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*Laser Vision Correction
Cornea and External Disease
Cataract and Implant Complications
Specialty Contact Lenses*

21 January 2003

Atty Fredric S. Eisenberg
Litvin, Blumberg, Matusow & Young
Philadelphia, PA

MEDICAL REPORT

Dear Atty Eisenberg:

We appreciate the opportunity to evaluate **Keith Wills**, a 44 year old gentleman who, in 1997, underwent bilateral LASIK surgery utilizing an excimer laser operating with a 5 mm treatment zone for attempted correction of approximately - 11 diopters of myopia. Unfortunately these procedures were complicated by initial overcorrection requiring several enhancement interventions, and Mr. Wills has developed persistent glare, halo and starburst phenomena with multiple "ghost" images. These symptoms are somewhat improved but not alleviated with the use of soft contact lenses. Mr. Wills has attempted the use of rigid gas permeable contact lenses but is unable to obtain adequate fitting.

On examination, uncorrected visual acuity in the right eye is 20/30- and in the left eye 20/30+, albeit with subjectively significant multiple imaging. With manifest refraction OD: +0.50 - 2.25 x 110 gives 20/40 vs. OS: -1.00 - 1.25 x 125 gives 20/40. With gas permeable contact lenses and spectacle over-refraction, 20/30 is obtained with each eye. Keratometry is OD: 36.0 x 150 by 36.0 x 70 and OS: 37.0 x 55 by 36.5 x 135 without distortion. Externally both eyes are uninfamed. Neuromuscular exam reveals pupillary diameters under dim light conditions of 6 mmOU (Colvard pupillometer). By slitlamp the corneas are clear with LASIK flaps in good position. The tear film is stable and without irregularity despite the presence of minor microstriae centrally. There is no significant interface debris and no epithelial implantation. The remainder of the anterior segment is normal. Intraocular pressures are 14 by applanation. Schirmer tear testing is normal. Dilated ophthalmoscopy is unremarkable. Ultrasonic pachymetry is 405 microns OD vs. 430 microns OS. Eye-Sys corneal topography displays reasonably well centered ablations with minor surface irregularities bilaterally. Orbscan topography is confirmatory and does not disclose significant posterior ectasia. Finally, with soft contact lenses inserted, the fit and centration are adequate and cannot be improved in the opinion of our contact lens specialist, Dr. Rand.

In summary, Mr. Wills has undergone bilateral LASIK surgery, and as result thereof suffers the problems of multiple and ghost imaging as could have been anticipated in a patient with extremely high myopic correction and moderately large pupils treated with a relatively small diameter corneal ablation zone. There may also be micro-aberrations of the corneal surface, and this can only be ascertained with wave front scanning with is not available to us at this time. Whether such technology will be able to afford future benefit to the patient by additional enhancement is uncertain, as the corneas are now thinned to the limit of safety. Further efforts with contact lens fitting, specifically with gas permeable or other specialized lenses would be required to provide additional improvement, although Mr. Wills has of course already demonstrated difficulty in tolerating such lenses. Finally, consideration of pupil-constricting medications such as dilute Pilocarpine or Alphagan may diminish the visual distortions, recognizing that their use would be a chronic (ie potentially life-long) situation.

Again, thank you for the opportunity to participate in this patient's evaluation and management.

Sincerely,


Kenneth R. Kenyon, MD

KRK/jg: Doc.Kwills.1.03

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