Corneal Hydration Control in Diabetes Mellitus

Bonnie C. Weston,* William M. Bourne,* Kenneth A. Polse,† and David O. Hodge‡

Purpose. To assess the effects of diabetes mellitus on corneal structure and function.

Methods. The authors measured endothelial permeability to fluorescein and corneal deswelling for 7.5 hours after 2 hours of hypoxic contact lens wear in 20 patients with diabetes who had nonproliferative retinopathy and 21 age-matched control subjects. Central corneal endothelial photographs were also taken. Corneal deswelling rates, expressed as percent recovery per hour (PRPH), and open eye steady state (OESS) thickness were estimated by nonlinear regression techniques.

Results. The OESS thickness was greater in patients with diabetes than in controls (562 ± 35 μm versus 559 ± 24 μm, P = 0.02). During hypoxia, the diabetic corneas swelled less (7.7% ± 1.8% versus 9.9% ± 1.6%, P < 0.001) and had less endothelial permeability (3.55 ± 0.83 × 10⁻⁴ cm/min versus 4.14 ± 0.68 × 10⁻⁴ cm/min, P = 0.02) than the controls. During normoxia after contact lens removal, however, diabetic and control corneas had similar deswelling rates and permeabilities. Corneal autofluorescence was increased in the patients with diabetes (8.1 ± 3.1 versus 6.0 ± 1.9 ng/ml fluorescein equivalents, P = .005). The endothelial cells of the two groups were morphologically similar. Within the group with diabetes, however, those with moderate nonproliferative retinopathy had larger coefficients of variation of cell area and smaller percentages of hexagonal cells than those with mild nonproliferative retinopathy.

Conclusions. Although the diabetic corneas were thicker and more autofluorescent than control corneas, during hypoxia they swelled less and had decreased endothelial permeability. During normoxia, however, no difference was found in endothelial permeability or deswelling rate. The effects of diabetes on endothelial cell morphologic features appear to be related to the severity of the diabetes. Invest Ophthalmol Vis Sci. 1995;36:586–595.

A number of investigators have reported abnormalities in corneal endothelial function in diabetes mellitus, both in animals1,2 and humans.3-5 A recent study by Keoleian and colleagues,6 however, failed to reveal any functional abnormality in the form of increased corneal thickness or change in endothelial permeability to fluorescein in humans with type I diabetes of long duration under fair control. The tests in that study7 were conducted on corneas in the resting, unstressed state. After the surgical stress of phacoemulsification, however, the transfer coefficient for fluorescein is elevated in diabetic corneas compared to those of controls.7 Thus, diabetic corneas, despite a normal baseline barrier function, may not have sufficient functional reserve to handle the stress of induced corneal edema normally. For an in vivo test of corneal hydration control in the stressed state, corneal deswelling can be measured after contact lens-induced hypoxic edema.8 Investigators using a modification of this method have reported a decreased ability to recover from corneal edema in diabetic rabbits’ and humans.9 We sought to obtain more information about diabetic corneal hydration control by using this “stress” test in human patients with diabetes and simultaneously measuring the corneal endothelial permeability to fluorescein and cellular morphologic features.

METHODS

We recruited 20 patients (12 men, 8 women) with diabetes (15 with insulin-dependent type I diabetes...
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and 5 with adult-onset type II diabetes) of at least 10 years’ duration and 21 age-matched (≥6 years) and sex-matched (13 men, 8 women) control subjects from the local community for this study. One additional subject with diabetes was originally recruited but did not complete the protocol. Only patients with diabetes who had nonproliferative background retinopathy and diabetes of at least 10 years’ duration were included. The protocol followed the tenets of the Declaration of Helsinki and was approved by our Institutional Review Board. After obtaining written informed consent, we performed a complete ophthalmic examination for screening on all potential subjects, including slit lamp biomicroscopy, applanation tonometry, and ophthalmoscopy. All subjects had clear corneas and anterior chambers without inflammation. Based only on the ophthalmoscopic examination, the retinopathy was graded according to the modified Airlie House classification,9 similar to the grades described by Stolwijk et al.10 The control group had no ocular abnormalities. Any subject with a history of ocular surgery, photocoagulation, contact lens wear, trauma, inflammation, glaucoma, ptosis, or severe keratoconjunctivitis sicca was excluded. No subject was taking topical ocular medications or systemic medications that affect the eye.

All subjects, both patients with diabetes and controls, underwent identical procedures. On study day 1 for each subject, central corneal thickness was measured in each eye every half hour from approximately 1:30 to 4:30 PM (either six or seven measurements) with a modified Haag–Streit (Koniz, Switzerland) optical pachometer equipped with fixation lights and a potentiometer that allows direct entry of readings into computer memory.11 The operator was not aware of the individual thickness readings as they were recorded. Each measurement was the mean of 10 consecutive readings. The measurement was repeated if the standard deviation of the readings was 10 μm or more. The same investigator (BCW) performed all pachometry measurements, recalibrating the instrument daily. Before fluorescein was instilled for tonometry, the autofluorescence of the central cornea was measured with a two-dimensional scanning ocular fluorophotometer. Measurements were made separately with two wavelengths of the argon laser (457.9 nm and 488.0 nm) for excitation; the emission window centered on the cornea. After 2 hours, at approximately 11 AM, pachometry readings were taken in each eye every 20 minutes for 2 hours and then every 30 minutes for 5 more hours; fluorophotometry readings were taken every 60 minutes for 7 hours.

The methods for data analysis have been described in detail elsewhere;8,15,17 a general description will suffice here. Based on the assumption that corneal deswelling is a first-order process operative only upon the amount of stromal swelling, i.e., the thickness in excess of the open eye steady state (OESS) thickness (the thickness that, once attained, is maintained in the open eye without further thinning), one can write the following differential equation:

\[
\frac{dq}{dt} = -D(q - B)
\]

where q is corneal thickness, t is the deswelling time (in these experiments, the time in minutes since removal of the contact lens), D is the deswelling rate constant, and B is the OESS thickness. The solution to this equation was used as the model for corneal deswelling:

\[
q(t) = B + Se^{-Dt}
\]

where \(q(t)\) is the measured corneal thickness at time t, and S is the induced swelling (the thickness in excess of B at t = 0). The measured experimental data were fit by nonlinear regression (S-PLUS, Statistical Systems, Seattle, WA) to this model to obtain the best-
2.0 4.0 6.0 8.0
Time after contact lens removal (hr)

FIGURE 1. Typical deswelling curve. Nonlinear regression analysis was used to calculate the exponential rate of deswelling (dotted line) and the OESS thickness (solid line). The six OESS thickness measurements obtained on the afternoon of study day 1 are shown at time zero; in the analysis, they are assumed to occur at t = 10,000 minutes. No measurements in the first 30 minutes after contact lens removal are used to calculate the deswelling curve.

To measure the morphologic features of the central corneal endothelial cells, we digitized the apices of 100 cells from images of the photographic negatives magnified 500 times. The mean and standard devia-
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<table>
<thead>
<tr>
<th>Measurement</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
<th>P*</th>
<th>MDDf</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>51.2</td>
<td>14.2</td>
<td>22-72</td>
<td>50.9</td>
<td>15.2</td>
<td>20-71</td>
<td>0.96</td>
<td>14.8</td>
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<tr>
<td>Intraocular pressure (mm Hg)</td>
<td>15.0</td>
<td>3.9</td>
<td>10-24</td>
<td>13.9</td>
<td>2.8</td>
<td>9-20</td>
<td>0.15</td>
<td>3.4</td>
</tr>
<tr>
<td>Deswelling rate constant, D (min⁻¹)</td>
<td>0.018</td>
<td>0.006</td>
<td>0.008-0.033</td>
<td>0.017</td>
<td>0.004</td>
<td>0.012-0.023</td>
<td>0.38</td>
<td>0.005</td>
</tr>
<tr>
<td>Percent recovery per hour, PRPH (%)/hr</td>
<td>64.0</td>
<td>11.7</td>
<td>38.2-85.8</td>
<td>62.5</td>
<td>7.6</td>
<td>51.3-74.5</td>
<td>0.63</td>
<td>9.9</td>
</tr>
<tr>
<td>Open eye steady state (OESS) thickness (µm)</td>
<td>562</td>
<td>35</td>
<td>482-623</td>
<td>559</td>
<td>24</td>
<td>499-588</td>
<td>0.02</td>
<td>—</td>
</tr>
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<td>8:00 AM thickness (µm)†</td>
<td>566</td>
<td>36</td>
<td>486-632</td>
<td>543</td>
<td>26</td>
<td>505-600</td>
<td>0.02</td>
<td>—</td>
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<tr>
<td>Induced swelling (µm)†</td>
<td>44</td>
<td>9</td>
<td>30-60</td>
<td>54</td>
<td>7</td>
<td>41-63</td>
<td>&lt;0.001</td>
<td>—</td>
</tr>
<tr>
<td>Induced swelling (%)†</td>
<td>7.7</td>
<td>1.8</td>
<td>5.1-11.1</td>
<td>9.9</td>
<td>1.6</td>
<td>7.1-12.0</td>
<td>&lt;0.001</td>
<td>—</td>
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<td>Endothelial permeability, AM (×10⁻⁷ cm/min)</td>
<td>3.55</td>
<td>0.83</td>
<td>1.68-4.98</td>
<td>4.14</td>
<td>0.68</td>
<td>2.64-5.72</td>
<td>0.02</td>
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<td>Endothelial permeability, PM (×10⁻⁷ cm/min)</td>
<td>3.85</td>
<td>0.60</td>
<td>2.91-5.07</td>
<td>4.03</td>
<td>0.53</td>
<td>3.09-5.17</td>
<td>0.31</td>
<td>0.57</td>
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<tr>
<td>Corneal autofluorescence, 457.9 nm (ng/ml) fluorescent equivalents</td>
<td>8.1</td>
<td>3.1</td>
<td>4.9-17.5</td>
<td>6.0</td>
<td>1.9</td>
<td>3.8-10.2</td>
<td>0.005§</td>
<td>—</td>
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<tr>
<td>Corneal autofluorescence, 488.0 nm (ng/ml) fluorescent equivalents</td>
<td>4.1</td>
<td>1.5</td>
<td>2.2-9.4</td>
<td>3.1</td>
<td>0.9</td>
<td>1.7-5.2</td>
<td>0.007§</td>
<td>—</td>
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<tr>
<td>Endothelial cell density (cells/mm²)</td>
<td>2541</td>
<td>361</td>
<td>1623-3140</td>
<td>2601</td>
<td>353</td>
<td>2049-3212</td>
<td>0.59</td>
<td>361</td>
</tr>
<tr>
<td>Coefficient of variation of cell area (mean/SD)</td>
<td>0.33</td>
<td>0.06</td>
<td>0.25-0.44</td>
<td>0.31</td>
<td>0.07</td>
<td>0.22-0.48</td>
<td>0.52†</td>
<td>0.07</td>
</tr>
<tr>
<td>Hexagonal endothelial cells (%)</td>
<td>57.3</td>
<td>7.6</td>
<td>47.0-76.5</td>
<td>60.4</td>
<td>7.6</td>
<td>46.5-72.0</td>
<td>0.20</td>
<td>7.6</td>
</tr>
</tbody>
</table>

* Two-tailed Student’s t-test for means (except § below).
† N = 20 in each group (8:00 AM thickness not recorded in one control subject).
‡ Increase in thickness from 8:00-10:30 AM, from just before contact lens insertion to just after removal. N = 20 in each group (8 AM thickness not recorded in one control subject).
§ Wilcoxon rank sum test.
||MDD = minimum detectable difference with 90% power (α = 0.05, β = 0.10).

RESULTS

The mean values for each of the test parameters measured in the 20 patients with diabetes and 21 controls are listed in Table 1. The age range of the patients with diabetes was 22 to 72 years and of the controls was 20 to 71 years. The duration of diabetes ranged from 10 to 50 years (mean ± standard deviation 23.0 ± 12.6 years). There was no significant difference between the 15 patients with type I diabetes and the 5 patients with type II diabetes for any of the parameters we tested. Nonproliferative background diabetic retinopathy was present in all patients. Based upon the results of ophthalmoscopic examination in the worse eye, the retinopathy was graded as follows: 13 eyes, grade 2 (minimal nonproliferative retinopathy); 6 eyes, grade 3 (moderate nonproliferative retinopathy); and 1 eye, grade 4 (severe nonproliferative or preproliferative retinopathy). The 21 controls were all grade 1 (no retinopathy). The mean intraocular pressure was not significantly different between the patients with diabetes and the controls.

Total serum glycosylated hemoglobin levels, which approximate average blood glucose levels during the previous 2 to 3 months, were considered relative indicators of diabetic control. Although obtaining glycosylated hemoglobin levels was not part of the pro-
In this study, the values were recorded in the medical records within 2 months of this study in 10 subjects with diabetes (9 eyes grade 2 and 1 eye grade 3 retinopathy). The mean glycosylated hemoglobin value in these 10 subjects was 10.0% ± 1.3% (range, 8.0% to 12.1%), similar to the mean level of 10.0% in the 14 patients with diabetes in our previous study, which had similar entry criteria. The interpretation of total glycosylated hemoglobin values for our clinical laboratory is as follows: good diabetic control, <9%; fair control, 9 to 12%; and poor control, > 12%. Based on the assumption that the 10 patients with diabetes for whom glycosylated hemoglobin was recorded are representative of the entire group, the average level of glycemic control in the diabetic group was fair.

Pachometry

Each corneal thickness measurement was the mean of 10 consecutive readings. The mean of the standard deviations in 1410 stress thickness measurements (11 AM to 6 PM) in the 82 eyes was 5.2 μm, with no significant difference between the patients with diabetes (5.3 μm) and controls (5.1 μm, P = 0.21). Ninety-five percent of the standard deviations were <8.1 μm.

We found no difference between the PRPH values for the 20 patients with diabetes and 21 controls. Using 7 hours of corneal thickness recovery data beginning 30 minutes after the hypoxic contact lens was removed, we recorded mean PRPH values of 64.0% ± 11.7%/hour and 62.5 ± 7.6%/hour for the group with diabetes and the control group, respectively (P = 0.63). We can be 90% certain that the true difference, if any, in PRPH between these two groups is not more than 9.9% (Table 1). The PRPH decreased significantly with age (Fig. 2) in all 41 subjects (r = -0.48, P = 0.001). The correlation between PRPH and age was also significant in the 20 patients with diabetes (r = -0.60, P = 0.005) but was only suggestive in the 21 controls (r = -0.36, P = 0.10). The OESS thickness (Fig. 3) was significantly greater in patients with diabetes than in controls (562 ± 35 μm versus 539 ± 24 μm, P = 0.02), as was the 8 AM thickness (566 ± 36 μm versus 543 ± 26 μm, P = 0.02). The induced swelling (Fig. 4), however, was significantly less in patients with diabetes than in controls (7.7% ± 1.8% versus 9.9% ± 1.6%, P < 0.001). The peak corneal thickness measurements at 10:30 AM were invariably lower than the thickness predicted for t = 0 by the nonlinear regression, indicating that the deswelling rate was slower during the initial 30 minutes after contact lens removal.

Fluorophotometry

The endothelial permeability to fluorescein during the period of hypoxia, while the contact lens was in place (AM permeability, Fig. 5), was significantly decreased in the patients with diabetes compared to the controls (3.55 ± 0.83 × 10⁻⁴ cm/minute versus 4.14 ± 0.68 × 10⁻⁴ cm/minute, P = 0.02). After the contact lens was removed (PM permeability), there was no significant difference between the two groups. In the control group, the AM and PM permeabilities were similar. The PM permeabilities were calculated from the hourly fluorescence measurements from 11 AM
Figure 5. Hypoxic endothelial permeability (AM) during period of hypoxic contact lens wear. The horizontal lines denote the mean values for the diabetic (8.55 × 10⁻⁴ cm/minute) and control (4.14 × 10⁻⁴ cm/minute) groups.

Figure 6. Corneal autofluorescence at an excitation wavelength of 457.9 nm. The horizontal lines denote the mean values for the diabetic (8.1 ng/ml fluorescein equivalents) and control (6.0 ng/ml fluorescein equivalents) groups.

Figure 7. Coefficient of variation of endothelial cell area for grade 2 and grade 3 retinopathy. The horizontal lines denote the mean values for the grade 2 (0.31) and grade 3 (0.38) groups.

Figure 8. Percentage of hexagonal endothelial cells for grade 2 and grade 3 retinopathy. The horizontal lines denote the mean values for the grade 2 (59.5%) and grade 3 (51.8%) groups.

DISCUSSION

Pachometry

The OESS thickness was significantly increased in the group with diabetes, confirming the results of others in humans and animals. We did not find increased thickness in a previous study, perhaps because that investigation lacked sufficient power to detect a similar difference. The present study does not explain the cause of increased corneal thickness in diabetes. There are several possible explanations, such as inhibition of the endothelial pump, increased stromal swell-
Altered stromal swelling pressure appears unlikely, with deswelling measurements on a different day after contact lens removal and at least 3 hours after removal of the stress lens, we eliminated the need for a second day of measurements and obtained more reliable estimates of the OESS thickness in these subjects with normal deswelling.

By recording the corneal thickness hourly for more than 7 hours after contact lens removal, we obtained more reliable estimates of the OESS thicknesses. Mandell et al measured corneal deswelling for at least 3 hours after contact lens removal and obtained the data by a coupled exponential model with deswelling measurements on a different day after the eye was patched shut all night; they included estimates of OESS thickness with asymptotic standard errors as large as 15 μm. Herse and Hooker measured corneal deswelling for 3 hours after contact lens removal only; they did not report the results of their OESS thickness estimates or the asymptotic standard errors they accepted. In contrast, the standard errors of our OESS thickness estimates ranged from 0.8 μm to 2.6 μm (mean = 1.3 μm) in the 20 patients with diabetes and from 0.6 μm to 2.1 μm (mean = 1.2 μm) in the 21 controls. If we excluded the direct OESS thickness measurements from the first experimental day and included only the thickness measurements during the 7 hours after contact lens removal, the standard errors of the OESS thickness estimates ranged from 1.1 μm to 5.2 μm (mean = 2.0 μm) in the patients with diabetes and from 0.9 μm to 3.8 μm (mean = 1.8 μm) in the controls. When the first day’s measurements were excluded, the mean OESS estimate changed little—from 562.2 μm to 561.5 μm in the patients with diabetes and from 538.8 μm to 538.4 μm in the controls. Therefore, by measuring the corneal thickness for 7 hours rather than for 3 hours after removal of the stress lens, we eliminated the need for a second day of measurements and obtained more reliable estimates of OESS thickness in these subjects with normal deswelling.

The stromal swelling induced by 2 hours of contact lens-induced hypoxia was significantly less in the patients with diabetes. If we ignore fluid exchanges across the epithelium and limbus, which are likely to be minor, this finding could only result from less net fluid flow into the cornea across the endothelium in the patients with diabetes than in the controls. Three factors, alone or in combination, in the diabetic corneas compared to the control corneas during the hypoxic period would produce less swelling: less endothelial permeability, less stromal swelling pressure, and greater endothelial pump rate. The first factor was indeed present—the measured permeability to fluorescein in the patients with diabetes was less (Table 1). The second factor was probably present because the corneal thickness was greater in the patients with diabetes, and Herse found the same swelling pressure—hydration—thickness relationship in normal and diabetic rabbit corneas. In addition, less osmotic swelling would have been induced if the corneal epithelium of the patients with diabetes produced less lactate. The third factor could have been present if the endothelial pump were less affected by epithelial hypoxia in the patients with diabetes than in the controls. McNamara et al recently reported that decreased stromal pH resulted in a decreased amount of hypoxic swelling. Our findings of decreased endothelial permeability to fluorescein are thus consistent with a lower stromal pH induced by hypoxia in the patients with diabetes than in the controls.

We found no difference in deswelling rate or PRPH between the diabetic and control corneas. In a recent study of 12 human patients with diabetes and 14 controls by Herse and Hooker, a difference in PRPH of 27% was present. Our study could rule out such a difference with greater than 90% confidence (Table 1). We have no explanation for these disparate results. If the diabetic corneas in the two studies were truly different from each other, it could reflect a difference in the effects of diabetes in the two groups, either from differences in the severity of the disease or in its medical control. The PRPH decreased significantly with age in our subjects (Fig. 2), confirming the results of Plose et al. In the study by Herse and Hooker, the patients with diabetes were older than the controls, but it is unlikely that this difference accounted for the decreased PRPH that they found.

Endothelial permeability and deswelling rates were similar in the patients with diabetes and the controls after contact lenses were removed. If the corneal thicknesses were similar, this finding would suggest that the endothelial pump in the two groups. Because the diabetic OESS thickness was greater, however, the swelling pressure may have been less, requiring a lower pump rate to result in a similar deswelling rate. Thus, this study has not ruled out a decreased endothelial pump rate in the group with diabetes. More study is needed to define these relationships better in human and diabetic corneas.

Fluorophotometry

We found no significant difference in endothelial permeability to fluorescein between the patients with diabetes and the controls from 11 AM to 6 PM. The
corneas were not hypoxic during this period; we consider the permeability measured over this interval to be the normal permeability for each cornea. This finding of no effect of diabetes on corneal endothelial permeability confirms the results of a previous study using similar techniques,6 of a study of human corneas in vitro,28 and of a study of diabetic rats and guinea pigs.29 In contrast, Lass et al30 found a significant 31% increase in diabetic endothelial permeability, but their findings may result from the maldistribution of stromal fluorescein that occurs with their method, as demonstrated by Carlson et al.16

The endothelial permeability from 8 to 11 AM, during the period of contact lens-induced hypoxia, was significantly less in the group with diabetes. This finding is consistent with the lower contact lens-induced swelling that occurred in the diabetic corneas. One possible explanation is that under these conditions, more edema occurs in the diabetic endothelial cells than in the normal cells, thus narrowing the paracellular pathway. Such a possibility is plausible because both metabolic30 and cytoskeletal31 abnormalities have been noted in diabetic corneal endothelial cells.

The diabetic corneas had significantly increased autofluorescence at both excitation wavelengths (λex), 457.9 and 488.0 nm. The range of emission wavelengths (λem) accepted by our fluorophotometer was 515 to 600 nm.15 This finding confirms the results of our previous study of patients with diabetes with λem = 488.0 nm6 and of the results of Stolwijk et al with λem = 430 - 490 nm and λem = 530 to 630 nm.10,32 Greater fluorescence resulted from excitation at 457.9 nm than at 488.0 nm, which is consistent with mitochondrial flavoproteins33 as its source, as suggested by others.34,35 Most of the fluorescence is likely to originate in the epithelium.36 The proportional increase in fluorescence in the patients with diabetes is the same for both excitation wavelengths (38%), suggesting that the fluorescence has the same source in both groups. The diabetic corneas may contain more of the same fluorophore or may exhibit local conditions that enhance its fluorescence, such as alterations in oxidative state,37 pH, temperature, light filtering characteristics of the overlying tissue, or interaction with other molecules.

The 38% increase in autofluorescence in the group with diabetes is similar to the 40% increase found by Stolwijk et al10 in patients with diabetes with minimal nonproliferative retinopathy (grade 2). The majority (13 of 20) of our patients had grade 2 retinopathy.

Specular Microscopy
We found no difference between the patients with diabetes and controls in central endothelial cell density, confirming many previous studies of the morphologic aspects of diabetic corneal endothelial cells.26,27-29 These same reports, however, also consistently demonstrated an increased coefficient of variation of cell area (polymegethism) and decreased percentage of hexagonal cells (pleomorphism) in the diabetic corneas, which were not seen in the present study. This discrepancy must result from one of two possibilities: either the endothelial cells of these patients with diabetes were not affected by the disease or our study could not demonstrate the effect. The former possibility would imply that these patients with diabetes are different from those in the former studies, who perhaps had milder or better controlled disease. The patients with diabetes in our previous investigation, however, in which a morphologic difference was present,6 appeared to be similar to those of the present study, as judged by the degree of retinopathy and the available glycosylated hemoglobin values. The latter possibility, that our study could not demonstrate a morphologic abnormality, is perhaps more plausible. The present study lacked sufficient statistical power to detect with 90% confidence (Table 1) morphologic differences of the size present in our previous study6 or in those of others. Our subjects were also older than those of former investigations; because polymegethism and pleomorphism increase with age,14 the differences between patients with diabetes and controls may be less in older subjects. Finally, the control group appears to have been morphologically, but not physiologically, atypical, decreasing our chances of finding statistically significant differences in the patients with diabetes. The present control group had substantially more polymegethism and pleomorphism than the controls in our former studies,6,17 more so than can be attributed to the difference in age. Therefore, although the current group with diabetes had more polymegethism (coefficient of variation of cell area 0.33 versus 0.29) and pleomorphism (percentage of hexagonal cells 57% versus 68%) than the patients with diabetes in our previous study,7 it was not statistically significantly different from the current control group. Despite the lack of a morphologic difference from the control group, the six patients with diabetes with grade 3 retinopathy had significantly more polymegethism and pleomorphism than the 13 patients with diabetes with grade 2 retinopathy (Figs. 7 and 8). This finding suggests a positive correlation between the severity of the diabetes and its morphologic effects on endothelial cells. A direct correlation between diabetic control and endothelial morphologic abnormalities has been demonstrated in diabetic dogs,40 although such a correlation was not found in humans.40 For several reasons, more data are required to confirm this suggested relationship. First, the present study contained small numbers for stratification into
groups. Second, the grading of retinopathy was based on clinical ophthalmoscopic examination rather than photographic evaluation. Third, no significant differences between retinopathy grades were noted for any of the other measures such as PRPH, OESS thickness, induced swelling, endothelial permeability, or corneal autofluorescence.

**Key Words**

corneal endothelial permeability, corneal deswelling, diabetic cornea, corneal thickness, corneal endothelial morphology, corneal endothelial pump

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