Macular relocation after photodynamic therapy for recurrent choroidal neovascular membrane: visual results and histopathological findings

P Stanga, P Hiscott, K Li, D Wong

Background/aims: The findings in a patient treated with photodynamic therapy (PDT) followed by macular relocation surgery (MRS) are presented.

Methods: Histopathological evaluation of the choroidal neovascular membrane (CNV) specimen including immunohistochemical assessment.

Results: Microscopy revealed one CNV area that was richly vascular with attached retinal pigment epithelial cell monolayer and another area that was made up of densely collagenous avascular tissue with adherent fragments of Bruch’s membrane and glial elements.

Conclusion: The findings suggest that the PDT treated part of the CNV may have been adherent to the neuroretina and may have contributed to the formation of the macular hole. Caution is advised when considering MRS for CNV previously treated PDT.

We considered that photodynamic therapy (PDT)1 and Macular Relocation Surgery (MRS)2 not to be mutually exclusive treatments and that in some patients it might be feasible and worthwhile to undertake MRS when PDT has failed.

PATIENT AND METHODS

An 81 years old male patient with bilateral age related macular degeneration (AMD) and a predominantly classic subfoveal choroidal neovascular membrane (CNV) underwent PDT with verteporfin (Visudyne, Novartis Ophthalmics, Duluth, GA, USA) to the right eye according to published treatment guidelines.3 This eye subsequently developed a predominantly classic subfoveal CNV recurrence (Fig 1A). The patient declined re-treatment with PDT and sought macular relocation surgery. Following counselling, the patient was offered the surgery. Immediate preoperative vision was 20/80 (54 letters at 1 metre on the logMAR chart as measured by TAP study protocol refraction and by accredited optometrist).4

The surgery consisted of phacoemulsification, intraocular lens implant, vitrectomy, 360° retinotomy, excision of the choroidal neovascularisation-retinal pigment epithelium (RPE) complex, relocation of the macula superiorly, and the injection of internal tamponade agent (1200 centistokes silicone oil) but without peeling of the epiretinal membrane formation, we thought it was appropriate to use a prolonged tamponade to reattach the retina. Further surgery therefore involved a fluid air exchange, the injection of 1200 centistokes silicone oil but without peeling of the epiretinal membranes (Fig 1E).

Thirty four days after this third surgery the retina remained attached and the best corrected vision under silicone oil was 20/126 (45 letters at 1 metre). According to the patient the peripheral vision was restored and there was a small central scotoma.

DISCUSSION

It is relatively rare to obtain histology of CNV treated after PDT. Ghazi et al5 and Schnurrbusch et al6 reported the histological findings in surgically excised classic CNV treated with PDT. Ghazi et al studied one specimen by electron microscopy. The authors concluded that PDT causes endothelial cell...
were not aware that we caused a hole during the ERM peel procedure. Although the ERM specimen did not show any evidence of neuroretinal tissue attached to it, we cannot exclude the possibility that we did cause a tear in the macula during peeling.

We speculate that PDT may have a role in modulating a wound healing-type response at the site of the CNV (thus increasing the chances of a CNV neuroretinal adhesion). PDT has been shown to cause vacuolisation of the cytoplasm of the RPE and its separation from the underlying Bruch’s membrane. Such physical damage could induce RPE cell mediated repair. It is also conceivable that PDT could induce a glial cell mediated response. If this was the case, it would explain the presence of glial cells on the CNV. It is interesting that the glial elements were found on the surface of the avascular component of our specimen, consistent with our interpretation that the neuroretina was adherent here.

The notion that one can perform MRS after PDT is dependent on the fact that the injury with the laser is selective and confined to the CNV and that the neuroretina remains intact. If the retina was mechanically weakened in some way by repeated surgery, PDT, and retinal detachment, then pucker peeling might be less feasible. Based on the experience of this case, we would advise caution when considering epiretinal membrane peeling in this situation.

None of the authors have a proprietary interest.

A larger version of the figure can be viewed on the website www.bjophthalmol.com/supplemental

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**Authors’ affiliations**

P Stanga, P Hiscott, K Li, D Wang, St Paul’s Eye Unit, Royal Liverpool University Hospital, Liverpool, UK. 
P Stanga, P Hiscott, Experimental Ophthalmology Unit, Department of Medicine, Liverpool University, Liverpool, UK.

Correspondence: Mr P E Stanga, Consultant Vitreoretinal Surgeon, Manchester Royal Eye Hospital, Oxford Road, Manchester M13 9WH, UK; Paulo.Stanga@CMMC.nhs.uk

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**Figure 1** [A] Thirty nine and a half seconds fluorescein angiography frame depicting a predominantly classic subfoveal recurrent CNV in an 81 year old male patient with bilateral AMD. This CNV had previously undergone PDT with verteporfin. (B) CNV section stained by haematoxylin and eosin (<100). Fragmented but was vascular where the RPE cell layer appeared to lack vessels where the RPE cell layer (arrows) adjacent to vascular area (V). The bulk of the specimen is avascular (A). Inset shows CNV section stained by DPAS and haematoxylin (<100). Probable fragments of inner Bruch’s membrane are now emphasised [arrowheads]. (C) CNV section stained by immunohistochemistry for cytokeratin (red reaction product, haematoxylin counterstain, x200) demonstrating glial elements on the densely collagenous area surface. (D) ERM specimen showing folded inner limiting lamina type material (arrows) with attached fibrocellular membrane [DPAS with haematoxylin, x200]. Inset shows vacuolated cells [arrowheads], presumably containing tamponade agent (haematoxylin and eosin, x50). (E) One day postoperative colour photograph showing the reattached retina under silicone oil tamponade and the edges of the macular hole [arrowheads].
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