Characteristics of Peripapillary Detachment in Pathologic Myopia

Noriaki Shimada, MD; Kyoko Ohno-Matsui, MD; Takeshi Yoshida, MD; Kenjiro Yasuzumi, MD; Ariko Kojima, MD; Kanako Kobayashi, MD; Soh Futagami, MD; Takashi Tokoro, MD; Manabu Mochizuki, MD

Objective: To evaluate the prevalence and clinical features of a newly recognized peripapillary lesion specific to high myopia, peripapillary detachment in pathologic myopia (PDPM), in a large series of patients with high myopia.

Methods: Three hundred twenty-four patients (632 eyes) with high myopia were enrolled in this study. We examined the prevalence, range, fluorescein and indocyanine green angiographic findings, and optical coherence tomography findings of PDPM for these patients. Visual field testing (Goldmann kinetic perimetry and the Humphrey 30-2 program) was also performed in the patients with PDPM.

Results: Peripapillary detachment in pathologic myopia was identified in 31 of 632 highly myopic eyes (4.9%). The optical coherence tomographic scan across the PDPM lesion revealed a localized detachment of retinal pigment epithelium adjacent to the optic nerve. Although PDPM was always situated adjacent to the inferior edge of the optic disc, in some patients it surrounded almost the entire optic disc. There was a steep excavation of the inferior myopic conus adjacent to the PDPM, and the inferotemporal retinal vein was markedly bent at the transition from the PDPM to the excavated myopic conus. Glaucomatous visual field defects were frequently detected in eyes with PDPM (71.0%).

Conclusions: The findings of this study indicate that PDPM is not uncommon among highly myopic eyes. Although its pathogenesis and pathologic significance require further classification, PDPM might be another indicator of visual field defects in high myopia.

Arch Ophthalmol. 2006;124:46-52

In many developed countries, a major cause of legal blindness is high myopia.1-3 In the United States, the prevalence of high myopia with a refractive error greater than −7.9 diopters (D) ranges from 0.2% to 0.4%.2 In Asia and the Middle East, high myopia is particularly common.4 In Japan, the number of cases of myopia is unknown, but pathologic or high myopia is estimated to affect 6% to 18% of the myopic population and approximately 1% of the general population.5

In highly myopic eyes, axial length elongation induces changes in the posterior fundus, including the optic disc.6 Typical changes of the myopic disc include tilting with the temporal side flattened and elevation of the nasal side with the edge raised. In addition, a concentric area of depigmentation, known as the myopic conus or temporal crescent, often surrounds the optic disc.

In 2003, Freund et al7 reported a newly recognized lesion around the optic disc in highly myopic eyes, termed peripapillary detachment in pathologic myopia (PDPM). They reported that PDPM is observed as an elevated, well-circumscribed, dome-shaped, yellow-orange lesion inferior to the optic disc along the inferior margin of the myopic conus by ophthalmoscopic examination. Optical coherence tomography (OCT) demonstrated a localized detachment of the retinal pigment epithelium (RPE) and retina corresponding to the PDPM in each of the 20 eyes of 15 patients examined. There was no apparent negative effect on visual function in their patients.

The clinical features, however, including the prevalence, pathogenesis, and clinical significance of PDPM, remain unclear. In the present study, we evaluated the prevalence and clinical features of PDPM in a large series of patients with high myopia to clarify the pathogenesis and clinical significance of this newly recognized peripapillary lesion.

METHODS

The study was performed according to the guidelines of the Declaration of Helsinki after obtaining informed consent. The study protocol was approved by the ethics committee of...
Tokyo Medical and Dental University, Tokyo, Japan. Three hundred twenty-four patients (632 eyes) with high myopia were identified using clinical records from 1988 to 2003 at the high myopia clinic at Tokyo Medical and Dental University and enrolled in this study. The inclusion criteria were: (1) refractive error of -8 D or more and (2) fundus changes typical of pathologic myopia: chorioretinal atrophy, lacquer cracks, and atrophic patches. Exclusion criteria included a history of retinal detachment surgery and ocular injuries. There were 109 men and 215 women with a mean age of 49.0±16.8 years (range, 7-85 years). The mean refractive error was -12.9±4.60 D (range, -8.25 to -27.0 D). The mean axial length was 28.2±1.30 mm (range, 25.9-33.3 mm). Each patient underwent a complete ophthalmologic examination, including best-corrected visual acuity measurement, intraocular pressure (IOP) measurement, anterior segment biomicroscopy, visual field testing, and dilated fundus examination using stereoscopic observation. Color fundus photographs were obtained from all patients. Using color fundus photographs, we identified eyes with a yellow-orange lesion inferior to the optic disc suggestive of PDPM.

Then, the eyes with a yellow-orange lesion were prospectively examined in detail. To confirm RPE detachment, OCT was performed in the eyes with a yellow-orange lesion inferior to the optic disc as described by Freund et al. Using a commercially available OCT machine (OCT 2000 scanner; Zeiss-Humphrey, San Leandro, Calif), the OCT images were generated using 6-mm radial scans in a spoke-like pattern according to the manufacturer's protocol. The OCT operator closely monitored patient fixation under direct visualization, and scanning was repeated until all reasonable attempts were made to obtain excellent fixation maintained over the entire 1.92 seconds.

In each eye for which OCT confirmed PDPM, the range of PDPM was determined both ophthalmoscopically as well as by OCT. The range of PDPM was categorized into 3 groups: grade 1, PDPM formed less than a semicircle around the optic disc or myopic conus; grade 2, PDPM formed more than a semicircle around the optic disc or myopic conus but less than three fourths around the optic disc or myopic conus; grade 3, PDPM surrounded more than three fourths of the optic disc or myopic conus.

Fluorescein fundus angiography was performed in all the patients with PDPM using a Topcon TRC-50IA fundus camera (Topcon, Tokyo) after injection of 4 mL of sodium fluorescein into the cubital vein. Indocyanine green (ICG) angiography was also performed with a Topcon TRC-50IA fundus camera in patients who agreed to the examination. For the ICG angiographic procedure, 50 mg of ICG (Ophthagreen, Santen Pharmaceutical, Tokyo) dissolved in 5 mL of distilled solution was injected into the cubital vein. Informed consent was obtained from all patients before performing angiography.

Visual field testing (Goldmann kinetic perimetry) was also performed. Visual fields were examined after complete correction of refraction anomalies using disposable soft contact lenses. Field defects were detected by Goldmann perimetry, and glaucomatous visual field loss was examined. Glaucomatous visual field loss included at least 1 of the following defects that could not be explained by myopic fundus changes: (1) arcuate or paracentral scotoma, at least 4 contiguous points on the pattern deviation plot depressed at P<.005; (2) nasal step at least 2 horizontal points in width (10°) on the pattern deviation plot depressed at P<.05; or (3) advanced glaucomatous field loss. Changes in the PDPM area were retrospectively examined in the cases for which a series of fundus photographs had been taken before enrollment to the present study.

Peripapillary detachment in pathologic myopia was ophthalmoscopically identified in 31 of 632 eyes (4.9%). The Table shows the clinical data for these 31 eyes (23 patients: 13 men, 10 women; mean±SD age, 57.7±14.3 years; range, 39-78 years). The mean±SD refractive error in eyes with PDPM was -11.4±3.53 D (range, -8.25 to -21.0 D), and the mean±SD axial length was 27.7±1.42 mm (range, 25.3-30.1 mm). The mean±SD logarithm of the minimum angle of resolution (logMAR) was 0.59±0.34 (range, 0-1.52). Five patients had macular choroidal neovascularization caused by pathologic myopia. Tilted optic discs were observed in 29 (93.5%) of 31 eyes, and posterior staphyloma was detected in 19 (61.3%) of 31 eyes by stereoscopic observation. A peripapillary crescent (myopic conus) was observed in all eyes with PDPM.

The distribution of patients' ages among patients with high myopia with PDPM and without PDPM is shown in Figure 1. Peripapillary detachment in pathologic myopia was never observed in patients younger than age 30 years. Figure 2 and Figure 3 show the distribution of the refractive error and axial length in highly myopic eyes with and without PDPM, respectively. Although PDPM was mainly observed in eyes with a relatively mild refractive error or short axial length within patients with high myopia, there was no obvious trend.

In all the patients with ophthalmoscopically detected PDPM, the OCT scan across the PDPM lesion revealed what appeared to be a localized detachment adjacent to the optic nerve (Figures 4, 5, 6, and 7). In all the patients, fluid appeared to be beneath both the neurosensory retina and the RPE. In 3 patients, OCT revealed an apparent discontinuity or cleft in the retinal layers at the point of transition from the PDPM to the myopic conus (Figure 6B and Figure 7E).

Regarding the range of PDPM, 20 (64.5%) of 31 eyes had grade 1 involvement, 7 eyes (22.6%) had grade 2...
Figure 1. Distribution of age in patients with peripapillary detachment in pathologic myopia (PDPM) (gray) and without PDPM (black).

Figure 2. Distribution of refractive errors in patients with peripapillary detachment in pathologic myopia (PDPM) (gray) and without PDPM (black).

Figure 3. Distribution of axial length measurements in patients with peripapillary detachment in pathologic myopia (PDPM) (gray) and without PDPM (black).

Figure 4. Case 1, A 60-year-old man. A and B, The right fundus shows a yellow inferonasal peripapillary elevated lesion at the inferior edge of the optic disc and conus, clearly distinct from the myopic conus. There is a deep excavation in the inferior part of the myopic conus, and the inferotemporal retinal vein is markedly bent at the border edge between the myopic conus and peripapillary detachment in pathologic myopia (PDPM) (arrowhead). Arrow indicates the location of the optical coherence tomographic (OCT) scan (E). C, Fluorescein fundus angiogram in the early phase reveals hypofluorescence at the PDPM area (arrows). D, Fluorescein fundus angiogram in the late phase shows hyperfluorescence at the PDPM area (arrows). E, The OCT scan across the PDPM shows a nonreflective area that appears to be beneath the retinal pigment epithelium and retina corresponding to the PDPM area (arrows). The left side of the scan is the optic disc. F, Goldmann kinetic perimetry reveals an arcuate scotoma, nasal step, and mild temporal wedge that are not explained by myopic fundus changes. I-4 indicates target size I and illumination 4; V-4, target size V and illumination 4; II-4, target size II and illumination 4.
Figure 5. Case 2, A 68-year-old man. A, The left fundus shows a yellow peripapillary elevated lesion almost all around the optic disc, clearly distinct from the myopic conus (arrowheads). There is a deep excavation in the inferior part of the myopic conus, and the inferotemporal retinal vein was strongly bent at the border of myopic conus and peripapillary detachment in pathologic myopia (PDPM) (black arrow). Choroidal neovascular membrane with pigmentation is observed in the macula. White arrow indicates the location of the optical coherence tomographic (OCT) scan (B). B, The OCT scan across the PDPM shows a nonreflective area beneath both the retinal pigment epithelium and retina corresponding to the PDPM area. The left side of the figure shows the optic disc. C and D, Fluorescein fundus angiogram of the left fundus. A fluorescein angiogram reveals early hypofluorescence (C) and the late staining (D) at the PDPM area (arrowheads). E and F, Indocyanine green (ICG) angiograms of the left fundus. The ICG angiogram demonstrates that the inferotemporal retinal vein enters into the PDPM space (arrowheads) and eventually flows back into the center of the optic disc (E, arrowheads). The ICG angiogram demonstrates mild hypofluorescence at the PDPM area in the late phase (F, arrowheads).

Figure 6. Case 3, A 48-year-old man. A, The right fundus shows a small, yellow inferonasal peripapillary elevated lesion at the inferior edge of the optic disc (arrowheads). Arrow indicates the location of the optical coherence tomographic (OCT) scan (B). B, The OCT scan across the peripapillary detachment in pathologic myopia (PDPM) shows a nonreflective area beneath both the retinal pigment epithelium (RPE) and retina corresponding to the area of PDPM. An OCT scan through the PDPM reveals what appears to be a full-thickness defect in the retina-RPE layers (arrow). C, Goldmann kinetic perimetry reveals a nasal step and arcuate scotomas that are not explained by myopic fundus changes. I-4 indicates target size I and illumination 4; V-4, target size V and illumination 4; I-2, target size I and illumination 2. D, Humphrey C30-2 program demonstrates arcuate scotomas and nasal step.
involvement, and 4 eyes (12.9%) had grade 3 involvement. Regardless of the range of the lesion, PDPM consistently included the area inferior to the optic disc in all patients. There was a deep and steep excavation of the inferior myopic conus adjacent to the PDPM in 26 (83.9%) of 31 eyes by stereoscopic observation using +90 D lenses. In these 26 eyes with steep excavation of the myopic conus, the inferotemporal retinal vein markedly bent at the transition from the PDPM to the myopic conus (Figure 4B). Moreover, in 7 patients with extreme excavation of the myopic conus, the inferotemporal retinal vein appeared to enter into the PDPM space after bending at the border between the myopic conus and PDPM (Figure 5A) or even disappear at the border of the myopic conus and PDPM in 6 patients (Figure 7A).

Fluorescein fundus angiography was performed in all patients with PDPM. In most patients (20/23), the fluorescein angiogram showed early hypofluorescence and late hyperfluorescence in the PDPM area (Figure 4 and Figure 5). In 3 patients, however, fluorescein angiograms consistently revealed mild hypofluorescence in the PDPM area. There was no early hyperfluorescence typical of serous pigment epithelial detachments or leakage suggestive of active choroidal neovascularization. Indocyanine green angiograms revealed hypofluorescence in the area of PDPM (Figure 5 and Figure 7) in all 15 patients who agreed to the examination. Indocyanine green angiogram also demonstrated a markedly bent inferotemporal retinal vein at the border between the myopic conus and PDPM, which eventually refluxed into the center of the optic disc (Figure 5E).

Goldmann visual field examination was performed in all highly myopic eyes with PDPM and in 564 of 601 eyes without PDPM. Among 31 eyes with PDPM, a characteristic glaucomatous visual field defect was detected in 22 eyes (71.0%). A Humphrey visual field analyzer was used in 15 of these 22 eyes and confirmed the visual field defects in all the eyes examined. The IOP of these 22 eyes was 13.2 ± 3.5 mm Hg (range, 10-22). Of 22 eyes, 18 received glaucomatous medical treatments. On the other hand, among 564 eyes without PDPM, a characteristic glaucomatous visual field defect was detected in 130 eyes (23.0%). There was a significant difference in the incidence of glaucomatous visual field defect between the eyes with PDPM and without PDPM (Fisher exact probability test, P < .05).

Thirty-one eyes with PDPM had a history of periodic examinations for an average ± SD time of 7.3 ± 3.5 years (range, 0.5-13 years) before the enrollment to the present study. There were no changes noted in the size of the PDPM by retrospective review of serial photographs in any of these patients.

**REPORT OF CASES**

**CASE 1**

A 60-year-old man was examined for high myopia in both eyes. His best-corrected visual acuity was 0.7 OD and 0.6 OS. The refractive error was −13.0 D in the right eye and −15.0 D in the left, and the axial length measurements were 27.4 mm in the right eye and 28.2 mm in the left. The right eye.

---

**Figure 7. Case 4. A 53-year-old man. A.** The right fundus shows a yellow peripapillary elevated lesion mainly situated superotemporal to the optic disc in addition to a small lesion inferior to the optic disc. There is a deep excavation of the myopic conus, and the inferior retinal veins seem to disappear at the edge of the myopic conus (white arrows). Black arrow indicates the location of the transition from the PDPM to the myopic conus (Figure 5A) or even disappear at the border of the myopic conus and PDPM in 6 patients (Figure 7A).

**B.** Goldmann kinetic perimetry with PDPM and without PDPM (Fisher exact probability test, P < .05).
eye had a tilted disc with a peripapillary myopic conus. The right eye had a yellow inferonasal peripapillary elevated lesion at the inferior edge, clearly distinct from the myopic conus (Figure 4A and B). There was a deep excavation in the inferior part of the myopic conus. Abnormal retinal vasculature was observed; the inferotemporal retinal vein was markedly bent at the border edge between the myopic conus and the PDPM (Figure 4B, arrowhead). A fluorescein angiogram of the right eye revealed initial hypofluorescence and late hyperfluorescence of the PDPM area (Figure 4C and D). An OCT scan revealed a nonreflective area that appeared to be beneath the RPE and retina corresponding to the area of PDPM (Figure 4E; along the arrow in Figure 4B). Goldmann kinetic perimetry revealed an arcuate scotoma and a nasal step that were not explained by myopic fundus changes (Figure 4F). Magnetic resonance imaging did not detect any intracranial lesions. The IOP was 12 mm Hg in both eyes. The patient was prescribed antiglaucomatous eye drops and was followed up.

CASE 2

A 68-year-old man was examined for high myopia in both eyes. He suffered from myopic choroidal neovascularization in the left eye. His best-corrected visual acuity was 0.9 OD and 0.1 OS. The refractive error was −10.0 D in both eyes, and the axial length measurements were 28.4 mm in the right eye and 28.0 mm in the left. The left eye had a yellow peripapillary elevated lesion that surrounded almost the entire optic disc and was clearly distinct from the myopic conus (Figure 5A, arrowheads). There was a deep excavation in the inferior part of the myopic conus, and the inferotemporal retinal vein was strongly bent at the border of the myopic conus and PDPM (Figure 5A, black arrow). The bent retinal vein appeared to enter the PDPM space after bending. An OCT scan showed a nonreflective area that appeared to be beneath both the RPE and retina corresponding to the PDPM area (Figure 5B; along the white arrow in Figure 5A). A fluorescein angiogram of the left eye revealed early hypofluorescence and late hyperfluorescence at the PDPM area (Figure 5C and D). Indocyanine green angiography also demonstrated mild hypofluorescence at the PDPM area (Figure 5F). Indocyanine green angiography demonstrated that the inferotemporal retinal vein enters the PDPM space (arrowheads of Figure 5E) and eventually flows back into the center of the optic disc (Figure 5E).

CASE 3

A 48-year-old man was examined for high myopia in both eyes. His best-corrected visual acuity was 1.2 OD and 1.2 OS. The refractive error was −12.0 D in the right eye and −12.0 D in the left, and the axial length measurements were 27.7 mm in the right eye and 27.5 mm in the left. The right eye had a yellow inferonasal peripapillary elevated lesion at the inferior edge of the optic disc (Figure 6A, arrowheads). An OCT scan showed a nonreflective area that appeared to be beneath both the RPE and retina corresponding to the PDPM area (Figure 6B; along the arrow in Figure 6A). An OCT scan through the PDPM and the myopic conus revealed what appeared to be a full-thickness defect in the retina-RPE layers (Figure 6B, arrow). Goldmann kinetic perimetry using the V-4, I-4e, and I-2e isopters revealed a nasal step and arcuate scotomas that were not explained by the myopic fundus change (Figure 6C). The Humphrey C30-2 program also demonstrated arcuate scotomas and a nasal step (Figure 6D). Magnetic resonance imaging did not detect any intracranial lesions in this patient. The IOP was 12 mm Hg in both eyes. The patient was prescribed antiglaucomatous eye drops and was followed up.

CASE 4

A 53-year-old man was examined for high myopia in both eyes. His best-corrected visual acuity was 0.8 OD and 1.0 OS. The refractive error was −9.5 D in the right eye and −8.75 D in the left, and the axial length measurements were 27.0 mm in the right eye and 26.9 mm in the left. The right eye had a yellow peripapillary elevated lesion mainly situated superotemporal to the optic disc in addition to a small lesion inferior to the optic disc (Figure 7A). An OCT scan showed a nonreflective area that appeared to be beneath both the RPE and retina corresponding to the PDPM area (Figure 7E; along the black arrow in Figure 7A). An OCT scan through the PDPM and the myopic conus revealed what appeared to be a full-thickness defect in the retina-RPE layers (Figure 7E, arrow). There was a deep excavation of the myopic conus, and the optic disc was difficult to observe because of marked tilting and excavation (Figure 7A). The inferior retinal veins seemed to disappear at the edge of the inferior myopic conus (Figure 7A, white arrows). Goldmann kinetic perimetry using the V-4 and I-4e isopters revealed a nasal step and arcuate scotomas that were not explained by myopic fundus change (Figure 7B). Indocyanine green angiograms demonstrated consistent hypofluorescence at the PDPM area (Figure 7C and D). Magnetic resonance imaging did not detect any intracranial lesions. The IOP was 10 mm Hg in both eyes. The patient was prescribed antiglaucomatous eye drops and was followed up.

COMMENT

In the present study, PDPM was identified in 31 (4.9%) of 632 highly myopic eyes. Although this is the prevalence among patients with high myopia who were followed up in our university clinic, the clinical characteristics (patient age, refractive error, and axial length) of the subject population ranged widely and are therefore likely to be representative of a larger population. Many of the findings of the present study differed from those of Freund et al. First, PDPM was not always confined to the inferior edge of the optic disc in our study. Although PDPM was always located adjacent to the inferior edge of the optic disc, PDPM surrounded almost the entire optic disc in some patients, and moreover, PDPM was predominantly located superotemporal to the optic disc in 1 patient (case 4). Second, abnormalities of retinal vasculature were frequently detected (83.9% of eyes with PDPM) in our study. The inferotemporal retin-
nal vein was markedly bent at the border edge between the myopic conus and PDPM. In some patients with extreme excavation of the myopic conus, this inferotemporal retinal vein appeared to enter the PDPM space after bending at the border between the myopic conus and the PDPM (Figure 5A) or even disappear at the border of the myopic conus and the PDPM (Figure 7A). Freund et al also observed anomalous vasculature in 1 patient, with an inferotemporal vein that appeared to be emanating from the peripapillary RPE lesion rather than from the optic disc. In our study, ICG angiography clearly delineated that this bent retinal vein eventually refluessed into the center of the optic disc (Figure 5). In eyes with deep and steep excavation of the myopic conus, the peripapillary neurosensory retina as well as the retinal vein might be extensively stretched and folded into the PDPM space. This study suggested that the bent retinal vein at the border between the myopic conus and PDPM was a common phenomenon in patients with PDPM, although whether marked bending of the retinal vein eventually impairs retinal venous flow is uncertain.

The pathogenesis of PDPM is not clear. Freund et al suggested that PDPM is an incomplete form of choroidal coloboma because of the consistent inferior location to the optic nerve in their study. The more widespread distribution of PDPM around the optic disc in our patients suggests that this possibility is unlikely. Also, PDPM was never noted in patients younger than 30 years, which suggests that PDPM develops later with age and might not be a congenital lesion. Freund et al also suggested that PDPM represents the gravitation of subretinal fluid originating from the area of the optic disc or optic pits. In our study, an OCT scan of the edge of the lesion demonstrated an absence of all the retinal layers at the margin of the PDPM in 3 patients. Although it is unclear whether the cleft demonstrated by OCT reflects a true defect in the retina histopathologically, it is possible that vitreous fluid penetrated the subretinal space through a defect in the retinal layers at the inferior margin of the myopic conus in the area within the very atrophic retina. If the hypothesis of Freund et al is correct, then it is more probable that the PDPM represents a neurosensory retinal detachment rather than a serious pigment epithelial detachment. Fluorescein angiographic findings showed different intensity of fluorescence in the area of PDPM among patients. These findings might be attributable to differences in the nature of the fluid within PDPM or differences in the condition of RPE cells overlying PDPM.

A difference between our study and study by Freund et al was the high prevalence of visual field defects among highly myopic eyes with PDPM in our study. In our study, glaucomatous visual field defects were detected in 22 (71.0%) of 31 eyes, which were examined by Goldmann visual field perimetry. Humphrey visual field testing confirmed the abnormal results in some of these patients. The prevalence of visual field defects in eyes with PDPM was significantly higher than that in eyes without PDPM. In contrast, Freund et al reported no peripapillary visual field defects in 4 patients who had previous visual field testing (Humphrey 30-2). It is unclear why the visual field results were markedly different between the 2 studies. Because more widespread PDPM was detected in our patients, our study might have included more advanced PDPM cases. The possible mechanism of the concomitant visual field defects in the eyes with PDPM is not clear; however, most of the eyes with PDPM had tilted discs and a deeply excavated myopic conus inferior to the optic disc. These findings suggest that the distorted structure of the neurosensory retina caused by marked tilting of the optic disc and steep excavation of the inferior myopic conus rather than PDPM itself might cause subsequent mechanical damage to the neurosensory retina. This hypothesis might be supported by the finding that the dominant location of visual field defects and PDPM lesions sometimes does not match, as in case 4. The clinical diagnosis of glaucoma is sometimes difficult to make in highly myopic eyes because of anomalous optic disc changes and atypical visual field changes. Although there is some possibility that the visual field defects observed in the present study were not caused purely by glaucoma, this study suggests that the presence of PDPM might be a novel sign that indicates the existence of concomitant visual field defects in patients with high myopia.

From the retrospective review of serial photographs taken, no changes were noted in the size and shape of PDPM in any of the patients. Freund et al described 1 patient with a progressive involution of the PDPM in both eyes during a 15-year follow-up. In our study, there were no patients with involuted PDPM. The long-term course of PDPM should be investigated to determine whether PDPM eventually regresses.

In conclusion, we evaluated the prevalence and characteristics of PDPM in a large series of patients with high myopia. Although its pathogenesis and pathologic significance remains to be clarified, PDPM might be another indicator for the development of visual field changes in high myopia.

Submitted for Publication: October 25, 2004; accepted January 3, 2005.

Correspondence: Kyoko Ohno-Matsui, MD, Department of Ophthalmology and Visual Science, Tokyo Medical and Dental University, 1-5-45 Yushima, Bunkyo-ku, Tokyo 113, Japan (k.ohno.oph@tmd.ac.jp).

Financial Disclosure: None.

REFERENCES
