A 45 year old lady visited our Sitapur Eye Hospital, sitapur for visual examination complaining of progressive blurred vision in OU 20 years back she had undergone RK surgery.

**METHODOLOGY:**
Her refractive error values before surgery: -6.5 D (OD) 
-8.5 D (OS)

Uncorrected VA: 6/15 (OU)
Auto refraction: +3.75DS/-1.50DC*129 (OD)
+4.00DS/-1.25DC*82 (OS)
BCVA with specs: +3.50DS/-1.50DC*130 (OD) 6/9.5
+3.25DS/-1.50DC*80 (OS) 6/12

Slit lamp examination: clear cornea with 9 radial incisional scars (OU)

Lenses: clear

Optic zone (after RK): 2.4-2.5 mm (OD)
                2.2-2.4 mm (OS)
Fundus Examination: remarkable

IOP: 19mmHg (OU)

Corneal topography( Pentacam): central corneal flattening with power 27.3D

The patient was therefore diagnosed as having hyperopia with astigmatism following RK

Prompted by an intolerance of glasses, the patient asked for treatment using contact lenses.

First trial: RGPCls (Rigid gas permeable contact lens)

**NOTED:** marked decentration & poor fitting due to central corneal flattening

Second trial: conventional PSSCL (which is thick in the centre & can therefore correct hyperopia & low grade astigmatism)

**NOTED:** Inferior decentration with good movement

After insuring the patients living habits the daily disposable PSSCLs would fully fill most of her needs & provides greater comfort. The patient was satisfied with her corrected visual acuity.

**RESULT:**
The final prescription was a Johnson & Johnson daily disposable PSSCL +3.50D

<table>
<thead>
<tr>
<th>In OD</th>
<th>BC=8.5mm</th>
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<tbody>
<tr>
<td>DIA=14.2mm</td>
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<td>VA=6/6</td>
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<table>
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<tr>
<th>In OS</th>
<th>+3.75D</th>
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<tbody>
<tr>
<td>BC= 8.5mm</td>
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<tr>
<td>DIA= 14.2mm (6/6).</td>
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**DISCUSSION:**
Radial Keratotomy (RK) was developed in 1974 by Svyatoslav Fyodorov, a Russian ophthalmologist. It has been largely supplanted by newer operations such as PK, LASIK, Epi-LASIK and the phakic IOL. The patient who have undergone RK may present with hyperopia for many years after the procedure; in such patients presenting with hyperopia LASIK and surface ablation have been effective. Non-surgical corrective methods contact lenses including RGPCls, OD-RGPCls, hybrid lenses & SCL may improve vision. This case report suggest that PSSCLs are ideal for refractive correction of hyperopia with astigmatism following RK because hyperopia

The complications of RK range from the seriously sight-threatening to less severe problems, including corneal perforations, accidental incisions across the visual axis, a decentered clear zone, limbal incisions, visual fluctuations, corneal edema glare and falsely low IOP values. RK may also confer a greater chance of iatrogenic keratoconus.

Case suggests that PSSCLs are ideal for refractive correction of hyperopia with astigmatism following RK, because they have a thick center that may better correct both astigmatism and hyperopia. Furthermore, PSSCLs with a thick center can correct the flat central cornea caused by RK; for this reason, they may possess better centration and stability, as well as confer a more stable tear lens.

PSSCLs are easy to apply and are relatively affordable. After ascertaining the living habits of our patient, we decided that a daily disposable SCL might most meet her needs. Ultimately, we prescribed a daily disposable PSSCL, which has all the advantages of the conventional PSSCL and avoids the need for disposable plus toric SCLs.

Our patient showed acceptable fitting and reached a satisfactory corrected visual acuity. This case study followed the Declaration of Helsinki on medical protocol.

**CONCLUSION:**
Patients diagnosed as having hyperopia with astigmatism following RK may benefit from the PSSCL, as the lens confers better corrected visual acuity and acceptability.

**REFERENCES:**