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Medical interventions for fungal keratitis

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ABSTRACT

Background
Fungal keratitis is a fungal infection of the cornea. It is common in agricultural tropical countries but relatively uncommon in developed countries. Although there are medications available, their effectiveness is unclear.

Objectives
To examine the effect of different antifungal drugs in the management of fungal keratitis.

Search methods
We searched CENTRAL (which contains the Cochrane Eyes and Vision Group Trials Register) (The Cochrane Library 2011, Issue 8), MEDLINE (January 1950 to August 2011), EMBASE (January 1980 to August 2011), Latin American and Caribbean Literature on Health Sciences (LILACS) (January 1982 to August 2011), the metaRegister of Controlled Trials (mRCT) (www.controlled-trials.com) and ClinicalTrials.gov (www.clinicaltrials.gov). There were no date or language restrictions in the electronic searches for trials. The electronic databases were last searched on 29 August 2011.

Selection criteria
We included all relevant randomised controlled trials (RCTs) on medical therapy for fungal keratitis.

Data collection and analysis
Two review authors selected studies for inclusion into the review, assessed trials for risk of bias and extracted data. Interventions were compared by the proportions of participants that did not heal after a specific time of therapy. No meta-analysis was performed because the trials studied different medications with different concentrations.

Main results
We included nine trials in this review; seven conducted in India, one in Bangladesh and one in Egypt. A total of 568 participants were randomised to the following comparisons: 1% topical itraconazole versus 1% topical itraconazole and oral itraconazole, different concentrations of silver sulphadiazine versus 1% miconazole, 1% silver sulphadiazine ointment versus 1% miconazole ointment, 2% econazole versus 5% natamycin, different concentrations of topical chlorhexidine gluconate versus 5% natamycin, 0.2% chlorhexidine gluconate versus 2.5% natamycin and voriconazole 1% versus natamycin 5%. The included trials were small and of variable quality. Differences between different regimens were not statistically different, which may reflect the low sample sizes.
Authors’ conclusions

Based on the trials included in this review, there is no evidence to date that any particular drug, or combination of drugs, is more effective in the management of fungal keratitis. The trials included in this review were of variable quality and were generally underpowered.

Plain Language Summary

Medical interventions for fungal infection of the clear front part of the eye (cornea)

Fungal keratitis (fungal infection of the cornea) occurs rarely in higher income countries but is relatively common in lower income countries. If left untreated the cornea may perforate and may lead to blindness. Although there are a number of medications available, it is not clear which is the most effective and cost-effective. This review identified nine randomised controlled trials with 568 participants using different combinations of antifungal drugs. The trials were mainly conducted in India; they were small and of variable quality. Although there were some observed differences, these could have occurred by chance; none of the studies were large enough to determine conclusively which agents work best. Further trials with a larger sample size are required in order to answer this important question.

Background

Description of the condition

Fungal infections can involve different parts of the eye and periorcular tissues including the lacrimal apparatus, conjunctiva, eyelids and bony orbit. The most common sites for fungal infections of the eye involve the cornea and the retina or vitreous (O’Brien 1997). In the past few decades there have been increased reports of fungal infections of the eye (O’Day 1996). These can be mainly attributed to increased clinical awareness and improved laboratory techniques and may also have been caused by widespread use of corticosteroids, antibiotics, immunosuppressants, chemotherapeutic drugs and ocular prosthetic devices (O’Brien 1997).

Epidemiology

Fungal keratitis or keratomycosis is relatively uncommon in developed countries. There have been no high quality published reports on the incidence rates of the disease. In the United States, it has been reported that the total number of fungal keratitis cases annually is approximately 1500 (O’Day 1996). It is, however, more common in agricultural and tropical countries. In South Florida, a nine year survey from 1968 to 1977 revealed that 133 out of 633 cases of corneal ulcers were fungal in origin (Liesegang 1980). In the Philippines, a 25 year survey on central microbial keratitis revealed a total of 430 cases (Valentino 2000). The most common etiologic agents included Fusarium, Aspergillus fumigatus and Aspergillus flavus. In Hyderabad, India, a ten year study on fungal keratitis showed 1,352 culture proven cases, the most common etiologic agents included Fusarium, Aspergillus, and Curvularia spp (Gopinathan 2002). The most common predisposing factor in fungal keratitis is trauma associated with plant material. Other risk factors include long-term corticosteroid use and immuno-compromised patients (O’Day 1996).

Presentation and diagnosis

Fungal infections almost always present in an insidious manner. The infection may be recognised within days or weeks and it is not uncommon for the traumatised epithelium to heal completely before signs of infection appear. During this latent period the patient may be asymptomatic. However, within a few days or weeks the patient might complain of discomfort, photophobia and discharge. During this period, a persistent infiltrate at the site of previous superficial trauma is present which may increase in size and density in time. The epithelium tends to heal over this inflammatory focus, although there may be recurrent episodes of epithelial breakdown. The cornea becomes slightly thickened and ‘satellite’ lesions may develop peripheral to the focal area of infiltration. If not treated, the inflammatory signs gradually progress causing permanent breakdown of the epithelium, stromal ulceration, or formation of Descemetocoele (corneal thinning). The cornea may eventually perforate. Neovascularisation may occur as a result of inflammation, which may lead to severe scarring of the cornea. Associated signs indicating the severity of inflammation include the presence of hypopyon (pus in the anterior chamber) and ciliary injection. Fungi can invade the deep stroma with great rapidity.
It is important to determine the etiologic agent of the corneal ulcer. Combined infections with bacteria and fungi or even with multiple fungi might occur. Diagnosis is usually achieved by scraping material from the base of the ulcer. Some of this material is stained for fungi and bacteria, the rest is cultured on solid and liquid media. In severe cases where diagnosis is unclear it may be necessary to take a larger corneal biopsy.

**Description of the intervention**

Management of fungal keratitis is mainly by antifungal agents. Keratoplasty or corneal transplant is usually reserved for acute management of corneal perforation and for visual rehabilitation following corneal scarring.

The number of antifungal agents available for therapy is few compared with the number of pathogens capable of infecting the eye (O’Brien 1997). Current antifungal agents are divided into four groups: polyenes, imidazoles, triazoles and fluorinated pyrimidines. These drugs can be administered topically, intravenously or orally. Topical antifungals can cause toxicity such as punctate keratitis, chemosis recurrent corneal epithelial erosions and conjunctival injection. Subconjunctival injections are quite painful and ulceration and necrosis of the conjunctival epithelium may occur.

Current practice in the treatment of fungal keratitis involves the use of topical antifungal drops such as natamycin and topical amphotericin B. Newly discovered triazoles such as voriconazole and posaconazole are also being studied as treatment for fungal keratitis (Galarreta 2007; Tu 2007). In developing countries, where the incidence of fungal keratitis is higher, the costs and availability of these polyene drops may be an issue. Hence, various studies have been performed to validate the effectiveness of chlorhexidine drops as an inexpensive alternative to the treatment of fungal keratitis (Martin 1996). Combination therapy using several antifungal drugs has been studied. The concomitant use of corticosteroids and antifungal agents remains controversial (O’Brien 1997).

In India, due to unavailability and high price of antifungal drugs, different antiseptic agents were studied in vitro and revealed a good dose response for chlorhexidine gluconate while povidone iodine showed a good response in all concentrations (Martin 1996). This initial study was then followed by a randomised controlled trial (RCT) to further determine the clinical effectiveness of chlorhexidine in confirmed fungal keratitis patients (Rahman 1997).

**How the intervention might work**

Antifungal medications such as the polyenes work by binding to the ergosterol in the cell membrane of the fungal organism. Likewise, imidazoles affect the plasma membrane formation by affecting the ergosterol through microsomal P-450 enzyme. Pyrimidines are transformed to fluorouracil in the cell, therefore blocking the thymidine synthesis (Mabon 1998).

**Why it is important to do this review**

The gold standard for the treatment of fungal keratitis has not been identified. Due to the low incidence of the disease it is difficult to perform large trials, especially in developed countries. A systematic review of available trials will, therefore, contribute to the evidence base.

**OBJECTIVES**

To assess the effects of different antifungal drugs in the management of fungal keratitis.

**METHODS**

Criteria for considering studies for this review

**Types of studies**

We considered only RCTs in this review.

**Types of participants**

We included trials where the participants had fungal keratitis diagnosed clinically or microbiologically. We also included trials which included both people with or without corneal perforation, if separate data were available for those without perforation. We excluded studies of participants with mixed bacterial and fungal infections.

**Types of interventions**

We considered studies using various antifungal drugs in the management of fungal keratitis. This included placebo controlled trials or trials comparing one antifungal agent against another. We also considered trials comparing antifungal drugs with superficial keratectomy.

**Types of outcome measures**

**Primary outcomes**

1. Clinical improvement: defined as lessening of pain, decrease in size of infiltrate, disappearance of satellite lesions, rounding
out of feathery margins of the ulcer, disappearance of hypopyon, decrease congestion and healing of epithelium defect. Clinical improvement was assessed on a weekly basis.

2. Clinical cure: defined as healing of the corneal epithelium with scarring of the cornea. Clinical cure was assessed as absence of epithelial defect, absence of cellular reaction in the anterior chamber, presence of corneal vessels and scarring. Clinical cure was usually expected between six to eight weeks. Time to clinical cure was a measured outcome.

Secondary outcomes
1. recurrence;
2. therapeutic success based on the initial size of ulcer;
3. cost-effectiveness of treatment;
4. compliance with treatment;
5. complications: number of participants that experienced complications of fungal keratitis. Complications may include corneal thinning or descemetocoele formation, corneal perforation and endophthalmitis;
6. adverse outcomes as reported in trials. These include: chemosis, punctate keratopathy, recurrent epithelial erosions, conjunctival injections, ulceration and necrosis of conjunctiva, hepatotoxicity and renal toxicity;
7. quality of life.

Follow up
We included trials with at least two months follow up.

Search methods for identification of studies

Electronic searches
We searched the Cochrane Central Register of Controlled Trials (CENTRAL) 2011, Issue 8, part of The Cochrane Library, www.thecochranelibrary.com (accessed 29 August 2011), MEDLINE (January 1950 to August 2011), EMBASE (January 1980 to August 2011), Latin American and Caribbean Literature on Health Sciences (LILACS) (January 1982 to August 2011), the metaRegister of Controlled Trials (mRCT) (www.controlled-trials.com) and ClinicalTrials.gov (www.clinicaltrials.gov). There were no language or date restrictions in the search for trials. The electronic databases were last searched on 29 August 2011. See: Appendices for details of search strategies for CENTRAL (Appendix 1), MEDLINE (Appendix 2), EMBASE (Appendix 3), LILACS (Appendix 4), mRCT (Appendix 5) and ClinicalTrials.gov (Appendix 6).

Searching other resources
We searched the reference lists of identified trial reports to find additional trials. We contacted investigators and pharmaceutical companies to identify additional published, unpublished and ongoing studies. We used the Science Citation Index to find studies that have cited the identified trials. We searched conference abstracts for additional studies but journals were not handsearched.

Data collection and analysis

Selection of studies
Titles and abstracts resulting from the searches were reviewed independently by two review authors against the inclusion criteria for the review. We obtained full copies of the studies that definitely or possibly met the inclusion criteria for further assessment on whether the paper should be excluded or included. We contacted trialists for further information in order to determine the relevance of the study.

Data extraction and management
Two review authors extracted details about the methods, participants, interventions, outcomes measured and other details of the included studies and transferred them to the ‘Characteristics of included studies’ table in RevMan (Review Manager 2011). One review author extracted data using the form developed by the Cochrane Eyes and Vision Group. A second author compared the extraction to the original reports. If data were missing or difficult to determine from a paper, the trialists were approached for clarification and verification. Data were entered into RevMan by one review author, and the second author checked for errors.

Assessment of risk of bias in included studies
Assessment of the risk of bias of studies was undertaken in accordance with the methods given in Chapter 8 the Cochrane Handbook for Systematic Reviews of Intervention (Higgins 2011). Two review authors independently assessed the studies and disagreements between authors were resolved by discussion. Four bias domains were considered: selection bias, performance bias, detection bias and attrition bias. Assessment was based on the following questions:

1. Selection bias (random sequence generation and allocation concealment): was the sequence of allocation of participants to groups randomly generated and concealed until after treatments were allocated?
2. Performance bias (masking of participants and researchers): were the recipients of care unaware of their assigned treatment? Were persons providing care unaware of the assigned treatment?
3. Detection bias: were persons assessing outcome unaware of the assigned treatment?
4. Attrition bias: were rates of follow up similar in the comparison groups? Was the analysis ‘intention-to-treat’ (were all participants analysed as randomised)?

Medical interventions for fungal keratitis (Review)
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We assessed each parameter as 'low risk of bias', 'high risk of bias' or unclear. We contacted trialists for clarification of any parameter graded as unclear. In the protocol we planned to conduct a sensitivity analysis excluding studies at high risk of bias: the current review does not include any meta-analysis so that was not done.

**Data synthesis**

We presented summary measures for dichotomous data as relative risk ratios. For continuous data we calculated the weighted mean difference. We presented the point estimate and confidence intervals with a 95% confidence interval for individual results. We did not pool data from the individual trials but in the protocol we specified that we would use the fixed-effect model if the total number of trials in the comparison was three or less provided that heterogeneity had not been detected either statistically or by review. If the number of trials was more than three we planned to use the random-effects model.

**Sensitivity analysis**

We did not conduct sensitivity analysis as we did not do a meta-analysis. If possible we will do so for future updates so that we can assess how robust the review results were to key decisions and assumptions that were made during the review. Analysis of data will be repeated with the following adjustments:

1. exclusion of studies at greater risk of bias;
2. exclusion of unpublished studies;
3. changing inclusion criteria such as lowering methodological cut-off points.

**RESULTS**

**Description of studies**

See: Characteristics of included studies; Characteristics of excluded studies; Characteristics of ongoing studies.

**Results of the search**

The electronic searches resulted in 471 reports of possible medical interventions for fungal keratitis. Twenty three abstracts were retrieved in full for further assessment. Six RCTs were identified for inclusion (Agarwal 2001; Mohan 1987; Mohan 1988; Prajna 2003; Rahman 1997; Rahman 1998).

An updated search was done in January 2007 and February 2010. The searches yielded a total 206 and 23 references respectively. The Trials Search Co-ordinator (TSC) scanned the search results for both updates and removed any references which were not relevant to the scope of the review. The update searches did not identify any references which met the inclusion criteria for the review.

A further update search was done in August 2011. After deduplication the search identified a total of 50 references. The TSC scanned the search results and removed 41 references which were not relevant to the scope of the review. We reviewed the remaining nine references of which five were published reports of studies and four were reports of ongoing studies. We assessed the five published reports of studies for potential inclusion in the review. We obtained full-text copies of three studies and have included them in the review (Arora 2011; Mahdy 2010; Prajna 2010). The remaining two reports did not meet the inclusion criteria. Of the four reports of ongoing studies trial NCT00557362 is the initial report of the published paper by Prajna 2010. The three other reports of ongoing studies are relevant to the review and have been added to the studies awaiting assessment section and the results will be included in the review when the studies have been completed (NCT00996736; NCT00997035; NCT00516399).

Contact with first authors of identified trials and searching the reference lists of these studies failed to identify any additional trials. We also approached pharmaceutical companies producing antifungal agents but there was no information on additional trials.

**Included studies**

See the 'Characteristics of included studies' table for additional details for included studies.

**Size of studies**

The nine included trials randomised a total of 568 participants: Agarwal 2001 (54 participants); Arora 2011 (30); Mahdy 2010 (48); Mohan 1987 (30) Mohan 1988 (40); Prajna 2003 (116); Prajna 2010 (120); Rahman 1997 (60); Rahman 1998 (70).

**Types of participants**

Seven of the trials were conducted in India with one trial conducted in Bangladesh (Rahman 1998) and one trial in Egypt (Mahdy 2010). Trials included people with a wide range of ages, from seven to 84 years of age, although in general the patient populations were younger rather than older, with average ages less than 50 years. The majority of the participants were male; the percentage male ranged from 64% to 78% in the included trials.

The majority of the trials included participants with microbiological evidence of fungal keratitis. Two trials (Agarwal 2001; Mahdy 2010) included participants based on a clinical definition only.

**Types of interventions**

Table 1 summarises the antifungals studied. The trials were heterogeneous in terms of types of antifungals studied. Seven antifungal drugs in different preparations and routes of administration.
were used. Agarwal 2001 compared topical and systemic itraconazole versus topical itraconazole. Mohan 1987 compared 0.5% and 1% silver sulphadiazine in ointment form to 1% miconazole ointment while Mohan 1988 compared 1% silver sulphadiazine versus 1% miconazole ointment. Prajna 2003 compared 2% econazole and 5% natamycin in topical preparations. Rahman 1997 compared different concentrations of chlorhexidine gluconate versus 5% natamycin while Rahman 1998 compared 0.2% chlorhexidine gluconate versus 2.5% natamycin. Arora 2011 and Prajna 2010 compared topical voriconazole 1% with natamycin 5% and Mahdy 2010 compared amphotericin B combined with subconjunctival injection of fluconazole with amphotericin B alone. Agarwal 2001, Mohan 1987 and Mohan 1988 were cross-over trials. Data on the first treatment was used for the review.

Types of outcome measures

The majority of trials considered healing of ulcer, or time taken for ulcer to heal, as the primary outcome. Prajna 2010 specified visual acuity as the primary outcome. Follow-up varied: Rahman 1997 and Rahman 1998 considered healing of ulcer at three weeks; Mohan 1987 and Prajna 2003 considered healing at four weeks; Mohan 1988 did not specify a cut-off time but noted healing of ulcers within two to four weeks; Agarwal 2001 considered healing of ulcer at six weeks as primary outcome; Arora 2011 followed up for a minimum of 10 weeks, or until the ulcer healed; Prajna 2010 specified the main outcome at three months; and Mahdy 2010 also followed up for three months. The trials noted a healed ulcer based on slit lamp findings such as disappearance of hypopyon and circumoral congestion, absence of fluorescein staining. Local and systemic adverse reactions were noted by some trials.

Excluded studies

See the 'Characteristics of excluded studies' table for details.

Risk of bias in included studies

See Figure 1 and Figure 2.
Figure 1. Risk of bias summary: review authors' judgements about each risk of bias item for each included study.

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**Allocation**
Only three trials reported adequate methods of sequence generation and allocation concealment (Prajna 2010; Rahman 1997; Rahman 1998).

**Blinding**
Masking of participants was not always possible. Only Mohan 1988 and Prajna 2010 reported adequate masking of participants, personnel and outcome assessment.

**Incomplete outcome data**
Arora 2011, Mohan 1987; Mohan 1988, Prajna 2010 and Rahman 1997 had reasonably complete data. In the other studies, attrition bias was considered to be possible.

**Selective reporting**
Selective reporting was not considered to be a major problem in the included trials but it was not always possible to assess this adequately.

**Other potential sources of bias**
Trials by Mohan 1987, Mohan 1988 and Agarwal 2001 were crossover trials which can be a potential source of bias.

**Effects of interventions**

**Treatment failure**

1. **Topical itraconazole versus topical and systemic itraconazole**
The combination of topical (1%) and oral itraconazole (100 mg twice daily for three weeks) did not appear to confer any additional advantage to itraconazole alone (Agarwal 2001) with a relative risk (RR) of 1.0; 95% confidence interval (CI) 0.37 to 2.71.

2. **Silver sulphadiazine versus miconazole**
The results of two studies by the same author (Mohan 1987; Mohan 1988) indicated that silver sulphadiazine was more effective than miconazole, however, the confidence intervals were wide and the results were also compatible with a greater efficacy of miconazole. Mohan 1987: silver sulphadiazine (0.5% and 1%) compared to 1% miconazole gave a RR (of failure, i.e. not healing of ulcer) of 0.63; 95% CI 0.21 to 1.83. Mohan 1988: 1% silver sulphadiazine ointment compared to 1% miconazole ointment: RR 0.44; 95% CI 0.16 to 1.21. The pooled estimate of these two trials was 0.51 (95% CI 0.25, 1.07) (Analysis 1.1).

3. **Econazole versus natamycin**
In Prajna 2003, there appeared to be little difference in the effects of econazole and natamycin: RR 0.99; 95% CI 0.8 to 1.21.

4. **Chlorhexidine gluconate versus natamycin**
In two trials by the same investigators (Rahman 1997; Rahman 1998) there was some evidence for a favourable effect of chlorhex-
idine compared to natamycin in response at five days (Analysis 2.1), however, the results on healing of the ulcer at 21 days was less conclusive (Analysis 2.2).

5. Voriconazole versus natamycin

Arora 2011 and Prajna 2010 found no evidence for any difference between these two antifungal agents. However, Arora 2011 was rather small and it was not possible to combine the results of these studies because of differences in outcomes presented. Prajna 2010 found that people treated with voriconazole had a 1 line better best correct visual acuity compared to people treated with natamycin at three months, however, this difference was not statistically significant.

6. Amphotericin B combined with fluconazole (subconjunctival injection)

Mahdy 2010 found a higher proportion of ulcers healed with combination treatment (amphotericin B and fluconazole) (83%) compared to amphotericin alone (67%), however, this study was considered to be at relatively high risk of bias (Figure 1).

**Adverse reactions**

Mild side effects were noted in topical itraconazole, which included:

1. corneal oedema in two cases;
2. increased intraocular pressure in two cases; and
3. prolonged congestion in four cases.

On the other hand, no significant side effects were reported in patients with oral itraconazole.

Mild local allergic reactions were observed in three eyes using silver sulphadiazine ointment as reported in Mohan 1988.

Prajna 2003 did not elaborate on the ocular and systemic adverse reactions due to 2% econazole and 5% natamycin. No systematic adverse effects were recorded in Prajna 2010. There were nine corneal perforations in the natamycin group and 10 in the voriconazole group. No adverse reactions to study medications were noted in Arora 2011. In Mahdy 2010 two cases of subconjunctival haemorrhage associated with the injection site were noted but no conjunctival necrosis.

There was no report of significant systemic or ocular adverse reactions from both chlorhexidine gluconate and natamycin. A case of temporary punctate epitheliopathy was observed in one participant receiving chlorhexidine gluconate. This was attributed to increased frequency of application of the drops. No early cataract formation was observed at six months to one year after treatment for participants exposed to chlorhexidine gluconate and natamycin.

Comparing multiple small clinical trials. The current review includes nine trials comparing different antifungal drugs in topical drops, ointment and oral preparations for the treatment of fungal keratitis. All trials were done in developing countries since the incidence is higher compared to developed countries such as the United States. There are still no large multicentre randomised trials on the treatment of fungal keratitis.

Seven antifungal agents, namely: voriconazole, econazole, itraconazole, miconazole, natamycin, chlorhexidine gluconate and silver sulphadiazine were studied. The latter two are not part of the conventional drugs which act on the hyphal cell membranes. Use of alternative drugs such as chlorhexidine gluconate and silver sulphadiazine may indicate that conventional drugs are not always available, are expensive and ineffective. Since fungal keratitis is more common in developing countries the use of inexpensive alternative drugs is promising. In addition, a less financial incentive has been offered to pharmaceutical companies to invest in the development of ocular antifungal agents. The only commercially available antifungal drug in the United States is natamycin (Natacyn 5% by Alcon Laboratories). In Asia and Africa, Natacyn is given as a service drug but with limited availability. In India, topical natamycin is manufactured by a local pharmaceutical company, however, no clinical trials have been done on this drug.

Three pairs of trials had the same primary author. One pair compared different concentrations of the drug chlorhexidine gluconate with natamycin, while the other pair compared different concentrations of silver sulphadiazine with miconazole. Succeeding studies may have based the concentration of the study drug from the previous trials. The other pair considered different formulations.

Although natamycin was used as the control drug in four of the six trials, it is not yet considered as the gold standard for treatment for fungal ulcer because of low success rate.

Comparing treatment effects of all the drug preparations studied, silver sulphadiazine ointment has the lowest proportion of participants with treatment failure followed by itraconazole in both treatment arms, miconazole ointment, chlorhexidine gluconate, econazole. The drug with the highest failure proportion with failed ulcer was natamycin (2.5% and 5%). However, these comparisons between treatment arms of different studies do not represent randomised comparisons (it is effectively an observational study), thus these differences may reflect differences in the different populations studied.

**DISCUSSION**

This systematic review aimed to provide a critical, quantitative overview of previous clinical research and to yield, where possible, summary effect measures with increased statistical power by combining multiple small clinical trials. The current review includes nine trials comparing different antifungal drugs in topical drops, ointment and oral preparations for the treatment of fungal keratitis. All trials were done in developing countries since the incidence is higher compared to developed countries such as the United States. There are still no large multicentre randomised trials on the treatment of fungal keratitis.

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Three pairs of trials had the same primary author. One pair compared different concentrations of the drug chlorhexidine gluconate with natamycin, while the other pair compared different concentrations of silver sulphadiazine with miconazole. Succeeding studies may have based the concentration of the study drug from the previous trials. The other pair considered different formulations.

Although natamycin was used as the control drug in four of the six trials, it is not yet considered as the gold standard for treatment for fungal ulcer because of low success rate.

Comparing treatment effects of all the drug preparations studied, silver sulphadiazine ointment has the lowest proportion of participants with treatment failure followed by itraconazole in both treatment arms, miconazole ointment, chlorhexidine gluconate, econazole. The drug with the highest failure proportion with failed ulcer was natamycin (2.5% and 5%). However, these comparisons between treatment arms of different studies do not represent randomised comparisons (it is effectively an observational study), thus these differences may reflect differences in the different populations studied.

**Summary of main results**

Based on the nine trials included in this review, there is no evidence that any particular drug, or combination of drugs, is more effective in the management of fungal keratitis. However, the trials...
included in this review were of variable quality and were generally underpowered.

**Overall completeness and applicability of evidence**

The evidence supporting the treatment of fungal keratitis appears to be weak. Only nine trials of variable quality were identified. The trials considered different preparations and comparisons and so it was not possible usefully to pool the data. Treatment regimens such as amphotericin B and other new drugs such as voriconazole have not yet been studied in a large scale manner.

**Quality of the evidence**

The review provides weak evidence for the drugs used in management of fungal keratitis. Nine trials with 568 participants have been included using different antifungal medications. There was no consistent drug of comparison (control). We did not combine results since the drugs used were different.

**Potential biases in the review process**

An exhaustive search on the trials was done. However, there are few RCTs on fungal keratitis since the disease is rare in developed countries. Since fungal keratitis is more often studied in developing countries, unpublished reports might have been excluded.

**Agreements and disagreements with other studies or reviews**

Most of the trials on management of fungal keratitis gathered during the literature search are case series. Only the RCTs were included in the review.

**Authors’ conclusions**

**Implications for practice**

The first line of treatment in fungal keratitis is topical antifungal agents. Although it is prudent to wait for culture and sensitivity results before instituting medical therapy, fungi do not grow as fast as bacteria even under well-controlled conditions. Thus, antifungal agents are administered promptly once fungal elements are seen on microbiology examination.

Current antifungal agents used in the treatment of fungal keratitis in the RCTs are varied. Furthermore, the different studies are weak, owing to their small sample size. The results of these studies also did not show a significant difference among the heterogeneous interventions. There is little evidence to support the use of any particular drug, or combination of drugs.

**Implications for research**

There is a need for future multicentre RCTs with a large sample size and the treatment given can be any of the interventions in the previous RCTs. Since the price of these drugs are likewise prohibitive to patients in developing nations, cost-effectiveness of these drugs should also be examined. The search for a cheaper and more effective treatment alternative to what has already been proposed still continues.

**Acknowledgements**

The Cochrane Eyes and Vision Group have prepared and will execute the electronic searches. We would like to thank Anupa Shah, Katherine Henshaw, Sally Green, Steve McDonald, Liam Smeeth, Ruben Lim Bon Siong, Leo Cubillan, Alejandro De Leon, Anna Lisa Yu, Johann Michael Reyes, Jaime FlorCruz, Guo Baoqi, Maol ing Wei of the Chinese Cochrane Center and Richard Wormald. We would also like to thank the peer reviewers especially Catey Bunce for comments on the review and Mark Wilkins for comments on the protocol.

Richard Wormald (Co-ordinating Editor for CEVG) acknowledges financial support for his CEVG research sessions from the Department of Health through the award made by the National Institute for Health Research to Moorfields Eye Hospital NHS Foundation Trust and UCL Institute of Ophthalmology for a Specialist Biomedical Research Centre for Ophthalmology. The views expressed in this publication are those of the authors and not necessarily those of the Department of Health.
REFERENCES

References to studies included in this review

Agarwal 2001 [published data only]

Arora 2011 [published data only]

Mahdy 2010 [published data only]

Mohan 1987 [published data only]

Mohan 1988 [published data only]

Prajna 2003 [published data only]

Prajna 2010 [published data only]

Rahman 1997 [published data only]

Rahman 1998 [published data only]

References to studies excluded from this review

Jones 1975 [published data only]

Kalavathy 2002 [published data only]

Kalavathy 2005 [published data only]

Lavingia 1986 [published data only]

Mabon 1998 [published data only]

Mahashabde 1997 [published data only]

Maichuk 1990 [published data only]

Maichuk 1991 [published data only]

Maichuk 1994 [published data only]

Maichuk 1995 [published data only]

Martin 1996 [published data only]

Mitsui 1987 [published data only]

Panda 1996 [published data only]
Rao 1997 {published data only}  

Ray 2002 {published data only}  

Sun 1996 {published data only}  

Xie 2001 {published data only}  

References to ongoing studies

NCT00516399 {published data only}  

NCT00996736 {published data only}  

NCT00997035 {published data only}  

Additional references

Galarreta 2007  

Glanville 2006  

Gopinathan 2002  

Higgins 2011  

Liesegang 1980  

O’ Brien 1997  

O’ Day 1996  

Review Manager 2011  

Tu 2007  

Valenton 2000  

References to other published versions of this review

FlorCruz 2008  

* Indicates the major publication for the study
**Characteristics of included studies**  
*ordered by study ID*

### Agarwal 2001

| Methods | Randomised controlled cross-over trial  
Masking: It is impossible to be masked due to systemic intervention compared to topical only |
| --- | --- |
| Participants | Setting: Calcutta, India  
54 patients divided into 2 groups. Group I comprised new patients and Group II comprised patients who had been previously treated with agents. No inclusion and exclusion criteria elaborated. Clinically suspected cases were included  
Male (69%), 50% aged 21 to 40 years  
No participants were reported to be excluded or dropped in the study. Patients were followed up for 6 months |
| Interventions | 1% topical itraconazole versus 1% topical itraconazole and 100 mg BID for 3 weeks oral itraconazole. Topical itraconazole was prepared by mixing 100 mg of itraconazole powder with 100 mL artificial tear solution. Oral itraconazole was discontinued after 3 weeks while topical itraconazole was continued for 6 weeks after resolution of keratitis |
| Outcomes | Main outcome was healing of corneal ulcer, within 6 weeks. Favourable response was further graded based on corneal opacity and visual acuity. Other parameters included residual corneal opacity, best corrected visual acuity and rate of improvement. Side effects such as oedema, glaucoma and congestion were also reported if present |
| Notes | This is a preliminary study. Aspergillus was common etiology found. Fusarium was not responsive to itraconazole |

### Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Unclear risk</td>
<td>“The patients were divided into two groups” on the basis of new and untreated patients but no other information is given</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>Not reported</td>
</tr>
<tr>
<td>Blinding of participants and personnel (performance bias) All outcomes</td>
<td>High risk</td>
<td>Not reported but treatments different</td>
</tr>
<tr>
<td>Blinding of outcome assessment (detection bias) All outcomes</td>
<td>High risk</td>
<td>Not reported but treatments different</td>
</tr>
</tbody>
</table>
### Incomplete outcome data (attrition bias)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Risk</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Unclear</td>
<td>Not possible to assess</td>
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</tbody>
</table>

### Selective reporting (reporting bias)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Risk</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Unclear</td>
<td>Not possible to assess</td>
</tr>
</tbody>
</table>

### Arora 2011

#### Methods
Randomised controlled trial

#### Participants
Setting: Tertiary care hospital in India
30 people with fungal keratitis, confirmed by microbiology
Predominantly male (group A 67% male, group B 73% male). Average age 37.9 (15.1) years in group A and 48.5 (13.5) years in group B

#### Interventions
5% natamycin versus 1% voriconazole. Patients were followed up for a minimum of 10 weeks, or until complete resolution of the ulcer

#### Outcomes
Resolution of the ulcer and visual acuity

### Notes

#### Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors' judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Unclear risk</td>
<td>“This study was randomized, double-masked, interventional, pilot study of patients with fungal keratitis”. Methods, first paragraph</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>“Double masking of treatment assignment was achieved by dispensing the medications in identical opaque bottles and by having the ward nurses wipe any white residue from the patient’s eye prior to study assessment as natamycin is delivered via suspension, whereas VRC is in solution”. Methods, first paragraph</td>
</tr>
<tr>
<td>Blinding of participants and personnel (performance bias)</td>
<td>Unclear risk</td>
<td>“Double masking of treatment assignment was achieved by dispensing the medications in identical opaque bottles and by having the ward nurses wipe any white residue from the patient’s eye prior to study assessment as natamycin is delivered via suspension, whereas VRC is in solution”. Methods, first paragraph</td>
</tr>
<tr>
<td>Blinding of outcome assessment (detection bias)</td>
<td>Low risk</td>
<td>“Double masking of treatment assignment was achieved by dispensing the medications in identical opaque bottles and by having the ward nurses wipe any white residue from the patient’s eye prior to study assessment as natamycin is delivered via suspension, whereas VRC is in solution”. Methods, first paragraph</td>
</tr>
<tr>
<td>Arora 2011 (Continued)</td>
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<tr>
<td></td>
<td></td>
<td>patient’s eye prior to study assessment as natamycin is delivered via suspension, whereas VRC is in solution”. Methods, first paragraph</td>
</tr>
<tr>
<td></td>
<td></td>
<td>There were no reported drop outs in both treatment and control groups. Follow up ranged from 10 days to 60 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The primary outcome was defined as the &quot;time taken for the complete resolution of the ulcer&quot;. Methods, last paragraph</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Various other outcomes reported e.g., visual acuity and mean size of the ulcer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mahdy 2010</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods</td>
<td>Randomised controlled trial</td>
<td></td>
</tr>
<tr>
<td>Participants</td>
<td>Setting: hospital in Egypt</td>
<td></td>
</tr>
<tr>
<td></td>
<td>48 people with clinical signs of fungal keratitis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male (65%), aged 15 to 64 years, average age 44 years</td>
<td></td>
</tr>
<tr>
<td>Interventions</td>
<td>Topical amphotericin B (0.5 mg/ml) and subconjunctival fluconazole (2mg/ml) compared to topical amphotericin B alone</td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td>Healing of corneal ulcer. Follow-up 3 months</td>
<td></td>
</tr>
</tbody>
</table>

Notes

**Risk of bias**

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Unclear risk</td>
<td>“The study is a prospective, randomized one…” Page 282 “Eyes with similar clinical and laboratory findings were classified into 2 groups of treatment.” Page 282</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>High risk</td>
<td>No description on method of allocation concealment however the study groups were exactly matched for fungal species (table 2) which is unlikely on this number of patients if the allocation was truly random</td>
</tr>
<tr>
<td>Blinding of participants and personnel (performance bias) All outcomes</td>
<td>High risk</td>
<td>Participants were not masked</td>
</tr>
</tbody>
</table>
### Mohdy 2010  (Continued)

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors' judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blinding of outcome assessment (detection bias)</td>
<td>High risk</td>
<td>Outcome assessors were not masked</td>
</tr>
<tr>
<td>All outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias)</td>
<td>Unclear risk</td>
<td>Not reported</td>
</tr>
<tr>
<td>All outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Unclear risk</td>
<td>Difficult to judge from report</td>
</tr>
</tbody>
</table>

### Mohan 1987

**Methods**

Randomised controlled cross-over trial  
Six ulcers had no response. No significant systemic and ocular side effects noted

**Participants**

Setting: New Delhi, India  
Included patients were positive for KOH smear  
30 patients were included; 10 for 0.5% silver sulphadiazine, 10 for 1% silver sulphadiazine and 10 for 1% miconazole  
Age and sex not reported

**Interventions**

0.5% topical silver sulphadiazine, 1% topical silver sulphadiazine and 1% topical miconazole all in ointment form

**Outcomes**

Main outcome was healing described as absence of fluorescein staining, disappearance of hypopyon, lack of circumcorneal congestion and negative culture

**Notes**

Silver sulphadiazine had 100% effectiveness in Fusarium ulcers
Mohan 1987  (Continued)

| Incomplete outcome data (attrition bias) | Low risk | “Each patient was given a coded antifungal ointment tube of 5g to be applied 5 times a day and the entire study was conducted in a double blind manner” Page 573
| | | “At the end of the trial, the code was broken and the results analyzed” Page 573
| Selective reporting (reporting bias) | Low risk | “There was no fallout from this study on account of poor patient compliance” Page 573
| | | Probably not a problem as they reported ulcers responding to treatment

Mohan 1988

| Methods | Randomised controlled double masked cross-over trial
Follow-up not stated but rather average healing time. Forty smear positive patients (20 each) were analysed. No reported cases of lost to follow-up
| | |
| Participants | Setting: New Delhi, India
Included patients were smear positive. No exclusion criteria given
Male (78%), aged 14 to 68 years
| | |
| Interventions | 1% topical silver sulphadiazine versus 1% miconazole both in ointment preparations.
In absence of improvement in one week, participants were switched to other drug.
Interventions were continued for 2 more weeks after healing. Mean days of resolution of ulcers was 20.7 for miconazole and 23.9 for silver sulphadiazine
| | |
| Outcomes | Healing is described as disappearance of hypopyon and circumcorneal congestion, absence of staining and a negative report for culture. Local and systemic adverse effects were noted
| | |
| Notes | Ulcers were graded based on size and hypopyon. On cross-over, miconazole resistant fusarium ulcers were healed by silver sulphadiazine. Aspergillus was the most common etiologic agent
| | |

**Risk of bias**

| Bias | Authors’ judgement | Support for judgement |
| | | |
| Random sequence generation (selection bias) | High risk | “The patients were assigned alternately to each of two groups” Page 192 |
| Allocation concealment (selection bias) | High risk | Not reported but as sequence was alternate allocation we have assumed that concealment was not possible |
**Mohan 1988** *(Continued)*

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blinding of participants and personnel (performance bias) All outcomes</td>
<td>Low risk</td>
<td>“The two ointments were coded and supplied to the patients in identical packings.” Page 192/193 “At the end of the study the code was broken and the results analyzed” Page 193</td>
</tr>
<tr>
<td>Blinding of outcome assessment (detection bias) All outcomes</td>
<td>Low risk</td>
<td>“At the end of the study the code was broken and the results analyzed” Page 193</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias) All outcomes</td>
<td>Low risk</td>
<td>“Three patients (two on miconazole and one on silver sulphadiazine) developed local allergic reactions, possibly due to the ointment base. They were excluded from further analysis and do not form part of the study material” Page 193 Low risk of bias recorded here as this is quite a low proportion with missing data and was distributed between the two groups</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>Probably not a problem as reported ulcers responding to treatment</td>
</tr>
</tbody>
</table>

**Prajna 2003**

<table>
<thead>
<tr>
<th>Methods</th>
<th>Randomised controlled trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting: Aravind, India</td>
<td></td>
</tr>
<tr>
<td>Participants</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Interventions</td>
<td>2% econazole and 5% natamycin in topical eye drops/ suspension. Atropine sulfate ointment were given to both groups</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Main outcome is healed ulcer defined as completely healed epithelial defect with no fluorescein staining, non progression of stromal infiltration</td>
</tr>
<tr>
<td>Notes</td>
<td>Follow duration was 4 weeks</td>
</tr>
</tbody>
</table>

**Risk of bias**

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
</table>
### Prajna 2003

(Continued)

<table>
<thead>
<tr>
<th>Bias</th>
<th>Unclear risk</th>
<th>&quot;…subjects were randomized to receive either…” Page 1235</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Unclear risk</td>
<td></td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>Not reported</td>
</tr>
<tr>
<td>Blinding of participants and personnel (performance bias) All outcomes</td>
<td>High risk</td>
<td>&quot;Since natamycin is available as a suspension, and precipitates in the corneal tissue, it was not possible to mask the investigator to the drugs used on subsequent visits.” Page 1235</td>
</tr>
<tr>
<td>Blinding of outcome assessment (detection bias) All outcomes</td>
<td>Unclear risk</td>
<td>&quot;Since natamycin is available as a suspension, and precipitates in the corneal tissue, it was not possible to mask the investigator to the drugs used on subsequent visits.” Page 1235</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias)</td>
<td>High risk</td>
<td>&quot;Four of the 116 patients randomized at baseline did not return for further follow-up (Fig 1) and were dropped from the study.” Page 1236</td>
</tr>
<tr>
<td>All outcomes</td>
<td></td>
<td>However this contradicts figure 1 where 5 people lost to follow-up by week 4. Also large numbers of people “exited” the study due to clinical worsening or reaction to drops. By week 4 25/61 in the econazole group and 22/55 of natamycin group remained in the study</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>Reported “time to cure” and no indication of any unreported variables</td>
</tr>
</tbody>
</table>

### Prajna 2010

Method

Multicentre double masked randomised controlled trial

Participants

120 people with fungal keratitis at Aravind Eye Hospital, India
Male (66%), average age in each of four study groups ranged from 45 to 50 years

Interventions

Topical natamycin versus topical voriconazole

Outcomes

Best spectacle-corrected visual acuity at 3 months. Other outcomes included scar size, perforations

Notes

Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Low risk</td>
<td>“This study was a randomized, double-masked, clinical trial of patients with fungal corneal ulcers.” Page 673. Patients were block randomized in groups of 4 (using the statistical package R; <a href="http://www.r-project.org">http://www.r-project.org</a>) by T.P.” Page 673</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Low risk</td>
<td>“Double-masking of treatment assignment was achieved by dispensing the medications in identical opaque bottles and by having the ward nurses wipe any white residue from the patient’s eye prior to study assessment. In addition, patients were no longer receiving treatment at 3 months, the time that the primary outcome of final visual acuity was measured. Only the biostatisticians responsible for the randomization coding and the study pharmacist were unmasked.” Page 673</td>
</tr>
<tr>
<td>Blinding of participants and personnel (performance bias)</td>
<td>Low risk</td>
<td>“Double-masking of treatment assignment was achieved by dispensing the medications in identical opaque bottles and by having the ward nurses wipe any white residue from the patient’s eye prior to study assessment. In addition, patients were no longer receiving treatment at 3 months, the time that the primary outcome of final visual acuity was measured. Only the biostatisticians responsible for the randomization coding and the study pharmacist were unmasked.” Page 673</td>
</tr>
<tr>
<td>Blinding of outcome assessment (detection bias)</td>
<td>Low risk</td>
<td>“Double-masking of treatment assignment was achieved by dispensing the medications in identical opaque bottles and by having the ward nurses wipe any white residue from the patient’s eye prior to study assessment. In addition, patients were no longer receiving treatment at 3 months, the time that the primary outcome of final visual acuity was measured. Only the biostatisticians responsible for the randomization coding and the study pharmacist were unmasked.” Page 673</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias)</td>
<td>Low risk</td>
<td>“Efficacy endpoints were analyzed on an intent-to-treat basis for all randomized patients enrolled in the study. The primary analysis included the actual 3-month data when available and last observation carried forward for...”</td>
</tr>
</tbody>
</table>
Sensitivity analyses were also performed in which we separately (1) assigned surgical patients the value 1.7 instead of 1.9, (2) assigned patients with perforation (but no surgery) the value 1.7 or 1.9 (instead of using last observation carried forward), (3) analyzed only patients with complete followup, or (4) used multiple imputation (recursive random partitioning-based hot deck method). 11/120 lost to follow-up but evenly distributed across study groups 2/2/4/3.

<table>
<thead>
<tr>
<th>Missing values</th>
<th>Low risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity analyses were also performed in which we separately (1) assigned surgical patients the value 1.7 instead of 1.9, (2) assigned patients with perforation (but no surgery) the value 1.7 or 1.9 (instead of using last observation carried forward), (3) analyzed only patients with complete followup, or (4) used multiple imputation (recursive random partitioning-based hot deck method).</td>
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</table>

Selective reporting (reporting bias) | Low risk |
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<tbody>
<tr>
<td>The primary efficacy endpoint was BSCVA at 3 months in the study eye, using a linear regression model with 3-month logMAR BSCVA as the outcome variable and treatment arm (voriconazole vs natamycin) and enrollment logMAR BSCVA and scraping (yes or no) as covariates.</td>
<td></td>
</tr>
<tr>
<td>Other prespecified endpoints included BSCVA at 3 weeks, adjusting for enrollment BSCVA, and infiltrate/scar size at 3 weeks and 3 months, adjusting for enrollment infiltrate/scar size.</td>
<td></td>
</tr>
</tbody>
</table>

**Rahman 1997**

<table>
<thead>
<tr>
<th>Methods</th>
<th>Randomised controlled double masked trial. Two patients were lost to follow-up after randomisation for unknown reasons. Follow-up was at least 21 days</th>
</tr>
</thead>
</table>
| Participants | Setting: Aravind Eye Hospital in Madurai, India  
Included patients were smear positive for hyphal elements  
Excluded were patients with only one eye, patients with diabetes mellitus, polymicrobial infections, those unwilling to participate fully or attend for follow up, children under 1 year of age and perforated ulcers  
Male (76%), aged 50 years and above (33%) |
| Interventions | Concentration of chlorhexidine gluconate was varied (0.05%, 0.1% and 0.2%) compared to 5% natamycin. Rescue drugs is given if there is no improvement at 5 days |
| Outcomes | Outcome measures were response at 5 days, cure by day 21 and toxicity. Favorable response was defined as relief of symptoms, improvement of at least one the following signs of inflammation. Healing at 21 days characterised as intact epithelium, with or without scar formation, but no perforation, anterior staphyloma, no adherent leukoma, no fluorescein staining, no hypopyon and improvement of vision or vision no worse than |

**Medical interventions for fungal keratitis (Review)**

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Notes: Data was also stratified based on severity of ulcers. Twelve patients with severe ulcers were excluded in the analysis of outcome at 21 days since only 1 (from chlorhexidine gluconate 0.05%) had favourable response. Fusarium was the most common etiologic agent cultured.

### Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Low risk</td>
<td>“The randomization was computer generated by statisticians at Aravind, using the one-sample run test.” Page 143</td>
</tr>
</tbody>
</table>
| Allocation concealment (selection bias) | Low risk           | “… 60 consecutive patients were randomly allocated in a double-masked fashion.” Page 142  
“The bottles were prepared and labelled only with the randomized numbers by the Aravind executive staff” Page 143 |
| Blinding of participants and personnel (performance bias) | Low risk           | “… 60 consecutive patients were randomly allocated in a double-masked fashion.” Page 142  
“The bottles were prepared and labelled only with the randomized numbers by the Aravind executive staff” Page 143 |
| Blinding of outcome assessment (detection bias) | Unclear risk       | “… 60 consecutive patients were randomly allocated in a double-masked fashion.” Page 142  
“The bottles were prepared and labelled only with the randomized numbers by the Aravind executive staff” Page 143  
But for “treatment failures” the code was broken on day 5 so presumably all assessments after that date were unmasked |
| Incomplete outcome data (attrition bias) | Low risk           | “Two patients were lost to follow-up, so that 58 patients were left in the study” Page 144 |
| Selective reporting (reporting bias) | Unclear risk       | A number of different outcome measures reported and no indication as to whether these were all outcomes on which data collected |
### Rahman 1998

<table>
<thead>
<tr>
<th>Methods</th>
<th>Randomised controlled trial with follow up at least 6 months. Seventy one patients were eligible but one was excluded because it was a mixed infection. Seventy patients were randomised to two arms 35 each. Six patients (3 on each arms) were dropped due to incomplete follow-up. Only 32 were assessed at 21 days</th>
</tr>
</thead>
</table>
| Participants | Setting: Bangladesh  
Included patients where smear positive for hyphal elements. Excluded were patients with only one eye, patients with diabetes mellitus, polymicrobial infections, those unwilling to participate fully or attend for follow up, children under 1 year of age and perforated ulcers  
Male (74%), aged 50 to 75 years (26%) |
| Interventions | 0.2% chlorhexidine gluconate drops prepared from 20% solution compared to 2.5% natamycin  
Source of natamycin from the EITC Chittagong. Both drops were given one drop hourly for first 3 hours, then hourly for 2 days, 2 hourly for 5 days, and 3 hourly for 2 weeks - a total of three weeks. No improvement at 5 days was assessed as treatment failure. Rescue drugs were given |
| Outcomes | Healing at 21 days characterised as intact epithelium, with or without scar formation, but no perforation, anterior staphyloma, no adherent leukemia, no fluorescein staining, no hypopyon and improvement of vision or vision no worse than baseline  
Divided analysis to smear positive and culture positive cases  
Toxicity to drug and cataract were also assessed on long term follow-up |
| Notes | This is a follow-up study done by Rahman. Chlorhexidine gluconate 0.2% was used based on the previous study. Ulcers were graded based on size of ulcer. Classified severe if size is greater than 6 mm. Aspergillus and Fusarium were the two most common etiology |

### Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Low risk</td>
<td>“The randomization of individuals was computer generated in London....” Page 920</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Low risk</td>
<td>“... and the codes for the alternative treatments sealed in serially numbered opaque envelopes, which were opened in sequence by the research ophthalmologist as the trial progressed.” Page 920</td>
</tr>
</tbody>
</table>
| Blinding of participants and personnel (performance bias) All outcomes | High risk | “It was not possible to mask the ophthalmologist or nurses to the medications because of their different appearances” Page 920  
Blinding of participants not stated directly but can be inferred that they were masked |
Blinding of outcome assessment (detection bias)  
All outcomes: High risk

“It was not possible to mask the ophthalmologist or nurses to the medications because of their different appearances” Page 920

Incomplete outcome data (attrition bias)  
All outcomes: High risk

13/35 of chlorhexidine 0.2% group dropped out of the study by 21 days compared to 3/36 of the natamycin 2.5% group. Page 921, figure 1

Selective reporting (reporting bias)  
Unclear risk

Main outcome was healing at 21 days of treatment but other follow-up periods also available and not clear that this outcome was pre-specified or not

BID: twice-daily dose  
KOH: potassium hydroxide

**Characteristics of excluded studies [ordered by study ID]**

<table>
<thead>
<tr>
<th>Study</th>
<th>Reason for exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jones 1975</td>
<td>This is a lecture on the principles in the management of keratomycosis</td>
</tr>
<tr>
<td>Kalavathy 2002</td>
<td>The article is a commentary to Agarwal 2001</td>
</tr>
<tr>
<td>Kalavathy 2005</td>
<td>This is not a RCT. The first fifty consecutive patients received natamycin while the next fifty patients were given itraconazole</td>
</tr>
<tr>
<td>Lavingia 1986</td>
<td>This is an in vitro study on antifungal properties of amphotericin B</td>
</tr>
<tr>
<td>Mabon 1998</td>
<td>The article is not a RCT but an overview on fungal keratitis</td>
</tr>
<tr>
<td>Mahashabde 1987</td>
<td>This is a case series</td>
</tr>
<tr>
<td>Maichuk 1990</td>
<td>This is a case series using antifungal agents for different ocular fungal infections</td>
</tr>
<tr>
<td>Maichuk 1991</td>
<td>This is a case series using antifungal agents for different ocular fungal infections</td>
</tr>
<tr>
<td>Maichuk 1994</td>
<td>This is a case series using antifungal agents for different ocular fungal infections</td>
</tr>
<tr>
<td>Maichuk 1995</td>
<td>This is a case series</td>
</tr>
<tr>
<td>Martin 1996</td>
<td>The article is an in vitro study</td>
</tr>
</tbody>
</table>
This is a case series

It is not a RCT. Six consecutive eyes were treated with topical fluconazole

It is a commentary to another article

The article is a another commentary to Agarwal 2001

There was attempt at randomisation. There was no mention of centralised randomisation. Masking of patients was impossible due to different form of the medication given. Masking of care givers and outcome assessors was not reported although difficult to perform because the treatments are in different forms (suspension and oil mixture). There was also no report on drop out rates

This is a retrospective study on severe fungal ulcers which needed penetrating keratoplasty

RCT: randomised controlled trial

**Characteristics of ongoing studies [ordered by study ID]**

**NCT00516399**

<table>
<thead>
<tr>
<th>Trial name or title</th>
<th>A Clinical Trial of the Treatment of Fungal Corneal Ulcers With Povidone-Iodine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods</td>
<td>Randomised controlled trial</td>
</tr>
<tr>
<td>Participants</td>
<td>People with fungal corneal ulcers</td>
</tr>
<tr>
<td>Interventions</td>
<td>Povidone-iodine 1.25% ophthalmic solution compared to natamycin ophthalmic suspension, USP 5%</td>
</tr>
</tbody>
</table>
| Outcomes            | Following text from entry on clinicaltrials.gov:  
Number of days until disappearance of hypopyon and criteria for recovery and cure are met and subject is discharged home. Number of treatment failures. Ocular complications from the infection and ocular and systemic complications from the treatment.  
[Time Frame: Inferior outcome is defined as cure time under povidone-iodine treatment, which is at least 4 days longer than cure time under natamycin, or time until criteria for improvement to hospital discharge is reached.  
[Designated as safety issue: Yes ] |
| Starting date       | March 2008                                                                     |
| Contact information | Sherwin J Isenberg, M.D. isenberg@ucla.edu                                      |
| Notes               | http://clinicaltrials.gov/ct2/show/NCT00516399  
Trial as yet unpublished: completion date September 2011 |
<table>
<thead>
<tr>
<th>Trial name or title</th>
<th>Mycotic Ulcer Treatment Trial I (MUTT I)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods</td>
<td>Randomised controlled trial</td>
</tr>
<tr>
<td>Participants</td>
<td>People with corneal ulcer aged 16 years and older</td>
</tr>
<tr>
<td>Interventions</td>
<td>Natamycin 5% compared to voriconazole 1%</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Following text from entry on clinicaltrials.gov: Primary Outcome Measures: Best spectacle-corrected logMAR visual acuity [Time Frame: 3 months from enrollment] [Designated as safety issue: No] The primary analysis is best spectacle-corrected logMAR visual acuity, correcting for enrollment BSCVA and treatment arm in a multiple linear regression model. The pre-specified non-inferiority margin is less than 1.5 lines logMAR acuity. (Adjusted three-month visual acuity confidence bounds for the difference between the voriconazole and natamycin groups which meet or exceed 0.15 logMAR units would not permit noninferiority to be declared.) Note that this design also allows declaration of superiority (2-sided alpha of 0.05, corrected for an interim analysis) Secondary Outcome Measures: Best spectacle-corrected logMAR visual acuity [Time Frame: 3 weeks after enrollment] [Designated as safety issue: No] Best spectacle-corrected logMAR visual acuity at 3 weeks after enrollment, adjusting for enrollment BSCVA and treatment arm in a multiple linear regression model Best spectacle-corrected logMAR visual acuity only in Indian sites [Time Frame: 3 weeks and 3 months after enrollment] [Designated as safety issue: No] Best spectacle-corrected logMAR visual acuity only in Indian sites, 3 weeks and 3 months after enrollment, adjusting for enrollment BSCVA and treatment arm in a multiple linear regression model Hard contact-lens corrected visual acuity measured in logMAR [Time Frame: 3 months after enrollment] [Designated as safety issue: No] Hard contact-lens corrected visual acuity measured in logMAR 3 months after enrollment Size of infiltrate/scar [Time Frame: 3 weeks and 3 months after enrollment] [Designated as safety issue: No] Size of infiltrate/scar at 3 weeks and 3 months after enrollment, using enrollment infiltrate scar/size as a covariate Time to resolution of epithelial defect [Time Frame: At the time of resolution of epithelial defect] [Designated as safety issue: No] Time to resolution of epithelial defect Number of perforations and other adverse events [Time Frame: At the time of perforation/adverse event] [Designated as safety issue: No] Minimum inhibitory concentration of isolates [Time Frame: 3 months after enrollment] [Designated as safety issue: No] Microbiological cure at 7 days [Time Frame: 7 days after enrollment] [Designated as safety issue: No]</td>
</tr>
<tr>
<td>Starting date</td>
<td>April 2010</td>
</tr>
<tr>
<td>Contact information</td>
<td>Tom Lietman, MD <a href="mailto:tom.lietman@ucsf.edu">tom.lietman@ucsf.edu</a></td>
</tr>
<tr>
<td>Notes</td>
<td><a href="http://clinicaltrials.gov/ct2/show/NCT00996736">http://clinicaltrials.gov/ct2/show/NCT00996736</a></td>
</tr>
</tbody>
</table>
**NCT00997035**

<table>
<thead>
<tr>
<th>Trial name or title</th>
<th>Mycotic Ulcer Treatment Trial II (MUTT II)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods</td>
<td>Randomised controlled trial</td>
</tr>
<tr>
<td>Participants</td>
<td>People aged 16 years or older with fungal corneal ulcer</td>
</tr>
<tr>
<td>Interventions</td>
<td>Topical voriconazole 1% combined with oral voriconazole compared to topical voriconazole 1% alone</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Following text from entry on clinicaltrials.gov:</td>
</tr>
<tr>
<td></td>
<td><strong>Primary Outcome Measures</strong>: Rate of perforation [Time Frame: 3 months from enrollment] [Designated as safety issue: No] Comparison of rate of perforation between the treatment groups (topical voriconazole with oral voriconazole vs. topical voriconazole with oral placebo)</td>
</tr>
<tr>
<td></td>
<td><strong>Secondary Outcome Measures</strong>: Best spectacle-corrected logMAR visual acuity [Time Frame: 3 weeks after enrollment] [Designated as safety issue: No] Best spectacle-corrected logMAR visual acuity at 3 weeks after enrollment, adjusting for enrollment BSCVA and treatment arm in a multiple linear regression model</td>
</tr>
<tr>
<td></td>
<td>Best spectacle-corrected logMAR visual acuity only in Indian sites [Time Frame: 3 weeks and 3 months after enrollment] [Designated as safety issue: No] Best spectacle-corrected logMAR visual acuity only in Indian sites, 3 weeks and 3 months after enrollment, adjusting for enrollment BSCVA and treatment arm in a multiple linear regression model</td>
</tr>
<tr>
<td></td>
<td>Best spectacle-corrected logMAR visual acuity [Time Frame: 3 months after enrollment] [Designated as safety issue: No] Best spectacle-corrected logMAR visual acuity 3 months after enrollment, adjusting for enrollment BSCVA and treatment arm in a multiple linear regression model</td>
</tr>
<tr>
<td></td>
<td>Hard contact-lens corrected visual acuity measured in logMAR [Time Frame: 3 months after enrollment] [Designated as safety issue: No] Hard contact-lens corrected visual acuity measured in logMAR 3 months after enrollment</td>
</tr>
<tr>
<td></td>
<td>Size of infiltrate/scar [Time Frame: 3 weeks and 3 months after enrollment] [Designated as safety issue: No] Size of infiltrate/scar at 3 weeks and 3 months after enrollment, using enrollment infiltrate size as a covariate</td>
</tr>
<tr>
<td></td>
<td>Time to resolution of epithelial defect [Time Frame: At the time of resolution of epithelial defect] [Designated as safety issue: No]</td>
</tr>
<tr>
<td></td>
<td>Number of adverse events [Time Frame: At the time of adverse event] [Designated as safety issue: No]</td>
</tr>
<tr>
<td></td>
<td>Minimum inhibitory concentration of isolates [Time Frame: 3 months after enrollment] [Designated as safety issue: No]</td>
</tr>
<tr>
<td></td>
<td>Microbiological cure at 7 days [Time Frame: 7 days after enrollment] [Designated as safety issue: No]</td>
</tr>
<tr>
<td>Starting date</td>
<td>May 2010</td>
</tr>
<tr>
<td>Contact information</td>
<td>Nisha Acharya, MD, MS <a href="mailto:nisha.acharya@ucsf.edu">nisha.acharya@ucsf.edu</a></td>
</tr>
</tbody>
</table>
### DATA AND ANALYSES

#### Comparison 1. 1% silver sulphadiazine versus 1% miconazole

<table>
<thead>
<tr>
<th>Outcome or subgroup title</th>
<th>No. of studies</th>
<th>No. of participants</th>
<th>Statistical method</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulcer healed at 2 to 4 weeks</td>
<td>2</td>
<td>70</td>
<td>Risk Ratio (M-H, Fixed, 95% CI)</td>
<td>0.51 [0.25, 1.07]</td>
</tr>
</tbody>
</table>

#### Comparison 2. Chlorhexidine versus natamycin

<table>
<thead>
<tr>
<th>Outcome or subgroup title</th>
<th>No. of studies</th>
<th>No. of participants</th>
<th>Statistical method</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favourable response at 5 days</td>
<td>2</td>
<td>128</td>
<td>Risk Ratio (M-H, Fixed, 95% CI)</td>
<td>0.46 [0.28, 0.77]</td>
</tr>
<tr>
<td>Ulcer healed at 21 days</td>
<td>2</td>
<td>110</td>
<td>Risk Ratio (M-H, Fixed, 95% CI)</td>
<td>0.77 [0.55, 1.08]</td>
</tr>
</tbody>
</table>

#### Analysis 1.1. Comparison 1 1% silver sulphadiazine versus 1% miconazole, Outcome 1 Ulcer healed at 2 to 4 weeks.

Review: Medical interventions for fungal keratitis

Comparison: 1 1% silver sulphadiazine versus 1% miconazole

Outcome: Ulcer healed at 2 to 4 weeks

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Silver sulphadiazine</th>
<th>Miconazole</th>
<th>Risk Ratio (Non-event)</th>
<th>Weight</th>
<th>Risk Ratio (Non-event)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mohan 1987</td>
<td>15/20</td>
<td>6/10</td>
<td></td>
<td>37.2 %</td>
<td>0.63 [0.21, 1.83]</td>
</tr>
<tr>
<td>Mohan 1988</td>
<td>16/20</td>
<td>11/20</td>
<td></td>
<td>62.8 %</td>
<td>0.44 [0.16, 1.21]</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>40</td>
<td>30</td>
<td></td>
<td>100.0 %</td>
<td>0.51 [0.25, 1.07]</td>
</tr>
</tbody>
</table>

Total events: 31 (Silver sulphadiazine), 17 (Miconazole)
Heterogeneity: Chi² = 0.21, df = 1 (P = 0.65); I² = 0.0%
Test for overall effect: Z = 1.79 (P = 0.073)
Test for subgroup differences: Not applicable
### Analysis 2.1. Comparison 2 Chlorhexidine versus natamycin, Outcome 1 Favourable response at 5 days.

**Review:** Medical interventions for fungal keratitis

**Comparison:** 2 Chlorhexidine versus natamycin

**Outcome:** 1 Favourable response at 5 days

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Chlorhexidine n/N</th>
<th>Natamycin n/N</th>
<th>Risk Ratio(Non-event)</th>
<th>Weight</th>
<th>Risk Ratio(Non-event)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rahman 1997</td>
<td>24/42</td>
<td>7/16</td>
<td>43.4 %</td>
<td>0.76</td>
<td>[ 0.44, 1.33 ]</td>
</tr>
<tr>
<td>Rahman 1998</td>
<td>31/35</td>
<td>18/35</td>
<td>56.6 %</td>
<td>0.24</td>
<td>[ 0.09, 0.63 ]</td>
</tr>
</tbody>
</table>

**Total (95% CI):** 77 51 100.0 % 0.46 [ 0.28, 0.77 ]

Total events: 55 (Chlorhexidine), 25 (Natamycin)

Heterogeneity: Chi² = 4.90, df = 1 (P = 0.03); I² =80%

Test for overall effect: Z = 3.00 (P = 0.0027)

Test for subgroup differences: Not applicable

---

### Analysis 2.2. Comparison 2 Chlorhexidine versus natamycin, Outcome 2 Ulcer healed at 21 days.

**Review:** Medical interventions for fungal keratitis

**Comparison:** 2 Chlorhexidine versus natamycin

**Outcome:** 2 Ulcer healed at 21 days

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Chlorhexidine n/N</th>
<th>Natamycin n/N</th>
<th>Risk Ratio(Non-event)</th>
<th>Weight</th>
<th>Risk Ratio(Non-event)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rahman 1997</td>
<td>20/32</td>
<td>7/14</td>
<td>29.7 %</td>
<td>0.75</td>
<td>[ 0.38, 1.49 ]</td>
</tr>
<tr>
<td>Rahman 1998</td>
<td>14/32</td>
<td>9/32</td>
<td>70.3 %</td>
<td>0.78</td>
<td>[ 0.54, 1.14 ]</td>
</tr>
</tbody>
</table>

**Total (95% CI):** 64 46 100.0 % 0.77 [ 0.55, 1.08 ]

Total events: 34 (Chlorhexidine), 16 (Natamycin)

Heterogeneity: Chi² = 0.01, df = 1 (P = 0.91); I² =0.0%

Test for overall effect: Z = 1.52 (P = 0.13)

Test for subgroup differences: Not applicable

---

Medical interventions for fungal keratitis (Review)

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### Table 1. Anti-fungal agents studied in the included trials

<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention</th>
<th>Dose</th>
<th>Treatment duration</th>
<th>Intervention</th>
<th>Dose</th>
<th>Treatment duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agarwal 2001</td>
<td>Topical itraconazole</td>
<td>1%, every hour</td>
<td>For 6 weeks after keratitis resolved</td>
<td>Oral itraconazole</td>
<td>100 mg twice daily</td>
<td>For 6 weeks after keratitis resolved</td>
</tr>
<tr>
<td></td>
<td>Topical itraconazole</td>
<td>1%, every hour</td>
<td></td>
<td>Topical itraconazole</td>
<td>1%, every hour</td>
<td></td>
</tr>
<tr>
<td>Arora 2011</td>
<td>Topical natamycin</td>
<td>5%, every hour</td>
<td>Two weeks “Further dosage titrated according to the patient’s response”</td>
<td>Topical voriconazole</td>
<td>1%, every hour</td>
<td>Two weeks “Further dosage titrated according to the patient’s response”</td>
</tr>
<tr>
<td>Mahdy 2010</td>
<td>Topical amphotericin B</td>
<td>0.05%, every two hours</td>
<td>20 injections, first 10 every day, second 10 every two days</td>
<td>Topical amphotericin B</td>
<td>0.05%, every two hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subconjunctival injection of fluconazole</td>
<td>0.5 ml of 2 mg/ml, daily</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mohan 1987</td>
<td>Topical silver sulphadiazine</td>
<td>Two doses studied: 0.5% and 1% applied 5 times a day</td>
<td></td>
<td>Topical miconazole</td>
<td>1%, applied 5 times a day</td>
<td></td>
</tr>
<tr>
<td>Mohan 1988</td>
<td>Topical silver sulphadiazine</td>
<td>1%, applied 5 times a day</td>
<td>If no improvement after 1 week, switched to other treatment, treatment continued for 2 weeks after clinical healing of ulcer</td>
<td>Topical miconazole</td>
<td>1%, applied 5 times a day</td>
<td>If no improvement after 1 week, switched to other treatment, treatment continued for 2 weeks after clinical healing of ulcer</td>
</tr>
<tr>
<td>Prajna 2003</td>
<td>Topical natamycin</td>
<td>5%, every hour between 7am and 9pm</td>
<td>Four weeks</td>
<td>Topical econazole</td>
<td>2%, every hour between 7am and 9pm</td>
<td>Four weeks</td>
</tr>
<tr>
<td>Prajna 2010*</td>
<td>Topical natamycin</td>
<td>5%, every hour while awake</td>
<td>Every hour for one week followed by every two hours</td>
<td>Topical voriconazole</td>
<td>1%, every hour while awake</td>
<td>Every hour for one week followed by every two hours</td>
</tr>
<tr>
<td>Study</td>
<td>Drug 1</td>
<td>Concentration</td>
<td>Dosage and Duration</td>
<td>Drug 2</td>
<td>Concentration</td>
<td>Dosage and Duration</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------</td>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Rahman 1997</td>
<td>Topical natamycin</td>
<td>5%</td>
<td>Day 1: Half-hourly for three hours, hourly during waking hours for rest of day Days 2 to 5: 2-hourly Then 3-hourly for a further 2 weeks. If no improvement at 5 days swapped to another treatment</td>
<td>Topical chlorhexidine gluconate</td>
<td></td>
<td>Three doses studied: 0.05%, 0.1% and 0.2% Day 1: Half-hourly for three hours, hourly during waking hours for rest of day Days 2 to 5: 2-hourly Then 3-hourly for a further 2 weeks. If no improvement at 5 days swapped to another treatment</td>
</tr>
<tr>
<td>Rahman 1998</td>
<td>Topical natamycin</td>
<td>2.5%</td>
<td>Half-hourly for first 3 hours, then 1 hourly for 2 days, 2 hourly for 5 days, and 3 hourly for 3 weeks. If no improvement at 5 days treatment changed</td>
<td>Topical chlorhexidine gluconate</td>
<td>0.2%</td>
<td>Half-hourly for first 3 hours, then 1 hourly for 2 days, 2 hourly for 5 days, and 3 hourly for 3 weeks. If no improvement at 5 days treatment changed</td>
</tr>
</tbody>
</table>

* Participants were also randomized to “scraping of the corneal epithelium”
Appendix 1. CENTRAL search strategy

#1 MeSH descriptor Eye Infections, Fungal
#2 MeSH descriptor Keratitis
#3 fung* near keratit*
#4 fung* near infect* near eye*
#5 fung* near infect* near ocular
#6 keratomycosis
#7 keratomicosis
#8 (#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7)
#9 MeSH descriptor Antifungal Agents
#10 MeSH descriptor Natamycin
#11 natamycin*
#12 MeSH descriptor Chlorhexidine
#13 chlorhexidine*
#14 MeSH descriptor Econazole
#15 econazole*
#16 MeSH descriptor Itraconazole
#17 itraconazole*
#18 MeSH descriptor Miconazole
#19 miconazole*
#20 anti fung*
#21 antifung*
#22 (#9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21)
#23 (#8 AND #22)

Appendix 2. MEDLINE (OVID) search strategy

1 randomized controlled trial.pt.
2 (randomized or randomised).ab,ti.
3 placebo.ab,ti.
4 dt.fs.
5 randomly.ab,ti.
6 trial.ab,ti.
7 groups.ab,ti.
8 or/1-7
9 exp animals/
10 exp humans/
11 9 not (9 and 10)
12 8 not 11
13 exp eye infections, fungal/
14 exp keratitis/
15 (fung$ adj2 keratitis$).tw.
16 (fung$ adj3 infect$ adj3 eye$).tw.
17 (fung$ adj3 infect$ adj3 ocular).tw.
18 keratomycosis.tw.
19 or/13-18
20 exp antifungal agents/
21 exp natamycin/
22 natamycin$.tw.
23 exp chlorhexidine/
The search filter for trials at the beginning of the MEDLINE strategy is from the published paper by Glanville (Glanville 2006).

### Appendix 3. EMBASE (OVID) search strategy

1 exp randomized controlled trial/
2 exp randomization/
3 exp double blind procedure/
4 exp single blind procedure/
5 random$.tw.
6 or/1-5
7 (animal or animal experiment).sh.
8 human.sh.
9 7 and 8
10 7 not 9
11 6 not 10
12 exp clinical trial/
13 (clin$ adj3 trial$).tw.
14 ((singl$ or doubl$ or trebl$ or tripl$) adj3 (blind$ or mask$)).tw.
15 exp placebo/
16 placebo$.tw.
17 random$.tw.
18 exp experimental design/
19 exp crossover procedure/
20 exp control group/
21 exp latin square design/
22 or/12-21
23 22 not 10
24 23 not 11
25 exp comparative study/
26 exp evaluation/
27 exp prospective study/
28 (control$ or prospectiv$ or volunteer$).tw.
29 or/25-28
30 29 not 10 (930488)
31 30 not (11 or 23)
32 11 or 24 or 31
33 exp keratomycosis/
34 exp keratitis/
35 (fung$ adj2 keratit$).tw.
36 (fung$ adj3 infect$ adj3 eye$).tw.
Appendix 4. LILACS search strategy

eye$ or ocular and fungal keratitis or keratomycosis

Appendix 5. metaRegister of Controlled Trials search strategy

fungal keratitis

Appendix 6. ClinicalTrials.gov search strategy

fungal keratitis

WHAT’S NEW

Last assessed as up-to-date: 29 August 2011.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 December 2011</td>
<td>New citation required but conclusions have not changed</td>
<td>Issue 2, 2012: Three new trials were included in the update (Arora 2011; Mahdy 2010; Prajna 2010).</td>
</tr>
<tr>
<td>15 December 2011</td>
<td>New search has been performed</td>
<td>Issue 2, 2012: Electronic searches were updated, risk of bias tables have been completed for all included trials and text modified. A new author joined the review team to help with updating the review</td>
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HISTORY

Review first published: Issue 1, 2008

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>22 October 2008</td>
<td>Amended</td>
<td>Converted to new review format.</td>
</tr>
<tr>
<td>13 November 2007</td>
<td>New citation required and conclusions have changed</td>
<td>Substantive amendment</td>
</tr>
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</table>

CONTRIBUTIONS OF AUTHORS

NVF conceived the review question, co-ordinated the review, organised retrieval of full text copies, wrote to authors of papers for additional information, provided additional data about papers, obtained and screened data on unpublished studies, analysed and interpreted data, performed previous work that was the foundation of the review and wrote the review.

NVF and IP screened initial search results, screened retrieved papers against inclusion criteria, extracted and entered data into RevMan.

Update Issue 2, 2012

NVF and JE screened search results, appraised quality of papers, extracted and entered data into RevMan and wrote the update.

DECLARATIONS OF INTEREST

None known.

SOURCES OF SUPPORT

Internal sources

- NIHR/Department of Health, UK.

  Funded JE to assist in updating the version published in Issue 2, 2012.

External sources

- No sources of support supplied
INDEX TERMS

Medical Subject Headings (MeSH)
Antifungal Agents [*therapeutic use]; Eye Infections, Fungal [*drug therapy]; Keratitis [*drug therapy; microbiology]; Randomized Controlled Trials as Topic

MeSH check words
Humans