Contributions of the Capsulorrhexis to Straylight

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**Objectives:** To quantify the effect of the capsulorrhexis on straylight and to determine optimal capsulorrhexis size.

**Methods:** Fifty-six pseudophakic eyes with intact capsulorrhexis were included in the study. Straylight was measured with a straylight meter before and after pupil dilation. Capsulorrhexis and pupil diameter were measured and opacity of the anterior capsule was graded (on a scale of 0-5) with the slitlamp. Capsulorrhexis size and opacity were compared with the difference in straylight values between natural and dilated pupils.

**Results:** The mean capsulorrhexis diameter was 4.5 mm (range, 2.9-6.2 mm). Most anterior capsular rims were opaque in the area of contact with the intraocular lens (62.5% higher than grade 1). Mean straylight before pupil dilation was logs=1.25 (range, 0.68-2.13), which increased to 1.46 (range, 0.88-2.22) after pupil dilation, which corresponds to a 62% increase (P<.001). The effect of capsulorrhexis size and opacity on the increase in straylight in scotopic conditions can be quantified by the following formula: $\Delta s = 19 \times (\text{grading of anterior capsular rim}) \times (\text{fraction of pupil area covered by rhexis})$.

**Conclusions:** The influence of size and opacity of the capsulorrhexis via straylight is described in a quantitative model. Capsulorrhexis size must be greater than 4 mm to prevent functional problems at night.

posterior capsule opacity and posterior capsule wrinkling. An eccentric or too-large capsulorrhexis that does not cover the peripheral IOL optic may also cause troublesome visual symptoms owing to light scattering by the bare edge of the optic. However, a smaller capsulorrhexis makes cataract removal and proper IOL placement more difficult. Although patients with a small capsulorrhexis (4.5-5.0 mm) were shown to have better visual performance postoperatively than patients with a large capsulorrhexis (6.0-7.0 mm), a small capsulorrhexis may further contract and lead to increased glare. Visual acuity (VA) effects are usually small, but a decrease in VA may result from capsular phimosis or obliteration of the pupillary area by capsule contraction.

By means of the straylight meter, it is now possible to study, in a precise manner, straylight effects on the capsulorrhexis. Such study may reveal an optimal capsulorrhexis size in a functional manner. This study was designed to determine the effect of size and opacity of the anterior capsulorrhexis on postoperative straylight and thus disability glare in patients with pseudophakia.

METHODS

Straylight measurements were performed prospectively in 47 consecutive patients with pseudophakia (56 eyes). All patients had undergone uncomplicated phacoemulsification with implantation of a posterior chamber IOL in the capsular bag. In all patients, a continuous curvilinear capsulorrhexis (CCC) was performed as part of the phacoemulsification procedure. A foldable aspheric IOL (Acrysof SN60WF or SA60AT; Alcon, Hünenberg, Switzerland) was implanted in the capsular bag after irrigation and aspiration of the cortical remnants. Exclusion criteria were other ocular conditions, especially corneal or vitreous opacities, pupil abnormalities, posterior capsule opacification, intraoperative complications that result in a damaged CCC, and decentered implants.

Straylight measurements and slitlamp examinations took place at a median time after cataract extraction of 49 days (10%-90% interval, 8-539 days). Pupil diameter was measured with a standardized template in increasing steps of 0.5 mm under ambient lighting conditions, correspondent to the light level in the straylight meter. Best-corrected VA (BCVA) was determined with the Early Treatment of Diabetic Retinopathy Study chart (which measures logMAR acuity), in accordance with the modified Early Treatment of Diabetic Retinopathy Study protocol. Straylight measurements were achieved in accordance with the compensation comparison principle, by means of the straylight meter. The pupils were then dilated with tropicamide and phenylephrine hydrochloride eyedrops. Thirty minutes later slitlamp examination was performed. Horizontal and vertical diameters of the capsulorrhexis opening were measured in steps of 0.1 mm by means of the adjustable ruler on the slitlamp. A semiquantitative (range, 0-5) slitlamp grading of the opacity of the anterior capsular rim was recorded, with 0 indicating clear; 1, mild opacification; 2, moderate diffuse opacification; 3, moderate diffuse opacification with areas of intense opacification or capsular folding; 4, intense opacification with capsular folding; and 5, dense white opacification with capsule contraction and/or capsular phimosis that obscures details of posterior intraocular structures. Funduscopy of the posterior segment was performed and the presence and amount of vitreous opacities documented. Straylight measurements were repeated.

RESULTS

The mean age of the patient population was 66.2 years (range, 31-87 years). Mean BCVA was logMAR 0.2 (range, 1.6 to −0.1; Snellen VA fraction: mean, 20/30; range, 3/100-20/16). The mean pupil diameter before dilation was 2.8 mm (range, 2.4-5 mm). After dilation the mean pupil diameter became 5.7 mm (range, 3-7 mm). All IOLs were clear; none contained a great amount of glistenings or other opacities.

In 91% of eyes the margins of the capsulorrhexis could be seen only after pupil dilation. In 5 eyes a narrow edge of the anterior capsule was visible before pupil dilation. The capsulorrhexis was usually smaller than the dilated pupil (mean diameter of the CCC, 4.5 mm; range, 2.9-6.2 mm). Most anterior capsular rims were opaque in the area of contact with the IOL material, which leads to a
white ring over the peripheral IOL optic (62.5% greater than grade 1; Table).

The mean straylight value before pupil dilation was a log of 1.25 (range, 0.68-2.13; Figure 1). The mean straylight value after pupil dilation increased to a log of 1.46 (range, 0.88-2.22; Figure 1). Forty-five eyes (80.4%) showed an increase in straylight after pupil dilation (Figure 1 and Figure 2). The mean increase in log, after pupil dilation was 0.21 log unit, which corresponds to a 62% increase in straylight. The increase in straylight after pupil dilation was statistically significant (paired t test, \( P < 0.001 \)). No statistically significant relationship was found between straylight values and BCVA in our population (Pearson correlation, \(-0.174\); 2-tailed \( P = .20 \)). Because only undilated eyes were considered, the range of straylight may not have been great enough to detect a correlation. To exclude the influence of postoperative corneal edema, a comparison was made between patients who were examined within 30 days after phacoemulsification (mean log, 1.33) and patients who were examined 30 days or longer postoperatively (mean log, 1.36). No significant differences in straylight values between these groups were found.

In Figure 3 the difference in the s value between dilated and undilated pupils is shown and fitted with the model function explained in the “Methods” section. The constant \( C \) that relates the straylight value to the capsulorrhexis grade was found to be 19.

Studies have been performed with pseudophakic eyes to determine which factors influence quality of vision postoperatively. However, straylight-dependent symptoms occur separately from VA-associated symptoms.\(^2,3,8\) Statistically, some relation between VA and straylight may occur in the population because media disturbances can be expected to affect both VA and straylight, although probably not to the same degree. In our population the relation did not reach statistical significance, in correspondence with earlier research that shows a weak relationship.\(^2\) This information stresses that straylight results from different processes than VA. Because straylight measure-
ment rests on an equalization test, VA cannot in a causative sense influence the result of a straylight test. During straylight measurement, the patient observes which of 2 test fields shows more flicker. The point of identity between these 2 test fields is not influenced by VA. Identity remains the same, independent of VA. This has been verified in laboratory experiments (van den Berg, September 1990, unpublished data). It must be stressed that straylight is an aspect of visual function, although the term straylight might suggest it to be a purely optical entity. Straylight assesses the strength of the hindering spreading of light as seen by the person. However, it is the spreading at relatively large angles (typically $>1^\circ$) as opposed to the spreading of light that governs VA and contrast sensitivity (in the range of minutes of arc). It governs disability glare and in general the quality of vision in most visual scenes because of the general prevalence of large luminosity differences in that type of scene. Both VA and contrast sensitivity do not take that factor into account. In extreme cases of media turbidity both domains of light spreading may overlap, and the distinction gets lost. Normally, straylight is an independent aspect of visual function. A study of 4242 drivers investigated the ways that straylight measurements relate to lens opacity grading (Lens Opacities Classification System III), VA, contrast sensitivity, and self-reported impairments of visual function. From correlation analysis, it was found that straylight is a vision impairment not directly related to VA and contrast sensitivity, and, moreover, that if VA is known, contrast sensitivity has limited added value. As mentioned previously, this independence of straylight and VA may be understood from the underlying processes that govern both aspects of visual function. A VA assessment is not sufficient to assess the visual disability of a person and visual problems caused by straylight, additional vision measures are required to understand the impact of vision loss on everyday life. The results of the large study of European drivers support this assertion. Straylight measurements are necessary to fully understand the subjective concerns of the patient. With the straylight meter it is possible to capture functional concerns, such as straylight and disability glare, in an objective parameter (s). In this study, a functional model was developed that shows the effect of capsulorrhexis size and anterior capsule opacity on the parameter s. Figure 3 is a graphic representation of this functional model, as explained in the “Methods” section of the Abstract.

The model function describes, in a quantitative sense, the way the difference in straylight before and after pupil dilation in pseudophakic eyes is dependent on the amount of opacity of the anterior capsular rim and size of the capsulorrhexis. In healthy, phakic eyes, straylight values remain approximately equal between natural and dilated pupils. However, among patients with pseudophakia, pupil dilation seems to play a significant role in increasing straylight as capsulorrhexis becomes visible in the pupil area and starts to affect visual function by the increase of intraocular light scatter. When more of the pupillary area is taken up by the anterior capsular rim, this rim will contribute more to the falling of scattered light into the eye in a proportional manner. The proportionality constant (b) will depend on the opacity of this rim. The proportionality constant was chosen as $C \times (\text{grading of the rim})$, and the constant C was estimated to be 19. This model supposes a directly proportional relationship between (subjective) grade and (objective) amount of straylight. Closer analysis of the data suggested that this relationship is nonlinear, with the higher grades giving relatively more (than proportionally) straylight compared with the lower grades. Because the improvement of the model fit shown in Figure 3 was small, the linear model is still a good approximation, and the nonlinearity was not included in the present model. The linear model gives an approximation of the expected differences in straylight values between natural and dilated pupils and is good enough to detect and quantify clinically relevant variation.

To implement this quantitative measure into ophthalmic practice, it is necessary to consider the known effect of an increase in straylight on visual performance. In healthy, young eyes the normal straylight value is approximately 0.87 log, (s = 7.4). With increasing age, the straylight value in healthy eyes may increase to approximately 1.17 log, (s = 15) at the age of 65 years. This means a 2-fold increase in the straylight parameter (s). A large part of the otherwise-healthy elderly population accepts this increase and may not even realize its occurrence because the increase in straylight develops gradually. In Figure 3 the difference in the straylight parameter (s) between dilated and natural pupils is shown on the y-axis ($\Delta s$). With consideration of the described example, a $\Delta s$ of 15 would double the amount of straylight when the pupil is dilated compared with the normal value for a 65-year-old patient. This value (s = 30, which corresponds to log, = 1.47) is considered a limit value for safe driving because higher $\Delta s$ means more straylight and problems with disability glare. In accordance with the functional model, $\Delta s$ is influenced by both grading of anterior capsule opacity and the area of the pupil surface covered by capsulorrhexis. This means that in ophthalmic practice, there are 2 ways to ensure a minimum of straylight concerns in patients with pseudophakia. First, polishing of the anterior capsule during phacoemulsification to minimize postoperative anterior capsule opacity may be performed routinely. Intraoperative cleaning of the anterior capsule may also help in the stabilization of the size of the capsulorrhexis opening and prevent contraction.

The second way to reduce postoperative straylight concerns is to ascertain that the capsulorrhexis does not occupy too much space in the pupillary area. The minimum diameter of the capsulorrhexis necessary to prevent the induction of extra straylight to the amount of a $\Delta s$ of 15 can be determined with the model. In this study, the mean grade of anterior capsule opacity was 1.7, and the mean pupil diameter after dilation was 5.7 mm. When these values are taken into account, the model determines that at a capsulorrhexis diameter of 4 mm, doubling of straylight occurs. If we consider doubling to be an acceptable limit value, then the capsulorrhexis diameter should be at least 4.0 mm to minimize the occurrence of serious postoperative straylight problems in scotopic light conditions. In our study capsulorrhexis size was, as a rule, larger; this is why most points in Figure 3 cluster close to zero.

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Figure 1 shows that large variations in straylight exist among patients with pseudophakia before pupil dilation who therefore did not have anterior capsule involvement. Straylight increases with age in healthy eyes, mostly because of increased disturbances to optical media, such as cataracts. In pseudophakic eyes the effect of age on the amount of straylight is supposed to be less important because the disturbing cataract is removed. However, as can be seen in Figure 1, straylight values do not return to values of a healthy, young eye. Some influence of age or surgery on pseudophakic eyes is thus assumed and should be clarified by further research. Relationships between several intraocular factors and postoperative glare complaints were studied previously. Influences of IOL type, IOL strength, and posterior capsular opacification on glare in patients with pseudophakia were shown. In this study 2 different types of IOL were included, both manufactured by Alcon and made of acrylic. The SN60WF is a blue-blocker and corrects for some spherical aberration, whereas the SA60AT does not have these characteristics. The SN60WF is thinner than the SA60AT. A large range of IOL powers were included, which leads to (small) differences in IOL thickness as well. Although these characteristics should not affect forward scatter, some influence of these factors on straylight values cannot be excluded. Currently, these effects are being studied in vitro.

In our study none of the IOLs contained a great amount of glistenings or other opacities. When only a few glistenings are present, it is not likely to influence straylight values in a major way. This was experimentally established (unpublished data) with the setup of the studies on straylight from human donor crystalline lenses and can theoretically be understood by means of the calculations that relate scatter (worst case; ie, isotropic) to straylight, as detailed earlier. Because in our study only paired measurements of the same eyes (before and after pupil dilation) were compared, the effect of the capsulorrhexis was isolated. Influences of other intraocular factors were considered more or less stable within each patient and were excluded from the functional model. The exclusive use of intrindividual comparisons also made the large variation in postoperative intervals and age in our study population acceptable. Separate studies that use the new straylight assessment technology should be performed to determine the importance of other intraocular factors on straylight levels.

The functional pupil area in the elderly patient is limited because of age-related miosis. Although the effect of the anterior capsular rim may be negligible during the daytime, under scotopic lighting conditions it may become clinically relevant and lead to glare. Another possible source of increased straylight concerns postoperatively is a surgically damaged iris or pupil, which results in an oversized and/or poorly reacting pupil. Previous studies that focused on the effect of pupil diameter on glare perception in patients with pseudophakia found mostly that mean glare score increased significantly with moderate pupil dilation. The introduction of anterior capsule opacities into the pupillary area is generally suggested to cause this effect. This effect was also shown in our study. It is important to protect the integrity of the pupil during surgery, and to allow it to constrict normally in bright light conditions postoperatively.

In summary, straylight concerns can be a source of dissatisfaction in otherwise satisfied patients with pseudophakia. Measurements with the straylight meter are clinically useful in the evaluation of visual dysfunction not detected by VA assessment. This measurement can be used to verify and better understand subjective concerns of glare disability. In this study it has been possible to document and quantitatively assess the influence of the anterior capsular rim on the postoperative occurrence of disability glare. Through a functional model, we have been able to determine the minimum diameter of the capsulorrhexis (4.0 mm) that is necessary to avoid the occurrence of a serious straylight increase under scotopic lighting conditions.

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