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ABSTRACT
Introduction: The crosslinking (CXL) procedure using the standard Dresden protocol is established as the gold standard for the treatment of progressive keratoconus. Aim: The aim of this paper is to correlate the pachymetry and elevation back map (EBM) changes in the period from 3 to 12 months of keratoconus patients after the CXL procedure. Methods: Forty-four eyes of 34 patients with keratoconus were analyzed after performed standard Dresden protocol CXL procedure. All of them underwent complete preoperative examination with a follow up of 12 months with a focus on pachymetry and EBM changes performed by Oculus Pentacam (Scheimpflug technology) analysis. Results: Pachymetry changed significantly in 12 months post cross-linking, especially in the first 6 months after which it slightly increased. Differences in EBM preoperatively and 12 months postoperatively were not statistically significant. Conclusion: Corneal pachymetry in keratoconus patients decreases after the CXL procedure. Differences in pachymetry preoperatively and 3, 6 and 12 months postoperatively were statistically significant, but the value of corneal thickness increased from the third month to 12 months post-op. Differences in EBM preoperatively and 12 months postoperatively were not still statistically significant, which is good, because the increase in elevation, as one of the signs of progression of the keratoconus - did not occur. Keywords: corneal cross-linking, keratoconus, pachymetry, elevation back map.

1. INTRODUCTION
Keratoconus is a chronic, bilateral, non-inflammatory disorder characterized by progressive steepening, thinning and apical scarring of the cornea (1). It is considered to be a noninflammatory corneal disorder characterized by changes in corneal collagen structure and organization (2). A reduced number of collagen cross-links and pepsin digestion higher than normal induce an overall structural weakness of the corneal tissue, resulting in stiffness that is only 60% that of the normal cornea (3). Decreased mechanical corneal stability plays an important role in the progressive protrusion of the keratoconic cornea, resulting in mild to marked impairment of visual acuity owing to irregular astigmatism, progressive myopia, corneal thinning, and central corneal scarring (1). Corneal topography remains the gold standard to evaluate ectatic diseases (4). Corneal pachymetry - corneal thinning is a key pathologic feature of keratoconus; therefore, a keratoconus diagnosis based on corneal thickness measurement may offer additional information not available on topography. Corneal thickness has been proposed to be a useful parameter for the clinical identification of keratoconus. The posterior surface of the cornea is not optically as important as the anterior surface (5), but it is structurally more fluid and therefore a sensitive indicator of abnormality. This occurs because corneal lamellar disposition and proteoglycan composition allow posterior fibers to buckle inward, while anterior fibers remain under tension and retain their shape. Often, rather than the magnitude of the posterior irregularity, the posterior elevation map is a better indicator of corneal instability whether due to disease, healing or ectasia. Keratoconus management has significantly changed over the last two decades. The advent of new interventions such as cornea cross-linking, intrastromal corneal ring segments, and combined treatments provide corneal clinicians a variety of treatment options for the visual rehabilitation of keratoconus patients (6). Collagen cross-linking (CXL) is the treatment that increas-
es the biomechanical strength of the human cornea by about 300% by the combined action of a photosensitizing substance (riboflavin) and ultraviolet (UV) light from a solid-state UVA source (7). The treatment creates additional chemical bonds inside the anterior 200–300 microns of the corneal stroma using photopolymerization. There is minimal exposure to the surrounding structures of the eye (8). Collagen cross-linking increases the resistance to pepsin digestion by enhancing corneal anti-collagenase activity and induces a thicker collagen fiber diameter (9). Posterior measurements are often the first indicators of future ectatic disease, despite completely normal anterior curvature. Examination of the posterior corneal surface can often reveal pathology that would otherwise be missed if one was relying on anterior analysis alone.

2. AIM

The aim of this paper is to correlate the pachymetry and elevation back map (EBM) changes in the period from 3 to 12 months of keratoconus patients after the CXL procedure.

3. PATIENTS AND METHODS

Forty-four eyes of 34 patients with manifest keratoconus were included in this study. This was a prospective study that enrolled patients treated with CXL at Eye Clinic Svjetlost Sarajevo from January 2017 to January 2018. Twenty-four of them had a procedure performed on one eye, and 10 patients had binocular treatments. Informed consent was obtained from every patient before surgery. Inclusion criteria were: patients diagnosed with keratoconus and progression of the steepest meridian of 1 diopter (D) or more within a year, but not more than 60 D, a subjective decrease of visual acuity (VA), CDVA of 0.8 or less, age frame of 15 to 40 years, and pachymetry of 400 micrometers (µm) or more. Every patient had a complete preoperative ophthalmological examination before deciding if the patient met the criteria for the study. Topography measurements of the keratoconic corneas were taken with a high-resolution imaging system that uses a rotating Scheimpflug camera (Pentacam, Oculus Optikgeräte GmbH, Wetzlar, Germany). Scheimpflug imaging provides the measurement of the entire corneal thickness by determining the front and back surfaces of the cornea. Keratoconic eyes have thinner corneas than normal eyes, with less volume and a more gradual increase in these parameters from the thinnest point toward the periphery (10). Corneal thickness is defined as the thinnest point in the corneal thickness map. The elevation map is defined as the height of the cornea about the “best fit sphere,” or the radius of curvature that best matches the average curvature of the map. Elevation maps measure corneal height in micrometers and have a counterintuitive interpretation (11). The posterior elevation maps were evaluated and posterior corneal elevation values from the corneal apex were analyzed. Elevation based Scheimpflug imaging has advantages over Placido based systems in that it allows measurements of both the anterior and posterior corneal surfaces and the computation of a complete pachymetric map.

4. RESULTS

Pachymetry

Differences in pachymetry preoperatively and 3 months postoperatively were statistically significant, *p*=0.0001. Preop pachy was 451.36±28.25 micrometers (µm), while 3 months postop it decreased to 418.18±35.79 µm. Six months of postop differences in pachy were also statistically significant *p*=0.0001, where pachymetry decreased to 418.86±41.01. After 12 months of follow up, postop differences are still statistically significant, *p*=0.0001, and values were 431.86±36.78. The results are presented in Table 1 and Figure 1.

| Pachymetry | Mean   | Std. Deviation | Std. Error Mean |
|------------|--------|----------------|-----------------|
| Preop      | 451.36 | 28.251         | 6.023           |
| 3 months   | 418.18 | 35.789         | 7.630           |
| Preop      | 451.36 | 28.251         | 6.023           |
| 6 months   | 418.86 | 41.011         | 8.744           |
| Preop      | 451.36 | 28.251         | 6.023           |
| 12 months  | 431.86 | 36.775         | 7.840           |

Table 1. Pachymetry values preoperatively and 3, 6 and 12 months postoperatively.
Figure 1. Error bars of pachymetry preoperatively and 12 months postoperatively after CXL

**Elevation back map (EBM)**

Differences in EBM preoperatively and 3 months postoperatively were statistically significant, p=0.017. Preop EBM was 63.77±20.52, while 3 months postop it decreased to 58.82±21.04. Six months postop differences in EBM were not statistically significant, p=0.582, where EBM increased to 65.09±20.94. After 12 months of follow up postop differences were not still statistically significant, p=0.527, and values were 65.09±19.82. The results are presented in Table 2 and Figure 2.

| Time period (months) | Mean   | Std. Deviation | Mean   |
|----------------------|--------|----------------|--------|
| Preop                | 63.77  | 20.517         | 4.374  |
| 3 months             | 58.82  | 21.039         | 4.485  |
| Preop                | 63.77  | 20.517         | 4.374  |
| 6 months             | 65.09  | 20.937         | 4.464  |
| Preop                | 65.09  | 19.816         | 4.225  |

Table 2. Elevation back map (EBM) preoperatively and 3, 6 and 12 months postoperatively

Figure 2. EBM changes preoperatively and after follow up of 12 months

5. **DISCUSSION**

Studies (12) have reported that the repeatability of pachymetry measurements taken by Pentacam was high. Pachymetry and elevation parameters show high repeatability and reproducibility in several studies where posterior elevation measurements are more accurate in detecting keratoconus (13). Ambrósio et al. introduced the analysis of corneal thickness spatial profiles and demonstrated significant differences in absolute thickness and percentage thickness increase as a function of distance from the thinnest point between normal and KC eyes (14). In our study pachymetry at baseline was 451.36±28.25 micrometers (µm), and at 12 months ut decreased to 431.86±36.78 µm (difference was statistically significant p< 0.0001). Henriques et al. performed CXL for treatment of keratoconus and found that mean pupil center pachymetry measured using Pentacam optical pachymetry at baseline, was 490.68+/−30.69 µm. At 12 months they had decreased to 470.09+/−29.01 µm, a significant difference (p<0.05) (15). Their results are similar to our study. Collagen fiber compression, changes in corneal hydration and edema, keratocyte apoptosis and changes in glycosaminoglycans may play an important role in defining corneal thickness (16). CXL affects central cornea more than periphery; so more decrease in pachymetry compared with periphery induces an increased average progression index. The rotating Scheimpflug device we used measures posterior elevation by fitting the best-possible sphere to the posterior cornea. It is believed that the first sign of ectsasia is an alteration in the posterior corneal shape (17). Sedaghat et al. (18) reported that anterior BFS and elevation did not change significantly after CXL, however, posterior BFS and elevation increased 6 months postoperatively, and remained stable during the 12 months follow-up. An increase in posterior elevation can reduce corneal dioptric power and myopia in patients, which may have a role in improved postoperative visual acuity. Our study showed that differences in elevation back map preoperatively 63.77±20.52 and 12 months postoperatively were not still statistically significant, p=0.527, and values were 65.09±19.82. Our results are similar to Sedaghat’s research. However, Grewal et al. (19) reported that the corneal surface remained stable, and anterior and posterior elevation did not change after CXL. In another study, 80% of the 10 eyes, that had undergone CXL to treat keratoconus, showed a decrease in the anterior and posterior elevation, respectively at the end of the 12 months follow-up (15). The controversy in these results may partially be explained by the difference in the devices used for analyzing corneal elevation.

6. **CONCLUSION**

Corneal pachymetry in keratoconus patients decreases after the CXL procedure. That is one of the reasons why minimal pachymetry before CXL should be at least 400 microns. Differences in pachymetry preoperatively and 3, 6 and 12 months postoperatively were statistically significant, but the value of corneal thickness increased from the third month to 12 months post-op. Our study showed that differences in elevation back map preopera-
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respectively and 12 months postoperatively were not still statistically significant, which is good, because the increase in elevation, as one of the signs of progression of the keratoconus - did not occur.

**Author’s contribution**: All the authors gave substantial contributions to the conception or design of the work in acquisition, analysis, or interpretation of data for the work. All authors had a part in article preparing for drafting or revising it critically for important intellectual content, and gave final approval of the version to be published and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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