A retrospective study of nine cases of Acanthamoeba keratitis

Tetsuya Mutoh
Isao Ishikawa
Yukihiro Matsumoto
Makoto Chikuda
Dokkyo Medical University Koshigaya Hospital, Saitama, Japan

Purpose: To evaluate the clinical features of Acanthamoeba keratitis in nine patients diagnosed at Dokkyo Medical University Koshigaya Hospital, Saitama, Japan.

Methods: In nine eyes of nine patients, Acanthamoeba keratitis was diagnosed by direct light microscopy of corneal scrapings stained by the Parker ink-potassium hydroxide method between September 2006 and September 2009. Their clinical features and course were studied retrospectively. Antifungal eye drops, systemic antifungal therapy, and surgical debridement of the corneal lesions were performed in all patients.

Results: At presentation, the clinical stage was initial in six cases, transient in one case, and complete in two cases. The patients were all contact lens wearers who had washed their lens storage cases with tap water. After treatment, final visual acuity was improved in six cases, unchanged in one case, and worse in two cases. The patient with the worst final vision (hand motion) had rheumatoid arthritis and was taking oral prednisolone, which led to corneal perforation and prevented adequate debridement from being done.

Conclusion: Acanthamoeba keratitis is closely related to wearing contact lenses and washing the lens storage case with tap water. Although final visual acuity improved after treatment in most patients, insufficient surgical debridement resulted in a poor visual prognosis.

Keywords: surgical debridement, Acanthamoeba keratitis, contact lens wearers

Introduction

Acanthamoeba is a free-living amoeba that is ubiquitously found in the environment and has been isolated from the soil, air, fresh water, and sea water. The organism exists in two forms, which are the motile trophozoite (15–45 µm long) and the dormant double-walled cyst (10–25 µm in diameter). The trophozoites feed on other microorganisms, such as bacteria and fungi, and thus are more prominent in environments rich in various microorganisms.

Acanthamoeba keratitis was first reported in 1974 and was initially recognized as an extremely rare form of infectious keratitis occurring after ocular trauma. During the 1980s, a dramatic increase in the incidence of Acanthamoeba keratitis was seen in contact lens wearers, and it was then recognized to occur in association with use of contact lenses. In Japan, Acanthamoeba keratitis has tended to show an increase since the first report of this condition in 1988. Although daily disposable contact lenses were believed to be safe, Acanthamoeba keratitis has also occurred in persons wearing such lenses.

Standard treatment for Acanthamoeba keratitis includes topical antiamoebic eye drops, systemic antifungal therapy, and surgical debridement. We have treated this
keratitis according to the method of Ishibashi,6 and have obtained a good visual prognosis in some patients.13,14 However, there was a patient who had been treated with oral prednisolone, in whom adequate debridement could not be performed and the visual prognosis was poor. There was another patient in whom treatment was stopped and keratitis recurred. Final visual acuity was 0.5 in this patient.

We present nine cases of Acanthamoeba keratitis that were managed at the Department of Ophthalmology of Dokkyo Medical University Koshigaya Hospital in Saitama, Japan.

Materials and methods
In nine eyes of nine patients, Acanthamoeba keratitis was diagnosed by direct light microscopy of corneal specimens stained by the Parker ink-potassium hydroxide method6,15 between September 2006 and September 2009. Because a definite diagnosis was made by confirmation of Acanthamoeba in corneal lesions with direct examination or culture,6,15 these patients were studied retrospectively.

The initial clinical stage, type of contact lens and multipurpose solution, method of washing the contact lens storage case, initial visual acuity, final visual acuity, and performance of surgical debridement were analyzed. We followed the criteria of Ishibashi’s classification at the initial clinical stage.6,15 Pseudodendrites of the epithelium, tiny white infiltrates, and radial keratoneuritis were seen in the initial stage. A ring infiltrate is seen in the transient stage. Corneal disciform structures are seen in the completed stage. Decimal visual acuity data were converted into the logarithm of the minimum angle of resolution (log MAR) values, and a change >0.2 log MAR was judged as improvement or worsening of vision. Counting fingers and hand motion were converted into a decimal visual acuity of 0.01 and 0.002, respectively. The method of surgical debridement is only to scrape the corneal lesion with a spatula, taking care not to perforate.

Table 1 shows the treatment of the patients. All nine patients were diagnosed and treated by a single ophthalmologist.

Results
The clinical stage at presentation was initial in six cases, transient in one case, and complete in two cases. Case 1 showed improvement of visual acuity to 1.0 by three weeks after the start of treatment, and no amoebae were found in corneal scrapings after six weeks of treatment. Therefore, her keratitis was judged to be cured and treatment was stopped. However, one month later, the keratitis recurred and progressed to the complete stage. Case 3 was initially diagnosed as having uveitis, and referral to the special corneal clinic of our hospital was delayed. Accordingly, the keratitis had reached the transient stage before treatment was started (Table 2).

All nine patients were contact lens wearers, with the type of lens being frequent replacement contact lens in six cases, planned replacement contact lens in two cases, and daily disposable contact lens in one case. All patients occasionally wore their lenses for longer than recommended (Table 2). The type of multipurpose solution used was identified in five patients but remained unknown in four patients (Table 3). All patients also washed their lens storage cases with tap water. Case 7 sometimes used her daily disposable contact lens for 2–3 days at a time, keeping the lenses in the storage case at night (Table 3).

Initial decimal visual acuity ranged from counting fingers 0.01 to 0.9 or from 0.046 to 2.0 as log MAR values. Final decimal visual acuity ranged from hand motion 0.002 to 1.2, while the log MAR values were from −0.079 to 3.699. When both final visual acuity and initial visual acuity were compared as log MAR values, visual acuity was improved in six cases, was unchanged in one case, and was worse in two cases (Table 4).

Surgical debridement was performed 3–14 times. In Case 7, debridement was inadequate because she had been taking oral prednisolone for rheumatoid arthritis and corneal perforation occurred after six debridement procedures. Subsequently, she wore a contact lens to protect the anterior chamber, and received antifungal eye drops plus systemic

Table 2 Clinical summary of the nine patients: Part 1

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Initial clinical stage</th>
<th>Age</th>
<th>Sex</th>
<th>Lens type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Initial</td>
<td>33</td>
<td>F</td>
<td>PRCL (Monthly Fine)</td>
</tr>
<tr>
<td>2</td>
<td>Initial</td>
<td>16</td>
<td>F</td>
<td>FRCL (2 WEEK ACUVUE)</td>
</tr>
<tr>
<td>3</td>
<td>Initial</td>
<td>41</td>
<td>M</td>
<td>FRCL (Medalist)</td>
</tr>
<tr>
<td>4</td>
<td>Initial</td>
<td>30</td>
<td>F</td>
<td>FRCL (2 WEEK ACUVUE)</td>
</tr>
<tr>
<td>5</td>
<td>Initial</td>
<td>21</td>
<td>M</td>
<td>FRCL (O2OPTICS)</td>
</tr>
<tr>
<td>6</td>
<td>Initial</td>
<td>20</td>
<td>F</td>
<td>FRCL (2 WEEK AQUA1R)</td>
</tr>
<tr>
<td>7</td>
<td>Transient</td>
<td>37</td>
<td>F</td>
<td>DDCL (1-DAY ACUVUE)</td>
</tr>
<tr>
<td>8</td>
<td>Complete</td>
<td>17</td>
<td>F</td>
<td>FRCL (2 WEEK ACUVIE)</td>
</tr>
<tr>
<td>9</td>
<td>Complete</td>
<td>45</td>
<td>M</td>
<td>FRCL (2 WEEK ACUVIE)</td>
</tr>
</tbody>
</table>

Abbreviations: F, female; M, male; PRCL, Planned Replacement Contact Lenses; FRCL, Frequent Replacement Contact Lenses; DDGL, Daily Disposable Contact Lenses.
It is unclear why the initial stage can differ between sides or why most cases are unilateral when there are generally no differences of contact lens storage and wearing between the right and left eyes. Although all patients in the present series were contact lens wearers, about 10% of amoebic keratitis occurs in patients with eye trauma and the diagnosis is often delayed in such cases. The incidence of Acanthamoeba keratitis should be very low in wearers of daily disposable lenses because they are not exposed to the risk of inadequate disinfection and contaminated lens storage cases. However, these lenses are not safe when worn improperly. Many of the patients did not know what type of multipurpose solution they had used. Generally, their consciousness of contact lens care was poor. All of the patients in this series believed that the contact lens storage case was sterile after washing with tap water and soap. However, Acanthamoeba is found in tap water, and does not die even if the lens case is dried. Strictly speaking, washing the face and hands with tap water before wearing contact lens may cause Acanthamoeba keratitis. At least, contact lens wearers should not wash their storage cases with tap water and should exchange old storage cases for new ones.

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Initial visual acuity (logMAR)</th>
<th>Final visual acuity (logMAR)</th>
<th>Change of visual acuity</th>
<th>Surgical debridement (No. of procedures)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.5</td>
<td>0.301</td>
<td>0.301</td>
<td>unchanged 14</td>
</tr>
<tr>
<td>2</td>
<td>0.5</td>
<td>0.301</td>
<td>-0.079</td>
<td>improved 3</td>
</tr>
<tr>
<td>3</td>
<td>0.9</td>
<td>0.046</td>
<td>-0.079</td>
<td>unchanged 13</td>
</tr>
<tr>
<td>4</td>
<td>0.1</td>
<td>1</td>
<td>-0.079</td>
<td>improved 3</td>
</tr>
<tr>
<td>5</td>
<td>0.05</td>
<td>1.301</td>
<td>-0.079</td>
<td>improved 5</td>
</tr>
<tr>
<td>6</td>
<td>0.07</td>
<td>1.155</td>
<td>-0.079</td>
<td>improved 5</td>
</tr>
<tr>
<td>7</td>
<td>0.01</td>
<td>2</td>
<td>3.699</td>
<td>worsened 13</td>
</tr>
<tr>
<td>8</td>
<td>CF</td>
<td>2</td>
<td>0.301</td>
<td>improved 14</td>
</tr>
<tr>
<td>9</td>
<td>0.04</td>
<td>1.399</td>
<td>0.155</td>
<td>improved 3</td>
</tr>
</tbody>
</table>

Abbreviations: CF, counting fingers; HM, hand motion.
slow in patients with diabetes mellitus or those taking oral steroids. If *Acanthamoeba* keratitis occurs in such patients, there is a high risk of corneal perforation with poor final visual acuity, as in case 7. We should have performed surgical debridement more gently in case 7. Kandori et al performed surgical debridement up to five times, in addition to phototherapeutic keratectomy and lamellar keratoplasty for preventing graft recurrence of amoebic infection. However, the results of therapeutic penetrating keratoplasty are poor in patients with *Acanthamoeba* keratitis, and some of them suffer from recurrence of amoebic infection in the graft. More study is needed to establish effectiveness of phototherapeutic keratectomy and lamellar keratoplasty for preventing graft recurrence of amoebic infection.

Topical polyhexamethylene biguanide and propamidine treatment are effective for this amoebic keratitis but topical antifungal drugs are also effective. It is difficult to treat patients with *Acanthamoeba* keratitis, and some of them suffer from recurrence of amoebic infection in the graft. More study is needed to establish effectiveness of phototherapeutic keratectomy and lamellar keratoplasty for preventing graft recurrence of amoebic infection.

Judging from the present nine cases, no contact lens are completely safe, and washing contact lens storage cases in tap water is clearly dangerous. More education is needed for contact lens wearers in order to prevent such infections. Surgical debridement may be a useful adjunct to treatment for *Acanthamoeba* keratitis.

**Disclosure**

The authors report no conflicts of interest in this work.

**References**


