Eye pain is common. Around 2-5% of general practice patients have an eye complaint featuring pain in and around the eye (ocular, periocular, and periorbital pain, described here collectively as eye pain). Among patients attending an ophthalmic emergency department in New Zealand, more than 50% of new referrals were from general practices, with eye pain being the most common symptom. The authors suggested that referrals could be reduced with better initial diagnosis.

Eye pain with an inflamed, red eye is common and can be readily triaged for a management plan, in most cases by simple examination with a direct ophthalmoscope or pen torch. This is discussed elsewhere in relation to the differential diagnosis and treatment of conjunctivitis and when to refer for slit-lamp examination for sight threatening ocular surface inflammation or uveitis.

Eye pain in an uninflamed (white) eye is less common. Guidelines for the diagnosis of conjunctivitis have been produced by the Dutch College of General Practitioners, and evidence based summaries on management of the red eye are available (http://cks.nice.org.uk/red-eye), but no validated guidelines for the painful, inflamed or uninflamed, eye have been developed. The present advice is based on a review of the literature (see box 1 for details) and a questionnaire based survey of patients attending an emergency hospital eye service (box 2).

The painful uninflamed eye, particularly if associated with reduced vision, presents a difficult diagnostic challenge, but key causes of the pain can be quickly deduced by using the steps below.

**What does the patient with eye pain fear most?**

Patients with eye pain are most often concerned about a possible threat to sight, as shown by our recent survey of patients attending hospital eye services (see box 2). Observational studies and the results of a controlled study also reported that patients have difficulty describing the pain in terms of its onset, duration, nature, and severity. A systematic review of therapies for trigeminal neuralgia revealed that, if the patient feels there is a low or negligible risk to sight, relief of pain becomes the predominant concern.

**Initial assessment**

When a patient presents with eye pain in an otherwise “quiet” uninflamed eye, it is critical to identify potential sight threatening conditions with the following steps:

1. Ask if the pain is in or around the eye
2. Ask if the vision has changed
3. Check visual acuity (such as Snellen chart testing)
4. Check if the apparently white eye has any signs of inflammation even if mild: examine carefully the external eye, including those parts of the globe under the lids, for signs of occult trauma (subconjunctival haemorrhage), conjunctivitis, or foreign bodies (see below and fig 1).

Both pain located in the eye (ophthalmic eye pain) and pain located around the eye (non-ophthalmic eye pain) are relatively common. In most cases the threat to sight is low (even in inflamed eyes). However, determining if this risk exists is the main object of the consultation, and requires further steps in the assessment, which should address all symptoms not only the pain.
What to look for next

**Ophthalmic causes of eye pain**

Serious sight threatening causes of eye pain in the uninflamed eye in which the vision may or may not be reduced at the time of examination include occult trauma, posterior uveitis (fig 2⇓), optic neuritis (fig 3⇓), and, rarely, chronic glaucoma (fig 4⇓) (see table 1⇓).

In checking for these conditions, ask:

- Is there a history of recent or past trauma? This includes pain after accidental or surgical trauma (pain after cataract and laser refractive surgery may rarely persist for weeks to months)
- Is there evidence of trauma on examination of the external eye and lids (for example, in the pupil shape and reactions to light or colour of the iris)? Examine with a bright pen torch or a direct ophthalmoscope, of the globe, the external eye and lids (using a cotton bud, see fig 1⇓). A retained subtarsal, periocular, or corneal foreign body can cause pain in an uninflamed eye. A retained intraocular foreign body and intraocular haemorrhage due to blunt trauma may alter the colour of the iris (heterochromia)
- Is there low level eye “ache” with unexplained reduced vision (reduction of more than 2 lines on a Snellen chart)? This may suggest chronic uveitis (fig 2⇓), scleritis (fig 5⇓), or chronic glaucoma (fig 4⇓)
- Is the pain of a dull, persistent, occasionally throbbing nature with headache? This suggests chronic angle closure glaucoma or neovascular (neovascular) glaucoma (fig 4⇓), for instance, associated with retinal vein occlusion or diabetic eye disease. Angle closure may occur in patients with chronic obstructive pulmonary disease
- Is the pain of sudden onset or acute, especially on eye movement, and associated with visual loss? This set of symptoms is pathognomic of optic neuritis (fig 3⇓).

Non-sight threatening ophthalmic causes of eye pain are the most likely to present to general practice. These include optical causes (refractive error, eye strain), ocular surface disease (dry eye disease, Sjögren’s syndrome), and a range of lid diseases (fig 6⇓) (see table 1⇓). Careful examination, using a bright pen torch or a direct ophthalmoscope, of the globe, the external eye and the everted lids (using a cotton bud, see fig 1⇓) will reveal the cause.

**Non-ophthalmic causes of eye pain**

Serious, sight threatening, non-ophthalmic causes of eye pain in the uninflamed eye, in which the vision may or may not be reduced at the time of examination, include various forms of vascular disease such as intracranial aneurysms, giant cell arteritis (more usually scalp pain), and, rarely, transient ischaemic attacks (see table 2⇓).

In checking for these conditions, ask the patient:

- Is there a history or evidence of scalp pain or tenderness or jaw claudication or pain on swallowing, all features of giant cell arteritis?
- Is there a history of headache, which might indicate raised intracranial pressure, as well as less serious causes such as sinusitis, migraine, cluster headaches?
- Is there a history of diplopia or signs of ocular muscle paresis—such as lid droop, divergent squint—as can occur with impending rupture of an intracranial aneurysm?
- Is there a history of transient ischaemic attacks (episodes of unilateral severe visual loss, with pain or headache in the pre-recovery or post-recovery phase)? Transient ischaemic attacks are a rare cause of sight threatening eye pain and may predicate a stroke, particularly if they occur in younger adults.
• Is there a history of shingles or a vesicular rash suggesting shingles, leading to post-herpetic neuralgia? Periocular skin pain and tenderness may also occur before the onset of vesicles.

Non-sight threatening non-ophthalmic causes of eye pain are a common cause of eye pain presented in general practice and include conditions such as sinus disease, migraine, trigeminal neuralgia, a range of lid diseases, and unusual causes of atypical facial pain.14 15

When to refer

Patients with eye pain in an uninflamed eye should be referred to secondary care as follows:

• **Immediately (within hours)**—if there is evidence of acute onset sight loss (more than two lines on Snellen chart) or suspicion of giant cell arteritis or raised intracranial pressure

• **Soon (within days)**—if there is a perceived risk of sight loss based on the suspected diagnosis (such as chronic glaucoma or uveitis)

• **For investigation**—if there is no perceived threat to sight but the symptoms are affecting quality of life and wellbeing (such as cluster headaches, migraine, unmanageable ocular surface disease).

We acknowledge the important contributions of Professor Amada J Lee, University of Aberdeen, Division of Statistics, for assistance with analysing the data from the patient survey. We thank Kamran Khan, Oliver Chadwick, and Paul Chua, trainee ophthalmologists, NHS Grampian, for providing the clinical images.

Contributors: LK contributed to the design of the study, the survey of patients, and writing the paper. JVF contributed to the design of the study and writing the paper. ADD contributed to the design of the study, the survey of the patients, and writing the paper. JVF is guarantor for the paper.

Competing interests: We have read and understood the BMJ policy on declaration of interests and have no relevant interests to declare.

The views expressed are those of the authors and not necessarily those of the National Health Service, the NIHR or the Department of Health.

Provenance and peer review: Commissioned; externally peer reviewed.


Cite this as: **BMJ** 2015;351:h3216

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## Tables

### Table 1  Ophthalmic causes of eye pain in an uninflamed (white) eye

<table>
<thead>
<tr>
<th>Condition</th>
<th>Possible clinical indicator</th>
<th>Age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sight threatening</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma</td>
<td>History</td>
<td>Any</td>
</tr>
<tr>
<td>Posterior uveitis</td>
<td>Floaters</td>
<td>Any</td>
</tr>
<tr>
<td>Optic neuritis</td>
<td>Pain on eye movement</td>
<td>Adults</td>
</tr>
<tr>
<td>Chronic glaucoma</td>
<td>Persistent dull headache</td>
<td>Adults</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-sight threatening</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refractive error</td>
<td>“Eye strain”</td>
<td>Adults</td>
</tr>
<tr>
<td>Dry eye disease</td>
<td>“Grittiness”</td>
<td>Adults</td>
</tr>
<tr>
<td>Sjögren’s syndrome</td>
<td>Dry eyes and mouth</td>
<td>Adults</td>
</tr>
<tr>
<td>Meibomitis</td>
<td>Epiphora</td>
<td>Adults</td>
</tr>
<tr>
<td>Trichiasis</td>
<td>Entropion</td>
<td>Older adults (&gt;65 years)</td>
</tr>
<tr>
<td>Exposure keratitis</td>
<td>Ectropion</td>
<td>Older adults (&gt;65 years)</td>
</tr>
<tr>
<td>Subtarsal foreign body</td>
<td>“FB” sensation*</td>
<td>Any</td>
</tr>
</tbody>
</table>

*A subtarsal foreign body (FB) may be completely symptomless, but it commonly induces an “FB” sensation which is more than a feeling of grittiness, rather a roughness located to a specific position under the lid.
Table 2 | Non-ophthalmic causes of eye pain in an uninflamed (white) eye

<table>
<thead>
<tr>
<th>Sight threatening</th>
<th>Non-sight threatening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intracranial aneurysm</td>
<td>Third nerve palsy</td>
</tr>
<tr>
<td>Benign intracranial hypertension (raised intracranial pressure)</td>
<td>Disc swelling</td>
</tr>
<tr>
<td>Giant cell arteritis</td>
<td>Skin or scalp tenderness</td>
</tr>
<tr>
<td>Herpes zoster</td>
<td>Post herpetic neuralgia</td>
</tr>
<tr>
<td>Herpes zoster</td>
<td>Pre-vesicle stage</td>
</tr>
<tr>
<td>Sinusitis</td>
<td>Chronic headache, retro-orbital pain</td>
</tr>
<tr>
<td>Migraine</td>
<td>Headache, photophobia, nausea, vomiting</td>
</tr>
<tr>
<td>Trigeminal neuralgia</td>
<td>Severe episodic pain*</td>
</tr>
<tr>
<td>Atypical facial pain</td>
<td>Cluster headaches</td>
</tr>
</tbody>
</table>

*In this condition the pain is restricted to the trigeminal nerve distribution.
Figures

![Figures](image_url)

**Fig 1** An apparently uninflamed white eye when in primary position of gaze (a) and looking down with eyelid retracted (b) masks a low level of inflammation caused by allergic papillary conjunctivitis and revealed by evertting the upper lid (c): note the papillae made visible at margin by evertting the lid (arrows) and the prominent conjunctival vessels on the everted lid surface.

**Fig 2** Uninflamed chronically painful white eye with panuveitis and reduced vision. Small keratic precipitates (inflammatory cell deposits on the corneal endothelium) are barely visible (arrows).
**Fig 3** Funduscropy of an uninflamed, acutely painful (on movement) white eye showing the swollen disc of optic neuritis associated with acute loss of vision.

**Fig 4** Uninflamed painful white eye showing fine abnormal “rubeotic” iris new vessels (arrow). Rubeosis of the iris is commonly associated with secondary glaucoma.

**Fig 5** Uninflamed bilateral severely painful eyes due to posterior scleritis showing exudative retinal detachment and vitreous “haze” (infiltration with inflammatory cells and protein exudate). (a) external appearance of right white, uninflamed eye; (b) fundus appearance of right eye in (a) showing vitreous “haze” (indistinct view of optic disc and retinal vessels) and inferior retinal detachment (arrow); (c) and (d) same as (a) and (b) but left eye.
Fig 6 Uninflamed, mildly painful (“irritated”) eye due to meibomitis, causing a disturbed tear film (lack of oily layer) and excessive tear evaporation, with secondary “dry eye” disease. The openings of the meibomian gland ducts are blocked as shown by the yellow spots on the lower lid (arrows).