Histopathological and Immunohistochemical Analysis of Melt-Associated Retroprosthetic Membranes in the Boston Type 1 Keratoprosthesis

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The Boston type 1 keratoprosthesis (KPro) is an artificial cornea used for the management of corneal diseases not amenable to standard keratoplasty.1 Despite improved outcomes, the Boston KPro continues to carry significant risk for complications. Of these, the most common is retroprosthetic membrane (RPM) formation, which occurs in 25% to 65% of eyes.2-7

Despite their high incidence, RPMs are poorly understood. A histological analysis of 4 RPM specimens by Stacy et al8 showed minimal inflammation in the membranes. However, other investigators have suggested that anterior chamber inflammation is a risk factor for RPM formation and that the use of more biocompatible materials (eg, titanium) in the Boston KPro construct or the administration of perioperative corticosteroids may retard RPM growth.2,9-11

Given recent data that RPM formation may increase the risk of donor corneal melt,12 further investigation of RPMs is warranted. To the best of our knowledge, no dedicated histological study of melt-associated RPMs has previously been performed. To clarify the role of inflammation in RPMs and to further characterize melt-associated RPMs, we performed a histopathological and immunohistochemical analysis of RPM specimens obtained from Boston KPro devices explanted because of donor corneal melt.

IMPORTANCE Retroprosthetic membrane (RPM) formation is the most common complication associated with the Boston type 1 keratoprosthesis and has been associated with corneal melt.

OBJECTIVE To identify the histological and immunohistochemical characteristics of RPMs associated with corneal melt.

DESIGN, SETTING, AND PARTICIPANTS Observational histopathological case series at a tertiary eye care referral center among patients who underwent Boston type 1 keratoprosthesis explantation because of donor corneal melt at the Illinois Eye and Ear Infirmary between January 1, 2011, and January 1, 2012.

EXPOSURES Seven RPM specimens from 7 eyes were stained with hematoxylin-eosin, cytokeratin 7, cytokeratin AE1/3, smooth muscle actin, vimentin, and CD34. Light microscopy was used to evaluate specimens for inflammation and epithelial ingrowth. XY-karyotyping using fluorescence in situ hybridization was performed on 4 specimens with known donor-recipient sex mismatch.

MAIN OUTCOMES AND MEASURES Histological and immunohistochemical characteristics of RPMs.

RESULTS Inflammatory cells were present in 4 of 7 RPMs. In 3 of 4 sex-mismatched specimens, tissue XY-karyotyping of the RPM interphase cells was consistent with the host sex karyotype. The fourth specimen showed a mixture of recipient-type and donor-type cells.

CONCLUSIONS AND RELEVANCE Melt-associated RPMs show variable degrees of inflammation. Most membranes seem to originate from a proliferation of host cells, but donor tissue may contribute in some cases.
Methods

Study Design
After obtaining institutional review board approval at the University of Illinois at Chicago, a retrospective evaluation of RPM specimens obtained from Boston KPros explanted because of corneal melt was performed. All available RPM pathology specimens obtained between January 1, 2011, and January 1, 2012, at our institution were identified (institutional review board exemption for informed consent was obtained). The clinical history for each patient was reviewed. Immunohistochemistry was used to characterize the membranes. Anti-CD34 (clone QBEnd/10; Ventana Medical Systems) and α–smooth muscle actin (SMA) stains (clone 1A4; Ventana Medical Systems) were used to distinguish normal stromal keratocytes (CD34 positive) from fibrous keratocytic downgrowth (SMA positive) and to highlight vascularity within the membranes.13 Pankeratin (clone AE1/AE3/PCK36; Ventana Medical Systems) was used to identify epithelium. Anti–cytokeratin 7 (clone OV-TL 12/30; Ventana Medical Systems) was used to identify conjunctival epithelium (Figure 1). Epithelial cells were negative for vimentin.

Fluorescence In situ Hybridization
To further characterize the cellular origin (donor or recipient) of the RPM tissue, fluorescence in situ hybridization (FISH) was performed on a subset of specimens. Donor sex and recipient sex for each study patient were reviewed for donor-recipient sex mismatch. Cases in which a male patient received a female donor cornea or a female patient received a male donor cornea were identified. Fluorescence in situ hybridization was then performed using a dual color X/Y (alpha satellite, spectrum orange/satellite III, and spectrum green) centromere enumeration probe (Vysis).15 Results were then scored by a cytogenetics consultant masked to the sex of the recipients and donors to determine the XY-karyotype of the interphase cellular population.

Results
In total, 7 RPM specimens obtained from 7 consecutive eyes following Boston KPro explantation because of donor corneal melt were included in the study. Demographic data for each patient are summarized in the Table. A lymphocytic infiltrate was identified on hematoxylin-eosin staining in 4 of 7 samples (Figure 1). Two had mild inflammation, while 2 others had severe inflammation. Both specimens with severe inflammation were obtained from patients treated for aniridia (Table). A proliferation of nonkeratinizing stratified epithelium was present along the surface of the explanted membrane specimens in 4 of 7 samples (Figure 1). Pankeratin (cytokeratin AE1/3) and cytokeratin 7 showed strong cytoplasmic immunoreactivity suggestive of epithelial ingrowth of conjunctival origin (Figure 1). Epithelial cells were negative for vimentin.

Of 4 patients with histological evidence of epithelial ingrowth, one (case 2 in the Table) had clinical epithelial downgrowth at the time of Boston KPro explantation, with cyclitic membranes, hypotony, and a dense epiretinal membrane. In 2 specimens with no epithelial ingrowth, epithelium was found within stumps of tissue removed from the backplate holes.

In total, 5 of 7 specimens had SMA staining consistent with fibrous stromal (keratocytic) downgrowth. Six of them had significant vascularity on CD34 and SMA staining.

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Diagnosis</th>
<th>Eye</th>
<th>Age at KPro Implantation, y</th>
<th>Sex</th>
<th>Seidel Test at Explantation</th>
<th>Cellular Inflammation</th>
<th>Immunohistochemistry</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Peters anomaly</td>
<td>Right</td>
<td>3</td>
<td>M</td>
<td>M</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>2a</td>
<td>Aniridia</td>
<td>Left</td>
<td>12</td>
<td>F</td>
<td>M</td>
<td>–</td>
<td>++</td>
</tr>
<tr>
<td>3</td>
<td>Aniridia</td>
<td>Left</td>
<td>37</td>
<td>F</td>
<td>M</td>
<td>NT</td>
<td>++</td>
</tr>
<tr>
<td>4</td>
<td>Chemical injury</td>
<td>Left</td>
<td>41</td>
<td>M</td>
<td>F</td>
<td>NT</td>
<td>+</td>
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<tr>
<td>5</td>
<td>Cicatricial conjunctivitis</td>
<td>Right</td>
<td>65</td>
<td>M</td>
<td>M</td>
<td>+b</td>
<td>–</td>
</tr>
<tr>
<td>6</td>
<td>AKC</td>
<td>Left</td>
<td>83</td>
<td>M</td>
<td>F</td>
<td>–</td>
<td>+</td>
</tr>
<tr>
<td>7</td>
<td>Idiopathic LSCD</td>
<td>Left</td>
<td>84</td>
<td>M</td>
<td>M</td>
<td>–</td>
<td>–</td>
</tr>
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Abbreviations: AKC, atopic keratoconjunctivitis; CK, cytokeratin; F, female; KPro, keratoprosthesis; LSCD, limbal stem cell deficiency; M, male; NT, not tested; SMA, α–smooth muscle actin; −, absent; +, present; ++, higher degrees of one condition that is present, eg, inflammation.

a Clinical epithelial downgrowth.
b Seidel positivity with manipulation.
In total, 4 cases of known donor-recipient sex mismatch were identified (Table). In 3 of 4 cases, 100% of the interphase cells in the RPM specimen showed an XY-karyotype consistent with the recipient’s sex (Figure 2). In the fourth case, which involved a male recipient and a female donor cornea (case 6 in the Table), 69% of the interphase cells were XY, and 31% of the cells were XX (Figure 2). The findings were consistent with mixed contributions to the RPM from both recipient and donor tissues.

Discussion

To our knowledge, this is the first dedicated histological study of RPMs explanted from eyes with a Boston type 1 KPro and sterile corneal melt. The only other histological study of RPMs, by Stacy et al., was based on 4 RPMs (2 were associated with corneal melt). The authors concluded that inflammation was not a likely requisite for the formation of RPMs. In contrast, our study showed chronic inflammatory cells in 4 of 7 RPMs. Therefore, it is likely that inflammation has a role in at least some cases of melt-associated RPMs. Furthermore, therapeutic intervention with local or systemic corticosteroids may benefit a subset of patients with inflammatory RPM components (eg, those with aniridia in our study).

Based on observations of stromal downgrowth through breaks in Descemet membrane at the wound margin, Stacy et al. proposed that RPMs are derived from host corneal stroma. However, our FISH analysis of sex-mismatched donor-host pairs suggested that, while most RPMs seem to originate from host tissue, donor tissue may also contribute in some eyes. Based on this, we postulate that stromal downgrowth from donor tissue may occur as well at the wound margin or through the backplate holes.

Another notable finding in this study was the presence of epithelial ingrowth between the backplate and RPM in 4 of 7 of our melt-associated specimens. The isolated presence of epithelium in the backplate holes in 2 of our RPMs suggests that epithelium may localize to the posterior backplate through the holes. Despite the high incidence of epithelial ingrowth between the backplate and RPM in our study (in 4 of 7 cases), clinical evidence of epithelial downgrowth was rare. One explanation for this is that the RPM may provide a physical barrier to invasion of epithelium into the anterior chamber. This conjecture is consistent with the low rates of aqueous leakage on Seidel testing in our patients despite the presence of full-thickness corneal melts.

The major weaknesses of the study are its retrospective nature and the small sample size, which may limit the extrapolation of these findings to all melt-associated RPMs. Because tissue was analyzed retrospectively, the quality of tissue obtained varied.

Conclusions

Melt-associated RPMs seem to be heterogeneous tissues showing varying degrees of inflammation. Retroprosthetic membranes appear to be derived mainly from host cells; however,
Contributions from donor tissue seem possible. Further study is needed to better describe the inciting factors for RPM for-

Figure 2. Fluorescence In Situ Hybridization

A and B, Fluorescence in situ hybridization using a dual color X/Y (spectrum orange/spectrum green) probe and diamidino-2-phenylindole counterstaining showing representative interphase cells from donor-recipient sex-mismatched retroprosthetic membranes. C, In retroprosthetic membranes obtained from 2 female recipients who received male corneas, 100% of the cells showed an XX-karyotype. D, In one retroprosthetic membrane from a male recipient who received a female cornea, 100% of the cells showed an XY-karyotype. In another retroprosthetic membrane from a male recipient who received a female cornea, a mixture of XY and XX cells was observed.