Experimental posterior penetrating eye injury in the rabbit. I. Method of production and natural history

PHILIP E. CLEARY AND STEPHEN J. RYAN

From the Department of Ophthalmology, University of Southern California, and Estelle Doheny Eye Foundation, Los Angeles, California, USA

SUMMARY A technique has been developed which produces an experimental posterior penetrating eye injury that reproducibly results in traction retinal detachment in rabbit eyes. The standard injury is an incision through the pars plana with vitreous prolapse and incarceration; the wound is then carefully closed with microsurgical techniques. It appears that blood in the vitreous is an essential factor in the development of vitreous traction and of traction retinal detachment. The model, which has been successfully transferred to Rhesus monkey eyes, is considered useful for further histological, electromicroscopical, electrophysiological, and ultrasound studies of posterior penetrating injuries of the eye. Our immediate goal is to assess in a controlled experiment whether pars plana vitrectomy can interrupt the sequence of events leading to traction retinal detachment after a posterior penetrating injury.

Although the prognosis for penetrating eye injuries has greatly improved, this is largely reflected in injuries which involve only the anterior segment (Moncrieff and Scherible, 1945; Snell, 1945; Roper-Hall, 1959; Remky et al., 1967; Watz and Reim, 1973; Eagling, 1975). Unfortunately there has been little change in the prognosis for injuries to the posterior segment in the past 15 years (Johnson, 1971; Eagling, 1975), and severe injuries involving both the anterior and the posterior segments still result in a blind or excised eye in most cases (Johnson, 1971; Cinotti and Maltzman, 1975; Eagling, 1975). Many of these eyes suffer an exfoliative choroidal haemorrhage, with disruption of the intraocular contents and prolapse of the retina, so that there is no potential for visual recovery (Eagling, 1975). However, not all eyes losing useful vision are damaged beyond potential repair; for injuries confined to the posterior segment traction retinal detachment is the main reason for loss of vision (Johnson, 1971; Eagling, 1975; Faulborn et al., 1977). Clinical and histopathological observations suggest that fibrovascular ingrowth from the scleral wound, vitreous haemorrhage, injury to the lens, and injury to the ciliary body may all contribute to a fibroplastic response within the vitreous, which often progresses to the formation of a cicatricial membrane, in which detached retina may be incorporated (Hogan and Zimmerman, 1964; Coles and Haik, 1972; Eagling, 1975).

It has been postulated that the importance of the vitreous is that it provides a framework or scaffold for fibrosis from other sources. Removal of this scaffold is a rationale for vitrectomy in the treatment of complicated penetrating injuries which involve the posterior segment (Coles and Haik, 1972). Furthermore, after a posterior penetrating injury the blood is typically loculated within the vitreous (Winthrop et al., 1978), and removal of this blood by vitrectomy may reduce the stimulus to inflammation and organisation.

The introduction of pars plana vitrectomy has offered a new approach to the treatment of complicated posterior penetrating injuries (Machemer and Norton, 1972; Michels and Ryan, 1975; Peyman et al., 1975; Benson and Machemer, 1976; Hutton et al., 1976; Faulborn et al., 1977; Conway and Michels, 1978). Yet despite the encouraging preliminary results the indications and optimum timing for vitrectomy remain a matter of controversy. Attempts to address the issues by establishing a

Address for reprints: Mr Philip E. Cleary, FRCS, Ardkeen Hospital, Waterford, Ireland
randomised controlled clinical trial have been unsuccessful so far (Hutton et al., 1976; Faulborn et al., 1977; Ryan and Allen, personal communication). And certainly the incongruity of penetrating eye injuries with many variables in each individual injury will demand a very large number of patients within a trial to provide a statistically significant result.

Since variables are subject to more precise control in a laboratory environment than in a random patient population, we undertook a study to develop in an experimental animal a model of a posterior penetrating eye injury. Our objective was an injury with the least number of variables, which reproducibly resulted in traction (specifically, non-rhegmatogenous) retinal detachment. The present report describes the method of production and natural history of an experimental posterior penetrating injury in the rabbit eye.

**Materials and methods**

Pigmented rabbits of either sex, weighing 4 to 5 lb (1.8 to 2.3 kg), were anesthetised by intravenous injection of pentobarbitone; analgesia was obtained by a retrobulbar injection of 0.5 ml saline solution containing 5 mg of lignocaine. The pupils were dilated with 1 drop of cyclopentolate 1% and 1 drop of phenylephrine 10%. The eye was gently prolapsed and secured by a lid suture. Surgery was carried out under sterile conditions and with the magnification of a Zeiss OPMI 6 operating microscope.

The standard wound was a stab incision with a Graefe knife through the pars plana to the centre of the vitreous cavity. This incision was lengthened to 8 mm with scissors, with avoidance of the lens and the peripheral retina. Gel vitreous prolapsed spontaneously through the wound, with rupture of the vitreous face, in a manner similar to that encountered in the perforated human eye. The prolapsed vitreous was abscissed and the wound carefully closed with interrupted sutures of 8–0 silk, with particular attention to good wound apposition. After wound closure the fundus was inspected by indirect ophthalmoscopy and the area of the wound and peripheral retina examined by scleral indentation. Eyes were excluded when the peripheral retina in the area of the wound could not be clearly seen. In some eyes 0.4 ml of autologous blood, drawn immediately beforehand, was injected through a 25-gauge needle inserted through the wound into the midvitreous under ophthalmoscopic control. In others, 0.4 ml of balanced salt solution was injected. The blood or balanced salt solution was injected slowly under low pressure; 0.4 ml could be easily injected without reflux through the wound.

The animals were observed at weekly intervals after surgery. Fundus photographs, descriptions, and drawings of the fundi were made. For histological study eyes were enucleated at varying intervals (Table 1).

**Results**

During the first week the anterior chamber and vitreous were hazy, but during the second week the media slowly cleared in the eyes without the blood in the vitreous.

**Standard incision and blood injection**

Fifty-four eyes had a standard incision through the pars plana and injection of 0.4 ml of autologous blood into the midvitreous under ophthalmoscopic control. Some eyes were enucleated for histology at 3-day intervals after injury, and others were examined clinically at weekly intervals for up to 3 months (Table 1). At up to 9 days after injury the retina was attached in all 9 eyes examined histologically; at 12 days the retina was detached in 2 out of 4 eyes, and at 15 days the retina was detached in 6 out of 7 eyes that were enucleated (Table 1).
resulting in elevation of the area of the medullary rays (Fig. 1), and the late appearance was of total retinal detachment with the entire retina drawn up into the area of the wound (Fig. 4). The peripheral retina showed a characteristic appearance of being dragged forward towards the wound. This characteristic rolling forward of the peripheral retina on to the pars plana might involve its entire circumference (Fig. 2).

**STANDARD INCISION AND INJECTION OF BALANCED SALT SOLUTION**

Fifteen eyes had a standard incision through the pars plana and injection of 0.4 ml of balanced salt solution. These eyes were documented clinically for 3 months after injury (Table 1). Vitreous strands or membranes were not identified by ophthalmoscopy in these eyes, nor was fibrous proliferation from the area of the wound into the vitreous. One eye had a spontaneous vitreous haemorrhage at the time of the incision, and 4 weeks later, when the vitreous haemorrhage had cleared, a traction retinal detachment was observed. In the other 14 eyes the retinas remained attached.

**STANDARD INCISION WITH INJURY TO THE RETINA**

Fourteen eyes suffered unintentional retinal damage at the time of injury, either by disinsertion of the peripheral retina adjacent to the wound or by direct laceration of the retina. During the incision through the pars plana 10 of these eyes suffered a spontaneous choroidal and subretinal haemorrhage, and the blood ruptured through the peripheral retina so that torn retina was prolapsed into the wound. In the other 4 eyes the standard incision was too far posterior and involved the peripheral retina. Retinal

The remaining 34 eyes were enucleated at varying intervals between 18 days and 3 months after injury, and the retina was detached in all but 6 (Table 1).

The fundus appearance was obscured by blood in the vitreous for at least 6 weeks after injury. As the blood cleared, vitreous strands and membranes were observed extending across the anterior vitreous and anteroposteriorly to the retina (Fig. 1). From the wound, scar tissue extended into the vitreous—often on the surface of the adjacent detached retina (Figs. 3 and 4). The clinical findings were confirmed by gross examination of the enucleated eyes with the dissecting microscope. It was possible to identify changes in the vitreous with strands of vitreous extending from the wound to the posterior retina (Fig. 1), and strands extending from the wound to the peripheral retina in the area of the vitreous base (Fig. 2). The configuration of the retinal detachment suggested the presence of vitreoretinal traction; the earliest appearance was of traction from the wound to the posterior retina,
Experimental posterior penetrating eye injury in the rabbit

detachment was total in 10 eyes and incomplete in 4. Typically, at 3 to 4 weeks after injury these eyes showed the appearance of fixed retinal folds, starfolds, pigment granules on the surface of the retina, and funnel-type retinal detachments. In 4 eyes large posterior retinal tears occurred and in 3 eyes smaller oval tears. These retinal tears were not identified at the time of injury.

Discussion

For penetrating injuries which are confined to the posterior segment traction retinal detachment is the main reason for loss of vision (Eagling, 1975; Hutton et al., 1976; Benson and Machemer, 1976; Faulborn et al., 1977). The experimental injury in the rabbit eye incorporates few variables and results in traction retinal detachment which is highly reproducible. Progressive detachment of the retina has been produced previously in experimental animals but usually as a result of retinal hole formation (Foulds, 1963; Machemer and Norton, 1968). By contrast, our specific aim was to produce traction retinal detachment and to avoid direct damage to the retina, thus excluding rhegmatogenous retinal detachment as another variable.

Injection of blood into the rabbit vitreous by a needle puncture alone may result in retinal detachment due to a posterior retinal tear (Freilich et al., 1966) or related to the growth of scar tissue into the vitreous along the needle track and subsequent traction on the retina (Constable, 1975; Swan, 1977). In preliminary experiments we investigated the effects of a single injection of autologous blood into the rabbit vitreous by a needle puncture, but we were unable to produce traction retinal detachment with the reproducibility that we desired (Cleary and Ryan, 1978). Furthermore, since some vitreous loss is a frequent accompaniment of penetrating trauma, it was felt desirable to include this as a component of the experimental model.

In the rabbit eye, after injury and intravitreal blood injection, retinal detachment occurred typically at between 12 and 15 days. During the development of retinal detachment the configuration of the peripheral and posterior retina, as well as the orientation of vitreous strands, suggested the presence of vitreous traction. The characteristic rolling forward of the peripheral retina, which might involve its entire circumference (Fig. 1),
might be related to vitreoretinal adhesion in the area of the vitreous base. Similarly, the early detachment of the posterior retina could be attributed to anterior-posterior vitreous traction related to the vitreoretinal adhesion in the area of the medullary rays in the posterior fundus of the rabbit.

We have observed a similar appearance of traction on the peripheral retina in the region of the vitreous base not only in rabbit eyes but also in monkey eyes and in human eyes enucleated after penetrating injuries (Cleary and Ryan, 1978; Winthrop et al., 1978). Clinically we have also observed in patients after a posterior penetrating injury that this characteristic dragging forward of the peripheral retina on to the pars plana may precipitate and be the only cause of total retinal detachment. In the human eye, however, unlike the rabbit’s, the cortical vitreous is not so adherent to the posterior retina (Foos, 1975), and typically, after a posterior penetrating injury, the vitreous becomes detached posteriorly without subsequent direct traction on the posterior retina. The exception is a double perforating injury with incarceration of vitreous in both the anterior and posterior wound, when antero-posterior vitreous traction may be observed.

In this study, although our aim was to avoid direct damage to the retina, in some eyes the peripheral retina was involved in the standard incision, while in others a profuse choroidal and subtretinal haemorrhage occurred at the time of injury, and blood ruptured through the peripheral retina, disinserting it. This explosive type of haemorrhage in the rabbit eye has its counterpart in the most severe penetrating injuries in human eyes (Eagling, 1975; Barry, 1975).

In eyes with clear media, and retinal tears and funnel-shaped retinal detachments, we observed the appearance of fixed retinal folds and starfolds with pigment on the surface of the retina. The clinical appearance resembled massive periretinal proliferation (Machemer and Lagua, 1975). The histopathological features will be reported in detail in a separate communication.

The experimental evidence in this study supports clinical observations on the importance of blood in the vitreous in the development of vitreous traction and, ultimately, traction retinal detachment after a posterior penetrating eye injury (Johnson, 1971; Percival, 1972; Eagling, 1975; Faulborn et al., 1977). We have successfully transferred this method of experimental posterior penetrating injury to rhesus monkey eyes and have shown that traction retinal detachment is also highly reproducible in the primate eye. We believe that this experimental model can provide much information of clinical relevance and the opportunity to examine mechanisms which underlie the development of traction retinal detachment. The many variables which complicate penetrating injuries may be isolated and investigated, such as the effects of vitreous loss, the role of blood and its different components in the vitreous, the effects of lens injury, and the admixture of lens material and vitreous. It will be of value to have precise histopathological correlation of ultrasound and bright-flash electroretinographic findings.

Finally, we shall investigate in a controlled experiment the role and optimum timing for vitrectomy in the treatment of a posterior penetrating injury.

We thank Ms Kate Borkowski for technical assistance and Mr Zoltan Yuhasz for the illustrations.

References


Experimental posterior penetrating eye injury in the rabbit

Experimental posterior penetrating eye injury in the rabbit. I. Method of production and natural history.
P E Cleary and S J Ryan

doi: 10.1136/bjo.63.5.306

Updated information and services can be found at:
http://bjo.bmj.com/content/63/5/306

These include:

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/