

Panel: Worst Case Scenario

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I. Case 1

a. Background

- i. 61 yo M with history of cGVHD 2' SCT for Leukemia
- ii. Recalcitrant persistent epithelial defect (PED)
- iii. Referred by cornea specialist in 2008 for scleral lens consultation and treatment
 - 1. Therapeutic management of PEDs
 - a. Review literature and precedent for approach
 - b. Review avg outcomes

b. Case Details

- i. 95% PED with 50% stromal thinning
- ii. On systemic and topical immunosuppression
- iii. Overnight wear of scleral
 - 1. Treatment approach
 - a. Slow healing

c. Case Highlights

- i. After more than 2 months
 - 1. Complete healing unattained
- ii. At the 3-month mark
 - 1. Patient passed away
 - a. Complications 2' pneumonia
 - 2. Thought/Believe then: "Poor protoplasm for sclerals"

d. Personal Experience

- i. What would we do differently today?
 - 1. Role of topical steroids in immunosuppression
 - a. Compromising healing
 - b. Share recent case to illustrate example

II. Case 2

a. Background

- i. 44 yo F with history of Stevens-Johnson Syndrome (SJS)
 - 1. Monocular
 - 2. Successful and stable with sclerals for 12 years
 - a. 19mm
 - i. To protect ocular surface from lid margin keratinization
 - b. BCVA 20/30-20/40
 - c. Replenishment 1-2 x/day

b. Case Details

- i. Seeks refitting elsewhere
 - 1. 16mm

- 2. Very low vault
- ii. Lens settling over time 1-2 weeks
 - 1. PED
 - 2. Melt
 - 3. Glue Repair
- iii. Central Bullous edema at baseline
 - 1. BCVA 20/100
 - 2. Monocular patient
- iv. Strategy
 - 1. Minimize suction
 - 2. SJS-Ectasia relationship
 - a. High order aberrations

c. Personal Experience

- i. Key take aways
 - 1. Importance of suction in scleral lens outcomes
 - 2. Keep at top of mind
 - a. SJS-Ectasia relationship
 - i. Effects still underrepresented in literature and conferences