Ultrasound biomicroscopic measurement of
development of anterior chamber angle

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Abstract

Aim—to establish normative values for the anterior segment in normal infants and children in relation to age.

Methods—Anterior segments were measured in 46 normal infants and children (21 males and 25 females, aged from 1 to 60 months (mean 17.09 (SD 16.99) months)), by use of ultrasound biomicroscopy.

Results—Anterior chamber depth, trabecular-iris angle, angle opening (trabecular-iris) distances at 250 and 500 µm from the scleral spur, and the thickness of the thickest part of the iris were 1724–3473 µm (2505 (SD 480) µm), 15.35–44.79° (28.74 (7.46)°), 116–367 µm (247.4 (65.9) µm), 166–509 µm (349.5 (87.1) µm), and 249–579 µm (434.6 (74.6) µm), respectively. All factors in this study showed a significant correlation with logarithm of age (r = 0.937, p = 0.0001; r = 0.867, p = 0.0001; r = 0.917, p = 0.0001; r = 0.929, p = 0.0001; r = 0.748, p = 0.0001), and significantly correlated with each other.

Conclusions—Ultrasound biomicroscopy is a powerful tool for obtaining precise images and measurement of the development of the anterior segment in infants and children. Normative values were established for anterior segment dimensions in relation to age. Anterior chamber depth, trabecular-iris angle, angle opening distances at 250 and 500 µm from the scleral spur, and iris thickness showed linear increases in relation to logarithm of age.

(Patients and methods)

Patients Forty six normal infants and children were selected for study. The study protocol and consent forms were approved by the human subjects committee on Amagasaki Hospital. Informed consent for each infant was obtained from at least one parent. Infants with malformations were excluded from the study, as were genetic disorders, suspected intrauterine infections, or retinopathy of prematurity greater than stage II.

Ultrasound biomicroscopic measurements were made of the right eye of each infant. Ultrasound biomicroscope 840 (Zeiss-Humphrey, San Leandro, CA, USA) with a 50 Hz transducer and ultrasound biomicroscope UX-02 (Rion, Tokyo, Japan) with a 30 Hz transducer were used. Each infant or child was placed in a supine position. For infants, an infant Bangarter speculum, rather than an eye cup, was used to separate the eyelids after a drop of 0.5% proxymetacaine (proparacaine) had been applied. The palpebral fissure was filled with 2.5% methylcellulose as a coupling medium. Scanning was performed by manipulating the eyeball with a muscle hook without pressure on the eyeball and placing the probe close to the area of interest.

We repeated each measurement three times to confirm reproducibility and eliminate artefacts.

Anterior chamber depth (ACD) was measured as an axial distance from the internal corneal surface to the lens surface. Ultrasound biomicroscopic cross sectional views through the angle region were obtained for most of the measurements, which were made in the temporal meridian; views were as vertical as possible, as determined from the screen image.

The following variables were measured: ACD,
trabecular-iris angle (TIA), angle opening distance at 250 and 500 µm from the scleral spur (AOD250 and AOD500), and iris thickness, as described by Palvin et al.67 Iris thickness was measured at the thickest part of the iris. A summary of the definition of factors is shown in Table 1.

**STATISTICS**
Values were expressed as mean (SD) and as a range. Regression analysis was performed to determine the precise relation of the ACD, TIA, AOD250, AOD500, and iris thickness to age. Because our interest is in the prediction of...
Measurement of development of anterior chamber angle

The ACD was significantly correlated with TIA, AOD250, AOD500, and iris thickness (r = 0.923, p = 0.0001; r = 0.861, p = 0.0001; r = 0.856, p = 0.0001; r = 0.655, p = 0.0001). The AOD250 was significantly correlated with AOD500 and iris thickness (r = 0.923, p = 0.0001; r = 0.648, p = 0.0001). There was a significant correlation between AOD250 and iris thickness (r = 0.673, p = 0.0002).

Table 3 Regression analysis and correlation coefficients of anterior chamber depth (ACD), trabecular-iris angle, AOD250, AOD500, and iris thickness in relation to age

<table>
<thead>
<tr>
<th>Variable</th>
<th>r</th>
<th>p Value</th>
<th>Regression quotation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACD</td>
<td>0.937</td>
<td>0.0001</td>
<td>1779.819 + 769.257 \times \log (age (months))</td>
</tr>
<tr>
<td>TIA</td>
<td>0.867</td>
<td>0.0001</td>
<td>18.16 + 11.206 \times \log (age (months))</td>
</tr>
<tr>
<td>AOD250</td>
<td>0.929</td>
<td>0.0001</td>
<td>151.539 + 101.328 \times \log (age (months))</td>
</tr>
<tr>
<td>AOD500</td>
<td>0.917</td>
<td>0.0001</td>
<td>220.551 + 136.671 \times \log (age (months))</td>
</tr>
<tr>
<td>Iris thickness</td>
<td>0.748</td>
<td>0.0001</td>
<td>344.393 + 95.584 \times \log (age (months))</td>
</tr>
</tbody>
</table>

Table 4 Regression analysis and correlation coefficients between anterior chamber depth (ACD), trabecular-iris angle, AOD250, AOD500, and iris thickness

<table>
<thead>
<tr>
<th>Variable</th>
<th>r</th>
<th>p Value</th>
<th>Intercept</th>
<th>Slope</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACD v TIA</td>
<td>0.913</td>
<td>0.0001</td>
<td>-6.918</td>
<td>0.140</td>
</tr>
<tr>
<td>ACD v AOD250</td>
<td>0.877</td>
<td>0.0001</td>
<td>-45.379</td>
<td>0.117</td>
</tr>
<tr>
<td>ACD v AOD500</td>
<td>0.890</td>
<td>0.0001</td>
<td>-55.646</td>
<td>0.162</td>
</tr>
<tr>
<td>ACD v iris thickness</td>
<td>0.667</td>
<td>0.0001</td>
<td>170.644</td>
<td>0.105</td>
</tr>
<tr>
<td>TIA v AOD250</td>
<td>0.861</td>
<td>0.0001</td>
<td>36.072</td>
<td>7.352</td>
</tr>
<tr>
<td>TIA v AOD500</td>
<td>0.856</td>
<td>0.0001</td>
<td>62.936</td>
<td>9.773</td>
</tr>
<tr>
<td>TIA v iris thickness</td>
<td>0.655</td>
<td>0.0001</td>
<td>246.667</td>
<td>6.540</td>
</tr>
<tr>
<td>AOD250 v AOD500</td>
<td>0.923</td>
<td>0.0001</td>
<td>38.214</td>
<td>1.259</td>
</tr>
<tr>
<td>AOD250 v iris thickness</td>
<td>0.648</td>
<td>0.0001</td>
<td>247.302</td>
<td>0.757</td>
</tr>
<tr>
<td>AOD500 v iris thickness</td>
<td>0.673</td>
<td>0.0002</td>
<td>233.087</td>
<td>0.577</td>
</tr>
</tbody>
</table>

The ACD, TIA, AOD250, AOD500 and thickness of the thickest part of the iris for the group of infants and children are shown in Table 2. The ACD, TIA, AOD250, AOD500 and iris thickness were 1724–3473 µm (2505 (SD 480) µm), 15.35–44.79° (28.74 (7.46)°), 116–367 µm (247.4 (65.9) µm), 166–509 µm (349.5 (87.1) µm), and 249–579 µm (434.6 (74.6) µm), respectively. The ACD, TIA, AOD250, AOD500 and iris thickness significantly correlated to age (r = 0.937, p = 0.0001; r = 0.861, p = 0.0001; r = 0.890, p = 0.0001; r = 0.677, p = 0.0001), as shown in Table 3. The slopes and intercepts for the regression analysis, with correlation coefficients with p values, are shown in Table 3.

Discussion

We measured the anterior segments of infants and children, and established normative values and 95% prediction limits for anterior chamber depth, trabecular-iris angle, AOD250, AOD500, and iris thickness in relation to age. Anterior chamber depth, trabecular-iris angle, AOD250, and AOD500 showed a significant increase in relation to logarithm of age. Several investigators reported the development of the axial length and the anterior chamber depth.15–20 Sampolesi and Caruso11 and Kiskis et al.31 demonstrated a significant correlation of
axial length and corneal diameter with logarithm of age. The growth of the axial length and corneal diameter had been reported to be divided into three growth periods: a rapid natal phase in the first year and a half, the following slower infantile phase from the second to sixth year, and the final slow juvenile phase lasting until the age of 13 years. Our measurements also showed that the development of the anterior segment dimensions had a rapid growth phase from birth to approximately 1.5 years and a following slower growth phase.

General anaesthesia is usually required for a thorough examination of children under 5 years of age. The general condition of some infants often precludes examination under general anaesthesia. The opacity of anterior media and iridocorneal abnormalities, which are frequently seen in patients with developmental glaucoma, prevent observation with conventional methods such as slit lamp biomicroscopy. To overcome the difficulties, we have developed a method for measuring the anterior segment of neonates and obtaining live images by use of ultrasound biomicroscopy and a muscle hook with topical anaesthesia. Ultrasound biomicroscopy allows one to make precise measurements of the anterior segments even in premature neonates.

It is well known that the diagnosis of congenital glaucoma and the consequent indication of surgical intervention depend on clinical symptoms and intraocular pressure. Sampolesi and Caruso and Reibakdi showed that, in cases with borderline pressure levels that do not show any meaningful deviation from the normal, axial length measurements with ultrasonography are helpful in treating those patients. Kiskis et al reported that the corneal diameter was a more reliable guide than the axial length in the assessment of congenital glaucoma. In eyes with congenital glaucoma, the corneal diameter increases more than the axial length. In our preliminary study, we measured anterior segments of patients with congenital glaucoma and found that their ACD, TIA, AOD250, and AOD500 were greater than upper 95% prediction limits. The use of the ultrasound biomicroscopy would facilitate the evaluation of anterior segments. However, the measurements of the dimensions of the anterior segments is needed in cases with borderline pressure levels.

We established normative values for anterior segment in infants and children. These data provide the first information on the development of the anterior segments. The normative values should greatly aid ophthalmologists in evaluating anterior segment dimensions of infants and children who are suspected of having congenital glaucoma and congenital anomalies.