Keratoprosthesis: a short review

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 Though the concept of an artificial cornea seems attractive (on the analogy of the intraocular lens), it is important to understand the limitations of this treatment mode, before we attempt a critique

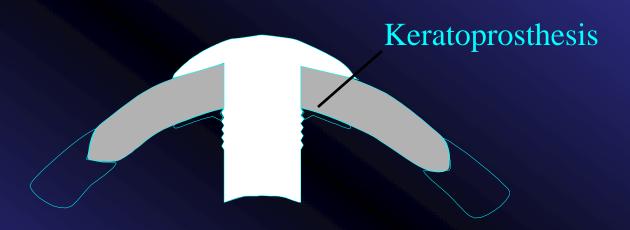
Limitations of any keratoprosthesis

- Possibility of extrusion
- Possibility of infection
- Impossible to monitor glaucoma
- Fundus view poor so retinal treatment difficult (if required)
- Complications like retroprosthesis membrane occur frequently
- All keratoprostheses do not work in pemphigoid

Possibility of extrusion

- Maximum with Cardona nut and bolt type
- Less with Worst Singh type and with Fydorov Zhukov types
- Osteo-odontokeratoprosthesis (Strampelli) also has lesser extrusion rates

Nut and bolt keratoprosthesis



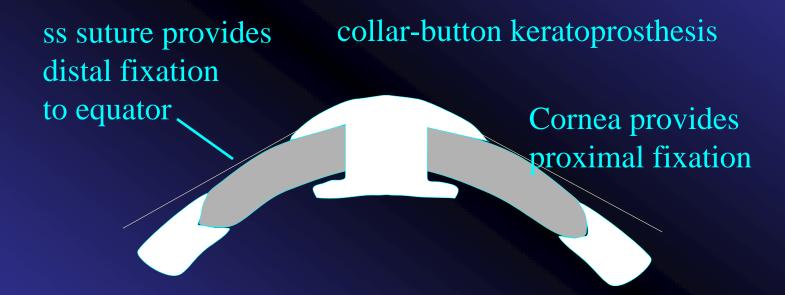
Cardona Nut and Bolt type keratoprosthesis

Intrastromally supported keratoprostheses



Keratoprosthesis with intrastromal fixation

Worst-Singh Keratoprosthesis



Fyodorov-Zhukov Keratoprosthesis

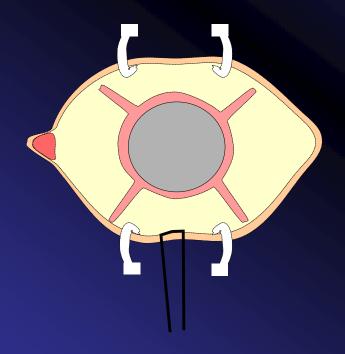


Possibility of infection

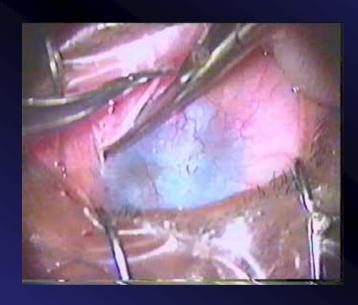
 Omnipresent in all types of keratoprosthesis irrespective of design as there is a potential space between the plastic cornea and the tissues which can allow infection to track into the eye.

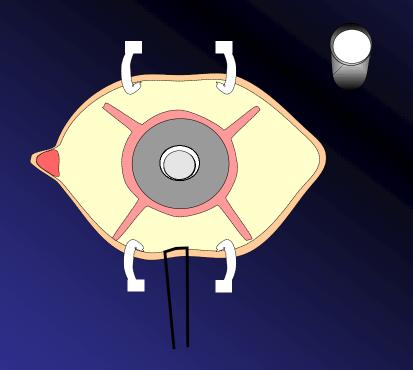
Worst-Singh type of keratoprosthesis



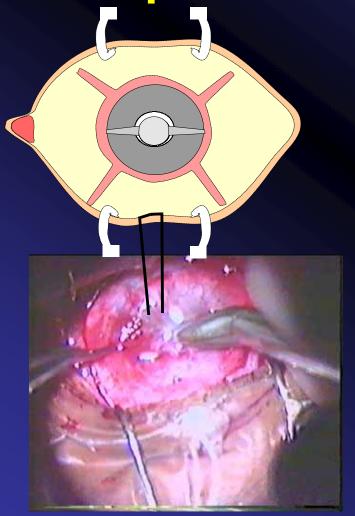


A peritomy is done and 4 incisions extended towards the equator



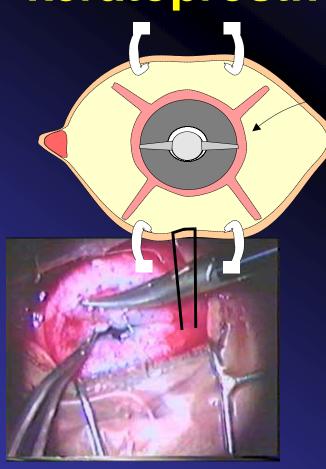


A small central trephination is done



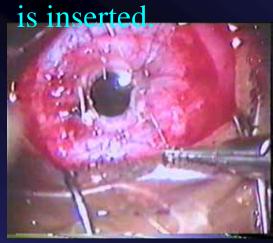
A horizontal extension of the circular opening is made and the lens, if any, extracted.

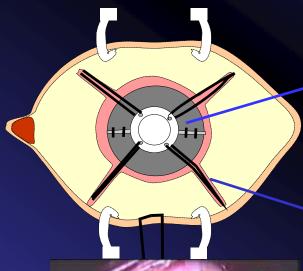






The collar-button shaped keratoprosthesis





proximal fixation by cornea

distal fixation to equator

by ss suture

