Corneal endothelial changes under induced intraocular pressure elevation: a scanning and transmission electron microscopic study in rabbits

S. MELAMED, I. BEN-SIRA, AND Y. BEN-SHAUL

From the 1Department of Ophthalmology, Beilinson Medical Center, Tel-Aviv University, Petah-Tikva, Israel, and the 2Department of Microbiology, the George S. Wise Faculty of Life Sciences, Tel-Aviv University, Tel-Aviv, Israel

SUMMARY  Intraocular pressure was artificially raised to 60–70 mmHg in 7 albino rabbits for periods of 15 minutes to 4 hours. The corneal endothelium of these eyes was studied by transmission and scanning electron microscopy. A correlation between exposure time to elevated IOP, clinical signs observed by slit-lamp examination, and extent of morphological damage is clearly shown. In eyes exposed to high pressure for 15 and 30 minutes corneas remained transparent and only minimal changes could be detected by SEM, which consisted of small areas of cells with unevenness of their surface, occasional cellular ruptures, and diminution of cilia and microvilli. After 1–2 hours of exposure small, solitary corneal opacifications appeared. In these eyes more severe morphological changes affecting larger areas were observed, with additional cellular blebbing, excariocytosis, cellular rupture, disintegration, and disappearance seen in SEM. Thin sections revealed swelling of mitochondria, disorganisation of endoplasmic reticulum, and the existence of myelin bodies. In eyes exposed for 3 and 4 hours to high IOP diffuse corneal haziness, implying stromal oedema, appeared. In these eyes the areas affected were larger, the extent of damage being more severe. Many areas were bare of endothelium, surrounded by scattered cellular debris, and showed cells with ballooning surfaces and multiple ruptures. Even in severe cellular damage cellular junctions appeared intact. It is assumed that endothelial cells are more sensitive to IOP elevation than the cellular junctions and that injury to the active pump system due to morphological damage is responsible for the resultant corneal oedema.

It is widely accepted that endothelial integrity and metabolic activity are essential for continuous maintenance of corneal dehydration and transparency. On the one hand the endothelium is the site of a metabolically dependent fluid pump that counteracts fluid leakage, while on the other it acts as a barrier to solutes from the anterior chamber.2–6 Corneal oedema accompanying acute glaucoma was shown to result from noncompensated corneal endothelium.1,2,4,6 This noncompensation, which allows excessive flow of fluid to the corneal stroma, might be explained by two mechanisms: (1) High intraocular pressure (IOP) affects the metabolic active-pumping mechanism without any morphological changes, thus reducing resistance to aqueous flow to the stroma with resultant stromal oedema.6 (2) Elevated IOP causes morphological cellular damage, thus reducing anatomically and functionally the barrier to flow of fluid into the stroma. In 47 eyes with chronic glaucoma decreased concentration of endothelial cells along with progressive atrophy and degeneration were described.6 More recently other investigators using scanning electron microscopy (SEM) and transmission electron microscopy (TEM)1,5–8 have shown various morphological changes which could be attributed to the nonfunctioning endothelium. Among these changes were flattening of cells, blebbing of cellular surface, intracellular vacuolisations, nuclear expulsion (excaryocytosis), and complete endothelial disorganisation or disappearance.

All these morphological changes were clearly shown by Svedbergh5,6 in monkey eyes exposed to moderate IOP (33–44 mmHg) for 3–7 hours. However, in that study the IOP was elevated by adjusting the height of a reservoir containing mock
aqueous humor connected to the anterior chamber. Although it is acceptable that high IOP was the main cause for the morphological changes described, some additional damage could be attributed to the perfusion of the anterior chamber. Perfusion of the cornea in vitro with Ringer bicarbonate without application of high pressure resulted in variable ultrastructural changes such as vacuolisation, mitochondrial and endoplasmic reticulum swelling, and complete intracellular disorganisation.11

The purpose of the present study was to investigate the extent and character of endothelial ultrastructural changes in relation to different exposure periods of elevated IOP and the extent of the resulting stromal oedema. In order to minimise possible damage due to perfusion and turbulence near the endothelium the IOP was artificially elevated by connecting a reservoir of normal saline to the vitreous through the pars plana.

Materials and methods

Seven albino rabbits of 2.5–3.5 kg body weight were anaesthetised by injection of pentobarbitone sodium (30 mg/kg) intravenously. After deep anaesthesia was achieved the IOP was artificially elevated in the right eye, the left eye serving as a control. IOP elevation was carried out by connecting a reservoir of normal saline through the pars plana to the vitreous. The height of the reservoir was adjusted between 81 and 95 cm, creating an IOP of 60–70 mmHg. The rate of IOP elevation was verified by measurement with hand-held applanation tonometer (Perkins).

To eliminate the possible effect of saline perfusion 2 control eyes were connected to the reservoir adjusted to a height of 10 cm, keeping IOP within normal limits. During the period of IOP elevation we carried out slit-lamp examination, looking for signs of corneal oedema, ciliary congestion, flattening of the anterior chamber, pupillary diameter, and its reaction to light. Eyes examined were exposed to different period of IOP elevation, lasting 15 minutes, 30 minutes, 1 hour, 90 minutes, and 2, 3, and 4 hours.

At the end of the exposure time both eyes were enucleated and buttons of cornea were immediately cut from the globe. The corneas were immersed in 2% glutaraldehyde in 0.1 M cacodylate buffer, pH 7.4, and fixed at 4°C overnight. For thin sectioning and TEM the tissue was postfixed in 2% OsO4 in the same buffer and embedded in Epon. Thin sections on grids were stained with uranyl acetate and lead citrate. Preparations were examined and photographed in a Jeol-100B electron microscope at 80 kV. For SEM fixed pieces of cornea were postfixed with OsO4 as above, washed and dehydrated in a series of ethyl alcohols. Drying was carried out from liquid CO2 by the critical point method. After drying, preparation were coated with either gold or gold-palladium (60–40%) by sputtering and photographed in a Jeol-S35 scanning electron microscope at 20–25 kV.

Results

On slit-lamp examination slight corneal opacification could be detected after 1–2 hours of exposure to high IOP. Diffuse stromal oedema appeared only after 3–4 hours of exposure. Ciliary congestion could be observed after 30 minutes, while pupillary mid-dilatation and nonreaction to light could be detected only after 1 hour. Flattening of the anterior chamber was noticed immediately.

In the control eyes (including the 2 eyes perfused with saline) the endothelial appearance resembled previously reported descriptions.12–13 In TEM the cells appeared flat, with numerous mitochondria and organised rough endoplasmic reticulum. Apical tight junctions were observed between cells with occasional pinocytotic vesicles and cilia on the cell surface. In SEM endothelial cells appeared flat, hexagonal in shape, with randomly distributed microvilli and cilia on the cell surface. Sharply demarcated, interdigitating cellular borders were also observed (Fig. 1). In eyes exposed for 15 and...
Fig. 2  Border area between nonaffected endothelium (bottom) and minimally damaged cells after 15 minutes of exposure to elevated IOP. Note unevenness of cellular surface and diminution of microvilli and cilia. × 3000.

Fig. 3  Minimal damage to endothelium after 30 minutes of elevated IOP. Normally appeared endothelium (right) is adjacent to cells with attenuated cell surface, blebbing (b), and cellular ruptures (arrows). × 3000.

Fig. 4  Endothelial cell after exposure of 1 hour to high pressure. Distention and swelling of mitochondria (M) and endoplasmic reticulum (ER) is evident. Note vacuolisations (V) and myelin body (MB). × 18 000.
Corneal endothelial changes under induced intraocular pressure elevation

30 minutes to elevated IOP only anterior chamber flattening and ciliary congestion were observed by slit-lamp examination. No signs of corneal oedema or regional opacification were detected. Thin sections of the endothelial cells in these eyes were completely normal. In SEM only minimal changes could be seen. Most of the cells appeared normal, but in small, scattered areas unevenness of cellular surface along with slight swelling of cellular content were evident. Occasional ruptured cell surfaces were encountered. Cilia and microvilli were observed less frequently (Figs. 2, 3).

In eyes exposed for 1–2 hours to high pressure, small solitary corneal opacifications could be seen on slit-lamp examination, along with pupillary mid-dilatation and nonreaction to light. Increased ciliary congestion and anterior chamber flattening were also observed. Eyes exposed to high IOP for 3 and 4 hours showed further deterioration of corneal opacification to more diffuse haziness, indicating progression of corneal oedema.

In thin sections affected cells showed disorganisation and swelling of endoplasmic reticulum and mitochondria along with vacuolisations and myelin bodies (probably evidence of cellular destruction) (Fig. 4). Despite intracellular damage junctional complexes appeared intact, unaffected by acutely elevated IOP.

SEM, enabling the observation of large areas of the affected endothelium, disclosed different types of cellular damage. It was evident that larger areas of the endothelium were damaged when the eyes were exposed to elevated IOP for 3–4 h. Moreover, it was possible to monitor different types of mor-

---

Fig. 5 An area of severely damaged endothelium after exposure of 4 hours to elevated IOP. The centre of insulated area is devoid of endothelium (D), surrounded by ruptures cells and cellular debris. At right normal endothelium (E) is seen and at left minimally damaged cells are shown. ×750.

Fig. 6 Severely damaged endothelium. Ruptured cell containing empty crater after nuclear expulsion. ×6000.

Fig. 7 Severely damaged endothelium. Bare area (Descemet's membrane) surrounded by ruptured disintegrated cells. ×3000.
mitochondrial and disintegration were small hours damage ruptures remained changes logical of cell time morphological changes In time to Discussion only, surfaces nuclear or disappeared (Figs. 5-7). of completely scattered cellular and included cellular ocytosis, of (unevenness to Fig. 8 of 168 Along with the study surface, bare endothelium, more which had passed in correlation through these cells, in eyes and 30 slight areas and 1-2 spots corneal opacity, with 110 mmHg. Kaye et al., studying corneal behaviour in vitro under pressure of 60-80 mmHg, found the endothelial barrier to deteriorate before the metabolically dependent pump mechanism fails. TEM revealed no morphological changes (duration of high pressure was not stated). More recent morphological studies using TEM and SEM disclosed flattening of cells, blebbing of cellular surface, excaryocytosis, and endothelial disintegration. It seems that for a diffuse corneal oedema to develop a certain threshold of decompensation must be reached. We believe that unaffected endothelium in eyes exposed to high pressure for short
periods can compensate for the rather small damaged and leaky areas, thus keeping corneal stroma dehydrated and transparent. However, if the extent of damage is more severe, as seen in eyes exposed for longer periods, the remaining functioning endothelium loses its ability to compensate for the larger leaking areas, and a diffuse corneal oedema results. In the rabbit cornea under IOP of 60–70 mmHg this decompensation appears after 3 to 4 hours of exposure.

This work was made possible by a grant from the Israeli Ministry of Health.

References