A 38 year old black female presented with a progressive, white, elevated lesion in her left eye. The lesion was removed by superficial keratectomy with amniotic membrane graft, and histopathology demonstrated corneal keloid. There was no recurrence after 1 year of follow up.

**INTRODUCTION**

A keloid is an abnormal proliferation of scar tissue that forms in response to injury or surgery. Keloid formation in the cornea is extremely rare and presents as a well demarcated, elevated, glistening white lesion. Symptoms can include irritation, decreased visual acuity and difficulty in lid closure. Previous history of trauma, inflammation, or infection is likely (1). Histopathology can confirm the diagnosis and reveals hylanized and unorganized collagen, activated stromal fibroblasts, hyperplastic epithelium, and disrupted Bowman’s layer (2). Superficial keratectomy with amniotic membrane graft has been shown to be an effective treatment modality with a low rate or recurrence.

**CASE HISTORY**

Patient Demographics: 38 year old black female

Chief Complaint: Blur, redness, and discomfort of the left eye due to a large, white lesion. The lesion started months prior but symptoms and size have been progressive.

Ocular History: Nasal pterygium excision of the left eye 4 years prior

Review of Systems: Keroid behind the right ear

**PHYSICAL EXAM**

Visual Acuity:
Right Eye: 20/20
Left Eye: 20/40, PH 20/25

Slit Lamp Biomicroscopy:
Right Eye: Unremarkable
Left Eye: Nasal pterygium with 0.5 mm of regrowth, and a 3mm V x 5mm H elevated, opaque, white lesion extending from the corneal epithelium to anterior stroma (Figure 1).

**DIAGNOSIS, TREATMENT & MANAGEMENT**

Superficial keratectomy (SK) with amniotic membrane graft (AMG) were performed. Preservative free artificial tears, ofloxacin QID and 1% pred forte QID were initiated post operatively.

Pathology Results: Collagen and rare fibroblasts consistent with corneal keloid (Figure 2).

1 Week Post Op: Successful removal of keloid was seen (Figure 3). The AMG melted and the BCL instilled in OR was removed. The patient was directed to continue medication regimen.

1 year post op there has been no recurrence and the patient remains on artificial tears.

**REFERENCES**
