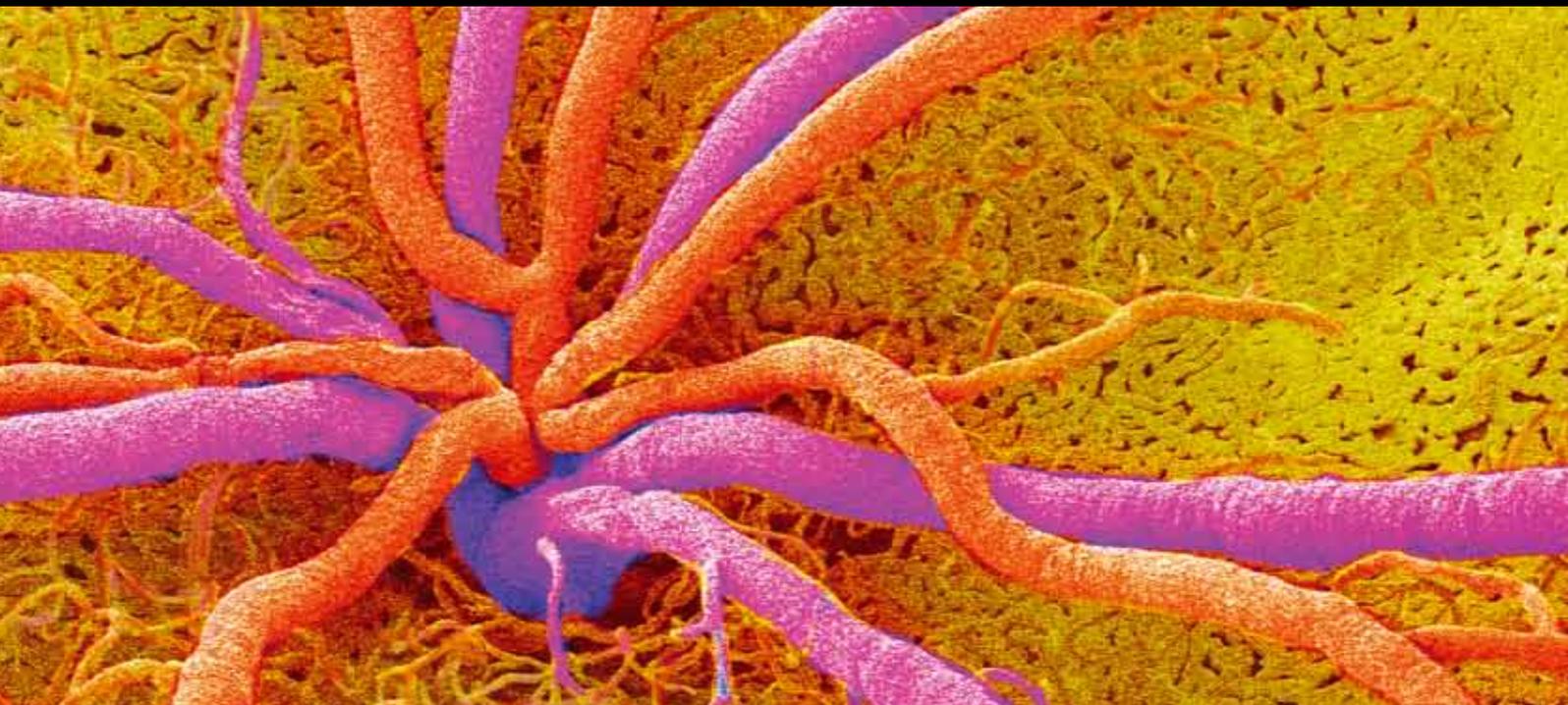


Keratoconus and Keratoectasia: Advancements in Diagnosis and Treatment

Guest Editors: Antonio Leccisotti, Ioannis M. Aslanides,
Johnny E. Moore, and Sunil Shah





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Editorial

Keratoconus and Keratoectasia: Advancements in Diagnosis and Treatment

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Keratoconus (KC) and iatrogenic keratoectasia are receiving increasing attention, due to the improvements in diagnostic modalities and the availability of therapeutic options, which now include collagen cross-linking, intrastromal implants, intraocular lenses, microwave remodeling, and anterior lamellar keratoplasty.

Limitations of surgical treatments of keratoconus are well known. Intrastromal implants, built in various shapes and now implanted more safely through femtosecond-laser-obtained stromal channels, still retain reduced predictability as for the refractive results and do not modify the structure of the diseased cornea. Anterior lamellar keratoplasty, even in its more advanced and technically difficult variant of deep anterior lamellar keratoplasty (DALK), cures the disease by the (almost) complete replacement of the ectatic stroma but, even when a regular and transparent interface is achieved, final refractive errors and higher-order aberrations may severely affect visual rehabilitation. The use of femtosecond laser in DALK to shape the donor and recipient margins has not significantly improved the picture yet.

Parasurgical treatments of KC are therefore regarded as a temporary or definitive alternative to surgical interventions. Among the newest ideas, the promising use of microwave to heat and reshape the corneal apex shares the principle with previous modalities of thermal keratoplasty, which were characterized by regression and induction of irregular

astigmatism. The long-term validity of microwave reshaping is, therefore, still being investigated.

The use of collagen corneal cross-linking (CXL) with riboflavin and ultraviolet (UV) has rapidly expanded in the world and is currently regarded as the only recognized treatment to slow or arrest KC progression, obtaining in some cases a significant improvement of corneal curvature and regularity. However, as most new treatments, CXL is still far from being ideal. Riboflavin for CXL is unreasonably expensive; the treatment is long and tedious and is followed by postoperative pain and slow visual rehabilitation. Complications are not uncommon, including infections and scarring. The indications to the treatment are still debated as for age, KC stage, and corneal thickness. Alternative attempts to reduce the CXL operating time by increasing the irradiation energy or by avoiding epithelial removal have been made, but all deviations from the defined original protocol may reduce the efficacy of treatment, and therefore new treatment protocols are currently further investigated.

In this special issue, various and new aspects of CXL are examined, rehabilitation with contact lenses of KC is reviewed, and the features of posterior KC at ultrasound biomicroscopy are evaluated.

Patient selection for CXL is not completely codified, and age limits are conventionally established. For example, the Italian National Health Service limits CXL reimbursement

for patients between 12 and 40 years, the lower limit being dictated by common sense and the upper limit by the presumption of spontaneous KC stabilization after 40. A. Caporossi and Mazzotta et al., leading experts of CXL, in their original study in this issue, compare KC stabilization, improvement of corneal curvature, visual acuity, and aberrations 48 months after CXL in different age groups, concluding that the highest benefits were obtained in younger eyes.

CXL procedure was originally developed to stiffen the keratoconic cornea, but its indications have been recently extended to postrefractive surgery ectasia, to infectious keratitis (due to a powerful antimicrobial action), and to corneal edema, where CXL temporarily reduces the space for fluid accumulation. These new indications of CXL, as well as its physical and chemical background, biomechanical effects, and clinical results, are thoroughly reviewed in the paper by M. Hovakimyan et al., where the real possibilities of transepithelial CXL and of the new approach combining photorefractive keratectomy (PRK) and CXL are discussed.

Several reports of infectious keratitis after CXL have recently raised the issue of CXL safety: it would appear that the risk of infection is considerably higher than after PRK. The length of the procedure or the slow epithelialization time could be the reasons for such increased infectious risk. In addition, the peculiar “demarcation” haze, regarded as a demonstration of the cross-linking effect, can sometimes turn into a significant, long-term scar. These complications and others are well reviewed in the paper by S. Dhawan et al.

Fortunately, most patients with KC will never need to undergo any surgical or parasurgical procedure. Visual rehabilitation is sometimes possible with the sole help of spectacles, but the reduction of higher-order aberrations is only possible with contact lenses. The extended wear of contact lenses and the difficult adaptation in keratoconic eyes imply a thorough knowledge of various contact lens models available: this is the subject of the article by Ozkurt et al.

The paper by B. Rejda et al. is a case report of a rare, nonprogressive variant of KC, circumscribed posterior keratoconus. The correct diagnosis of this form of ectasia is only possible by modern three-dimensional imaging technique, and in this case ultrasound biomicroscopy and slit scanning topography were used to reveal the protrusion of the posterior corneal surface.

In this historical period we are directly witnessing the rise (and fall) of many therapeutic modalities for KC, but we can nevertheless look with optimism at the future of a complex and multiform disease, characterized by individualised treatment and prognosis. We hope that this special issue will contribute to stimulating discussion.

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Case Report

Bilateral Circumscribed Posterior Keratoconus: Visualization by Ultrasound Biomicroscopy and Slit-Scanning Topography Analysis

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This paper documents a rare nonprogressive developmental disorder—bilateral circumscribed posterior keratoconus—in a 60-year-old man referred for a cataract surgery. For the first time ultrasound biomicroscopy was used to visualise the local anterior bulging of the posterior corneal surface with concomitant thinning of the stroma. The amount of localized posterior depression, corneal thickness and the refractive power of both the posterior and anterior corneal curvature were measured using slit-scanning topography analysis (Orbscan).

1. Introduction

Abnormal variation of the posterior corneal curvature may occur in two forms: the generalized posterior keratoconus, characterized by an regular increase of the curvature of the entire posterior corneal surface has, and the circumscribed posterior keratoconus, in which a localized paracentral or central posterior corneal indentation is seen [1]. In the generalized form, the corneal stroma typically remains clear. In contrast, the circumscribed posterior keratoconus shows stromal opacities overlying the localized anterior ectasia of the posterior surface, which may occupy the full stromal thickness [2]. The visual loss is not progressive and moderate [3]. Vision deterioration usually is caused by corneal scarring or amblyopia. Circumscribed posterior keratoconus is usually bilateral and sporadic, but familial cases have been also documented [4]. Despite the anterior protrusion in some cases, posterior keratoconus does not progress to anterior keratoconus and normally requires no treatment. Usually it is detected during routine ophthalmic examination. We describe a case of bilateral posterior circumscribed keratoconus.

2. Case Report

The 60-year-old white male of Mediterranean origin presented for a cataract extraction on his left eye. Visual acuity was 20/25 in the right eye and light perception in the left eye due to cataract formation. There was no amblyopia in the left eye before the onset of cataract. The patient denied history of injury, reporting only a bilateral ocular infection in childhood was reported. There were no systemic conditions.

Slitlamp examination revealed a bilateral paracentrally localized depression of the posterior curvature measuring 3 mm in diameter. There was scarring in the overlying corneal stroma (Figures 1, 2, and 3). An intraepithelial iron line was noted at the base of the lesion temporally. A few retrocorneal melanin granules were present (Figure 3). An irregular mosaic-like pattern was noted using retroillumination (Figure 4). The posterior depression was clearly detectable using ultrasound biomicroscopy (Humphrey, Zeiss, Oberkochen) (Figure 5) and slit-scanning topography analysis (Orbscan, Bausch and Lomb) (Figure 6). The amount of localized posterior depression was 75 μm as indicated by topography. Corneal thickness measured 450 μm within the lesion and 540 μm in the adjacent healthy

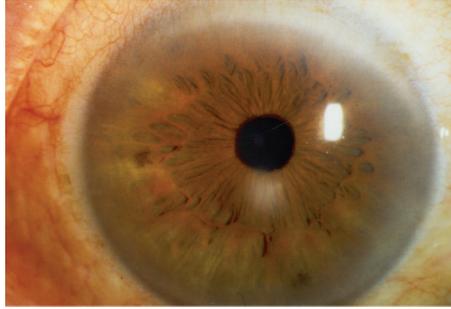


FIGURE 1: Right eye showing paracentrally inferiorly circumscribed corneal opacification.

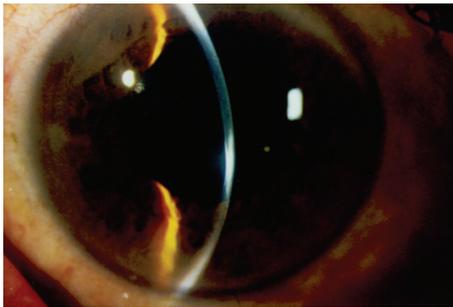


FIGURE 2: Slitlamp photograph showing circumscribed protrusion of the posterior corneal curvature with concomitant stromal thinning and an opacification of the overlying stroma.

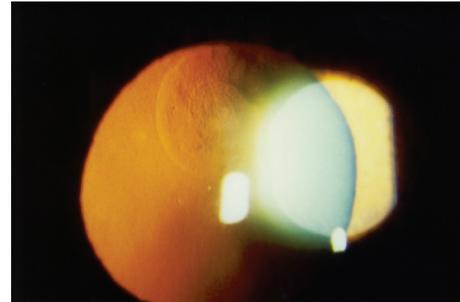


FIGURE 4: Retroillumination shows an irregularity with mosaic-like pattern. Note the sharp margin of the round lesion (arrow). There is a second sharp round line (arrowhead), forming a central and a peripheral zones.

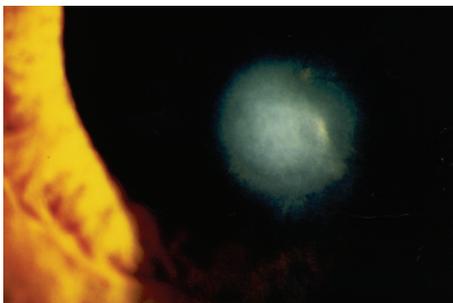


FIGURE 3: High magnification shows a relatively dense opacification of the cornea. Note the retrocorneal melanin granules at the edge of the stromal opacity.

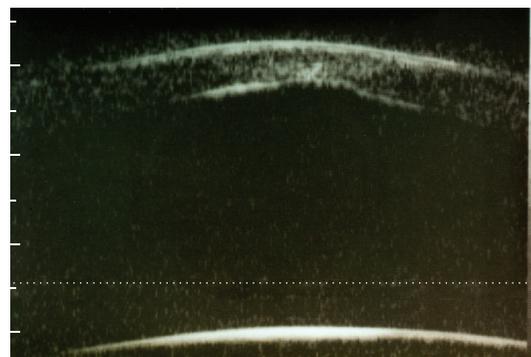


FIGURE 5: Ultrasound biomicroscopy shows the local anterior bulging of the posterior corneal surface with concomitant thinning of the stroma. Note the configuration of the enhanced stromal reflectivity (arrowhead) corresponding to the stromal opacity.

cornea using the Orbscan system. The refractive power of both the posterior and anterior corneal curvature was 50 to 56 diopters within the paracentral area. Otherwise, both eyes were unremarkable. Following phacoemulsification and posterior chamber lens implantation visual acuity increased to 20/50 in the left eye. The examination of the fundus and vitreous revealed no pathological findings.

3. Discussion

The clinical and topographic findings in this patient are consistent with the *paracentral keratoconus posterior circumscriptus* [5]. This is the first report on ultrasound

biomicroscopy to visualise the local anterior bulging of the posterior corneal surface with concomitant thinning of the stroma. Light microscopy of this abnormality has shown focal disorganization of basal epithelium and basement membrane, a replacement of Bowman's layer by fibrous tissue, a thinned stroma with an irregular arrangement of the central collagen lamellae, and a variable appearance of Descemet's membrane [6] with posterior excrescences indentating the vacuolated endothelium correspond to the corneal guttae seen in specular reflection [7]. Iron deposits

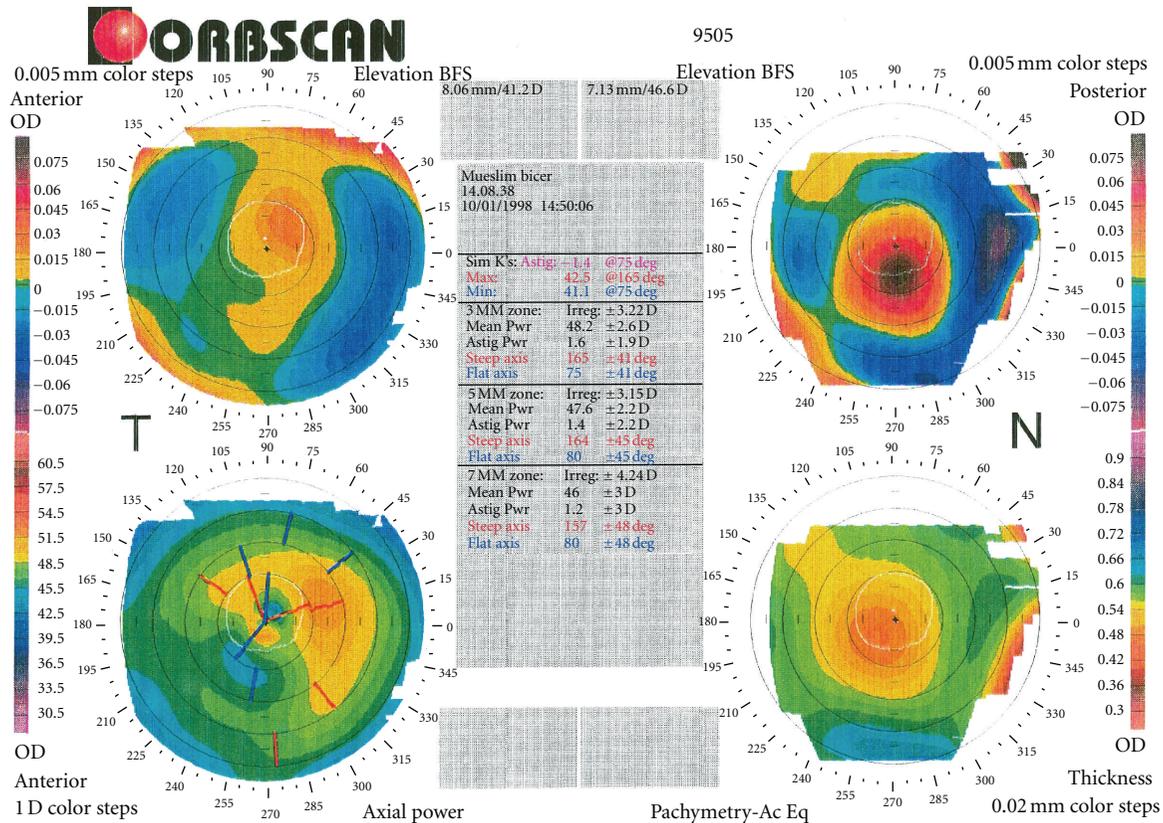


FIGURE 6: Slit-scanning topography analysis of the posterior corneal curvature (Orbscan) shows the circumscribed protrusion of the posterior surface, located paracentrally inferiorly. The color code indicates a “bulging” of about 75 μm .

are present in the basal and suprabasal epithelium, corresponding to the brownish epithelial line observed clinically [7], indicating an irregularity of the anterior corneal surface. Visualisation of the posterior keratoconus using corneal topography analysis has been reported so far in a few cases [7, 8].

The condition is thought to be a developmental disorder. The light microscopy findings suggest an early pathogenic mechanism probably originated in the fifth or sixth month of gestation [6]. It is classified as one of the anterior chamber cleavage anomalies (mesenchymal dysgenesis), as there are other anterior segment and systemic developmental abnormalities, as well as melanin depositions surrounding the posterior depression and iridocorneal adhesions [7]. However, not all cases share this phenomenon. Acquired cases occur and are usually associated with trauma [9, 10]. The mechanism in such cases involves an oblique penetrating injury with splitting of the inner corneal layers. Differential diagnosis also includes congenital disorders as Peter’s anomaly and congenital hereditary endothelial dystrophy but they are usually found in new borns. Inflammation process as perforated corneal ulcer may also be taken into consideration, but it is usually unilateral. In most of the cases of posterior keratoconus the vision is not affected, rarely it may be associated with other ocular abnormalities as polar cataract, lenticonus, and ectopia lentis.

Conflict of Interests

None of the four authors has a financial interest in any technique mentioned above.

References

- [1] S. Duke-Elder, “Part 2. Congenital deformities,” in *System of Ophthalmology: Normal and Abnormal Development*, vol. 3, pp. 510–511, Mosby, St. Louis, Mo, USA, 1963.
- [2] S. A. F. Al-Hazzaa, C. S. Specht, I. W. McLean, and D. J. Harris, “Posterior keratoconus: case report with scanning electron microscopy,” *Cornea*, vol. 14, no. 3, pp. 316–320, 1995.
- [3] D. B. Karlin and G. N. Wise, “Keratoconus posticus,” *American Journal of Ophthalmology*, vol. 52, no. 1, pp. 119–121, 1961.
- [4] S. K. Rao and P. Padmanabhan, “Posterior keratoconus. An expanded classification scheme based on corneal topography,” *Ophthalmology*, vol. 105, no. 7, pp. 1206–1212, 1998.
- [5] W. P. Haney and H. F. Falls, “The occurrence of congenital keratoconus posticus circumscriptus,” *American Journal of Ophthalmology*, vol. 52, no. 1, pp. 53–57, 1961.
- [6] J. H. Krachmer and M. M. Rodrigues, “Posterior keratoconus,” *Archives of Ophthalmology*, vol. 96, no. 10, pp. 1867–1873, 1978.
- [7] M. J. Mannis, J. Lightman, and R. D. Plotnik, “Corneal topography of posterior keratoconus,” *Cornea*, vol. 11, no. 4, pp. 351–354, 1992.

- [8] N. Charles, M. Charles, J. O. Croxatto, D. E. Charles, and D. Wertheimer, "Surface and orbscan II slit-scanning elevation topography in circumscribed posterior keratoconus," *Journal of Cataract and Refractive Surgery*, vol. 31, no. 3, pp. 636–639, 2005.
- [9] M. A. Coté and R. N. Gaster, "Keratohematoma leading to acquired posterior keratoconus," *Cornea*, vol. 13, no. 6, pp. 534–538, 1994.
- [10] R. Williams, "Acquired posterior keratoconus," *British Journal of Ophthalmology*, vol. 71, no. 1, pp. 16–17, 1987.

Review Article

Contact Lens Visual Rehabilitation in Keratoconus and Corneal Keratoplasty

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Keratoconus is the most common corneal dystrophy. It's a noninflammatory progressive thinning process that leads to conical ectasia of the cornea, causing high myopia and astigmatism. Many treatment choices include spectacle correction and contact lens wear, collagen cross linking, intracorneal ring segments implantation and finally keratoplasty. Contact lenses are commonly used to reduce astigmatism and increase vision. There are various types of lenses are available. We reviewed soft contact lenses, rigid gas permeable contact lenses, piggyback contact lenses, hybrid contact lenses and scleral-semiscleral contact lenses in keratoconus management. The surgical option is keratoplasty, but even after sutur removal, high astigmatism may stil exists. Therefore, contact lens is an adequate treatment option to correct astigmatism after keratoplasty.

1. Introduction

Keratoconus is a Greek word (kerato: cornea; konos: cone) meaning cone-shaped protrusion of the cornea. Keratoconus is a condition with noninflammatory, progressive thinning and steepening of the central and/or paracentral cornea. It is the most common primary ectasia and usually occurs in the second decade of life and affects both genders and all ethnicities. The estimated prevalence in the general population is 54 per 100,000 [1].

Etiology is unknown and most likely multifactorial. Recent research suggests that keratoconus somehow accelerates the process of keratocyte apoptosis, which is the programmed death of corneal cells that occurs following injury. Minor external traumas, such as poorly fitted contact lenses, ocular allergies [2], and eye rubbing mostly due to atopy [3] can release cytokines from the epithelium that stimulate keratocyte apoptosis. Early studies demonstrated elevated levels of collagenolytic and gelatinolytic activities in keratoconic corneas. Although thought to be a non-inflammatory disease, inflammatory molecules, such as interleukins and tumor necrosis factor, have been shown to be elevated in keratoconus, and these inflammatory molecules may mediate production and activation of proteases [4]. Genetics may

play a role in the etiology of keratoconus, in that some patients may have a genetic predisposition [5]. Genetic heterogeneity consists of allelic heterogeneity (different mutations in the same locus) and/or locus heterogeneity with different loci producing the same phenotype. To date, locus heterogeneity has been extensively observed in KTCN studies. Linkage analysis and association studies are the two main approaches used to identify the causative genes. Linkage analysis identifies chromosomal region(s) associated with the disease and the gene(s) mapped to that regions [6] In complex disease, where more than one gene is considered, gene-gene interaction should also be investigated. One of the attempts to present the disease more realistically in a linkage analysis is a method allowing for analyzing two distinct loci simultaneously. Such analysis performed in an Australian pedigree by Burdon et al., identified 1p36.23–36.21 and 8q13.1–q21.11 loci [7]. To date, only one keratoconus locus, 5q21.2, previously reported by Tang et al. [8] has been replicated by Bisceglia et al.

2. Familial Keratoconus

Although the majority of patients presenting to ophthalmologists with keratoconus have a sporadic form of the disease,

there is growing evidence of familial keratoconus and the involvement of genetic factors [9]. Ninety percent of pedigrees with familial keratoconus display an autosomal dominant inheritance with reduced penetrance [10]. Numerous loci have been mapped in keratoconus families, and research is ongoing to identify causative genes involved in keratoconus development and progression, such as a locus for autosomal dominant keratoconus was mapped in Finnish families to 16q22.3–q23.1 [11]. More than two dozen syndromes are associated with keratoconus, including Down syndrome, connective tissue disorders, including osteogenesis imperfecta, and some subtypes of Ehlers-Danlos syndrome [12]. The complexity of keratoconus makes it difficult to identify factors influencing its development. Identification of genetic factors might allow to develop both specific diagnostic tests and keratoconus gene therapy in the future.

Keratoconus can involve each layer of the cornea. Early degeneration of basal epithelial cells can be followed by disruption of the basement membrane. The stroma has normalized collagen fibers but low numbers of collagen lamellae, which results in stromal thinning. The irregular superficial opacities and scars at or near the apex of the cone represent structural breaks in Bowman's layer. Vogt's striae are fine, and parallel striations stress lines of the stroma might be present. Moreover, cornea demonstrated endothelial cell pleomorphism and polymegathism and endothelial cell degeneration [13]. Finally if there is a spontaneous tear in Descemet's membrane, aqueous flows into stroma creates acute corneal edema called "hydrops."

3. Contact Lens in Keratoconus

Soft contact lenses have limited role in correcting corneal irregularity, as they tend to drape over the surface of the cornea and result in poor visual acuity. Early in the disease, soft lenses with toric design may be adequate to correct myopia and regular astigmatism. However, soft lenses designed *specifically* for keratoconus (e.g., KeraSoft) have a useful role in early keratoconus or where a patient may be intolerant of RGP. Soft lenses tend to be more comfortable compared with RGPs. Rigid gas permeable (RGP) lenses are required as the condition progresses in order to correct the irregular astigmatism. The aim is to provide the best vision possible with the maximum comfort. All keratoconus contact lenses should be ordered in a moderate to high Dk rigid gas permeable material to avoid epithelial hypoxia and corneal erosion during the long wearing schedule of keratoconus patient. These lenses have different fitting types.

- (i) The three-point-touch design is the most popular and the most widely fitted design for keratoconic patients. Three-point-touch actually refers to the area of apical central contact and two other areas of bearing or contact at the midperiphery in the horizontal direction [14].
- (ii) Apical clearance: in this type of fitting technique, the lens vaults the cone and clears the central cornea, resting on the paracentral cornea. The potential advantages are reducing central corneal scarring. However,

the disadvantages are causing a poor tear film, corneal oedema, and poor visual acuity as a result of bubbles under the lens.

- (iii) The apical bearing technique: the weight of the lens is supported by the area on the apex of the cornea but not elsewhere on the cornea. The advantage of this fit is that patients may have good visual acuity obtained as a result of apical touch. But it also may accelerate the corneal scarring due to touch [15].

In some keratoconic patients, the steepness of the corneal apex and the radical flattening of the mid-peripheral and peripheral cornea limit the effective use of spherical lenses to correct irregularity. An aspheric lens with a high eccentricity value will become flatter quicker compared to a spherical curve. This allows you to select a relatively steep base curve radius to match the apex of the cornea and the highly aspheric posterior designs provide better alignment and weight distribution over a larger area of the cornea. This often provides improved lens centration and comfort. The aim of aspheric lens fit should be good centration, central alignment or slight central bearing, good movement (1 mm), and peripheral clearance. There are various types of lenses with monocurve or multicurve design.

The McGuire System: The McGuire system was first introduced in 1978 and consists of three diagnostic lens sets, nipple, oval, or globus. McGuire system has four peripheral curves that make the lens easy to fit [16].

The Rose K is a unique keratoconus lens design with complex computer-generated peripheral curves based on data collected by Dr. Paul Rose of Hamilton, New Zealand. The system (26 lens set) incorporates a triple peripheral curve system [17, 18].

Piggyback Lenses are used for difficult cases, for instance in cases of RGP lens intolerance, proud nebulae in keratoconus, or apical dimpling or where there are areas of recurrent epithelial erosion. The system consists of a rigid lens fitted on top of a soft lens aiming to obtain same visual acuity as with a single lens. Soft lens must be a silicone hydrogel lens with a high Dk/t [19].

Hybrid Lens System; The Softperm lens (Ciba Vision) is a hybrid lens with a RGP centre surrounded by a soft hydrophilic skirt. The SynergEyes is relatively new and with a high Dk hybrid lens, it could be used for early keratoconus due to its aspherical design. These lenses tend to be used in cases of RGP lens intolerance. A recent study performed by Abdalla et al. demonstrated that such RGP intolerant patients showed great optical improvement with this hybrid lens [20]. But the main limitations are giant papillary conjunctivitis and peripheral vascularization.

Scleral and Semiscleral Lenses have proven to be extremely beneficial for patients with highly irregular and/or asymmetric keratoconic corneas. These patients will benefit from a large diameter (13.5 to 16.0 mm) semiscleral lens design. Schornack et al. showed a dramatic improvement in visual acuity by using scleral lens in a study [21, 22].

4. Contact Lens following Keratoplasty

For keratoconus surgery might be considered when patients are no longer able to tolerate their gas-permeable contact

lenses, when a successful contact lens fit is no longer possible or because of unresolving corneal hydrops. Penetrating keratoplasty (PK) or full-thickness corneal transplant, historically has been the most common surgical correction for irregular astigmatism resulting from keratoconus. The corneal graft is susceptible to epithelial, stromal, and endothelial forms of inflammatory rejection from the host's immune response. The purpose of deep anterior lamellar keratoplasty (DALK) is to preserve host Descemet's membrane and endothelium. This may decrease overall graft rejection episodes, including stromal and epithelial rejection.

The main reason of decreased visual acuity after keratoplasty is most likely high astigmatism. Generally, even after suture removal, residual astigmatism still cause visual problems. Various types of treatment modalities are tried with contact lenses: sclerals, rigid gas permeable and reverse geometry hydrogel lenses, and silicone hydrogel soft toric contact lenses, in order to improve lens and optical stability, but no common consensus is approved yet [23–25].

If postresidual astigmatism is under 4D, a hard gas permeable, large-diametered contact lens will be recommended, bearing in mind that donor cornea diameter should be smaller than contact lens diameter, eventually. If astigmatism is under 1D, soft contact lenses would be successful to correct refractive status. In a recent study, Geerards et al. successfully fitted large-diameter (12 mm) tricurve rigid gas-permeable contact lenses for 90 (47%) of 190 penetrating keratoplasty patients with good tolerance [26]. Intralimbal rigid gas-permeable contact lenses are found effective in increasing visual acuity after penetrating keratoplasty, keratoconus and pellucid marginal degeneration as well [27]. Also special design contact lenses can improve visual acuity after penetrating keratoplasty. Gruenauer-Kloevekorn et al. fitted 4 different types of special contact lenses in 28 eyes, and nearly in all patients visual acuity significantly improved [28]. In conclusion, there are many contact lens options available to correct postkeratoplasty astigmatism before conducting any surgical method.

References

- [1] M. Romero-Jiménez, J. Santodomingo-Rubido, and J. S. Wolffsohn, "Keratoconus: a review," *Contact Lens and Anterior Eye*, vol. 33, no. 4, pp. 157–166, 2010.
- [2] A. M. Bawazeer, W. G. Hodge, and B. Lorimer, "Atopy and keratoconus: a multivariate analysis," *British Journal of Ophthalmology*, vol. 84, no. 8, pp. 834–836, 2000.
- [3] C. W. McMonnies, "Mechanisms of rubbing-related corneal trauma in keratoconus," *Cornea*, vol. 28, no. 6, pp. 607–615, 2009.
- [4] S. A. Balasubramanian, D. C. Pye, and M. D. P. Willcox, "Are proteinases the reason for keratoconus," *Current Eye Research*, vol. 35, no. 3, pp. 185–191, 2010.
- [5] M. Štabuc-Šilih, M. Stražisar, M. Ravnik Glavač, M. Hawlina, and D. Glavač, "Genetics and clinical characteristics of keratoconus," *Acta Dermatovenerologica Alpina, Pannonica et Adriatica*, vol. 19, no. 2, pp. 3–10, 2010.
- [6] F. Brancati, E. M. Valente, A. Sarkozy et al., "A locus for autosomal dominant keratoconus maps to human chromosome 3p14-q13," *Journal of Medical Genetics*, vol. 41, no. 3, pp. 188–192, 2004.
- [7] K. P. Burdon, D. J. Coster, J. C. Charlesworth et al., "Apparent autosomal dominant keratoconus in a large Australian pedigree accounted for by digenic inheritance of two novel loci," *Human Genetics*, vol. 124, no. 4, pp. 379–386, 2008.
- [8] Y. G. Tang, Y. S. Rabinowitz, K. D. Taylor et al., "Genomewide linkage scan in a multigeneration Caucasian pedigree identifies a novel locus for keratoconus on chromosome 5q14.3-q21.1," *Genetics in Medicine*, vol. 7, no. 6, pp. 397–405, 2005.
- [9] F. Karimian, S. Aramesh, H. M. Rabei, M. A. Javadi, and N. Rafati, "Topographic evaluation of relatives of patients with keratoconus," *Cornea*, vol. 27, no. 8, pp. 874–878, 2008.
- [10] A. E. Hughes, D. P. Dash, A. J. Jackson, D. G. Frazer, and G. Silvestri, "Familial keratoconus with cataract: linkage to the long arm of chromosome 15 and exclusion of candidate genes," *Investigative Ophthalmology and Visual Science*, vol. 44, no. 12, pp. 5063–5066, 2003.
- [11] H. Tynismaa, P. Sistonen, S. Tuupainen et al., "A locus for autosomal dominant keratoconus: linkage to 16q22.3-q23.1 in Finnish families," *Investigative Ophthalmology and Visual Science*, vol. 43, no. 10, pp. 3160–3164, 2002.
- [12] A. Hestnes, T. Sand, and K. Fostad, "Ocular findings in Down's syndrome," *Journal of Mental Deficiency Research*, vol. 35, no. 3, pp. 194–203, 1991.
- [13] C. W. Sturbaum and R. L. Peiffer, "Pathology of corneal endothelium in keratoconus," *Ophthalmologica*, vol. 206, no. 4, pp. 192–208, 1993.
- [14] L. L. Jae and M. K. Kim, "Clinical performance and fitting characteristics with a multicurve lens for keratoconus," *Eye and Contact Lens*, vol. 30, no. 1, pp. 20–24, 2004.
- [15] K. K. Leung, "RGP fitting philosophies for keratoconus," *Clinical and Experimental Optometry*, vol. 82, no. 6, pp. 230–235, 1999.
- [16] C. Coral-Ghanem and M. R. Alves, "Fitting Monocurve and Bicurve (Soper-McGuire design) rigid gas-permeable contact lenses in keratoconus patients: a prospective randomized comparative clinical trial," *Arquivos Brasileiros de Oftalmologia*, vol. 71, no. 3, pp. 328–336, 2008.
- [17] Y. B. Ozkurt, T. Sengor, S. Kurna et al., "Rose K contact lens fitting for keratoconus," *International Ophthalmology*, vol. 28, no. 6, pp. 395–398, 2008.
- [18] A. M. Betts, G. L. Mitchell, and K. Zadnik, "Visual performance and comfort with the Rose K Lens for Keratoconus," *Optometry and Vision Science*, vol. 79, no. 8, pp. 493–501, 2002.
- [19] C. O'Donnell and C. Maldonado-Codina, "A hyper-Dk piggyback contact lens system for keratoconus," *Eye and Contact Lens*, vol. 30, no. 1, pp. 44–48, 2004.
- [20] Y. F. Abdalla, A. F. Elsahn, K. M. Hammersmith, and E. J. Cohen, "Synergeyes lenses for keratoconus," *Cornea*, vol. 29, no. 1, pp. 5–8, 2010.
- [21] M. M. Schornack and S. V. Patel, "Scleral lenses in the management of keratoconus," *Eye and Contact Lens*, vol. 36, no. 1, pp. 39–44, 2010.
- [22] W. Vreugdenhil, A. J. Geerards, and C. J. Vervaeke, "A new rigid gas-permeable semi-scleral contact lens for treatment of corneal surface disorders," *Contact Lens and Anterior Eye*, vol. 21, no. 3, pp. 85–88, 1998.
- [23] C. Katsoulos, V. Nick, K. Lefteris, and M. Theodore, "Fitting the post-keratoplasty cornea with hydrogel lenses," *Contact Lens and Anterior Eye*, vol. 32, no. 1, pp. 22–26, 2009.

- [24] B. E. Wietharn and W. T. Driebe, "Fitting contact lenses for visual rehabilitation after penetrating keratoplasty," *Eye and Contact Lens*, vol. 30, no. 1, pp. 31–33, 2004.
- [25] J. C. Lin, E. J. Cohen, C. J. Rapuano, and P. R. Laibson, "RK4 (reverse-geometry) contact lens fitting after penetrating keratoplasty," *Eye and Contact Lens*, vol. 29, no. 1, pp. 44–47, 2003.
- [26] A. J. M. Geerards, W. Vreugdenhil, and A. Khazen, "Incidence of rigid gas-permeable contact lens wear after keratoplasty for keratoconus," *Eye and Contact Lens*, vol. 32, no. 4, pp. 207–210, 2006.
- [27] Z. Ozbek and E. J. Cohen, "Use of intralimbal rigid gas-permeable lenses for pellucid marginal degeneration, keratoconus, and after penetrating keratoplasty," *Eye and Contact Lens*, vol. 32, no. 1, pp. 33–36, 2006.
- [28] C. Gruenauer-Kloevokorn, U. Kloevokorn-Fischer, and G. I. W. Duncker, "Contact lenses and special back surface design after penetrating keratoplasty to improve contact lens fit and visual outcome," *British Journal of Ophthalmology*, vol. 89, no. 12, pp. 1601–1608, 2005.

Review Article

Collagen Cross-Linking: Current Status and Future Directions

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Collagen cross-linking (CXL) using UVA light and riboflavin (vitamin B₂) was introduced as a clinical application to stabilize the cornea by inducing cross-links within and between collagen fibers. CXL has been investigated extensively and has been shown clinically to arrest the progression of keratoconic or post-LASIK ectasia. With its minimal cost, simplicity, and proven positive clinical outcome, CXL can be regarded as a useful approach to reduce the number of penetrating keratoplasties performed. Small case series have also indicated that CXL is beneficial in corneal edema by reducing stromal swelling behavior and in keratitis by inhibiting pathogen growth. Despite these encouraging results, CXL remains a relatively new method that is potentially associated with complications. Aspects such as side effects and recurrence rates have still to be elucidated. In light of the growing interest in CXL, our paper summarizes present knowledge about this promising approach. We have intentionally endeavored to include the more relevant studies from the recent literature to provide an overview of the current status of CXL.

1. Introduction

Keratoconus is a noninflammatory, usually bilateral disorder, which manifests as progressive corneal instability characterized by abnormal thinning and steepening of the cornea [1]. This abnormal curvature of the cornea changes its refractive power, often resulting in irregular astigmatism and myopia and leading to mild to marked impairment in the quality of vision.

The definitive cause underlying the development of keratoconus remains unclear. However, it appears to be a heterogeneous condition that may be produced by a variety of unrelated abnormalities of a metabolic and biochemical nature. The most common presentation of keratoconus is as a sporadic disorder, in which only a significant minority of patients exhibit a family history with autosomal dominant or recessive transmission [2].

The morphological signs of keratoconus include formation of Fleischer's ring—a pigmented ring that results from the accumulation of ferritin particles in the cytoplasm of epithelial cells and widened intercellular spaces—as shown by electron microscopy [3], breaks in Bowman's membrane, filled with cells, collagen, and PAS-positive material [4], stromal thinning and abnormal keratocyte morphology [5], and

endothelial polymorphism [6]. In histopathological and biochemical studies, keratoconic corneas are characterized by increased levels of proteases and other catabolic enzymes, decreased levels of tissue inhibitors of metalloproteinases (TIMPs), increased collagenolytic activity, significantly increased expression of IL-4 receptors, apoptotic cell death of keratocytes, and dramatic changes in collagen orientation and distribution [7–11].

A number of medical and surgical approaches have been used in the treatment of keratoconus. First-line treatment for patients with keratoconus is to fit rigid gas-permeable (RGP) contact lenses [12]. However, RGPs do not slow the rate of progression of the cone but merely improve visual acuity. The irregular shape of the cornea means that these lenses are challenging to fit, and the procedure requires a great deal of time and patience, with RGP fitting becoming more difficult and less successful as disease severity progresses. Moreover, owing to the formation of raised subepithelial nodular scars at or near the cone apex, contact lens intolerance can occur due to erosion and discomfort [13].

Intrastromal corneal ring segment (Intacs) implantation is a minimally invasive surgical procedure for keratoconic corneas that flattens the central corneal curvature when spectacles or contact lenses are no longer effective in improving

visual acuity. The long-term tolerance of Intacs in keratoconic eyes without any significant sight-threatening complications has been reported in several studies [14, 15]. However, like contact lenses, they do not affect the corneal tissue nor do they arrest or slow keratoconus progression; instead they address the refractive consequences of the pathology by changing the shape of the cornea. The mechanical technique of tunnel creation can cause epithelial defects at the keratotomy site, anterior and posterior perforations, shallow or uneven placement of the segments, introduction of epithelial cells into the channel, and stromal thinning [16]. The femtosecond laser has been reported to reduce these complications due to more precise localization of the channel [17]. A rare but very important complication of Intacs is postimplantation infection, which may occur even many months after the initial procedure [18].

Keratoconus is one of the most common indications for keratoplasty worldwide and is in fact the leading indication in some countries [19]. Between 10% and 20% of keratoconus patients require a keratoplasty, and the procedure is increasingly indicated in the more advanced stages. The indications for keratoplasty in keratoconic patients are visual acuity below 0.5 despite optimal correction, intolerance to contact lenses, progressive corneal thinning, a decentered cone, and the presence of opacities in the visual axis. However, keratoplasty is not exempted from complications and limitations. Publications on most of the common type of keratoplasty—penetrating keratoplasty (PK)—have shown poor graft survival rates, due primarily to the continual loss of donor endothelial cells [20]. Early suture removal, as well as suture technique and graft size, has been suggested as playing a crucial role in graft failure [21]. Graft neovascularization may be a further factor associated with increased risk of graft rejection [22].

A particular problem in PK is recurrence of keratoconus caused by progressive thinning of the recipient peripheral stroma [23]. PK for keratoconus is associated with a high degree of graft astigmatism that may limit or delay visual rehabilitation. In some patients, a stable visual outcome may take several years to achieve. Another limitation of keratoplasty is the cutting of corneal nerves, leading to reduced corneal sensitivity [24].

A second surgical option for keratoconus is a deep anterior lamellar keratoplasty (DALK), involving exchange of only the epithelium and stroma. This approach has the advantage of preserving the endothelium of the recipient cornea, thus reducing risk of infection and rejection. The DALK technique involves manual dissection, which often yields an uneven bed and an irregular interface with suboptimal visual outcome. Recent improvements in surgical technique and advances in instrumentation have helped to improve the match between patient and donor corneas, leading to visual outcomes that are comparable with those after PK [25].

In recent years, the above-mentioned treatment strategies have been supplemented by collagen cross-linking using UVA light and riboflavin (vitamin B2). This is a relatively new approach, which directly targets stromal instability. Unlike all previous keratoconus management techniques, it is the only approach designed to arrest the progression of the disease.

In conformity with the agreement reached at the Third Corneal Cross-Linking Congress 2007 (Zurich, Switzerland), we will use the term CXL throughout this paper to denote the combined treatment using riboflavin and UVA light.

The idea of using CXL for corneal stiffening was conceived in Germany in the 1990s [26]. The impressive clinical results initially achieved in Germany have prompted worldwide use of CXL. Currently, there are over 300 centers performing CXL in Europe, and the technique has also been used in Canada since 2008. The US Food and Drug Administration (FDA) recently approved the start of three clinical trials in the United States.

2. Background to Collagen Cross-Linking

Collagen I is the major macromolecular constituent of the corneal stroma, although collagen types III, V, and VI are also represented. The corneal stroma possesses the mechanical strength needed to form the anterior coat of the eye, whilst maintaining the high degree of transparency required for light transmission. Light transmission through the cornea is a result of a particular, cornea-specific arrangement of collagen fibrils. Corneal collagen uniquely forms small (32 nm), uniformly spaced fibrils that are organized into larger bundles or fibers (termed corneal lamellae) of varying thickness (1–2 μm) and width (5–100 μm) that are arranged in interweaving orthogonal layers throughout the stroma. They are thinner and more interwoven in the anterior cornea [27]. The characteristic collagen fibril arrangement in the cornea is believed to be maintained by the influence of different molecular subtypes within collagen fibrils and by proteoglycan macromolecules which associate in a specific manner within the collagen.

Collagen is synthesized by keratocytes in the form of its precursor molecule, called procollagen, which has two additional peptides, one at each end. In the extracellular space, specialized enzymes known as procollagen proteinases remove the two extension peptides from the ends of the molecule. The processed molecule, now referred to as collagen, undergoes posttranslational modification and begins to form fibrils and then fibers. This precisely controlled, enzyme-regulated process involves the enzyme lysyl oxidase and results in oxidation of the amino acids lysine and hydroxylysine to their respective aldehydes, which condense with other aldehydes to form intra- and intermolecular cross-links.

Another mechanism that changes the physical properties which influence the strength of the stromal tissue is nonenzymatic glycation, a phenomenon that is related to the reduced metabolic turnover of collagen and occurs through the reaction of collagen with glucose and its oxidation products. The twin findings that keratoconus progression slows with age and that keratoconus is uncommon in diabetic patients are related to collagen cross-linking via nonenzymatic glycation [28, 29].

The induction of additional cross-links is a well-established method for tissue stabilization in the polymer industries, in the preparation of prosthetic heart valves, for hardening dentistry fillings, and for tissue hardening in pathology [30]. Additional cross-link induction can be achieved by

various methods, for example, nonenzymatic glycation, irradiation using UV light with or without photosensitizer, and aldehyde reactions.

The microscopic correlate of decreased corneal rigidity in keratoconus has been attributed to reductions in collagen cross-links and in molecular bonds between neighboring stromal proteoglycans. In light of this knowledge, additional cross-link induction in the corneal stroma by photopolymerization was proposed as a means of stiffening the cornea and hence of slowing disease progression.

3. Cross-Linking to Stabilize the Cornea

By actively increasing the degree of covalent bonding between and within the molecules of extracellular matrix, such as collagen type I and proteoglycans, therapeutic cross-linking was reasonably expected to enhance corneal rigidity and to slow or even arrest the progression of keratoconus. To investigate the possibility of cross-link induction in corneal stromal tissue, enucleated porcine eyes were divided into eight test groups (10 eyes each) that were treated with UV-light (254 nm), 0.5% riboflavin, 0.5% riboflavin and UV-light (365 nm), 5% riboflavin and blue light (436 nm), 5% riboflavin and sunlight, and the chemical agents glutaraldehyde (0.1% and 1%) and Karnovsky's solution (0.1%) [31, 32].

Measurement of biomechanical properties revealed that the greatest stiffening effect occurred after treatment with 1% glutaraldehyde. Statistically significant stiffening was also achieved in all groups except for UV-light alone and riboflavin alone.

Among all the protocols developed, the combination of UVA-light with riboflavin was selected for future experiments. The other cross-linking methods were recognized as being impractical in a clinical setting because of cytotoxicity and development of corneal haze and scarring (e.g., glutaraldehyde treatment) or application problems and prolonged treatment times (e.g., glycerinaldehydes).

Riboflavin (vitamin B2) is the precursor of flavin mononucleotide (FMN) and flavin adenine dinucleotide (FAD), which are coenzymes that play a crucial role in the metabolism of proteins, fats, and carbohydrates. Riboflavin is an essential constituent of living cells and is noncytotoxic. It acts as a photomediator, considerably increasing the absorption of UVA light on exposure to corneal stroma. It has been demonstrated that absorption of UVA light within the lamellae of corneal stroma is approximately 30%, whereas combination with the photomediator properties of riboflavin increases this absorption from 30% to 95% [31, 32]. Following exposure, riboflavin is excited into a triplet state thereby generating reactive oxygen species: singlet oxygen and superoxide anions then react with available groups nearby. The precise mechanism of CXL at the molecular level has not yet been elucidated; currently, all evidence for CXL is indirect and chemical proof is awaited. One of the most plausible mechanisms of collagen cross-linking in CXL is thought to be the creation of additional chemical bonds between histidine, hydroxyproline, hydroxylysine, tyrosine, and threonine amino-acid residues. Importantly, CXL can also

cause cross-linking of other classes of macromolecules within the corneal stroma, such as proteoglycans, either to one another or to collagen molecules [33].

4. Experimental Studies to Assess Corneal Response to CXL and Its Effectiveness

Experimental studies in rabbits have demonstrated dose-dependent keratocyte damage in a CXL procedure with surface irradiance ranging from 0.75 to 4 mW/cm² [34]. At a surface irradiance of 3 mW/cm² complete cell loss was observed in rabbit corneas, as shown by histology and in vivo CLSM [35, 36], whereas the same surface irradiance led to cell loss only in the anterior 250–300 μm of the corneal stroma in humans [37].

Experimental studies have shown numerous Ki-67-positive fibroblasts shortly after cross-linking [35, 36], whereas only a few α-SMA-positive myofibroblasts were detected in the central cross-linked area [38]. Histopathological examination of human CXL-treated corneas has confirmed these findings by immunohistochemical analysis for Ki-67 and α-SMA [39]. This evidence indicates that the activation of keratocytes after corneal cross-linking occurs mainly by means of their transformation into fibroblasts. This may explain why no (or only mild) opacities have been observed after cross-linking in the above-mentioned studies, bearing in mind that the degree of opacity correlates directly with the number of activated keratocytes.

It is known that TGF-β triggers the differentiation of myofibroblasts from fibroblasts [40]. TGF-β is released by injured epithelial cells, and it can easily reach the adjacent stroma by penetrating the basement membrane if the latter is defective and irregular. In CXL, the epithelial sheet is removed while basement membrane integrity is retained; this feature may explain the almost complete absence of myofibroblasts and only mild (or even absent) opacification in the central treated area.

Endothelial cell density is regarded as a vitally important criterion for CXL safety. The possible cytotoxic effect of CXL has been carefully investigated in vitro in porcine endothelial cell cultures [41] and in experiments in rabbits [42], where dose-dependent endothelial cell loss was found. The latter study demonstrated necrotic and apoptotic cell death accompanied by significant edema at a standard surface UVA dose of 3 mW/cm². It was shown later, however, that the endothelial monolayer had already regained its integrity 1 week after CXL, a finding that can be attributed to the proliferative capability of rabbit endothelial cells [35, 36].

It has been shown that Young's modulus and corneal rigidity are abnormally decreased in keratoconic eyes [43]. The biomechanical effect of CXL on cornea has been studied in enucleated human and porcine eyes, and stress-strain measurements were performed to evaluate changes in corneal rigidity after CXL [44]. A significant increase in corneal rigidity was shown in treated corneas, as indicated by a rise in stress. Increases in Young's modulus were also measured both in porcine and human corneas (by factors of 1.8 and 4.5, resp.). Further investigations of biomechanical properties have revealed a significantly stronger stiffening

effect in anterior than in posterior stroma, both for enucleated porcine and human corneas [45]. These findings correlate positively with measurements of the thermomechanical behavior of collagen-cross-linked porcine corneas which showed a higher shrinkage temperature in the anterior stroma compared to the posterior stroma due to the higher degree of cross-linking of the anterior stroma [46].

Long-lasting improvements in the biomechanical properties of corneal tissue have been confirmed in rabbit studies for up to 8 months after CXL [47]. Morphologically, the effect of CXL has been demonstrated by measuring collagen fibril diameter in rabbit corneas [48]; transmission electron microscopy revealed a statistically significant increase in collagen fiber diameter in both anterior and posterior stroma, although this effect was more pronounced in the anterior stroma. The morphological effect of CXL has also been investigated using immunofluorescence. In one recent study, corneas with Fuchs endothelial dystrophy and bullous keratopathy from patients who had undergone CXL 7 to 90 days prior to penetrating keratoplasty were investigated by immunofluorescence for collagen type I and compared with control groups with same disorders [49]. Cross-linked corneas showed a fluorescent anterior lamellar zone with condensed and highly organized collagen fibers, which was not the case in the non-cross-linked group. The intensity of fluorescent staining was shown to decrease gradually in an anterior-posterior direction. It should be also noted that the same study demonstrated a diminution of the cross-linking effect over time.

CXL has been reported to have a certain impact on the biochemical properties of corneal tissue by increasing the resistance of corneal matrix against digestion by proteolytic enzymes such as pepsin, trypsin, and collagenase [50]. The authors attribute the stabilizing biochemical effect of CXL to alterations in the tertiary structure of collagen fibrils, thus denying the proteolytic enzymes access to their target sites.

It has been proposed that a positive correlation exists between corneal stiffness and intraocular pressure (IOP) [51]. On the basis of this correlation, an increase in IOP can be expected following CXL as indirect confirmation of the efficacy of cross-linking. In fact, IOP increases have been recorded in patients after CXL, reflecting increased corneal rigidity [52–54].

Two-photon microscopy has been used in rabbit corneas to visualize cross-linking effects on cells and collagen after CXL by detecting second harmonic generation (SHG) and autofluorescence [55]. In this study, the grade of cross-linking was quantified by autofluorescence lifetime measurements. CXL effects were detected for up to 2 weeks in the anterior stroma. Future experiments with longer follow-up are required to determine the stability of these effects.

5. Corneal Response to CXL In Vivo

Alongside histological studies in animals, *in vivo* confocal laser-scanning microscopy (CLSM) now provides a noninvasive modality for observing the corneal response to CXL. *In vivo* CLSM offers obvious advantages as a noninvasive imaging technique that permits dynamic investigations to be

conducted over long observation periods [56]. Importantly, *in vivo* CLSM not only provides an overview of the tissues but also allows quantification of acquired images, thus yielding quantitative as well as qualitative data, and this is a key aspect when evaluating the safety and duration of the effects achieved. The first results obtained with *in vivo* CLSM after CXL were published in 2006 [57]. This study demonstrated epithelial regeneration and normal morphology as early as day 5 after CXL. Subepithelial stromal nerve fibers were noted to have disappeared immediately after CXL: initial signs of regeneration were observed 1 month after the operation and continued throughout the postoperative period, with normal morphology and corneal sensitivity being restored after 6 months. In the same patients, disappearance of keratocytes in the anterior stroma and rarefaction in the posterior stroma were reported soon after treatment [58]. In good agreement with previous experimental studies, a repopulation process was demonstrated, revealing activated keratocytes in the anterior and intermediate stroma. Normal endothelial morphology and density were observed by *in vivo* CLSM during the entire follow-up period. These findings were confirmed in a larger patient cohort that was followed using *in vivo* CLSM for up to 3 years [59]. Interestingly, this study with a longer follow-up showed that, despite complete nerve fiber regeneration at 6 months postoperatively, the plexus structure could not be defined until 1 year after CXL. A later *in vivo* study with CLSM, again with 3-year follow-up, confirmed these findings [60]. In this study, occasional inflammatory cells were present in the different epithelial layers 1 month after CXL. Importantly, this had never been reported previously in patients, whereas experimental animal studies had revealed inflammatory cell activation in corneal stroma after CXL [35, 61]. Notably, the authors also showed that the degree of stromal changes observed after the first week varied among patients and was unrelated to the severity of keratoconus. Using *in vivo* CLSM, Kymionis et al. [62] have shown that tissue alterations after CXL are quite similar in patients with keratoconus and post-LASIK corneal ectasia.

In vivo CSLM has revealed early and late demarcation lines between treated and untreated stroma. Demarcation lines have also been detected by slit-lamp examination [63] and anterior segment optical coherence tomography [64]. All the aforementioned *in vivo* CLSM studies have yielded relatively similar results regarding the cellular and extracellular changes after CXL. Although *in vivo* CLSM is an indispensable tool for the dynamic sequential study of wound healing after CXL, the technique is limited in that it depicts only small areas (300 μm) and image interpretation is based on morphological features and reflectivity. It is still strongly recommended that every excised cornea should be investigated by electron microscopy and immunohistochemistry.

6. Clinical Results

Widely accepted parameters for evaluating the clinical outcome of refractive corrections and CXL include uncorrected visual acuity (UCVA), best corrected visual acuity (BCVA),

uncorrected distance visual acuity (UDVA), corrected distance visual acuity (CDVA), apex curvature, and topography-derived outcomes of maximum and average keratometry values.

A prospective, nonrandomized pilot study published in 2003 reported the earliest clinical experiences in a series of 23 eyes with moderate or advanced progressive keratoconus [65]. During follow-up, which lasted for between 3 months and 4 years, not only disease progression was at least halted, but, in 70% cases, there was also a statistically significant improvement in BCVA, correlating with a reduction of the maximal keratometry readings by 2 diopters and of the refractive error by 1.14 diopters.

In an uncontrolled retrospective study, Raiskup-Wolf et al. [66] showed that the flattening process continues over a period of years: they followed a large cohort of patients (480 eyes of 272 patients) for up to 6 years and reported arrested keratoconus progression and significant improvements in visual acuity. The long-term stabilization of keratoconic corneas without significant side-effects has also been demonstrated in 44 eyes for up to 48 months after CXL [67], also accompanied by a reduction in the mean K value by 2 diopters and gradually increasing improvements in UCVA and BCVA during the observation period. The statistical significance of these values was maintained after 36 and 48 months of follow up.

Vinciguerra et al. [68] have described the outcome of CXL in 28 eyes with progressive keratoconus, using the fellow eye as control. This nonrandomized study revealed a statistically significant improvement in UCVA and BCVA, with a reduction in the steepest simulated keratometry meridian by as much as 6.16 diopters. Keratoconus in the untreated fellow eye showed progression over the same period.

In light of experimental studies reporting increased corneal stiffness after CXL, efforts have also been undertaken to evaluate biomechanical parameters such as corneal hysteresis and corneal resistance factor after CXL [69, 70]. Using the Ocular Response Analyzer, both studies revealed only slight, statistically nonsignificant changes in biomechanical parameters. This inconsistency has been attributed to the different methodologies used and to inherent differences between in vitro and in vivo models. Comparisons between treated and untreated eyes of the same patients, performed over a 1-year period following CXL, showed significant flattening and hence decreases in keratoconus indices in the CXL-treated cornea; these findings were seen as indicating a shift toward a more regular corneal shape, whereas the same parameters in the control eyes indicated disease progression [71]. All these studies have concluded that the improvement in vision after CXL is produced by a decrease in astigmatism and corneal curvature as well as by an increase in corneal rigidity, leading to topographical homogenization.

Despite the positive outcomes reported from nonrandomized clinical studies, these findings are still preliminary and should be interpreted with caution. It is clear that conclusive evidence regarding the effects of CXL will emerge only from multiple randomized controlled trials (RCTs) with a more robust design, and, to date, the literature on CXL includes only a very small number of such RCTs. In the

Melbourne study, which was conducted in 49 patients, statistically significant differences were observed between control and treatment groups in terms of BCVA and K values for up to 12 months after CXL [72]. More recently, another group has published an RCT reporting on one-year results after CXL for the treatment of keratoconus and corneal ectasia [73]. CXL was shown to be effective in improving UDVA, CDVA, the maximum K value, and the average K value. Keratoconus patients displayed greater improvement in topographic measurements than patients with corneal ectasia.

Combination of CXL with other treatment modalities also appears to be useful for enhancing clinical outcomes in keratoconus management. The combination of topography-guided PRK with CXL is reported to be an optimal method for attaining greater effects in progressive keratoconus [74, 75], as reflected in rapid and significant improvements in visual acuity (both UCVA and BCVA) and marked correction of corneal irregularities, as shown by topographic evaluation. Comparison of sequential versus same-day simultaneous CXL and topography-guided PRK demonstrated the greater impact of the same-day procedure in reducing K values, improving visual acuity, and lessening corneal haze [76]. Furthermore, the addition of CXL to Intacs insertion has resulted in significantly greater clinical improvements in keratoconus than Intacs insertion alone [77]. However, these data are preliminary, and further confirmation is required from future studies.

7. Alternative Strategies

Although CXL has proved itself in clinical practice, efforts are still being made to modify the standard protocol to increase patient safety and comfort. Two factors in particular are critical to ensure the success of CXL therapy: a certain minimum corneal thickness prior to CXL and the guaranteed presence of a specific concentration of riboflavin. The standard protocol for CXL uses 0.1% riboflavin in 20% dextran.

Quite recently, a novel protocol using hypoosmolar riboflavin solution has been developed for the management of thin corneas [78]. The hypoosmolar solution achieved preoperative swelling of thin corneas, thus enabling CXL to be undertaken and keratoconus progression to be arrested in all cases treated. It should be mentioned, however, that all corneas included had a minimum stromal thickness of 323 μm . Importantly, CXL failure has been reported in an extremely thin cornea, suggesting that a minimum preoperative stromal thickness of 330 μm is needed for successful CXL [79].

The widely accepted standard protocol for CXL involves corneal epithelial debridement to facilitate the penetration of riboflavin into the stroma. However, deepithelialization is accompanied by pain, foreign body sensation, and discomfort in the form of burning and tearing for many days. Moreover, epithelial debridement reduces total corneal thickness, and this can have dramatic repercussions in extremely thin corneas. Researchers and clinicians have therefore been motivated to develop a variant of the standard CXL technique without deepithelialization, thus offering patients

safer and faster CXL while retaining the efficacy of the standard approach.

An immunofluorescence confocal imaging study on enucleated porcine eyes has shown that, without previous deepithelialization, CXL had no effect on collagen type I organization, confirming the belief that the intact epithelium acts as barrier to riboflavin absorption [80]. The necessity for deepithelialization as an initial step in CXL has also been demonstrated *in vitro* on porcine eyes by other investigators [81, 82]. Analysis of corneal light transmission spectra in these studies clearly revealed that riboflavin was able to penetrate into the stroma only in completely abraded corneas.

In one clinical study, deepithelialization was customized on the basis of pachymetric measurements so that the cornea was left intact in regions thinner than 400 μm and removed in regions with adequate thickness [83]. This study demonstrated an increase in the safety of CXL, as well as satisfactory results in stabilizing keratoconus, but without detailing special effects and alterations in specific areas. To evaluate intrastromal concentrations of riboflavin in CXL with and without epithelial debridement, half of the corneas (from keratoconus patients enrolled for keratoplasty) underwent CXL with abrasion and half without [84]. Quantitative HPLC analysis demonstrated that a theoretically safe and effective concentration of riboflavin was obtained only after epithelial debridement, confirming previous results. In a similar comparative study, customized deepithelialization was performed in two keratoconus patients, and anterior segment OCT and *in vivo* CLSM were used to compare CXL effects in epithelium-on and epithelium-off regions of the same cornea [85]. Both techniques detected strong CXL effects (e.g., the demarcation line and keratocyte disappearance followed by haze) in the deepithelialized regions, whereas the corneal stroma under the intact epithelium seemed to be spared.

Another morphological modification of the CXL protocol without deepithelialization proposes the use of benzalkonium chloride (BAC) [86], given its ability to increase epithelial permeability by loosening tight junctions [87]. In an experimental comparative study, CXL incorporating application of 0.005% BAC was performed on rabbit corneas with intact epithelium [88]. The biomechanical stiffening effect was reduced by about one-fifth compared with standard CXL. Increasing the BAC concentration further to 0.02% clearly affected epithelial permeability to riboflavin, thus increasing the absorption coefficient and achieving greater stiffening effects, as reflected in a significant increase in Young's modulus and stress-strain values [89]. Moreover, study of resistance to enzymatic digestion revealed that corneas with intact epithelium treated with CXL without BAC dissolved in collagenase solution after 6 days, whereas corneas with intact epithelium undergoing CXL with BAC behaved like controls (standard CXL protocol) and did not dissolve even after 14 days.

In a prospective, consecutive clinical study in patients with progressive keratoconus, CXL with intact epithelium and pretreatment with BAC, and other substances enhancing epithelial permeability revealed less pronounced effects than

standard CXL [90]. Despite a positive effect on CDVA, corneal curvature was maintained and did not improve.

The long-term efficacy and possible side effects of CXL without deepithelialization require further assessment in randomized, controlled studies with longer observation periods.

8. Other Applications of CXL

As the technique has grown in popularity in recent years, other potential applications for CXL in ophthalmology have been proposed.

8.1. Ectasia. Ectasia following corneal excimer laser refractive surgery is a postoperative thinning of the cornea, encountered mainly after LASIK. In the most advanced cases, penetrating keratoplasty may even be required. Thanks to its ability to stabilize the biomechanics of the cornea, CXL has been proposed as a therapeutic method of arresting keratectasia progression. The first study to investigate the advantages of CXL in post-LASIK ectasia showed an increase in biomechanical stability sufficient to prevent the progression of keratectasia [91]. A reduction in maximum keratometric readings and an increase in biomechanical stability were also confirmed in a larger group (10 patients) for up to 12 months [92]. CXL has been reported to improve BSCVA in eyes with post-LASIK ectasia without any significant side effects [93]. *In vivo* CLSM disclosed relatively similar corneal alterations after CXL both in keratoconic and in post-LASIK corneal ectasia eyes [62]. The positive impact of CXL in conjunction with PRK has been shown in a case of post-LASIK ectasia [94]. As a qualifying remark, it should be pointed out that the longest follow-up in these studies has been 1 year. Despite these promising early results, studies with longer follow-up and larger patient numbers are needed to evaluate the effectiveness and safety of CXL in the management of post-LASIK keratectasia.

Another form of corneal ectasia is pellucid marginal degeneration (PMD)—a noninflammatory disorder characterized by a peripheral band of thinning of the corneal segment between the 4 o'clock and 8 o'clock positions. One case report describes a patient with bilateral PMD who underwent CXL unilaterally, on the side with more profound ectasia [95]. The treated eye was examined during the first year after treatment. Reduced corneal astigmatism and improved visual acuity were detected at 3 months and remained stable through the 12-month interval. The endothelial cell count and corneal thickness remained unchanged from the preoperative assessment to 12 months, confirming the safety of CXL. A significant positive clinical outcome has also been obtained in PMD patients by combining CXL with photorefractive keratectomy [96] or with topography-guided transepithelial surface ablation [97].

8.2. Keratitis. Keratitis is a corneal disease that may result from infection (with bacteria, fungi, yeasts, viruses, and amoebae) or from immunological disorders (sterile keratitis). Attempts have been made in recent years to assess the effects of CXL in infectious keratitis, with a possible view

to making it a treatment option. The antibacterial effectiveness of CXL has been demonstrated in vitro against some common pathogens, selected from a panel of clinical ocular isolates obtained from patients with severe bacterial keratitis [98]. CXL has also exhibited antimicrobial effects in vitro against fungal pathogens, such as *Candida albicans*, *Fusarium* sp., and *Aspergillus fumigatus* [99]. The ability of CXL to inhibit pathogen growth has the potential to make it an effective tool in the management of infectious keratitis. In a small case series with bacterial and fungal keratitis, Iseli et al. [100] demonstrated immediate regression of the corneal melting process and a decrease in infiltrate size after CXL in most patients. A later study has confirmed this observation and demonstrated symptomatic relief and arrest of melting progression in corneas with bacterial keratitis [101].

CXL has also been beneficial in treating a patient with *Escherichia coli* keratitis [102], leading to complete healing of corneal ulceration, regression of edema, and disappearance of painful symptoms.

The antimicrobial effects of CXL have two possible mechanisms, and, in all probabilities, these operate in synergy. Firstly, the pathogens implicated in corneal melting are known to act by enzymatic digestion. Since CXL has been reported to increase tissue resistance to enzymatic digestion [50], the improvement in symptoms can be attributed to the greater resistance of corneal tissue to enzyme activity. Secondly, the phenomenon of cell apoptosis after CXL may include not only keratocytes but also pathogens, thus arresting the infectious process.

Despite these promising results, both studies referred to above were limited in terms of case numbers, and further extensive investigations are needed before CXL can be incorporated into routine clinical practice for the treatment of keratitis.

8.3. Corneal Edema. Endothelial dysfunction results in corneal swelling (edema) and visual impairment. The most common conditions associated with edema are bullous keratopathy and Fuchs dystrophy. In an experimental study, Wollensak et al. [103] demonstrated in enucleated porcine eyes that the CXL procedure altered the swelling pattern of the cornea, minimizing hydration. It is hypothesized that CXL strengthens the interfiber attachments, thereby reducing the space for fluid accumulation and so increasing the optical clarity of the cornea. The antiedematous effect of CXL potentially makes it a useful tool in the clinic for treating corneal edema. Reduced corneal edema, increased corneal clarity, and improved visual acuity were demonstrated during the 2-month follow-up period after CXL in two cases of bullous keratopathy associated with corneal ulcer or infectious keratitis [104]. CXL performed in eyes with endothelial decompensation and nonhealing ulcers led to significant benefit in only half of nonhealing ulcer cases, whereas a significant decrease in corneal thickness and improvement in symptoms was noted in 10 of 11 corneas with endothelial decompensation for up to 3 months after treatment [105]. However, in another clinical study where CXL was performed in patients with bullous keratopathy and Fuchs dystrophy, measurements of central corneal thickness for up

to 6 months indicated that CXL reduced edema only temporarily [106]. Moreover, in advanced cases of corneal edema, CXL had only little effect, suggesting that the greater stromal impairment in these patients interfered with riboflavin penetration, thus resulting in less benefit. On the other hand, stable reductions in corneal thickness have been demonstrated in bullous keratopathy and Fuchs dystrophy for up to 8 months after CXL [107]. This inconsistency can be explained by the fact that Wollensak et al. [107] used pretreatment with 40% glucose for 1 day prior to CXL, allowing dehydration of the cornea and more precise estimation of corneal thickness. The importance of dehydrating the swollen cornea prior to CXL has also been demonstrated by another group in Fuchs dystrophy patients with various degrees of edema [108]. Although the results reported by Wollensak et al. [107] appear to be more reliable, their study included only a very limited number of patients. Future studies with longer follow-up and larger patient numbers are necessary to assess the efficacy and limitations of CXL in the treatment of corneal edema. At present, as a minimally invasive and safe procedure, CXL can be recommended at least for those patients awaiting keratoplasty.

9. Complications after CXL

Although CXL is one of the most promising developments in the management of keratoconus, the potential for adverse outcomes should not be underestimated.

9.1. Stromal Haze. Corneal scarring (diffuse subepithelial opacification) that was slow to resolve has been reported in a 41-year-old man after CXL; this complication responded to topical application of steroids, eventually resolving gradually after several months [109]. Subclinical stromal haze that does not impair patients' vision has also been detected by other groups using confocal microscopy [59, 110]. Raiskup et al. [111] demonstrated CXL-induced permanent corneal haze in approximately 8.6% of all treated eyes. The haze of varying degrees after CXL took up to 12 months to resolve completely [66].

Interestingly, haze formation correlates positively in all studies with the stage of keratoconus; all patients who developed haze had advanced keratoconus, thinner corneas, Vogt's striae, and higher keratometry values. Consequently, the development of haze may be attributed not to CXL itself but to the stage of keratoconus. Objective quantification of the time course of CXL-induced haze suggests that it peaks at 1 month, plateaus at 3 months, and then gradually decreases thereafter [112].

More recently, corneal haze formation has been reported in the posterior stroma in 2 patients (7% of all treated cases) after CXL [113]. Notably, both patients had mild rather than advanced keratoconus. Even though haze developed near the apex of the cone, away from the central visual axis, these cases indicate that not only keratoconus stage but other factors too may have contributed to this phenomenon. Further research is needed to investigate this aspect carefully with regard to the safety of CXL.

A far higher incidence of haze has been observed in 46.42% of keratoconic eyes treated with simultaneous customized PRK and CXL [114]. Posterior linear stromal haze was visualized clinically by slit-lamp biomicroscopy, and, in the same corneas, in vivo CLSM revealed highly reflective, spindle-shaped keratocytes, which are associated with stromal repopulation and increased collagen deposition. Photoablation is highly likely to have been the factor that contributed to the more common occurrence of haze with this combined approach.

9.2. Keratitis. There is no direct evidence yet of any lowering of the corneal immune mechanisms following CXL. Nevertheless, there is a major risk of infection after standard CXL because the procedure involves deepithelialization followed by the application of a soft contact lens. There has been one case report of polymicrobial keratitis caused by *Streptococcus salivarius*, *Streptococcus oralis*, and *Staphylococcus* sp. 3 days after CXL [115]. The patient admitted that he had cleaned his bandage contact lens in his mouth, an action that was most probably the cause of keratitis. *Escherichia coli* infection occurred in a case 3 days after CXL, with multiple stromal infiltrations and moderate anterior chamber inflammation [116]. The bacterial keratitis was successfully treated with fortified tobramycin and cephazolin eye drops for several weeks. Furthermore, fungal keratitis has been reported as a complication 22 days after CXL despite complete epithelial recovery at day 5 [117]. Koppen et al. [118] have also published a case report series concerning 4 patients who developed severe keratitis, resulting in corneal scarring within the first few days after CXL.

Acanthamoeba keratitis with corneal melting has been reported in a 32-year-old woman 5 days following CXL [119]. The patient was unaware of wearing a bandage contact lens and repeatedly rinsed his face and eyelids with tap water. Because of corneal perforation, a large therapeutic keratoplasty à chaud was performed.

A case report has shown that CXL can induce herpetic keratitis with iritis even in patients with no history of herpetic disease [120]. Following steroids and acyclovir treatment, a significant improvement was observed, and there was no evidence of herpetic disease recurrence 2 months postoperatively. The same group reported on the diffuse lamellar keratitis during the first posttreatment days [121], which resolved after intensive treatment with topical corticosteroids during the following 2 weeks.

More recently, 2 cases of keratopathy have been reported after uneventful CXL for grade 3 keratoconus [122]. The pathogenesis in these cases remained unidentified. Corneal infiltrates slowly resolved after combined topical antibiotic/antifungal/steroids treatment.

Although the incidence of keratitis is low in these studies, it remains a very serious side effect of CXL.

10. Concluding Remarks

CXL, a procedure that uses UVA light in conjunction with riboflavin as a photomediator, creates new covalent cross-links between collagen fibrils, thus strengthening and

stabilizing the cornea. CXL is a topic that has been attracting growing interest over the past decade. It has been shown not only to arrest progression of keratectasia in progressive keratoconus and post-LASIK corneas but also to exert a moderately positive effect on visual status. Corneal edema and infectious keratitis have also been reported to benefit from CXL. Because most of the published clinical findings have come from nonrandomized studies, further corroboration is required from more robustly designed RCTs.

Attempts have been made to optimize CXL to minimize the potential for risk in very thin corneas or to reduce patient discomfort. The major safety concerns associated with CXL are ocular surface damage and endothelial cell damage. Although the safety of CXL has been demonstrated in numerous experimental animal studies, outcomes in patients are more complex than in animal models. Postoperative events vary markedly, depending on the stage of keratoconus in patients treated. Edema, stromal haze, and infectious keratitis have been reported as complications in the clinical setting—albeit very rarely. Further studies are therefore needed to extensively investigate the safety of the CXL procedure.

Because collagen turnover in the stroma is known to take several years, it remains unclear whether the changes in corneal stability reported after CXL will be permanent or whether its effects are time limited. The long-term effects of standard and modified protocols for CXL should be reviewed thoroughly in studies with longer follow-up.

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References

- [1] Y. S. Rabinowitz, "Keratoconus," *Survey of Ophthalmology*, vol. 42, no. 4, pp. 297–319, 1998.
- [2] M. Edwards, C. N. McGhee, and S. Dean, "The genetics of keratoconus," *Clinical and Experimental Ophthalmology*, vol. 29, no. 6, pp. 345–351, 2001.
- [3] T. Iwamoto and A. G. DeVoe, "Electron microscopical study of the Fleisher ring," *Archives of Ophthalmology*, vol. 94, no. 9, pp. 1579–1584, 1976.
- [4] B. F. Fernandes, P. Logan, M. E. Zajdenweber, L. N. Santos, D. P. Cheema, and M. N. Burnier Jr., "Histopathological study of 49 cases of keratoconus," *Pathology*, vol. 40, no. 6, pp. 623–626, 2008.
- [5] T. Iwamoto and A. G. DeVoe, "Particulate structures in keratoconus," *Archives d'Ophthalmologie et Revue Générale d'Ophthalmologie*, vol. 35, no. 1, pp. 65–76, 1975.
- [6] C. W. Sturbaum and R. L. Peiffer Jr., "Pathology of corneal endothelium in keratoconus," *Ophthalmologica*, vol. 206, no. 4, pp. 192–208, 1993.
- [7] A. J. Bron, "Keratoconus," *Cornea*, vol. 7, no. 3, pp. 163–169, 1988.
- [8] A. Ihalainen, T. Salo, H. Forsius, and L. Peltonen, "Increase in type I and type IV collagenolytic activity in primary cultures of keratoconus cornea," *European Journal of Clinical Investigation*, vol. 16, no. 1, pp. 78–84, 1986.
- [9] M. C. Kenney, M. Chwa, A. I. Oprobok, and D. J. Brown, "Increased gelatinolytic activity in keratoconus keratocyte

- cultures. A correlation to an altered matrix metalloproteinase-2/tissue inhibitor of metalloproteinase ratio," *Cornea*, vol. 13, no. 2, pp. 114–124, 1994.
- [10] S. E. Wilson, Y. G. He, J. Weng et al., "Epithelial injury induces keratocyte apoptosis: hypothesized role for the interleukin-1 system in the modulation of corneal tissue organization and wound healing," *Experimental Eye Research*, vol. 62, no. 4, pp. 325–327, 1996.
 - [11] K. M. Meek, S. J. Tuft, Y. Huang et al., "Changes in collagen orientation and distribution in keratoconus corneas," *Investigative Ophthalmology and Visual Science*, vol. 46, no. 6, pp. 1948–1956, 2005.
 - [12] J. S. Hwang, J. H. Lee, W. R. Wee, and M. K. Kim, "Effects of multicurve RGP contact lens use on topographic changes in keratoconus," *Korean Journal of Ophthalmology*, vol. 24, no. 4, pp. 201–206, 2010.
 - [13] S. Y. Kang, Y. K. Park, J. S. Song, and H. M. Kim, "Anterior stromal puncture for treatment of contact lens-intolerant keratoconus patients," *Graefes Archive for Clinical and Experimental Ophthalmology*, vol. 249, no. 1, pp. 89–92, 2011.
 - [14] C. S. Siganos, G. D. Kymionis, N. Kartakis, M. A. Theodorakis, N. Astryrakakis, and I. G. Pallikaris, "Management of keratoconus with Intacs," *American Journal of Ophthalmology*, vol. 135, no. 1, pp. 64–70, 2003.
 - [15] J. Colin and F. J. Malet, "Intacs for the correction of keratoconus: two-year follow-up," *Journal of Cataract and Refractive Surgery*, vol. 33, no. 1, pp. 69–74, 2007.
 - [16] D. P. Piñero, J. L. Alio, B. El Kady et al., "Refractive and aberrometric outcomes of intracorneal ring segments for keratoconus: mechanical versus femtosecond-assisted procedures," *Ophthalmology*, vol. 116, no. 9, pp. 1675–1687, 2009.
 - [17] M. H. Shabayek and J. L. Alió, "Intrastromal corneal ring segment implantation by femtosecond laser for keratoconus correction," *Ophthalmology*, vol. 114, no. 9, pp. 1643–1652, 2007.
 - [18] T. Bourcier, V. Borderie, and L. Laroche, "Late bacterial keratitis after implantation of intrastromal corneal ring segments," *Journal of Cataract and Refractive Surgery*, vol. 29, no. 2, pp. 407–409, 2003.
 - [19] M. Claesson, W. J. Armitage, P. Fagerholm, and U. Stenevi, "Visual outcome in corneal grafts: a preliminary analysis of the Swedish Corneal Transplant Register," *British Journal of Ophthalmology*, vol. 86, no. 2, pp. 174–180, 2002.
 - [20] J. H. Lass, A. Sugar, B. A. Benetz et al., "Endothelial cell density to predict endothelial graft failure after penetrating keratoplasty," *Archives of Ophthalmology*, vol. 128, no. 1, pp. 63–69, 2010.
 - [21] A. J. Epstein, T. N. de Castro, P. R. Laibson, E. J. Cohen, and C. J. Rapuano, "Risk factors for the first episode of corneal graft rejection in keratoconus," *Cornea*, vol. 25, no. 9, pp. 1005–1011, 2006.
 - [22] L. Lim, K. Pesudovs, and D. J. Coster, "Penetrating keratoplasty for keratoconus: visual outcome and success," *Ophthalmology*, vol. 107, no. 6, pp. 1125–1131, 2000.
 - [23] I. Kremer, R. C. Eagle, C. J. Rapuano, and P. R. Laibson, "Histologic evidence of recurrent keratoconus seven years after keratoplasty," *American Journal of Ophthalmology*, vol. 119, no. 4, pp. 511–512, 1995.
 - [24] G. N. Rao, T. John, N. Ishida, and J. V. Aquavella, "Recovery of corneal sensitivity in grafts following penetrating keratoplasty," *Ophthalmology*, vol. 92, no. 10, pp. 1408–1411, 1985.
 - [25] L. Fontana, G. Parente, A. Sincich, and G. Tassinari, "Influence of graft-host interface on the quality of vision after deep anterior lamellar keratoplasty in patients with keratoconus," *Cornea*, vol. 30, no. 5, pp. 497–502, 2011.
 - [26] E. Spörl, M. Huhle, M. Kasper, and T. Seiler, "Increased rigidity of the cornea caused by intrastromal cross-linking," *Ophthalmology*, vol. 94, no. 12, pp. 902–906, 1997.
 - [27] Y. Komai and T. Ushiki, "The three-dimensional organization of collagen fibrils in the human cornea and sclera," *Investigative Ophthalmology and Visual Science*, vol. 32, no. 8, pp. 2244–2258, 1991.
 - [28] A. Elsheikh, D. Wang, M. Brown, P. Rama, M. Campanelli, and D. Pye, "Assessment of corneal biomechanical properties and their variation with age," *Current Eye Research*, vol. 32, no. 1, pp. 11–19, 2007.
 - [29] T. Seiler, S. Huhle, E. Spoerl, and H. Kunath, "Manifest diabetes and keratoconus: a retrospective case-control study," *Graefes Archive for Clinical and Experimental Ophthalmology*, vol. 238, no. 10, pp. 822–825, 2000.
 - [30] O. Tomkins and H. J. Garzozzi, "Collagen cross-linking: strengthening the unstable cornea," *Clinical Ophthalmology*, vol. 2, no. 4, pp. 863–867, 2008.
 - [31] E. Spoerl, M. Huhle, and T. Seiler, "Induction of cross-links in corneal tissue," *Experimental Eye Research*, vol. 66, no. 1, pp. 97–103, 1998.
 - [32] E. Spoerl and T. Seiler, "Techniques for stiffening the cornea," *Journal of Refractive Surgery*, vol. 15, no. 6, pp. 711–713, 1999.
 - [33] A. S. McCall, S. Kraft, H. F. Edelhauser et al., "Mechanisms of corneal tissue cross-linking in response to treatment with topical riboflavin and long-wavelength ultraviolet radiation (UVA)," *Investigative Ophthalmology and Visual Science*, vol. 51, no. 1, pp. 129–138, 2010.
 - [34] G. Wollensak, E. Spoerl, M. Wilsch, and T. Seiler, "Keratocyte apoptosis after corneal collagen cross-linking using riboflavin/UVA treatment," *Cornea*, vol. 23, no. 1, pp. 43–49, 2004.
 - [35] G. Wollensak, E. Iomdina, D. D. Dittert, and H. Herbst, "Wound healing in the rabbit cornea after corneal collagen cross-linking with riboflavin and UVA," *Cornea*, vol. 26, no. 5, pp. 600–605, 2007.
 - [36] M. Hovakimyan, R. Guthoff, S. Knappe et al., "Short-term corneal response to cross-linking in rabbit eyes assessed by in vivo confocal laser scanning microscopy and histology," *Cornea*, vol. 30, no. 2, pp. 196–203, 2011.
 - [37] G. Wollensak, "Histological changes in human cornea after cross-linking with riboflavin and ultraviolet A," *Acta Ophthalmologica*, vol. 88, no. 2, pp. e17–e18, 2010.
 - [38] M. Q. Salomão, S. S. Chaurasia, A. Sinha-Roy et al., "Corneal wound healing after ultraviolet-A/riboflavin collagen cross-linking: a rabbit study," *Journal of Refractive Surgery*, vol. 27, no. 6, pp. 401–407, 2011.
 - [39] R. Mencucci, M. Marini, I. Paladini et al., "Effects of riboflavin/UVA corneal cross-linking on keratocytes and collagen fibres in human cornea," *Clinical and Experimental Ophthalmology*, vol. 38, no. 1, pp. 49–56, 2010.
 - [40] S. K. Masur, H. S. Dewal, T. T. Dinh, I. Erenburg, and S. Petridou, "Myofibroblasts differentiate from fibroblasts when plated at low density," *Proceedings of the National Academy of Sciences of the United States of America*, vol. 93, no. 9, pp. 4219–4223, 1996.
 - [41] G. Wollensak, E. Spörl, F. Reber, L. Pillunat, and R. Funk, "Corneal endothelial cytotoxicity of riboflavin/UVA treatment in vitro," *Ophthalmic Research*, vol. 35, no. 6, pp. 324–328, 2003.
 - [42] G. Wollensak, E. Spoerl, M. Wilsch, and T. Seiler, "Endothelial cell damage after riboflavin-ultraviolet-A treatment in the

- rabbit," *Journal of Cataract and Refractive Surgery*, vol. 29, no. 9, pp. 1786–1790, 2003.
- [43] C. Edmund, "Corneal elasticity and ocular rigidity in normal and keratoconic eyes," *Acta Ophthalmologica*, vol. 66, no. 2, pp. 134–140, 1988.
- [44] G. Wollensak, E. Spoerl, and T. Seiler, "Stress-strain measurements of human and porcine corneas after riboflavin-ultraviolet-A-induced cross-linking," *Journal of Cataract and Refractive Surgery*, vol. 29, no. 9, pp. 1780–1785, 2003.
- [45] M. Kohlhaas, E. Spoerl, T. Schilde, G. Unger, C. Wittig, and L. E. Pillunat, "Biomechanical evidence of the distribution of cross-links in corneastreated with riboflavin and ultraviolet A light," *Journal of Cataract and Refractive Surgery*, vol. 32, no. 2, pp. 279–283, 2006.
- [46] E. Spoerl, G. Wollensak, D. D. Dittert, and T. Seiler, "Thermomechanical behavior of collagen-cross-linked porcine cornea," *Ophthalmologica*, vol. 218, no. 2, pp. 136–140, 2004.
- [47] G. Wollensak and E. Iomdina, "Long-term biomechanical properties of rabbit sclera after collagen crosslinking using riboflavin and ultraviolet A (UVA)," *Acta Ophthalmologica*, vol. 87, no. 2, pp. 193–198, 2009.
- [48] G. Wollensak, M. Wilsch, E. Spoerl, and T. Seiler, "Collagen fiber diameter in the rabbit cornea after collagen crosslinking by riboflavin/UVA," *Cornea*, vol. 23, no. 5, pp. 503–507, 2004.
- [49] K. M. Bottós, A. L. Hofling-Lima, M. C. Barbosa et al., "Effect of collagen cross-linking in stromal fibril organization in edematous human corneas," *Cornea*, vol. 29, no. 7, pp. 789–793, 2010.
- [50] E. Spoerl, G. Wollensak, and T. Seiler, "Increased resistance of crosslinked cornea against enzymatic digestion," *Current Eye Research*, vol. 29, no. 1, pp. 35–40, 2004.
- [51] R. R. Krueger and J. C. Ramos-Esteban, "How might corneal elasticity help us understand diabetes and intraocular pressure?" *Journal of Refractive Surgery*, vol. 23, no. 1, pp. 85–88, 2007.
- [52] E. Coskunseven, M. R. Jankov II, and F. Hafezi, "Contralateral eye study of corneal collagen cross-linking with riboflavin and UVA irradiation in patients with keratoconus," *Journal of Refractive Surgery*, vol. 25, no. 4, pp. 371–376, 2009.
- [53] G. D. Kymionis, M. A. Grentzelos, G. A. Kounis et al., "Intraocular pressure measurements after corneal collagen crosslinking with riboflavin and ultraviolet A in eyes with keratoconus," *Journal of Cataract and Refractive Surgery*, vol. 36, no. 10, pp. 1724–1727, 2010.
- [54] P. Vinciguerra, E. Albè, A. M. Mahmoud, S. Trazza, F. Hafezi, and C. J. Roberts, "Intra- and postoperative variation in ocular response analyzer parameters in keratoconic eyes after corneal cross-linking," *Journal of Refractive Surgery*, vol. 26, no. 9, pp. 669–676, 2010.
- [55] P. Steven, M. Hovakimyan, R. F. Guthoff, G. Hüttmann, and O. Stachs, "Imaging corneal crosslinking by autofluorescence 2-photon microscopy, second harmonic generation, and fluorescence lifetime measurements," *Journal of Cataract and Refractive Surgery*, vol. 36, no. 12, pp. 2150–2159, 2010.
- [56] I. Jalbert, F. Stapleton, E. Papas, D. F. Sweeney, and M. Coroneo, "In vivo confocal microscopy of the human cornea," *British Journal of Ophthalmology*, vol. 87, no. 2, pp. 225–236, 2003.
- [57] C. Mazzotta, C. Traversi, S. Baiocchi, P. Sergio, T. Caporossi, and A. Caporossi, "Conservative treatment of keratoconus by riboflavin-UVA-induced cross-linking of corneal collagen: qualitative investigation," *European Journal of Ophthalmology*, vol. 16, no. 4, pp. 530–535, 2006.
- [58] C. Mazzotta, A. Balestrazzi, C. Traversi et al., "Treatment of progressive keratoconus by riboflavin-UVA-induced cross-linking of corneal collagen: ultrastructural analysis by Heidelberg retinal tomograph II in vivo confocal microscopy in humans," *Cornea*, vol. 26, no. 4, pp. 390–397, 2007.
- [59] C. Mazzotta, C. Traversi, S. Baiocchi et al., "Corneal healing after riboflavin ultraviolet-a collagen cross-linking determined by confocal laser scanning microscopy in vivo: early and late modifications," *American Journal of Ophthalmology*, vol. 146, no. 4, pp. 527–533, 2008.
- [60] J. O. Croxatto, A. E. Tytium, and C. J. Argento, "Sequential in vivo confocal microscopy study of corneal wound healing after cross-linking in patients with keratoconus," *Journal of Refractive Surgery*, vol. 26, no. 9, pp. 638–645, 2010.
- [61] S. Esquenazi, J. He, N. Li, and H. E. Bazan, "Immunofluorescence of rabbit corneas after collagen cross-linking treatment with riboflavin and ultraviolet A," *Cornea*, vol. 29, no. 4, pp. 412–417, 2010.
- [62] G. D. Kymionis, V. F. Diakonis, M. Kalyvianaki et al., "One-year follow-up of corneal confocal microscopy after corneal cross-linking in patients with post laser in situ keratomileusis ectasia and keratoconus," *American Journal of Ophthalmology*, vol. 147, no. 5, pp. 774–778, 2009.
- [63] T. Seiler and F. Hafezi, "Corneal cross-linking-induced stromal demarcation line," *Cornea*, vol. 25, no. 9, pp. 1057–1059, 2006.
- [64] M. Doors, N. G. Tahzib, F. A. Eggink, T. T. Berendschot, C. A. Webers, and R. M. Nuijts, "Use of anterior segment optical coherence tomography to study corneal changes after collagen cross-linking," *American Journal of Ophthalmology*, vol. 148, no. 6, pp. 844–851, 2009.
- [65] G. Wollensak, E. Spoerl, and T. Seiler, "Riboflavin/ultraviolet-A-induced collagen crosslinking for the treatment of keratoconus," *American Journal of Ophthalmology*, vol. 135, no. 5, pp. 620–627, 2003.
- [66] F. Raiskup-Wolf, A. Hoyer, E. Spoerl, and L. E. Pillunat, "Collagen crosslinking with riboflavin and ultraviolet-A light in keratoconus: long-term results," *Journal of Cataract and Refractive Surgery*, vol. 34, no. 5, pp. 796–801, 2008.
- [67] A. Caporossi, C. Mazzotta, S. Baiocchi, and T. Caporossi, "Long-term results of riboflavin ultraviolet a corneal collagen cross-linking for keratoconus in Italy: the siena eye cross study," *American Journal of Ophthalmology*, vol. 149, no. 4, pp. 585–593, 2010.
- [68] P. Vinciguerra, E. Albè, S. Trazza et al., "Refractive, topographic, tomographic, and aberrometric analysis of keratoconic eyes undergoing corneal cross-linking," *Ophthalmology*, vol. 116, no. 3, pp. 369–378, 2009.
- [69] Y. Goldich, Y. Barkana, I. Avni, and D. Zadok, "Goldmann applanation tonometry versus ocular response analyzer for intraocular pressure measurements in keratoconic eyes," *Cornea*, vol. 29, no. 9, pp. 1011–1015, 2010.
- [70] M. Sedaghat, M. Naderi, and M. Zarei-Ghanavati, "Biomechanical parameters of the cornea after collagen crosslinking measured by waveform analysis," *Journal of Cataract and Refractive Surgery*, vol. 36, no. 10, pp. 1728–1731, 2010.
- [71] T. Koller, H. P. Iseli, F. Hafezi, P. Vinciguerra, and T. Seiler, "Scheimpflug imaging of corneas after collagen cross-linking," *Cornea*, vol. 28, no. 5, pp. 510–515, 2009.
- [72] C. Wittig-Silva, M. Whiting, E. Lamoureux, R. G. Lindsay, L. J. Sullivan, and G. R. Snibson, "A randomized controlled trial of corneal collagen cross-linking in progressive keratoconus: preliminary results," *Journal of Refractive Surgery*, vol. 24, no. 7, pp. S720–S725, 2008.
- [73] P. S. Hersh, S. A. Greenstein, and K. L. Fry, "Corneal collagen crosslinking for keratoconus and corneal ectasia: one-year

- results," *Journal of Cataract and Refractive Surgery*, vol. 37, no. 1, pp. 149–160, 2011.
- [74] A. J. Kanellopoulos and P. S. Binder, "Collagen cross-linking (CCL) with sequential topography-guided PRK: a temporizing alternative for keratoconus to penetrating keratoplasty," *Cornea*, vol. 26, no. 7, pp. 891–895, 2007.
- [75] G. D. Kymionis, G. A. Kontadakis, G. A. Kounis et al., "Simultaneous topography-guided PRK followed by corneal collagen cross-linking for keratoconus," *Journal of Refractive Surgery*, vol. 25, no. 9, pp. S807–S811, 2009.
- [76] A. J. Kanellopoulos, "Comparison of sequential vs same-day simultaneous collagen cross-linking and topography-guided PRK for treatment of keratoconus," *Journal of Refractive Surgery*, vol. 25, no. 9, pp. S812–S818, 2009.
- [77] C. C. Chan, M. Sharma, and B. S. Wachler, "Effect of inferior-segment Intacs with and without C3-R on keratoconus," *Journal of Cataract and Refractive Surgery*, vol. 33, no. 1, pp. 75–80, 2007.
- [78] F. Hafezi, M. Mrochen, H. P. Iseli, and T. Seiler, "Collagen crosslinking with ultraviolet-A and hypoosmolar riboflavin solution in thin corneas," *Journal of Cataract and Refractive Surgery*, vol. 35, no. 4, pp. 621–624, 2009.
- [79] F. Hafezi, "Limitation of collagen cross-linking with hypoosmolar riboflavin solution: failure in an extremely thin cornea," *Cornea*, vol. 30, no. 8, pp. 917–919, 2011.
- [80] K. M. Bottós, J. L. Dreyfuss, C. V. Regatieri et al., "Immunofluorescence confocal microscopy of porcine corneas following collagen cross-linking treatment with riboflavin and ultraviolet A," *Journal of Refractive Surgery*, vol. 24, no. 7, pp. S715–S719, 2008.
- [81] S. Hayes, D. P. O'Brart, L. S. Lamdin et al., "Effect of complete epithelial debridement before riboflavin-ultraviolet-A corneal collagen crosslinking therapy," *Journal of Cataract and Refractive Surgery*, vol. 34, no. 4, pp. 657–661, 2008.
- [82] K. Samaras, D. P. O'Brart, J. Douth, S. Hayes, J. Marshall, and K. M. Meek, "Effect of epithelial retention and removal on riboflavin absorption in porcine corneas," *Journal of Refractive Surgery*, vol. 25, no. 9, pp. S771–S775, 2009.
- [83] G. D. Kymionis, V. F. Diakonis, E. Coskunseven, M. Jankov, S. H. Yoo, and I. G. Pallikaris, "Customized pachymetric guided epithelial debridement for corneal collagen cross linking," *BMC Ophthalmology*, vol. 9, no. 1, article 10, 2009.
- [84] S. Baiocchi, C. Mazzotta, D. Cerretani, T. Caporossi, and A. Caporossi, "Corneal crosslinking: riboflavin concentration in corneal stroma exposed with and without epithelium," *Journal of Cataract and Refractive Surgery*, vol. 35, no. 5, pp. 893–899, 2009.
- [85] V. Kaya, C. A. Utine, and O. F. Yilmaz, "Efficacy of corneal collagen cross-linking using a custom epithelial debridement technique in thin corneas: a confocal microscopy study," *Journal of Refractive Surgery*, vol. 27, no. 6, pp. 444–450, 2011.
- [86] R. Pinelli, "BAK: a better alternative to epithelium removal in cross linking," *Ophthalmology Times Europe*, vol. 2, pp. 36–38, 2006.
- [87] B. McCarey and H. Edelhauser, "In vivo corneal epithelial permeability following treatment with prostaglandin analogs (correction of analoges) with or without benzalkonium chloride," *Journal of Ocular Pharmacology and Therapeutics*, vol. 23, no. 5, pp. 445–451, 2007.
- [88] G. Wollensak and E. Iomdina, "Biomechanical and histological changes after corneal crosslinking with and without epithelial debridement," *Journal of Cataract and Refractive Surgery*, vol. 35, no. 3, pp. 540–546, 2009.
- [89] A. Kissner, E. Spoerl, R. Jung, K. Spekl, L. E. Pillunat, and F. Raiskup, "Pharmacological modification of the epithelial permeability by benzalkonium chloride in UVA/Riboflavin corneal collagen cross-linking," *Current Eye Research*, vol. 35, no. 8, pp. 715–721, 2010.
- [90] A. Leccisotti and T. Islam, "Transepithelial corneal collagen cross-linking in keratoconus," *Journal of Refractive Surgery*, vol. 26, no. 12, pp. 942–948, 2010.
- [91] M. Kohlhaas, E. Spoerl, A. Speck, T. Schilde, D. Sandner, and L. E. Pillunat, "A new treatment of keratectasia after LASIK with riboflavin/UVA light cross-linking," *Klinische Monatsblätter für Augenheilkunde*, vol. 222, no. 5, pp. 430–436, 2005.
- [92] F. Hafezi, J. Kanellopoulos, R. Wiltfang, and T. Seiler, "Corneal collagen crosslinking with riboflavin and ultraviolet A to treat induced keratectasia after laser in situ keratomileusis," *Journal of Cataract and Refractive Surgery*, vol. 33, no. 12, pp. 2035–2040, 2007.
- [93] P. Vinciguerra, F. I. Camesasca, E. Albè, and S. Trazza, "Corneal collagen cross-linking for ectasia after excimer laser refractive surgery: 1-year results," *Journal of Refractive Surgery*, vol. 26, no. 7, pp. 486–497, 2010.
- [94] G. D. Kymionis, D. M. Portaliou, V. F. Diakonis et al., "Management of post laser in situ Keratomileusis ectasia with simultaneous Topography Guided Photorefractive Keratectomy and Collagen Cross-Linking," *Open Ophthalmology Journal*, vol. 5, pp. 11–13, 2011.
- [95] L. Spadea, "Corneal collagen cross-linking with riboflavin and UVA irradiation in pellucid marginal degeneration," *Journal of Refractive Surgery*, vol. 26, no. 5, pp. 375–377, 2010.
- [96] G. D. Kymionis, A. E. Karavitaki, G. A. Kounis, D. M. Portaliou, S. H. Yoo, and I. G. Pallikaris, "Management of pellucid marginal corneal degeneration with simultaneous customized photorefractive keratectomy and collagen crosslinking," *Journal of Cataract and Refractive Surgery*, vol. 35, no. 7, pp. 1298–1301, 2009.
- [97] A. Stojanovic, J. Zhang, X. Chen, T. A. Nitter, S. Chen, and Q. Wang, "Topography-guided transepithelial surface ablation followed by corneal collagen cross-linking performed in a single combined procedure for the treatment of keratoconus and pellucid marginal degeneration," *Journal of Refractive Surgery*, vol. 26, no. 2, pp. 145–152, 2010.
- [98] S. A. Martins, J. C. Combs, G. Noguera et al., "Antimicrobial efficacy of riboflavin/UVA combination (365 nm) in vitro for bacterial and fungal isolates: a potential new treatment for infectious keratitis," *Investigative Ophthalmology and Visual Science*, vol. 49, no. 8, pp. 3402–3408, 2008.
- [99] A. Sauer, V. Letscher-Bru, C. Speeg-Schatz et al., "In vitro efficacy of antifungal treatment using riboflavin/UV-A (365 nm) combination and amphotericin B," *Investigative Ophthalmology and Visual Science*, vol. 51, no. 8, pp. 3950–3953, 2010.
- [100] H. P. Iseli, M. A. Thiel, F. Hafezi, J. Kampmeier, and T. Seiler, "Ultraviolet a/riboflavin corneal cross-linking for infectious keratitis associated with corneal melts," *Cornea*, vol. 27, no. 5, pp. 590–594, 2008.
- [101] K. Makhdomi, J. Mortensen, and S. Crafoord, "Infectious keratitis treated with corneal crosslinking," *Cornea*, vol. 29, no. 12, pp. 1353–1358, 2010.
- [102] T. M. Ferrari, M. Leozappa, M. Lorusso, E. Epifani, and L. M. Ferrari, "Escherichia coli keratitis treated with ultraviolet A/riboflavin corneal cross-linking: a case report," *European Journal of Ophthalmology*, vol. 19, no. 2, pp. 295–297, 2009.
- [103] G. Wollensak, H. Aurich, D. T. Pham, and C. Wirbelauer, "Hydration behavior of porcine cornea crosslinked with riboflavin and ultraviolet A," *Journal of Cataract and Refractive Surgery*, vol. 33, no. 3, pp. 516–521, 2007.

- [104] V. Kozobolis, G. Labiris, M. Gkika et al., "UV-A collagen cross-linking treatment of bullous keratopathy combined with corneal ulcer," *Cornea*, vol. 29, no. 2, pp. 235–238, 2010.
- [105] N. Ehlers, J. Hjortdal, K. Nielsen, and A. Søndergaard, "Riboflavin-UVA treatment in the management of edema and non-healing ulcers of the cornea," *Journal of Refractive Surgery*, vol. 25, no. 9, pp. S803–S806, 2009.
- [106] M. M. V. Cordeiro Barbosa, J. B. Barbosa Jr., F. E. Hirai, and A. L. Hofling-Lima, "Effect of cross-linking on corneal thickness in patients with corneal edema," *Cornea*, vol. 29, no. 6, pp. 613–617, 2010.
- [107] G. Wollensak, H. Aurich, C. Wirbelauer, and D. T. Pham, "Potential use of riboflavin/UVA cross-linking in bullous keratopathy," *Ophthalmic Research*, vol. 41, no. 2, pp. 114–117, 2009.
- [108] F. Hafezi, P. Dejica, and F. Majo, "Modified corneal collagen crosslinking reduces corneal oedema and diurnal visual fluctuations in Fuchs dystrophy," *British Journal of Ophthalmology*, vol. 94, no. 5, pp. 660–661, 2010.
- [109] C. I. Herrmann, T. Hammer, and G. I. Duncker, "Hazeformation (corneal scarring) after cross-linking therapy in keratoconus," *Ophthalmologie*, vol. 105, no. 5, pp. 485–487, 2008.
- [110] C. Mazzotta, A. Balestrazzi, S. Baiocchi, C. Traversi, and A. Caporossi, "Stromal haze after combined riboflavin-UVA corneal collagen cross-linking in keratoconus: in vivo confocal microscopic evaluation," *Clinical and Experimental Ophthalmology*, vol. 35, no. 6, pp. 580–582, 2007.
- [111] F. Raiskup, A. Hoyer, and E. Spoerl, "Permanent corneal haze after riboflavin-UVA-induced cross-linking in keratoconus," *Journal of Refractive Surgery*, vol. 25, no. 9, pp. S824–S828, 2009.
- [112] S. A. Greenstein, K. L. Fry, J. Bhatt, and P. S. Hersh, "Natural history of corneal haze after collagen crosslinking for keratoconus and corneal ectasia: scheimpflug and biomicroscopic analysis," *Journal of Cataract and Refractive Surgery*, vol. 36, no. 12, pp. 2105–2114, 2010.
- [113] L. S. Lim, R. Beuerman, L. Lim, and D. T. Tan, "Late-onset deep stromal scarring after riboflavin-UV-A corneal collagen cross-linking for mild keratoconus," *Archives of Ophthalmology*, vol. 129, no. 3, pp. 360–362, 2011.
- [114] G. D. Kymionis, D. M. Portaliou, V. F. Diakonis et al., "Posterior linear stromal haze formation after simultaneous photorefractive keratectomy followed by corneal collagen cross-linking," *Investigative Ophthalmology and Visual Science*, vol. 51, no. 10, pp. 5030–5033, 2010.
- [115] K. V. Zamora and J. J. Males, "Polymicrobial keratitis after a collagen cross-linking procedure with postoperative use of a contact lens: a case report," *Cornea*, vol. 28, no. 4, pp. 474–476, 2009.
- [116] M. Pollhammer and C. Cursiefen, "Bacterial keratitis early after corneal crosslinking with riboflavin and ultraviolet-A," *Journal of Cataract and Refractive Surgery*, vol. 35, no. 3, pp. 588–589, 2009.
- [117] S. Garcia-Delpech, M. Díaz-Llopis, P. Udaondo, and D. Salom, "Fusarium keratitis 3 weeks after healed corneal cross-linking," *Journal of Refractive Surgery*, vol. 26, no. 12, pp. 994–995, 2010.
- [118] C. Koppen, J. C. Vryghem, L. Gobin, and M. J. Tassignon, "Keratitis and corneal scarring after UVA/riboflavin cross-linking for keratoconus," *Journal of Refractive Surgery*, vol. 25, no. 9, pp. S819–S823, 2009.
- [119] P. Rama, F. di Matteo, S. Matuska, G. Paganoni, and A. Spinelli, "Acanthamoeba keratitis with perforation after corneal crosslinking and bandage contact lens use," *Journal of Cataract and Refractive Surgery*, vol. 35, no. 4, pp. 788–791, 2009.
- [120] G. D. Kymionis, D. M. Portaliou, D. I. Bouzoukis et al., "Herpetic keratitis with iritis after corneal crosslinking with riboflavin and ultraviolet A for keratoconus," *Journal of Cataract and Refractive Surgery*, vol. 33, no. 11, pp. 1982–1984, 2007.
- [121] G. D. Kymionis, D. I. Bouzoukis, V. F. Diakonis, D. M. Portaliou, A. I. Pallikaris, and S. H. Yoo, "Diffuse lamellar keratitis after corneal crosslinking in a patient with post-laser in situ keratomileusis corneal ectasia," *Journal of Cataract and Refractive Surgery*, vol. 33, no. 12, pp. 2135–2137, 2007.
- [122] P. Rodríguez-Ausín, R. Gutiérrez-Ortega, A. Arance-Gil, M. Romero-Jimenez, and G. Fuentes-Páez, "Keratopathy after cross-linking for keratoconus," *Cornea*, vol. 30, no. 9, pp. 1051–1053, 2011.

Review Article

Complications of Corneal Collagen Cross-Linking

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Cross-linking of corneal collagen (CXL) is a promising approach for the treatment of keratoconus and secondary ectasia. Several long-term and short-term complications of CXL have been studied and documented. The possibility of a secondary infection after the procedure exists because the patient is subjected to epithelial debridement and the application of a soft contact lens. Formation of temporary corneal haze, permanent scars, endothelial damage, treatment failure, sterile infiltrates, and herpes reactivation are the other reported complications of this procedure. Cross-linking is a low-invasive procedure with low complication and failure rate but it may have direct or primary complications due to incorrect technique application or incorrect patient's inclusion and indirect or secondary complications related to therapeutic soft contact lens, patient's poor hygiene, and undiagnosed concomitant ocular surface diseases.

1. Introduction

Keratoconus is a progressive, bilateral, often asymmetrical, and noninflammatory corneal ectasia. Prevalence of keratoconus is 1 : 2000 [1] and is usually diagnosed during the second and third decade of life. Currently available treatments for keratoconus (rigid contact lens, lamellar Keratoplasty, intacs) largely involve interventions which are done for tectonic, optical, or refractive purpose. Unfortunately, neither of those options treats the underlying cause of ectasia, and therefore cannot stop the progression of keratoconus.

Corneal collagen cross-linking (CXL) based on the combined use of the photosensitizer riboflavin and UVA light of 370 nm was introduced by Wollensak et al. from Germany in 2003. CXL is the only available treatment directed at the underlying pathology in keratoconic cornea, which is stromal biomechanical and structural instability leading to progressive ectasia. CXL induces covalent inter- and intrafibrillar collagen cross-links creating an increase in biomechanical rigidity of human cornea by about 300%. The cross-linking effect is maximal only in the anterior stroma. Corneal collagen cross-linking (CXL) is currently under investigation to determine if it can slow, stabilize, or even possibly reverse the progression of corneal ectasia in patients with

keratoconus [2]. The present paper is a review of literature on CXL complications.

2. Corneal Collagen Cross-Linking with Riboflavin and UVA

The main indication for CXL in ophthalmology has been the management of corneal ectasia, such as halting the progression of keratoconus. In addition, CXL has been proposed as a treatment modality for iatrogenic keratectasia [3], infectious melting keratitis [4], and bullous keratopathy [5]. The latter application utilizes the antioedematous effect of cross-linkage on the stroma. CXL with riboflavin and UVA has been sequentially combined with other modalities, namely, intrastromal ring segments [6] and photorefractive keratectomy (PRK) [7] for the treatment of keratoconus.

UVA irradiation can cause keratocyte and corneal endothelial cell destruction or death, as well as possible lens and retinal damage [8] as it has a toxic effect on cell viability, but there have been no reported complications on the endothelial cell count, lens, or retina due to the limitation of UVA transmission through the cornea [9]. It had also been suggested that CXL treatment be restricted to the anterior 250 μm to 350 μm of the stroma. Thus, CXL is not

recommended for patients whose corneas are thinner than 400 μm [10] because 85% to 90% of the UVA radiation is absorbed in the anterior 400 μm of the cornea; the procedure should not harm the patient's corneal endothelium, lens, and retina [11].

3. Technique

A standard CXL procedure begins with the administration of an anaesthetic, followed by debridement of the central 7 mm to 9 mm of the cornea to allow uniform diffusion of the riboflavin into the stroma [11]. Next, riboflavin 0.1% suspended in a dextran T500 20% solution is applied and allowed to permeate the cornea before UVA irradiation. UVA radiation of 370 nm wavelength and an irradiance of 3 mW/cm² at a distance of 5.4 mm from the cornea is applied for a period of 30 min, delivering a dose of 5.4 J/cm² [12]. Antibiotic eye drops are instilled as prophylaxis and a bandage contact lens is inserted, which is then removed at the followup visit once epithelial healing is complete.

4. Complications of CXL

Several long-term and short-term complications of CXL have been studied and documented [13, 14] which may be direct or primary due to incorrect technique application or incorrect patient's inclusion or indirect or secondary complications related to therapeutic soft contact lens, patient's poor hygiene, and undiagnosed concomitant ocular surface diseases (dry eye, blepharitis, etc.).

4.1. Postoperative Infection/Ulcer. Debriding the corneal epithelium theoretically exposes the cornea to microbial infection. Bacterial keratitis has been reported 3 days following treatment in which scraping revealed an *E. coli* infection [15]. Acanthamoeba keratitis due to eye washing under tap water as the patient was unaware of a bandage contact lens being inserted has been reported [16]. Poor contact lens hygiene resulting in polymicrobial keratitis caused by *streptococcus salivarius*, *streptococcus oralis*, and coagulase-negative *staphylococcus* sp. has been reported recently [17]. A patient with no history of herpetic keratitis developed herpes simplex keratitis geographical ulcer and iritis five days after treatment [18]. *Staphylococcus epidermidis* keratitis has also been reported 2 days after treatment [19]. Diffuse lamellar keratitis (stage 3) has been reported following treatment in a case of post-LASIK ectasia [20]. Severe keratitis with patient's contact lens and cornea scrapings positive for *pseudomonas aeruginosa* has also been reported recently [21]. Reactivated herpetic keratitis and neurodermatitis have also been reported following CXL [18, 22]. One study reported four cases of severe keratitis in a group of 117 keratoconic eyes treated with standard CXL [23].

Keratitis can occur following CXL because of presence of an epithelial defect, use of soft bandage contact lens, and topical corticosteroids in the immediate postoperative period. In cases of corneal infection after CXL, contact with the infectious agent likely occurred during the early

postoperative period rather than during surgery because CXL not only damages keratocytes, but it also kills bacteria and fungi. This effect is used to advantage when CXL is performed for infectious keratitis.

4.2. Corneal Haze. In a recently published retrospective study of 163 eyes with grade I–III keratoconus, approximately 9% of the 127 patients developed clinically significant haze after 1-year followup. The subset of patients developing steroid resistant haze appeared to have more advanced keratoconus, as reflected in a lower mean corneal thickness and higher keratometry value of the apex compared with the control group [24]. An older age, grade III or IV keratoconus (according to Krumeich's classification), and preoperative reticular pattern of stromal microstriae observed preoperatively by in vivo confocal microscopy [14] are considered risk factors for corneal haze post cross-linking. Advanced keratoconus should be considered at higher risk of haze development after CXL due to low corneal thickness and high corneal curvature [24].

After collagen cross-linking using riboflavin and UV-A, a lacunar honeycomb-like hydration pattern can be found in the anterior stroma with the maximum cross-linking effect, which is because of the prevention of interfibrillar cross-linking bonds in the positions of the apoptotic keratocytes [25]. The polygonal cross-linking network might contribute favorably to the biomechanical elasticity of the cross-linked cornea and to the demarcation of the anterior stroma after CXL on biomicroscopy [25], thus making lacunar edema a positive sign of efficient cross-linking. Another study documented stromal haze in 5 of 44 patients within 6 months of undergoing CXL. There has been a debate as to whether stromal haze is a normal finding after CXL because of its frequency [26].

Koller et al. [27] evaluated anterior stromal haze, which was graded on a scale used in cases after PRK [28]; the mean grade was 0.78, 0.18, and 0.06 at 1 month, 6 months, and 12 months, respectively. Previous confocal microscopy studies [26] report that a dense extracellular matrix compatible with clinical haze forms between 2 months and 3 months postoperatively.

The haze after CXL differs from the haze after PRK in stromal depth. Whereas haze after PRK is strictly subepithelial, haze after CXL extends into the anterior stroma to approximately 60% depth, which is on average equal to an absolute depth of 300 μm . Haze after CXL is different in clinical character from haze after other procedures, such as excimer laser photorefractive keratotomy. The former is a dustlike change in the corneal stroma or a midstromal demarcation line, whereas the latter has a more reticulated subepithelial appearance [29]. The haze may be associated with the depth of CXL into the stroma as well as the amount of keratocyte loss [26, 27].

Greenstein et al. [30] studied the natural course after CXL and found a significant postoperative increase in haze measured by both Scheimpflug densitometry and slit lamp assessment. The increase peaked at 1 month and plateaued between 1 month and 3 months. Between 3 months and

6 months, the cornea began to clear and there was a significant decrease in CXL-associated corneal haze which usually does not require treatment except for some low dose steroid medication in some cases. From 6 months to 1 year postoperatively, there continued to be a decrease in haze measurements. Typically late permanent scarring should be differentiated from the early postoperative temporary haze [31] which is often paracentral and compatible with good visual results. It may not be actually related to CXL itself but rather to the ongoing disease process and corneal remodeling.

Haze formation after CXL may be a result of back-scattered and reflected light, which decreases corneal transparency [32]. In vitro and ex vivo studies [33, 34] show that CXL leads to an immediate loss of keratocytes in the corneal stroma. In a confocal microscopy study, Mazzotta et al. [35] found that in eyes with keratoconus, activated keratocytes repopulated the corneal stroma starting at 2 months and that the repopulation was almost complete at 6 months. It is possible that these activated keratocytes contribute to the development of CXL-associated corneal haze. Other factors that may contribute to CXL-associated corneal haze include stromal swelling pressure changes [36], proteoglycan-collagen interactions [37], and glycosaminoglycan hydration [38]. Further study is needed to elucidate the pathophysiology of the development and time course of CXL-associated corneal haze.

4.3. Endothelial Damage. The endothelial damage threshold was shown to be at an irradiance of 0.35 mW/cm^2 , which is approximately twice compared with the 0.18 mW/cm^2 that reaches the corneal endothelium when using the currently recommended protocol [10]. It may be due to a stromal thickness less than $400 \mu\text{m}$ or incorrect focusing. If the procedure is done on a thinner cornea, it may lead to perforation. The recommended safety criteria must be observed because UV irradiation has potential to damage various intraocular structures.

4.4. Peripheral Sterile Infiltrates. Sterile corneal stromal infiltrates occur as a result of enhanced cell-mediated immunity to staphylococcal antigens deposited at high concentrations in areas of static tear pooling [39]. Sterile infiltration after CXL may be related to staphylococcal antigen deposition in areas of static tear pooling beneath the bandage contact lens [39].

4.5. Herpes Reactivation. Reactivation of HSV has been reported after emotional stress, trauma, fever, and laser surgery. These established clinical triggers are thought to be mediated by the adrenergic and sensory nervous systems. Exposure to UV light can also induce oral and genital herpes in humans and ocular herpes in animal models. Development of herpes keratitis and iritis after riboflavin-UVA treatment has been reported [18]. It seems that UVA light could be a potent stimulus to trigger/induce reactivation of latent HSV infections even in patients with no history of clinical herpes virus ocular infections. Significant corneal

epithelial/stromal trauma or actual damage of the corneal nerves could be the mechanism of HSV reactivation. The use of topical corticosteroids and mechanical trauma caused by epithelial debridement may be additional risk factors. Prophylactic systemic antiviral treatment in patients with a history of herpetic disease after cross-linking with UVA might decrease the possibility of recurrence.

4.6. Treatment Failure. CXL failure is largely defined as keratoconic progression following treatment. One study of 117 eyes from 99 patients who underwent CXL documented a failure rate of 7.6% at one-year followup [27]. The results also indicated that 2.9% of eyes lost two or more lines of snellen visual acuity. Age older than 35 years, cornea thickness $<400 \mu\text{m}$, and a preoperative CDVA better than 20/25 were identified as significant risk factors for complication. A high preoperative maximum keratometry reading was a significant risk factor for failure. Sterile infiltrates were seen in 7.6% of eyes and central stromal scars in 2.8%. The researchers concluded that changing the inclusion criteria may significantly reduce the complications and failures of CXL. Risk factors for CXL failure included a preoperative patient age of 35 years or older, spectacle-corrected visual acuity better than 20/25, and a maximum keratometry reading greater than 58.00 D [27].

5. Conclusion

Apart from haze and stromal hyperdensity after CXL with early or late onset as direct complication of the treatment, no other direct or primary complications of the procedure have been reported. Complications described in the literature are in the major part of indirect origin (infections, therapeutic contact lens, previous surgery (lasik), coexisting disorders of ocular surface, incorrect patient inclusion in the treatment, technical problems with UVA solid state emitter, wrong technique application, bad focusing, tilting, defocus, etc.). Therefore, only surgeons with sufficient experience in the management of corneal wound healing should perform this procedure. More studies are necessary to identify rare complications and to establish a list of indications regarding patient age, diagnosis, and the stage of keratectasia. The role of the UV light on the immune mechanisms of the cornea and its effect on corneal wound healing warrant further investigation. Repeat cross-linking treatments may become necessary in the long term. Considering that the turnover rate of stromal collagen fibres is several years, prospective studies with a followup of at least eight to ten years will be necessary.

References

- [1] Y. S. Rabinowitz, "Keratoconus," *Survey of Ophthalmology*, vol. 42, no. 4, pp. 297–319, 1998.
- [2] E. Spörl, M. Huhle, M. Kasper, and T. Seiler, "Artificial stiffening of the cornea by induction of intrastromal cross-links," *Ophthalmologie*, vol. 94, no. 12, pp. 902–906, 1997.
- [3] H. P. Iseli, M. A. Thiel, F. Hafezi, J. Kampmeier, and T. Seiler, "Ultraviolet a/riboflavin corneal cross-linking for infectious

- keratitis associated with corneal melts," *Cornea*, vol. 27, no. 5, pp. 590–594, 2008.
- [4] G. Wollensak, H. Aurich, C. Wirbelauer, and D. T. Pham, "Potential use of riboflavin/UVA cross-linking in bullous keratopathy," *Ophthalmic Research*, vol. 41, no. 2, pp. 114–117, 2009.
 - [5] N. Ehlers and J. Hjortdal, "Riboflavin-ultraviolet light induced cross-linking in endothelial decompensation," *Acta Ophthalmologica*, vol. 86, no. 5, pp. 549–551, 2008.
 - [6] A. J. Kanellopoulos and P. S. Binder, "Collagen cross-linking (CCL) with sequential topography-guided PRK: a temporizing alternative for keratoconus to penetrating keratoplasty," *Cornea*, vol. 26, no. 7, pp. 891–895, 2007.
 - [7] A. Caporossi, S. Baiocchi, C. Mazzotta, C. Traversi, and T. Caporossi, "Parasurgical therapy for keratoconus by riboflavin-ultraviolet type A rays induced cross-linking of corneal collagen. Preliminary refractive results in an Italian study," *Journal of Cataract and Refractive Surgery*, vol. 32, no. 5, pp. 837–845, 2006.
 - [8] E. Spoerl, M. Mrochen, D. Sliney, S. Trokel, and T. Seiler, "Safety of UVA-riboflavin cross-linking of the cornea," *Cornea*, vol. 26, no. 4, pp. 385–389, 2007.
 - [9] P. Vinciguerra, E. Albè, A. M. Mahmoud, S. Trazza, F. Hafezi, and C. J. Roberts, "Intra- and postoperative variation in ocular response analyzer parameters in keratoconic eyes after corneal cross-linking," *Journal of Refractive Surgery*, vol. 26, no. 9, pp. 669–676, 2010.
 - [10] G. Wollensak, E. Spoerl, M. Wilsch, and T. Seiler, "Endothelial cell damage after riboflavin-ultraviolet-A treatment in the rabbit," *Journal of Cataract and Refractive Surgery*, vol. 29, no. 9, pp. 1786–1790, 2003.
 - [11] G. Wollensak, "Crosslinking treatment of progressive keratoconus: new hope," *Current Opinion in Ophthalmology*, vol. 17, no. 4, pp. 356–360, 2006.
 - [12] G. Wollensak, E. Spoerl, and T. Seiler, "Riboflavin/ultraviolet-A-induced collagen crosslinking for the treatment of keratoconus," *American Journal of Ophthalmology*, vol. 135, no. 5, pp. 620–627, 2003.
 - [13] F. Raiskup-Wolf, A. Hoyer, E. Spoerl, and L. E. Pillunat, "Collagen crosslinking with riboflavin and ultraviolet-A light in keratoconus: long-term results," *Journal of Cataract and Refractive Surgery*, vol. 34, no. 5, pp. 796–801, 2008.
 - [14] A. Caporossi, C. Mazzotta, S. Baiocchi, and T. Caporossi, "Long-term results of riboflavin ultraviolet a corneal collagen cross-linking for keratoconus in Italy: the Siena Eye Cross Study," *American Journal of Ophthalmology*, vol. 149, no. 4, pp. 585–593, 2010.
 - [15] M. Pollhammer and C. Cursiefen, "Bacterial keratitis early after corneal crosslinking with riboflavin and ultraviolet-A," *Journal of Cataract and Refractive Surgery*, vol. 35, no. 3, pp. 588–589, 2009.
 - [16] P. Rama, F. Di Matteo, S. Matuska, G. Paganoni, and A. Spinelli, "Acanthamoeba keratitis with perforation after corneal crosslinking and bandage contact lens use," *Journal of Cataract and Refractive Surgery*, vol. 35, no. 4, pp. 788–791, 2009.
 - [17] K. V. Zamora and J. J. Males, "Polymicrobial keratitis after a collagen cross-linking procedure with postoperative use of a contact lens," *Cornea*, vol. 28, no. 4, pp. 474–476, 2009.
 - [18] G. D. Kymionis, D. M. Portaliou, D. I. Bouzoukis et al., "Herpetic keratitis with iritis after corneal crosslinking with riboflavin and ultraviolet A for keratoconus," *Journal of Cataract and Refractive Surgery*, vol. 33, no. 11, pp. 1982–1984, 2007.
 - [19] J. J. Pérez-Santonja, A. Artola, J. Javaloy, J. L. Alió, and J. L. Abad, "Microbial keratitis after corneal collagen crosslinking," *Journal of Cataract and Refractive Surgery*, vol. 35, no. 6, pp. 1138–1140, 2009.
 - [20] G. D. Kymionis, D. I. Bouzoukis, V. F. Diakonis, D. M. Portaliou, A. I. Pallikaris, and S. H. Yoo, "Diffuse lamellar keratitis after corneal crosslinking in a patient with post-laser in situ keratomileusis corneal ectasia," *Journal of Cataract and Refractive Surgery*, vol. 33, no. 12, pp. 2135–2137, 2007.
 - [21] N. Sharma, P. Maharana, G. Singh, and J. S. Titiyal, "Pseudomonas keratitis after collagen crosslinking for keratoconus: case report and review of literature," *Journal of Cataract and Refractive Surgery*, vol. 36, no. 3, pp. 517–520, 2010.
 - [22] E. Coskunseven, M. R. Jankov, and F. Hafezi, "Contralateral eye study of corneal collagen cross-linking with riboflavin and UVA irradiation in patients with keratoconus," *Journal of Refractive Surgery*, vol. 25, no. 4, pp. 371–376, 2009.
 - [23] C. Koppen, J. C. Vryghem, L. Gobin, and M. J. Tassignon, "Keratitis and corneal scarring after UVA/riboflavin cross-linking for keratoconus," *Journal of Refractive Surgery*, vol. 25, no. 9, pp. S819–S823, 2009.
 - [24] F. Raiskup, A. Hoyer, and E. Spoerl, "Permanent corneal haze after riboflavin-UVA-induced cross-linking in keratoconus," *Journal of Refractive Surgery*, vol. 25, no. 9, pp. S824–S828, 2009.
 - [25] G. Wollensak and H. Herbst, "Significance of the lacunar hydration pattern after corneal cross linking," *Cornea*, vol. 29, no. 8, pp. 899–903, 2010.
 - [26] C. Mazzotta, A. Balestrazzi, S. Baiocchi, C. Traversi, and A. Caporossi, "Stromal haze after combined riboflavin-UVA corneal collagen cross-linking in keratoconus: in vivo confocal microscopic evaluation," *Clinical and Experimental Ophthalmology*, vol. 35, no. 6, pp. 580–582, 2007.
 - [27] T. Koller, M. Mrochen, and T. Seiler, "Complication and failure rates after corneal crosslinking," *Journal of Cataract and Refractive Surgery*, vol. 35, no. 8, pp. 1358–1362, 2009.
 - [28] K. D. Hanna, Y. M. Pouliquen, G. O. Waring, M. Savoldelli, F. Fantes, and K. P. Thompson, "Corneal wound healing in monkeys after repeated excimer laser photorefractive keratectomy," *Archives of Ophthalmology*, vol. 110, no. 9, pp. 1286–1291, 1992.
 - [29] J. D. Carr, R. Patel, and P. S. Hersh, "Management of late corneal haze following photorefractive keratectomy," *Journal of Refractive Surgery*, vol. 11, no. 3, pp. S309–S313, 1995.
 - [30] S. A. Greenstein, K. L. Fry, J. Bhatt, and P. S. Hersh, "Natural history of corneal haze after collagen crosslinking for keratoconus and corneal ectasia: scheinpflug and biomicroscopic analysis," *Journal of Cataract and Refractive Surgery*, vol. 36, no. 12, pp. 2105–2114, 2010.
 - [31] L. S. Lim, R. Beuerman, L. Lim, and D. T. H. Tan, "Late-onset deep stromal scarring after riboflavin—UV-A corneal collagen cross-linking for mild keratoconus," *Archives of Ophthalmology*, vol. 129, no. 3, pp. 360–362, 2011.
 - [32] C. J. Connon, J. Marshall, A. L. Patmore, A. Brahma, and K. M. Meek, "Persistent haze and disorganization of anterior stromal collagen appear unrelated following phototherapeutic keratectomy," *Journal of Refractive Surgery*, vol. 19, no. 3, pp. 323–332, 2003.
 - [33] G. Wollensak, E. Spoerl, M. Wilsch, and T. Seiler, "Keratocyte apoptosis after corneal collagen cross-linking using riboflavin/UVA treatment," *Cornea*, vol. 23, no. 1, pp. 43–49, 2004.
 - [34] J. S. Dhaliwal and S. C. Kaufman, "Corneal collagen cross-linking: a confocal, electron, and light microscopy study of eye bank corneas," *Cornea*, vol. 28, no. 1, pp. 62–67, 2009.

- [35] C. Mazzotta, A. Balestrazzi, C. Traversi et al., "Treatment of progressive keratoconus by riboflavin-UVA-induced cross-linking of corneal collagen: ultrastructural analysis by Heidelberg retinal tomograph II in vivo confocal microscopy in humans," *Cornea*, vol. 26, no. 4, pp. 390–397, 2007.
- [36] C. H. Dohlman, B. O. Hedbys, and S. Mishima, "The swelling pressure of the corneal stroma," *Investigative Ophthalmology*, vol. 1, pp. 158–162, 1962.
- [37] Y. M. Michelacci, "Collagens and proteoglycans of the corneal extracellular matrix," *Brazilian Journal of Medical and Biological Research*, vol. 36, no. 8, pp. 1037–1046, 2003.
- [38] G. Wollensak, H. Aurich, D. T. Pham, and C. Wirbelauer, "Hydration behavior of porcine cornea crosslinked with riboflavin and ultraviolet A," *Journal of Cataract and Refractive Surgery*, vol. 33, no. 3, pp. 516–521, 2007.
- [39] R. I. Angunawela, F. Arnalich-Montiel, and B. D. S. Allan, "Peripheral sterile corneal infiltrates and melting after collagen crosslinking for keratoconus," *Journal of Cataract and Refractive Surgery*, vol. 35, no. 3, pp. 606–607, 2009.

Clinical Study

Age-Related Long-Term Functional Results after Riboflavin UV A Corneal Cross-Linking

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Purpose. To report a comparative prospective long-term functional analysis after Riboflavin UV A corneal cross-linking (CXL) in three different age groups of patients affected by progressive keratoconus (KC). **Methods.** Functional analysis comprised paediatric patients (≤ 18 years) included 152 eyes (29.5%); intermediate group (19–26 years) 286 eyes (55.4%), and adults (≥ 27 years) 78 eyes (15.1%). CXL was performed according to the Siena protocol by using the Vega CBM (Caporossi-Baiocchi-Mazzotta) X linker (CSO, Florence, Italy) at Siena University by the same authors. Pre- and post-op examinations included UCVA, BSCVA, corneal topography, and surface aberrometry (CSO Eye Top, Florence, Italy), at 48 months followup. **Results.** At 48 months followup paediatrics, intermediate, and adult patients showed a mean gain in UCVA of +0.2, +0.14 and +0.12 Snellen lines. BSCVA gained by a mean of +0.21, +0.2, and +0.1 Snellen lines. K_{\max} was reduced by a mean value of -0.9 D, -0.6 D, and -0.5 D, respectively. Coma values improved by a mean of -0.45 μm , -0.91 μm , and -0.19 μm , respectively. Treatment ensured a long-term keratoconus stabilization in over 90% of treated patients. **Conclusion.** According to our long-term comparative results, epithelium-off Riboflavin UV A cross-linking should be the first choice therapy of progressive KC, particularly in paediatric age and patients under 26 years.

1. Introduction

Paediatric age at the time of diagnosis represents a negative prognostic factor for keratoconus progression, with increased probability of corneal transplant [1].

Particularly younger patients represent a population at high risk for more rapid progression of the disease [1, 2]. The long-term results reported in literature [3–5] have demonstrated the ability of cross-linking to slow the progression of keratoconus by a photo-polymerization reaction of stromal collagen fibres. Cross-linking photodynamic reaction is induced by the combined action of a photosensitizing substance (Riboflavina o vitamin B2) and ultraviolet (UV) A light, allowing a corneal stiffening by increasing the number of intrafibrillar, interfibrillar covalent bonds, and corneal collagen resistance against enzymatic degradation [6–8]. The long-term effects of the technique are related also to a process of collagen neosynthesis with a different structure and higher molecular weight [9–12] which confers to the corneal stroma

an increased resistance and lamellar compaction responsible of the variable functional modifications recorded after the treatment [11–14].

According to international results [3–5], cross-linking should be the primary choice in young patient with progressive keratoconus.

2. Purpose

To report a comparative prospective long-term functional analysis after cross-linking in three different age groups (≤ 18 years, between 19–26 years, and ≥ 27 years) of patients affected by progressive keratoconus.

3. Methods

Since 2004 to date more than 610 patients were treated by combined Riboflavin UV A corneal collagen cross-linking.

Present prospective nonrandomized open study comprised 516 eyes of 413 patients aged between 10 and 40 years, affected by progressive keratoconus.

The comparative functional analysis comprised the following:

- (1) paediatric group (18 years and under) included 152 eyes of 105 patients (29.5%),
- (2) intermediate group (19–26 years) included 286 eyes of 243 patients (55.4%),
- (3) Adult group (≥ 27 years) included 78 eyes of 65 patients (15.1%).

3.1. Inclusion Criteria. All patients included in the treatment protocol were affected by progressive keratoconus with a documented clinical and instrumental worsening at least in the last three months of observation. The parameters we considered to establish keratoconus progression were worsening of UCVA/BSCVA > 0.50 Snellen lines, increase of SPH/CYL > 0.50 D, increase of topographic symmetry index SAI/SI > 0.50 D, increase of maximum K reading > 0.50 D, reduction of the thinnest point at optical pachometry $\geq 10 \mu\text{m}$, clear cornea at biomicroscopic examination, absence of reticular dark striae at confocal laser microscopy *in vivo*. Patients without possibility of optical correction were also included. We considered “significant” for the inclusion in the study the variation of at least 3 of the parameters listed above (one clinical plus two instrumental). Statistical analysis was conducted by the Mann-Whitney U test for nonparametric data (UCVA and BSCVA) and by the paired t test for parametric data (maximum curvature power, symmetry indices and coma values).

3.2. Surgical Technique. The surgical procedure of corneal cross-linking with Riboflavina UVA was performed in all patients according to the Siena protocol [3] using the Vega CBM (Caporossi-Baiocchi-Mazzotta) X linker (CSO, Florence, Italy) developed in Italy at the Department of Ophthalmology of Siena University by the same Authors, under intellectual property of Siena University, Italy. The treatment was conducted under topical anaesthesia (4% lidocaine drops). After applying the eyelid speculum, a 9 mm diameter marker was used to mark the corneal epithelium in a central circle, then epithelium was removed with a blunt metal spatula. After epithelial scraping, a disposable solution of Riboflavin 0.1% and Dextrane 20% (Ricolin Sooft, Montegiorgio, Italy) was instilled for 10 minutes [15] of corneal soaking before starting UV A irradiation. The Riboflavin and Dextrane solution was administered every 2.5 minutes for a total of 30 minutes of UVA exposure (3 mW/cm^2). Treated eyes were dressed with a therapeutic soft contact lens bandage for 4 days and medicated with antibiotics (Ofloxacin drops 4 times/day), nonsteroidal anti-inflammatory drugs (Diclofenac drops 4 times/day) and lachrymal substitutes, until contact lens removal. After therapeutic corneal lens removal, fluorometholone 0.2% drops (3 times/day) and lacrimal substitutes were administered for 6 to 8 weeks.

3.3. Followup and Assessment Criteria. (1) 152 eyes of 105 patients ≤ 18 years (91 eyes with followup of 12 months, 74 eyes at 24 months, 25 eyes at 36 months, 7 at 48 months).

(2) 286 eyes of 243 patients between 19 and 26 years (108 eyes with followup 12 months, 83 eyes at 24 months, 56 eyes at 36 months, 11 at 48 months).

(3) 78 eyes of 65 patients ≥ 27 (35 eyes with followup 12 months, 25 eyes at 24 months, 12 eyes at 36 months, 8 at 48 months).

Pre- and postoperative examination included uncorrected visual acuity (UCVA), best spectacle corrected visual acuity (BSCVA), corneal topography and surface aberrometry (CSO Eye Top, Florence, Italy), optical pachometry (Visante OCT, Zeiss Meditech, Jena, Germany), and *in vivo* confocal microscopy (HRT II, Heidelberg, Rostock Cornea Module, Germany).

4. Results

According to epidemiology findings [16], we found a male/female ratio in the whole sample of 4 : 1; a male/female ratio in paediatric group of 6 : 1, and a male/female ratio of 3 : 1 in patients between 19 and 40 years old. These results, even if in a small group, differ from epidemiological data reported in the literature [16] were a male/female rate of 2 : 1 is reported. There was no statistical difference in the incidence of keratoconus between right and left eye in the whole population of 516 eyes and age-related groups.

4.1. Functional Results. Comparative UCVA in patients ≤ 18 years showed a mean gain of $+0.14$ ($P = 0.0037$), $+0.17$ ($P = 0.0043$), $+0.16$ ($P = 0.0051$) and $+0.2$ ($P = 0.006$) Snellen lines at 12, 24, 36, and 48 months of followup, respectively.

Patients between 19 and 26 years showed a mean gain of $+0.13$ ($P = 0.0034$), $+0.16$ ($P = 0.0041$), $+0.12$ ($P = 0.0032$), and $+0.14$ ($P = 0.0073$) Snellen lines at 12, 24, 36, and 48 months of followup, respectively.

Patients ≥ 27 years showed a mean gain of $+0.08$ ($P = 0.0036$), $+0.09$ ($P = 0.005$), $+0.12$ ($P = 0.0047$) and $+0.12$ ($P = 0.0071$) Snellen lines at 12, 24, 36, and 48 months of followup, respectively, (Figure 1).

Comparative BSCVA in patients ≤ 18 years showed a mean gain of $+0.15$ ($P = 0.0056$), $+0.19$ ($P = 0.0031$), $+0.18$ ($P = 0.0059$) and $+0.21$ ($P = 0.0079$) Snellen lines at 12, 24, 36, and 48 months of followup, respectively.

Patients between 19 and 26 years showed a mean gain of $+0.10$ ($P = 0.0052$), $+0.12$ ($P = 0.0045$), $+0.13$ ($P = 0.0056$), and $+0.2$ ($P = 0.0075$) Snellen lines at 12, 24, 36, and 48 months of followup, respectively.

Patients ≥ 27 years showed a mean gain of $+0.07$ ($P = 0.0054$), $+0.06$ ($P = 0.0067$), $+0.08$ ($P = 0.0069$), and $+0.10$ ($P = 0.0075$) Snellen lines at 12, 24, 36, and 48 months of followup, respectively, (Figure 2).

4.2. Topography Results. K_{max} in paediatric group varied by a mean of -0.7 D ($P = 0.006$), -0.8 D ($P = 0.0045$), -1.1 D ($P = 0.051$), and -0.9 D ($P = 0.071$); in the intermediate group (patients between 19 and 26 years) varied by a mean of -0.6 D ($P = 0.0053$), -0.5 D ($P = 0.0051$), -0.3 D ($P = 0.0045$), and -0.6 D ($P = 0.0091$); in adult group (patients

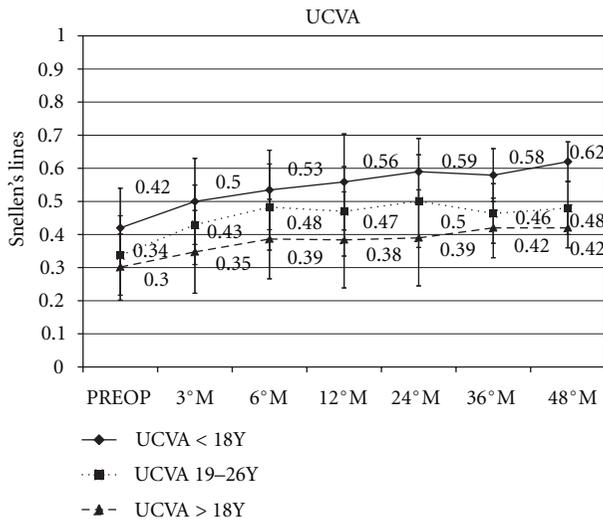


FIGURE 1: Graph showing visual performance during followup. After cross-linking, uncorrected visual acuity (UCVA) in patients ≤ 18 years showed a mean gain of +0.14, +0.17, +0.16, and +0.2 Snellen lines at 12, 24, 36, and 48 months of follow-up, respectively; in patients between 19 and 26 years showed a mean gain of +0.13, +0.16, +0.12, and +0.14 Snellen lines at 12, 24, 36, and 48 months of followup, respectively; and in patients ≥ 27 years showed a mean gain of +0.08, +0.09, +0.12, and +0.12 Snellen lines at 12, 24, 36, and 48 months followup, respectively.

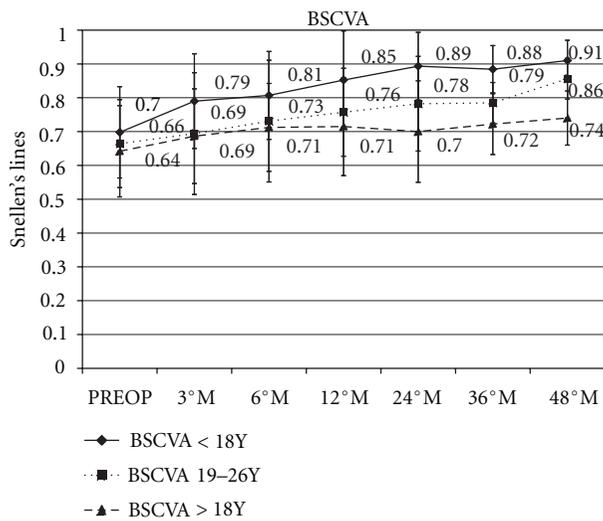


FIGURE 2: Graph showing visual performance during followup. After cross-linking, best spectacle-corrected visual acuity (BSCVA) in patients ≤ 18 years showed a mean gain of +0.15, +0.19, +0.18 and +0.21 Snellen lines at 12, 24, 36, and 48 months of followup, respectively; in patients between 19 and 26 years showed a mean gain of +0.10, +0.12, +0.13, and +0.2 Snellen lines at 12, 24, 36, and 48 months followup, respectively; in patients ≥ 27 years showed a mean gain of +0.07, +0.06, +0.08, and +0.10 Snellen lines at 12, 24, 36 and 48 months of followup, respectively.

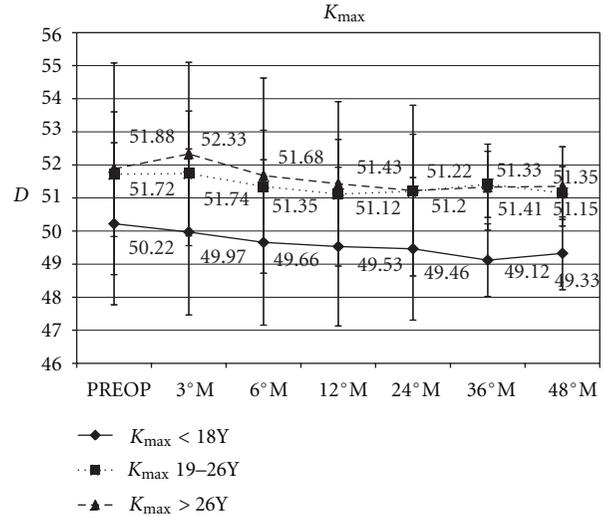


FIGURE 3: The graph showing computerized corneal topography results. The comparative topographic analysis showed a K_{max} variation in paediatric group by a mean of -0.7 D, -0.8 D, -1.1 D, and -0.9 D; in the intermediate group (patients between 19 and 26 years) varied by a mean of -0.6 D, -0.5 D, -0.3 D, and -0.6 D; in adult group (patients ≥ 27 years) varied by a mean of -0.4 D, -0.6 D, -0.5 D, and -0.5 D, at 12, 24, 36, and 48 months of followup, respectively, for each group.

≥ 27 years) varied by a mean of -0.4 D ($P = 0.0065$), -0.6 D ($P = 0.0074$), -0.5 D ($P = 0.0095$), and -0.5 D ($P = 0.0091$), at 12, 24, 36, and 48 months of follow-up, respectively for each group (Figure 3).

Surface asymmetry index (SAI_m) in paediatric patients improved by a mean value of, -0.42 D ($P = 0.0054$), -0.18 D ($P = 0.0066$), -0.24 D ($P = 0.091$), and -0.10 D ($P = 0.096$); in the intermediate group improved by a mean of, -1.05 D ($P = 0.0032$), -1.14 D ($P = 0.0021$), -0.84 D ($P = 0.0036$), and -0.65 D ($P = 0.076$); in adult group improved by a mean of, -0.52 D ($P = 0.0067$), -1.0 D ($P = 0.0077$), -0.17 D ($P = 0.0081$), and -1.11 D ($P = 0.0094$), (Figure 4).

Topographic superior-inferior symmetry index (SI_m) in paediatric patients varied by a mean of, $+0.3$ D ($P = 0.0098$), $+0.6$ D ($P = 0.011$), $+0.2$ D ($P = 0.017$), and $+1.5$ D ($P = 0.021$); in the intermediate group changed by a mean of, -0.42 D ($P = 0.0086$), -0.55 D ($P = 0.0079$), $+0.90$ D ($P = 0.091$), and $+0.40$ D ($P = 0.099$); in adult patients varied by a mean of, -0.26 D ($P = 0.0059$), -0.21 D ($P = 0.0048$), $+1.17$ D ($P = 0.012$), and -0.21 D ($P = 0.0011$) at 12, 24, 36, and 48 months of followup, respectively, (Figure 5).

4.3. Aberrometry Results. Coma values in paediatric patients improved by a mean of $-0.47 \mu\text{m}$ ($P = 0.0034$), $-0.52 \mu\text{m}$ ($P = 0.0025$), $-0.47 \mu\text{m}$ ($P = 0.0022$), and $-0.45 \mu\text{m}$ ($P = 0.0054$); in the intermediate group coma values decreased by

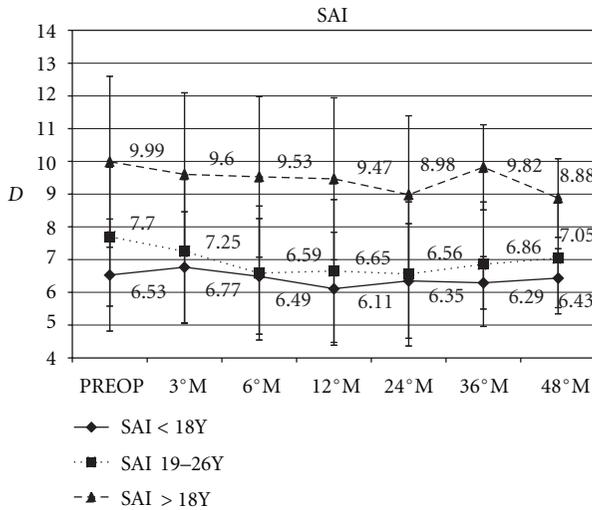


FIGURE 4: Graph showing anterior corneal surface aberrometry after corneal cross-linking (SAI m) in paediatric patients improved by a mean of, -0.42 D, -0.18 D, -0.24 D, and -0.10 D; in the intermediate group improved by a mean of, -1.05 D, -1.14 D, -0.84 D, and -0.65 D; in adult group improved by a mean of, -0.52 D, -1.0 D, -0.17 D, and -1.11 D.

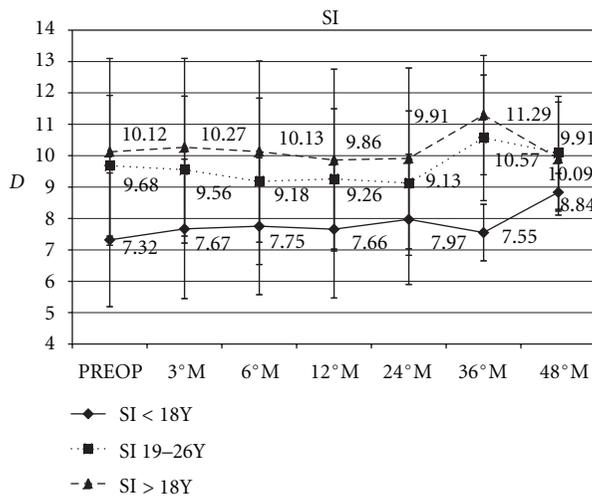


FIGURE 5: Graph showing topographic analysis of corneal symmetry using the superior-inferior index (SI). After cross-linking SI improved in paediatric patients by a mean of $+0.3$ D, $+0.6$ D, $+0.2$ D and $+1.5$ D; in the intermediate group changed by a mean of: -0.42 D, -0.55 D, $+0.90$ D, $+0.40$ D; in adult patients varied by a mean of: -0.26 D, -0.21 D, $+1.17$ D, -0.21 D at 12, 24, 36 and 48 months of follow-up respectively.

a mean of $-0.89 \mu\text{m}$ ($P = 0.0034$), $-0.96 \mu\text{m}$ ($P = 0.0065$), $-0.93 \mu\text{m}$ ($P = 0.0074$), and $-0.91 \mu\text{m}$ ($P = 0.0081$); in old patients we recorded a mean postoperative value of $-0.2 \mu\text{m}$ ($P = 0.0056$), $-0.18 \mu\text{m}$ ($P = 0.0045$), $-0.21 \mu\text{m}$ ($P = 0.0034$), and $-0.19 \mu\text{m}$ ($P = 0.0067$) at 12, 24, 36 and 48 months of followup respectively, (Figure 6).

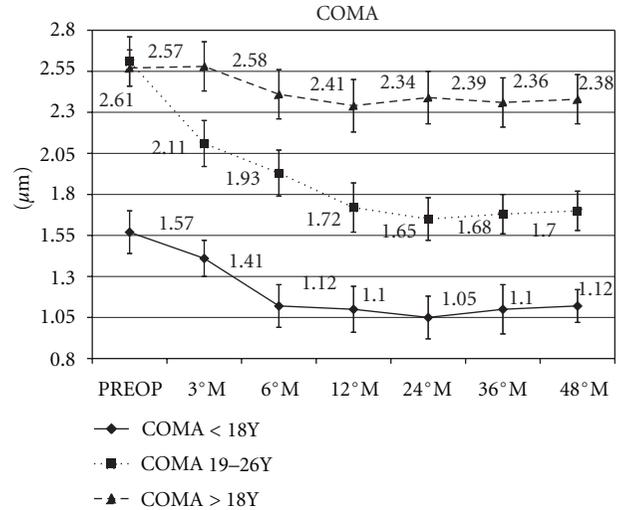


FIGURE 6: Graph showing the COMA analysis and the improving value in paediatric patients by a mean of $-0.47 \mu\text{m}$, $-0.52 \mu\text{m}$, $-0.47 \mu\text{m}$, and $-0.45 \mu\text{m}$; in the intermediate group coma values decreased by a mean of $-0.89 \mu\text{m}$, $-0.96 \mu\text{m}$, $-0.93 \mu\text{m}$, and $-0.91 \mu\text{m}$; in old patients we recorded a mean postoperative value of $-0.2 \mu\text{m}$, $-0.18 \mu\text{m}$, $-0.21 \mu\text{m}$, and $-0.19 \mu\text{m}$ at 12, 24, 36, and 48 months of followup, respectively.

5. Discussion

According to the literature in [1] and our previous reports [3], keratoconus progression is more frequent and faster in younger patients under 18 years old at the time of diagnoses, with higher probability to undergo a corneal transplantation [1, 3]. Therefore paediatric patients represent the goal of photo-induced Riboflavin UV A corneal collagen cross-linking [3].

The Italian pilot study “Siena CXL Paediatrics”, conducted on a large cohort of patients with a long-term follow up, demonstrated that there was a significant and fast functional improvement in younger patients after Riboflavin UV A corneal cross-linking.

As we recently published, it is however impossible to exactly predict the distribution of cross-links and the geometric redistribution of newly formed collagen [12, 14].

Long-term comparative analysis showed that functional results after Riboflavin UV A corneal collagen cross-linking among paediatric patients were slightly better, but without statistically significant differences with the results recorded in the intermediate group patients. On the other hand, patients over 27 years showed a positive but poorer functional response compared with other age groups.

The mean K_{max} variation and topographic surface asymmetry index results were statistically significant in the paediatric sample, particularly in the postoperative 24 months. After the 24th month, until the 48th month, the mean data results were statistically not significant, reasonably due to reduced number of patients in the longitudinal analysis.

The comparative aberrometric data of coma values showed a significant improvement in all analyzed groups, justifying the rapid improvement of visual acuity in all treated patients. In the paediatric group of our cohort, there was a minority of patients (about 5%) that, despite the treatment, showed a worsening trend or at least an instability of keratoconus. In our opinion, this concept should be remarked because the disease in this age group is more aggressive and the possibility of progression higher than in the others age groups. The instability of certain cases should be explained by the different genetic patterns of keratoconus [17–19] with relative biochemical modifications [20] potentially occurring in corneal stroma associated with negative influences of some environmental factors (allergy, atopy) [21–24].

Every time we decide to treat a paediatric patient under 18 years affected by progressive keratoconus, parents and patient himself should be well informed about the possibility that the treatment in a minority of cases could not warrant a total and long-lasting stabilization of the disease, with the possibility to repeat the cross-linking or to undergo alternative treatments. The “Siena CXL Paediatrics” pilot study demonstrated the effective ability of corneal cross-linking to retard keratoconus progression in all age groups with better functional response in patients under 26 years. Treatment ensured a long-term keratoconus stabilization in over 90% of treated cases. The lower functional response observed in patients over 27 years may be explained by a reduced collagen “plasticity” in the adult age, as well demonstrated in the literature [25, 26]. Cross-linking treatment may result in less effectiveness with increased failure and complication rate particularly in adult patients over 35 years, as reported in the literature [21]. According to our long-term comparative age-related analysis and results, the standard Riboflavin UV A cross-linking with epithelium removal should be the first choice therapy of progressive keratoconus in paediatric and under-26-year old patients with corneal thickness at least of 400 μm in the thinnest point.

Disclosure

The author(s) have no proprietary or commercial interest in any materials discussed in this paper.

References

- [1] S. W. Reeves, S. Stinnett, R. A. Adelman, and N. A. Afshari, “Risk factors for progression to penetrating keratoplasty in patients with keratoconus,” *American Journal of Ophthalmology*, vol. 140, no. 4, pp. 607–601, 2005.
- [2] G. Wollensak, “Crosslinking treatment of progressive keratoconus: new hope,” *Current Opinion in Ophthalmology*, vol. 17, no. 4, pp. 356–360, 2006.
- [3] A. Caporossi, C. Mazzotta, S. Baiocchi, and T. Caporossi, “Long-term results of riboflavin ultraviolet a corneal collagen cross-linking for keratoconus in Italy: the Siena eye cross study,” *American Journal of Ophthalmology*, vol. 149, no. 4, pp. 585–593, 2010.
- [4] F. Raiskup-Wolf, A. Hoyer, E. Spoerl, and L. E. Pillunat, “Collagen crosslinking with riboflavin and ultraviolet-A light in keratoconus: long-term results,” *Journal of Cataract and Refractive Surgery*, vol. 34, no. 5, pp. 796–801, 2008.
- [5] C. Wittig-Silva, M. Whiting, E. Lamoureux, R. G. Lindsay, L. J. Sullivan, and G. R. Snibson, “A randomized controlled trial of corneal collagen cross-linking in progressive keratoconus: preliminary results,” *Journal of Refractive Surgery*, vol. 24, no. 7, pp. S720–S725, 2008.
- [6] E. Spoerl, G. Wollensak, and T. Seiler, “Increased resistance of crosslinked cornea against enzymatic digestion,” *Current Eye Research*, vol. 29, no. 1, pp. 35–40, 2004.
- [7] G. Wollensak and E. Iomdina, “Biomechanical and histological changes after corneal crosslinking with and without epithelial debridement,” *Journal of Cataract and Refractive Surgery*, vol. 35, no. 3, pp. 540–546, 2009.
- [8] G. Wollensak, M. Wilsch, E. Spoerl, and T. Seiler, “Collagen fiber diameter in the rabbit cornea after collagen crosslinking by riboflavin/UVA,” *Cornea*, vol. 23, no. 5, pp. 503–507, 2004.
- [9] G. Wollensak, E. Spoerl, M. Wilsch, and T. Seiler, “Keratoctyocyte apoptosis after corneal collagen cross-linking using riboflavin/UVA treatment,” *Cornea*, vol. 23, no. 1, pp. 43–49, 2004.
- [10] G. Wollensak, E. Spoerl, and T. Seiler, “Stress-strain measurements of human and porcine corneas after riboflavin-ultraviolet-A-induced cross-linking,” *Journal of Cataract and Refractive Surgery*, vol. 29, no. 9, pp. 1780–1785, 2003.
- [11] C. Mazzotta, A. Balestrazzi, C. Traversi et al., “Treatment of progressive keratoconus by riboflavin-UVA-induced cross-linking of corneal collagen: ultrastructural analysis by Heidelberg retinal tomograph II in vivo confocal microscopy in humans,” *Cornea*, vol. 26, no. 4, pp. 390–397, 2007.
- [12] C. Mazzotta, C. Traversi, S. Baiocchi et al., “Corneal healing after riboflavin ultraviolet-A collagen cross-linking determined by confocal laser scanning microscopy in vivo: early and late modifications,” *American Journal of Ophthalmology*, vol. 146, no. 4, pp. 527–533, 2008.
- [13] G. Wollensak and B. Redl, “Gel electrophoretic analysis of corneal collagen after photodynamic cross-linking treatment,” *Cornea*, vol. 27, no. 3, pp. 353–356, 2008.
- [14] C. Mazzotta, T. Caporossi, R. Denaro et al., “Morphological and functional correlations in riboflavin UV A corneal collagen cross-linking for keratoconus,” *Acta Ophthalmologica*. In press.
- [15] S. Baiocchi, C. Mazzotta, D. Cerretani, T. Caporossi, and A. Caporossi, “Corneal crosslinking: riboflavin concentration in corneal stroma exposed with and without epithelium,” *Journal of Cataract and Refractive Surgery*, vol. 35, no. 5, pp. 893–899, 2009.
- [16] Y. S. Rabinowitz, “Keratoconus,” *Survey of Ophthalmology*, vol. 42, no. 4, pp. 297–319, 1998.
- [17] P. Liskova, P. G. Hysi, N. Waseem, N. D. Ebenezer, S. S. Bhattacharya, and S. J. Tuft, “Evidence for keratoconus susceptibility locus on chromosome 14: a genome-wide linkage screen using single-nucleotide polymorphism markers,” *Archives of Ophthalmology*, vol. 128, no. 9, pp. 1191–1195, 2010.
- [18] P. Liskova, P. G. Hysi, N. Waseem, N. D. Ebenezer, S. S. Bhattacharya, and S. J. Tuft, “Erratum in: Evidence for keratoconus susceptibility locus on chromosome 14: a genome-wide linkage screen using single-nucleotide polymorphism markers,” *Archives of Ophthalmology*, vol. 128, no. 11, p. 1431, 2010.
- [19] P. Paliwal, R. Tandon, D. Dube, P. Kaur, and A. Sharma, “Familial segregation of a VSX1 mutation adds a new dimension to its role in the causation of keratoconus,” *Molecular Vision*, vol. 17, pp. 481–485, 2011.

- [20] M. Tanwar, M. Kumar, B. Nayak et al., "VSX1 gene analysis in keratoconus," *Molecular Vision*, vol. 16, pp. 2395–2401, 2010.
- [21] T. Koller, M. Mrochen, and T. Seiler, "Complication and failure rates after corneal crosslinking," *Journal of Cataract and Refractive Surgery*, vol. 35, no. 8, pp. 1358–1362, 2009.
- [22] T. Georgiou, C. L. Funnell, A. Cassels-Brown, and R. O'Connor, "Influence of ethnic origin on the incidence of keratoconus and associated atopic disease in Asians and white patients," *Eye*, vol. 18, no. 4, pp. 379–383, 2004.
- [23] H. Wagner, J. T. Barr, and K. Zadnik, "Collaborative longitudinal evaluation of keratoconus (CLEK) study: methods and findings to date," *Contact Lens and Anterior Eye*, vol. 30, no. 4, pp. 223–232, 2007.
- [24] A. R. Pearson, B. Soneji, N. Sarvananthan, and J. H. Sanford-Smith, "Does ethnic origin influence the incidence or severity of keratoconus?" *Eye*, vol. 14, no. 4, pp. 625–628, 2000.
- [25] D. J. Cannon and P. F. Davison, "Aging, and crosslinking in mammalian collagen," *Experimental Aging Research*, vol. 3, no. 2, pp. 87–105, 1977.
- [26] D. J. Cannon and C. S. Foster, "Collagen crosslinking in keratoconus," *Investigative Ophthalmology and Visual Science*, vol. 17, no. 1, pp. 63–65, 1978.