Angioid streaks are linear dehiscences in the Bruch's membrane, which may be idiopathic or associated with diseases based on an alteration of collagen, such as pseudoxanthoma elasticum or Paget's disease. Therefore, we suggest that the angioid streaks could be associated with the AS, of which the physiopathological basis is an alteration of collagen type IV, a main component of all membranes in the body and, therefore, of Bruch's membrane.

Finally, we conclude that the high-resolution spectral domain OTC allows analysis of the microstructure of the layers of the retina, detecting incipient changes prior to viewing on fundoscopy. In this way, we are able to characterise new findings and establish an anatomic-functional correlation that justifies the visual impairment.

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Servicio de Oftalmología, Hospital General Universitario de Valencia, Valencia, Spain

* Corresponding author.
E-mail address: nurife@hotmail.com (N. Doménech-Aracil).
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When all else fails: Tectonic keratoplasty with silica gel re-dried cornea in a patient with high risk of corneal perforation☆

Cuando todo lo demás falla: queratoplastia tectónica con córnea silico-disecada en paciente con alto riesgo de perforación corneal

Dear Editor:

Corneal perforations require fast action to minimise ocular morbidity. Although the ideal theoretical action would be a corneal transplant, total or partial, depending on the location, there is no unanimity as regards the advantages and inconvenience of performing a queratoplasty immediately, to which we would have to add the difficulty of having a donor corneal tissue available at a given time.1

Fig. 1 – (a) Anterior segment optical coherence tomography showing corneal ulcer with stromal thinning in patient with penetrating keratoplasty. (b) Anterior segment optical coherence tomography: increase of corneal thickness 48 h after beginning topical treatment. (c) Anterior segment optical coherence tomography: descemetocele after self-medication with topical corticosteroids.

We present the case of a male patient, 41 years of age, under follow-up by our service, with corneal decompensation due to rejection after 2 penetrating queratoplasties. He consulted the emergency department for ocular redness, tearing and photofobia.

On anterior pole ophthalmological exploration he presented a 9 mm × 4 mm corneal button ulcer with corneal melting and associated descemetocele. Also, an intense conjunctival hyperaemia (Fig. 1a). Visual acuity was counting fingers 1 m away, stable in relation to the prior visit.

We set topical antibiotics, cycloplegic, autologous serum and placed a therapeutic contact lens. After 48 h, an improvement was observed in corneal thinning based on anterior pole optical coherence tomography (OCT) (Fig. 1b).

However, in one of the subsequent visits, the patient referred automedication with topical dexametasona for 24 h due to discomfort. In the OCT we noted significant corneal thinning, probably secondary to the effect of corticosteroids (Fig. 1c). Given the high risk of corneal perforation and the lack of a corneal bank, it was decided to use a corneal adhesive of isobutyl-2-cyanoacrylate with posterior graft of amniotic membrane and placing of a therapeutic contact lenses (Fig. 2a) However, after reabsorption of the glue, seidel reappears with a significant stromal lysis, and therefore it was decided to place a scleral patch (Fig. 2b).

Despite the strict follow-up, one month later the patient presented a visual acuity of light perception. Upon exploration we observed positive spontaneous Seidel test associated with ocular hypotony. Given the high risk of endophthalmitis and low visual acuity, it was finally decided to perform a tectonic queratoplasty with a silico-dessicated cornea (Fig. 2c). Currently, 6 weeks after the surgical procedure, the patient has

Fig. 2 – (a) Anterior pole biomicroscopy showing cianoacrilate adhesive, amniotic membrane graft and therapeutic contact lens in corneal thinning with risk of ocular perforation. (b) Anterior pole biomicroscopy: scleral patch where we observe positive spontaneous Seidel test. (c) Anterior pole biomicroscopy: penetrating keratoplasty with silico-dessicated corneal button.
experienced a subjective improvement, with no pain and stable visual acuity in relation to the beginning. Extreme or descemetocle thinnings may result in corneal perforations or microperforations, which must receive urgent treatment. The various therapeutic options include using adhesives such as cyanoacrylate, the use of an amniotic membrane multi-layer patch or “hot” keratoplasty, whether lamellar or penetrating.

In our case, given the high risk of perforation we decided to begin treatment with conservative methods, given that, although tectonic keratoplasty is the most effective theoretical method, the difficulties of obtaining donor corneal tissue, fresh or preserved, in addition to the increased risks of infection and rejection in a severely swollen eye, make the indication of a “hot” surgery controversial and difficult. Despite the fact that good results have been described with less aggressive methods, the development of our patient was torpid.

In conclusion, assessing the possibility of performing a tectonic keratoplasty is the first therapeutic option in patients with complex ocular surface disease presumably requiring several surgical procedures. The fact that we have silicon-dissicated corneas makes it easy to perform this procedure in the absence of fresh corneas.

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L. Hernandez Bel *, R. Calvo, N. Domenech, V. Castro, E. Cervera

Department of Ophthalmology, General Hospital, Valencia, Spain

* Corresponding author.
E-mail address: laura_hernandez_bel@hotmail.com (L. Hernandez Bel).
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Which scale should we choose to assess activity and severity in Graves orbitopathy? ☆

¿Qué escala debemos elegir para evaluar actividad y gravedad en la orbitopatía de Graves?

Dear Editor:

In Europe, the European Group On Graves’ Orbitopathy (EUGGOO) has popularised the use of the scale of activity known as CAS (Clinical Activity Score), together with another one to assess the severity of the Graves orbit (GO) 1,2 (Fig. 1). Both have solid academic grounds, since they were used in many research studies. However, they present certain controversial aspects we need to know before using them.

The CAS scale, although easy and quick to generate, grants all analysed items the same binary punctuation. Therefore, the changes are only documented when they appear or are solved, with none given more weight than the others: for instance, the onset of optic neuropathy does not represent a higher impact than conjunctival hyperaemia. Further, this system does not correlate the score obtained with the risk of developing complications: a patient with a low score may develop optical neuropathy; whereas another patient with a higher score may present chronic congestion of soft tissues, resistant to immunotherapy, but responsive to surgical decompression.

As regards the EUGGOO scale of severity, its categorisation of mild GO as moderate-severe results in imprecision in selecting the most appropriate treatment in each case. Also, it does not take into consideration the influence of the GO on the patients’ quality of life: a patient with optical neuropathy,