Microbial keratitis is a major cause of corneal opacity and loss of vision worldwide, and topical antimicrobial therapy is a critical component in its management. The study by Austin et al 1 found that there are regional variations in practice patterns influenced by concern over availability and toxicity versus broad-spectrum coverage and resistance. Respondents in the USA were more likely to treat with fortified antibiotics than their international peers.1 This raises some important points and questions in the treatment of suspected bacterial keratitis.

Why do some clinicians opt for monotherapy and others fortified antimicrobials? What is understood by combination therapy? What are the treatment considerations when the microbiological report says susceptible or resistant?

The clinical outcome in microbial keratitis is dependent on host factors, the virulence of the infecting bacteria and the minimum inhibitory concentration (MIC) of the antimicrobial against the respective bacteria.2–4 The MIC is used to determine susceptibility criteria in order to choose an appropriate antimicrobial for treatment.3–7 Although there is a relationship between clinical outcome and the MIC of antimicrobials in microbial keratitis, the actual MICs of the available antimicrobials against the respective isolate are seldom provided to the clinician. In addition, resistance and susceptibility are usually based on systemic breakpoint criteria rather than ophthalmic breakpoints.4 That is, the breakpoints that are used to determine resistance and susceptibility are based on the anticipated response of the bacteria against concentrations of the antimicrobial that can be achieved in serum. Clearly, the antimicrobial concentrations achieved in the cornea and aqueous humour following topical administration differ from that achieved in the serum following systemic administration. The corneal penetration and effectiveness of a topical antimicrobial agent is dependent on the physicochemical properties of the antimicrobial and structure of the cornea.8–11 In addition, the pH and protein binding of the local environment and interaction with other agents not only differ from systemic conditions but also differ in the non-inflamed to the inflamed eye added to mixing with the tear film.12–14 Furthermore, the concentration of an antimicrobial does not necessarily equate to the activity and bioavailability of the drug.15 The biological activity of an antimicrobial in the cornea is usually much lower than the chemical concentration and may be less than 10% of the instilled amount.12–15 For these reasons, the setting and use of ophthalmic breakpoints is very limited.

The comparative antimicrobial activity of antimicrobials against a particular bacterial species, however, is an important guide to selecting treatment. The fluoroquinolones are effective agents used to treat microbial keratitis.16 It is, however, important to be selective in choosing a particular fluoroquinolone for a particular bacteria. For example, for the equivalent concentration, ciprofloxacin has a better inhibitory effect against Pseudomonas aeruginosa than moxifloxacin or levofloxacin.7 The effectiveness of the fluoroquinolones against bacteria such as streptococcus and strains of staphylococci may be limited. Although the newer generation fluoroquinolones have enhanced activity against Gram-positive bacteria, these agents are not a panacea for the treatment of microbial keratitis, particularly with the emergence of resistant strains of staphylococci, streptococci and Enterobacteriaceae.17–21 As such, there is a need to consider other antimicrobials for topical administration, such as meropenem, or combination therapy.22–24

As opposed to single therapy, an antimicrobial combination offers a broader spectrum of activity and may reduce selective pressures. Either knowingly or unknowingly, ophthalmologists use combination therapy either simultaneously or
sequentially, for example, a fluorquinolone followed by chloramphenicol. This leads to an effect of indiff-
ference, addition, synergism or antagonism. Although
the use of combination therapy may increase the
spectrum, the potential benefit is to increase the
antimicrobial effect of the respective combination,
that is, an additive or preferably a synergistic effect.
For example, the combination of penicillin and
gentamicin in the treatment of enterococcal endocar-
ditis produces a synergistic effect, whereas
conversely, the combination of chloramphenicol and
penicillin in the treatment of pneumococcal menin-
gitis is antagonistic.26 It is important, therefore, to
select a combination which is either additive or
synergistic and to avoid a combination which is
antagonistic. For keratitis isolates, it has been shown
in vitro that the combination of meropenem and
ceftriaxone was synergistic in 20%–25% and either
additive or synergistic in 55%–60% of both Staphylo-
coccus aureus and P. aeruginosa keratitis isolates.22
Against S. aureus, the combinations of teicoplanin
with meropenem, ceftriaxone or moxifloxacin had
an additive or synergistic effect in more than 50% of
S. aureus keratitis isolates.22

Although there has been debate, an overriding issue
in improving the treatment of suspected microbial
keratitis is the need to sample a corneal ulcer and to
try and isolate the microorganism. Larger corneal
ulcers usually start off as smaller ulcers and the need
for a simple and readily available method for use in all
cases to identify and isolate the causative microor-
ganism(s) would be a significant advantage.29 30 This
together with adjunctive antibacterial therapy against
the bacterial toxins and virulence factors would be
significant forward steps in improving outcomes in
microbial keratitis.

There is a clear need to establish ophthalmic break-
points to aid the ophthalmologist in deciding on the
appropriate antimicrobial treatment. These would then
form the basis for author’s suggestion of a ‘well-
designed clinical trial on the treatment of bacterial
ulcers to help clinicians initiate the best treatment and
ultimately reduce morbidity.’

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