(3°) of the toric IOL after its sulcus fixation. Specifically, postoperative corneal astigmatism was 7.36 × 64°, which confirms the presence of a small induction of corneal astigmatism limiting the predictability of the IOL correction. Furthermore, Viestenz et al.² estimated that 3° of toric IOL rotation would lead to residual astigmatism that is 10% of the initial astigmatic power. Also, the separation between the optics of both IOLs may have played a role in the astigmatic undercorrection. On the other hand, adjustments are necessary for accurate calculations of IOL power when IOLS are placed on sulcus,³ and especially when these IOLs are combined with an in-the-bag lens in a piggyback format. We did not know whether these adjustments were considered in the mathematical approaches used by the manufacturer’s software.

Regarding CDVA, it also improved significantly from a prepiggyback implantation value of 0.7 to a postoperative value of 0.9. Postoperative aberrometric analysis revealed a reduced presence of internal coma and spherical aberration, with values compensating partially for the corneal levels of these 2 types of higher order aberrations. This suggests a potential aberrometric reduction with piggyback surgery, contributing to CDVA improvement, as well as to UDVA improvement. In addition, higher levels of ocular trefoil aberration were found in this case postoperatively that have a minor impact on visual outcomes, as expected according to the type of blur induced by this optical aberration.

In conclusion, piggyback toric IOL implantation in sulcus is an option to consider in cases of high and even severe corneal astigmatism in which corneal surgery for cylindrical correction is not possible due to an underlying corneal pathologic condition. More research is needed to improve the accuracy of IOL power calculation in such types of implantation to avoid astigmatic undercorrections.

### References

The eye was injected considerably, and a corneal ulcer with dense stromal infiltrate, measuring 1 × 2 mm, was observed in the inferotemporal cornea. When the patient was blinking, the bonding agent of an eyelash extension was in contact with the cornea at the site of the ulcer. Anterior chamber was deep with trace cells. The remainder of the examination including dilated fundoscopy was normal.

Corneal scrapings were performed and the patient was empirically started on fortified antibiotic eye drops (cefazolin 5% and gentamicin 1%), administered hourly to her left eye, including overnight.

Subsequently, *Hemophilus influenzae* was cultured from the corneal scrapings. The patient continued to improve with appropriate topical treatment, and the keratitis resolved fully (Fig. 2).

Semipermanent eyelash extensions appear to be increasingly popular as part of cosmetic enhancements. During the application process, single artificial lashes are glued to individual eyelashes. The resin used to bond the artificial and natural lash is permanent.

Minor complications associated with eye-lash extensions have been reported in 1 recent Japanese study. The authors believed that the increasing popularity of semipermanent eye lash extensions had led to a rapid increase in their ophthalmological consultation rooms for ocular disorders caused by the lashes themselves or the glue used as bonding agent between the actual lash and its artificial extension lash. That study assessed 170 females aged between 21 and 52 years with no previous ocular history. The most common disorders included keratoconjunctivitis caused by the glue or its removal agents and allergic blepharitis. Other reported problems included conjunctival erosions secondary to eyelid-fixing tapes and subconjunctival haemorrhage. The authors proceeded to assess 3 types of glue used to bond the lash extensions, and found all of them to contain elevated formaldehyde levels, thus concluding that the lash extensions, the bonding agents, and removal thereof can cause ocular disorders. The authors did not report any more serious complications such as keratitis described in the present case.

*Hemophilus influenzae* has been described as a causative organism in contact lens–related inflammatory events and keratitis. A case series assessing the clinical parameters of keratitis caused by *Hemophilus influenzae* identified risk factors including previous surgeries, herpes simplex keratitis, leukoma adherence, and exposure keratitis. Despite good response to appropriate antibiotic therapy, the authors reported variable visual outcomes.

To our knowledge, this is the first reported case of eyelash extensions causing bacterial keratitis. Eyelash extensions (including their bonding resin) should therefore be considered as potential risk factors for bacterial keratitis, and appropriate cultures for organisms allow treatment for less common pathogens.

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