Watzke-Allen Slit Beam Test in Macular Holes Confirmed by Optical Coherence Tomography

Vaughan Tanner, BSc, FRCOphth; Thomas H. Williamson, MD, FRCOphth

Objective: To examine the role, validity, and interpretation of Watzke-Allen slit beam testing in patients with idiopathic senile macular holes.

Methods: Thirty-seven consecutive patients with 40 full-thickness macular holes, confirmed on optical coherence tomography, were prospectively recruited. The Watzke-Allen slit beam test was used centrally and on the rim of the macular hole in both vertical and horizontal orientations.

Results: In 24 eyes, the beam was reported as thinned in both vertical and horizontal orientations when placed directly over the center of the macular hole. In 9 eyes, the Watzke-Allen slit was reported as broken in both vertical and horizontal orientations. In 6 eyes, the beam was reported as broken in one orientation and thinned in the other. In 1 eye, the beam was reported as kinked but not thinned or broken. When the beam was placed on the edge of the macular hole, all patients reported a displacement or bowing of the beam away from the center of the hole.

Conclusions: These findings confirm tangential traction of photoreceptors from a central foveal dehiscence as the causative mechanism in the development of the majority of macular holes. Careful interpretation of the Watzke-Allen sign may offer a technique for preoperatively determining visual prognosis.


DIOPATHIC FULL-THICKNESS macular holes (FTMHs) are a relatively common cause of visual loss, affecting approximately 3 in 1000 individuals. Those affected are characteristically women in the sixth or seventh decade of life with normal refractive errors. Following the first reports of success in the surgical treatment of this condition, there has been increased interest in the classification, pathogenesis, and differential diagnosis of idiopathic senile macular holes. In 1988 Gass and then Johnson and Gass described a classification scheme that emphasized the importance of tangential vitreous traction in the development of idiopathic senile macular holes and proposed that the prefoveal opacity seen in macular holes was composed of retinal tissue. Following the initial reports of recovery of excellent visual acuity in some patients following surgery, Gass reappraised his theory to suggest that in most cases no foveal tissue was lost from the macula and that the hole developed as a result of centrifugal displacement of photoreceptors from a central dehiscence of the umbo.

As a result of increased surgical intervention in this condition, accurate preoperative diagnosis of idiopathic senile macular holes and differentiation from similar conditions have assumed greater importance. The most common lesions simulating an FTMH are epiretinal membrane with pseudomacular hole, impeding macular holes that are not yet full thickness, and lamellar macular holes. Careful contact lens biomicroscopy is essential in differentiating FTMHs from pseudoholes. The diagnosis can usually be made on the presence of the distinguishing features of a true macular hole, which include drusenlike yellowish deposits in the base of the hole, a cuff of presumed subretinal fluid, a distinct hole margin, and, more controversially, the presence of an overlying prefoveal opacity.

Occasionally, the differential diagnosis is not straightforward, and several authors have suggested additional techniques to assist in the differentiation of true FTMHs from masquerading conditions. Examination techniques include use of a 50-µm argon laser aiming beam, Amsler grid testing, and the Watzke-Allen slit beam test. Fluorescein angiography, scanning laser ophthalmoscopy, laser biomicroscopy, retinal thickness analysis, and
PATIENTS AND METHODS

Thirty-seven consecutive patients with 40 FTMHs were prospectively recruited from a teaching hospital retinal clinic between March 1998 and March 1999. A complete ocular examination was performed, including best-corrected visual acuity measurement, using a standard examination lane with an illuminated Snellen visual acuity chart read at 6 m. A diagnosis of FTMHs was initially made on clinical features as observed with biomicroscopy of the macula and vitreomacular relationships using a Goldmann macula contact lens.

All patients were examined by OCT by one examiner (V.T.) to confirm the presence of a full-thickness retinal break. Before OCT examination, pupil dilation was performed using 1% tropicamide. A B-scan OCT of the macular region was obtained using a commercially available OCT machine (Zeiss-Humphrey, San Leandro, Calif) as described by Hee et al.21,22 Optical coherence tomography uses low-coherence interferometry to obtain information on tissue depth and reflectivity by analyzing a probe beam reflected from retinal structures and light returning from a variable reference optical delay pathway. All B-scan retinal images were composed of 100 consecutive A-scans acquired through the center of the macula in both vertical and horizontal orientations (Figure 1). Any patient who did not appear to have an FTMH on OCT examination was excluded from the study. The first 20 patients admitted to this study had the presence of an FTMH confirmed using the 50-µm laser aiming beam test12 in addition to OCT examination.

RESULTS

BASELINE INFORMATION

Forty FTMHs were examined in 37 patients (3 cases were bilateral). The mean age of the 27 women and 10 men was 70.1 years (range, 60–83 years). Twelve eyes were classified as stage 2 holes, 18 eyes as stage 3 holes, and 10 eyes as stage 4 holes. Mean duration of symptoms was 9.4 months (range, 4 weeks to 3 years). Visual acuity measures ranged from 6/9 to counting fingers. The right eye was affected in 21 cases and the left in 19 cases.

WATZKE-ALLEN TESTING

The subjective appearance of the Watzke-Allen slit beam test for each test position is shown in Figure 3. In 24 eyes, the slit beam was reported as unbroken and thinned centrally in both vertical and horizontal orientations. In this group the beam was reported as continuous but bowed away from the center of the macula when placed on the nasal or temporal and superior or inferior hole rim in the vertical and horizontal orientations, respectively.

In 9 eyes, the slit beam was reported as broken centrally in both vertical and horizontal orientations. In most cases this group also reported the slit beam as bowed away from the center of the macula when placed on the hole rim. In addition, 3 patients reported that the slit beam appeared to be thinned or have a small piece missing when placed on the hole rim.

In 5 eyes, the slit beam was reported as thinned centrally in the vertical orientation but broken horizontally. In 1 eye, the slit beam was reported as thinned centrally in the horizontal orientation but broken vertically. This group also reported the slit beam as bowed away from the center of the macula when placed on the hole rim.

In 1 patient with a very small grade 2 hole, it was not possible to accurately perform the full Watzke-
Allen test protocol, because the hole rim was too small. This patient reported a displacement of the vertically orientated beam when placed centrally over the hole. The slit beam was reported as straight and continuous when placed in all other test positions.

The mean duration of symptoms was 11.7 months in those who reported a broken slit beam in both vertical and horizontal orientations and 10.1 months in those who reported the beam as thinned in both orientations. Analysis revealed no statistically significant difference between the groups (W4,20=49.5, P=.50).

Of 24 eyes in which the slit beam was reported as thinned in both vertical and horizontal orientations, 8 eyes were classified as having stage 2 holes, 9 eyes as stage 3 holes, and 7 eyes as stage 4 holes. Of 9 eyes in which the slit beam was reported as broken in both vertical and horizontal orientations, 1 eye was classified as having a stage 2 hole, 3 eyes as stage 3 holes, and 5 eyes as stage 4 holes. Analysis revealed no statistically significant difference in hole classification between those reporting the slit beam as thinned centrally and those reporting it as broken (n=333, x²=1.73, P=.42).

The visual acuities of all patients are shown in Figure 4. Median visual acuity was 6/60 (range, 6/9 to counting fingers) in those reporting a broken beam in both vertical and horizontal orientations and 6/36 (range, 6/9 to counting fingers) in those reporting a thinned beam.

**PREFOVEAL OPACITIES**

Twenty-one eyes had prefoveal opacities. Eighteen were identified by Goldmann contact lens examination and confirmed on OCT examination. Three opacities were identified on OCT examination but could not be seen on Goldmann contact lens examination. Of 9 eyes in which a broken slit beam was reported in both vertical and horizontal orientations, 4 eyes (44%) were identified as having a prefoveal opacity either clinically or on OCT. Of 24 eyes in which a thinned slit beam was reported in both vertical and horizontal orientations, 13 eyes (54%) were identified as having a prefoveal opacity. Analysis revealed no statistically significant difference between the 2 groups (n=33; x²=0.095, P=.99).

---

**Figure 1.** Example of optical coherence tomography image used to confirm the presence of a full-thickness macular hole. In this case, the 3-mm horizontal scan taken through the center of the macula confirms a stage 4 macular hole in the left eye of a 63-year-old woman.

**Figure 2.** Description of the Watzke-Allen slit beam when placed directly over the center of the macular hole in both vertical and horizontal orientations.

**Figure 3.** Snellen visual acuity. Results displayed according to description of central slit beam in horizontal and vertical orientation. CF indicates counting fingers.

**Figure 4.** Watzke-Allen slit beam description. This chart was shown to patients to assist in describing the appearance of the slit beam when placed at different positions in the macular hole. When horizontal beam orientations were used, the chart was turned through 90°.
COMMENT

A positive Watzke-Allen sign is often used clinically to differentiate FTMHs from mimicking conditions. Several studies, including the Vitrectomy for Macular Hole Study Group, have used the presence of a reported break in the slit beam as an entry criteria for inclusion. We have shown that if the Watzke-Allen test is performed carefully, using a macular contact lens, the majority of patients with FTMHs do not report a break in the slit beam when placed directly over the center of the macular hole. Several other investigators have reported similar findings. Martinez et al. reported a thinning of the slit beam in 4 of 16 FTMHs confirmed with the 50-µm laser aiming beam test, and Asrani et al. reported a thinning of the slit beam in 8 of 22 FTMHs confirmed on a scanning retinal thickness analyzer. Tsujikawa et al. reported an additional 3 cases of thinning of the slit beam in FTMHs confirmed by scanning laser ophthalmoscopy.

In Watzke and Allen’s original description of the slit beam test, they report a range of patient responses in association with FTMHs, including a central break and peripheral bowing of the slit beam, which they attributed to displacement of photoreceptors. In our study, patients most often report a central thinning rather than a break of the slit beam. It may be that the option of reporting a thinning, in conjunction with use of a diagram to aid in response, encouraged patients to report this appearance. Use of the macular contact lens in performing the test allows more accurate placement of the slit beam and may also contribute to increased recognition of different slit beam appearances.

It is interesting to speculate why patients with a definite FTMH confirmed in our series by OCT should not report a definite break in the slit beam. If Gass’ theory of central dehiscence at the umbo and centrifugal traction of photoreceptors is correct, then there is, of course, no loss of foveal tissue in the creation of an FTMH. An individual photoreceptor has no sense of position and has a fixed visual direction. Therefore, when stimulated by incident light, the photoreceptor transmits a signal that is interpreted as originating from its original position, thus accounting for the complaint of metamorphopsia seen in conditions such as central serous retinopathy, subfoveal neovascular membranes, and, of course, FTMHs themselves. Therefore, in patients with functioning foveal tissue on the rim of an FTMH, a central break would not be reported as broken. A subjective thinning of the beam is likely, since the photoreceptors are more spread out on the rim of the hole than in their original, central foveal position.

Bowing of the slit beam when placed on the edge of an FTMH requires further explanation. For example, if the vertical beam is placed on the temporal rim of an FTMH in the right eye, it will stimulate photoreceptors that were originally situated more nasally. The beam will therefore be interpreted as having a small central bend or kink. Since the retinal image is inverted, the central kink in the beam of light will be perceived as pointing in a more temporal direction, ie, away from the center of the hole. A similar explanation can be provided for the observed positions of the slit beam when placed on the nasal, superior, and inferior hole rim.

This explanation for the reported observations with the Watzke-Allen slit beam test supports Gass’ theory of tangential traction with no loss of foveal tissue in the development of FTMHs. The observations also suggest that patients who report only a thinning of the slit beam have functioning foveal tissue on the rim of an FTMH and potentially a favorable prognosis following successful anatomical closure of the FTMH. However, in our series, the central slit beam was reported as broken rather than thinned in 9 eyes with FTMHs. One possible explanation for this finding is that patients with a central break in the slit beam have macular holes of longer duration in which the photoreceptors on the elevated rim of the FTMH have undergone secondary degeneration and are no longer functioning. This theory is not supported by the fact that in our series there was no statistically significant difference in mean duration of symptoms in patients reporting a central break in the slit beam (11.7 months) compared with those reporting a central thinning (10.1 months).

A second explanation for the finding of a central break in the slit beam is that in these eyes the FTMH was created by a different mechanism, resulting in loss of photoreceptors, compared with those holes in which only a thinning of the beam is reported. Such a mechanism involving loss of foveal tissue in the overlying prefoveal opacity was originally described by Gass and has also been suggested by other investigators studying the histopathologic characteristics of prefoveal opacities removed at the time of macular hole surgery. Some FTMHs are created via the loss of foveal tissue, then it may be this group that, despite anatomical closure of the hole, does not achieve significant improvement in visual acuity following macular hole surgery. This explanation is only partly supported by our series, since prefoveal opacities were seen in 4 of 9 of those reporting a broken Watzke-Allen slit beam in both vertical and horizontal orientations and in 13 of 24 of those reporting a thinned Watzke-Allen slit beam.

Patients who report a central break in the slit beam despite careful examination may not be expected to achieve as marked an improvement in visual acuity following surgery as those who report only a central thinning. The identification of this group with a readily available, inexpensive, and noninvasive test such as the Watzke-Allen slit beam test may therefore allow an opportunity to target surgery for cases with a better visual potential and may also prevent unnecessary intervention or alter the surgical technique in those who are unlikely to achieve a satisfactory result. We are currently following up this group of patients to determine if the appearance of a broken as opposed to a thinned slit beam on the preoperative Watzke-Allen test is associated with a poorer improvement in visual acuity following surgery.

Accepted for publication January 14, 2000.

We gratefully acknowledge the statistical advice provided by Barney Foot, MSc, Audit Fellow, Royal College of Ophthalmologists, London, England.
Corresponding author: Thomas H. Williamson, MD, FRCOphth, Vitreo-retinal Unit, Department of Ophthalmology, 9th Floor, North Wing, St Thomas’ Hospital, Lambeth Palace Road, London SE1 7EH, England (e-mail: TANNERONE@aol.com).

REFERENCES