Early Results of Penetrating Keratoplasty After Cultivated Limbal Epithelium Transplantation

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Objective: To describe the early results of penetrating keratoplasty (PKP) in patients who had previously undergone cultivated limbal epithelium transplantation.

Methods: Medical records of patients with limbal stem cell deficiency due to chemical burns who underwent PKP after cultivated limbal epithelium transplantation were reviewed for demographics, primary etiology, type of limbal transplantation, ocular surface stability, visual acuity, graft clarity, and complications. Histopathologic features of the recipient corneal buttons were studied with special attention to epithelial status.

Results: Of the 125 patients with limbal stem cell deficiency treated with cultivated limbal epithelium transplantation, 15 underwent PKP at a mean interval of 7 months (range, 2-12 months) following cultivated limbal epithelium transplantation (autologous, n=11; allogenic, n=4). All 4 patients treated with allogenic cultivated limbal epithelium transplantation were undergoing immunosuppressive therapy. Fourteen (93%) of the 15 eyes had a successful corneal graft with a stable corneal epithelium. Preoperative best-corrected visual acuity was less than 20/200 in 14 of the 15 eyes. At a mean ± SD follow-up of 8.3 ± 5.0 months after PKP, the best-corrected visual acuity was more than 20/60 in 8 eyes, 20/200 to 20/60 in 5 eyes, and less than 20/200 in 2 eyes. Three of the 15 eyes experienced corneal allograft rejection, which was managed successfully. One eye with graft rejection also had glaucoma. None of the limbal epithelial allografts showed signs of rejection.

Conclusions: Early results of PKP following cultivated limbal epithelium transplantation are favorable when performed after stabilizing the ocular surface. Adequate immunosuppression is essential for allogenic cultivated limbal epithelium transplantation to avoid rejection. Corneal allografts can separately reject the limbal allografts.


SEVERE OCULAR SURFACE DISORDERS WITH LIMBAL STEM CELL DEFICIENCY (LSCD) REQUIRE A COMPLEX APPROACH OF MULTIPLE SURGICAL PROCEDURES, SUCH AS LIMBAL TRANSPLANTATION AND PENETRATING KERATOPLASTY (PKP), FOR FINAL VISUAL REHABILITATION.1,2 THE OUTCOME OF PKP IN THESE CASES IS REPORTEDLY POOR.3,4 PENETRATING KERATOPLASTY PERFORMED IN AN EYE WITH LSCD CARRIES A HIGH RISK OF REJECTION4,6 AND NON-REJECTION-RELATED FAILURES. USE OF SYSTEMIC CYCLOSPORINE TO PREVENT REJECTION IN THESE HIGH-RISK GRAPHS HAS BEEN DISCUSSED AT LENGTH BY MANY AUTHORS,5,6 BUT CONSIDERING THE SIGNIFICANT ADVERSE EFFECTS5,7 AND HIGH COST INVOLVED WITH ONLY A MARGINAL IMPROVEMENT IN THE OUTCOME,6,8 THE ROLE OF SYSTEMIC CYCLOSPORINE IN THESE HIGH-RISK GRAPHS IS DEBATABLE. THE POOR RESULTS DUE TO NON-REJECTION-RELATED FAILURE, SUCH AS PERSISTENT EPITHELIAL DEFECT, COULD BE_attributed to the transfer of only the transient amplifying cells onto the central corneal surface after PKP. The transient amplifying cells, which have a limited life span and limited proliferative potential,9 fail to provide a stable epithelial surface to these grafts, necessitating the combination with a limbal transplantation procedure for better results. However, results of various limbal transplantation procedures combined with PKP are also not encouraging.10,12 Severely affected patients with unilateral LSCD require a large area of the limbus from contralateral normal eyes, and bilateral cases require similar tissues from the donor. Both of these procedures carry a risk of LSCD at the donor site.13 To avoid this potential complication, cultivated limbal epithelium transplantation is a better choice in these cases.14 Because cultivated limbal epithelium transplantation is a relatively new technique, there are no reports of the outcome of PKP following this procedure. We report herein the early results of PKP after cultivated limbal epithelium transplantation.
reported by Sangwan et al.15
and conjunctival epithelial cells was performed as previously
that involved the conjunctival surface, a co-culture of limbal
In the cases of LSCD with severe ocular surface dysfunction
days, by which time a confluent monolayer of the presumed
rum. The growth was monitored daily, and the medium was
man corneal epithelial cell medium with 10% fetal bovine se-
human amniotic membrane. The cells were cultured using hu-
central 10 mm of a 3
was shredded into small pieces. These were implanted over the
corneal epithelium medium to the tissue culture laboratory,
stromal tissue at the limbus. The conjunctiva was excised just
piece of conjunctival epithelium with 1 mm into clear corneal
was excised just
photographs of the patients were studied with special atten-
tion, complications, and final outcome. Histopathologic re-
plantation. The medical records of patients who underwent PKP
after the cultivated limbal epithelium transplantation were re-
by 10-0 nylon inter-
rupted sutures (extra sutures were placed if necessary) with knots
buried on the donor side. The recipient corneal button was sent
for histopathologic examination, and special attention was paid
to the epithelial status, epithelial stratification, and residual hu-
man amniotic membrane. Lensectomy, anterior vitrectomy, and
intraocular lens insertion were performed, depending on the
clinical situation in each case. At the end of the surgery, a sub-
conjunctival injection of dexamethasone sodium phosphate
(4 mg/mL) and gentamicin sulfate (20 mg/mL) was given.
However, PKP in these conditions warrants special men-
tion of the difficulties encountered during the surgery. Be-
cause most of the cases followed chemical burns, resulting in
some collagenolysis, and had involved pannus resection with
without superficial keratectomy, a significant disparity ex-
isted in graft-host thickness, leading to difficulty in graft host
position. Many of the patients had a disorganized anterior
segment with a complicated cataract, requiring lensectomy and
vitrectomy.

IMMUNOSUPPRESSION
Systemic immunosuppressants were administered to all pa-
tients with allogenic limbal grafts after adequate counseling re-
garding the adverse reactions. Baseline hematologic investiga-
tions and hepatic and renal parameters were obtained, and these
parameters were reassessed every 4 to 6 weeks. Our routine im-
munosuppression protocol is to start cyclosporine therapy sys-
temically in a dosage of 5 to 7 mg/kg 48 hours before surgery,
along with methylprednisolone, 1 g intravenously, for the first
3 consecutive postoperative days. During the postoperative pe-
riod, cyclosporine was tapered to the maintenance dosage of
1.5 to 2 mg/kg over 4 to 8 weeks, with diltiazem hydrochlo-
ride, 90 mg, added as an adjunct to cyclosporine to reduce the
cost and increase serum levels of cyclosporine.16,17 Diltiazem
also decreases the dose required to achieve immunosuppres-
sion and thus decreases the cost of the treatment. Diltiazem
by its antihypertensive effect helps to control hypertension, which
is the most common systemic adverse effect of the cyclospor-
ine.17 Use of immunosuppressants is being continued in all of
these patients. Both patients with allogenic-cultivated limbal
epithelium transplantation received systemic prednisolone ac-
cetate, 1 mg/kg, which was tapered on a weekly basis to the
maintenance dosage of 5 mg/d.

When rejection developed, patients were treated with fre-
quent topical corticosteroids. Patients who underwent allogenic-
cultivated limbal epithelium transplantation received systemic cor-
ticosteroids with continuing systemic immunosuppressants.

PATIENT FOLLOW-UP
Following cultivated limbal epithelium transplantation, all pa-
tients were treated with 1% prednisolone acetate eye drops 8
times a day tapered to once a day in 5 to 6 weeks and 0.3% cipro-
flaxacin hydrochloride eye drops 4 times a day for 1 week. Use
of the 0.3% ciprofloxacin eye drops was continued if there were
any epithelial defects or until the bandage contact lens was used.
We used to apply a bandage contact lens postoperatively, but
we have recently stopped this because we believe that it is not
required. The patients who underwent allogenic-cultivated lim-
bal epithelium transplantation were treated with 1% predniso-
one eye drops 2 times hourly, which was tapered to once a day
at 6 months, and these patients also received immunosuppres-
sants as described herein. The patients were seen on postop-
erative day 1, week 1, week 2, week 5, and monthly thereafter.
Each examination included a complete history, notation of new
ocular or systemic symptoms, a complete evaluation of the re-
cipient and donor sites, and notation of any signs of neovas-

SURGICAL TECHNIQUES
Our surgical techniques for cultivated limbal epithelium trans-
plantation have previously been reported.15 In brief, following
approval from the Institute Ethics Committee, prior informed
consent was obtained from the patients or guardians. Limbal
biopsy was performed on the healthy contralateral eye or a
healthy area of the same eye in cases of autologous transplanta-
tion and from the donor eye in cases of allogenic transplanta-
tion. The procedure included careful dissection of a 3 × 3-mm
piece of conjunctival epithelium with 1 mm into clear corneal
stromal tissue at the limbus. The conjunctiva was excised just
behind the pigmented line (palisades of Vogt), and the limbal
tissue that contained epithelial cells and a part of the corneal
stoma was excised. Both tissues were transported in human
corneal epithelium medium to the tissue culture laboratory,
where under strict aseptic conditions the donor limbal tissue
was shredded into small pieces. These were implanted over the
central 10 mm of a 3 × 4-cm, deepithelialized, and preserved
human amniotic membrane. The cells were cultured using hu-
man corneal epithelial cell medium with 10% fetal bovine se-
rum. The growth was monitored daily, and the medium was
changed every 2 days. The culture was maintained for 10 to 15
days, by which time a confluent monolayer of the presumed
limbal epithelial cells around the implanted tissues was achieved.
In the cases of LSCD with severe ocular surface dysfunction
that involved the conjunctival surface, a co-culture of limbal
and conjunctival epithelial cells was performed as previously
reported by Sangwan et al.15
At the time of limbal transplantation, the fibrovascular pan-

tus that covered the ocular surface was excised from the cor-
nea and sent for histopathologic examination. After release of
the symblepharon and adequate hemostasis with cautery, the
human amniotic membrane with the monolayer of cultivated
limbal epithelial cells was transplanted into the recipient. A
bandage contact lens was applied to prevent any damage from eye-

lid action. All of the cases were evaluated after the limbal trans-
plantation for corneal stromal scarring, and the cases with
scarring in the visual axis, leading to a decrease in vision, were
considered for PKP.
Penetrating keratoplasty was performed after a mean fol-
low-up of 7 months (range, 2-12 months) after cultivated lim-
bal epithelium transplantation, using donor corneas stored in
McCarey-Kaufmann medium. The recipient cornea was ex-
cised using a disposable handheld trephine, with 0.5 mm of graft-
host disparity. The graft was secured by 10-0 nylon inter-

PATIENTS
During the study period (May 2001 to September 2002), 125
cultivated limbal epithelium transplantation procedures were
performed at L V Prasad Eye Institute, Hyderabad, India, on
eyes with a diagnosis of LSCD, of which 15 eyes of 15 patients
underwent PKP after the cultivated limbal epithelium trans-
plantation. The medical records of patients who underwent PKP
after cultivated limbal epithelium transplantation were re-
viewed for demographics, primary etiology, previous surgical
procedures, preoperative and postoperative best-corrected vis-
ual acuity, type of cultivated limbal epithelium transplantation,
complications, and final outcome. Histopathologic re-
ports of recipient corneal buttons were also reviewed. Clinical
photographs of the patients were studied with special atten-
tion to any abnormalities in the limbal region, vascular en-
gorgement, conjunctival staining, epithelial defect in the lim-
bal area, and conjunctivalization after the rejection episodes.

METHODS

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keratoplasty; PL, perception of light; PR, projection of rays.

A total of 15 eyes of 15 patients underwent cultivated limbal epithelium transplantation followed by PKP for LSCD with a mean±SD follow-up of 15.3±5.1 months after cultivated limbal epithelium transplantation except 3 eyes, in which a co-cultivated (limbal and conjunctival) epithelium transplantation was performed (Table). All 4 patients with limbal allografts, of which 11 were alkali burns, 3 were acid burns, and 4 female. In all 15 eyes the origin of LSCD was chemical burns, of which 11 were alkali burns, 3 were acid burns, and 1 was due to an unknown chemical (Table). Six (40%) of the 15 eyes had a history of surgery in the form of allogenic bone marrow transplantation in 3 eyes (20%), PKP in 2 eyes (13%), and limbal transplantation in 1 eye (7%).

Eight (53%) of the 15 eyes had symblephara, ranging from the 2- to 10-o’clock hours. Fourteen (93%) of the 15 eyes had total LSCD with 360° loss of limbal pali-sades of Vogt and 360° conjunctivalization, whereas 1 (7%) of 15 had partial LSCD with loss of limbal pali-sades of Vogt of 120° and pannus localized to that area (Table).

All of the eyes underwent immunosuppression with cyclosporine and systemic corticosteroids, and 2 of them received diltia-zem tablets to decrease the dosage of cyclosporine.

The preoperative best-corrected visual acuity on the Snellen chart was less than 20/200 in 14 (93%) of 15 eyes.

### OUTCOME MEASURES

Primary graft failure was defined by nonresolving graft edema at 2 weeks. Graft rejection was diagnosed by slitlamp biomicroscopy findings and was subdivided into epithelial, subepithelial, and endothelial rejection. Failure of PKP was defined as nonresolving graft edema 3 months after graft rejection, persistent epithelial defect, or conjunctivalization.

### CLINICAL RESULTS

A total of 15 eyes of 15 patients underwent cultivated limbal epithelium transplantation followed by PKP for LSCD with a mean±SD follow-up of 15.3±5.1 months after cul-

### Table. Patient Profiles

<table>
<thead>
<tr>
<th>Age, y / Sex</th>
<th>Origin</th>
<th>Type of CLT</th>
<th>Preoperative BCVA</th>
<th>Final BCVA</th>
<th>Post-CLT Follow-up, mo</th>
<th>Post-PKP Follow-up, mo</th>
<th>Duration of CLT to PKP, mo</th>
<th>Post-PKP Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/F</td>
<td>Alkali burns</td>
<td>Contralateral-autologous*</td>
<td>PL + PR</td>
<td>20/200</td>
<td>20</td>
<td>11</td>
<td>9</td>
<td>Amblyopia</td>
</tr>
<tr>
<td>11/F</td>
<td>Alkali burns</td>
<td>Contralateral-autologous*</td>
<td>CF</td>
<td>20/40</td>
<td>12</td>
<td>5.5</td>
<td>6.5</td>
<td>Corneal allograft rejection, glaucoma</td>
</tr>
<tr>
<td>26/M</td>
<td>Alkali burns</td>
<td>Living-related allogenic*</td>
<td>CF</td>
<td>20/160</td>
<td>15.5</td>
<td>5.5</td>
<td>10</td>
<td>Corneal allograft rejection, glaucoma</td>
</tr>
<tr>
<td>14/M</td>
<td>Alkali burns</td>
<td>Contralateral-autologous</td>
<td>20/100</td>
<td>20/40</td>
<td>16</td>
<td>2</td>
<td>14</td>
<td>Corneal allograft rejection, glaucoma</td>
</tr>
<tr>
<td>21/M</td>
<td>Acid burns</td>
<td>Contralateral-autologous†</td>
<td>CF</td>
<td>20/40</td>
<td>19</td>
<td>13</td>
<td>6</td>
<td>Corneal allograft rejection, glaucoma</td>
</tr>
<tr>
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<td>Acid burns</td>
<td>Contralateral-autologous</td>
<td>CF</td>
<td>20/160</td>
<td>15.5</td>
<td>5.5</td>
<td>10</td>
<td>Corneal allograft rejection, glaucoma</td>
</tr>
<tr>
<td>6/F</td>
<td>Alkali burns</td>
<td>Contralateral-autologous</td>
<td>HM</td>
<td>20/30</td>
<td>17</td>
<td>13</td>
<td>4</td>
<td>Corneal allograft rejection, glaucoma</td>
</tr>
<tr>
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<td>Alkali burns</td>
<td>Contralateral-autologous</td>
<td>CF</td>
<td>20/50</td>
<td>22</td>
<td>18.5</td>
<td>3.5</td>
<td>Corneal allograft rejection, glaucoma</td>
</tr>
<tr>
<td>29/M</td>
<td>Acid burns</td>
<td>Ipsilateral-autologous</td>
<td>CF</td>
<td>20/80</td>
<td>7</td>
<td>1.5</td>
<td>5.5</td>
<td>Corneal allograft rejection, glaucoma</td>
</tr>
<tr>
<td>7/M</td>
<td>Alkali burns</td>
<td>Contralateral-autologous</td>
<td>HM</td>
<td>20/125</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>Corneal allograft rejection, glaucoma</td>
</tr>
<tr>
<td>23/F</td>
<td>Unknown chemical</td>
<td>Nonrelated allogenic</td>
<td>PL + PR</td>
<td>20/50</td>
<td>8.5</td>
<td>3</td>
<td>5.5</td>
<td>Corneal allograft rejection, glaucoma</td>
</tr>
<tr>
<td>29/M</td>
<td>Alkali and acid burns</td>
<td>Living related allogenic</td>
<td>CF</td>
<td>20/125</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>Corneal allograft rejection, glaucoma</td>
</tr>
<tr>
<td>25/M</td>
<td>Alkali burns</td>
<td>Contralateral-autologous</td>
<td>CF</td>
<td>20/40</td>
<td>15</td>
<td>9.5</td>
<td>5.5</td>
<td>Corneal allograft rejection, glaucoma</td>
</tr>
<tr>
<td>25/M</td>
<td>Alkali burns</td>
<td>Living related allogenic</td>
<td>HM</td>
<td>20/50</td>
<td>15</td>
<td>13</td>
<td>2</td>
<td>Corneal allograft rejection, glaucoma</td>
</tr>
<tr>
<td>30/M</td>
<td>Alkali burns</td>
<td>Ipsilateral-autologous</td>
<td>CF</td>
<td>20/80</td>
<td>13</td>
<td>6</td>
<td>7</td>
<td>Corneal allograft rejection, glaucoma</td>
</tr>
</tbody>
</table>

Abbreviations: BCVA, best-corrected visual acuity; CF, counting fingers; CLT, cultivated limbal epithelium transplantation; HM, hand motions; PKP, penetrating keratoplasty; PL, perception of light; PR, projection of rays.

*Co-cultivated (limbal and conjunctival) limbal epithelium.
†Combined with contralateral conjunctivolimbal autograft.
and 20/200 or better in 1 (7%) of 15 eyes. Final best-corrected visual acuity was less than 20/200 in 2 eyes (1 of which had primary graft failure), 20/200 to 20/60 in 5 eyes, and better than 20/60 in 8 eyes (Figure 1 and Figure 2). Thirteen corneal allografts (87%) were clear at the last follow-up. Of the other 2, 1 was a primary failure and 1 had resolving corneal allograft rejection.

Three of 15 eyes had acute corneal allograft rejection, of which 2 had living related cultivated limbal epithelium transplantation and 1 had autologous cultivated limbal epithelium transplantation. Two eyes had only endothelial rejection, whereas 1 eye had combined endothelial and epithelial rejection. One eye with graft rejection also had glaucoma, which was controlled with the treatment. All of the rejected corneal allografts responded favorably to the treatment.

HISTOPATHOLOGIC RESULTS OF RECIPIENT CORNEAL BUTTONS

All corneal buttons showed a multiple-layered normal corneal epithelium of 3 to 5 layers (Figure 3D). Only 2 corneal buttons showed the presence of residual amniotic membrane. One of the corneal buttons showed a focal presence of goblet cells. Immunohistochemical analysis with monoclonal antibodies (AE5) against cornea-specific cytokeratin K3 was performed on 12 recipient corneal buttons, of which 11 showed reactions positive for the cornea-specific phenotype of the epithelium (Figure 4F).

COMMENT

The limbal stem cell can be damaged by a variety of insults, of which one of the most common and important is chemical burns.9 Most of these cases of chemical burns have significant stromal scarring, necessitating PKP for visual rehabilitation. Before the role of limbal stem cells as a source of corneal epithelium was recognized, PKP in these eyes invariably failed.3 This was because the transient amplifying cells that were transferred onto the central corneal surface during PKP had a limited life span and limited proliferative potential8 and thus were unable to restore the ocular surface epithelium on a long-term basis. Limbal transplantation is performed in these cases to maintain the reservoir of corneal epithelial cells required for a stable and healthy corneal epithelium. Simultaneous PKP and limbal transplantation and their advantages have been addressed previously,18,19 but a greater risk of rejection of corneal grafts exists10,20 with an inflamed and vascularized recipient corneal stroma.4-6,21 Therefore, we prefer the 2-staged approach. The first stage is ocular surface reconstruction by cultivated limbal epithelium transplantation followed by the second stage of visual rehabilitation by performing PKP.

Various techniques of limbal transplantation have been reported in the literature, including keratolimbal allograft, which has produced disappointing long-term outcomes.10,12 The need for indefinite immunosuppression is also an issue in cases of allogenic limbal transplantation. The other techniques, such as living related conjunctival allogenic transplantation and conjunctival limbal autografts, may not be useful in total LSCD to replace the limbus in 360° owing to the risk of LSCD at the donor site.13 Hence, we prefer the technique of cultivated limbal epithelium transplantation. However, our technique of cultivated limbal epithelium transplantation is different from that reported by others.14,22 As reported previously,15 we used deepithelialized human amniotic membrane to cultivate limbal epithelium over it without 3T3 fibroblast coculture or air lifting. Our culture duration was also shorter because we did not wait for multiple layers to form. In our experience, a monolayer ultimately proliferates in vivo to produce stratified (multilayered) epithelium following transplantation. Our hypothesis is supported by the fact that follow-up PKP, all of the recipient corneal buttons showed normal stratified corneal epithelium (Figure 3D) with a cornea-specific phenotype (Figure 4F), which had grown into multiple layers after monolayer transplantation (Sangwan et al, unpublished data, 2001).
Cases of severe ocular surface damage with LSCD are often difficult to manage. Apart from limbal damage, conjunctival deficiency usually occurs as well. We tried to address this problem earlier and reported co-cultivation of conjunctival and limbal epithelial cells. Three of the 15 patients in this series had more severe ocular surface damage with symblephara and hence underwent co-cultivated (limbal and conjunctival) epithelium transplantation.

All of the recipients in our study were younger, ranging in age from 3 to 36 years (mean age, 20.3 years) (Table), sustained chemical burns, and subsequently had stromal vascularization in 4 quadrants. Eleven of the 15 patients in our study had a history of ocular surface surgical procedures, and 8 of the patients had symblephara at initial examination. Hence, considering the criteria suggested by the Collaborative Corneal Transplantation Studies Research Group for high-risk PKPs, all PKPs in our series were high risk. Conversely, our cases showed neither a high rejection rate (overall rejection rate, 20%) despite the age of the recipients and stromal vascularization nor a non-rejection-related failure as expected in cases of chemical burns. This substantial decrease of non-rejection-related failure could be explained by the cultivated limbal epithelium transplantation procedure preceding the PKP, which continued to supply healthy epithelium after PKP. Similarly, the fewer corneal graft rejection episodes, notwithstanding age of recipients and vascularized recipient corneal stroma, could be due to our stepwise approach, which included ocular surface reconstruction by cultivated limbal epithelium transplantation in the first step and PKP in the second. Because 4 of the 15 patients underwent allogenic limbal epithelium transplantation and immunosuppression, the effect of immunosuppression on the graft survival also cannot be overlooked. However, if we consider only the autologous limbal epithelium transplantation cases, all of them met the criteria of high-risk grafts and none were immunosuppressed. The corneal graft rejection rate in these cases was 9.1% (1 of 11), which is less than in any other reported series of high-risk grafts without immunosuppression, as described by Hill (73%), Poon et al (53%), and Rumelt et al (42%). To explain this relatively low rejection rate, we speculate that the cultivated limbal epithelium is devoid of Langerhans cells, which are believed to be the antigen-presenting cells and are in abundance at the limbus, forming one of the important components of the afferent arm of corneal allograft rejection. Thus, the recognition of corneal graft alloantigen is down-regulated, which in turn decreases the rate of rejection. However, further studies are needed in this direction to confirm our hypothesis. Similarly, we can-

Figure 3. Slitlamp photographs of case 5. A, Preoperative condition showing total limbal stem cell deficiency with extensive symblephara obliterating the superior and inferior fornices. B, Stable ocular surface and dense corneal scarring after autologous cultivated limbal epithelium transplantation with contralateral conjunctivolimbal autograft (6 weeks postoperatively). Bulbar conjunctiva, in the area of conjunctivolimbal autograft (inferior quadrant), shows a patch of vascularization and pigmentation. C, Clear and compact graft with a stable ocular surface after penetrating keratoplasty (13 months postoperatively). D, Hematoxylin-eosin-stained histopathologic section of the corneal button with multilayered corneal epithelium after autologous cultivated limbal epithelium transplantation (original magnification × 20).
not rule out the effect of the anti-inflammatory property of amniotic membrane, which was used as a carrier in these cases. We also noted that despite the central corneal graft rejection in 2 cases of allogenic limbal epithelium transplantation, none showed any signs of limbal allograft rejection. This finding supports similar findings with PKP after keratolimbal allograft transplantation reported by Shimazaki et al.

Several studies have indicated that all allogenic limbal transplantation cases, including those with living-related limbal allografts, require immunosuppression. We too believe in immunosuppression for allogenic cultivated limbal transplantation. Hence, we started administration of cyclosporine preoperatively and then continued with a maintenance dosage of cyclosporine for indefinite periods in the recipients with allogenic cultivated limbal epithelium transplantation. Along with systemic cyclosporine, we used diltiazem, a calcium channel blocker. Diltiazem is known to increase the plasma cyclosporine level by competitive inhibition of hepatic enzyme CYP450, which is required for the metabolism of cyclosporine. Thus, the cyclosporine dose can be reduced by 30% to 50% with a drastic reduction in medication cost. In high nontherapeutic doses, however, it may exert an immunosuppressive effect. It also provides renal protection from cyclosporine-induced nephrotoxicity. It is used in other solid organ transplantations but has not been reported for allogenic limbal transplantation.

Previous studies reported a poor final visual outcome of PKP with limbal transplantation. In our study, 14 (93%) of the 15 patients had a preoperative best-corrected visual acuity of hand movements to finger counting. At the last follow-up, 13 patients (87%) had an ambulatory visual acuity of better than 20/200 in the affected eye, of which 8 (53%) achieved a best-corrected visual acuity better than 20/60 (Figure 3). Although ours was a retrospective study, with a small number of cases and long-term results that are still awaited, we observed a definite trend toward better corneal graft survival and excellent visual outcome in these cases.

Certain issues related to PKP following limbal transplantation must be highlighted. Because such patients have already undergone pannus resection with or without superficial keratectomy, the recipient corneal stromal bed is usually thin and irregular, which could result in postoperative astigmatism. Associated conditions, such as eyelid abnormalities, glaucoma, and dry eye syndrome, may affect the final outcome and hence must be treated before PKP. Patients treated with allogenic limbal epithelium transplantation need to undergo immunosuppression even after the PKP.

In summary, we report the early outcome in 15 cases of PKP after cultivated limbal epithelium transplantation, which showed favorable results in the form of corneal graft survival and final visual acuity. However, further studies are required to understand immunologic rejection in cases of allogenic cultivated limbal epithelium transplantation.

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REFERENCES

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REFERENCES


Correction

Notice of Duplicate Publication of Figure. In the Clinical Sciences article by Sangwan et al titled “Early Results of Penetrating Keratoplasty After Cultivated Limbal Epithelium Transplantation,” published in the March 2005 issue of the ARCHIVES (2005;123:334-340), Figure 3 is the same figure as one previously published in an article by Sangwan et al (Figure 2) that appeared in Bioscience Reports (2003;23:169-174). The authors alerted us to the duplicate publication of the figure when they realized the error. This was an unintentional oversight. The ARCHIVES has since obtained permission from Springer Science and Business Media, the publisher of Bioscience Reports, to reprint the figure.