Methods. The Baron chamber used in our previous study,\(^1\) was adapted to be able to clamp corneal buttons and create a vacuum with a 31-year-old patient at the time of penetrating keratoplasty. Using techniques detailed previously,\(^1\) the corneal button was then flattened by the application of physiological saline into the central 6.3-mm region of the cornea. The central 6.3-mm region of the cornea was cut and a single cut was made at a depth of 150 µm from the surface using an Intralase 60-kHz femtosecond laser (Abbott Medical Optics Inc),\(^3\) thus splitting the cornea into anterior and posterior sections of roughly equal thickness. Wide-angle x-ray scattering patterns were collected at 0.25-mm intervals over each corneal button.

### Depth Profile Study of Abnormal Collagen Orientation in Keratoconus Corneas

In a previous study,\(^1\) we used femtosecond laser technology to cut ex vivo human corneas into anterior, mid, and posterior sections, after which x-ray scatter patterns were obtained at fine intervals over each specimen. Data analysis revealed the predominant orientation of collagen at each sampling site, which was assembled to show the variation in collagen orientation between central and peripheral regions of the cornea and as a function of tissue depth. We hypothesized that the predominantly orthogonal arrangement of collagen (directed toward opposing sets of rectus muscles) in the mid and posterior stroma may help to distribute strain in the cornea by allowing it to withstand the pull of the extraocular muscles. It was also suggested that the more isotropic arrangement in the anterior stroma may play a role in tissue biomechanics by resisting intraocular pressure while at the same time maintaining corneal curvature. This article, in conjunction with our findings of abnormal collagen orientation in full-thickness keratoconus corneas,\(^3\) received a great deal of interest from the scientific community and prompted the following question: how does collagen orientation change as a function of tissue depth when the anterior curvature of the cornea is abnormal, as in keratoconus? Herein, we report findings from our investigation aimed at answering this question.

### Figure 1. Corneal topography of the keratoconus cornea (recorded 12 years previously).\(^2\) The broken lines show the 6.3-mm region of the cornea cut with the femtosecond laser (circle) and the region of greatest corneal steepening depicted in Figure 2 (rectangle).

### Figure 2. Collagen orientation in the normal (A) and keratoconus (B) posterior stroma (central 6.3 mm). The highlighted regions of the posterior (C and D) and anterior (E and F) stroma are expanded. Large vector plots showing high collagen alignment are downsized (key).

neal section on station 102 at the Diamond Light Source. The data were analyzed to form vector plots—the radial extent of which, in any direction, is proportional to the number of fibrils preferentially aligned in that direction. These were assembled, and the larger plots scaled down, to show the predominant orientation of collagen throughout each tissue section.

Results. Abnormalities in collagen organization were seen in both the anterior and posterior stroma of the keratoconus cornea (Figure 2), with the most drastic disruption occurring within the region of greatest corneal steepening (Figure 1). In the posterior stroma, the normal orthogonal predominant orientation of collagen was absent; in the anterior stroma, the usual isotropic arrangement of collagen was replaced with more highly aligned unidirectional collagen.

Comment. The results indicate that a gross rearrangement of lamellae had occurred in both the anterior and posterior regions of the keratoconus corneal stroma (Figure 2). These findings support our belief that the specific arrangement of stromal collagen plays a significant role in the maintenance of normal corneal curvature.

Author Affiliations: Structural Biophysics Group, School of Optometry and Vision Sciences, Cardiff University, Cardiff (Drs Hayes, Boote, and Kamma-Lorger, Ms Dooley, and Prof Meek), and Department of Ophthalmology, Royal Glamorgan Hospital, Llantrisant (Dr Hawksworth), Wales; Centre for Sight, West Sussex (Drs Khan and Daya), and Diamond Light Source, Harwell Science and Innovation Campus, Oxfordshire (Dr Sorensen), England; and Department of Ophthalmology, Havener Eye Institute, Ohio State University, Columbus (Dr Lewis).

Correspondence: Prof Meek, School of Optometry and Vision Sciences, Cardiff University, Maindy Road, Cardiff CF24 4LU, Wales (meekkm@cf.ac.uk).

Financial Disclosure: None reported.

Funding/Support: This work was funded by grants G0600755 from the Medical Research Council and MX-2932 from the Science and Technology Facilities Council. Prof Meek is a Royal Society Wolfson Research Merit Award Holder.

Role of the Sponsors: The funding organizations had no involvement in the design and conduct of the study; collection, management, analysis, and interpretation of the data; or preparation, review, or approval of the manuscript.

Previous Presentation: This paper was presented at the Eurokeratoconus II meeting; September 23, 2011; Bordeaux, France.

Additional Contributions: Abbott Medical Optics allowed the loan and use of the IntraLase FS60 femtosecond laser. Dr Valerie Smith and the staff at the Bristol Eye Bank, Bristol, England, provided the normal cornea used in this study, and Mr Ashraf M. Mahmoud, Ohio State University, provided technical assistance.


Dacryops of Krause Gland in the Inferior Fornix in a Child

Dacryops of the accessory lacrimal glands are extremely rare, with only 4 previous cases reported to involve Krause glands in the last 60 years.1-4 Dacryops of Krause glands have not been reported in the inferior fornix. The cause is often unclear, although numerous causes of secondary dacryops are known.1-4

Report of a Case. An otherwise healthy 2-year-old girl had a left lower eyelid mass, noted since age 2 months.