Corneal Evaluation in Healthy Brazilian Children Using a Scheimpflug Topography System

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Abstract

**Purpose:** To identify the distribution and variation in corneal topography, thickness, and elevation in healthy Brazilian children as measured by the Pentacam Scheimpflug system (Oculus Optikgeräte GmbH, Wetzlar, Germany).

**Methods:** Healthy children between 7 and 11 years of age were scanned using the Pentacam Scheimpflug corneal topography system (Oculus Optikgeräte GmbH, Wetzlar, Germany). The exclusion criteria were inability to undergo the ocular exam, history of any ocular diseases (including strabismus, amblyopia, cataracts, retinal disorders, and allergic conjunctivitis), and topographic diagnosis of corneal ectasia based on the modified Rabinowitz/Donnell criteria for keratoconus. The right eye of each subject was selected for analysis. The parameters evaluated were central corneal thickness (CCT), thinnest pachymetry (TP), average pachymetric progression index (PPIave), anterior and posterior elevation (AE and PE), anterior and posterior best fit sphere (ABFS and PBFS), pachymetric difference between the apex and the thinnest point (PDAT), Ambrosio’s relational thickness (ARTMax), overall Belin/Ambrósio Enhanced Ectasia display score (BAD-D), simulated keratometry (SimK), astigmatism in SimK (SimK astig), maximum keratometry (K max), asphericity (Q value), and anterior chamber depth (ACD).

**Results:** A total of 160 children (69 male, 91 female) were included in this study. The mean age of the children was 8.82 ± 1.23 years (ranging from 7 to 11 years). The mean CCT was 553.81 ± 32 µm, and mean TP was 547.95 ± 32.06 µm. The TP was most commonly located in the inferotemporal quadrant in 93.125% (149) eyes. The mean PPIave was 1.00 ± 0.14, similar to that of normal adults. The mean ABFS and PBFS values were 7.49 ± 3.26 and 10.54 ± 6.25, respectively, ART Max and D averaged 446.57 ± 81.20 and 0.78 ± 0.65, respectively. Mean ± SD values for SimK, SimK astig, and K max were 43.35 ± 1.31 D, 0.92 ± 0.66 D, and 44.40 ± 1.45 D respectively. The K max and SimK astig values were close to those reported by other topographic systems for children. Q value and ACD averaged 0.39 ± 0.12 and 3.065 ± 0.2745 mm.

**Conclusion:** This study provides normative values for corneal topography, thickness, and elevation in healthy Brazilian children. These results may provide helpful information for diagnosis of corneal diseases in children. Further studies are needed to evaluate the role of tomography in identifying early forms of ectasia in this age group.

**Keywords:** Cornea; Children; Topography; Healthy; Pentacam; Scheimpflug

Introduction

In clinical practice and research involving the use of keratometric readings of the anterior surface of the eye, the study of the posterior aspects of the cornea and its pachymetric distribution are very important for understanding how the cornea behaves structurally. These parameters are needed to identify abnormal corneas and to predict how they will behave in the future and after surgical procedures. Until techniques such as slit-scanning and Scheimpflug imaging were developed, the field of corneal imaging was restricted to the analysis of the shape and optical quality of the cornea's anterior surface with Placido disc-based topography systems [1]. These are still the most commonly used technologies for corneal imaging, though they lack the ability to diagnose subclinical keratoconus, contact lens corneal warpage, and corneas that are not suitable for refractive surgeries. These new anterior segment imaging technologies are capable of reconstructing the three-dimensional structure of the cornea from two-dimensional optical cross-sections, greatly enhancing our ability to investigate the properties of the cornea. There are currently five devices on the market that are based on these technologies: Orbscan IIz (Bausch & Lomb Surgical, Inc), Pentacam (Oculus, Inc), the Galilei (Ziemer Ophthalmic Systems AG,) the Precisio (Ligi Tecnologie Medicali), and the Sirius (CSO Ophthalmic). The Orbscan IIz is the only slit-scanning-based technology; the others involve Scheimpflug-based technology [2].

The Pentacam corneal tomographer (Oculus Optikgeräte GmbH, Wetzlar, Germany) is a Scheimpflug-based topographer that can provide readings and analyses of the anterior and posterior surfaces of the cornea, as well as measurements of corneal thickness. Since its launch in 2004, it has become a popular device for evaluating the anterior segment of the eye. Previous studies have demonstrated excellent reproducibility of the automated measurements of the
anterior segment structures [3-6]. The Pentacam system may be used to
diagnose keratoconus, to screen corneas for refractive surgery, to
monitor post-surgical corneas, to calculate the keratometric index and
intraocular lens power, and to assess intraocular lens implants. Studies
have provided normative data on the anterior segments of adults [7], as
well as on changes in posterior corneal elevation following the use of
an excimer laser [8]. In order to avoid undetectable keratoconus, new-
generation devices now offer features and algorithms that help to
differentiate keratoconus from normal corneas [9,10]. It is important
to recognize the influences of aging on the shape of the anterior and
posterior surfaces of the cornea [11], especially in patients who have
cataracts and who have undergone corneal refractive surgery—in other
words, patients who are in most need for accurate keratometric
parameters in the selection of the correct intraocular lens [12].

Despite the vast amount of data on these corneal parameters in
adults, similar information on children is still scarce [13], which can
limit the use of the Pentacam for identifying abnormal corneas. Some
studies have shown that the onset of keratoconus typically occurs
during puberty [14]. However, when this condition develops sooner (as
in cases of pediatric keratoconus), it seems to progress faster and to be
more advanced at the time of diagnosis than keratoconus in adults
[15]. Due to its advanced stage at diagnosis, pediatric keratoconus
bears a higher risk of corneal scarring than adult cases, an issue which
reflects a greater need for penetrating keratoplasty [16]. All of this
information justifies the importance of obtaining keratometric,
pachymetric, and elevation data from pediatric patients in order to
diagnose corneal abnormalities earlier and, ideally, to avoid
progression to such advanced stages and subsequent losses in quality of
life.

The purpose of this study was to establish a database of normative
corneal topography measurements from healthy children between 7
and 11 years of age using the Pentacam corneal topography system.

Patients and Methods

The present study was reviewed and approved by the Research
Ethics Committee of the University of Campinas (UNICAMP) in
Campinas, São Paulo, Brazil under CAAE Registry number
54921916.9.0000.5404, and the tenets of the Declaration of Helsinki
were followed. The study was based on a retrospective review of the
ophthalmological medical records of healthy children enrolled in
second to fifth grade of the State of São Paulo public school system in
2011. As it was a retrospective review of the ophthalmological medical
records of patients that were examined in the past, the informed
consent was dispensed with no harm to the patients. The Honorato
Faustino State School was chosen randomly for these exams as part of
a partnership with the state government, and children from 7 to 11
years of age who agreed to participate of the study and whose parents
and guardians agreed to their participation were included. The
exclusion criteria were inability to undergo the ocular exam, history of
any ocular diseases (including strabismus, amblyopia, cataracts, retinal
disorders, and allergic conjunctivitis), and topographic diagnosis of
corneal ectasia based on the modified Rabinowitz/McDonnell criteria
for keratoconus [17]. The ocular tomographic exam was performed using
the OCULUS-Pentacam Scheimpflug Topography System.

During the examinations, the patients were comfortably positioned at
the instrument with proper placement on the chin rest and forehead
strap. The patients were asked to blink a few times and to open both
eyes and stare at the fixation target. The system, which was in
automatic release mode, started the scan after proper alignment was
obtained. Twenty-five single Scheimpflug images within captured for
each eye within 2 seconds. Two experienced ophthalmologists and
corneal specialists in a dimly lit room performed all of the
tomographic exams, and the tomography was repeated until acceptable
image quality was obtained (image quality defined as "OK" according to
the built-in Examination Quality Specifications). Details are shown in
Figure 1. The analysis of the captured images considered the
topographic, pachymetric, and elevation parameters, and maps,
graphs, and indices have been created.

Central corneal thickness (CCT) was recorded at the apex of the
cornea when the patient fixated on the target of the topographer. The
thinnest point (TP) and its distance to the CCT in micrometers (µm)
were recorded. All of these calculations are exemplified in Figure 2.

Anterior and posterior maps were used in the calculations of the
anterior and posterior elevations at the thinnest point (AETP and
PETP), as well as anterior and posterior elevation in the best fit sphere
(ABFS and PBFS) using a fixed optical zone of 8.0 mm, as seen in
Figure 3.

The mean value of the pachymetric progression index (PPIave) was
recorded, as were the anterior elevation (AE) and posterior elevation
(PE). The relational thickness parameter was calculated as the ratio of
the PPI value to Ambrosio’s relational thickness (ART), which refers to
the relational thickness of the TP with PPIMax (ARTMax). Using the
Belin/Ambrosio Enhanced Ectasia display, a calculation was made
based on the anterior and posterior elevations and on the
distribution of thickness and the overall value, which was referred to as BAD-D.

The BAD-D was recorded and used in the description of how the
thickness of the cornea changed between the thinnest area and the
periphery. Another parameter recorded was the asphericity of the
 cornea, which is measured by a Q value in which an oblate cornea has
a positive value and a prolate cornea has a negative value. To avoid
redundancy of the data, we included only the right eye. The data was
manually transferred to Microsoft Excel (Microsoft, Redmond,
Washington).

Statistical analyses were performed using the R Project software,
version 3.0 (R Foundation for Statistical Computing Platform, Vienna,
Austria). The mean, standard deviation, range, and confidence interval
(95% CI) were calculated for each parameter in question. The
probability of distribution was calculated using the skewness and
kurtosis descriptors.

Results

A total of 160 healthy children from 7 to 10 years of age were
included in this study. Of these subjects, 69 were male and 91 were
female (43.1% and 56.9%, respectively). The average patient age was
8.82 ± 1.23 years. Table 1 summarizes the results.
Simulated flat keratometry (flat SimK), simulated steep keratometry (steep SimK), and maximum keratometry (K max) in diopters (D) were 42.95 ± 1.32 (range: 39.10 to 46.70), 43.86 ± 1.40 (range: 40.20 to 48.00), and 44.40 ± 1.45 (range: 40.50 to 48.50), respectively; SimK and SimK astigmatism (SimK astig) values were 43.35 ± 1.31 (range: 39.65 to 47.00) and 0.92 ± 0.66 (range: 4.80 to 0), respectively, and they were also measured in diopters (D).

In the analysis of corneal thickness, the mean CCT was found to be 553.81 ± 32 µm (range: 481 to 640), and mean TP was 547.95 ± 32.06 µm (range: 469 to 629). The TP was most commonly located in the inferotemporal quadrant in 93.125% (149) eyes. The distribution of thickness was represented in PPIave and ARTMax, which were 1.00 ± 0.14 (range: 0.64 to 1.45) and 446.57 ± 81.20 (range: 223 to 745), respectively.
Table 1: Measurements from 160 children’s eyes evaluated using the OCULUS-Pentacam Scheimpflug topography system.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Mean ± SD</th>
<th>Range</th>
<th>Skew</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (y)</td>
<td>8.819 ± 1.233</td>
<td>7 to 11</td>
<td>-0.06</td>
<td>-1.13</td>
</tr>
<tr>
<td>CCT (µm)</td>
<td>553.81 ± 32</td>
<td>481 to 640</td>
<td>0.06</td>
<td>-0.67</td>
</tr>
<tr>
<td>TP (µm)</td>
<td>547.95 ± 32.06</td>
<td>469 to 629</td>
<td>0.05</td>
<td>-0.64</td>
</tr>
<tr>
<td>PPlave</td>
<td>1.00 ± 0.14</td>
<td>0.64 to 1.45</td>
<td>0.31</td>
<td>0.29</td>
</tr>
<tr>
<td>AE (µm)</td>
<td>3.20 ± 1.91</td>
<td>1 to 13</td>
<td>1.15</td>
<td>4.88</td>
</tr>
<tr>
<td>PE (µm)</td>
<td>5.09 ± 3.43</td>
<td>2 to 20</td>
<td>0.92</td>
<td>2.2</td>
</tr>
<tr>
<td>ABFS</td>
<td>7.49 ± 3.26</td>
<td>4 to 26</td>
<td>1.05</td>
<td>6.33</td>
</tr>
<tr>
<td>PBFS</td>
<td>10.54 ± 6.25</td>
<td>3 to 30</td>
<td>0.44</td>
<td>0.26</td>
</tr>
<tr>
<td>PDAT (µm)</td>
<td>5.86 ± 4.90</td>
<td>0 to 32</td>
<td>2.69</td>
<td>8.84</td>
</tr>
<tr>
<td>ART Max</td>
<td>446.57 ± 81.20</td>
<td>223 to 745</td>
<td>0.54</td>
<td>0.83</td>
</tr>
<tr>
<td>BAD-D</td>
<td>0.78 ± 0.65</td>
<td>1.14 to 2.42</td>
<td>0.13</td>
<td>0.15</td>
</tr>
<tr>
<td>SimK</td>
<td>43.35 ± 1.31</td>
<td>39.65 to 47.00</td>
<td>0.058</td>
<td>0.112</td>
</tr>
<tr>
<td>Flat SimK</td>
<td>42.95 ± 1.32</td>
<td>39.10 to 46.70</td>
<td>0.04</td>
<td>-0.23</td>
</tr>
<tr>
<td>Steep SimK</td>
<td>43.86 ± 1.40</td>
<td>40.20 to 48.00</td>
<td>0.21</td>
<td>-0.07</td>
</tr>
<tr>
<td>SimK Astig</td>
<td>0.92 ± 0.66</td>
<td>4.80 to 0.0</td>
<td>-1.7</td>
<td>10.95</td>
</tr>
<tr>
<td>K max</td>
<td>44.40 ± 1.45</td>
<td>40.50 to 48.50</td>
<td>0.15</td>
<td>-0.02</td>
</tr>
<tr>
<td>Q Value</td>
<td>-0.39 ± 0.12</td>
<td>-0.77 to -0.05</td>
<td>-0.203</td>
<td>0.07598</td>
</tr>
<tr>
<td>ACD</td>
<td>3.065 ± 0.2745</td>
<td>2.28 to 3.97</td>
<td>-0.2948</td>
<td>0.8669</td>
</tr>
</tbody>
</table>

SD: Standard deviation; 95% CI: Confidence Interval; CCT: Central Corneal Thickness; TP: Thin nest Pachymetry; P Plave: Average Pachymetric Progression Index; AE: Anterior Elevation; PE: Posterior Elevation; K: Keratometry; ARTMax: Maximum Ambrósio Relational Thickness; SimK: Simulated Keratometry; ABFS: Anterior Best Fit Sphere; PBFS: Posterior Best Fit Sphere; PDAT: Pachymetric Difference Between the Apex and the Thinnest Point; Kmax: Maximum Keratometry; BAD-D: Overall Belin/Ambrosio Enhanced Ectasia Display Score; ACD: Anterior Chamber Depth. The Pentacam Scheimpflug Corneal Topography (Oculus Optikgerate GmbH, Wetzlar, Germany).

With reports that the onset of keratoconus typically occurs during puberty [14] and that vision-related quality of life is worse among these patients [27], the detection of abnormal corneas in children has gained significant importance. It may be difficult to distinguish subclinical keratoconus from regular myopic astigmatism during a routine eye exam. Proper and prompt diagnosis of keratoconus is crucial for a better understanding of disease progression, for early treatment, and to avoid decreases in young patients' BCVA and the subsequent impact on productivity and quality of life [28]. While advanced keratoconus is easily diagnosed by slit-lamp biomicroscopy and corneal curvature readings, diagnosing subclinical keratoconus remains a challenge. Another benefit of topography evaluation is greater sensitivity to the subtle changes in topographic parameters in children with subclinical expressions of keratoconus and suspicious topographic corneal patterns. In patients who have already been diagnosed with keratoconus, topography exams are important for analyzing progression and establishing surgical indication.

Previous studies have provided substantial information and many normative values for corneal power, astigmatism, corneal thickness and pachymetric progression indices in adults. However, these parameters have not been studied in children using current tomographers such as the OCULUS-Pentacam Scheimpflug tomography system. Our study provides normative data resulting from the use of Pentacam Scheimpflug corneal topography in children from
This study on healthy children between 7 and 11 years of age found a relative similarity between children's mean CCT, TP, PPIave and BAD-D values and those of normal adults. The results also reflected a relative difference between children's values and the values in subclinical and keratoconus patients found by Ambrósio et al. [9], that studied 113 normal and 44 eyes with keratoconus from Brazilian patients aged between 11.7 to 78 years (mean 38.7 ± 17.9 years), and Vazquez et al. [30], that studied 189 normal and 44 eyes with keratoconus and their fellow eyes from Argentine patients aged between 14 and 71 years (mean 32.3 ± 8.1 years), as seen in Table 2. It seems that children's corneas become thinner from the periphery to the center the same way and as fast as adult corneas do, a finding that suggests that this parameter could be used to identify pediatric corneas that differ from healthy parameters. More studies are needed to significantly distinguish between normal and abnormal corneas based on these parameters.

<table>
<thead>
<tr>
<th>Current Study</th>
<th>Vázquez et al. - 2014</th>
<th>Ambrósio et al. - 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean ± SD</td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td>Mean ± SD</td>
<td>Mean ± SD</td>
</tr>
<tr>
<td>CCT (µm)</td>
<td>553.81 ± 32</td>
<td>532 ± 33</td>
</tr>
<tr>
<td>TP (µm)</td>
<td>547.95 ± 32.06</td>
<td>528 ± 32</td>
</tr>
<tr>
<td>PPIave</td>
<td>1.00 ± 0.14</td>
<td>0.97 ± 0.14</td>
</tr>
<tr>
<td>ART MAX</td>
<td>446.57 ± 81.20</td>
<td>445 ± 87</td>
</tr>
<tr>
<td>BAD-D</td>
<td>0.78 ± 0.65</td>
<td>1.03 ± 0.7</td>
</tr>
</tbody>
</table>

SD: Standard Deviation; 95% CI: Confidence Interval; SC: Sub Clinical; CCT: Central Corneal Thickness; KC: Kerato Conus; TP: Thinnest Pachymetry; PPIave: Average Pachymetric Progression Index; ARTMax: Maximum Ambrósio Relational Thickness; BAD-D: Overall Belin/Ambrosio Enhanced Ectasia Display score; The Pentacam Scheimpflug corneal topography system (Oculus Optikgerate GmbH, Wetzlar, Germany).

### Table 2: Measurements of 160 children's eyes and cutoff values in the current study and as reported in other studies.

K max (42.95 ± 1.32) and SimK astig (0.92 ± 0.66) values were found to be similar to those found through the use of other topographic systems with older technologies (computerized videokeratoscopy) and newer technologies (slit-scanning and Scheimpflug) among healthy children and adults [29,31]. These values represent a low overall level of corneal astigmatism in the pediatric population of this study. These indices were also found to be similar to those of other studies (Table 3).

<table>
<thead>
<tr>
<th>Method</th>
<th>No. of eyes</th>
<th>SimK max (D)</th>
<th>SimK min (D)</th>
<th>SimK Astig (D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Study</td>
<td>Pentacam</td>
<td>160</td>
<td>43.86</td>
<td>42.95</td>
</tr>
<tr>
<td>Ortiz-Toquero et al.</td>
<td>Galilei G4</td>
<td>56</td>
<td>44.22</td>
<td>43.22</td>
</tr>
<tr>
<td>Ortiz-Toquero et al.</td>
<td>Allegro-Topolyzer</td>
<td>56</td>
<td>44.07</td>
<td>43.12</td>
</tr>
<tr>
<td>Reddy et al.</td>
<td>Orbscan II z</td>
<td>100</td>
<td>44.26</td>
<td>43.56</td>
</tr>
<tr>
<td>Liu et al.</td>
<td>Orbscan</td>
<td>94</td>
<td>44.24</td>
<td>43.31</td>
</tr>
<tr>
<td>Bogan et al.</td>
<td>CMS</td>
<td>216</td>
<td>43.39</td>
<td>0.8</td>
</tr>
<tr>
<td>Rabinowitz et al.</td>
<td>TMS-1</td>
<td>390</td>
<td>43.7</td>
<td></td>
</tr>
</tbody>
</table>

### Table 3: Simulated keratometry (SimK) findings in different studies.

As Table 4 shows, we also compared the parameters between males and females and found the values to be similar. The mean Q value was -0.39 ± 0.12, a finding which suggests that children's corneas are more prolate than those of African-American adults (-0.26 ± 0.19) and of Caucasian adults (-0.20 ± 0.12) in studies that used the Pentacam [32]. Younger corneas seem to be more prolate than those of older patients (7 years -0.3919 ± 0.02438; 11 years -0.3309 ± 0.03195; p=0.1428), but...
Further studies on more subjects are needed to prove this information with statistical significance.

<table>
<thead>
<tr>
<th></th>
<th>Males (n: 69)</th>
<th>Females (n: 91)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean SD</td>
<td>Mean SD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCT</td>
<td>549.1 33.78</td>
<td>557.4 30.3</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>TP</td>
<td>543.7 34.21</td>
<td>551.2 30.12</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>PPlave</td>
<td>0.986 0.1369</td>
<td>1.002 0.1351</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>PE</td>
<td>4.406 3.683</td>
<td>5.604 3.169</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>ABFS</td>
<td>7.406 2.83</td>
<td>7.549 3.572</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>PBFS</td>
<td>6.739 6.416</td>
<td>6.902 5.796</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>PDAT (µm)</td>
<td>5.478 4.661</td>
<td>6.154 5.084</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>ART MAX</td>
<td>445.4 86.61</td>
<td>447.5 77.32</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>BAD-D</td>
<td>0.709 0.6337</td>
<td>0.8358 0.6637</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>SimK</td>
<td>43.13 1.557</td>
<td>43.61 1.303</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Flat SimK</td>
<td>42.68 1.432</td>
<td>43.15 1.197</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Sleep Sim K</td>
<td>43.58 1.556</td>
<td>44.08 1.244</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>SimK Astig</td>
<td>-0.901 0.6993</td>
<td>-0.9282 0.624</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>K max</td>
<td>44.06 1.595</td>
<td>44.66 1.271</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Q Value</td>
<td>-0.381 0.1673</td>
<td>-0.3756 0.1338</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>ACD</td>
<td>3.12 0.2664</td>
<td>3.023 0.2745</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

SD: Standard Deviation; CCT: Central Corneal Thickness; TP: Thinnest Pachymetry; PPlave: Average Pachymetric Progression Index; AE: Anterior Elevation; PE: Posterior Elevation; K: Keratometry; SimK: Simulated Keratometry; ABFS: Anterior Best Fit Sphere; PBFS: Posterior Best Fit Sphere; PDAT: Pachymetric Difference Between the Apex and the Thinnest Point; Kmax: Maximum Keratometry; BAD-D: Overall Belin/Ambrósio Enhanced Ectasia Display score; The Pentacam Scheimpflug corneal topography (Oculus Optikgerate GmbH, Wetzlar, Germany)

Table 4: Comparison of Pentacam parameters between male and female pediatric patients.

This study is the first to report on the corneal parameters of healthy Brazilian children. Some limitations must be noted, however: though the parameters are similar to those found in the general population, the age range of our study was between 7 and 11 years, and it is not known how the corneas of younger and older children behaves and whether these same parameters can be applied to other pediatric age groups. Because the current study is descriptive in nature, its statistical significance cannot be compared to that of other populations (such as adults and patients with keratoconus corneas). Therefore, it is difficult to determine similarities and differences between these findings and others. It is also important to note that, while the tomographic exam requires only two seconds capturing all of the images, the patient to remain immobile and fixate on the target, which could be difficult to achieve among younger patients.

This is the first study in the literature to provide normalized values for keratometry, pachymetry, and relational data from Brazilian children's corneas using the Pentacam Scheimpflug topography system. It can provide a good foundation for the comparison of abnormal pediatric corneal topography to normal cases. This data may prove useful in the field to help distinguish between normal and abnormal corneas, as well as in future comparative studies that consider different corneal diseases in children. Further studies are needed to evaluate the role of tomography in identifying early forms of ectasia in children.

References


