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Catching *Demodex* in the Act

Announcer:
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Dr. Koetting:
This is CE on ReachMD, and I'm Dr. Cecelia Koetting. I'm here today with Doug Devries, and we're going to be discussing the signs and symptoms of *Demodex* blepharitis.

Let's start with an overview of its prevalence. Doug, tell us about this. What can you tell us about the condition?

Dr. Devries:
Well, I was so wrong about this years ago. And as we're getting educated on *Demodex*, I mean, I would have said, Cecilia, in my practice it was probably 8%, but I didn't know how to look for it. And once that education took place, it very much is what it should be, close to 60%. And the TITAN study shows that, and we're seeing that. I see that in my practice. I'm sure you're seeing that prevalence as well.

Dr. Koetting:
Absolutely.

What's the story with the lifecycle the *Demodex* mite? Because I think this takes something important as far as when we think about treating them.

Dr. Devries:
It absolutely is, because when you start treating this, the symptoms are going to get better pretty quick, but that's only because you've killed the active mites. You haven't killed the eggs, and what you need to do is go through that whole lifecycle and continue. And that's why treatments now will indicate 6 weeks of treatment to actually take care of all the active mites and the inactive that are eggs that haven't hatched yet. So really it's about 18 days to 20 days, but you need to follow up on that. And I think that's what happens sometimes, is patients will cut it off because they start feeling better.

Dr. Koetting:
What are some of the signs and symptoms that you look for when you're thinking of *Demodex* or early *Demodex*? What are you looking for in clinic?

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Dr. Devries:
Well, there's so much overlap with ocular surface, but there's some differentiating factors too. And the first thing I'll look for is itch to see if a patient is actually rubbing across their eyelashes. And that's real telltale when they have that, because the itch of ocular allergy and others will be focused nasally in the nasal canthus, but when they are actually touching their eyelashes, and a lot of people do this and don't even realize they do it.

Dr. Koetting:
Yeah, now one of the things I think of, and probably later stage *Demodex*, right, is when you start to a see nice red line telangiectasia and then eyelash fallout.

Dr. Devries:
No question about it. The misdirected lashes, the missing lashes, are just so prevalent on that, and patients can't figure out why. And that's why a lot of patients will actually do copious amounts of lid hygiene and take away some of the signs that we're going to be looking for as clinicians.

Dr. Koetting:
Yeah, that look down for the collarettes that we know is pathognomonic at this point, right?

Dr. Devries:
Absolutely. Absolutely.

Dr. Koetting:
Yeah. So, what are the consequences of delayed diagnosis? What's the concern? What do you say to our colleagues who say, 'Eh, do I really need to deal with this? Is this really a problem?'

Dr. Devries:

Well, and I think that's what's been so amazing about actually treating *Demodex* blepharitis, is realizing how patients have adjusted their normalcy baselines to think that it's normal, but see those improvements. And really what I see is it's contributing irritation, inflammation, and bacteria, and when that happens, it's only going to increase. And while the *Demodex* could wax and wane, it takes a slow progression that keeps on advancing if not treated. And it's just so easy to give that patient relief that it's, why wouldn't you treat it?

Dr. Koetting:
Yeah, and one of the things that we've seen and started to understand, and actually was part of a study with this, was looking at correlation between *Demodex* mite load, or essentially looking at collarette grade, right, with associated meibomian gland atrophy. And what we found was that the higher levels of the collarettes, we also found higher correlation of atrophy. Does that really surprise you?

Dr. Devries:
No, it doesn't. And I mean, when we're looking for collarettes on the lashes and seeing what the mite leaves behind, it doesn't take into account the smaller cousin brevis that can get down into the meibomian glands. And we never have had an explanation of why do meibomian glands get occluded. And I mean from a theory standpoint it makes perfectly, perfectly good sense. And also from a treatment standpoint, when you see more glands, meibomian glands yielding secretions after a course of treatment.

Dr. Koetting:
Yeah, and we were all seeing that. It's nice when you have studies that back up what you think. But we definitely were all seeing that.

Dr. Devries:
Yeah, absolutely. And I think that was impressive to look at that, and it really kind of underscores why patients feel better. If all of a sudden you increase the meibum, decrease the evaporation, it makes sense that they would feel better.

Dr. Koetting:
Yeah. A big improvement in quality of life for many people.

Dr. Devries:

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Oh, I don't think there's any question about it, and it just, and again I can't overstate, patients that think they're asymptomatic after they've been treated now feel better.

Dr. Koetting:
Yeah.

Dr. Devries:
And that speaks to that MGD (meibomian gland disease) as well.

Dr. Koetting:
Absolutely. So we know that *Demodex* blepharitis is very prevalent. We just have to make sure we're taking the time to look. The life cycle matters when we talk about treatment, and MGD is a part of this story.

So, I want to say thank you, Doug, for an excellent discussion, and we thank our audience for joining us today. See you next time.

Dr. Devries:
Absolutely. Thank you, Cecilia.

Announcer:
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