Semiology of periventricular leucomalacia and its optic disc morphology

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Future studies that distinguish PVH from PVL may help to determine whether optic disc morphology reflects timing of injury

Periventricular leucomalacia is an end stage lesion that results from hypoxic-ischaemic injury to the white matter of the developing brain. This condition occurs in 32% of premature infants and is believed to develop between the 24th and 34th weeks of gestation. Periventricular leucomalacia most commonly involves the optic radiations adjacent to the trigone of the lateral ventricle, and the anterior corticospinal fibres adjacent to the intraventricular foramen. Clinically, it can produce decreased visual acuity, inferior visual field con- striction, visual cognitive impairment, ocular motility disturbances, and spastic diplegia. The association of periventricular leucomalacia with optic nerve hypoplasia presents a complex diagnostic challenge for the ophthalmologist. In 1995, Jacobson et al recognised that periventricular leucomalacia produces a unique form of bilateral optic nerve hypoplasia characterised by an abnormally large optic cup and a thin neuroretinal rim contained within a normal sized optic disc. They attributed this morphology to prenatal injury to the optic radiations, with retrograde transynaptic degeneration of retinogeniculate axons after the scleral canals had established normal diameters. The large optic cups can simulate glaucomatous optic atrophy, while some of the retinal nerve fibre layer contributes to the optic disc. Whether the pseudoglaucomatous cupping of PVL warrants classification as a segmental form of optic nerve hypoplasia or a congenital optic atrophy remains controversial.

In many cases, however, PVL produces diffuse optic nerve hypoplasia with no enlargement of the central cup. So if periventricular leucomalacia can eventu- ate in axonal loss with two distinct optic disc morphological outcomes, what is the ultimate determinant of morphology? A follow up study by Jacobson et al in this month’s JBO (p 000) attempts to address this question. If timing of injury is the determinant, it stands to reason that early gestational injury would produce diffuse diminution in optic nerve size, while late gestational injury (after the scleral canals had established normal diameters) would result in the neuroretinal rim area and produce large cups with normal sized discs.

This correlation would have far-reaching diagnostic implications, as the morphology of the optic disc could be used to assign an approximate timing of CNS injury. This study attempts to use neuroimaging to distinguish two types of PVL that reflect pathophysiological processes known to occur at different times in gestation. The authors use the term periventricular haemorrhage (PVH) to describe the periventricular haemorrhagic necrosis that is caused by venous infarction. This lesion is distinguishable neuropathologically from PVL—an ischaemic, usually non-haemorrhagic, and symmetrical lesion of the periventricular white matter of the premature infant. Unlike PVL, PVH results from early gestational injury and usually produces a unilateral lesion that is causally related to germinal matrix-intraventricular haemorrhage. The venous infarction associated with PVH is particularly prominent ante- riorly, while PVL has a predilection for the arterial border zones, particularly the posterior region near the trigone of the lateral ventricles. Despite their pathophysiological differences, in vivo distinction is confounded by the fact that PVH can also be associated with secondary periventricular haemorrhage (termed haemorrhagic PVL). Consequently, some studies have used haemorrhagic periventricular leucomalacia (ischaemic arterial PVL with secondary haemorrhage) to designate periventricular haemorrhagic infarction (the anterior haemorrhagic necrosis caused by venous infarction), demonstrating the diagnostic confusion that arises from these two overlapping mechanisms of prenatal white matter injury. The absence of clear inclusion criteria leaves open the possibility that it is severity of injury rather than timing of injury that determines morphology.
Deep sclerectomy

Physiology and histology of deep sclerectomy

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Results from animal studies should be applied with caution to the human clinical situation

The paper by Delarive et al in this month’s BJO (p 000) studies the aqueous outflow characteristics and histology of deep sclerectomy (DS)—with (DSC) and without collagen implants—in a rabbit model. This increasingly popular surgery has the advantage of fewer postoperative complications, as it is theoretically non-penetrating.1,2

The mechanism(s) by which DS and DSCI lower the IOP has been investigated non-invasively but not vigorously studied in an animal model with corresponding histology. Ultrasound biomicroscopy (UBM) studies in human eyes that underwent DS or DSCI have demonstrated formation of a sub scleral lake and an overhanging bleb.3,4 In half or more of the patients examined by UBM, a suprachoroidal space was identified.5 As a result, it has been postulated that aqueous flow through the trabeculo-descemetic membrane is absorbed into the subconjunctival space as well as the suprachoroidal space. Physiological and histological support for some of these UBM findings is provided in the present study. Formation of an intrascleral canal was observed. This structure corresponds to the sub scleral lake seen on UBM. The use of cationised ferritin in the perfusate demonstrated the development of new vessels around the canal, which may possibly facilitate drainage into a subchoroidal space. In eyes with the collagen implant, spindle cells were observed lining the canal. These cells may help maintain the long term viability of the canal, as suggested by the slightly higher outflow facility (OF) in DSCI eyes versus DS eyes (not statistically significant).

The OF was significantly increased in both groups over the 9 months of study. This correlates well with clinical studies showing good long term IOP reduction.6,7 However, in the rabbit model, IOP reduction was maintained for only 5 months. This probably reflects, in part, the fact that the rabbits had a normal baseline IOP (not elevated, as in glaucoma patients). At the normal pressures there is probably less outflow and lower OF, thus avoiding hypotony. This also correlates well with clinical findings in which hypotony is rare and the maintained IOPs tend to be slightly higher than in trabeculectomies.8

As always, results from animal studies should be applied with caution to the human clinical situation, particularly with respect to the rabbit model where inflammation and possibly vascular formation may be more vigorous. However, the authors should be congratulated for developing an excellent animal model of deep sclerectomy and providing physiological and histological evidence for the efficacy of this surgery. Future studies in patient eyes and cadaver specimens may further shed light on the mechanisms.

REFERENCES


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