



The Watering Eye: Why Understanding Epiphora Matters in Everyday Ophthalmology

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Few complaints seem as straightforward as a watering eye. Yet epiphora is a useful reminder that a symptom is not a diagnosis. Patients do not arrive describing “lacrimal pump dysfunction,” “punctal stenosis,” or “reflex tearing”; they simply say that their eye waters, sometimes constantly and sometimes only outdoors, when reading, or in the wind. Understanding why is the ophthalmologist’s task.

Epiphora may result from excessive tear production, impaired drainage, abnormal tear distribution, eyelid dysfunction, or more than one mechanism at the same time. Clinical series illustrate this heterogeneity. In a retrospective study of 320 symptomatic eyes, reflex tearing associated with dry eye accounted for 52.2%, whereas lacrimal passage abnormalities accounted for 21.3% [1]. In contrast, a tertiary lacrimal clinic reported post-sac obstruction and functional epiphora in 26% of symptomatic eyes each [2]. These figures should not be generalized across populations. Their variability is itself informative: the symptom alone does not tell us where the problem lies.

The watering dry eye is perhaps the best example. Tear-film instability and ocular surface irritation can provoke reflex tearing, while blepharitis, allergy, keratitis, trichiasis, and meibomian gland dysfunction may lead to the same complaint. Looking immediately for a blocked tear duct can therefore miss the real cause. The reverse is equally important: persistent, particularly unilateral, tearing should not automatically be labelled as dry eye without examining the lacrimal pathway.

The eyelids also deserve careful attention. Tear clearance depends on punctal position, blinking, eyelid tone, and lacrimal pump function as well as anatomical patency. Tse and colleagues proposed the BLICK framework - Blink dynamics, Lid malposition, Imbrication, Conjunctivochalasis, and Kissing puncta - to highlight abnormalities of tear distribution that can be overlooked when evaluation is reduced to ocular surface disease versus obstruction [3]. The practical lesson is simple: examination of the watering eye should begin with observation, not instrumentation.

A careful history and slit-lamp examination often narrow the diagnosis before any lacrimal test is performed. Laterality, intermittency, irritation, discharge, previous trauma or surgery, facial nerve dysfunction, and sinonasal history may all provide useful clues. Examination should include the ocular surface and tear film, eyelid position, puncta, blink, conjunctiva, and signs of inflammation or infection. When impaired drainage remains suspected, dye disappearance testing, probing, irrigation, and selected imaging can provide complementary information.

No single test, however, answers every question. A lacrimal system that is patent to irrigation does not necessarily drain normally in everyday conditions. This distinction is central to functional epiphora. In a large tertiary series, functional epiphora was diagnosed after excluding alternative causes in patients with patent syringing, normal dacryocystography, and delayed drainage on dacryoscintigraphy [2]. Earlier prospective work comparing clinical and radiologic lacrimal tests likewise showed that different tests provide different pieces of information and may need to be

interpreted together [4]. A recent systematic review confirms that functional epiphora remains a heterogeneous clinical entity with a less established evidence base than complete anatomical nasolacrimal obstruction [5].

This distinction has direct consequences for treatment. Dacryocystorhinostomy can bypass an appropriate outflow obstruction, but it cannot correct every watering eye. Depending on the mechanism, treatment may instead involve ocular surface therapy, correction of eyelid or punctal abnormalities, lacrimal intubation, other drainage procedures, or observation. Successful lacrimal surgery therefore begins before the operating room: it begins with the correct indication.

For this reason, evaluating epiphora should not be regarded as a niche skill limited to lacrimal surgeons. Most patients with tearing first present to general ophthalmologists or other ophthalmic subspecialists. Recognizing reflex tearing, eyelid malposition, punctal disease, or a likely drainage disorder allows appropriate treatment and, just as importantly, appropriate referral.

Perhaps the most useful question is not “Is the tear duct blocked?” but “Why are tears reaching the cheek?” That change in perspective encourages us to consider tear production, distribution, pumping, and drainage as parts of the same functional system. A watering eye may appear to be a minor complaint, but persistent tearing can interfere with vision, comfort, and daily activities. In epiphora, good management begins not with the syringe, but with understanding the mechanism.

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