A simplified Guidelines for Management of Patients with Keratoconus

“The key point in the success of treatment of Keratoconus is early Diagnosis”

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The ophthalmologist should arise the suspect of Keratoconus in teen ages with progressive astigmatism, spring catarrh children, and refractive demanding individuals and if there is a positive history of Keratoconus in the family as 10% of patients with Keratoconus have positive family history.

Once Keratoconus is suspected topography is ordered to confirm diagnosis; once Keratoconus is diagnosed order Pentacam to assess the stage of Keratoconus.

Patient’s counselling is mandatory, it should be explained clearly to the patient that there is a problem in his cornea that should be treated and then the cosmetic part of the residual refractive error could be managed after stabilizing his cornea.

Decision making depends on age, Pentacam, visual acuity and stability of the cornea.

The management differs before the age of thirty years. Than after the age of thirty as natural cross linking starts to occur after the age of thirty.

In young patients with good visual acuity (0.5 or more) Corneal Collagen Cross linking is a must once Keratoconus is diagnosed as it had been approved that is the only way to harden the cornea and halt the progression of Keratoconus, if the patient’s vision is not improving by glasses to 0.5, pin hole test is mandatory to overcome the irregular corneal multifocality and if the patient’s vision improves with pin hole test this means that after cross linking he will need gas permeable contact lenses or if intolerable to RGP; the intra corneal ring segment insertion with femto laser will benefit in regulating the irregular cornea.

If the patient does not fulfill the criteria of ICRS: as in thin cornea less than 400 microns in the center of the cone or steep k reading more than 64 Diopters; Deep anterior lamellar Keratoplasty is indicated, or if the patient had hydrops or opaque cornea penetrating Keratoplasty is indicated.”

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