

## Management of Intraepithelial and Invasive Neoplasia of the Cornea and Conjunctiva

### To the Editor:

I acknowledge Dr Zaki and Dr Farid for their effort in treating patients with invasive neoplasia of the cornea and conjunctiva.<sup>1</sup> However, there are some points in their study that should be addressed.

First, in the abstract, they mentioned that 10 eyes of 10 patients enrolled in their study, but in the subjects and methods section, they reported 10 eyes of 20 patients.

Second, they reported a cure even in patients with squamous cell carcinoma after 2 years of follow-up despite the fact that only half of the specimens had safety margins after excisional biopsy. As they mentioned, even recent studies have noted a recurrence rate of approximately 50% when there is pathologic evidence of residual tumor in the surgical margin and a 5% to 33% recurrence rate with clear margins.<sup>2</sup> It is hard to believe that there was a cure even in patients who had specimens not containing safety margins (1 squamous cell carcinoma and 4 cornea and conjunctiva intraepithelial neoplasia).

Finally, the logic for using cyclosporine A (0.05%) in these cases seems unclear. As the authors mentioned, corneal and conjunctival squamous cell carcinoma have been reported in patients undergoing organ transplantation who received systemic cyclosporine A because of its immunomodulator role that has been shown to specifically inhibit T-lymphocyte proliferation.<sup>3</sup> The mentioned report of the use of cyclosporine A (0.05%) was to prevent potential ocular surface side effects of mitomycin C and not to prevent the recurrence of the tumor.<sup>4</sup>

Hence, the safety and efficacy of its application for this group of patients should be reconsidered with special attention.

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## Management of Nontraumatic Corneal Perforation with Tectonic Drape Patch and Cyanoacrylate Glue

### To the Editor:

We read with interest the article “Management of Nontraumatic Corneal Perforation with Tectonic Drape Patch

and Cyanoacrylate Glue’ by Khalifa et al.<sup>1</sup> Cyanoacrylate tissue adhesive (CTA), fibrin glue, and amniotic membrane transplant with and without fibrin glue are the recommended therapeutic options for the treatment of corneal perforations.<sup>1–4</sup> The authors present a novel technique using tectonic drape patch for nontraumatic corneal perforation with tissue loss. We agree that this technique is a valuable option if amniotic membrane transplant, fibrin glue, and good-quality donor cornea are not available. However, we have been using a different technique for treating nontraumatic corneal perforations not amenable to CTA and bandage contact lens. The sterile hard paper piece of the transparent surgical drape (Tegaderm; 3M Health Care D-41453, Neuss, Germany) is cut according to the size of the corneal perforation. The CTA drop is placed in the center of the sterile paper piece. The corneal perforation is dried using cellulose sponge. The cyanoacrylate glue surface of the paper piece is then kept gently pressed over the corneal perforation for 30 seconds to allow polymerization (Fig. 1). We believe that despite drying the corneal perforation, some fluid still remains in the perforation track, and the CTA does not enter the anterior chamber. We do not apply bandage contact lens. We have used this technique for treating infective corneal perforations as well.

We also use rigid gas-permeable (RGP) contact lenses for treating



**FIGURE 1.** Sealed corneal perforation with glued drape patch.