondary care) Initiation/ recommendation only
<p>Evaporative (Meibomian Gland Dysfunction and lipid / tear film instability)</p>	<p>1st Line: Carmellose 0.5% eye drops</p> <p>2nd Line: <i>(In addition to or replacement of)</i> Carbomer 980 gel /drops</p> <p>Nighttime use options available: Xailin Night[®] eye ointment</p> <p>HydraMed Night <i>Sensitive</i>[®] (lanolin free – for sensitive patients)</p> <p>Artelac Nighttime Gel[®] (non-ointment option)</p>	<p>1st Line: Sodium hyaluronate 0.15% & trehalose 3% eye drops:</p> <p>TREHAPAN[®] *ICS preferred option Thealoz Duo[®]</p> <p>2nd Line: <i>(In replacement of)</i> Optive Fusion[®]</p> <p>Nighttime use options available: Xailin Night[®] eye ointment</p> <p>Hilo Night[®]</p> <p>HydraMed Night <i>Sensitive</i>[®] (lanolin free – for sensitive patients)</p> <p>Artelac Nighttime Gel[®] (non-ointment option)</p>	<p>1st Line: Sodium hyaluronate 0.15% & trehalose 3% eye drops:</p> <p>TREHAPAN[®] *ICS preferred option Thealoz Duo[®]</p> <p>and/or VisuXL[®] Gel eye drops</p> <p>Hydroxypropyl gum (Systane Ultra[®]) drops or UDVs where required</p> <p>Nighttime use options available: Xailin Night[®] eye ointment</p> <p>Hilo Night[®]</p> <p>HydraMed Night <i>Sensitive</i>[®] (lanolin free – for sensitive patients)</p> <p>Artelac Nighttime Gel[®] (non-ointment option)</p>	<p>Options available:</p> <p>Cationorm^{®+}</p> <p><i>*For use where combined aqueous deficient and meibomian gland dysfunction present. Consider replacement of 2 separate drops with Cationorm[®] as single drop)</i></p> <p>Systane balance[®]</p> <p>EvoTears[®]</p> <p>Optive Plus[®]</p> <p>Hylo-Dual[®] Intense</p> <p>Evolve HA 0.2%* (*under active ophthalmologist only)</p>

Type/ Severity	Mild (self-care) (refer patient to purchase Over-the-Counter)	Moderate Signpost to the <u>Community Urgent Eye Care Service (CUES)</u> If treatment failed with drops used for Mild dry eye	Severe Signpost to the <u>Community Urgent Eye Care Service (CUES)</u> If treatment failed with drops used for Moderate dry eye	Ophthalmologist (secondary care) Initiation/ recommendation only
Mixed Dry Eye Disease	<p>1st Line: Carmellose 0.5% eye drops</p> <p>2nd Line: <i>(In addition to or replacement of)</i> Carbomer 980 gel /drops</p> <p>Nighttime use options available: Xailin Night[®] eye ointment HydraMed Night <i>Sensitive</i>[®] (lanolin free – for sensitive patients) Artelac Nighttime Gel[®] (non-ointment option)</p>	<p>1st Line: Sodium hyaluronate 0.15% & trehalose 3% eye drops:</p> <p>TREHAPAN[®] *ICS preferred option Thealoz Duo[®]</p> <p>Or</p> <p>VisuXL[®] Gel eye drops</p> <p>Nighttime use options available: Xailin Night[®] eye ointment Hylo Night[®] HydraMed Night <i>Sensitive</i>[®] (lanolin free – for sensitive patients) Artelac Nighttime Gel[®] (non-ointment option)</p>	<p>1st Line: Sodium hyaluronate 0.15% & trehalose 3% eye drops:</p> <p>TREHAPAN[®] *ICS preferred option Thealoz Duo[®]</p> <p>and/or</p> <p>VisuXL[®] Gel eye drops</p> <p>Nighttime use options available: Xailin Night[®] eye ointment Hylo Night[®] HydraMed Night <i>Sensitive</i>[®] (lanolin free – for sensitive patients) Artelac Nighttime Gel[®] (non-ointment option)</p>	<p>Options available: Hylo-Dual[®] Intense Evolve HA 0.2%* (*under active ophthalmologist only)</p>

More severe complications requiring secondary care include marginal keratitis; scarring; neovascularisation and pannus; mild papillary conjunctivitis. These are **AMBER** recommended in Black Country ICS

AR

Amber Specialist Recommendation: Initiation and maintenance of prescribing in Primary Care following recommendation from a specialist.

- Acetylcysteine 5% eye drops* (Ilube®)
- Preservative free topical steroids drops**
- Cyclosporin topical drops[ⓧ]
- Oral tetracyclines^{***}

* Please Note: Other unlicensed acetylcysteine formulations are **RED**

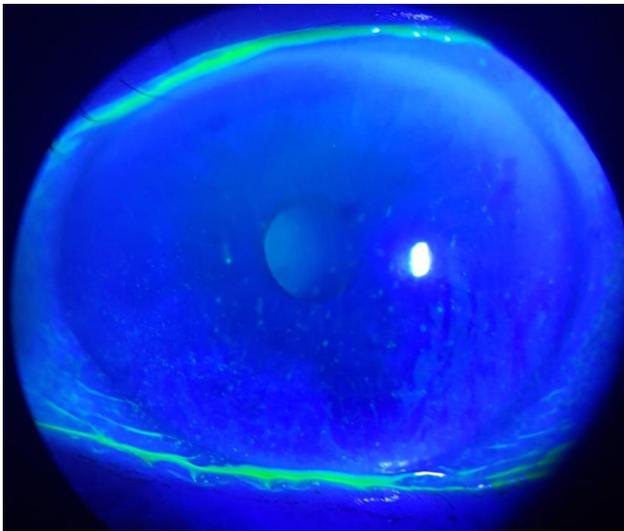
** Please Note: Duration of use to be clearly stipulated

ⓧ Please Note: different strengths available, % to be clearly stipulated

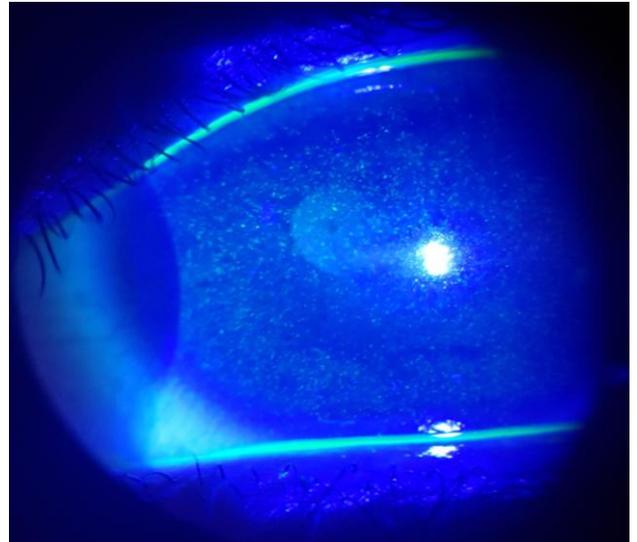
*** Please Note: Duration of use to be clearly stipulated

Appendix 3: Pictures of Corneal staining demonstrating severity of condition

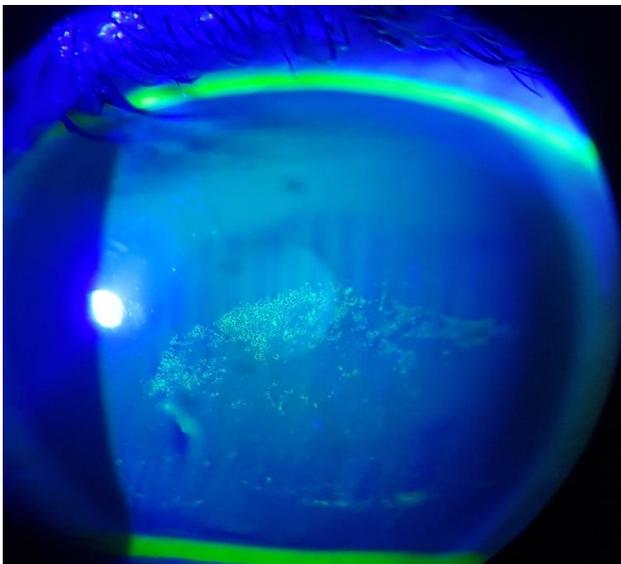
Mild



Moderate

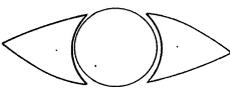
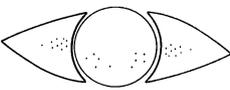
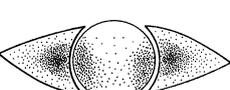


Severe



Appendix 4: Grading of Corneal and conjunctival staining

Oxford Scheme

Grading of corneal and conjunctival staining in the context of other dry eye tests					
PANEL	GRADE	DOT COUNT	LOG	VERBAL DESCRIPTOR	
	0	1	0	Absent	
	I	10	1.0	Minimal	
	II	32	1.5	Mild	
	III	100	2.0	Moderate	
	IV	316	2.5	Marked	
	V	>316	>2.5	Severe	

⁶Bron A, Evans VE, Smith JA. (2003). Grading of corneal and conjunctival staining in the context of other dry eye tests. *Cornea* 22(7): 640-50

Appendix 5: Symptoms of Dry Eye Syndrome

Symptoms	
Redness	Itchiness
Dry and Gritty	Eye pain
Discomfort/tired eyes which get worse in the day	Crusting
Mild sensitivity to light	Watery / wet eye
Sensitivity to temperature	Stinginess
Blurred vision which improves with blinking	Heavy eyes
Both eyes affected	Misdirected lashes
Difficulty opening eyes	Mucous discharge
Pain on other discomfort such as driving, reading, using a computer/ watching TV	

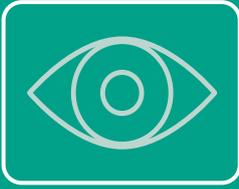
Appendix 6: Causes of Aqueous Dry Eye Syndrome/Disease

Aqueous Dry Eye Syndrome/Disease		
Sjogren's Syndrome	associated systemic diseases, e.g., rheumatoid arthritis, polyarteritis nodosa, systemic lupus erythematosus, Scleroderma and other overlap syndromes. Also occurs as primary Sjogrens.	
Non Sjogren's syndrome	lacrimal gland deficiency, age-related dry eye, inflammation, or immune related infiltration (rheumatoid and autoimmune disorders).	
Lacrimal gland obstruction	Trachoma	Erythema Multiforme
	Ocular mucous membrane pemphigoid	Chemical and thermal burns
Lacrimal gland deficiencies	Age related dry eye	Congenital alacrimia
	Lacrimal gland infiltration: Sarcoidosis, Lymphoma, Aids, Graft vs Host disease	
Hyposecretory states	Topical anaesthesia	Refractive surgery
	Trigeminal nerve injury	Neurotrophic keratitis
Systemic drugs	Antidepressants	Antipsychotics
	Anticholinergics	Antihistamines
	Chemotherapeutic agents	Anti-arrhythmic
	Antihypertensives	Antithyroid agents
	Opioid analgesics	

Appendix 7: Causes of Evaporative Dry Eye Syndrome/Disease

Evaporative Dry Eye Syndrome/Disease		
Intrinsic (direct effect on evaporation)	Meibomian gland dysfunction.	Lid aperture disorders (thyroid eye disease, ectropion, abnormal blink/ low blink rate, lagophthalmos)
	Genetically determined meibomian gland disorders	Systemic medicines: (Retinoids, Antihistamines, Oral contraceptives, Beta Blocker, Anticholinergics)
	Systemic medicines: (Retinoids, Antihistamines, Oral contraceptives, Beta Blocker, Anticholinergics)	Age related lacrimal gland deficiency
	Secondary to systemic disease (Rosacea, seborrheic dermatitis, atopic dermatitis, ichthyosis, psoriasis)	Secondary to local disease (Anterior Blepharitis, ocular surface disease)
Extrinsic (indirect effect via changes to ocular surface)	Environmental factors (Airconditioning, High velocity Wind, Low humidity)	Contact lens wearer
	Vitamin A deficiency	Ocular surface disease
	Topical medicines: Topical ophthalmic solutions especially those containing benzalkonium chloride	

Appendix 8: Blepharitis Aetiology⁸



Anterior marginal blepharitis (also known as Anterior Lid Margin Disease)

- Bacterial (usually staphylococcal)
 - Caused by:
 - (1) direct infection,
 - (2) reaction to staphylococcal exotoxin or
 - (3) allergic response to staphylococcal antigen
- Seborrhoeic (disorder of the ciliary sebaceous glands of Zeis)



Posterior marginal blepharitis

- Meiboman gland dysfunction (MGD) - bacterial lipases break down Meibomian lipids
- Meibomian secretion becomes abnormal both chemically and physically and tear film becomes unstable

Predisposing factors



Dry Eye Disease

- 50%* of people with staphylococcal blepharitis
- 25-40%* of people with seborrhoeic blepharitis
- Seborrhoeic blepharitis
- Seborrhoeic dermatitis (for example, of the scalp)
- Demodex folliculorum*: an ectoparasite that occurs normally in the lash follicles
- Long-term contact lens wear
- Ocular rosacea (a cause of posterior marginal blepharitis)



Symptoms

- Blepharitis may be asymptomatic. However, when present, the symptoms of anterior marginal blepharitis and posterior marginal blepharitis are similar:
- Ocular discomfort, soreness, burning, itching
 - Mild photophobia
 - Symptoms of dry eye including blurred vision and contact lens intolerance

Signs

Anterior marginal blepharitis (staphylococcal)

Lid margin hyperaemia	Lid margin swelling	Crusting of anterior lid margin (scales at bases of lashes)
Misdirection of lashes	Loss of lashes (madarosis)	Recurrent styes and (rarely) chalazia
Conjunctival hyperaemia	Secondary signs include: punctate epithelial erosion over lower third of cornea; marginal keratitis; phlyctenulosis; neovascularisation and pannus; mild papillary conjunctivitis	

Anterior marginal blepharitis (seborrhoeic)

Lid margin hyperaemia	Oily or greasy deposits on lid margins	Conjunctival hyperaemia
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Posterior marginal blepharitis (MGD)

Thick and/or opaque secretion at meibomian gland orifices, making it difficult or impossible to express oil by finger pressure	Foam in the lower tear film meniscus (due to excess tear film lipid)	Plugging of duct orifices with abnormal lipid leading to dilatation of glands and formation of microliths and chalazia
Conjunctival hyperaemia	Evaporative tear deficiency, unstable pre-corneal tear film	Secondary signs include interpalpebral area of cornea and conjunctiva and limbal areas

More severe complications requiring secondary care include marginal keratitis; scarring; neovascularisation and pannus; mild papillary conjunctivitis

Appendix 9: Patient Leaflet from Ophthalmology Department, DGFH

Available from: [Lid-Hyg-Bleph-Chalaz-v5-r06-2027-R-02034-SJJBMQST.pdf](#)⁷

Ophthalmology Department
Russells Hall Hospital

NHS
The Dudley Group
NHS Foundation Trust

Patient and GP Information Lid Hygiene / Blepharitis and Chalazion

Blepharitis is inflammation of the eyelid margins. There are several different types of blepharitis, but when combined with blockage of eyelid glands, it can cause a chalazion as explained below. These glands open onto the edges of the lids and produce an oil, which is an important component of the tears. This oil can become thicker in blepharitis and the glands can therefore get blocked.

You can help relieve the irritation by using some or all of the measures outlined in this information leaflet.

The treatment described will help to control your condition. It is not a cure. It can take a number of weeks before treatment starts to be effective.
Perseverance is essential.

A chalazion is a lump in the eyelid caused by a blocked meibomian gland, which typically occurs in patients with blepharitis (see below). Though treatment can include surgical drainage of the chalazion (called an 'incision and curettage'), if it has been present for a long time, is painful or limits vision and has not responded to other treatments (as described below) the chalazion will normally get better on its own over time and will usually do so quicker if managed as below. Surgical treatment of a chalazion does not cure the underlying tendency to form more lumps over time, so it's generally not an effective long-term treatment for most cases.

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The same precautions apply:

- Do use a bud once only.
- Do not dip a used bud into your solution.
- Do not use buds from eye to eye.



Antibiotic tablets / syrup (e.g. Doxycycline, Erythromycin)
These are frequently prescribed to reduce bacterial overload and to also reduce inflammation. They have effects on the thickened oil gland secretions which are commonly associated with blepharitis. Your doctor may ask you to take these for a number of months as they take time to work effectively. Please discuss any history of allergies with your doctor.

For children, a typical drug used is Erythromycin, usually 250mg twice daily for a month, and then once daily for a month (the dose is halved to 125mg in very small children). For adults who are not pregnant or who would not consider becoming pregnant in the near future, a drug such as Doxycycline 100mg once daily for a month, and then 50mg daily for up to three further months is a typical effective treatment.

These antibiotics can be seen as a way of controlling the blepharitis in the medium term – but use of a microwaveable blepharitis mask / compresses / lid hygiene will usually be needed in the longer term.

Omega 3 fatty acids
For adults with blepharitis, it may be helpful to take such supplements. If effective, results will be apparent after about three months. Flax seed oil is a vegetarian source. Most derive from fish oils, and oily fish in the diet may be helpful. These are food supplements and cannot be prescribed.

Lubricants
Where patients have dry eye symptoms, artificial tears can be helpful in some circumstances. Many drops are available, but some may work better than others and may be better in some blepharitis patients.

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Ophthalmology Department
Russells Hall Hospital

Treatment

Hot compresses

Hold a clean flannel / cotton wool soaked in comfortably hot water against the closed eyelids for five minutes. You will need to reheat the flannel in hot water, as necessary, when it cools. This melts the oils in the blocked glands. **Never share flannels with others.**

The alternative to hot compresses, often recommended in the eye clinic, is to use a device to heat the lids for longer than is achievable with a compress (microwaveable blepharitis masks). One such device is called a Meibopatch, which comes with a temperature strip on the box to check it is at the correct temperature (especially useful for children), but it is ideally kept on the eyes for six minutes, twice a day, so this requires some patience. Other examples of such devices are Optase and EyeBag. There are also moist heat USB plug-in devices which some may prefer. There are other brands and devices, all of which will be effective when used following their enclosed recommendations. They are available through chemists, opticians, directly or via the internet.

Lid massage following warming

Using a finger, firmly stroke the skin of the lids towards the lashes, e.g. downwards for the top lid and upwards for the bottom lid, or roll a pencil or similar object towards the lid margin.

Massage (as above) the whole width of the eyelids. This helps unblock the meibomian glands and expresses the oils.

Cleaning

Clean away any crusts that are present on the eyelids, particularly around the roots of the lashes, using fresh cotton buds dipped in cooled boiled water or diluted Bicarbonate of Soda. Dilute a quarter teaspoon of Bicarbonate of Soda with half a cup of freshly cooled and boiled water. Prepare a fresh solution each day. If this is not suitable for you, there are also commercially available lid wipes, foams and solutions which are effective and are easy to use. You may be asked to use very dilute baby (non-tearing) shampoo instead.

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Ophthalmology Department
Russells Hall Hospital

Currently, Systane Balance and Optive Plus are part of the formulary, and may be helpful in the oil imbalance in the tears. Other drops may be equally effective, and some trials of multiple preparations may be required to find what suits the individual.

If there is anything you do not understand, or you are concerned or worried about any part of the treatment, please contact The Urgent Referral Clinic team.

The **Urgent Referral Clinic** team at Russells Hall Hospital Eye Clinic:
01384 456111 ext. 3633 (9am to 4.30pm, Monday to Friday) on 01384 456111 ext. 3633 (9am to 4.30pm, Monday to Friday)

Eye emergency, out of hours

In case of an eye emergency after the closing hours of the Eye Clinic (including weekends and bank holidays), please contact the eye doctor on call by ringing the switchboard at:

Birmingham and Midland Eye Centre on 0121 507 4440
The doctor on call is usually based at the Eye Centre, City Hospital, Dudley Road, Birmingham. They may need to call you back, and if necessary, they will arrange for you to visit them.

Note: The information in this booklet is provided for information only. The information found is **not** a substitute for professional medical advice or care by a qualified doctor or other health care professional. **Always** check with your doctor if you have any concerns about your condition or treatment. This is only indicative and general information for the procedure. Individual experiences may vary and all the points may not apply to all patients at all times. Please discuss your individual circumstances with your eye doctor.

Author: Mrs S Joseph (Ophthalmology Staff grade)
Updated: (03.2018) Mr J S Barry and Mr M Quinlan (consultant ophthalmologists)

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Appendix 10: Eye product costings for information only* See [Appendix 2](#) for Formulary Choices and please note some of the products below can be purchased over-the-counter.

Drug Name	Indications	Dose	Proprietary name	Ingredients	Excipients	Suitable with contact lenses? ⁹	Pack Size	Price* £ as per DT /dm+d Jan 2026
CARBOMERS (Polyacrylic acid) OTC	Dry eyes including keratoconjunctivitis sicca, unstable tear film	Apply 3–4 times daily or as required	Clinitas Gel [®]	carbomer 980 (polyacrylic acid) 0.2%		**Wait 30 min after use before inserting contact lenses. <small>BUT NOT RECOMMENDED</small>	10 g	£1.58
			Viscotears [®]	carbomer 980 (polyacrylic acid) 0.2%	cetrimide	*Wait 15 min after use before inserting contact lenses.	10g	£1.59
			Lumecare [®] Long Lasting Tear Gel	carbomer 980 (polyacrylic acid) 0.2%	cetrimide	**Wait 30 min after use before inserting contact lenses.	10g	£1.60
			Carbomer 0.2% eye drops	Carbomer 0.2%	benzalkonium chloride	NOT STATED	10g	£2.80
			GelTears [®]	carbomer 980 (polyacrylic acid) 0.2%	benzalkonium chloride	**Wait 30 min after use before inserting contact lenses.	10g	£2.80
			Artelac Nighttime gel [®]	Carbomer 0.2%, Medium Chain Triglycerides	Cetrimide	*Wait 15 min after use before inserting contact lenses.	10g	£2.96
			Liquivisc [®]	carbomer 974P (polyacrylic acid) 0.25%	benzalkonium chloride	**Wait 30 min after use before inserting contact lenses.	10g	£4.50
Benzalkonium chloride containing products should be prescribed by BRAND			Viscotears [®] UDV	carbomer 980 (polyacrylic acid) 0.2%		**Wait 30 min after use before inserting contact lenses.	30 × 0.6-mL	£5.42
CARMELLOSE SODIUM	Dry eye conditions	Apply as required	Carmellose UDV	carmellose sodium 1%			30 x 0.4 mL	£3.00
			Celluvisc [®] UDV	carmellose sodium 1%		*Wait 15 min after use before inserting contact lenses.	30 x 0.4 mL	£3.00

CARMELLOSE SODIUM cont.	Dry eye conditions	Apply as required	Carmize® UDV	carmellose sodium 1%		*Wait 15 min after use before inserting contact lenses.	30 x 0.4 mL	£3.00
			Carmellose UDV	carmellose sodium 0.5%			30 x 0.4 mL	£5.75
			Carmize® UDV	carmellose sodium 0.5%		*Wait 15 min after use before inserting contact lenses.	30 x 0.4 mL	£5.75
			Celluvisc® UDV	carmellose sodium 0.5%		*Wait 15 min after use before inserting contact lenses.	30 x 0.4 mL	£4.80
			Optive®	carmellose sodium 0.5%, glycerol		Y	10ml	£7.49
			Optive Plus® (for meibomian gland dysfunction)	Carmellose sodium 0.5%, Castor oil 1%, Glycerin 0.25%		N	10ml	£7.49
LIQUID PARAFFIN	Dry eye conditions	Apply as required	Xailin night®	White soft paraffin, white mineral oil, lanolin alcohols		N	5g	£2.51
			HydraMed Night®	(Vitamin A) Retinol palmitate 250iu/g, liquid paraffin, white soft paraffin, wool fat			5g	£2.38
			HydraMed Night Sensitive® (lanolin free)	(Vitamin A) Retinol palmitate 250iu/g, liquid paraffin, white soft paraffin		**Wait 30 min after use before inserting contact lenses.	5g	£2.38
			Hylo Night®	Retinol palmitate 250iu/g, liquid paraffin, wool fat		N	5g	£2.75
MACROGOLS (Polyethylene glycols) Hydroxypropyl Guar	Dry eye conditions	Apply as required	Systane® Ultra	polyethylene glycol 400 0.4%, propylene glycol 0.3%, hydroxypropyl guar		Y	10ml	£7.06
			Systane® Ultra UDV	polyethylene glycol 400 0.4%, propylene glycol 0.3%, hydroxypropyl guar		Y	30 x 0.7 mL	£6.90
			Systane® Balance	polyethylene glycol 400 0.6%		Y	10ml	£7.72

Drug Name	Indications	Dose	Proprietary name	Ingredients	Excipients	Suitable with contact lenses?	Pack Size	Price* £ as per DT /dm+d Jan 2026
SODIUM HYALURONATE	Dry eye conditions	Apply as required	Eyeaze®	sodium hyaluronate 0.2%		Y	10ml	£4.15
			Hy-Opti®	sodium hyaluronate 0.2%		Y	12ml	£4.78
			Occufresh Everyday®	sodium hyaluronate 0.2%		Y	10ml	£3.49
			Ocusan® UDV	sodium hyaluronate 0.2%		Y	20 × 0.5 mL	£5.72
			Clinitas® UDV	sodium hyaluronate 0.4%	Note Each unit is resealable and may be used for up to 12 hours	Y	30 × 0.5 mL	£5.70
			Hylo-Forte®	sodium hyaluronate 0.2%		**Wait 30 min after use before inserting contact lenses.	10ml	£9.50
			Evolve HA®	sodium hyaluronate 0.2%		Y	10ml	£6.05
			ClinOptic®	sodium hyaluronate 0.4%		Y	10ml	£4.15
			Eyeaze®	sodium hyaluronate 0.4%		Y	10ml	£4.15
			HydraMed TS®	Sodium hyaluronate 0.2%, tamarind seed polysaccharide 0.2%		Y	10ml	5.74
			Optive Fusion®	Sodium hyaluronate 0.1%, carmellose sodium 0.5%, glycerol 0.9%		N	10ml	£7.49
			Thealoz Duo®	Sodium hyaluronate 0.15%, trehalose 3%		Y	10ml	£8.99
			TREHAPAN®	Sodium hyaluronate 0.15%, trehalose 3% PF		Y	10ml	£6.75
			VisuXL®	Sodium hyaluronate 0.1%, co-enzyme Q10 0.1%, vitamin E 0.5% PF		Y	10ml	£10.30
			Hylo Dual Intense®	Sodium hyaluronate 0.2%, ectoin 2%		N	10ml	£9.95
Due to differences in chain length and viscosity the strengths do not indicate equivalence			VisuXL® UDV	Sodium hyaluronate 0.1%, co-enzyme Q10 0.1%, vitamin E 0.5% PF		Y	30 x 0.33ml	£10.30

OIL EMULSIONS	Cationorm®	Mineral oils, glycerol, tyloxapol, poloxamer 188, tris-hydrochloride, tromethamine, cetalkonium chloride	Y	10ml	£8.70
OTHER eye drops used to include those recommended by the ophthalmologist	EvoTears®	Perfluorohexyloctane	N	3ml	£9.95
	Ilube®	Acetylcysteine 5%	N	10ml	£92.75
	Ikervis®	Ciclosporin 1mg/ml	N	30 x 0.3ml	£72.00

*Pricing correct as per Drug Tariff & NHS dm+d January 2026

Black Country Formulary applicable status to this guideline:

Status	Description
GREEN (OTC)	Over the counter preparation suitable for self-care/purchase if appropriate for MILD DRY EYE . If used as an add-on to first-line options in MODERATE TO SEVERE DRY EYE can be prescribed in Primary Care.
AMBER RECOMMENDED	Amber Specialist Recommendation: Initiation and maintenance of prescribing in Primary Care following recommendation from a specialist. MODERATE TO SEVERE DRY EYE can be prescribed in Primary Care
BLACK	Non-formulary Medicines with APC/Trust DTC has actively reviewed and do not recommend for use.

End of Document