Asymmetric Macular Structural Damage Is Associated With Relative Afferent Pupillary Defects in Patients With Glaucoma

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PURPOSE. We examined the relationship between relative afferent pupillary defects (RAPDs) and macular structural damage measured by macular thickness and macular ganglion cell-inner plexiform layer (mGCIPL) thickness in patients with glaucoma.

METHODS. A cross-sectional study was done of 106 glaucoma patients and 85 healthy individuals from the Diagnostic Innovations in Glaucoma Study. All subjects underwent standard automated perimetry (SAP) and optic nerve and macular imaging using Cirrus Spectral Domain Optical Coherence Tomography (SDOCT). Glaucoma was defined as repeatable abnormal SAP or progressive glaucomatous changes on stereo photographs. Pupil responses were assessed using an automated pupillometer, which records the magnitude of RAPD (RAPD score), with additional RAPD scores recorded for each of a series of colored stimuli (blue, red, green, and yellow). The relationship between RAPD score and intereye differences (right minus left eye) in circumpapillary retinal nerve fiber layer (cpRNFL) thickness, mGCIPL, macular thickness, and SAP mean deviation (MD), was examined using linear regression.

RESULTS. There was fair correlation between RAPD score and asymmetric macular structural damage measured by intereye difference in mGCIPL thickness ($R^2 = 0.285, P < 0.001$). The relationship between RAPD score and intereye difference in macular thickness was weaker ($R^2 = 0.167, P < 0.001$). Intereye difference in cpRNFL thickness ($R^2 = 0.350, P < 0.001$) and SAP MD ($R^2 = 0.594, P < 0.001$) had stronger association with RAPD scores compared to intereye difference in mGCIPL and macular thickness.

CONCLUSIONS. Objective assessment of pupillary responses using a pupillometer was associated with asymmetric macular structural damage in patients with glaucoma.

Keywords: pupillary response, pupillary reflex, glaucoma, macula, structural damage
The purpose of the current study was to determine the relationship between intereye differences in mGCIPL thickness and magnitude of RAPD measured using automated pupillometry in patients with glaucoma. We aimed to determine the degree of asymmetry in macular structural damage that might be required for a RAPD to become detectable.

**METHODS**

**Study Sample**

This was a cross-sectional study including both eyes of 191 participants from the Diagnostic Innovations in Glaucoma Study (DIGS), a previously described prospective longitudinal study. The study was conducted at the Hamilton Glaucoma Study (DIGS), a previously described prospective longitudinal study. Participants were classified as healthy or glaucomatous according to worse eye diagnosis. Eyes were classified as glaucomatous if they had repeatable (>3 consecutive) abnormal SAP test results on the 24-2 Humphrey visual field analyser test (Carl Zeiss Meditec, Inc.; Dublin, CA, USA). An abnormal SAP result was defined by a pattern standard deviation outside the 95% confidence limits (CI) or a glaucoma hemifield test result outside the reference range. Healthy subjects were recruited from the general population and required IOP < 21 mm Hg with no history of increased IOP and normal SAP in both eyes. Each subject had Cirrus SDOCT (software v. 5.2, model 4000; Carl Zeiss Meditec, Inc.), SAP using the Swedish interactive threshold algorithm (SITA Standard 24-2). Only subjects with open angles on gonioscopy were included. Subjects were excluded if they had a best-corrected visual acuity less than 20/40 or any other ocular or systemic disease that could affect the optic nerve or the visual field. Patients using systemic or topical cholinergic or anticholinergic medications (including pilocarpine) that might affect pupil responses were excluded.

**Optical Coherence Tomography**

The Cirrus SDOCT was used to acquire cpRNFL, mGCIPL, and total macular thickness measurements. This device has been described in detail previously. The cpRNFL thickness measurements were acquired using the optic disc cube 200 × 200 protocol using a 3-dimensional scan of a 6 × 6-mm area.
centered on the optic disc. Average cpRNFL thickness was calculated automatically from a 3.46-mm diameter circular scan (10.87 mm length) around the optic disc. The macular cube 200 × 200 protocol was used to acquire macular thickness data. This protocol is based on a 3-dimensional scan centered on the macula in which information from a 1024 (depth) × 200 × 200 point parallelepiped is collected. The ganglion cell analysis algorithm automatically segmented the mGCIPL, defined by the outer boundary of RNFL and outer boundary of inner plexiform layer. Cirrus SDOCT images were reviewed and included if well centered, signal strength > 7 and movement artifacts and segmentation errors were absent.

Standard Automated Perimetry

All visual fields were evaluated by the UCSD Visual Field Assessment Center (VisFACT). Visual fields with more than 33% fixation losses or more than 15% false-positive errors were excluded. Visual fields were reviewed further for the following artifacts: eyelid and rim artifacts, fatigue effects, inappropriate fixation, evidence that the visual field results were caused by a disease other than glaucoma and inattention.

Pupillometry Stimuli

Pupil responses were studied using the RAPDx (Konan Medical USA, Inc., Irvine, CA, USA), a binocular infrared pupillometer. The device measures bilateral pupil responses to monocularly presented visual stimuli. Stimuli are created using a single LCD screen with a central physical barrier creating two optical channels. The screen displays a target for fixation and during testing each portion of the screen can be enabled selectively to achieve separate stimulation of each eye. The screen is viewed at infinity through a pair of 50-mm objective lenses providing an approximate 25° field of view in each eye. Eyes also are illuminated by a pair of infrared emitting diodes, with peak emission at 880 nm, mounted at a 35° angle.

Under infrared conditions information regarding the “dark” pupil diameter is captured as camera pixels and this measurement is converted to millimeters using a scaling factor. The stimulus then is presented as a series of trials, either to the full field of each eye or limited to predetermined regions. The size, color, intensity, and length of time of each stimulus were controlled automatically via proprietary software.

Procedure

The full field stimulus testing strategy was used in this study. This stimulus extends to approximately 18° from fixation. Each trial consisted of a period of stimulation followed by a period of darkness during which the cameras record continuously. The total time of each trial was 2.0 seconds plus a 100-ms post-trial rest period during which no images were acquired. The full field white stimulus was presented for 200 ms of the 2.1-second duty cycle and 18 trials (nine for each eye) used this stimulus for a total test time of 37.8 seconds. The right eye was stimulated first, followed by the left, then the right, with continued stimulation alternating between eyes. The full-field stimuli had luminances of 384 (white stimulus), 88 (red stimulus; 605 nm), 27 (green stimulus; 555 nm), 23 (blue stimulus; 440 nm), and 380 (yellow stimulus; 576 nm) cd/m², and during all tests, there was a nominal background.
luminance of 0.01 cd/m². Testing was conducted under dark room conditions with an illuminance of <0.5 lux.

The pupillometer includes proprietary analysis software, which was used to parse the generated pupil diameter waveforms into specific metrics. The repetitions from each eye were averaged (median) before analysis to minimize noise inherent in the pupil responses. Parameters measured by the pupillometer include prestimulus pupil diameter (in millimeters), minimum pupil diameter following the stimulus (in millimeters), response amplitude (i.e., maximal contraction of the pupil as a percentage of the prestimulation size, that is, the prestimulus pupil diameter minus the minimum pupil diameter, divided by the prestimulus pupil diameter), response latency (time in milliseconds between stimulus onset and time when pupil velocity has reached 50% of the peak velocity of constriction), and time to peak constriction (in milliseconds).

An RAPD is defined as a difference in average pupillary constriction (response amplitude) when each eye is stimulated monocularly.9,26 An index of the direction and magnitude of pupil response asymmetry, known as the RAPD score, is generated automatically by the RAPDx device. The RAPD score is calculated as the difference in the amplitude of pupil constriction between stimulation of the two eyes using the following formula:27

\[ \text{RAPD score} = 10 \times \log_{10} \frac{\text{od}}{\text{os}} \]

where od is the mean response amplitude in both eyes, in response to right eye stimulation, and os is the mean response amplitude in both eyes in response to left eye stimulation. An RAPD score of 0 would be expected for a healthy subject. A positive value indicates a relative abnormality of the left afferent system and a negative value indicates a relative abnormality of the right afferent system.27 The RAPD score is useful as it conveys information regarding the direction as well as the magnitude of an RAPD. However, to investigate the effect of potential confounders, such as average disease severity, the absolute RAPD score also was calculated as an overall measure of asymmetry of the afferent visual pathways, regardless of which eye was affected. The arithmetic difference in response amplitude on stimulation of the better eye and on stimulation of the worse eye also was calculated.

### Statistical Analysis

Descriptive statistics included mean and standard deviation (SD) and t-tests for normally distributed variables; and median, interquartile range, and Wilcoxon rank-sum for nonparametrically distributed variables. The relationship between RAPD...
scores and intereye differences (right eye minus left eye) in structural parameters was examined using scatter plots and linear regression. The average cpRNFL thickness, mGCIPL, macular thickness, and SAP mean deviation (MD) were included in the analyses to evaluate the effect of disease severity on asymmetry needed for an RAPD. The effect of age also was examined as a covariate. All statistical analyses were performed with commercially available software (STATA, version 13; StataCorp LP, College Station, TX, USA). The \( \alpha \) level (type I error) was set at 0.05.

RESULTS

The study included 106 patients with glaucoma and 85 healthy controls. Of those with glaucoma, 67 had glaucoma in both eyes, 33 had glaucoma in one eye and suspected glaucoma in the other, and 6 had glaucoma in one eye and a putative healthy fellow eye. The demographic and clinical characteristics of participants are summarized in Table 1.

Subjects with glaucoma had an average MD of \(-6.9 \pm 7.3\) dB in the worse eye and \(-2.9 \pm 4.4\) dB in the better eye, which was significantly worse than in healthy subjects (\( P < 0.001 \) for both comparisons). The cpRNFL, mGCIPL, and macular thickness also were significantly thinner in the worse and better eyes of those with glaucoma compared to controls (Table 1).

Those with glaucoma also had greater asymmetry in SAP and SD-OCT measurements between eyes compared to healthy subjects. The mean (± SD) intereye difference in MD was 4.0 ± 4.9 dB in those with glaucoma compared to only 0.6 ± 0.4 dB in healthy subjects. Intereye difference in cpRNFL thickness was 9.2 ± 7.6 \( \mu \)m in patients with glaucoma, compared to only 3.8 ± 3.6 \( \mu \)m in healthy participants. Corresponding intereye differences in mGCIPL thickness were 6.8 ± 6.8 and 1.7 ± 1.8 \( \mu \)m, respectively.

The absolute RAPD score averaged 0.30 ± 0.35 in those with glaucoma compared to 0.15 ± 0.10 in healthy subjects (\( P = 0.006 \); Table 2). Figure 1 shows the distribution of absolute RAPD scores in healthy and glaucomatous subjects. Only 12 (14%) healthy subjects had an absolute RAPD score higher than 0.25 and none had higher than 0.50. However, in the glaucomatous group, 42 of 106 subjects (40%) had an absolute RAPD score higher than 0.25, 31 of 106 (29%) had an absolute RAPD score higher than 0.30, and 22 (21%) had an absolute RAPD score higher than 0.50. Subjects with glaucoma also had significantly greater intereye differences in pupil response latency and time to peak pupil constriction compared to healthy subjects (\( P = 0.031 \) and \( P = 0.006 \), respectively). Those with glaucoma also had, on average, a greater absolute RAPD score for blue (\( P = 0.013 \)), green (\( P < 0.001 \)), yellow (\( P < 0.001 \)), and red (\( P < 0.001 \)) color stimuli compared to healthy subjects (Table 2).

There was a significant association between RAPD scores and intereye differences in macular structural damage, as measured by intereye difference in mGCIPL thickness (\( R^2 = 0.285, P < 0.001 \)). The relationship between RAPD score and intereye difference in macular thickness was weaker (\( R^2 = 0.167, P < 0.001 \)) than that with mGCIPL. However, intereye differences in cpRNFL thickness (\( R^2 = 0.350, P < 0.001 \)) and SAP MD (\( R^2 = 0.594, P < 0.001 \)) had stronger associations with RAPD score than macular parameters (Table 3, Fig. 2).

Intereye asymmetry of glaucoma damage may be influenced by disease severity; for example, patients with bilateral end-stage glaucoma are likely to have less asymmetry than those with early glaucoma due to a floor effect in structural and functional measurements. In contrast, those with moderate glaucoma may have greater asymmetry than those with very early disease. Therefore, we included average MD of right and left eyes in a
multivariable regression analysis. Greater intereye difference in mGCIPL thickness remained associated with greater absolute RAPD score (Table 4) but worse average MD also was associated with greater absolute RAPD scores \( (P < 0.001) \). RAPD score increased by 0.021 for each 1 dB worse average MD. Similar effects of disease severity also were noted on the association between RAPD score with asymmetries in the other structural and functional variables, that is, intereye cpRNFL thickness \( (P < 0.001) \); absolute intereye SAP MD difference \( (P < 0.001) \), and absolute intereye macular thickness difference \( (P < 0.001) \). In multivariable analyses, age had no significant influence on the relationship between absolute RAPD score and absolute intereye mGCIPL thickness difference \( (P = 0.560) \), intereye differences in cpRNFL thickness, macular thickness, or SAP MD \( (P = 0.378, P = 0.156, \text{and } P = 0.888, \text{respectively}) \).

Although the association between RAPD scores obtained using colored stimuli and intereye differences in structural and functional parameters were significant, the associations with RAPD score to the white stimulus generally were stronger (Table 5, Fig. 3). Examples of patients included in the study are shown in Figures 4 to 6. Figure 4 is an example of a patient with advanced glaucoma in the right eye and mild glaucoma in the left eye showing a RAPD score of −1.21, while Figure 5 shows a patient with advanced glaucoma in both eyes and a RAPD score of only −0.12. Figure 6 shows a patient with mild glaucoma in both eyes and a RAPD score of only −0.09.

**DISCUSSION**

This study has shown that the magnitude of RAPD measured using an automated pupillometer is correlated with measures of macular structural asymmetry in glaucoma. Subjects with larger RAPDs had greater intereye differences in macular thickness and mGCIPL thickness, in addition to greater intereye differences in cpRNFL and SAP MD. To our knowledge, this is the first study to evaluate the relationship between magnitude of RAPD and macular structural damage in glaucoma.

Patients with glaucoma were more likely to have intereye asymmetry in structural and functional measurements than healthy controls, likely because, although glaucoma typically is a bilateral disease, changes often are worse in one eye than the other. Patients with glaucoma also had larger RAPD scores than controls, with average RAPD scores of 0.30 ± 0.35 and 0.15 ± 0.10, respectively. A significant association was seen between...
RAPD and intereye difference in mGCIPL ($R^2 = 0.285; P < 0.001$). For each 10-μm increase in mGCIPL asymmetry there was a 0.26 increase in RAPD score. Such association was stronger than that for total macular thickness, indicating that the mGCIPL parameter was a more useful indicator of the degree of pupillary defect in glaucoma. The stronger association between RAPD score and mGCIPL asymmetry is likely to be due to total macular thickness including nonneuronal support tissues, not directly involved in the pupillary light response. In contrast, mGCIPL thickness is a measurement of the inner layers containing RGCs.28–31

Although asymmetries in macular measurements were associated with RAPD, we found that the relationships between RAPD score and asymmetry in cpRNFL and SAP MD were stronger still, with $R^2$ of 0.350 and 0.594, respectively. This is likely explained by the fact that although the macula accounts for a large proportion of RGCs, RGCs outside this area are likely also to contribute to the pupillary reflex. As cpRNFL thickness measurements and SAP MD depend on the integrity of all RGC axons throughout the retina, this probably explains why these parameters showed higher association with pupillometry results.

We found an RAPD score of 0.50 is likely to correspond to intereye differences in cpRNFL and SAP MD of approximately 23 μm and 8 dB, respectively, which are similar results to those reported previously using the swinging flashlight test, suggesting that an intereye difference in cpRNFL thickness of 17% to 27%, or an intereye difference in SAP MD of 9.5 to 12 dB, would correlate with an RAPD of 0.3 to 0.6.8,14 As one might expect, we also found that the relationship between magnitude of RAPD and intereye difference in mGCIPL thickness depends on disease severity, with worse average MD associated with greater absolute RAPD scores. Our study included patients with a range of disease severities; however, there were few with very severe disease. Only 19 patients had a MD in the worse of eye of worse than −20 dB. It is important to note that in patients with advanced but symmetrical glaucoma in both eyes there is not likely to be an RAPD. Therefore, worse average MD will not always be associated with a larger RAPD.

Although the swinging flashlight test is a simple and widely available test of RAPD, automated pupillometry is likely to be a more sensitive method of quantifying abnormalities of the pupillary light reflex. Lankaranian et al.9 examined the ability of pupillometry to detect glaucoma and found an RAPD in 56% in 77 patients with glaucoma, compared to only 29% using swinging flashlight test. A recent systematic review, including
12 studies of pupillography, concluded that automated pupillometers were able to detect smaller intereye differences in pupil reactions than detectable using the swinging flashlight test. Further, although the swinging flashlight test is quick and easy to perform, it requires considerable practice to perform reliably and can be challenging in patients with dark irides or small or poorly reactive pupils. We did not use the swinging flashlight test in our study; however, previous studies have suggested an RAPD of more than 0.3 is likely to be abnormal. In the present study, 29% of patients with glaucoma had an RAPD score of 0.3 or more.

We evaluated pupil responses to a range of colored stimuli but the RAPD score to the white stimulus had the strongest association with all structural and functional parameters. However, patients with glaucoma did have greater RAPD scores for blue, green, yellow, and red colored stimuli compared to healthy subjects and there was an association between RAPD scores obtained using colored stimuli, and asymmetric structural and functional damage. These results are in agreement with previous studies that showed RAPD scores using different wavelengths stimuli were greater in glaucoma patients and correlated with intereye SAP MD difference. However, to minimize these effects, only the large full field flash stimulus was used. As another limitation of our study, there was a significant difference in the average age between glaucoma and controls. However, we did not find any significant influence of age on the magnitude of the RAPD score. In addition, although the pupillometer used different colored stimuli, it is important to emphasize that these stimuli do not selectively target specific RGC subtypes, such as intrinsically photosensitive RGCs (ipRGCs). This would be an interesting topic for further study, since targeting specific subgroups of RGCs may allow earlier detection of damage.

In conclusion, we found a significant association between the magnitude of an RAPD and intereye difference in mGCIPL and macular thickness. However, RNFL thickness parameters and the degree of visual field loss asymmetry had stronger relationships with pupillometry-measured RAPD and may be better indicators of the degree of expected pupillary afferent defect.

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