Relation between axial length of the eye and hypotensive effect of latanoprost in primary open angle glaucoma

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Aims: To study the effect of axial length on the hypotensive effect of latanoprost in primary open angle glaucoma (POAG) in a prospective, observational study.

Methods: The authors measured axial length and baseline intraocular pressure (IOP) of 109 eyes with POAG, and then repeated the IOP measurements at 1, 3, and 6 months after starting treatment with latanoprost.

Results: The mean IOP level was significantly lower in eyes with a shorter axial length compared with the eyes with a longer axial length both at 3 and 6 months of treatment (p = 0.03 and p = 0.04, respectively, ANOVA).

Conclusion: The hypotensive effect resulting from treatment with latanoprost could be related to ocular axial length.

Results

One eye from each of 109 patients (52 women, 52 men) were included in the study. Fourteen eyes had had YAG laser iridotomies for potential occlusion of narrow angles.

The mean axial length was 23.2 mm (range 19.3–32.7 mm). Seventy eyes had medium axial lengths, 21 long axial lengths, and 18 short axial lengths. The mean (standard error of mean, SEM) anterior chamber depth was 2.66 (0.32) mm.

The mean baseline IOP was 24.5 (4) mm Hg. There were no statistically significant differences between the axial length groups (p = 0.8 by ANOVA). One month after treatment, the IOP decreased significantly in the three study groups. The mean IOP was 17.7 (3) mm Hg in the MAL group, 18.7 (4) mm Hg in the SAL group, and 18.2 (4.1) mm Hg in the group with a SAL. There were no statistically significant differences between the groups (p = 0.5 by ANOVA) (fig 1).

Three months after treatment was started, the mean (SEM) IOP was 17.4 (3.5) mm Hg, 18.2 (4.1) mm Hg, and 15.8 (3.5) mm Hg, respectively, in the groups with medium, long, and short axial lengths. There was a statistically significantly greater decrease in IOP in the group with a SAL than the group with a LAL (p = 0.04, ANOVA) (fig 1).

After 6 months of therapy with latanoprost, the mean (SEM) IOP levels were 17.2 (3.7) mm Hg, 17.8 (3.2) mm Hg, and 15.5 (2.8) mm Hg, respectively, in the three groups. There was a statistically significantly greater reduction in IOP in the group with a SAL compared with the group with a LAL (p = 0.03 by ANOVA) (fig 1).

When we compared the groups of short and long axial length, and classified the patients as hyperresponders or...
hyporesponders to latanoprost, we found that most eyes that had a minimal response to latanoprost had LAL, whereas most of the eyes that had a greater than normal response had SAL (p = 0.04, χ² test) (fig 2).

An evaluation of the anterior chamber depth in the hyperresponders and the hyporesponders did not show a statistically significant difference.

Nineteen patients were lost to follow up after 3 months, 17 of them because of poor IOP control (one in the group with SAL, four in the group with LAL, and 12 in the group with MAL), and the other two because of poor tolerance.

**DISCUSSION**

We found that eyes with POAG and an SAL have a better response to treatment with latanoprost than eyes with an LAL. To our knowledge, this has not been previously reported. The mechanism of the relation between axial length and the response to latanoprost is unknown.

It is generally accepted that latanoprost decreases IOP by increasing the uveoscleral outflow of the aqueous humour, that finally leaves the eye through the sclera (transscleral outflow).

Eyes with a longer axial length usually have thinner sclera, and eyes with a shorter axial length tend to have thicker sclera. It is widely accepted that nanopithalamic eyes have a reduced transscleral flow that results from a thick sclera that decreases the uveoscleral outflow.

A number of studies have pointed to the possible role of matrix metalloproteinas (MMPs) in the pathogenesis of increased axial length in myopia. These enzymes also seem to be involved in the mechanism of action of latanoprost.

Aung and colleagues reported the superior IOP lowering effect of latanoprost compared with timolol in CACG, but the mechanism was not clear; in fact, it has been shown recently that its efficacy is independent of the height of the ciliary face. According to our results, it may be that it is the short axial length of these eyes and not the angle closure, that makes them more sensitive to the ocular hypotensive effect of latanoprost.

Because eyes with shorter axial lengths have a thicker sclera, a diminished basal uveoscleral outflow possibly may result. Therefore, the potential hypotensive effect of latanoprost could be greater, because this aqueous outflow pathway is underused. Another possibility is that if the MMPs are active in the growth of the globe that occurs while myopia is developing, then these eyes may become less sensitive to these enzymes, which in turn seem to be the ones that regulate the effect of latanoprost at the biochemical level.

The difference in IOP reduction between the SAL and LAL groups was not apparent until 3 months after latanoprost therapy started, and this may be related to the fact that some time may be needed for the MMPs to degrade the extracellular matrix and increase uveoscleral outflow.

Given the greater efficacy of latanoprost in lowering IOP in eyes with a short axial length, this agent could be considered as the first line therapy in these eyes with either CACG or POAG. It is clear that more studies are needed to further elucidate the factors that affect the variability in hypotensive response to prostaglandin analogues.

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