Acute Panretinal Structural and Functional Abnormalities After Intravitreous Ocriplasmin Injection

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In October 2012, the US Food and Drug Administration approved ocriplasmin for the treatment of symptomatic vitreomacular adhesion. Ocriplasmin is a recombinant truncated form of plasmin with proteolytic activity against fibronectin and laminin, components of the vitreous gel. The combined results of 2 phase 3 randomized clinical trials demonstrated that a single intravitreous injection of ocriplasmin resulted in resolution of vitreomacular adhesion in 26.5% of patients vs 10.1% of control subjects injected with placebo. Reported adverse events included transient visual disturbances such as floaters, photopsias, and visual impairment. Herein, we report that such visual disturbances may be accompanied by substantial panretinal functional and structural abnormalities and propose a mechanism for this toxic reaction.

REPORT OF A CASE

This retrospective case study was exempt from institutional review board oversight. After written informed consent, a 63-year-old woman received intravitreous ocriplasmin (0.125 mg/0.1 mL) injection in the right eye for a small macular hole with vitreomacular adhesion (Figure 1). Her preinjection visual acuity was 20/40 OD. Several hours later, she experienced brilliant white photopsias that evolved during the evening into multiple white floaters on a black background, with no discernible vision in the injected eye. The visual function recovered partially during the next 4 days, and she noted nyctalopia and a yellow tint to her vision. She was referred to us 9 days after injection with persistent visual loss in the right eye.

Visual acuity with correction measured 20/125 OD and 20/25 OS. Color vision was normal by Ishihara testing. There was 1 mm of anisocoria with the smaller pupil in the right eye. Fundus biomicroscopy of the right eye (Figure 2) demonstrated a prepapillary vitreous (Weiss) ring, with otherwise clear media. The macula exhibited a full-thickness hole with a cuff of surrounding subretinal fluid. The retinal arterioles were diffusely attenuated. The fundus periphery appeared normal. Examination of the left eye was unremarkable.

Spectral-domain optical coherence tomography of the right eye revealed an enlarged full-thickness macular hole with smooth, scalloped edges, as well as attenuation or loss of the external limiting membrane, photoreceptor ellipsoid layer, and cone outer segment tips line (Figure 2). Goldmann visual field testing revealed constriction of all isopters in the right eye compared with the left eye (eFigure in the Supplement).

Full-field electroretinography (ERG) in the right eye exhibited a severely reduced rod B-wave to less than 10% of normal amplitude and delayed implicit time (Figure 3). The dark-adapted combined rod-cone response in the right eye was reduced to approximately 50% of normal, with the B-wave more severely depressed than the A-wave compared with the
of acute severe panretinal dysfunction after ocriplasmin injection documented and quantified by fundus photography, Goldmann visual field testing, spectral-domain optical coherence tomography, and electrophysiological responses.

Of 976 patients receiving ocriplasmin injection in clinical trials, 9 patients were reported to have experienced an acute decrease in vision within 24 hours of injection.4 In 8 of 9 patients, the vision returned to baseline, with a median recovery time of 2 weeks, although the range extended to 1 year. Seventeen patients were reported to have dyschromatopsia with a yellow tint. Of 141 patients with ERG data, 11 patients had decreased A-wave and B-wave amplitudes within 1 month of ocriplasmin injection. The severity of reduction was not specified. Seven patients showed resolution, while 4 patients demonstrated persistently depressed ERG responses. Freund and coauthors5 recently described a patient with disruption of the ellipsoid layer after ocriplasmin injection.

Possible mechanisms of retinal injury from ocriplasmin injection include mechanical effects from a transient increase in vitreomacular traction, enzymatic activity of ocriplasmin on the retinal extracellular matrix, and other toxic effects not specific to the proteinase activity of ocriplasmin. We believe the first postulate is unlikely given the global nature of the retinal alterations compared with the focal nature of vitreomacular traction.

Enzymatic activity of ocriplasmin includes cleavage of fibronectin and laminin, the latter being prominent in Bruch membrane, the interphotoreceptor matrix, the external limiting membrane, the outer plexiform layer, the inner plexiform layer, and the internal limiting membrane.6 In the outer plexiform layer, laminin localizes to the synaptic ribbon
consistent with the important role of laminin in the photoreceptor-bipolar synapse.

In our patient, the ERG in the affected eye demonstrated panretinal dysfunction, with significant reduction in every variable. Notably, B-waves were reduced more than A-waves were, which suggests postreceptoral (eg, bipolar cell) dysfunction in addition to decreased photoreceptor activity. These results are consistent with the important role of laminin in the photoreceptor-bipolar synaptic ribbon. In addition, rod function seemed to be more severely affected than cone function. Furthermore, spectral-domain optical coherence tomography demonstrated disruption of the ellipsoid and cone outer segment tip lines, consistent with the presence of laminin in the interphotoreceptor matrix.

Given the growing number of anecdotal reports of visual disturbances after ocriplasmin injection and the multiple lines of evidence showing retinal toxic effects in the patient described herein, physicians should exercise caution when considering ocriplasmin injection for vitreomacular adhesion. Long-term follow-up observation of this patient and similar individuals will be necessary to determine the reversibility of the anatomical and functional abnormalities that may occur acutely after injection.

**REFERENCES**