A healthy 27-year-old woman with a corneal ulcer underwent fibrin gluing with a bandage contact lens twice, due to an impending perforation. The ulcer lesion slowly progressed, unresponsive to topical antibiotics and amphotericin B. We removed the gluing patch and performed a corneal or scraping or biopsy with multiple amniotic membrane grafts to seal the thinned or perforated cornea. Three days after the surgery, the corneal cultures grew *Fusarium*, as well as *Enterococcus faecalis*. Three weeks after surgery, the outermost layer of amniotic membranes, serving as a temporary patch, was removed. The anterior chamber was clear without cells. The signs of infection clinically and symptomatically cleared up four weeks later. Two months after surgery, the lesion became enhanced by amniotic membranes. The use of fibrin glue in infectious keratitis should be avoided, because it not only masks the underlying lesion, but it also interferes with drug penetration into the underlying lesion.

Key Words: Corneal perforation, Corneal ulcer, Fibrin glue, Tissue adhesives, Tissue glue
was observed at the margin of the lesion, even when obscured by overlying fibrin glue. Topical amphotericin B (0.15%) was applied every hour. Corneal scraping was not performed and disease progression was observed for two days, because the lesion margin was overlaid with the gluing patch and the risk of perforation was high when the gluing patch was handled. The ulcer lesion slowly progressed and the symptoms, including ocular pain, conjunctival injection was aggravated. We decided to remove the gluing patch and perform a corneal scraping and biopsy with a multiple amniotic membrane graft to seal the thinned or perforated cornea. When the overlying fibrin glue was carefully removed, a masked lesion was revealed. Necrotic, infiltrated debris had expanded, surrounding the lesion, and an iridocorneal adhesion under the ulcerative lesion was observed (Fig. 1B). Micro-leaking was found at the center of the thinned ulcer base. Corneal scraping for microbiologic evaluation was carefully done at the ulcerative base and margin and necrotic tissue was also debrided to improve drug penetration. The adhesiolysis was done between the iris and cornea. A three-layered amniotic membrane was patched over the ulcerative lesion and the outermost layer covered the lesion over 3 mm from the margin of the lesion, including the half cornea and limbus. Finally, intracameral cefuroxime (1 mg/0.1 mL) and amphotericin B (0.5 μg/0.1 mL) were injected. On the second day after the surgery, the size of the ulcer had decreased and the conjunctival injection, lid swelling, ocular pain gradually improved. Three days after the surgery, the corneal cultures grew Fusarium, as well as Enterococcus faecalis. Fortunately, Enterococcus faecalis is susceptible to levofloxacin and cephalosporin. Topical amphotericin B (0.15%) and gatifloxacin were still continuously administered hourly and the patient was also started on oral itraconazole. Topical cycloplegics and an-