Keratoconus is a non-inflammatory thinning disorder in which the cornea assumes a conical shape.\textsuperscript{1,2} Earliest references to the disorder are attributed to the French Dudell in 1729, when he described a patient with protruding conical corneas and associated poor vision. The German anatomist and surgeon, Burchard Mauchart, provided a slightly more detailed account of the condition in 1748.\textsuperscript{3} Mauchart presented an early description of a case of likely keratoconus, which he called staphyloma diaphanum.

The disorder was described in much greater detail by a British physician John Nottingham in 1854 in his book *Practical Observations on Conical Cornea: And On the Short Sight, and Other Defects of Vision Connected With It*.\textsuperscript{4} Nottingham provided a meticulous account of the clinical signs of a conical cornea with thinning, protrusion, and weakness. This was the first time that the condition (later termed keratoconus) was described as a single entity unique from other ectatic diseases with similar findings. In 1859, Sir William Bowman, an English surgeon, expanded on the condition when he described the use of the retinoscope and the retinoscopic reflex to further classify keratoconus.\textsuperscript{5} Bowman’s work described the technique of pulling the iris into a slit configuration (stenopeic slit) to improve vision in patients with keratoconus.

The disorder received its current name “keratoconus” when Johann Horner wrote a thesis entitled “Treatment of Keratoconus.”\textsuperscript{6} The accepted management of keratoconus at that time was one ascribed to a fellow German ophthalmologist, Albrecht von Graefe. This treatment technique used silver nitrate to scar the cornea, changing the shape to reduce corneal steepening and thereby improve vision. A miotic agent and pressure patching was also employed to hasten healing, further flatten the cornea, and sharpen images.

In 1888, a less invasive approach to treatment was introduced by Eugene Kalt, a French physician.\textsuperscript{7} Kalt fabricated a glass scleral shell to be used as a contact lens in patients with keratoconus. This early contact lens improved vision by flattening the cornea and reducing astigmatism. These lenses were a vast improvement over glasses and the stenopeic slit, which only marginally improved vision in advanced disease.

Early gross descriptions of keratoconus were limited in their ability to effectively classify the condition. Keratoconus was initially broadly defined based on the shape and location of the cone. These included round, or nipple cones, with a central conical protrusion, and oval cones, often with inferior sagging and projection. Amsler’s studies in the early 20th century contributed greatly to the clinical detection of the disease. Amsler used a Placido’s disk to classify early keratoconus into keratoconus fruste and mild keratoconus (Figure 3-1).\textsuperscript{2,8} These classifications were based on the deviation of horizontal axis symmetry from the normal. A 1- to 4-degree deviation was labeled keratoconus fruste and a 4- to 8-degree deviation was early or mild keratoconus. In 1980, Perry further classified advanced cones using histopathological evaluation. He noted that nipple-shaped cones are typically limited in diameter and have a center mostly in the lower nasal quadrant, while oval or sagging cones are larger and more commonly in the inferotemporal quadrant close to the periphery.\textsuperscript{9} Perry found that the oval cone is usually associated with a higher incidence of corneal hydrops, with increased scarring and greater difficulty in fitting contact lenses.