Vitreoretinal surgery for macular hole after laser assisted in situ keratomileusis for the correction of myopia

J F Arevalo, F J Rodriguez, J L Rosales-Meneses, A Dessouki, C K Chan, R A Mittra, J M Ruiz-Moreno

Methods: To describe the characteristics and surgical outcomes of full thickness macular hole surgery after laser assisted in situ keratomileusis (LASIK) for the correction of myopia.

Results: Macular hole formed 1–83 months after LASIK (mean 13 months). 11 out of 13 (84.6%) patients were female. Mean age was 45.5 years old (25–65). All eyes were myopic (range −0.50 to −19.75 dioptres (D); mean −8.4 D). Posterior vitreous detachment (PVD) was not present before and was documented after LASIK on 42.8% of eyes. Most macular hole were unilateral, stage 4 macular hole, had no yellow deposits on the retinal pigment epithelium, had no associated epiretinal membrane, were centric, and had subretinal fluid. The mean diameter of the hole was 385.3 μm (range 200–750 μm). A vitrectomy closed the macular hole on all eyes with an improvement on final best corrected visual acuity (VA) on 13 out of 14 (92.8%) patients.

Conclusions: This study shows that vitreoretinal surgery can be successful in restoring vision for most myopic eyes with a macular hole after LASIK.

RESULTS

We found 14 eyes (13 patients) with full thickness macular hole after LASIK. The macular hole formed 1–83 months after LASIK (mean 13 months). In 57.1% of cases it developed ≤6 months after LASIK, and in 28.5% of cases it developed 1 year or more after LASIK. Eleven (84.6%) patients were female. The mean age was 45.5 years old (range 25–65 years). All eyes with macular hole after LASIK were myopic (range −0.50 to −19.75 D; mean −8.4 D). Posterior vitreous detachment was not present before and was documented after LASIK in 42.8% of eyes (table 1). A vitrectomy was performed at a mean of 60 days (range 1 day to 18 months).

Abbreviations: IC, indocyanine; LASIK, laser assisted in situ keratomileusis; OCT, optical coherence tomography; PRK, photorefractive keratectomy; PVD, posterior vitreous detachment; VA, visual acuity.
to 18 months) after the diagnosis of macular hole. Surgery closed the macular hole on all 14 eyes that underwent surgical management with an improvement on final best corrected visual acuity in 13 out of 14 (92.8%) patients (table 2). The mean follow up after surgery was 17.7 months (3–70 months).

Table 2 outlines detailed characteristics of the macular hole of our case series. The mean diameter of the macular hole was 385.3 μ, and the range was from 200 to 750 μ. A centric macular hole was found in all eyes. The macular hole was unilateral in 12 of 13 patients (although one of those patients had an impending macular hole (stage 1) in the fellow eye). A stage 4 macular hole was found in seven eyes (50%). There was absence of yellow deposits on the retinal pigment epithelium (RPE) of the macular hole in 12 eyes (85.7%). Twelve eyes (85.7%) lacked a surrounding epiretinal membrane (ERM). Twelve eyes (85.7%) had subretinal fluid surrounding the macular hole; four of those eyes (all with −10.00 D of myopia) had extensive subretinal fluid in the posterior fundus (table 1).

A vitrectomy closed the macular hole on all eyes with an improvement on final best corrected visual acuity (VA) on 13 out of 14 (92.8%) patients. Poor VA (20/200 or worse) occurred in four (28.5%) eyes as a result of associated extensive subretinal fluid in the posterior fundus, and cataract. Six (42.8%) eyes out of 14 eyes had a VA outcome of 20/100. Only four (28.5%) eyes out of 14 eyes had a VA outcome of 20/40 (table 2).

**SELECTED CASE REPORT**

A 30 year old woman (case 2), with −13.00 D of myopia in the right (RE) and −10.00 D in the left eye (LE), underwent bilateral laser in situ keratomileusis in June 2001. Six months after surgery, she noted the onset of blurred vision involving her LE. Retinal examination revealed a stage 4 macular hole in the LE (fig 1A) associated with a posterior pole retinal...
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Figure 1  (A) Retinal examination revealed a stage 4 macular hole (arrow) in the left eye associated with a posterior pole retinal detachment, and a best corrected visual acuity (BCVA) of counting fingers. (B) Optical coherence tomography (OCT) image showing features of both foveal retinal detachment and retinoschisis. (C) OCT after vitrectomy reveals a closed macular hole with a BCVA of 20/150.

detachment, and a best corrected visual acuity of counting fingers. OCT image showed features of both foveal retinal detachment and retinoschisis (fig 1B). Best corrected visual acuity recovered to 20/150 with macular hole closure 4 months after successful vitrectomy, and fluid-gas exchange (fig 1C).

DISCUSSION

Our findings support previous studies that showed the characteristics and demographics of myopic macular holes to be different from those of idiopathic macular holes.

Myopic macular holes tend to develop in young subjects and may be associated with a retinal detachment surrounding the macular hole.11-15

In the present series, posterior vitreous detachment was not present before and was documented after LASIK on 42.8% of eyes. Luna et al16 have used kinetic ultrasonography to demonstrate vitreoretinal alterations after LASIK, including partial or total PVD in 24% (12 eyes) in high myopes. Their findings are consistent with similar results in almost half of myopic eyes with macular hole after LASIK in our series.

Macular hole surgery can achieve substantial VA improvement, but the results do not seem to be as favourable as those reported for typical idiopathic macular holes in recent series.17-19 In our series, only four (28.6%) eyes out of 14 had a VA outcome of 20/40. Case 12 was our only case with loss of VA after vitrectomy. However, silicone oil removal and cataract extraction are still pending, and could potentially improve final VA. Our results should be interpreted with caution, since multiple surgeons with different surgical techniques and training participated in this study.

The pathogenesis of macular hole remains controversial. Certainly, vitreofveal traction is felt to be the predominant force together with pre-existing degenerative changes in the fovea.19 Chan and Lawrence20 have stated that LASIK surgery has certain features that may induce postoperative vitreoretinal interface changes. For instance, the acute intraocular pressure rise associated with the mechanical stretch of the vitreous base induced by the suction ring as well as the shock waves generated by the excimer laser may lead to vitreoretinal traction.21-23 Retinal breaks and detachment have also been reported to occur after laser in situ keratomileusis.24-26

Our findings are not generalisable to all myopic eyes that undergo LASIK. However, myopia is a risk factor for macular hole formation.27 It is possible that vitreoretinal interface changes occurring after laser in situ keratomileusis may predispose certain myopic eyes to form a macular hole. Nevertheless, there are not enough hard data in the literature to determine if these are just myopic holes that would have developed anyway regardless of LASIK.

OCT before LASIK may be helpful to identify those eyes at risk for the development of a macular hole. Chan et al28 have recently introduced the concept of a stage 0 macular hole based on OCT observations of the vitreoretinal interface in fellow eyes of patients with unilateral idiopathic macular holes, and to evaluate the subsequent risk of progression to a full thickness macular hole. In a retrospective observational case series of 94 patients with a unilateral stage 2, 3, or 4 full thickness macular hole. They found that in 27 (28.7%) of 94 clinically normal fellow eyes, OCT detected an abnormality of the vitreoretinal interface but normal foveal anatomy. Eyes with severe and moderate vitreoretinal abnormalities seemed to share characteristic features on OCT that increased their risk of macular hole development (stage 0 macular hole). Univariate analysis revealed that the presence of a stage 0 macular hole was significantly associated with an almost sixfold increase in the risk of macular hole formation (relative risk: 5.8, 95% confidence interval: 1.16 to 28.61, p = 0.03). They concluded that a stage 0 macular hole has a normal biomicroscopic appearance clinically, but has salient features on OCT as a result of oblique vitreous traction. Optical coherence tomographic findings consist of a normal foveal contour and normal retinal thickness and must include the presence of a preretinal, minimally reflective, thin band inserting obliquely on at least one side of the fovea. The presence of a stage 0 macular hole in the fellow eye is a significant risk factor for the development of a second macular hole.

An important limitation of our study is that, owing to its retrospective nature, OCT was not performed before LASIK. In addition, follow up was not consistent and it is possible that patients who developed a macular hole after LASIK were seen by other ophthalmologists outside of our institutions. Thus, we did not attempt to determine the incidence of macular hole formation after LASIK.

In summary, we present 14 eyes of 13 patients with no presurgical sign of a macular hole, which developed a full thickness macular hole after laser in situ keratomileusis. Our study shows that vitreoretinal surgery can be successful in restoring vision for most myopic eyes with a macular hole after LASIK. Vitreoretinal interface changes may have a role in macular hole formation after LASIK for the correction of myopia. Future prospective investigation involving a large number of myopic eyes with ultrasonic or ocular coherence tomographic studies may be valuable for determining vitreoretinal interface changes before and after LASIK.

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