Unrecordable pulsatile ocular blood flow may signify severe stenosis of the ipsilateral internal carotid artery

Y Barkana, A Harris, L Hefez, M Zaritski, D Chen, I Avni

Aim: To examine the relation between stenosis of the internal carotid artery (ICA) and pulsatile ocular blood flow (POBF).

Methods: In 57 eyes of 30 patients who were referred for Doppler ultrasound examination of the ICA we measured POBF and analysed the correlation with degree of ipsilateral ICA stenosis.

Results: There was a significant negative correlation between POBF and ipsilateral ICA stenosis (Pearson correlation coefficient, \( r = -0.516, p < 0.0001 \)). In 14 eyes POBF could not be measured by the OBF tonometer, and in 11 of these cases (79%) severe stenosis (>75%) of the ipsilateral ICA was present. When these eyes were excluded from analysis, there was no correlation between POBF and ICA stenosis \( (r = -0.02, p = 0.91) \). Among these 43 eyes in which POBF could be measured it ranged 667–2095 \( \mu \text{L/min} \) with a mean of 970.72 \( \mu \text{L/min} \).

Conclusion: Low or unrecordable POBF may signify severe stenosis of the internal carotid artery. POBF is not a direct reflection of ipsilateral ICA blood flow.

The OBF system (OBF Labs Ltd, Malmesbury, UK) is one of two systems that have been introduced for the measurement of pulsatile ocular blood flow (POBF). The instrument repeatedly measures the intraocular pressure (IOP) with a pneumatic applanation tonometer during the cardiac pulse cycle and, based on IOP variation with time, calculates the pulsatile ocular blood flow. It has gained popularity for use in ocular blood flow studies because of its ease of use and good reproducibility. Recent clinical publications have reported significant abnormalities in POBF in patients with normal tension glaucoma (NTG), age-related macular degeneration, retinitis pigmentosa, and following regional ocular anaesthesia.

Stenosis of the internal carotid artery (ICA) has been associated with various ophthalmic disorders such as ocular ischaemic syndrome, glaucoma, and vascular occlusions.

To further characterise the role of POBF in health and disease, in this work we examined the relation of POBF to ICA stenosis. This relation has not been systematically characterised previously.

METHODS

We recruited consecutive patients who had carotid Doppler ultrasound examination in our institute. Only patients who could be tested in the sitting position were referred for POBF examination. Patients with arrhythmia or nystagmus were excluded. In addition, any significant ocular abnormality revealed on slit lamp examination such as corneal scar, glaucoma, or previous surgery excluded that eye from the study.

Ultrasound Doppler examination of the ICA included the peak systolic velocity (PSV), end diastolic velocity (EDV), and estimated percentage stenosis.

Ocular pulse amplitude (PA) and POBF were measured by the OBF machine. All measurements were made by the same investigator (YB) using the OBF tonometer mounted on a slit lamp with the patient seated after topical anaesthesia with Benoxinate HCl 0.4%. Values reported by the machine were average of five best pulses during approximately 10 seconds of probe application to the eye. If the machine could not detect five measurable pulses during that period on three consecutive attempts, we marked the result as zero, denoting it as unrecordable.

Correlation between POBF values and ipsilateral ICA US-Doppler parameters was evaluated using Pearson correlation coefficient. SPSS for Windows software, version 10.0, was used for the analysis.

RESULTS

Fifty seven eyes of 30 patients were included in the study. There were 21 males and nine females with mean age of 66 (SD 12) years.

Figure 1 is a scattergram demonstrating values of POBF and degree of ipsilateral ICA stenosis. There was a significant negative correlation between these two parameters (Pearson correlation coefficient, \( r = -0.516, p < 0.0001 \)).

POBF was unrecordable by the OBF tonometer in 14 eyes, and in 11 of these cases (78.6%) ultrasound showed ipsilateral severe ICA stenosis (greater than 75% of the lumen). When these 14 eyes were excluded from analysis, there was no correlation between POBF and degree of ICA stenosis \( (r = -0.02, p = 0.91) \).

Among the 43 eyes in which OBF was recorded, it ranged from 667–2095 \( \mu \text{L/min} \) with a mean of 970.72. Severe stenosis of the ICA was observed in six of the 43 eyes (14%).

In 17 of the examined ICA we observed stenosis greater than 75% of the lumen; in 11 ipsilateral eyes, POBF could not be recorded by the machine (64.7%).

In seven patients, there was severe ICA stenosis on one side only (Table 1). In five of these patients, POBF was unrecordable in the eye ipsilateral to the stenosis, and was

![Figure 1](http://bjo.bmj.com/)
normal on the contralateral side. In one patient, POBF was 1306 µl/min on the side with 90% ICA stenosis and 1809 µl/min on the side with 30% ICA stenosis. In one patient POBF was 1650 µl/min on the side with 99% ICA stenosis and was unrecordable on the other side with only 30% stenosis.

In five patients, measurements were made before and after endarterectomy. In these cases POBF was not detectable preoperatively, and normalised following surgery (1185–1951 µl/min, average 1410).

Similar results were obtained when PA, PSV, or EDV were used for analysis, and consequently they are not included.

Heart rate, as measured by the OBF instrument, ranged from 42–90 beats per minute (mean 67.65 (13.9)).

### DISCUSSION

There is current interest in determining whether reduced ocular blood flow is partly responsible for various eye diseases, such as glaucoma and age related macular degeneration. Proponents of the vascular pathogenetic hypothesis of open angle glaucoma (OAG) claim that chronic or intermittent decrease in blood flow to the optic nerve is partially responsible for the glaucomatous optic neuropathy. For example, the incidence of OAG has been reported to be attributable to a stenotic innominate artery, with equal values measured following the dilation of the stenotic vessel. Two cases were reported by Claridge and James where POBF was measured before and after surgery for ICA stenosis. In one case POBF was unrecordable before surgery and 173 µl/min postoperatively. In the second case POBF increased significantly from 280 to 758 µl/min. In our study we observed the normalisation of POBF in five cases following ICA surgery after being unrecordable preoperatively.

POBF values in our study were somewhat higher than previously reported in healthy eyes. Mori et al reported POBF values ranging from 290.7–1201.6 µl/min with a mean of 593.3 µl/min in 80 normal subjects using the Langham OBF tonometer (Langham Ophthalmic Technologies, Timonium, MD, USA). Yang et al reported a range of 306–1645 with a mean of 775.9 µl/min in 83 healthy eyes using the OBF tonograph (OBF Laboratories, UK Ltd, Wilts, UK) which is similar to the one we used. POBF values in the present study ranged 667–2095 with a mean of 970.72 µl/min.

In conclusion, we have demonstrated that inability to record POBF in healthy eyes may be related to severe stenosis of the ICA, and that severe ICA stenosis may signify a marked reduction in the pulsatile component of ocular blood flow. Clinicians using the OBF tonometer should be aware of this association and consider its implications for the general health of their patients. The significance of carotid artery stenosis to ocular blood flow in health and disease requires further investigation.

Authors’ affiliations
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Table 1 Stenosis of the internal carotid artery (ICA) and pulsatile ocular blood flow (POBF) in seven patients with unilateral severe ICA stenosis.
REFERENCES

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