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A Rare Case Presentation On Mooren\'s Ulcer 1 2 3 ABSTRACT 4 Peripheral ulcerative keratitis has a rare etiology, according to the authors. Moore's ulcer is a persistent, 5 excruciating, and chronic ulcerative peripheral keratitis that starts as a narrow, crescent corneal 6 infiltration near the limbus and spreads both centrally and circumferentially. A non-infectious peripheral 7 ulcerative keratitis or a peripheral bacterial ulcer are mistaken as Mooren's ulcer. 8 9 INTRODUCTION 10 Bowman originally characterized Mooren's ocular ulcer in 1849 [1]. McKenzie defined it as an 11 ulcusrodens or corneal chronic serpiginous ulcer [2]. The authors would like to report a 34-year-old male 12 patient who had no systemic illnesses and had Mooren's ulcer, an uncommon cause of peripheral 13 ulcerative keratitis. Patients usually complained of ocular pain and ulcers at the periphery of the cornea 14 when they first arrived, and they were characterized by an overhanging lip of the margin that exclusively 15 affected the anterior corneal layers in right eye [3].There are no other associated systemic diseases with 16 Mooren's ulcer, which is an idiopathic illness. The corneal stroma is the target of antibodies in this 17 autoimmune condition [4]. Mooren's ulcers are frequently misdiagnosed and treated incorrectly; 18 understanding this can assist distinguish and diagnose from other causes of peripheral ulcerative 19 keratitis, such as infective keratitis, pellucid and Terriens marginal degeneration, etc., and enable 20 appropriate response. 21 CASE REPORT 22 A 34-year-old man complained of pain in right eye for the past two months when he arrived at Maharani 23 Laxmi Bai Medical College, Jhansi, Ophthalmology OPD. 24 Two months ago, the patient seemed to be doing well until he began to complain of pain, a feeling of a 25 foreign body, and photophobia in his right eye, which was accompanied by a clear, watery discharge. The 26 patient subsequently visited a nearby physician, who recommended topical antibiotics and oral 27 painkillers. The symptoms did not go away. After that, the patient kept instilling the same eye drops. 28 After two months, the patient came to our ophthalmology outpatient department (OPD) complaining of 29 excruciating pain in right eye. He provided no history of joint discomfort, vesicles or skin rashes over his 30 face or any other portion of his body, violent trauma, or chemical injuries. There were no systemic 31 illnesses in the patient. 32

The results of the slit lamp examination were as follows: the right eye had a BCVA of 6/24, normal lids, 33 minor circum-corneal congestion, normal iris and sclera, and no anterior chamber reaction. 34

Between four and seven o'clock, the cornea had a peripheral ulcer inferiorly. The ulcer was crescentic in 35 shape and progressed over time. It had an overhanging edge and was severely eroded. Stromal melting 36 was evident. The area between the ulcer and the limbus was not clearly defined. Where the ulcer must 37 have first spread, a thinner, scarred, and vascularized cornea was observed inferiorly (Figs. 1).Along with 38 having a BCVA of 6/18 and normal lids, sclera, iris, and anterior chamber& no other significant finding. 39 Investigations revealed normal hemoglobin, RBC, WBC, and ESR. 40 The patient had negative serology results for Hepatitis C, RA factor (rheumatoid arthritis), ANA (systemic 41 lupus erythematous), and VDRL (suspicious syphilis). The results of the Liver and Renal Function Tests 42 were normal.In order to prevent further infection, our patient underwent conjunctival recession under 43 local anesthesia, two clock hours on either side of the ulcer, and 4 mm posterior to the corneoscleral 44 limbus. Following surgery, prednisolone acetate 1% per hour was administered, and topical antibiotics 45 were started. After a follow-up, the ulcer had healed without progressing, however the corneal scarring 46 had not improved vision. 47 48 49 Fig-1: Right eye on slit lamp with diffuse illumination 50 showing ulcer in inferior margin of cornea 51 52 DISCUSSION 53 Mooren's ulcer is a rare disorder that primarily affects adults without systemic diseases, while it can 54 sometimes occur in children [5, 6]. Young men from Nigeria are most frequently affected [7]. 55 Ulcers have been categorized by Wood and Kaufman [8]. 56 In elderly patients, type I is a benign or normal Mooren's ulcer that is unilateral, has mild to moderate 57 symptoms, and responds well to medication and surgery. 58

In 75% of instances, type II is a bilateral atypical or malignant Mooren's ulcer that presents with 59 considerable pain and other symptoms. It typically affects younger people

and does not respond well to 60 treatment [9]. 61 The following conditions are linked to Mooren's ulcer: helminth, hepatitis C infection, herpes simplex, 62 zoster, syphilis, TB, trauma, foreign bodies, chemical burns, and, following cataract surgery, penetrating 63 keratoplasty and lamellar keratoplasty [10,11]. 64 Although the precise etiology of Moore's ulcer is uncertain, the autoimmune explanation is supported by 65 pathological examination of the affected area, which reveals plasma cells, neutrophils, mast cells, and 66 eosinophils [12]. Using the indirect immunological fluorescence method, Schaap and his associates 67 discovered circulating IgG and IgA antibodies in cells of the cornea and conjunctival epithelium [13]. 68 According to Martin and associates, corneal antigen can change as a result of any infection, trauma, or 69 systemic illness [14]. 70 Patients with Moore's ulcers have pain that is accompanied by redness, wetness, photophobia, and 71 blurred vision from irregular astigmatism, iritis, and corneal opacity. The limbus is where the ulceration 72 first starts, and it then moves toward the cornea's center. Mooren's ulcer is characterized by the 73 overhanging of the ulcer's margins due to involvement of the corneal stroma. It may be linked to 74 cataracts, glaucoma, iritis, and infrequently, ulcer perforations [15]. 75 Complete blood count, erythrocyte sedimentation rate, rheumatoid factor, complement fixation, 76 antinuclear antibodies, anti-neutrophil cytoplasmic antibodies, circulating immune complexes, liver 77 function tests, renal function tests, tests to detect treponemal infection such as VDRL test, urine analysis 78 with microscopy, and chest X-ray are some of the laboratory tests that can be used to diagnose Moore's 79 ulcer. 80 Prednisolone acetate or phosphate is used to initiate topical steroidal therapy. Topical antibiotics and 81 cycloplegics are also administered to prevent subsequent infections [16]. 82 If topical steroids are ineffective after 7–10 days, deep infiltrating ulcers can be treated with systemic 83 steroids, such as prednisolone [17]. Because it stops perforations, therapeutic bandaging contact lenses 84 will be beneficial. 85 Interferon alpha eyedrops are created by diluting injectable recombinant IFN-2 alpha with a balanced 86 salt solution free of preservatives. One million international units per milliliter is its concentration. For 87 the first week, it can be provided on a two-hourly basis. Systemic

immunosuppressive drugs, such as 88 cyclophosphamide, methotrexate, and azathioprine, can also be employed. A medication called 89 cyclosporine has been utilized recently; it helps to lower the number of helper T cells and increases 90 suppressor T cells, which slows the progression of the disease [18]. 91 Topical or subconjunctival anesthetic can also be used for conjunctival recession. Bare sclera excision is 92 the method used for conjunctival excision. To stop the inflammatory process, partial penetrating 93

keratoplasty and superficial lamellar keratectomy may be performed. Tissue adhesives are used to treat 94 perforations. 95 96 CONCLUSION 97 Our patient's ulcer was healed by conjunctival recession using topical corticosteroid and antibiotic eye 98 drops, an ancient method that may not even be effective. To prevent surgery, further research is needed 99 to determine the efficacy and dependability of novel treatments. 100 101 REFERENCES 102 1. Tabbara KF. Mooren's ulcer. Int Ophthalmol Clin. 103 1986 Winter; 26(4):91-8. 104 2. Mckenzie H. Disease of the Eye. 1854.p 631. 105 3. Myron Y, Jay SD. Ophthalmology. 4thedition. China: 106 Elsevier sunders; 2014. 107 4. Brad B. Kanski's clinical ophthalmology a systematic 108 approach. 8th edition. China: Elsevier's; 2016. 109 5. Nettleship, E. Chronic Serpiginous Ulcer of the 110 Cornea (Mooren's Ulcer).TransOphthal Soc UK.1902; 111 22: 103-115. 112 6. Hogan, M.J, Zimmerman, L.E. Ophthal- mic 113 Pathology, edition 2, Philadelphia: W. B. Saunders Co; 114 1962. 115 7. Majekodunmi AA. Ecology of Mooren's ulcer in 116 Nigeria. Doc Ophthalmol. 1980 Oct 15;49(2):211-9. 117 8. Wood TO, Kaufman HE. Mooren's ulcer. Am J 118 Ophthalmol. 1971 Jan;71(1 Pt 2):417-22. 119 9. Lewallen S, Courtright P. Problems with current 120

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