Detection and Quantification of Retinal Nerve Fiber Layer Thickness in Optic Disc Edema Using Stratus OCT

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Objective: To investigate the ability of optical coherence tomography (OCT) to assess changes in retinal nerve fiber layer (RNFL) thickness in optic disc edema.

Methods: Prospective observational case series in a private eye clinic (Centro Salus). Twelve consecutive eyes (9 patients) with optic disc edema were analyzed, including 6 patients with anterior ischemic optic neuropathy, 1 patient with multiple sclerosis–associated papillitis, and 2 patients with bilateral papilledema. Peripapillary scans of the RNFL were obtained using Stratus OCT (software version 3.0; Carl Zeiss Meditec, Dublin, Calif). Repeated measurements were performed in 7 patients during a follow-up ranging from 8 to 30 weeks. The main outcome was RNFL thickness measurement.

Results: Optical coherence tomography detected and quantified diffuse thickening of the RNFL. Compared with eyes in a control group of 75 healthy subjects, eyes with optic disc edema showed a significant increase in the mean RNFL thickness in all quadrants (temporal, \( P = .002 \); superior, \( P < .001 \); nasal, \( P < .001 \); and inferior, \( P < .001 \)). In patients who were followed up, progressive thinning was observed as the disease evolved toward optic atrophy or clinical resolution.

Conclusions: Optical coherence tomography can identify and measure RNFL edema. This ability of OCT may help elucidate pathophysiological mechanisms in optic disc edema and provide a valuable aid to clinicians.

Arch Ophthalmol. 2006;124:1111-1117

Quantification of the peripapillary retinal nerve fiber layer (RNFL) thickness can provide clinicians with objective information about the optic nerve in different pathologic conditions. Several imaging techniques can be used to obtain such a measurement; most recently, optical coherence tomography (OCT) has demonstrated several merits. This technology has been used extensively to quantify RNFL thickness in atrophic diseases such as glaucoma, Leber hereditary optic neuropathy, traumatic optic neuropathy, and band atrophy.1-4 In all of these pathologic conditions, OCT has demonstrated an ability to clearly identify reductions in RNFL thickness; however, few studies5,6 have used OCT to investigate optic neuropathies in which RNFL thickening occurs due to optic disc edema. Such RNFL thickening has not been fully evaluated or thoroughly defined using other instruments, such as scanning laser polarimetry (SLP) or confocal scanning laser ophthalmoscopy. Results of the only 2 studies7,8 performed using SLP suggest that this technology may, indeed, be unable to detect increases in RNFL thickness during the acute phase of optic neuritis or anterior ischemic optic neuropathy (AION). Conversely, confocal scanning laser ophthalmoscopy has been shown to accurately detect optic nerve changes in papilledema, but investigations using this instrument have focused more on optic disc volume than on RNFL thickness.9-11

Quantification of RNFL changes is likely to enhance our knowledge about the pathogenesis and natural history of optic neuropathies that have an RNFL swelling component and may be a useful tool to assess the efficacy of treatments aimed at decreasing RNFL edema. Hence, the main objective of this study was to determine whether OCT is able to identify and measure peripapillary RNFL thickening in patients with optic disc edema arising from different causes.

Methods

This was a prospective observational case series study performed in a private eye clinic.
nerve fiber layer (RNFL) (arrows); asterisks indicate the true outer edge of the RNFL. B, Failure to identify the inner edge of the RNFL (asterisks). Data from such images were excluded from the study.

Figure 1. Analysis artifacts caused by Stratus OCT software version 3.0 (Carl Zeiss Meditec, Dublin, Calif). A, Misidentification of the outer profile of the retinal nerve fiber layer (RNFL) (arrows); asterisks indicate the true outer edge of the RNFL. B, Failure to identify the inner edge of the RNFL (asterisks). Data from such images were excluded from the study.

Table 1. Clinical Features and Retinal Nerve Fiber Layer (RNFL) Thickness in Patients With Optic Disc Edema

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Eye</th>
<th>Disease</th>
<th>Visual Acuity at Presentation</th>
<th>Duration of Follow-up, wk</th>
<th>RNFL Thickness at Presentation, µm</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>OS</td>
<td>NAION</td>
<td>20/20</td>
<td>30</td>
<td>Mean: 316, Temporal: 118, Superior: 218, Nasal: 171, Inferior: 324</td>
</tr>
</tbody>
</table>

Abbreviations: MS, multiple sclerosis; NA, not applicable; NAION, nonarteritic anterior ischemic optic neuropathy.

We examined 12 eyes in 9 patients (6 men and 3 women [mean ± SD age, 55.4 ± 19.6 years]) with optic disc edema who had been recruited for the study: 6 patients with AION (unilateral in 5 patients and bilateral in 1 patient), 1 patient with unilateral multiple sclerosis–associated papillitis, and 2 patients with bilateral papilledema (Table 1). At initial examination, the mean visual acuity was 20/40 (reference range, 20/200 to 20/20). Using OCT, we were able to visualize a thickened and slightly hyporeflective RNFL in all cases (representative patients 1, 7, and 8 in Table 1 are discussed herein); OCT also correctly identified RNFL boundaries in all eyes. Retinal nerve fiber layer thickness values for each quadrant and the 360° mean measurements are given in Table 1. The mean RNFL thickness was statistically higher in the study group than in the control group in all quadrants and in the 360° mean measurement (Table 2).

In addition to RNFL thickening, peripapillary circular OCT scans showed a hyporeflective space above the retinal pigment epithelium (Figure 2, A). This space could also be visualized using linear scans crossing the optic nerve head: in this case, the hyporeflective space...
revealed a triangular shape with the apex pointing away from the optic nerve (Figure 2, bottom).

In the 7 patients with adequate follow-up (range, 2-7 months), OCT detected a progressive thinning in the RNFL toward normal or atrophic values. Representative patients 1, 7, and 8 in Table 1 are described in the next section.

### REPORT OF CASES

**NONARTERITIC AION (PATIENT 1)**

A 70-year-old man had a 1-week history of visual loss, which had suddenly occurred in his left eye shortly after awakening. A diagnosis of nonarteritic AION was easily reached as he had already been diagnosed as having nonarteritic AION in the right eye in 1984. The patient was under treatment for hypertension, and on both occasions he experienced visual loss shortly after undergoing heart surgery. Examination of the left eye revealed a visual acuity of 20/32 and a swollen and mildly hyperemic optic disc (Figure 3). The clinical history and inflammation markers were not suggestive of giant cell arteritis. Optical coherence tomography visualized diffuse thickening of the RNFL, and the Humphrey VF test showed an altitudinal hemifield defect. Optical coherence tomography also revealed a thickened hyporeflective space between the RNFL and the retinal pigment epithelium. Fluorescein angiography showed diffuse optic disc hyperfluorescence. The Humphrey VF test and OCT were repeated at 2, 3, 4, 6, 8, 12, and 30 weeks after the visual loss onset. Since the first examination, a gradual thinning of the RNFL could be observed in all quadrants. At the 8-week follow-up, the RNFL thickness was slightly lower than that in the control group in each quadrant; subsequent examinations showed further decreases in the RNFL thickness, and the RNFL values at the 30-week follow-up were atrophic not only in the superior sector (which corresponded to the VF area that was affected) but also in the inferior sector of the optic disc (Figure 4). This thinning occurred more slowly and to a lesser degree in the inferior quadrant, which showed partial preservation (corresponding to preservation of the superior VF); in the meanwhile, the hyporeflective space disappeared (Figure 3, bottom center). At the last follow-up examination, the visual acuity was 20/25, and the VF test results showed a reduction in the mean defect (10.94 vs 13.56 µm; Figure 3, bottom right).

**MULTIPLE SCLEROSIS–ASSOCIATED PAPILLITIS (PATIENT 7)**

A 29-year-old man was referred because of sudden loss of vision in the right eye. The visual acuity was 20/200 OD; an examination of the fundus showed diffuse edema and hyperemia of the optic disc, in which the limits were hard to define (Figure 5). A wide defect involving the superior and nasal VFs was observed; OCT revealed diffuse edema of the RNFL in all quadrants and a hyporeflective space between the retinal pigment epithelium and the RNFL, mainly in the superior quadrant. Hyperfluorescence of the optic disc (mainly in the temporal quadrant) was evident on fluorescein angiography. Contrast-enhanced magnetic resonance imaging with gadolinium revealed a localized plaque on the retrolaminal portion of the optic nerve. After a comprehensive workup, including a lumbar puncture, a diagnosis of multiple scler-

### Table 2. Comparison of Retinal Nerve Fiber Layer (RNFL) Thickness in Patients and Control Subjects

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean ± SD (95% confidence interval)</th>
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<tr>
<td>Patients</td>
<td>217.9 ± 40.9 (191.9-243.9)</td>
</tr>
<tr>
<td>Control subjects</td>
<td>100.8 ± 12.7 (97.8-103.7)</td>
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*Data are given as mean ± SD (95% confidence interval). P = .002 for the temporal quadrants and P<.001 for the remaining measurements.*

Figure 2. Anterior ischemic optic neuropathy. A, Circular peripapillary scan shows a hyporeflective space (asterisks) between the retinal nerve fiber layer (RNFL) and the retinal pigment epithelium. B, Linear scan vertically crossing the optic disc reveals (on both sides of the disc) a triangle-shaped wide hyporeflective space beneath the edematous RNFL. Insets show the corresponding fundus image as viewed through the instrument monitor.
Rosis–associated optic neuritis was made. At the last follow-up (30 weeks), the patient had recovered a visual acuity of 20/20 OD, and a small relative scotoma was still evident on the VF examination. Optical coherence tomography demonstrated the RNFLs of the inferior and temporal quadrants to be atrophic.

**BILATERAL PAPILLEDEMA (PATIENT 8)**

A 69-year-old man affected with liver carcinoma and multiple metastases was referred because of a 2-week history of progressive visual loss in the right eye. Fundus examination revealed asymmetric bilateral papillitis–associated optic neuritis was made. At the last follow-up (30 weeks), the patient had recovered a visual acuity of 20/20 OD, and a small relative scotoma was still evident on the VF examination. Optical coherence tomography demonstrated the RNFLs of the inferior and temporal quadrants to be atrophic.

**COMMENT**

This case series study shows that OCT may be helpful in the detection, characterization, and monitoring of RNFL swelling in the event of optic disc edema. Observing and documenting changes in RNFL thickness in retinal and optic nerve diseases can be difficult. It was not until 1972 that Hoyt et al12 demonstrated the efficacy of red-free direct and indirect ophthalmoscopy for visualizing the RNFL. It was subsequently found that nerve fiber layer photographs taken with blue-green light permit a more careful analysis of RNFL swelling.
and thinning. More recently, sophisticated methods such as OCT, SLP, and confocal scanning laser ophthalmoscopy have been developed for this purpose. Most studies have focused, however, on atrophic diseases of the optic nerve that lead to axonal loss and, consequently, RNFL thinning. Only a few attempts have been made to visualize and quantify RNFL thickness when RNFL swelling predominates; using OCT, retinal nerve fiber layer thickening was reported in mild papilledema, in eyes with inflammatory optic neuropathies or retinal vein occlusion, and in asymptomatic carriers of Leber hereditary optic neuropathy mitochondrial DNA mutations. However, this is the first report, to our knowledge, showing the ability of OCT to identify and quantify RNFL thickening in the case of severe edema of the optic disc, as occurs in AION or in papilledema. Quantification of RNFL edema using this technology may provide a useful objective index for following the clinical course of these diseases. In addition, in vivo imaging by OCT may help to elucidate the pathogenesis of optic disc edema in general and these optic neuropathies in particular. The information acquired would be complementary to the data obtained from histopathologic studies, in which collection of large samples is difficult and longitudinal observations are impossible.

The small sample size of this study does not allow us to generalize our findings to delineate profiles for each of the optic neuropathies that produce optic disc edema. However, we offer a few observations that we believe deserve further attention. Patient 1 went on to show not only resolution of RNFL swelling but also further thinning of the nerve fibers in all quadrants. Although there was a greater degree of thinning in the superior quadrant (which corresponded with the sector of AION involvement and inferior VF loss), loss also occurred in the inferior quadrant. This suggests (1) that in AION there is also damage to the so-called uninvolved sector (which explains why the entire optic disc swells) and (2) that the residual surviving fibers in the less involved sector are sufficient for an intact VF. This latter observation supports the hypothesis by Quigley and Green that there is sufficient redundancy in the optic nerve to preclude a VF defect until more than 50% of the fibers are lost.

Another unexpected and interesting finding of OCT was common to all of the cases of optic disc edema examined, namely, a hyporeflective subretinal space (possibly representing subretinal fluid) above the retinal pigment epithelium. Meridian scans of the optic nerve disclosed this space as having a triangular shape (Figure 2, bottom). The widest part of the triangle abutted the side of the optic nerve head; the tapered apex pointed away. Although the clinical and pathogenetic significance remains to be explained, there are a couple of intriguing hypotheses. The first hypothesis is that extensive swelling of the optic nerve head pushes the nerve fibers overlying the disc anteriorly, and as these fibers are attached to the RNFL over the retina, they are drawn forward. This produces an upward traction that generates a space below the retina. The resulting hydrostatic force counters the osmotic forces, allowing for fluid accumulation in the unrestricted subretinal space. The second hypothesis is that subretinal fluid accumulates because of increased tissue and venous pressure caused by venous stasis at the level of the optic nerve head; this has been alluded to in previous OCT investigations.

Our findings agree with those of Menke et al., who demonstrated the ability of Stratus OCT to identify peripapillary RNFL thickening in optic disc edema; however, their sample differed from ours because they did not include any case of AION or papilledema but only evaluated eyes with retinal vein occlusion and inflammatory optic neuropathies. This difference is likely to

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**Figure 5.** Multiple sclerosis–associated papillitis. A, At the first visit, optical coherence tomography shows a thickened retinal nerve fiber layer (RNFL) in all quadrants and a subretinal hyporeflective space (asterisks) (left), a superior defect of the visual field (middle); and diffuse edema in the optic disc (right). B, At the 30-week follow-up, the evolution toward atrophy is confirmed by reduced thickness of the RNFL in the temporal and inferior quadrants (left), the visual field has improved (middle), and only a relative central scotoma persists (right). T indicates temporal; S, superior; N, nasal; and I, inferior.
account for the higher mean ± SD values of RNFL thickness in our study (217.9 ± 40.9 vs 122 ± 23 μm).

As observed by Menke et al,6 the RNFL thickness measurements obtained using OCT differ considerably from those previously obtained using SLP.7,8 This discrepancy is probably related to the properties of SLP, which measures form birefringence of the structural elements (neurofilaments and microtubules) within the RNFL and generates the RNFL thickness from such a measurement. Optic disc edema is likely caused not by an increase in the number of neurofilaments and microtubules but rather by intracytoplasmic swelling of ganglion cell axons. The swollen axons are congested with mitochondria, and the microtubules are in disarray.17 Indeed, this disruption of the alignment of the microtubules within axons has significant implications and likely decreases their polarization effect, thus giving a false SLP reading of thinning.

The present study has limitations. The small sample size does not allow us to generalize our findings and is insufficient to detect differences among the various types of optic neuropathy producing disc edema as far as RNFL thickening is concerned. Our results must also be evaluated with caution because the reproducibility of RNFL thickness measurements by means of Stratus OCT in the event of optic disc edema has not been formally assessed. Finally, the cases herein were imaged using only OCT (without the use of other technologies such as confocal scanning laser ophthalmoscopy or SLP); hence, any comparison of technologies is premature. These issues can be explored in further studies.

Figure 6. Papilledema. First row, Optic nerve appearance and visual field of the right eye (A and B) and left eye (A’ and B’) at the first examination, revealing an asymmetric papilledema. Second row, On the same day, Stratus OCT (software version 3.0; Carl Zeiss Meditec, Dublin, Calif) shows diffuse thickening of the retinal nerve fiber layer (RNFL) in the right eye (C) and normal thickness in the left eye (C’). Third row, Two months later, the optic disc is pale in the right eye (D), and the corresponding visual field (E) remains constricted, while in the left eye the superior and inferior poles of the optic disc are mildly hyperemic (D’), and the corresponding visual field shows a lower sensitivity (E’). Fourth row, At the same time, the RNFL is markedly thinned in the right eye (F), and a thickening of the superior and inferior poles is observed in the left eye (F’). T indicates temporal; S, superior; N, nasal; and I, inferior.
CONCLUSIONS

The present study illustrates the value of OCT in the assessment of optic disc edema. This is an in vivo quantitative and objective measure that can detect, characterize, and monitor axonal swelling, the core change associated with disc edema. Optical coherence tomography can also be used to follow up the subsequent resolution of axonal swelling and thinning of the RNFL, which are essential aspects of optic atrophy. Future studies using OCT in various optic neuropathies hold the promise of elucidating the reversible and irreversible changes associated with optic disc edema.

Submitted for Publication: November 7, 2005; final revision received February 14, 2006; accepted February 19, 2006.

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Financial Disclosure: None reported.

REFERENCES