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1 We thank Drs. Saad and Gatinel for their interesting observation. We agree that a  
2 quantitative definition might have been useful for both suspect keratoconus and forme  
3 fruste keratoconus (FFKC). Unfortunately these definitions, such as those by  
4 Rabinowitz or Maeda and Klyce,<sup>1,2</sup> rely only on front corneal topography indexes, i.e.  
5 on abnormalities of the anterior corneal curvature and shape. On the contrary, we also  
6 included cases with suspect abnormalities of the posterior corneal surface and the  
7 pachymetric map. At this moment, there are no standardized and scientifically  
8 accepted indexes for these parameters, and as a consequence we had to select eyes  
9 with subclinical keratoconus on the basis of a topographic and tomographic  
10 qualitative examination.

11 As regards FFKC, we agree that our inclusion criteria were different with respect to  
12 those selected by Saad et al in their previous study,<sup>3</sup> as we enrolled patients with mild  
13 topographic changes, while their group of FFKC did not present topographic  
14 changes. We based our selection on the definition of FFKC provided by Klyce,<sup>4</sup> who  
15 stated that FFKC can be defined (in case of unilateral keratoconus) as the “fellow eye  
16 that has no clinical findings of any sort except for certain topographical changes”. In  
17 our sample these topographical changes could be observed on the anterior and/or  
18 posterior corneal surface: further studies are needed to evaluate the sensitivity and  
19 specificity of our approach when examining FFKC eyes with no topographic changes.

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22 algorithm embodying minimal topographic criteria for diagnosing keratoconus. J  
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25 screening with corneal topography analysis. Invest Ophthalmol Vis Sci  
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- 29 4 -Klyce SD. Chasing the suspect: keratoconus. Br J Ophthalmol 2009;93:845-847.
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