
LETTERS TO THE EDITOR

Sir,

I note that in their paper describing the treatment of recurrent erosions of the cornea,¹ Bernauer *et al.* dismiss mechanical debridement of the cornea as a method of treatment of recalcitrant cases. However, they may have proved its efficacy.

Before they can claim that excimer laser treatment has any added benefit, they really need to do a controlled trial to compare debridement followed by laser, with debridement alone.

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Reference

1. Bernauer W, De Cock R, Dart JKG. Phototherapeutic keratectomy in recurrent corneal erosions refractory to other forms of treatment. *Eye* 1996;10:561-4.

Sir,

Mr Kyle has raised an important issue. Mechanical debridement of the cornea is not dismissed in our paper. It was referred to as superficial keratectomy and two references were given.^{1,2} This technique requires removal of all the epithelium to the limbus. We agree that a randomised control trial is required to test the different techniques for the management of refractory recurrent corneal erosion syndrome. Because the natural history of recurrent erosion is benign, with relatively few patients requiring invasive treatment,³ we believe this would have to be a multicentre trial to recruit enough patients. Until this is done we could not comment on the relative efficacy of superficial keratectomy versus laser treatment for the management of this condition.

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References

1. Buxton JN, Fox ML. Superficial epithelial keratectomy

in the treatment of epithelial basement membrane dystrophy. *Arch Ophthalmol* 1983;101:392-5.

2. Buxton JN, Carstad WH. Superficial epithelial keratectomy. *Cornea* 1987;6:292-7.
3. Hykin PH, Foss AE, Pavesio C, Dart JKG. The natural history and management of recurrent corneal erosion: a prospective randomised trial. *Eye* 1994;8:35-40.

Sir,

Karen Goodall and colleagues¹ described three case histories from keratitis patients, the aetiology of the infection being *Acanthamoeba* but the medical picture being reminiscent of adenovirus keratitis. We have reported similar observations.² Adenovirus keratitis was the preliminary clinical diagnosis in a contact lens wearer who presented at casualty with a painful red eye, when symptoms had been apparent for some 10 days. There was punctate epithelial keratitis reminiscent of early adenovirus infection. After a further 8 days, various sub-epithelial infiltrates had developed. At this stage, *Acanthamoeba* was isolated from a corneal scrape.

Early recognition in a soft contact lens wearer of unilateral conjunctival inflammation, with photophobia and excessive lacrymation, in the presence of a 'typical' epitheliopathy or pseudo-dendrite, with sub-epithelial opacities in some patients, provides a strong index of suspicion of *Acanthamoeba* keratitis. The clinical diagnosis is reinforced if there is excessive pain and corneal perineuritis is observed using the slit lamp. The observation of Goodall *et al.* in cases of adenoviral corneal infection, that focal sub-epithelial opacities are present later beneath epithelial lesions, and that this feature is unusual before 6-9 days, is a useful parameter for differential diagnosis. A further potentially confusing situation is afforded by the so-called tight fit or over-wear syndrome, which can present in the contact lens wearer with conjunctival inflammation, punctate epithelial keratitis and sub-epithelial infiltrates.³ The latter triad of signs can be readily confused clinically with both adenovirus infection of the cornea and early *Acanthamoeba* keratitis.

Investigations of contact lens wearing patients with a clinical diagnosis of adenovirus keratoconjunctivitis should, if possible, include isolation of the virus from the swabs or conjunctival scrapings, using susceptible cell cultures. This is time-consuming