arteriovenous nickings (AVNs) may cause branch retinal vein occlusion,1 and their prevalence correlates with arterial pressure2 and with lacunar stroke.3

Thus, AVNs are surrogates of the retinal and cerebral microcirculations. However, despite its clinical importance, the pathophysiology of AVNs has received limited attention. This may be because there is a general acceptance of the concept postulating that the vein is crushed by the bypassing artery. This belief persists despite the fact that histologies have consistently reported that venous changes were related to perivascular changes described either as glial proliferation,4 glial edema,5 or extracellular deposits.6 Furthermore, clinical studies of AVNs using high-resolution imaging have failed to evidence external compression of veins7 or parietal thickening of arterioles.8

Clinical studies of AVNs are impaired by the extreme variability of their presentation and the difficult access of the arteriovenous interface. In this regard, of interest are cases of venous remodeling occurring where an artery and a vein are close yet not overlapping6,15 because the arteriovenous interface is directly observable. Here, we analyzed such cases using high-resolution imaging to better understand the relationship between the arteriovenous interface and venous changes.

Methods

This institutional clinical study, conducted from January 2013 to September 2014, was carried out according to the principles outlined in the Declaration of Helsinki. Approval of the Ethics Committee of the Saint-Antoine Hospital (Paris, France) was obtained. Seven adult patients showing venous remodeling proximal to arterioles were recruited. Each patient received full oral and written information and gave written consent prior to inclusion.

Infrared and 488-nm reflectance imaging and optical coherence tomography were obtained using combined scanning laser ophthalmoscope–optical coherence tomography (Spectralis; Heidelberg Engineering). Adaptive optics (AOs) infrared fundus images were obtained with a commercially available fundus imaging AO camera (rtx1 camera; Imagine Eyes) using a previously described procedure.8 The AO camera illuminates the fundus with a noncoherent light delivered by a superluminescent diode at 840 nm, covering a 4° × 4° area (ie, approximately 1.2 mm × 1.2 mm in emmetropic eyes). For imaging acquisition, the gaze of the left eye was oriented with an external target, which allowed the exploration of the fundus of the right eye up to approximately 30° from the disc.
From A to D, the adaptive optics images are of cases 1 to 4. In each panel, the magnification is shown to the right of the original adaptive optics image. The arteriolar wall (between white arrowheads) does not enter in contact with the venous lumen. The black arrowheads indicate peak venous narrowing (bars = 125 μm; see also eFigure 1 in the Supplement).

Variations of lumen diameter (orange lines) and of intervascular space (blue lines) were measured along venous segments. The black arrows point to venous narrowings.
Arteries and veins were semiautomatically segmented from AO images using a custom software running under Matlab (MathWorks). The segmentation algorithm is based on the detection of 4 curves parallel to the central reflection, which are refined using a deformable model incorporating a parallelism constraint. Graphic representations of the venous diameter and of the width of the intervascular space (i.e., the distance between the venous lumen and the outer limit of the arteriolar wall) along a given venous segment were generated.

Results

Seven cases of focal venous remodeling without arteriovenous crossing from 7 patients were documented. Their mean age was 65.9 years (range, 54-80); 3 were women; and 4 had arterial hypertension. Three were fellow eyes of branch retinal vein occlusion. Part of the data from case 4 was previously reported. The regions of interest were located along temporal arcades, up to 3 mm from the disc. The affected vessels had a diameter of 100 μm to 150 μm. There was unequivocal deviation of the vein toward the arteriole in 6 of the 7 cases. Adaptive optics imaging allowed a high-power view of the arteriolar wall, the arteriovenous interface, and the venous morphology (Figure 1 and eFigure 1 in the Supplement). Nicking of the vein at the side opposite to the arteriole was noted in 3 cases (1, 4, and 5). Adaptive optics imaging could delineate the area between the outer boundary of the arteriole and the venous lumen. At sites of maximal narrowings, the reduction of venous diameter ranged from 40% to 77%, while the width of the intervascular space ranged from 16 μm to 42 μm (Figure 2; eFigure 1 in the Supplement).

We then examined AO images of common presentations of AVNs (that is, within arteriovenous crossing) to search for similar venous changes. For this, we retrospectively examined AO images of AVNs occurring at arteriovenous crossings from other eyes to determine whether similar changes may be present (Figure 3). Focal narrowing, venous dragging toward the arteriole, and paravascular opacification in AVNs were present; some combined several of these features.

Discussion

There has been a longstanding yet unsubstantiated consensus among clinicians about the compressive nature of the arteriovenous conflict underlying AVNs. Our findings support the conclusions of histology and in vivo studies suggesting that the paradigm of arterial crushing as the cause of venous nicking stems from a misinterpretation of fundus photographs. We indeed found here that veins close to arterioles, but without detectable arteriovenous contact, may undergo marked phenotypical changes comprising nicking, narrowing, opacification, and/or dragging. Nicking of the venous wall on the side opposite to the arteriole, venous dragging toward the arteriole, and the presence of an arteriovenous gap up to 40 μm do not fit easily with the hypothesis of an arterial compression. Similar findings were retrospectively evidenced in AVNs occurring with arteriovenous overlap from other patients, which suggest that classic AVNs may also imply indirect arteriovenous interaction.

Our findings suggest that the interaction between arteries and veins leading to AVNs is mediated by the paravascular milieu. Such hypothesis of an indirect arteriovenous interaction has been pre-
AVNs are related to biological markers of inflammation and mediating such arteriovenous interaction may either be derived from the metabolism of arteries or be immunomodulators or vasomodulators. It is known that AVNs are related to biological markers of inflammation and that veins are responsive to vasoactive compounds. Chronically increased venous tone could induce rearrangement of the scaffold of smooth muscle cells of veins, similarly to what is observed in arterioles during arterial hypertension. The role of venous flow turbulence in this process is unclear because laminar flow may be present even in severe venous narrowings (eFigure 2 in the Supplement).

There is indirect evidence that AVNs may regress, suggesting that AVNs have a dynamic component. Therefore, further investigations may address the natural history of AVNs. Histology of arteriovenous crossings may address glial cells, the arrangement of intracellular actin networks, and/or the extracellular matrix. The presence of vasoactive or inflammatory metabolites, in particular small and/or lipophilic molecules, which may cross the blood-retinal barrier, may also be explored. It is unclear whether experimental studies will be contributive because we have as of yet failed to identify AVNs in rodent and nonhuman primate eyes (M.P.; unpublished data; 2013). Given the proximity of the central artery and vein within the optic nerve, it is plausible that central retinal vein occlusion may be related to a similar interaction. It may also be of interest to document whether similar changes occur in the brain.

Conclusions

In summary, this study found that arteriovenous nickings do not necessarily involve an arteriovenous compression. Instead, the topology of venous changes suggests a retractive process originating in the intervascular space. These findings have important implications for the understanding of retinal vein occlusions and cerebrovascular aging.

REFERENCES


