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Visual Neuroscience

Increment Threshold Functions in Retinopathy of Prematurity

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PURPOSE. To assess scotopic background adaptation in subjects with a history of preterm birth and retinopathy of prematurity (ROP). Retinopathy of prematurity is known to have long-term effects on rod photoreceptor and rod-mediated postreceptor retinal function.

METHODS. Rod-mediated thresholds for detection of 3° diameter, 50 ms stimuli presented 20° from fixation were measured using a spatial forced choice method in 36 subjects (aged 9–17 years) with a history of preterm birth and 11 age similar term-born subjects. Thresholds were measured first in the dark-adapted condition and then in the presence of 6 steady background lights (−2.8 to +2.0 log scot td). A model of the increment threshold function was fit to each subject’s thresholds to estimate the dark-adapted threshold (TDA) and the Eigengrau (A0, the background that elevates threshold 0.3 log unit above TDA).

RESULTS. In subjects with a history of severe ROP, both TDA and A0 were significantly elevated relative to those in former preterms who never had ROP and term-born control subjects. Subjects who had mild ROP had normal TDA but elevated A0. Neither TDA nor A0 differed significantly between former preterms who never had ROP and term-born controls.

CONCLUSIONS. The results suggest that in severe ROP, threshold is affected at a preadaptation site, possibly the rod outer segment. In mild ROP, changes in the Eigengrau may reflect increased intrinsic noise in the photoreceptor or postreceptor circuitry or both.

Keywords: retinopathy of prematurity, increment threshold, retinal adaptation, photoreceptors, visual psychophysics

The onset of retinopathy of prematurity (ROP) occurs at preterm ages during a period of rapid development of the rod photoreceptor outer segments.1 Electroretinographic studies of infants with a history of ROP found significant deficits in both rod photoreceptor (a-wave) and rod-mediated postreceptor (b-wave) sensitivity compared with term-born control infants.1 In electroretinographic studies of children and adolescents, those with a history of mild ROP showed persistent deficits in rod photoreceptor sensitivity but normal postreceptor sensitivity, which we interpreted as evidence of remodeling of the postreceptor retina.2 In those with severe ROP, both photoreceptor and postreceptor sensitivity remained abnormal.5

Convergence of signals from rods to photoreceptor cells is fundamental to retinal organization and plays a role in determining visual threshold.3,4 We found that the critical area for complete spatial summation in ROP subjects was significantly larger than in controls.5 Thus, increased spatial pooling of rod input to postreceptor circuitry may be a factor involved in the normalization of sensitivity in mild ROP subjects.5

To probe further into rod-mediated function in ROP, we measured visual thresholds in subjects with a history of preterm birth first in the dark and then in the presence of steady background lights. Dim backgrounds have little effect on threshold; as background intensity is increased, thresholds are elevated according to Weber’s law.6–8 The resulting increment threshold functions can be analyzed to assess the effects of ROP on receptor and postreceptor function.9,10 Adaptation to changing levels of illumination requires adjustment of retinal signals in photoreceptors and postreceptor neural cells.11

METHODS

Subjects

Thresholds were measured in 36 subjects with a history of preterm birth (Table). Gestational age at birth ranged from 24 to 32 weeks (median: 27 weeks) and birthweight from 530 to 2070 g (median: 998 g). Although, on average, those with severe ROP were born earlier and had lower birthweight, there was considerable overlap among the preterm groups. All subjects had serial fundus examinations in the newborn intensive care nursery following a schedule similar to that used in multicenter clinical trials.12 In the international classification of retinopathy of prematurity (ICROP) classification of active ROP, location of the retinopathy is specified by zone, severity by stage, and extent by clock hours.13 Retinopathy of prematurity is an active disease at preterm ages and resolves by the early postterm weeks.14 We categorized each subject based on the results of examinations in the nursery according to maximum severity of acute-phase ROP as severe ROP (n = 10); mild ROP (n = 14); or no ROP (n = 12). Those in the severe category had been treated by laser ablation of avascular peripheral retina. In all severe ROP subjects, the retina was clinically healed; the region of treated retina was peripheral to the 20° site of the test stimuli. The maximum severity was stage 3; three had zone 1 disease and none had...
retinal detachment. Those in the mild category had ROP that, by clinical criteria, resolved completely without treatment. Their maximum severity of ROP was stage 1 or 2 in zone II or III. They all had two eyes. Those in the no ROP category had serial examinations and ROP was never detected. The subjects ranged in age from 9 to 17 years (median: 13.5 years) at the time of testing. A total of 11 healthy, term-born control subjects aged 10 to 17 years (median: 12.8 years) also participated.

The study conformed to the tenets of the Declaration of Helsinki and was approved by the Children’s Hospital Committee on Clinical Investigation. Written informed consent was obtained from the parents and assent from the children before each session.

**Procedure**

Rod-mediated thresholds for detection of 50 ms, 3° diameter, blue (Wratten 47B, λ < 440 nm) spots were obtained using a two-alternative, spatial-forced choice procedure. A red light-emitting diode (LED) fixation target that subtended 30 min arc and flickered at 1 Hz was at the center of the screen. Stimuli were presented on a rear projection screen 20° to the right or left of the fixation target. For the background conditions, a steady red (Wratten 29, λ > 610 nm) circular, 90° diameter field, concentric with the fixation target, was shown on the screen. Calibrated neutral density filters controlled the intensity of the test and background lights.

After 30 minutes of dark adaptation, the subject sat 50 cm in front of the rear projection screen and viewed the screen with both eyes. On each trial, the subject was asked to look at the fixation target and to report the position (right or left) of the test stimulus. The subject received feedback on every trial. Threshold was measured using a transformed up-down staircase that estimated the 70.7% correct point of the psychometric function. At least five alternations (consisting of two reversals) of response type (correct, incorrect) were obtained. Subjects were tested first in the dark-adapted (no background) condition and then in the presence of each of a series of six backgrounds that produced retinal illuminance of approximately /C0.8 to /C0.2 log scot td.

**Calibrations**

The luminance of the test and background lights was measured with a calibrated photodiode (IL 1700; International Light, Newburyport, MA, USA) placed in the position of the subject’s eyes. The scotopic troland values of the stimuli were calculated taking each subject’s measured pupil diameter into account.

**Analyses**

A model of the increment threshold function (Fig. 1) was fit to each subject’s thresholds to calculate the values of dark-adapted threshold (TDA) and Eigengrau (A0) that minimized the sum of squared deviations from:

\[ \log T = \log T_{DA} + \log [1 + (I/A_0)] \]  

where T is the threshold at background intensity I, A0 is the background that raises the threshold 0.3 log unit above the dark-adapted threshold and approaches estimated values of intrinsic retinal noise.

According to classical psychophysical theory, a disease that affects the rod photoreceptor distal to the site of adaptation (presumably the rod outer segment) and reduces the ability of the rod to absorb photons or to produce an input to the postreceptor retina will affect both the test and background light equally. Equal reduction of quantum catch...
from both the test and background stimuli produces equal
elevation of both $T_{DA}$ and $A_0$. Plotted on log-log coordinates,
the increment threshold function is shifted both vertically and
horizontally by equal amounts (Fig. 1, dashed curve). A disease
that affects the more proximal retinal pathways, at or after the
site of adaptation, reduces effectiveness of the test flash but
not of the background; the increment threshold function is
shifted vertically but not horizontally (Fig. 1, dotted curve).

Analysis of variance was used to evaluate $T_{DA}$ and $A_0$ for
significant differences among the groups (severe ROP, mild
ROP, no ROP, and term-born). The Scheffé test was used in
post-hoc comparisons. The parameter $T_{DA}$ of the model was
compared with the actual dark-adapted threshold using
repeated measures analysis of variance. For all tests, the level
of significance was $P \leq 0.01$.

**RESULTS**

Increment threshold functions from a representative subject of
each group are shown in Figure 2. These subjects had $T_{DA}$ near
the median value for their group. To assess goodness of fit of
Equation 1, we calculated RMS errors for each subject and
compared across groups using analysis of variance. There was
no significant difference in goodness of fit between groups ($F =
2.15; df: 3, 43; P = 0.108$). We also calculated standard errors
for the parameters $T_{DA}$ and $A_0$ for each subject. Analysis of
variance showed that the standard errors did not vary
significantly among the groups ($T_{DA}: F = 2.59; df: 3, 43;
P = 0.065; A_0: F = 0.675; df: 3, 43; P = 0.572$).

The values of the calculated parameters $T_{DA}$ and $A_0$ are
shown for every subject in Figure 3. Analysis of variance
showed that $T_{DA}$ varied significantly between groups ($F = 13.9;
df: 3, 43; P < 0.001$). Results of Scheffé tests indicated that
$T_{DA}$ values in mild ROP, no ROP, and term-born subjects did not
differ significantly but $T_{DA}$ in severe ROP subjects was
significantly higher than in the other groups. The Eigengrau
($A_0$) also varied significantly with group ($F = 31.8; df: 3, 43;
P < 0.001$). Post hoc tests showed that $A_0$ values in severe ROP
subjects were significantly higher than in mild ROP subjects;
both of these values were significantly higher than $A_0$ values in
the no ROP and term-born groups. Values of $A_0$ in the no ROP
and term-born subjects did not differ from each other and were
within the range reported in other psychophysical studies of
healthy mature subjects. The measured dark-adapted
threshold did not differ significantly from the calculated value,
$T_{DA}$, in any group ($F = 0.95; df: 1, 43; P: ns$).

Figure 4 plots deficits in $T_{DA}$ as a function of deficits in $A_0$
for each subject. The deficit for each subject is expressed
relative to the mean for each of the parameters in term-born
control subjects. Of the severe ROP subjects, 9 of the 10 show
approximately equal changes in $T_{DA}$ and $A_0$; their points lie
close to the diagonal. This is consistent with ROP affecting a
preadaptation site. One severe ROP subject had a $T_{DA}$ value in
the normal range but elevated $A_0$; his ICROP classification and
treatment were similar to that of others in his group. Most of
the mild ROP subjects (12 of 14) had $A_0$ values that exceed the
normal range, consistent with increased retinal noise either in
the photoreceptor, the postreceptor neural circuitry, or both.

Although $T_{DA}$ in the mild group did not differ significantly from

![Figure 1. Model of the rod increment threshold function.](image-url)
the no ROP and term-born groups (Fig. 3, upper panel), six mild ROP subjects had deficits in TDA that exceeded the normal range, perhaps a consequence of low rod photoreceptor sensitivity.1,2 The severity of ROP in these six subjects was not worse than in others in the mild ROP group.

DISCUSSION

The present results add to the previously reported evidence1,2,5,21 that ROP has long-lasting effects on the sensory retina and provide new evidence of postreceptor retinal dysfunction in mild ROP. Retinopathy of prematurity, whether mild or severe, perturbs photoreceptor and postreceptor function long after active ROP has resolved. Preterm birth alone has little effect on rod system adaptation; increment threshold functions of subjects in the no ROP group are normal and indistinguishable from those in term-born controls.

In severe ROP, the dark-adapted threshold (TDA) and Eigengrau (A0) are elevated by equal amounts. The changes in quantum catch delivered by the test and by the background are equal. This produces a diagonal shift in the function as displayed on log-log coordinates. The diagonal shift that we found in severe ROP subjects (Fig. 4) indicates alteration at a preadaptation site, perhaps the rod outer segment. The range of backgrounds used in the present study is expected to have little effect on sensitivity of the rod photoreceptor.17,22

Figure 2. Representative increment threshold functions. Log threshold is plotted as a function of log background for subjects from the three groups of former preterm subjects: severe ROP, mild ROP, and no ROP. Data from a term-born control subject are also shown. In each panel, the model parameters TDA (in log scot td s) and A0 (in log scot td) are indicated.
FIGURE 3. Dark-adapted threshold ($T_{DA}$) and Eigengrau ($A_0$). Upper panel: $T_{DA}$ values in severe ROP, mild ROP, no ROP, and term-born control groups. Lower panel: $A_0$ values in the groups. In both panels, each subject is represented by a point and the horizontal bars indicate the median value for each group. The number of subjects in each group is indicated.
Reduced quantum catch secondary to disorganized rod outer segments, shortened outer segments, or inefficient phototransduction may account, in part, for our results. These explanations are not necessarily mutually exclusive. We previously reported that rod photoreceptor sensitivity and saturated response amplitude, estimated from the a-wave of the electroretinogram, remain low in children and adolescents with a history of ROP. Specifically, median rod sensitivity was less than 50% of normal and saturated response amplitude was approximately 40% of normal in children aged 9 to 18 years with a history of severe ROP. Furthermore, we have previously reported disorganized and dysmorphic rods, despite an abundance of rhodopsin, in a rat model of ROP.

In mild ROP, the $T_{DA}$ value was normal in most subjects, perhaps a consequence of increased spatial pooling of the remodeled postreceptor retinal circuitry. The Eigengrau ($A_0$) was abnormal even if $T_{DA}$ was normal (Fig. 3). The value of $A_0$ depends on noise arising in the photoreceptor and the postreceptor retinal circuitry, as well as on temporal and spatial summation of retinal signals. Both spatial and temporal summation are abnormal in mild ROP. Perhaps noise in the postreceptor retinal circuitry is elevated in the remodeled retina of mild ROP subjects.

The present results show that ROP has significant long-term effects on function of rod photoreceptors and postreceptor neural circuitry. Our increment threshold results confirm that the deficit in dark-adapted sensitivity, inferred from ERG a-wave results, is located before the site of adaptation, probably at the rod outer segment. In mild ROP, although the dark-adapted threshold is normal, there is evidence of higher than normal intrinsic retinal noise. Thus, the results herein add to the mounting evidence of the importance of the neurosensory retina in the ROP disease process.

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