Limited macular translocation with scleral retraction suture

P Sullivan, L Filsecker, J Sears

Background/aims: Macular translocation with scleral imbrication is a new technique for treating subfoveal choroidal neovascular membranes (CNV). This procedure shortens the sclera but may result in a minimal decrease in the internal circumference of the globe and limits the amount of foveal displacement. The authors propose a new scleral retraction suture aimed at decreasing the internal circumference of the globe in an effort to increase foveal displacement.

Methods: Using a cadaver model, they compared the amount of scleral shortening using a standard scleral imbrication technique and a modified three suture scleral retraction technique. Sections of the globes were digitised and specialist software was used to estimate the amount of scleral shortening. Three patients with subfoveal choroidal neovascularisation underwent limited macular translocation using pars plana vitrectomy and macular detachment with the modified scleral suture technique. The main outcome measures were visual acuity, foveal displacement, and complications.

Results: In the cadaver model, the scleral retraction suture resulted in a flatter internal scleral fold compared to the standard suture technique and created approximately 890 µm of effective scleral shortening. In the patients who underwent macular translocation and laser photocoagulation of the CNV, visual acuity improved in two patients and worsened in one patient. The range of foveal displacement was 1400–2400 µm.

Conclusion: The foveal displacements achieved in this limited study compared to median displacement previously published using standard suture techniques demonstrates that the scleral retraction suture technique may be a useful adjunct to limited macular translocation. The advantage of this type of suture in conjunction with translocation may depend on the effective scleral shortening offered by this retraction suture.

A ge related macular degeneration (AMD) is a leading cause of severe central visual loss in Western countries. While the majority of patients with AMD have an atrophic form, 10–20% develop exudative macular detachment, often with severe visual loss. This results in an acute decrease in vision, with 87% of patients with subfoveal choroidal neovascular membrane (CNV) having 20/200 vision or worse after 2 years. Laser photocoagulation provides stabilisation in vision for those with small subfoveal lesions, but leads to a well known immediate loss of central vision. Photodynamic therapy (PDT), the second proved type of treatment, is effective in stabilising vision in some patients with subfoveal CNV. Two year follow up studies require treatment on an average of every 3 months. Other non-surgical treatments, such as indocyanine green (ICG) angiography guided treatment of feeder vessels, radiotherapy, and antiangiogenic therapy, were not yet proved to be effective in controlled clinical trials. One of the Submacular Surgery Trial treatment arms is evaluating the efficacy of surgical extraction of eligible subfoveal CNV in AMD.

The concept of retinal relocation was first described in 1983 by Lindsey et al. Macular translocation was first performed in humans by Machemer and Steinhorst 10 years later. Initial techniques using 360 degree or 180 degree retinotomies were technically difficult, resulted in torsional diplopia from large translocations, and were associated with a high risk of retinal detachments with proliferative vitreoretinopathy (PVR). Newer translocation techniques have been developed to minimise surgical trauma and postoperative complications. These limited macular translocations (LMT) were pioneered by DeJuan, who used imbrication sutures, with or without scleral resection. Lewis has used scleral clips to produce a decreased internal circumference of the eye wall. The extent of translocation with scleral infolding created by imbrication is limited by the height of the invaginated scleral-choroidal fold, as the retina must still cover the internal fold, and by the amount of retinal stretching.

We conducted a prospective study to determine the results and complications of a modification of the limited macular translocation technique initially described by de Juan and colleagues. We evaluated the effectiveness of a modified circumferential retraction suture technique to retract and compress the scleral-choroidal fold in an attempt to shorten the internal circumference of the globe, thereby increasing the extent of retinal translocation.

MATERIALS AND METHODS

Cadaver model

We performed scleral imbrication on two human cadaver globes. On one globe, a scleral infolding technique similar to that used by Lewis et al was performed. Three 5-0 nylon circumferential mattress sutures were placed in the superotemporal quadrant 9 mm and 15 mm from the surgical limbus (Fig 1A). No crescent-shaped lamellar scleral excision was performed. On the second globe, the modified scleral imbrication suture technique was used (Fig 1B). Three 5-0 nylon circumferential mattress sutures were placed in the superotemporal quadrant at 10 mm, 12.5 mm, and 15.0 mm from the surgical limbus (Fig 1B).

Abbreviations: AMD, age related macular degeneration; CNV, choroidal neovascular membrane; ICG, indocyanine green; IVFA, intravenous fluorescein angiography; LMT, limited macular translocations; PBS, phosphate buffered saline; PDT, photodynamic therapy; PVR, proliferative vitreoretinopathy
The globes were immediately fixed in 4% paraformaldehyde in phosphate buffered saline (PBS), pH 7.4, for 45 minutes then removed to 20% sucrose overnight at 4°C. Next, the globes were sectioned in an anterior-posterior plane through the imbrication, and the cut surface photographed (Fig 2A and B). The images were then digitised and the amount of effective scleral shortening was measured three times. Scion Image software was used to measure the internal length of imbricated sclera, and approximates the length of sclera and choroid the overlying retina would traverse if attached. The difference between the mean of the two distances is an estimation of the effective scleral shortening.

Patients
Three consecutive patients underwent limited macular translocation for subfoveal CNV due to AMD using a modified scleral imbrication suture technique. All surgeries were performed by JS at the Cole Eye Institute between February and December 2000. Informed consent was obtained before surgical intervention.

After making a 270 degree peritomy, the superior and lateral rectus muscles were isolated with Jameson muscle hooks and 2-0 silk sutures. Three 5-0 Ethilon sutures were placed in the superotemporal quadrant (Fig 3A and B). Each one of these was placed at 50% scleral thickness in an S-shaped horizontal mattress configuration at 10 mm, 12.5 mm, and 15 mm from the surgical limbus. A standard three port pars plana vitrectomy with elevation of the posterior hyaloid was performed. The temporal half of the retina was detached using a 39 gauge retinal translocation irrigating cannula with balanced salt solution. An air-fluid exchange and Lewis retinal manipulator was used to complete the macular detachment. The three scleral sutures were tightened with the internal eye pressure reduced to 15 mm Hg (Fig 4A and B). A 75% air-fluid exchange was performed. On the operating room table at the end of the surgery, the patients were rolled temporally, then elevated to an upright position where they remained until the next day. In this way, the air bubble was rolled nasally and then superiorly, from attached retina to detached retina.

Measurements of the distance of macular translocation were made using a micrometer calibrated for intravenous fluorescein angiography (IVFA) negatives using a Zeiss 30 degree fundus camera, similar to the reticule used for assessing CNV diameter before photodynamic therapy. The distance from the centre of the CNV to a vascular landmark was measured in the preoperative and postoperative angiograms. The difference between the two was the effective macular translocation. If possible, the preoperative and postoperative angiogram negatives were superimposed to check the translocation distance.

RESULTS
Cadaver model
The standard imbrication sutures result in a single infolding of choroid and sclera (Fig 1A and 2A). The mean internal length of imbricated sclera and the distance the retina had to traverse the underlying choroid and sclera was both 4.61 mm. The modified imbrication sutures create a double infolding of the choroid and sclera.
choroid and sclera (Fig 1B and 2B). The mean internal length of imbricated sclera was approximately 5.84 mm, and the distance the overlying retina had to traverse was 4.95 mm (Table 1). The difference between these was 890 μm, and represents an estimation of effective scleral shortening (Table 1).

Clinical case No 1
An 86 year old woman presented with decreased vision in the right eye for 1 month. Best corrected visual acuity was 20/400 right eye and 20/20 left eye. The anterior segment examination showed well centred posterior chamber intraocular lenses in both eyes.

The right fundus showed a subfoveal CNV with surrounding subretinal blood and overlying neurosensory detachment (Fig 5A). The left fundus showed drusen and RPE mottling. Fluorescein angiography of the right eye showed a classic, subfoveal CNV measuring 3.0 mm in greatest linear dimension centred on the fovea. The greatest linear dimension of the surrounding blood was 6.0 mm (Fig 5A). The inferior edge of the CNV was 5600 μm from a vessel above it that was used as a fixed reference point on the retina. The inferior edge of the CNV was 1200 μm from the foveal centre.

After informed consent was obtained, the patient underwent an inferior macular translocation with scleral compression sutures 3 days after presentation. On the second postoperative day, the IVFA showed a classic, well defined, extrafoveal CNV (Fig 5B). The inferior edge of the lesion was 4200 μm from the vessel used as a fixed point on the retina, demonstrating a foveal displacement of 1400 μm. Laser photocoagulation of the CNV was performed the same day.

Visual acuity decreased to 20/80, right eye, because of cataract 2 months after surgery. Her postoperative keratometry readings demonstrated 42.50/47.00 dioptres at 83 degrees.

Clinical case No 2
A 77 year old woman presented with a 2 day history of a sudden decrease in vision in her right eye. Best corrected visual acuity was 20/200 right eye and 20/60 left eye. The anterior segment examination showed moderate nuclear sclerosis in both eyes.

Dilated funduscopy of the right eye demonstrated a subfoveal CNV with surrounding subretinal blood. Fluorescein
angiography of the right eye revealed subfoveal hyperfluorescence beneath thick blood that was difficult to determine if the complex was classic, occult, or combined classic and occult CNV (Fig 6A). It was impossible to determine exactly where the edge of the CNV was with respect to the foveal centre.

After informed consent was obtained, the patient underwent an inferior LMT 1 day after presentation. On postoperative day 1, the patient had a moderate vitreous haemorrhage and small nasal haemorrhagic choroidal detachment. Both spontaneously resolved. Postoperative fluorescein angiography of the right eye showed a well defined occult CNV (Fig 6B). The inferior edge of a chorioretinal lesion nasal to the fovea (Fig 6A and B) used for measurement of translocation distance was 4300 µm from the retinal vessel preoperatively and postoperatively was 2000 µm from this vessel, demonstrating a total foveal displacement of 2300 µm from its previous location. The patient underwent laser photocoagulation of the CNV the same day. One year after LMT, and 2 weeks after cataract surgery, her visual acuity improved to 20/60 right eye. Postoperative keratometry readings demonstrated 41.75/45.50 dioptres at 105 degrees.

Clinical case No 3
An 80 year old woman presented with decreased vision in the right eye for 2 months. Best corrected visual acuity was 2/200 right eye, and 20/200 left eye. The anterior segment examination showed well centred posterior chamber intraocular lenses in both eyes.

The right fundus showed a subfoveal disciform scar with scattered drusen. The left fundus showed central macular subretinal blood and lipid. Fluorescein angiography of the left eye showed a classic subfoveal CNV measuring 5300 µm in greatest linear dimension (Fig 7A). The inferior edge of the CNV was 800 µm from the foveal centre. After informed consent was obtained the patient underwent an inferior LMT 2 weeks after presentation. One week later, fluorescein angiography of the left eye demonstrated a macular translocation with a juxtafoveal CNV (Fig 7B). Using a reference vessel and the centre of the CNV, preoperative distance was measured at 2900 µm; postoperative measurement using the same reference point was 500 µm, demonstrating a translocation of 2400 µm. The centre of the CNV was used because there was a delay in obtaining the postoperative fluorescein angiogram, and the CNV increased in size. Laser treatment was delayed 7 days because the patient was admitted to an outlying hospital with possible bowel obstruction. Laser photocoagulation was attempted, but a fluorescein angiogram revealed persistent subfoveal leakage. Photodynamic therapy was performed. Four months after treatment, the patient’s visual acuity was 20/400 left eye. Manifest refraction did not improve visual acuity because of the subfoveal nature of the persistent CNV. Keratometry measurements were not obtained.

DISCUSSION
Subfoveal choroidal neovascularisation represents 58%–67% of the exudative form of AMD. Its proper management is controversial despite the numerous treatment options available. The Macular Photocoagulation Study demonstrated a clear benefit for extrafoveal CNVM. However, for new and recurrent subfoveal CNVM, only limited success has been realised. In the MPS, a majority of patients with subfoveal CNVM had an immediate and irreversible loss of central vision from the treatment. While for selected patients with small,
genic rhegmatogenous retinal detachments. These were
1500 patients had improved vision after translocations of 350
underwent postoperative laser photocoagulation, and all
outcomes for three patients who underwent LMT for subfoveal
by fluorescein angiography.

Figure 7 Case 3. (A) Preoperative fluorescein angiogram left eye
demonstrates subfoveal CNV. (B) Postoperative fluorescein
angiogram left eye shows barely juxtafoveal CNV despite
translocation of 2400 µm.

well demarcated lesions this was better than the natural his-
tory of subfoveal CNV, many physicians and patients are
unwilling to use this method to control visual loss. Since then,
2 year results of the treatment of exudative AMD with photo-
dynamic therapy (TAP) study demonstrated less visual loss in
those patients with greater than 50% classic subfoveal lesions
by fluorescein angiography.

After 2 years, 59% of treated patients and 31% of control patients lost three or fewer lines of
vision. However, only 3.5% of patients with subfoveal CNV
and AMD are eligible. Although the results were less impres-
sive, the verteporfin therapy of subfoveal choroidal neovascu-
larisation in age related macular degeneration (VIP) study
demonstrated less visual loss in those with occult and no clas-
sic component to the CNV, especially in those with small
lesions (<4 disc areas) or with lower levels of visual acuity
(20/50 or worse). After 2 years, 45% of treated patients and
31% of untreated patients lost three or fewer lines of vision.
Early reports of surgical excision of subfoveal CNVM from the
submacular surgery trial (SST) have suggested poor visual
results.

De Juan et al were the first to describe limited macular
translocation (LMT) using small posterior retinotomies,
partial thickness scleral resection, and circumferential scleral
imbrication sutures in an attempt to minimise complications of
360 degree retinotomy and retinal rotation. They reported
outcomes for three patients who underwent LMT for subfoveal
CNV associated with AMD and angiod streaks. Two patients
underwent postoperative laser photoagulation, and all
patients had improved vision after translocations of 350 µm to
1500 µm. Two patients underwent repeat vitrectomy for iatro-
genic rhegmatogenous retinal detachments. These were
secondary to an open retinotomy and a sclerotomy site tear.
Two years later, the same group published a report of inferior
limited macular translocation in 102 patients with new or
recurrent subfoveal CNV associated with AMD.

Lesions were 1–9 Macular Photocoagulation Study (MPS) disc areas. The
range of foveal displacement achieved was 200–2800 µm
(median 1200 µm), and all patients with displacement to an
extrafoveal or juxtafoveal location (62%) received photo-
agulation. By 6 months, 48% of patients had two or more lines of
visual improvement, 16% had six or more lines of visual
improvement and 49% had vision better than 20/100. Compli-
cations other than those attributable to vitreotomy surgery
included CNV at the retinotomy in two eyes and macular fold
in three eyes.

In the 2 years since the original report, several authors have
reported their experience with variations of the limited macu-
lar translocation. Lewis et al described their experience in 10
patients with new or recurrent subfoveal CNV associated with
AMD. The lesions were six or less MPS disc areas and not
associated with subfoveal haemorrhages. The technique was
similar to that used by de Juan, but all translocations were
inferior, no scleral resection was performed, the scleral imbr-
imation was smaller and two CNV complexes were surgically
excised. Postoperative visual acuity decreased in six eyes and
increased in four eyes. The range of foveal displacement was
114–1919 µm (mean 1286 µm). Two patients had iatrogenic
retinal breaks, one of which required reoperation for a detach-
ment, and three had folds through the fovea.

Additional variations in imbrication technique have been
performed in an attempt to increase the predictability of foveal
displacement. The theory of displacement is based on
shortening of the internal scleral circumference that allows
repositioning of the fovea. However, the real decrease in the
internal scleral circumference is minimal owing to the fact
that the retina still has to cover the imbricated area. Interest-
ingly, a single report of limited macular translocation without
any imbrication resulted in a foveal displacement of 500 µm. The
mechanism of action may be retinal elasticity and stretching rather than shortening of the internal cir-
cumference of the globe. Using six cadaver globes, Lin et al compared
scleral infolding with a 6 mm circumferential scleral imbrica-
tion and scleral outpouching using a 7 mm interrupted radial
mattress suture. They demonstrated a dramatic anteroposte-
rior shortening with outpouching compared to infolding (4.61
mm v. 0.36 mm). However, their case report of a limited macu-
lar translocation using this suture technique resulted in a
foveal displacement of 1800 µm. This displacement is not as
dramatic as one would expect, given that the presumed scleral
shortening with the outpouching is more than 12 times larger
than with infolding. Lewis has reported another technique of
outpouching using metallic clips. This technique has the
advantage of achieving maximal shortening of the internal
scleral circumference, and resulted in at least 1644 µm of
foveal displacement in six patients using 4 mm, radially
oriented clips. Together, these findings would suggest that
scleral shortening contributes to foveal displacement, but is not
the sole mechanism. In addition, there may not be a 1:1
relation between peripheral shortening and foveal displace-
ment. Elasticity of viable retina, extent, and location of intra-
operative retinal detachment, postoperative positioning, reti-
nal folds, and other undetermined factors may also contribute
to foveal displacement in patients undergoing limited macular
translocation.

The procedure described here is a simple modification of
the original technique. It incorporates a third bite to the standard
suture, and traverses 5 mm of sclera. The range of foveal
displacements achieved using this technique was 1400–2400 µm.
While this is a small series, it suggests that use of the proposed
scleral retraction suture may lessen the risk of smaller,
inadequate amounts of foveal displacement. This technique
does not make the amount of translocation predictable. The
cadaver model demonstrated that the scleral retraction
produces a double infolding of sclera. This may result in a true
decrease in the internal circumference of the globe, and
decrease the length of sclera the retina must cover when reattached. Despite the lack of definitive proof of internal circumstance shortening using this modification, at the very least the technique does not increase the risk of the original procedure. The modified suture technique may be a useful adjunct to the standard suture technique, especially in patients who have a thin sclera where clips pose a threat of perforation. The redundant retinal fold was located inferiorly in all patients, adjacent to the border of detached and attached retina in the inferonasal quadrant.

Limited macular translocation is a technique under investigation and currently there is no randomised, controlled clinical trial demonstrating its benefit in improving long term visual acuity or quality of life. Age related macular degeneration is a medical disease that ultimately may be defeated by a medical therapeutics. In the interim, surgical intervention may be appropriate for a select group of patients. Nevertheless, it seems to be an alternative that may offer the best chance of improvement in visual acuity, as long as the possible complications of vitreotomy surgery and other complications of macular translocation such as choroidal haemorrhage are understood in advance by the patient and surgeon. Further improvements in surgical technique may improve the predictability of foveal displacement and increase the utility of limited macular translocation in patients with subfoveal CNV from AMD or other associated conditions.

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Authors’ affiliations
P Sullivan, J Sears, Cole Eye Institute, Cleveland Clinic Foundation, Cleveland, OH, USA
L Filsecker, Fundacion Oftalmologica Los Andes, Santiago, Chile

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