X linked retinoschisis

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Background
Haas first described what is now acknowledged as being X linked retinoschisis (XLRS) nearly a century ago in a paper entitled 'Ueber das Zusammenvorkommen von Veränderungen der Retina und Choroidea'. Accompanying his description of the disease in two males was a beautiful drawing of the typical radiating cystic maculopathy. The fact that subsequent authors failed to observe these macular changes and instead described the peripheral retinal features of the disease is testimony perhaps to his shrewd powers of observation. Although Haas believed the retinal and choroidal changes were inflammatory in origin, Pagenstecher published a pedigree some 15 years later which showed an X linked pattern of inheritance. The variable clinical manifestations of the disease are exemplified by the wide variety of names that have been ascribed to XLRS in the past. 'Anterior retinal dialysis', 'neuroretinal disease in males', 'congenital cystic detachment of the retina', and 'congenital vascular veins' were variously used to describe the condition before Jager coined the term X linked retinoschisis. There are no other systemic associations and experience does not support Jager's assertion that all affected patients were 'from their early youth very difficult and extremely irritable persons'.

Clinical features
XLRS has been described worldwide in white, black, and Asian people. Although considered a rare condition it is much underdiagnosed and is among the commonest causes of juvenile macular degeneration. The largest series of patients has been described in Finland where XLRS had a carrier prevalence of 14 per 10 000 population and it was considered to be the commonest X linked condition in that country before the increased recognition of fragile X syndrome. XLRS is fully penetrant and although retinal signs have been described in infants as young as 3 months of age, affected males usually present at school age when reading difficulties are detected. Less commonly the disorder may present in early infancy with squint, nystagmus, and bilateral highly elevated bullous retinoschisis often with haemorrhage within the schisis cavity or into the vitreous. The bullous peripheral retinoschisis may subsequently undergo spontaneous reattachment leaving pigment demarcation lines and a visual prognosis that is often better than the initial appearance would suggest.

Foveal schisis (Figs 1A and B) is characteristic of XLRS occurring in 98–100% of patients, according to Deutman. Although macular changes are present in all affected patients others have found the typical foveal schisis to be present in only about 70% of patients. Foveal schisis is most common in younger patients but pigment demarcation lines and macular colobomas are also seen. In older patients the typical radiating striae regress leaving a somewhat blunted foveal reflex. This probably accounts for the normal maculae reported in some affected patients who nevertheless had reduced visual acuity. In patients over 50 years of age macular pigmentary changes and retinal pigment epithelial (RPE) atrophy are common (Fig 2). Some authors have described the coalescence of foveal microcysts to form macrocysts owing to the breakdown of intraretinal septae and have correlated this with progressive failure in vision.

Figure 1 (A and B) An 18-year-old male with X linked retinoschisis showing the typical foveal schisis. The superficial radiating striae are best appreciated when examined under red-free conditions.
Peripheral retinoschisis is present in around 50% of patients. The splitting occurs in the superficial layers of the retina and as such retinal vessels may lie in either the outer or inner leaf or cross from one to the other through the schisis cavity. The inner leaf of the schisis tends to fragment with time leaving large inner leaf breaks (Fig 3) and membranous remnants on the posterior hyaloid face, so called vitreous veils and coursing through with time membranous remnants with retinoschisis.30

Refractive flecks.35 The inner leaf of Schisis, senile or outer retinoschisis, at the posterior hyaloid face.34 Dendritiform foveals from Goldmann-Favre syndrome has been reported.33 Other unusual manifestations of the disease include dragging of the retinal vessels, subretinal exudates, and retinal flecks. Refractive errors are common, usually hypermetropia and strabismus is present in up to 29% of patients.10 22

Vitreous haemorrhage and retinal detachment are the most serious complications of XLRS. About 20% of patients develop retinal detachment, although Deutman reported it in none of his patients.10 Fluid may gain access to the subretinal space either through outer leaf breaks in areas of peripheral retinoschisis with inner leaf holes or through full thickness retinal tears following vitreous detachment. Vitreous haemorrhage occurs in up to 40% and usually results from rupture of unsupported retinal vessels or rarely from neovascularisation. Neovascular glaucoma has occasionally been reported following vitreous haemorrhage or retinal detachment in XLRS.

Differential diagnosis
Foveal schisis is not confined to XLRS. It is also a feature of Goldmann-Favre syndrome but the pattern is much coarser than in XLRS.12 The autosomal recessive inheritance, severe nystagmus, pigmentary retinopathy, and reduced a- and b-waves on the electroretinogram (ERG) help to differentiate this condition.43 Rarely foveal schisis may be a feature of rod-cone dystrophy or be inherited as an autosomal dominant or recessive condition. In determining the mode of inheritance it is important to exclude consanguinity which has been the explanation for apparent male to male transmission and females manifesting the disease in XLRS families. Females with Turner's syndrome (XO) may also manifest the disease.
intraretinal filaments are produced by defective Müller cells and that their extracellular accumulation leads to degeneration of these cells and subsequent schisis formation. An accumulation of this material could perhaps account for the tense bulous retinoschisis cavities seen in infancy, which may subsequently discharge into the vitreous cavity through inner leaf breaks and result in flattening of the schisis.

Electrophysiology and psychophysiology
A characteristic reduction in the b-wave amplitude of the ERG is seen in all patients with XLRS. The full field ERG abnormalities seen even in patients with schisis confined to the fovea, indicate widespread retinal dysfunction. Although the a-wave is normal in the early stages of the disease indicating that the photoreceptors are not primarily involved, older affected patients may show a reduction in the a-wave and electro-oculogram (EOG) reflecting secondary involvement of photoreceptors and RPE. Other conditions, such as congenital stationary nightblindness, Duchenne muscular dystrophy, and some cone dystrophies exhibit a reduced b-wave but these conditions may be distinguished from XLRS by their clinical features and psychophysical tests.

Studies using intraretinal microelectrodes in the mud-puppy have demonstrated that the Müller cell has a similar intensity-response curve to the b-wave of the ERG. Other components of the ERG that are known to arise from inner or middle retina are affected in XLRS: both the cone and rod oscillatory potentials (OPs) and the scotopic threshold response (STR) — a small electronegative response that is produced at stimuli so dim that the scotopic b-wave is not evident — are absent. There is wide disparity between the reduction in electrophysiological and psychophysical responses: while the STR and b-wave may be profoundly reduced, absolute thresholds and dark adaptation curves are normal or only minimally elevated.

The psychophysical determination of rod-cone interaction has been of interest in identifying the site of the abnormality in XLRS. In normal individuals, the ability of cones to perceive flicker deteriorates as rods dark adapt. Conversely, when dark adapted rods are exposed to dim light this function improves. This normal suppressive rod-cone interaction is thought to be mediated by postsynaptic feedback onto cones via horizontal cells and may be absent in some affected males and obligate carriers of XLRS. However, variable results have been reported in affected males and the test seems to be dependent on the method used to demonstrate the rod-cone interaction.

Pathophysiology
The underlying biological abnormality in XLRS is unknown. A primary defect within the Müller cell would concur with observations of histopathology and electrophysiology. The Müller cell, the principal glial cell of the retina, spans the full depth of the retina and is in intimate contact with photoreceptors and cells of the middle retinal layers. Its basement membrane forms part of the ILM. A defect in this cell may therefore be expected to affect neural processing in the middle and inner retinal layers as well as produce structural defects in the ILM and NFL. The Müller cell has been shown to be central to the migration and organisation of other retinal cells during development, possibly via a Müller cell derived diffusable factor. A gene defect in the Müller cell could therefore account for the whole host of structural and physiological abnormalities found in XLRS. Further evidence for a
Müller cell defect has been presented by de Jong et al; they demonstrated the Mizuo phenomenon in five patients who had XLRS and a tapetal reflex. A similar change in retinal colour had been shown on leakage of potassium ions from a microelectrode in the cat and monkey retina. In the normal situation light exposure results in hyperpolarisation of the photoreceptors and an increase in extracellular potassium ions, whereas in the dark adapted state the photoreceptors depolarise and the extracellular potassium ion concentration is lower. The Müller cell transports the potassium ions from the outer retina into the vitreous cavity via its endfoot processes. In XLRS the inability of defective Müller cells to mop up the increased extracellular potassium ions on exposure to light could account for the tapetal reflex and Mizuo phenomenon observed in this disease.

Other theories of pathophysiology have been proposed. Ewing et al postulated a vascular theory to the development of XLRS, based upon choroidal filling defects and slowing of the retinal circulation demonstrated by fluorescein angiography in some patients. They proposed that the retinoschisis resulted from delayed development of the retinal and choroidal vasculature in which the retina outgrows its blood supply inferotemporally. The demonstration of capillary dropout in schitic as well as non-schitic areas of the retina has also supported this theory, but it would not explain the presence of foveal schisis. Scheeps believed that the vitreous plays an important role on the basis that peripheral retinoschisis tended to flatten following vitreous detachment. It was thought that vitreous traction could cause splitting of the retina by inadequate growth or by shrinkage of an abnormally adherent vitreous gel.

**Carrier state**

In other X linked ocular diseases such as X linked ocular albinism, X linked retinitis pigmentosa, and choroideremia, female heterozygotes may express some features of the disease. This is due to the random inactivation of one X chromosome in every cell (lyonisation) so that the normal copy or the disease gene is inactivated in approximately half of all cells. Although some female carriers of XLRS have been reported to show signs of the disease, close scrutiny of these reports shows that many of the features reported such as macular degeneration, lattice, and senile retinoschisis are normal findings within the general population. Most large series have reported that there are no pathognomonic features of the carrier state and the ERG, OPs, and STR are all normal in obligate carriers. It is unclear why female heterozygotes do not express any clinical abnormalities, but it may be related to the subtlety of the retinal changes in affected males. In fact, Arden et al demonstrated that some female carriers do show a lack of normal rod-cone interaction on psychophysical testing but this test has not proved to be of practical value. Carrier detection of XLRS therefore currently relies on genetic linkage studies using polymorphic markers that flank the disease locus.

**Molecular genetics**

The locus for XLRS has been localised to the Xp22 region of the distal short arm of the X chromosome with no evidence of genetic heterogeneity. A multitude of highly polymorphic microsatellite markers has recently become available in this region. These dinucleotide repeat sequences show great variation in length within the general population, which makes them ideal for tracking the disease gene for the purposes of carrier detection or gene mapping. They have the added advantage that they can be used with the polymerase chain reaction (PCR), so that small amounts of DNA can be amplified rapidly for analysis. Key recombination events in two British pedigrees have localised the gene for XLRS to a 2–3 cM region flanked by the microsatellite markers (DXS207, DXS1053) distally and DXS999 proximally. Polymorphic markers, which lie close to and flank the proximal and distal sides of the XLRS locus, now exist which can be used for carrier detection. The improved localisation of the gene means that positional cloning and characterisation of the XLRS gene should be feasible in the near future.

**Management and prognosis**

There is no known cure for XLRS but correct and early diagnosis is important for accurate prognosis, genetic counselling, and facilitating educational requirements in a child with visual handicap. Strabismus, refractive errors, and amblyopia should be corrected to maximise visual potential. Attempts to flatten peripheral retinoschisis by treating the outer leaf with laser photocoagulation have led to a high incidence of retinal detachment, but panretinal photocoagulation has been used successfully to treat disc and peripheral new vessels. Vitreous haemorrhage usually clears spontaneously, although vitrectomy may be required to reduce the risk of amblyopia in young children if the haemorrhage is particularly dense or persistent. Variable success rates have been reported following scleral buckling for retinal detachment and vitrectomy with internal tamponade offers the best outcome. In one case internal tamponade of an outer leaf break was facilitated by the removal of the whole of the inner leaf of the schisis cavity without deleterious effect.

Young patients affected by XLRS show moderate visual impairment. Visual acuity is usually in the 6/12 to 6/24 range and some patients have been reported with normal acuity. The disease is probably slowly progressive but others report stable vision in uncomplicated cases. Most patients, however, retain reasonable vision until their fifth or sixth decades when some deterioration does occur due to macular atrophy. Total blindness is an exception, although Forsius reported that all patients over 70 years of age had a visual acuity of less than 6/60.

**Future**

At present the underlying molecular defect in XLRS is unknown. However, steady progress in mapping the Xp22 region should lead to the cloning and characterisation of the gene for XLRS. This would permit reliable carrier detection and will also enhance our understanding of the role of the Müller cell in the pathology of XLRS leading to possible therapies in the future.

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