Deep lamellar keratoplasty with lyophilised tissue in the management of keratoconus

Andrew G A Coombes, James F Kirwan, Chad K Rostron

Abstract
Aims—Data are presented on the use of deep lamellar keratoplasty (DLK) using lyophilised donor corneal tissue, in the management of patients with keratoconus (KC).
Method—The results of DLK on 44 eyes (42 patients) are reported. The mean patient age was 29.8 years (range 10–56). Mean follow up was 25 months (range 6–100). In seven patients with mental handicap or severe mental illness, the collection of acuity and refractive data was limited.
Results—Perforation of Descemet’s membrane (DM) occurred in nine cases (20%). A double anterior chamber formed in five cases, which resolved spontaneously in three patients. Persistent epithelial defects occurred in two cases, one of which necessitated replacement of the graft. The median postoperative uncorrected visual acuity was 6/36. The median corrected postoperative acuity was 6/9. Those with more than 1 year of follow up (n=25) had a significantly better acuity (p=0.015). This group achieved 6/12 or better in 80% (n=20) and 6/6 or better in 40% (n=10). The mean postoperative spherical error was +0.28 (SD 3.49) dioptres (D). The mean refractive cylinder was 3.85 (1.87) D.
Conclusion—This detailed retrospective study of DLK for the treatment of patients with KC, with an average follow up of 2 years, highlights the advantages and disadvantages of this technique.

Keratoconus (KC) is a progressive ectatic stromal dystrophy and one of the commonest indications for corneal grafting.\(^1\)\(^2\) The visual results following lamellar corneal grafts, without the removal of all stromal tissue, reportedly deliver poor optical results.\(^3\) Since the visual outcome following penetrating keratoplasty (PK) is often excellent,\(^4\) this technique has become the accepted standard surgical treatment. However, patients suffering from KC are generally young, and significant risks are associated with PK, in particular endothelial failure, graft rejection, and side effects from topical steroids. It has been shown that the optical results of lamellar keratoplasty can be improved by deep lamellar keratoplasty (DLK), where a deep dissection approaching the bulk of stroma has been removed, if a pre-DM plane has been defined by the air/hydrodissection, it is filled with viscoelastic through a small puncture. This allows the central posterior stromal fibres to be excised with scissors. If no pre-DM cleavage plane is created, lamellar dissection is performed as deeply as possible without perforation. If perforation occurs, because further lamellar resection is difficult, donor tissue is then applied to the bed.

<table>
<thead>
<tr>
<th>Table 1 Age and follow up (n=44)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
</tr>
<tr>
<td>Mean</td>
</tr>
<tr>
<td>SD</td>
</tr>
<tr>
<td>Range</td>
</tr>
</tbody>
</table>

Department of Ophthalmology, St George’s Hospital, London, UK
A G A Coombes
J F Kirwan
C K Rostron

Correspondence to:
Mr C K Rostron,
Department of Ophthalmology, St George’s Hospital, Blackshaw Road, London SW17 0QT, UK
rostron@sghms.ac.uk

Accepted for publication
27 February 2001
The rehydrated donor button is sutured in place with interrupted monofilament sutures (1/0 polyester or 10/0 nylon). Finally, the eyelids are closed with a temporary tarsorrhaphy suture, until epithelialisation is complete. In mentally ill or handicapped patients we use either a botulinum toxin ptosis or a bandage contact lens instead. Topical antibiotic ointment is used until epithelialisation, and topical corticosteroid (betamethasone) is tapered over 2–3 months.

**Results**

**VISUAL ACUITIES AND REFRACTIVE OUTCOME (SEE TABLES 2 AND 3)**

Those with more than 1 year follow up had a significantly better visual outcome (p=0.015). The final corrected visual acuity was independent of DM rupture or the presence of a double anterior chamber immediately after surgery (p=0.846). Six patients wore contact lenses after surgery and their median corrected acuity was 6/6. The remainder wore glasses or remained uncorrected.

The mean refractive cylinder of 3.85 (SD 1.87) D (n=37), contrasted with the mean keratometric cylinder of 4.65 (2.78)D (n=28). In most cases the keratometric values were simulated from topographic maps (Tomey TMS). One patient had required astigmatic keratotomy (AK) and a second underwent laser in situ keratomileusis (LASIK) to correct postoperative ametropia.

**SURGERY**

Lyophilised tissue was supplied by the Keratec Eye Bank at St George’s Hospital and, for one patient, Allergan Medical Optics. Host and donor trephine diameters were the same size in all procedures. The average graft diameter was 8.51 (0.43) mm, the majority having 100% stromal thickness. One patient had DLK with a keratometric cylinder of 4.65 (2.78)D (n=28). In most cases the keratometric values were simulated from topographic maps (Tomey TMS). One patient had required astigmatic keratotomy (AK) and a second underwent laser in situ keratomileusis (LASIK) to correct postoperative ametropia.

**DISCUSSION**

The visual acuities in this study are similar to those previously reported following DLK. Our median overall corrected acuity was 6/9, and 76% achieved better or equal to 6/12. The significant improvement in acuity after a year of follow up has been noted in previous studies.6-7 In a study of 113 eyes (none with KC) Sugita and Kondo recorded a mean postoperative corrected acuity of between 6/9 and 6/12, and 62.8% achieved 6/12 or better.8 A separate study of 24 eyes with KC reported excellent visual results with DLK using fluid injection to achieve deep dissection.9-12 The mean follow up in this study, which excluded patients with an intraoperative DM rupture or a previous episode of hydrops, was 13 months. At this stage, all but one patient (95.8%) achieved 6/9 or better and 24% achieved 6/6. In contrast, after 1 year, our group achieved 6/9 or better in 64% of patients, and 40% achieved 6/6.
The mean astigmatism we observed was 3.9D of refractive cylinder and 4.7D of keratometric cylinder. A study of DLK in 17 eyes reported mean keratometric astigmatism of 3.2D with an in situ adjusted running suture. Suture removal usually increases astigmatism and since we had removed the interrupted sutures in most cases, our results appear broadly comparable. Studies addressing post-PK astigmatism demonstrate a variable outcome, possibly dependent on the technique employed. Overall, the level of astigmatism after DLK compares favourably with the best results following PK. One of our patients was treated with LASIK to correct postgraft ametropia. The high intraocular pressure produced by cutting the LASIK flap carries a danger of wound dehiscence. This is of particular concern following PK, even many years after surgery. In contrast, DLR may present the opportunity for earlier treatment with LASIK. Another advantage of DLK is that it does not suffer rejection, a complication of PK that has been reported following excimer laser treatment.

To reduce myopia following PK for KC, the diameter of host and donor trephine should be the same. We used the same size trephines, although all donor tissue was precut in the eye bank from the epithelial surface, with the donor corneoscleral segment mounted on an artificial anterior chamber. Our postoperative spherical equivalent averaged approximately −2D. The use of lyophilised donor material necessitates the protection of the cornea during epithelialisation, usually with a tarsorrhaphy. This is
underlined by two cases with persistent epithelial defects, one of which suffered a graft melt that required replacement. Where a tarsorhaphy cannot be performed, a botulinum toxin induced protective ptosis is usually successful in promoting epithelialisation. This takes time to develop and, in the interim, a bandage contact lens may help.

The principal complication during DLK is DM rupture. This occurred in 20% of our series. The rate of this complication in previous reports varies between 0% and 39.2%. In our study, no intraoperative DM tear necessitated conversion to a PK. In contrast, the only other study that has focused on DLK in the treatment of KC managed DM perforations by changing to a penetrating technique. We believe it is unnecessary to convert to a PK (Fig 1) and confirmed the finding by Sugita and Kondo that the visual results of patients with or without a DM rupture do not differ significantly. Sugita and Kondo also found that, at 1 year post-surgery, the endothelial cell density was the same irrespective of this complication. In our study, one patient who had suffered an episode of hydrops after surgery, had an intraoperative DM rupture. This is not unexpected since a break in DM, albeit healed, would already exist. Surgery in these cases may be considered as contraindicated and would proceed with the expectation of DM rupture. Five patients developed a double anterior chamber following surgery and in two cases this persisted. These two were treated with fibrinogen glue placed between DM and the donor cornea. The glue slowly absorbed, successfully eliminating the double anterior chamber.

One of the patients from early in our series underwent successful PK 1 year after DLK to improve the visual outcome. Performing the PK within the lamellar graft is simple, since the tissue thickness is likely to be normal compared with peripheral host cornea. As lyophilised tissue may not sensitise the recipient to donor antigens, not only are lyophilised grafts free from rejection, but they should not increase subsequent PK rejection.

Our postoperative topical corticosteroid regimen is of a short duration compared with our post-PK treatment. The higher corticosteroid requirement following PK is an important consideration in patients with glaucoma (one patient in this study). It is also of relevance in the formation of cataract or where there is a history of herpes simplex keratitis. One of our patients had a persistent postoperative mydriasis. This patient had a double anterior chamber that was treated with fibrinogen glue, combined with air injected into the anterior chamber. This may have caused iris sphincter ischaemia and Urrets-Zavalia syndrome. Mydriatic agents have been previously implicated as a cause, and all our patients were treated with cyclopentolate 1% for 1–2 weeks after surgery.

In our study, seven patients had either severe mental illness or handicap. Although relatively successful outcomes have been reported using PK in such patients, DLK offers the advantage of more rapid wound healing. A number of our patients also suffered atopic or allergic conjunctivitis. Such ocular surface disease increases the risk of PK rejection and this highlights a further group of KC patients in whom the use of DLK is advantageous.

**Conclusion**

Despite its technical difficulty and time consuming nature, DLK is a promising technique. Importantly, its complications do not necessarily compromise outcome. In patients with KC, the optical results of DLK approach those of PK, but it offers the advantage of no graft rejection, and long term graft survival. There is increasing interest in DLK but debate exists over which graft technique is preferable. This study has shown that the spectrum of risk and benefit differs between DLK and PK. However, with a mean follow up of only 2 years, the long term advantages of the technique remain to be seen.

This work was supported in part by Keratec, registered charity No 80386.


Deep lamellar keratoplasty with lyophilised tissue in the management of keratoconus

Andrew G A Coombes, James F Kirwan and Chad K Rostron

doi: 10.1136/bjo.85.7.788

Updated information and services can be found at:
http://bjo.bmj.com/content/85/7/788

These include:

References
This article cites 19 articles, 5 of which you can access for free at:
http://bjo.bmj.com/content/85/7/788#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Topic Collections
Articles on similar topics can be found in the following collections
- Cornea (524)
- Ocular surface (618)
- Ophthalmologic surgical procedures (1223)

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/