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At the Intersection of DB, DED, MGD, and Other Forms of Blepharitis

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Dr. Devries
This is a CE on ReachMD, and I'm Dr. Douglas Devries, and here with me is Dr. Cecilia Koetting, and in this episode we're going to discuss the clinical features of lid margin disease and the different forms of blepharitis.

So, Cecilia, let's start off and kind of review the clinical features and their similarities between lid margin disease and *Demodex*.

Dr. Koetting:
Absolutely. And I think that this is a really good thing to think about and just remind ourselves, right, when we talk about lid margin disease, and that can incorporate telangiectasia, so we get some blood vessel growth, we can see biofilm that's there, we can see actual scurf being more of a bacterial buildup that's there, we can start to see saponification. And then with *Demodex* blepharitis the nice thing is that you can have all of that, but you can still see collarettes, right. And as soon as you see a collarette there's no question as to what's going on. You know you've got *Demodex* blepharitis, so they overlap, and a lot of times you're going to find both in place. But I think it's important when you're trying to figure out what you're going to reach for treatment. When you see a collarette, you know you've got *Demodex* overgrowth.

Dr. Devries:
It's so interesting that you'd say that, because really until we really understood, because in DEWS I MGD lid margin wasn't even mentioned. In II it became prevalent. And now, with *Demodex* it really has made an awareness, because as anterior segment, I always felt the lid just kind of got in the way of looking at the lens and the cornea, but to really take that time, and I would say that I have seen my clinical exam change as a result of that.

Dr. Koetting:
Yeah, yeah, and mine too. I think that the other end of it too is meibomian gland dysfunction and seeing the poor expression, poor quality, the inability to get the oil out. And that is another part of the same story, but we tend to separate it into two different things, and I think that unfortunately, we shouldn't be doing that, right. I think that one is begets the other, and they're both part of, oftentimes, a lot of the same underlying causes, whether that be *Demodex*, bacteria, inflammation, right. And I think we have to remember that that's part of the story as well.

Dr. Devries:

Yeah, and I absolutely could not have said it better. When we're looking at this, it's all tied in. And so, what are some of the other comorbidities that we see with lid margin disease?

Dr. Koetting:
So a lot of signs of rosacea. I feel like I diagnose rosacea more than dermatologists do. We know that it's there, it's one of those underdiagnosed, whether that's ocular rosacea, which we tend to see signs of that before, and not forgetting to stop and look for *Demodex*, for little collarettes on the bridge of the nose, the Alpenglow sign that Laura Periman helped to teach us. That essentially if we see little collarettes on the bridge of the nose you probably have facial rosacea, and what happens if we treat the eyes but we don't treat the face.

Dr. Devries:
That's such an important point, because really the Alpenglow sign really indicates that there's *Demodex* brevis. That's our cousin that we have of the *Demodex* folliculorum. And yeah great work to Laura in discovering this. But Alpenglow is—and you see this all the time in the Rockies, I see it in the Sierras—when the sun's going down or the sun's coming up and you look at that horizon on there, you see these little things poking up called trees you really don't define, and that's Alpenglow. So really, really nice job by Laura. And I think that's an important part that's really starting to emerge, because we haven't had anything that really says 'okay this could be a brevis also.'

Dr. Koetting:
The other one is definitely my glaucoma patients, especially those who are on a prostaglandin analog, right. We know that's pro-inflammatory, it changes the pH of the skin that may make them more prone to having bacterial overgrowth or to housing a good environment for our *Demodex*.

Dermatochalasis, start talking about anything, the hooding, that might lead to a little bit more of, again, a favorable environment for these little guys.

Dr. Devries:
Well, and when we look at prevalence and we look at comorbidities and we look at glaucoma, like you said, we look at contact lens wear, we look at those patients that have, our cataract patients. We see that those comorbidities and all of those numbers seem to hang pretty close to about 60%. And then it means that if we're not having the patient look down, and sometimes even kicking up the magnification, we're going to miss those. And, I mean, there's just so many prevalence, and blepharitis still about 60%.

I mean we just see so much of this overlap. Just like you said, it's one in the same. But we need to take the time to actually look. And I think it's just a matter of habit, telling the patient to look down, look down at the table if you need to kick up the magnification and just impressing on those meibomian glands like you said because that correlation that we have with MGD, I mean that really is an indication at that point that, ah, this could be the causative agent of that.

Dr. Koetting:
Absolutely, absolutely.

Dr. Devries:
Well, Cecilia, thanks for the great discussion on this. I think that this awareness that we have over*Demodex* blepharitis has literally changed my practice in how I approach patients and it helps me solve a lot of problems and give patients a lot of comfort.

Dr. Koetting:
Absolutely.

Announcer:
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