The Complications of Myopia: A Review and Meta-Analysis

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AEGH and CAE contributed equally to the work presented here and should therefore be regarded as equivalent first authors.

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PURPOSE. To determine the risk between degree of myopia and myopic macular degeneration (MMD), retinal detachment (RD), cataract, open angle glaucoma (OAG), and blindness.

METHODS. A systematic review and meta-analyses of studies published before June 2019 on myopia complications. Odds ratios (OR) per complication and spherical equivalent (SER) degree (low myopia SER ≤ –0.5 to > –3.00 diopter [D]; moderate myopia SER ≤ –3.00 to > –6.00 D; high myopia SER ≤ –6.00 D) were calculated using fixed and random effects models.

RESULTS. Low, moderate, and high myopia were all associated with increased risks of MMD (OR, 13.57, 95% confidence interval [CI], 6.18–29.79; OR, 72.74, 95% CI, 33.18–159.48; OR, 845.08, 95% CI, 230.05–3104.34, respectively); RD (OR, 3.15, 95% CI, 1.92–5.17; OR, 8.74, 95% CI, 7.28–10.50; OR, 12.62, 95% CI, 6.65–23.94, respectively); posterior subcapsular cataract (OR, 1.56, 95% CI, 1.32–1.84; OR, 2.55, 95% CI, 1.98–3.28; OR, 4.55, 95% CI, 2.66–7.75, respectively); nuclear cataract (OR, 1.79, 95% CI, 1.08–2.97; OR, 2.39, 95% CI, 1.03–5.55; OR, 2.87, 95% CI, 1.43–5.73, respectively); and OAG (OR, 1.59, 95% CI, 1.33–1.91; OR, 2.92, 95% CI, 1.80–4.52 for low and moderate/high myopia, respectively). The risk of visual impairment was strongly related to longer axial length, higher myopia degree, and age older than 60 years (OR, 1.71, 95% CI, 1.07–2.74; OR, 5.54, 95% CI, 1.33–1.91; OR, 1.33–1.91; and OR, 87.63, 95% CI, 34.50–222.58 for low, moderate, and high myopia in participants aged >60 years, respectively).

CONCLUSIONS. Although high myopia carries the highest risk of complications and visual impairment, low and moderate myopia also have considerable risks. These estimates should alert policy makers and health care professionals to make myopia a priority for prevention and treatment.

Keywords: myopia, myopic macular degeneration, retinal detachment, cataract, open angle glaucoma

Myopia or nearsightedness is a refractive error caused by excessive axial elongation.1,2 Myopia can be corrected optically by glasses, contact lenses, or refractive surgery. Nevertheless, it has been associated with complications, such as myopic macular degeneration (MMD), retinal detachment (RD), cataract, and open angle glaucoma (OAG).3 These complications can lead to irreversible visual impairment later in life.4

The most important complication of myopia is MMD, which is a common cause of visual impairment, particularly for high myopia.5 Characteristics of MMD are lacquer cracks, Fuchs spot, choroidal neovascularization (CNV), or choroidal atrophy.6 Posterior staphyloma is sometimes considered a specific type of MMD, whereas others consider it rather a risk factor for developing MMD.5,7 Common peripheral retinal lesions in high myopia patients are RD, pigmentedary degeneration, lattice degeneration, and pavingstone degeneration, of which RD is the most sight-threatening.1,8 For cataract, the relationship with myopia is less evident. In particular, nuclear cataract may result in a myopic shift, which hampers determination of the original refractive error.9 Considering OAG, Perkins et al.10 already published in 1982 about a higher percentage of myopic patients in the OAG population. A meta-analysis performed on 11 population-based studies also identified an increased risk of OAG for myopic persons.11 Whether visual field progression in myopes is similar to other OAG patients is still unclear.

High myopia (spherical equivalent [SER] ≤ –6 D) is associated with reduced vision-related quality of life and has significant socioeconomic impact.12 The incidence of myopia and high myopia is rising globally, and it is expected that the burden of its complications will lead to considerable visual impact.
Complications of Myopia

Morbidity in the near future. Myopia is already the most common cause of irreversible visual impairment in the working population. A recent study estimated $6 billion global productivity loss due to MMD, and this financial burden will undoubtedly become worse in the coming decades.

Although the association with myopic complications has been well established, precise risk estimates of MMD, RD, cataract, and OAG per degree of myopia are yet unknown. In this review, we aim to provide a systematic review of the visual morbidity of myopia. First, we calculated the risk estimates of the most prevalent complications, that is, MMD, RD, cataract, and OAG, by performing meta-analyses on all existing data. Because data on other myopia-related complications, such as posterior staphyloma, retinoschisis, and dome-shaped macula, are limited, we did not include these in our review. Second, we explored the impact of these complications on best-corrected visual acuity (BCVA). Considering that cataract can be surgically treated, we also investigated whether this procedure is safe and effective in myopic patients. The risk estimates derived from this study may create awareness among eye care providers for vision-threatening complications associated with myopia and help to inform myopic patients.

Methods

We followed the guidelines of the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) statement for the meta-analyses. As published literature was used, ethical approval was not required.

Search Methods

We conducted an extensive literature search in PubMed on myopia and myopia-related complications using the following MeSH terms: "myopia," "myopia, degenerative," "visual acuity," "retinal degeneration," "choroidal neovascularization," "retinal detachment," "cataract," and "glaucoma." The complete PubMed search strategy is available in Supplementary Table S1, and the PRISMA flow diagram is available in Supplementary Figure S1. Titles and abstracts of articles, published before June 1, 2019, were independently reviewed for relevancy by two authors (AEGH and CAE) and included when the following criteria were met: (1) full text available; (2) written in English; and (3) subject of article was myopia, complications, visual consequences of myopia, epidemiology of myopia, or epidemiology of visual impairment. Any discrepancies between the two authors were solved by a thorough discussion with other experts until consensus was reached. A manual search was additionally performed by screening of the references of the included articles. All observational studies were considered for inclusion in the meta-analyses.

Data Extraction and Quality Assessment

We obtained (1) geographic region of data collection; (2) period of data collection; (3) risk estimates of MMD, RD, cataract, and OAG for myopia and different myopia categories; and (4) visual acuity (VA) data of myopic patients with and without complications from each selected study. We assessed the quality of all studies using the criteria proposed by Sanderson et al. The variables examined included the definitions of the exposures (any, low, moderate, and high myopia), definitions of the outcome variables (MMD, RD, cataract, and OAG), number of participants, age ranges, sex prevalence, study design, and confounding factors used for adjustment. Crude odds ratios (ORs) were calculated for MMD when they were not reported in the studies, using the following formula:

\[
\text{OR} = \frac{\text{myope with complication/myope without complication}}{\text{emmetrope with complication/emmetrope without complication}}
\]

If the number of cases was zero, it was set to 1 for the OR calculation. Refractive error was categorized into five groups: no myopia (SER > −0.5 diopter D), any myopia (SER ≤ −0.5 D), low myopia (SER < −0.5 to > −3.00 D), moderate myopia (SER ≤ −3.00 to > −6.00 D), and high myopia (SER ≤ −6.00 D), in line with the most recent classification system.

Data Syntheses

Meta-analyses were performed using a previously validated method in Microsoft Excel 2010 (Microsoft, Redmond, WA, USA); forest plots for all complications and myopia categories were constructed in GraphPad Prism 5 (GraphPad, San Diego, CA, USA). A fixed or random effects model was used depending on the number of included studies and the critical value of the calculated Q statistic on the χ² distribution. The Q statistic was calculated as the weighted sum of squared differences between individual study effects and the pooled effect across different studies. We calculated I² to investigate heterogeneity between studies, using the formula: \((Q-df)/Q\times100\%\) (df represents degrees of freedom). We used a fixed effects model if heterogeneity was low, that is, the calculated Q was lower than the critical value on a χ² distribution, and we used a random effects model otherwise. Heterogeneity was considered as no, low, moderate, or high for values of <25%, 25% to 50%, 50% to 75%, and ≥75%, respectively.

Results

Myopic Macular Degeneration

Prevalence of MMD. The prevalence of MMD in population-based studies varied from 0.2% in rural central India, to 1.2% in Caucasian Australians, and 4.0% in the Singapore Epidemiology of Eye Diseases (SEED) study (Table 1). Definitions of MMD differed slightly among studies (Supplementary Table S2). After stratification for myopia degree, the prevalence ranged from 13.3% to 65.4% in high myopes, 0.3% to 7.8% in moderate myopes, and 0.1% to 7.0% in low myopes (Fig. 1). In six nonpopulation-based studies focusing on high myopia patients only, MMD prevalence ranging from 8.3% to 64.0% was reported (Supplementary Table S3). A remarkably low MMD prevalence (<15%) among high myopia patients was reported in two studies. The first study was performed in a very young population, Singaporean men aged 19 to 25 years, and the second study was performed in asymptomatic Chinese patients aged 18 years and older, possibly explaining the low prevalence. The study of Zhao et al. included the most myopic and oldest participants of which 96.9% had at least a tessellated fundus, and 54.5% also had diffuse, patchy, or macular atrophy.

Our meta-analyses, including eight population-based studies, revealed an increased OR for any myopia (OR,
### TABLE 1. Characteristics of the Studies Investigating the Relationship Between Myopia and MMD

<table>
<thead>
<tr>
<th>Study</th>
<th>Authors</th>
<th>Country</th>
<th>Region</th>
<th>Data Collection Period</th>
<th>Total participants (n)</th>
<th>Study type</th>
<th>Age, y *</th>
<th>Male Sex (%)</th>
<th>Definition of Myopia (D)</th>
<th>Myopia (%)</th>
<th>High myopia (%)</th>
<th>Total MMD (%)</th>
<th>MMD Definition (Supplementary Table S2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Mountains Eye Study</td>
<td>Vongphanit et al. 23</td>
<td>Australia</td>
<td>Urban</td>
<td>1992–1993</td>
<td>3583</td>
<td>Prospective</td>
<td>67 (49–97)</td>
<td>43.5</td>
<td>Low: ≤−1 to −3; Moderate: −3 to −5; High: ≤ −5</td>
<td>16.8</td>
<td>2.7</td>
<td>1.2</td>
<td>a (excluding tessellation)</td>
</tr>
<tr>
<td>Beijing Eye Study</td>
<td>Liu et al. 24</td>
<td>China</td>
<td>53.9% urban, 46.1% rural</td>
<td>2001</td>
<td>4319</td>
<td>Prospective</td>
<td>57 (40–101)</td>
<td>45.8</td>
<td>Low: ≤−0.5 to −2; Moderate: ≤ −6</td>
<td>23.3</td>
<td>2.4</td>
<td>3.1</td>
<td>a (excluding tessellation)</td>
</tr>
<tr>
<td>Handan Eye Study</td>
<td>Gao et al. 25</td>
<td>China</td>
<td>Rural</td>
<td>2006–2007</td>
<td>603</td>
<td>Prospective</td>
<td>52 (&gt; 29)</td>
<td>46.4</td>
<td>Moderate: ≤−0.5 to −5; High: ≤ −5</td>
<td>26.6</td>
<td>2.1</td>
<td>0.9</td>
<td>a (excluding tessellation)</td>
</tr>
<tr>
<td>Shihpai Eye Study</td>
<td>Chen et al. 28</td>
<td>Taiwan</td>
<td>Urban</td>
<td>1999–2000</td>
<td>1058</td>
<td>Prospective</td>
<td>72 (65–91)</td>
<td>60.4</td>
<td>Any: ≤−1; High: ≤ −6</td>
<td>30.8</td>
<td>4.2</td>
<td>3.0</td>
<td>b (≥M3; excluding tessellation)</td>
</tr>
<tr>
<td>Central India Eye and Medical Study</td>
<td>Jonas et al. 27</td>
<td>India</td>
<td>Rural</td>
<td>2006–2009</td>
<td>4561</td>
<td>Prospective</td>
<td>49 (30–100)</td>
<td>46.3</td>
<td>Any: ≤−1; High: ≤ −6</td>
<td>16.6</td>
<td>0.5</td>
<td>0.02</td>
<td>c (excluding tessellation)</td>
</tr>
<tr>
<td>Hisayama Study</td>
<td>Asakuma et al. 26</td>
<td>Japan</td>
<td>Urban</td>
<td>2005</td>
<td>1892</td>
<td>Prospective</td>
<td>64 (&gt; 39)</td>
<td>41.0</td>
<td>Low: ≤−1; Moderate: ≤ −2; High: ≤ −6</td>
<td>49.0</td>
<td>3.7</td>
<td>1.7</td>
<td>d (excluding tessellation)</td>
</tr>
<tr>
<td>Chinese American Eye Study</td>
<td>Choudhury et al. 30</td>
<td>United States</td>
<td>Urban</td>
<td>2010–2013</td>
<td>4582</td>
<td>Prospective</td>
<td>– (&lt; 49)</td>
<td>63</td>
<td>Low: ≤−0.5 to −2; Moderate: &lt; −5</td>
<td>32.2</td>
<td>8.0</td>
<td>3.1</td>
<td>c (excluding tessellation)</td>
</tr>
<tr>
<td>Singapore Epidemiology of Eye Diseases</td>
<td>Wong et al. 29</td>
<td>Singapore</td>
<td>Urban</td>
<td>2004–2011</td>
<td>8716</td>
<td>Prospective</td>
<td>57 (40–80)</td>
<td>49.6</td>
<td>Low: ≤−0.5 to −5; Moderate: ≤ −6</td>
<td>35.7</td>
<td>6.0</td>
<td>4.0</td>
<td>c (excluding tessellation)</td>
</tr>
</tbody>
</table>

* Mean (range).
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FIGURE 1. Prevalence of MMD among groups with any, low, moderate, and high myopia derived from eight population-based studies.

102.11; 95% confidence interval [CI], 52.60–198.22, moderate heterogeneity); low myopia (OR, 13.57; 95% CI, 6.18–29.79, high heterogeneity); moderate myopia (OR, 72.74; 95% CI, 33.18–159.48, moderate heterogeneity); and high myopia (OR, 845.08; 95% CI, 230.05–3104.34, no heterogeneity) (Fig. 2).23–30 The association between axial length (AL) and MMD was investigated in three studies. In a Russian population-based study, patients with MMD had a 1.22 mm increased AL compared with those without MMD.38 In the Chinese American Eye Study, 80.4% of the participants in the fourth quartile of AL (AL ≥ 25.60 mm) had a particular lesion (MMD including tessellation, tilted disc, and parapapillary atrophy), whereas in the third (AL 24.65–25.60 mm), second (AL 23.85–24.65 mm), and first quartile (AL < 23.85 mm) the percentage was 50.1%, 31.9%, and 17.3%, respectively.30 In the Hisayama study, MMD (excluding tessellation, tilted disc, and parapapillary atrophy) was only observed in eyes ≥23.0 mm in men and ≥22.0 mm in women, and the discriminating ability for the presence of MMD was highest at 25.9 mm in men and 25.3 mm in women.39

Visual Burden of MMD. BCVA was measured in eight studies; they all showed a worse BCVA in eyes with MMD compared with eyes without MMD (Supplementary Table S4; Fig. 3).23–25,27,28,36,40 Macular atrophy had the largest impact on BCVA, followed by CNV, patchy atrophy, diffuse atrophy, or lacquer cracks according to a longitudinal study of MMD patients in Japan. Patients with only a tessellated fundus did not have a decreased BCVA.42 Other studies also reported that patients with macular atrophy, CNV, or Fuchs spot had worse BCVA compared with those with patchy or diffuse atrophy, lacquer cracks, or tessellated fundus (Fig. 4).23–25,30,41,45 Progression of MMD to more severe stages was more frequent in older patients.42

Retinal Detachment

Incidence of RD. Annual incidence rates of RD ranged from 5.4 per 100,000 persons in Croatia (95% CI, 4.1–6.4), to 16.5 per 100,000 persons in Japan (95% CI, 15.0–18.1) (Table 2).44,47,117,118,120–126 Annual incidence of RD per degree of refractive error was only investigated by Burton et al.,44 reporting increased incidence rates of RD with decreasing SER from 3 in 100,000 persons with hyperopia (>0 D), to 102 in 100,000 persons with high myopia (<–9 D) (Table 2). Five case-control studies were available for meta-analyses to determine the relationship between myopia and RD in various refractive error categories (Table 3).45–49 All but one study showed a significant higher odds of RD for myopic persons (<0 D) compared with nonmyopic persons (Fig. 5).45–49 Pooled analyses revealed an increased OR for any myopia (OR, 3.45; 95% CI, 1.08–11.00, no heterogeneity); low myopia (OR, 3.15; 95% CI, 1.92–5.17, no heterogeneity); moderate myopia (OR, 8.74, 95% CI, 7.28–10.50, no heterogeneity); and high myopia (OR, 12.62; 95% CI, 6.65–23.94, no heterogeneity).
**Visual Burden of RD.** Three studies reported BCVA after RD in myopic patients, and they all concluded that visual prognosis was often worse in myopic RD compared with nonmyopic RD. The number of patients with postoperative BCVA of <20/200 was 34% in the high myopia group (SER < -6D) compared with 19% in those without high myopia. Four studies reported on the association between myopia and reattachment of the macula after surgery. Two of these studies mentioned that reattachment of the macula after detachment was less successful in highly myopic patients, requiring more reoperations.

**Cataract**

**Myopia and Development of Various Types of Cataract.** The association between myopia and incident or prevalent cataract was investigated in three prospective and eight cross-sectional studies. Nine out of 11 studies identified a strong association between myopia and posterior subcapsular cataract (PSC). Our meta-analysis revealed a strong association for any myopia (OR, 2.09; 95% CI, 1.60–2.74, no heterogeneity), low myopia (OR, 1.56; 95% CI, 1.32–1.84, no heterogeneity), moderate myopia (OR, 2.55; 95% CI, 1.98–3.23, no heterogeneity), and high myopia (OR, 4.55; 95% CI, 2.67–7.75, no heterogeneity) (Fig. 6). Seven out of the 11 studies reported an association between myopia and nuclear cataract, and our meta-analysis showed a significant association for any myopia (OR, 2.51; 95% CI, 1.53–4.13, no heterogeneity); low myopia (OR, 1.79; 95% CI, 1.08–2.97, no heterogeneity); moderate myopia (OR, 2.39; 95% CI, 1.03–5.55, no heterogeneity); and high myopia (OR, 2.86; 95% CI, 1.43–5.73, no heterogeneity). Regarding cortical cataract, neither prospective nor cross-sectional studies reported an association (Fig. 7). Our meta-analysis showed a summary OR of 1.15 (95% CI, 0.94–1.40, no heterogeneity) for any myopia; OR, 0.99 (95% CI, 0.85–1.15, no heterogeneity) for low myopia; OR, 1.06 (95% CI, 0.83–1.35, no heterogeneity) for moderate myopia; and OR, 1.07 (95% CI, 0.81–1.40, low heterogeneity) for high myopia (Fig. 8).

**The Risk of Cataract Extraction (CE).** To investigate whether CE is equally safe in myopic versus nonmyopic patients, we included seven studies investigating the associa-
FIGURE 3. BCVA in eyes with and without MMD.

FIGURE 4. BCVA in eyes with different stages of MMD.
Table 2. Annual Incidence of RD

<table>
<thead>
<tr>
<th>Authors</th>
<th>Country</th>
<th>Data Collection Period</th>
<th>Total RD Cases</th>
<th>Male Sex (%)</th>
<th>Age Cases, y*</th>
<th>Annual Incidence per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laatikainen et al.121 (1985)</td>
<td>Finland</td>
<td>1978–1981</td>
<td>310</td>
<td>48.7</td>
<td>54.2 ± 1.0 (5.7–83.0)</td>
<td>6.9 (5.5–8.7)</td>
</tr>
<tr>
<td>Li et al.126 (1987)</td>
<td>Sweden</td>
<td>1971–1975</td>
<td>590</td>
<td>46.6</td>
<td>59.5 (–)</td>
<td>9.8</td>
</tr>
<tr>
<td>Ivansevic et al.120 (1999)</td>
<td>Croatia</td>
<td>1988–1998</td>
<td>278</td>
<td>54.4</td>
<td>58.3 ± 15.3 (7–89)</td>
<td>5.4 (4.1–6.4)</td>
</tr>
<tr>
<td>Haga et al.117 (2017)</td>
<td>Japan</td>
<td>2009–2011</td>
<td>897</td>
<td>62</td>
<td>54.4 ± 15.5 (6–95)</td>
<td>16.5 (15.0–18.1)</td>
</tr>
<tr>
<td>Mitry et al.123 (2011)</td>
<td>United Kingdom</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Li et al.122 (2003)</td>
<td>China</td>
<td>1999–2000</td>
<td>519</td>
<td>57</td>
<td>51 (median) (4–84)</td>
<td>8.0 (7.3–8.7)</td>
</tr>
<tr>
<td>Ivansevic et al.120 (1999)</td>
<td>Croatia</td>
<td>1988–1998</td>
<td>278</td>
<td>54.4</td>
<td>58.3 ± 15.3 (7–89)</td>
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<td>Mitry et al.123 (2011)</td>
<td>United Kingdom</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zou et al.47 (2002)</td>
<td>China</td>
<td>1999</td>
<td>61</td>
<td>47.5</td>
<td>40–59 (median group)</td>
<td>11.3</td>
</tr>
<tr>
<td>Burton44 (1989)</td>
<td>United States</td>
<td>1976</td>
<td>172</td>
<td>55.9</td>
<td>55 ± 17.9</td>
<td>3 (&lt;–0.00 D)</td>
</tr>
<tr>
<td>Chou et al.45 (2007)</td>
<td>Taiwan</td>
<td>1995–2001</td>
<td>4,569</td>
<td>58.2</td>
<td>43 ± 18.2</td>
<td>102 (&lt;–6.00 D)</td>
</tr>
<tr>
<td>The Eye Disease Case-Control Study Group46 (1993)</td>
<td>United States</td>
<td>1986–1990</td>
<td>1,391</td>
<td>47.4</td>
<td>(21–80)</td>
<td>1.00</td>
</tr>
<tr>
<td>Zou et al.47 (2002)</td>
<td>China</td>
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<td>122</td>
<td>58.2</td>
<td>43 ± 18.2</td>
<td>102 (&lt;–6.00 D)</td>
</tr>
<tr>
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<td>1,391</td>
<td>47.4</td>
<td>(21–80)</td>
<td>1.00</td>
</tr>
</tbody>
</table>

*Mean ± SD (range).

Table 3. Characteristics of the Studies Investigating the Relationship Between Myopia and RD

<table>
<thead>
<tr>
<th>Authors</th>
<th>Country</th>
<th>Data Collection Period</th>
<th>Total Participants (n)</th>
<th>Study Type</th>
<th>Male Sex (%)</th>
<th>Age, y*</th>
<th>Definition of Myopia (D)</th>
<th>Adjusted Covariates</th>
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<tbody>
<tr>
<td>Ogawa and Tanaka49 (1988)</td>
<td>Japan</td>
<td>1961–1985</td>
<td>12,837</td>
<td>Case-control</td>
<td>–</td>
<td>–</td>
<td>≤ –0.75</td>
<td>Crude OR</td>
</tr>
<tr>
<td>Chen et al.45 (2018)</td>
<td>China</td>
<td>2012</td>
<td>749</td>
<td>Case-control</td>
<td>100</td>
<td>21.2 (19–25)</td>
<td>≤ –6.00</td>
<td>Crude OR</td>
</tr>
<tr>
<td>The Eye Disease Case-Control Study Group46 (1993)</td>
<td>United States</td>
<td>1986–1990</td>
<td>1,391</td>
<td>Case-control</td>
<td>47.4</td>
<td>(21–80)</td>
<td>≤ –1.00</td>
<td>Crude OR</td>
</tr>
<tr>
<td>Zou et al.47 (2002)</td>
<td>China</td>
<td>1999</td>
<td>122</td>
<td>Case-control</td>
<td>–</td>
<td>–</td>
<td>&lt;0.00</td>
<td>Crude OR</td>
</tr>
<tr>
<td>Chou et al.45 (2007)</td>
<td>Taiwan</td>
<td>1995–2001</td>
<td>4,569</td>
<td>Case-control</td>
<td>58.2</td>
<td>43 ± 18.2</td>
<td>≤ –1.00</td>
<td>Age and sex</td>
</tr>
</tbody>
</table>

*Mean ± SD (range).

between CE in myopic patients and development of RD after CE (Fig. 9; Supplementary Table S5).67–73 In five retrospective case series, prevalence of RD in myopic patients ranged from 0% to 3.84%.67–71 Two case–control studies and one cohort study reported a significant risk of RD after CE in myopic patients (1.27% vs. 0.28%, P < 0.001; 8.0% vs. 1.2%, P < 0.01, and HR, 6.12; 95% CI, 5.84–6.41), and the association was stronger in patients undergoing CE aged younger than 55 years (HR, 25.05; 95% CI, 24.76–25.18).72–74 The presence of posterior vitreous detachment prior to CE was not reported.67–71,73,74

Open Angle Glaucoma

The Association Between Myopia and OAG. We performed a meta-analysis of 14 population-based studies on the association between myopia and OAG (Table 5).61,66,75–86 Diagnosis of OAG was based on visual field defects and optic disc aberrations in most studies. The overall OR was 1.95 (95% CI, 1.74–2.19, no heterogeneity) for any myopia compared with emmetropia. The association became stronger with increasing myopia degree; the overall pooled OR was 1.59 (95% CI, 1.33–1.91, no heterogeneity) for low myopia (> –3 D); and OR, 2.92 (95% CI, 1.89–4.52, no heterogeneity) for moderate/high myopia (≤ –3 D) (Fig. 10).

Visual Burden of OAG. Seven retrospective studies, four case only, and three case–control studies reported on the association between myopia and visual field loss progression (Fig. 11; Supplementary Table S6). OAG patients with normotensive intraocular pressure under treatment were included in all studies, and follow-up length ranged from 2 to 10 years. Myopia was identified as a risk factor for visual field progression in OAG in three studies.87–89 However, the other four studies did not report an association.90–93 Whether progressive OAG is an important cause of myopic visual morbidity therefore remains questionable. Lack of data hampered investigation of the association between myopia and VA in OAG patients.
Complications of Myopia

**FIGURE 5.** Forest plot of RD in any myopia (random effects model; Q = 1.7; I^2 = 0.0); low myopia (random effects model; Q = 3.7; I^2 = 0.5); moderate myopia (fixed effects model; Q = 2.8; I^2 = 0.6); and high myopia (random effects model; Q = 3.3; I^2 = 0.4). Red lines with diamond represents the summary OR per myopia category. Summary OR for myopia categories are as follows: any myopia OR, 3.45 (95% CI, 1.08–11.00); low myopia OR, 3.15 (95% CI, 1.92–5.17); moderate myopia OR, 8.74 (95% CI, 7.28–10.50); and high myopia OR, 12.62 (95% CI, 6.65–23.94).

**VISUAL BURDEN OF MYOPIA**

Vision loss from any cause in myopia was investigated in only a few studies. A study using data from the Rotterdam Study, performed in The Netherlands, showed that 34.6% of the high myopes will eventually develop bilateral visual impairment (25.0%) or blindness (9.6%). Visual impairment (VA <0.3 and VA ≥0.05) and blindness (VA <0.05) were defined according to the World Health Organization criteria in this study. The risk of visual impairment in high myopia started to increase already before the age of 60 years. Another Dutch study, including population-based, family-based, and case–control data, investigated the association between myopia, AL, and visual impairment. An overall risk of visual impairment was reported, which increased myopia degree (OR, 0.92, 95% CI, 0.62–1.35 for SER –0.5 to > –3 D; OR, 1.71, 95% CI, 1.07–2.74 for SER –3 to > –6 D; OR, 5.54, 95% CI, 3.12–9.85 for SER –6 to > –10D; OR, 7.77, 95% CI, 3.36–17.99 for SER –10 to > –15 D; OR, 87.63, 95% CI, 3.49–222.58 for SER < –15 D in participants aged ≥60 years). AL was a stronger predictor for visual impairment or blindness than refractive error. The cumulative risk of visual impairment or blindness increased from 6.9% in eyes less than 24 mm, up to 90.6% in eyes of 30 mm or greater in participants aged 75 years or older.

For those with AL ≥26 mm, one in three was at risk of developing bilateral low vision with increasing age. The rise in cumulative risk started at age 55 years for participants with SER ≤ –10 D, and at age 65 years for participants with SER –6 D to –10 D, and showed an almost exponential increase for SER ≤ –10D thereafter (Fig. 12). Considering visual function, 10 studies reported on ERG responses (multifocal and full-field ERG) in mostly healthy adults with different ALs, and identified decreased amplitudes of both a- and b-wave responses, correlating negatively with AL. Contrast sensitivity was only investigated in healthy myopic participants, and multiple studies reported a decreased contrast sensitivity in myopic compared with emmetropic participants.

**DISCUSSION**

Our study showed that myopia is associated with MMD, RD, PSC, and OAG. The risk of these complications was not only increased for high myopia, but also for low or moderate myopia. Overall, myopic patients had 100-fold higher risk of MMD, three-fold higher risk of RD, three-fold higher risk of PSC, and an almost doubled risk of OAG. MMD was by far the most hazardous complication. Emmetropic eyes, which served as the reference, did not
### Table 4. Characteristics of the Studies Investigating the Relationship Between Myopia and Cataract

<table>
<thead>
<tr>
<th>Study</th>
<th>Authors</th>
<th>Country</th>
<th>Data Collection Period (n)</th>
<th>Study Type</th>
<th>Total Participants (n)</th>
<th>Ethnicity</th>
<th>Male Sex (%)</th>
<th>Age, y *</th>
<th>Definition of Myopia (D)</th>
<th>Adjusted Covariates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Mountains Eye Study (BMES)</td>
<td>Kanthan et al.</td>
<td>Australia</td>
<td>1992–2004 2564 Prospective –</td>
<td>43.3</td>
<td>(49–97)</td>
<td>Low: -1 to &gt; -3.5</td>
<td>Moderate: -3.5 to &gt; -6</td>
<td>High: ≤ -6</td>
<td>Age, sex</td>
<td></td>
</tr>
<tr>
<td>Salisbury Eye Evaluation (SEE)</td>
<td>Chang et al.</td>
<td>United States</td>
<td>1988–1990 2520 Cross-sectional 73.6% White 26.4% Black</td>
<td>42.1</td>
<td>73.0 ± 5.1</td>
<td>Low: -0.5 to &gt; -4</td>
<td>Moderate: -4 to &gt; -6</td>
<td>High: ≤ -6</td>
<td>Age, race, sex, tobacco use, education, and clustering between eyes</td>
<td></td>
</tr>
<tr>
<td>Beaver Dam Eye Study (BDES)</td>
<td>Wong et al.</td>
<td>United States</td>
<td>1992–1994 3654 Cross-sectional</td>
<td>43.3</td>
<td>66 (49–97)</td>
<td>Low: -1 to &gt; -3</td>
<td>Moderate: -3.5 &gt; -6</td>
<td>High: ≤ -6</td>
<td>Age, sex</td>
<td></td>
</tr>
<tr>
<td>Blue Mountains Eye Study (BMES)</td>
<td>Lim et al.</td>
<td>Australia</td>
<td>1992–1994 3654 Cross-sectional</td>
<td>43.3</td>
<td>66 (49–97)</td>
<td>Low: -0.5 to &gt; -3</td>
<td>Moderate: -3.5 &gt; -6</td>
<td>High: ≤ -6</td>
<td>Age, sex</td>
<td></td>
</tr>
<tr>
<td>Singapore Malay Eye Study (SiMES)</td>
<td>Pan et al.</td>
<td>Singapore</td>
<td>2004 3280 Cross-sectional Malay –</td>
<td>– (40–80)</td>
<td>– –</td>
<td>Low: -0.5 to &gt; -3</td>
<td>Moderate: -2 to &gt; -5</td>
<td>High: &lt; -5.0</td>
<td>Age, sex, body mass index, systolic blood pressure, HbA1c, smoking history, and education level</td>
<td></td>
</tr>
<tr>
<td>Singapore Indian Eye Study</td>
<td>Pan et al.</td>
<td>Singapore</td>
<td>2007 3400 Cross-sectional Indian –</td>
<td>– (40–84)</td>
<td>– –</td>
<td>Any: ≤ -0.5</td>
<td>Low: -0.5 to &gt; -3</td>
<td>High: -3 to &lt; -6</td>
<td>Age, sex, smoking, education, body mass index, hypertension, and total cholesterol level</td>
<td></td>
</tr>
<tr>
<td>The Casteldaccia Eye Study</td>
<td>Giuffre et al.</td>
<td>Italy</td>
<td>– 1068 Case-control White –</td>
<td>≥ 40</td>
<td>Any: &gt; -1.5</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Barbados Eye Study</td>
<td>Wu et al.</td>
<td>Barbados</td>
<td>1997–2003 4036 Cross-sectional Black</td>
<td>43 (40–84)</td>
<td>Any: &lt; -0.5</td>
<td>Age, sex, SES, lens opacity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Handan Eye Study</td>
<td>Duan et al.</td>
<td>China</td>
<td>2006–2007 6544 Cross-sectional Chinese</td>
<td>46.3</td>
<td>52.0 ± 11.8</td>
<td>Any: &lt; -0.5</td>
<td></td>
<td></td>
<td>Age, sex, education, diabetes, and smoking status</td>
<td></td>
</tr>
<tr>
<td>The Tanjong Pagar Survey</td>
<td>Wong et al.</td>
<td>Singapore</td>
<td>1997–1998 1029 Cross-sectional Chinese</td>
<td>45.6</td>
<td>(40–81)</td>
<td>Any: ≤ -0.5, low: -0.5 to &gt; -3, moderate: -3.0 to &gt; -6</td>
<td>High: &lt; -6</td>
<td></td>
<td>Age, sex, country of birth, occupation, smoking status, arthritis, diabetes mellitus, vitamin C supplements, calcium channel blockers</td>
<td></td>
</tr>
<tr>
<td>The Visual Impairment Project</td>
<td>Mukesh et al.</td>
<td>Australia</td>
<td>1992–1999 2392 Prospective Caucasian</td>
<td>45</td>
<td>62.5 ± 10.9</td>
<td>Any: &lt; -1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Mean ± SD (range). SES, socio-economic status.
### Table 5. Characteristics of the Studies Investigating the Relationship Between Myopia and OAG

<table>
<thead>
<tr>
<th>Study</th>
<th>Authors</th>
<th>Data Collection Period</th>
<th>Total Participants (n)</th>
<th>Study Type</th>
<th>Ethnicity</th>
<th>Age, Y</th>
<th>Glaucoma Definition</th>
<th>Definition of Myopia (D)</th>
<th>Adjusted Covariates</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Barbados Eye Study</td>
<td>Wu et al.66 1999</td>
<td>1997–2003</td>
<td>4,036</td>
<td>Cross-sectional</td>
<td>Black</td>
<td>40–84</td>
<td>GVFL, optic disc abnormalities</td>
<td>Any: &lt; −0.5</td>
<td>Age, sex, SES, lens opacity, Age, sex, family history</td>
</tr>
<tr>
<td>The Blue Mountains Eye Study</td>
<td>Mitchell et al.75 1999</td>
<td>1992–1994</td>
<td>3,654</td>
<td>Cross-sectional</td>
<td>White</td>
<td>49–97</td>
<td>GVFL, CD-ratio ≥0.7 or asymmetry ≥0.3</td>
<td>Any: ≤ −1.0, Low: ≤1.0 to &gt; −3.0, High: ≤ −3.0</td>
<td>Age, sex, family history, DM, steroid use, typical migraine history, hypertension, pseudoexfoliation</td>
</tr>
<tr>
<td>Visual Impairment Project</td>
<td>Weih et al.76 2001</td>
<td>1992–1996</td>
<td>4,498</td>
<td>Cross-sectional</td>
<td>Diverse</td>
<td>≥40</td>
<td>IOP ≥22 mm Hg, GVFL, CD-ratio ≥0.7 or asymmetry ≥0.3, family history of glaucoma treatment</td>
<td>Any: ≤ −0.5</td>
<td>Age, rural residence, and family history</td>
</tr>
<tr>
<td>The Beaver Dam Eye Study</td>
<td>Wong et al.77 2003</td>
<td>1987–1988</td>
<td>4,670</td>
<td>Cross-sectional</td>
<td>White</td>
<td>43–86</td>
<td>GVFL, IOP ≥22 mm Hg, CD-ratio ≥0.8 or asymmetry ≥0.2, history of glaucoma</td>
<td>Any: ≤ −1.0, Low: ≤1.0 to &gt; −3.0, High: ≤ −3.0</td>
<td>Age, sex</td>
</tr>
<tr>
<td>The Aravind Comprehensive Eye Survey</td>
<td>Ramakrishnan et al.78 2003</td>
<td>1995–1997</td>
<td>5,150</td>
<td>Cross-sectional</td>
<td>Indian</td>
<td>≥40</td>
<td>GVFL, CD-ratio ≥0.9 or asymmetry ≥0.3, optic disc abnormalities, normal gonioscopy</td>
<td>Any: ≤ −0.5</td>
<td>Age, sex, DM, hypertension, pseudoexfoliation</td>
</tr>
<tr>
<td>The Tajimi Study</td>
<td>Suzuki et al.79 2006</td>
<td>2000–2001</td>
<td>2,874</td>
<td>Cross-sectional</td>
<td>Japanese</td>
<td>≥40</td>
<td>Optic disc abnormalities, perimetric results, other ocular findings</td>
<td>Any: ≤ −1.0, Low: ≤1.0 to &gt; −3.0, High: ≤ −3.0</td>
<td>Age, IOP</td>
</tr>
<tr>
<td>The Beijing Eye Study</td>
<td>Xu et al.80 2007</td>
<td>2001</td>
<td>4,319</td>
<td>Cross-sectional</td>
<td>Chinese</td>
<td>≥40</td>
<td>Optic disc abnormalities, GVFL</td>
<td>Any: &lt; −0.5, Low: &lt; −0.5 to &gt; −3, High: (&lt; −8)</td>
<td>Age, IOP</td>
</tr>
</tbody>
</table>
### Table 5. Continued

<table>
<thead>
<tr>
<th>Study</th>
<th>Authors</th>
<th>Data Collection Period</th>
<th>Total Participants (n)</th>
<th>Study Type</th>
<th>Ethnicity</th>
<th>Age, Y</th>
<th>Glaucoma Definition</th>
<th>Definition of Myopia (D)</th>
<th>Adjusted Covariates</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Meiktila Eye Study</td>
<td>Casson et al.81, 2007</td>
<td>2005</td>
<td>1,997</td>
<td>Cross-sectional</td>
<td>Diverse</td>
<td>≥40</td>
<td>CD-ratio ≥0.7 or ≥0.6 with asymmetry ≥0.3, reduced NRRW, GVFL, &gt;900 of TM visible</td>
<td>Any: &lt; −0.5</td>
<td>Age, IOP, AL</td>
</tr>
<tr>
<td>The Andhra Pradesh Eye Disease Study</td>
<td>Garudadri et al.82, 2010</td>
<td>1996–2000</td>
<td>3,724</td>
<td>Cross-sectional</td>
<td>Indian</td>
<td>≥40</td>
<td>Asymmetrical CD-ratio, NRRW reduced to 0.1, GVFL Any: &lt; −0.5</td>
<td>Age: DM, sex, IOP, hypertension</td>
<td></td>
</tr>
<tr>
<td>The Singapore Malay Eye Study</td>
<td>Perera et al.83, 2010</td>
<td>2010–2013</td>
<td>3,109</td>
<td>Cross-sectional</td>
<td>Malay</td>
<td>40–80</td>
<td>Optic disc abnormalities, GVFL Any: ≤ −1.0; Low: ≤ −1.0 to &gt; −3.0</td>
<td>Age: sex, IOP, education, height, CCT, hypertension, HbA1c</td>
<td></td>
</tr>
<tr>
<td>The Los Angeles Latino Eye Study</td>
<td>Kuzin et al.84, 2010</td>
<td>2000–2003</td>
<td>5,927</td>
<td>Cross-sectional</td>
<td>Latino</td>
<td>≥40</td>
<td>Optic disc abnormalities, GVFL Any: ≤ −1.0; Low: ≤ −1.0 to &gt; −3.0</td>
<td>Age: sex, IOP, DM, sex, family history, NO, CP</td>
<td></td>
</tr>
<tr>
<td>National Health and Nutrition Examination Survey</td>
<td>Qiu et al.85, 2013</td>
<td>2005–2008</td>
<td>5,277</td>
<td>Cross-sectional</td>
<td>Diverse</td>
<td>≥40</td>
<td>GVFL Any: ≤ −1.0; Low: ≤ −1.0 to &gt; −2.99</td>
<td>Age: sex, ethnicity, income, and education</td>
<td></td>
</tr>
<tr>
<td>Singapore Indian Eye Study</td>
<td>Pan et al.86, 2013</td>
<td>2007</td>
<td>3,400</td>
<td>Cross-sectional</td>
<td>Indian</td>
<td>40–84</td>
<td>Optic disc abnormalities, GVFL Any: ≤ −0.5; Low: ≤ −0.5 to &gt; −2.99</td>
<td>Age: sex, education, HbA1c, total cholesterol level, IOP, and central corneal thickness in generalized estimating equation models</td>
<td></td>
</tr>
<tr>
<td>Korean National Health and Nutrition Examination Survey</td>
<td>Chon et al.86, 2013</td>
<td>2008–2011</td>
<td>13,433</td>
<td>Cross-sectional</td>
<td>Korean</td>
<td>≥40</td>
<td>Optic disc abnormalities (CD-ratio ≥0.9, GVFL, or IOP &gt;21 mm Hg and VA &lt;3/60)</td>
<td>Any: ≤ −1.0; Low: ≤ −1.0 to &gt; −2.99</td>
<td>Age: sex, income, and education</td>
</tr>
</tbody>
</table>

CCT, central corneal thickness; CD, cup disc; CP, corneal power; DM, diabetes mellitus. NO, lens nuclear opacification; SES, socio-economic status; TM, trabecular meshwork.
Complications of Myopia

Any myopia
- Wu et al. (1999)
- Lim et al. (1999)
- Wong et al. (2001)
- Wong et al. (2003)
- Chang et al. (2005)
- Guiffre et al. (2005)
- Mukesh et al. (2006)
- Pan et al. (2013)**
- Duan et al. (2013)
- Kanthan et al. (2014)

Low myopia
- Lim et al. (1999)
- Wong et al. (2001)
- Wong et al. (2003)
- Pan et al. (2013)**
- Kanthan et al. (2014)**

Moderate myopia
- Lim et al. (1999)
- Wong et al. (2001)
- Pan et al. (2013)**
- Kanthan et al. (2014)**

High myopia
- Lim et al. (1999)
- Wong et al. (2001)
- Pan et al. (2013)**
- Kanthan et al. (2014)**

PSC Cataract

Any myopia
- Wu et al. (1999)
- Lim et al. (1999)
- Wong et al. (2001)
- Wong et al. (2003)
- Chang et al. (2005)
- Guiffre et al. (2005)
- Mukesh et al. (2006)
- Pan et al. (2013)**
- Duan et al. (2013)
- Kanthan et al. (2014)

Low myopia
- Lim et al. (1999)
- Wong et al. (2001)
- Wong et al. (2003)
- Pan et al. (2013)**
- Kanthan et al. (2014)**

Moderate myopia
- Lim et al. (1999)
- Wong et al. (2001)
- Pan et al. (2013)**
- Kanthan et al. (2014)**

High myopia
- Lim et al. (1999)
- Wong et al. (2001)
- Pan et al. (2013)**
- Kanthan et al. (2014)**

**Represents Pan et al. 2013 Singapore Malay Eye Study.
**Represents Pan et al. 2013 Singapore Indian Eye Study.

Figure 6. Forest plot of PSC in any myopia (random effects model; Q = 11.6; I² = 13.8); low myopia (fixed effects model; Q = 7.5; I² = 19.7); moderate myopia (fixed effects model; Q = 7.5; I² = 19.2); and high myopia (random effects model; Q = 6.0; I² = 0.14). Red lines with diamond represents the summary OR per myopia category, which are as follows: any myopia OR, 2.09 (95% CI, 1.60–2.74); low myopia OR, 1.56 (95% CI, 1.32–1.84); moderate myopia OR, 2.55 (95% CI, 1.99–3.28); and high myopia OR, 4.55 (95% CI, 2.67–7.75). *Represents Pan et al. 2013 Singapore Malay Eye Study. **Represents Pan et al. 2013 Singapore Indian Eye Study.

Our meta-analysis revealed an increased risk for RD in all myopia groups, with higher risk for those with more severe myopia. The OR for moderate myopia was already 8.7, and given the relatively high frequency of myopes in this category, the RD prevalence is expected to rise dramatically. Frequency data of RD per degree of myopia were limited in literature, but Japan and Taiwan reported remarkably higher incidence rates of RD than other countries with a lower myopia prevalence. This confirms the notion that RD rates will increase when myopia becomes more prevalent. The visual prognosis of myopic RD appeared to be worse than nonmyopic RD in some studies, but this needs more comprehensive research.

Our meta-analysis identified a strong association between myopia, PSC, and nuclear cataract, but not between myopia and cortical cataract. Three mechanisms have been proposed to explain the relationship between myopia and cataract. First, myopic eyes may be exposed to a higher level of oxidative stress caused by faster vitreous liquefaction, or by a decreased level of glutathione, an antioxidative agent in the lens of myopic eyes leading to cataract formation. Second, the higher level of byproducts of lipid peroxidation in myopia may increase cataract formation. Third, longer AL may lead to diminished diffusion of nutrients from the posterior chamber to the lens causing cataract. This mechanism seems less plausible because the aqueous humor also provides nutrients to the lens. It should be noted that the association between myopia and nuclear cataract may be influenced by the myopic shift occurring with this type of cataract. Cataract is a disorder that can be resolved rather easily by performing CE. In myopic patients, however, reports suggest an increased risk of postsurgery RD, as CE causes a disruption of the capsular-zonular diaphragm and vitreous traction of a thin peripheral retina may then
Complications of Myopia

**FIGURE 7.** Forest plot of nuclear cataract in any myopia (random effects model; $Q = 9.3; I^2 = 0$); low myopia (random effects model; $Q = 5.7; I^2 = 0$); moderate myopia (random effects model; $Q = 4.0; I^2 = 0.0$); and high myopia (random effects model; $Q = 5.0; I^2 = 0.0$). Red lines with diamond represent the summary OR per myopia category, which are as follows: any myopia OR, 2.51 (95% CI, 1.53–4.13); low myopia OR, 1.79 (95% CI, 1.08–2.97); moderate myopia OR, 2.39 (95% CI, 1.03–5.55); and high myopia OR, 2.87 (95% CI, 1.43–5.73).

*Represents Pan et al.60 2013 Singapore Malay Eye Study. **Represents Pan et al.61 2013 Singapore Indian Eye Study.

The positive association between myopia and OAG is in line with previous reports.11 Distinguishing myopic optic neuropathy from OAG remains a challenge, and may have led to misclassification and invalid estimations of the calculated OR.115 Considering that myopic eyes have larger optic disc sizes, and therefore larger excavations, OAG is prone to misdiagnosis. The underlying mechanism for a predisposition to OAG is still unclear. Doshi et al.90 mentioned that longer AL leads to tilting of the optic disc, and may possibly cause damage to the axons in the lamina cribrosa. Considering the differences in study design and definitions myopic OAG may unlikely progress to central visual field defects.

To our knowledge, this is the first systematic review and meta-analysis regarding complications associated with myopia. One of the strengths is the completeness of our literature search. We believe that we included all observational studies performed from 1988–2019 in the meta-analyses. Another asset is the estimations of risk per refractive error category, which elucidated the profound risk increase for the higher degrees of myopia, but also revealed substantial risks for the much more common low and moderate myopia. Limitations of our study include the different defini-
Complications of Myopia

FIGURE 8. Forest plot of cortical cataract in any myopia (random effects model; $Q = 11.5$; $I^2 = 12.8$); low myopia (fixed effects model; $Q = 0.9$; $I^2 = 0.0$); moderate myopia (fixed effects model; $Q = 7.15$; $I^2 = 30.1$); and high myopia (fixed effects model; $Q = 6.7$; $I^2 = 25.9$). Red lines with diamond represents the summary OR per myopia category, which are as follows: any myopia OR, 1.15 (95% CI, 0.94–1.40); low myopia OR, 0.99 (95% CI, 0.85–1.15); moderate myopia OR, 1.06 (95% CI, 0.83–1.35); and high myopia OR, 1.07 (95% CI, 0.81–1.40).

*Represents Pan et al.60 2013 Singapore Malay Eye Study. **Represents Pan et al.61 2013 Singapore Indian Eye Study.

FIGURE 9. Prevalence of RD after CE in myopic patients. Horizontal axis represent different studies investigating RD rate. Two studies are case–control studies (Ripandelli et al.73 2003 and Jeon et al.72 2011), the other five studies are retrospective case series. The vertical axis represent the prevalence of RD.

Regarding clinical management, the results from our meta-analyses suggest that vision-threatening complications used for myopic complications, in particular for MMD and OAG. We strived to use the recently defined guidelines by the International Myopia Institute to optimize uniformity between studies, but sometimes had to apply best clinical judgement if this was not possible.20 Our decisions may have affected the results. Another limitation was the lack of multimodal imaging to detect all retinal complications; most studies only used color fundus photographs. In particular, retinoschisis, macular hole, different types of staphylomas, and peripheral lesions are better visualized with other imaging techniques, such as optical coherence tomography and wide-field imaging. We therefore chose to focus only on MMD, OAF, cataract, and OAG. We expect that future studies will provide more results using newer and multimodal imaging techniques. Finally, although AL is more closely related to myopic complications than refractive error, we could not study this for most complications, as data on eye biometry were missing.
FIGURE 10. Forest plot of OAG in any myopia (fixed effects model; \( Q = 8.3; I^2 = 0.0 \)); low myopia (fixed effects model; \( Q = 0.3; I^2 = 0.0 \)); and moderate/high myopia (random effects model; \( Q = 2.6; I^2 = 0.0 \)). Red lines with diamond represents the summary OR per myopia category, which are as follows: any myopia OR, 1.95 (95% CI, 1.74–2.19); low myopia OR, 1.59 (95% CI, 1.33–1.91); moderate/high myopia OR, 2.92 (95% CI, 1.89–4.52).

FIGURE 11. Overview of visual field progression (%) between nonmyopic and myopic patients. Different refractive error categories were indicated by orange patterns. Patients were categorized as myopic if refractive error category was unavailable. Doshi et al.\(^90\) found 0% progression in the group \( \text{SER} \leq -6 \text{ D} \).

can appear from moderate myopia onward. There is a strong relationship between myopia degree, age of the participant, and visual impairment; more severe myopia results in an earlier onset of visual-threatening complications.\(^4,5\) Therefore both factors should be taken into account regarding screening programs and clinical guidelines. A period of 20 years between diagnosis and perimetric blindness was estimated for OAG patients with average visual field loss progression.\(^116,117\) A significant visual loss over a follow-up period of 10 years was determined for the natural course of MMD.\(^40,42\) Considering the asymptomatic period and window of possible action before the onset of complications, we advise an ophthalmologic screen at the age of 30 in myopic patients with \( \text{SER} \leq -10 \text{ D} \), and at the age of 50 in patients with \( \text{SER} \leq -6 \text{ D} \) to \( -10 \text{ D} \).

CONCLUSIONS

This literature review and meta-analyses provide detailed risk estimates of myopic complications. One in three high myopes is at risk of bilateral low vision with age. Low and moderate myopes are less likely to develop such a severe visual outcome; nevertheless, they are at significant risk to develop MMD, RD, cataract, and OAG. This not
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only affects the individual patient, it has a major impact on health care and society, in particular because future generations may become even more myopic. Awareness of the complications of myopia among patients, physicians, and policy makers is crucial, and a global strategy for prevention and treatment of myopia progression should become a priority.

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