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CASE REPORT

Case of acute zonal occult outer retinopathy with abnormal pattern visual evoked potentials

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Abstract: Electrophysiological and morphological findings were studied in a case of acute zonal occult outer retinopathy (AZOOR) showing abnormal pattern visual evoked potentials (VEPs) at the onset and significant functional recovery in the natural course. A 21-year-old woman presented with acute onset of photopsia and a large scotoma in the right eye of 2 weeks duration. Her visual acuity was 20/20 in both eyes with no ophthalmoscopic and fluorescein angiographic abnormalities. However, a relative afferent pupillary defect and an enlarged blind spot were found in the right eye. The pattern VEPs were severely reduced when the right eye was stimulated. The amplitudes of both rod and cone full-field electroretinographics (ERGs) were reduced in the right eye. The amplitudes of the multifocal ERGs were reduced in the area of the enlarged blind spot. Irregularities in the inner segment/outer segment (IS/OS) line of the photoreceptors were observed over the nasal fovea by optical coherence tomography (OCT). The patient was followed without treatment. The enlarged blind spot disappeared in 3 months after the onset. At 5 months, reappearance of the IS/OS line was detected by OCT. At 6 months, the P_{100} recovered to normal values. At 1 year, the reduced full-field ERGs were almost normal size and the multifocal ERGs in the area corresponding to the enlarged blind spot were also improved. ERG findings are crucial for differentiating AZOOR from retrobulbar neuritis, especially in patients with abnormal pattern VEPs. The pattern VEPs, full-field ERGs, multifocal ERGs, and OCT images can be abnormal in the early phase of AZOOR, but they can all improve during the natural course.

Keywords: AZOOR, pattern VEP, full-field ERG, multifocal ERG, OCT

Introduction

Acute zonal occult outer retinopathy (AZOOR), first reported in 1993 by Gass,[1] is characterized by an acute onset of photopsia, scotoma, minimal funduscopic changes, and electroretinographic (ERG) abnormalities affecting one or both eyes. The presence of abnormal ERGs is important for the diagnosis of AZOOR, and the ERG findings suggest a dysfunction of the photoreceptors.[1–5] Recent optical coherence tomographic (OCT) studies have shown morphological alterations of the photoreceptors.[6–9]

Although a viral or autoimmune etiology has been suspected, no cause is readily identifiable in this group of generally healthy patients. Some patients with AZOOR have been misdiagnosed with optic nerve disorders because they had an afferent pupillary defect, a scotoma, and no obvious fundus abnormalities.[1–3]

It has been reported that the natural course of AZOOR is varied,[1–3] although there is still no known treatment. There are few detailed reports about AZOOR patients who showed subjective and objective improvements in their visual function.

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We report a case of AZOOR, showing abnormal pattern visual evoked potentials (VEPs) at the onset and significant functional recovery in the natural course.

Case report

A healthy 21-year-old woman reported that she had a sudden onset of photopsia and a large scotoma in the right eye on August 14, 2008. She visited her ophthalmologist on August 15, and the initial examination showed no abnormalities of the fundus in both eyes but a large scotoma was detected by static perimetry in the right eye. She was referred to us for further examination on August 29. She reported that she had no systemic problems and was not taking any medications. Her best-corrected visual acuity was 20/20 bilaterally, and the refractive error was –9.5 diopters in the right eye and –8.5 diopters in the left eye. However, she had a relatively afferent pupillary defect in the right eye. The results of ophthalmoscopy (Figure 1A), fluorescein angiography (Figure 1B), blood screening, and brain magnetic resonance imaging (MRI) were within normal limits. Static perimetry with the Humphrey field analyzer showed an enlarged blind spot in the right eye (Figure 1C). The pattern VEPs elicited by transient and steady-state stimuli to the right eye were severely reduced (Figure 2). She was suspected of having retrobulbar neuritis at this point of time. VEPs were recorded by Nihon Kohden MEB-2200 Neuropack (Tokyo, Japan) with the active electrode placed at Oz. The reference electrode was located at the right earlobe and the ground electrode at the left earlobe. The visual stimulus was a black and white check board pattern generated on a television monitor. The check size was 20 minutes of arc. The contrast was 80%, and the mean luminance was kept at 50 cd/m^2. The stimulus field of the pattern was 7 × 11 degrees. The pattern was reversed at three reversals per second for transient VEP, and 10 reversals per second for steady-state VEP. The electrodes were connected to a preamplifier with a bandpass of 1 to 100 Hz, and for each measurement, 100 responses were averaged. The patient fixed on a point in the center of the pattern monocularly from an observing distance of 170 cm, with an undilated pupil under full refractive correction.

To eliminate the possibility that the patient had AZOOR, full-field ERGs and multifocal ERGs were recorded. The amplitudes of the rod and cone responses in the right eye were reduced to about 50% of those in

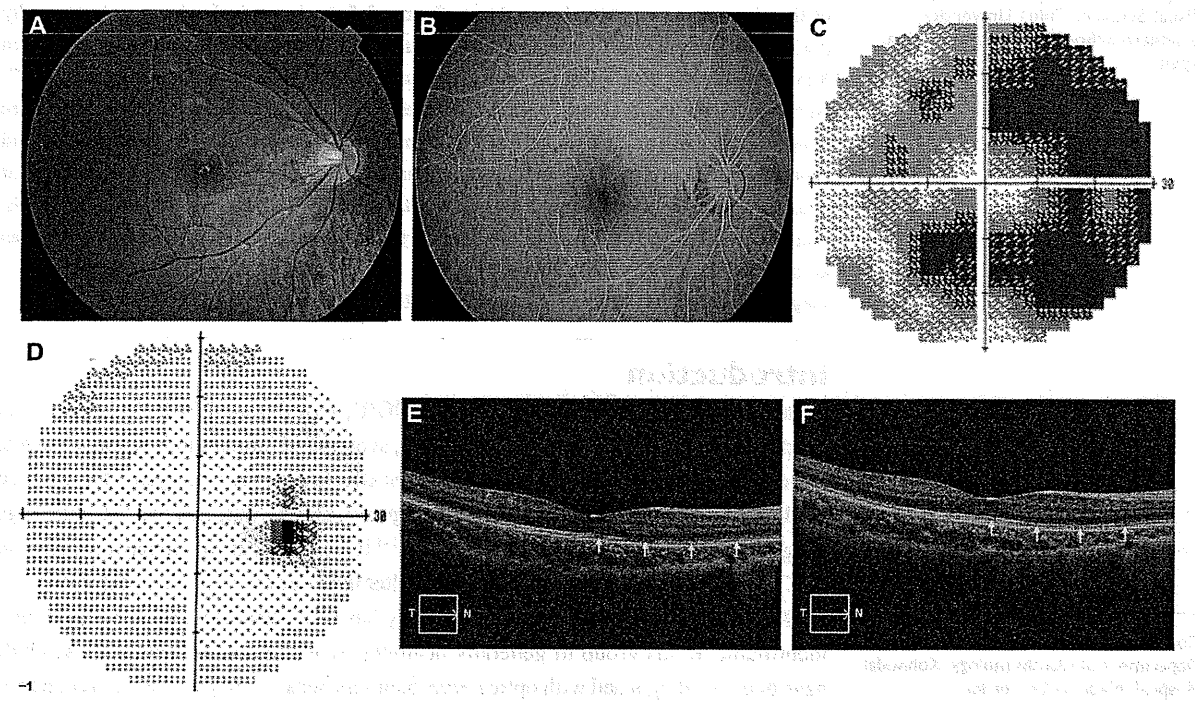

Figure 1 Fundus photograph, fluorescein angiographic image, Humphrey static perimetry, and Optical coherence tomography (OCT) of the right eye. **(A)** Fundus photograph at the onset showing that the retina was normal. **(B)** Fluorescein angiography at the onset showing normal vascular pattern and no leakage. **(C)** Humphrey static perimetry at the onset showing enlarged blind spot (30-2 strategy MD –21.97 dB). **(D)** Humphrey static perimetry 3 months after the onset showing marginally enlarged blind spot (30-2 strategy MD –1.90 dB). **(E)** OCT image at the onset showing irregular inner segment/outer segment (IS/OS) line over the nasal fovea. **(F)** OCT image 5 months after the onset showing reappearance of IS/OS line over the nasal fovea.
Abbreviation: MD, mean defect.

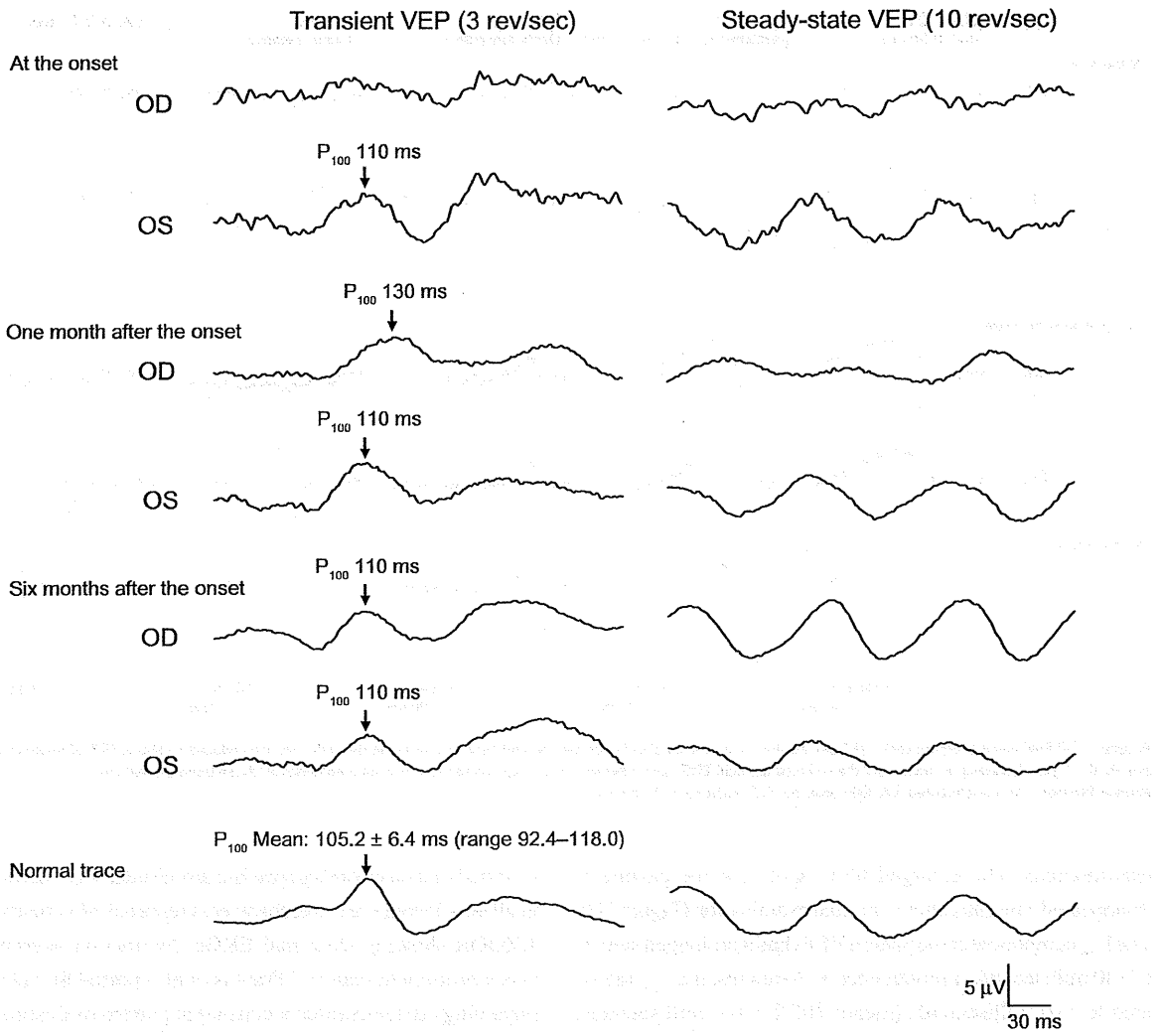

Figure 2 Pattern visual evoked potentials (VEPs). At the onset, pattern VEPs are severely reduced in the right eye. One month after the onset, the P_{100} component of the pattern VEPs has a prolonged latency of 130 milliseconds. Six months after the onset, the P_{100} recovers to 110 milliseconds.
Abbreviations: OD, right eye; OS, left eye.

the left eye (Figure 3). The multifocal ERGs recorded from the area of the enlarged blind spot were reduced (Figure 4). Irregularities in the inner segment/outer segment (IS/OS) line of the photoreceptors over the nasal fovea were observed by Fourier-domain OCT (HD-OCT; Carl Zeiss Meditec, Oberkochen, Germany) (Figure 1E). Serum anti-recoverin was negative. She was diagnosed with AZOOR from these findings. Full-field ERGs were recorded by Nihon Kohden Neuropack 9400, following dilation of the pupils and 30 minutes of dark adaptation. A contact lens electrode was used. The reference electrode was placed at the forehead and the ground electrode at the earlobe. The flash strength was 0.01 cd s m^{-2} for rod response, 80.0 cd s m^{-2} for combined rod–cone response and oscillatory potentials, and 3.0 cd s m^{-2} for cone response and flicker. Light adaptation and background luminance was 25 cd/m^2. Responses were amplified with a bandpass of 0.2 to 1000 Hz. First-order Kernel multifocal ERGs were recorded with the Visual Evoked Response Imaging System (VERIS science 4.1; EDI, San Mateo, CA). A Burian-Allen bipolar contact lens electrode was used. The visual stimuli consisted of 61 and 103 hexagonal elements with an overall subtense of approximately 60°. The luminance of each hexagon was independently modulated between black (3.5 cd/m^2) and white (138.0 cd/m^2) according to a binary M-sequence at 75 Hz. The surround luminance was 70.8 cd/m^2.

The patient was followed without any treatment, and more comprehensive examinations were made in her follow-up

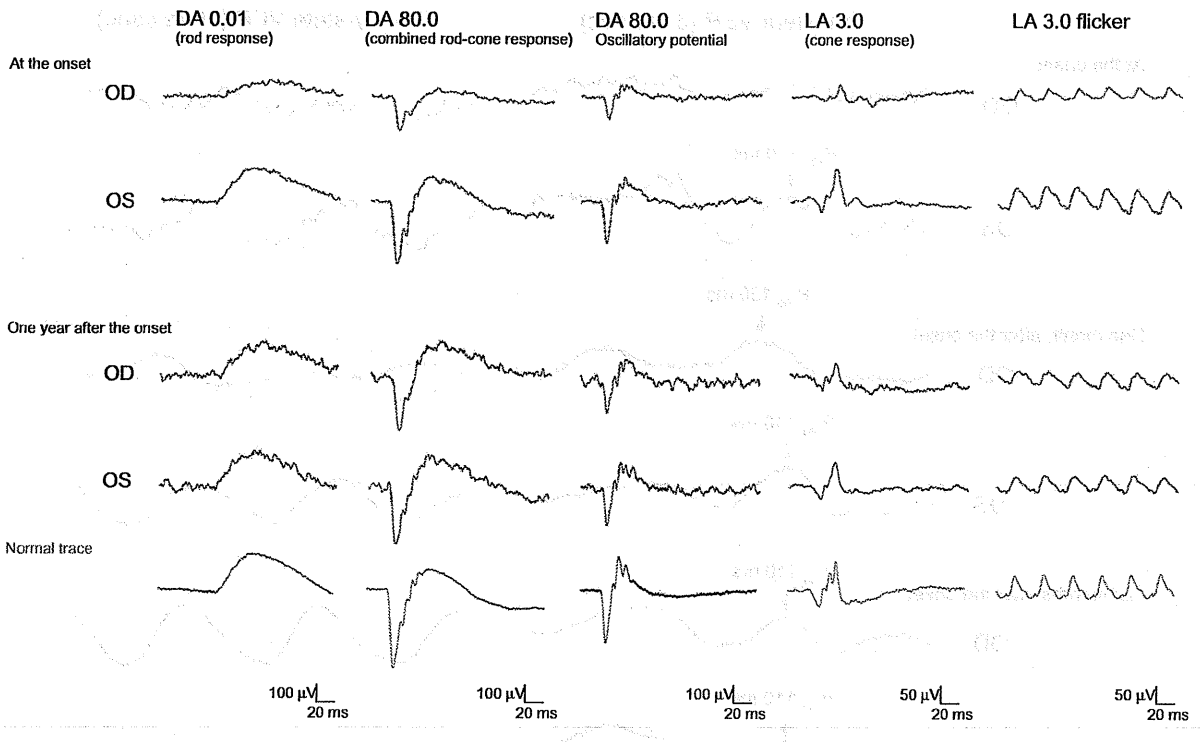

Figure 3 Full-field electroretinographics (ERGs). At the onset, the amplitudes of the rod and cone responses in the right eye are reduced to about 50% of those in the left eye. At the 1 year follow-up examination, the reduced full-field ERGs are improved to be approximately the same amplitudes as those from the left eye.
Abbreviations: DA, dark adapted; LA, light adapted; OD, right eye; OS, left eye.

examinations. The enlarged blind spot in static perimetry disappeared 3 months after our initial examination (Figure 1D). The P_{100} component of the pattern VEPs had a prolonged latency of 130 milliseconds 1 month later. At 6 months, the P_{100} recovered to 110 milliseconds (mean: 105.2 ± 6.4 milliseconds; normal range: 92.4–118.0 milliseconds) (Figure 2). At 5 months, reappearance of the IS/OS line was detected by OCT over the nasal fovea (Figure 1F). At the 1 year follow-up examination, her best-corrected visual acuity was 20/20 in both eyes. The reduced full-field ERGs were improved to be approximately the same amplitudes as those from the left eye (Figure 3). A mild improvement of the reduced multifocal ERGs was also observed (Figure 4). The other findings had not worsened.

Discussion

In 1993, Gass introduced AZOOR to describe a previously unrecognized syndrome occurring predominantly in young females. In his original series of 13 patients, affected individuals typically presented with acute onset of photopsia, scotoma, minimal funduscopic changes, and ERG abnormalities affecting one or both eyes.[1] The presence of abnormal ERGs is essential for the diagnosis of AZOOR. Gass et al reported that electroretinographic amplitudes were depressed in all 90 affected eyes.[2] Jacobson et al reported 24 patients with AZOOR showing abnormal ERGs. Interocular asymmetry was a prominent feature.[4] Francis et al reported that electrophysiology demonstrated a consistent pattern of dysfunction both at the photoreceptor/retinal pigment epithelial complex but also at inner retinal levels in 28 patients with AZOOR.[5]

Our case presented with a sudden onset of photopsia and a large scotoma in the right eye at the onset. The normal fundus, large scotoma, and the afferent pupillary defect made us suspect retrobulbar neuritis at first. But the absence of retrobulbar pain at rest or on eye movement, which is a common symptom in retrobulbar neuritis,[10] and the presence of photopsia, which is a typical symptom of AZOOR,[1–5] made us suspect AZOOR at the same time. Further examinations were taken to make a definite diagnosis.

Our patient had an extinguished P_{100} component of the pattern VEPs at the onset, although her visual acuity was 20/20. Fluorescein angiography showed normal vascular pattern and no leakage. MRI showed no changes in the optic nerve. Strikingly, in full-field ERGs, the amplitudes of both rod and cone responses were reduced in the right eye. The amplitudes of the multifocal ERGs were reduced in the area

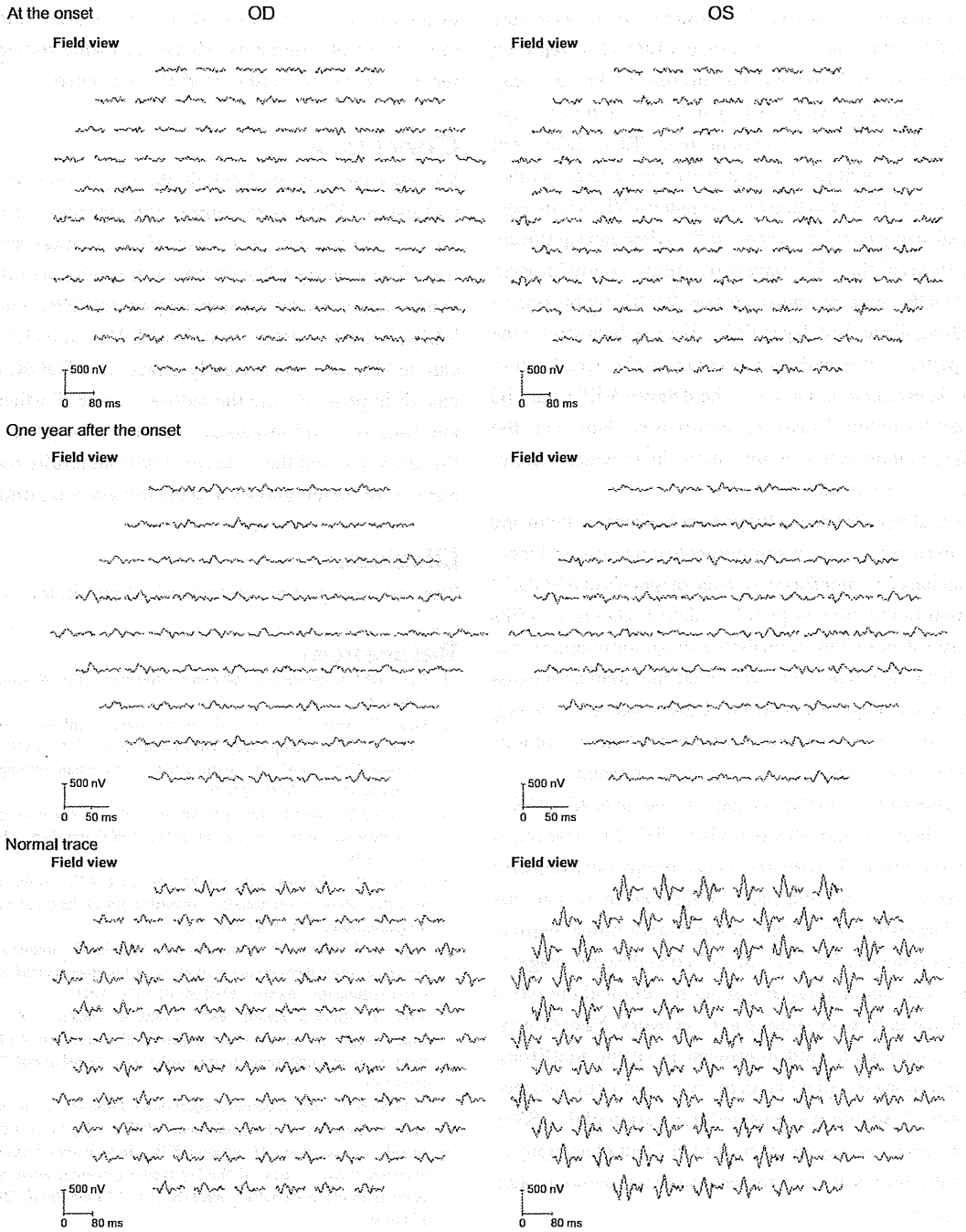

Figure 4 Multifocal electroretinographics (ERGs). At the onset, the multifocal ERGs are reduced in the right eye. At the 1 year follow-up examination, the multifocal ERGs have improved but are still reduced especially from the temporal retina. Shorter duration protocol with 61 hexagonal elements was used for the latest recording, because acceptable responses to 103 hexagonal elements could not be obtained due to fatigue of the patient during the recording.
Abbreviations: OD, right eye; OS, left eye.

of the enlarged blind spot. She was diagnosed with AZOOR because of ERG abnormalities. Serum anti-recoverin was negative, which was helpful to reduce the possibility that she had cancer-associated retinopathy. Irregularities in the IS/OS line of the photoreceptors were observed by OCT. The findings of OCT helped make the diagnosis.

It is known that a delayed latency of the pattern VEPs is not a specific sign of optic neuropathy because it is also found

in eyes with retinal diseases.[11–15] However, there were few reports of AZOOR showing abnormal VEPs. Gass reported that 80% of AZOOR patients had normal VEPs, and only one patient with poor visual acuity of 20/70 in the right eye and 20/300 in the left eye had abnormal VEPs.[1] Takai et al reported five AZOOR patients who had no delay in the VEPs.[7] Patients of AZOOR who had normal pattern VEPs with normal visual acuity have been reported.[16,17] Although significant abnormalities of the VEPs have rarely been reported in eyes with AZOOR, our case showed that AZOOR can be associated with significantly delayed VEPs. The mechanisms for the altered pattern VEPs without a decrease in the visual acuity was not determined in our case. The delayed VEP might be explained by reduced macular sensitivities. However, the possibility of inner retina or optic nerve involvement cannot be completely excluded.

Gass et al reported that in the presence of normal fundi, the most frequent misdiagnosis was retrobulbar neuritis, and there was a median of 17 months delay in the diagnosis of AZOOR.[2] In addition to the afferent pupillary defect, abnormal VEPs could mislead the ophthalmologist to a diagnosis of optic nerve disease. This case report serves to alert the ophthalmologist to consider the diagnosis of AZOOR and consider recording ERGs in individuals presenting with unexplained scotoma, particularly where photopsia are a prominent feature.

It has been reported that the natural course of AZOOR is varied.[2,3] Gass et al reported that visual field loss stabilized within 6 months in 37 patients (72%), progressed stepwise in two patients (4%), and partly improved in 12 patients (24%).[2] Degenerations of the photoreceptor outer segment have been detected by OCT at the convalescent stage.[6–9] There are few detailed reports about the clinical course of AZOOR patients who show some recovery. Yasuda et al reported a case with mild improvement of the multifocal ERGs, but morphological changes were not demonstrated in the report.[18] Spaide et al reported restoration of the IS/OS line in the areas of improved visual field, but electrophysiological alterations of these patients were not demonstrated in the report.[9]

Our case had a recovery of retinal function as assessed by not only visual field tests, but also full-field ERGs and multifocal ERGs. Morphological improvements were confirmed by OCT in parallel. Although it is difficult to compare the order or degree of improvement of each parameter, our case demonstrated that subjective and objective functional recovery could occur in the eyes with AZOOR. The irregular IS/OS line at the onset might have reflected incomplete loss of photoreceptor. In this case, the incomplete impairment of photoreceptor might have been associated with the visual function recovery. Further studies are needed.

Conclusion

We reported a case of AZOOR showing profoundly abnormal pattern VEPs at the onset, and significant functional recovery in the natural course. ERG findings are crucial for differentiating AZOOR from retrobulbar neuritis, especially in patients with abnormal pattern VEPs. The pattern VEPs, full-field ERGs, multifocal ERGs, and OCT images can be abnormal in the early phase of AZOOR, but they can all improve during the natural course. Further studies and long-term follow-up are needed to better understand this disorder, and these findings will hopefully reduce the number of misdiagnoses and unnecessary treatments.

Disclosure

The authors report no conflicts of interest in this work.

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Highly Reflective Foveal Region in Optical Coherence Tomography in Eyes with Vitreomacular Traction or Epiretinal Membrane

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Objective: To report the optical coherence tomography (OCT) findings in eyes with vitreomacular traction (VMT) or with an epiretinal membrane (ERM).

Design: Retrospective case series.

Participants: Fifty-four eyes of 45 consecutive patients with subjective visual disturbances resulting from VMT or idiopathic ERM were studied.

Methods: The morphologic features of the photoreceptor layer at the foveal center were determined and the central foveal thickness (CFT) was measured by spectral-domain (SD) OCT.

Main Outcome Measures: The morphologic characteristics of the foveal region observed by SD OCT.

Results: A roundish or diffuse highly reflective region was observed between the photoreceptor inner segment/outer segment junction line and the cone outer segment tip line at the center of the fovea. This highly reflective region was present in 7 of 7 cases of VMT and 30 of 47 cases of ERM. In the ERM cases, the mean CFT of the cases with the highly reflective region was significantly thicker than that in cases without it. The highly reflective region disappeared when the inward traction on the fovea was released surgically or spontaneously.

Conclusions: The highly reflective region is a characteristic sign observed in the OCT images of eyes with VMT and ERM, and it has been termed the *cotton ball sign* after its appearance. The presence of the cotton ball sign indicates an inward traction on the fovea and may be a predictor of visual impairment.

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Vitreomacular tractions (VMTs) and epiretinal membranes (ERMs) cause morphologic distortions of the retinal surface and lead to functional changes such as metamorphopsia and decreased visual acuity.[1–4] Surgical removal of the VMT or ERM is effective in restoring good visual function. Similar recovery is obtained when the traction is released spontaneously.

Optical coherence tomography (OCT) has shown that a vertical or tangential traction of the retina causes wrinkling of the internal limiting membrane, flattening of the foveal pit, and intraretinal cystic changes.[5–11] Moreover, recent spectral-domain (SD) OCT has shown that eyes with VMT and ERM have structural abnormalities of the photoreceptors at the fovea, for example, loss of the photoreceptor inner/outer segment (IS/OS) junction line.[12–17] The abnormalities in the IS/OS junction line were correlated significantly with poorer visual function; however, the relationship between these abnormal OCT findings and the foveal traction has not been determined definitively. The SD OCT studies have shown a roundish or diffuse highly reflective region at the center of the fovea in all of the cases of VMT and in cases of ERM with increased central foveal thickness (CFT). The authors named this highly reflective region the *cotton ball sign*, after its appearance.

The aim of this study was to determine the characteristics and correlations of this abnormal sign in the OCT images and the retinal physiologic features. This study showed that the cotton ball sign disappeared when the foveal traction was released surgically or spontaneously. The presence of the cotton ball sign is good evidence that there is inward traction on the photoreceptors.

Patients and Methods

This was a retrospective case series performed in the Department of Ophthalmology, National Tokyo Medical Center, Tokyo, Japan. Informed consent was obtained from all of the subjects for the tests after an explanation of the procedures to be used. The procedures used adhered to the tenets of the Declaration of Helsinki, and approval to perform this study was obtained from the Review Board/Ethics Committee of the National Tokyo Medical Center.

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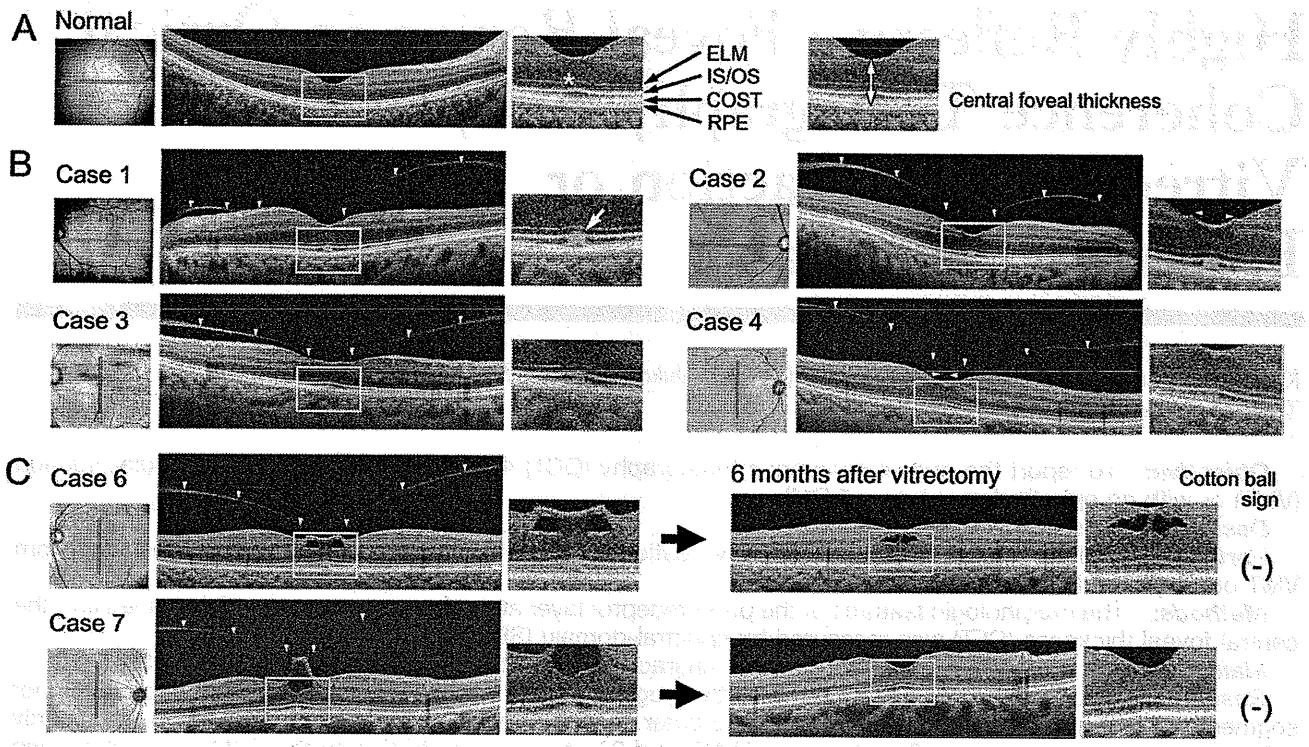

Figure 1. Optical coherence tomography (OCT) images of eyes with vitreomacular traction (VMT) with the foveal images magnified on the right. Fundus images on the left indicate the location of the OCT scans. A, Normal control OCT image from a 22-year-old woman. Outer retinal structures with high reflectivity are indicated by arrows: external limiting membrane (ELM), photoreceptor inner segment/outer segment (IS/OS) junction, cone outer segment tip (COST) line, and retinal pigment epithelium (RPE). The foveal bulge is indicated by an *asterisk*. The central foveal thickness is measured as the distance between the inner retinal surface and inner border of the RPE (*white arrow*). B, Optical coherence tomography images of eyes with VMT. The border of the posterior vitreous is indicated by *arrowheads*. The roundish highly reflective region between IS/OS junction line and COST line is the cotton ball sign and is identified by a *white arrow* in case 1. C, Two eyes with VMT before and 6 months after vitrectomy. In both cases, the vitreous traction was released and the cotton ball sign was not present after the surgery.

Inclusion and Exclusion Criteria

Fifty-four eyes of 45 patients (average age, 69.0±9.2 years; range, 34–85 years) with subjective visual disturbances resulting from VMT or idiopathic ERM were studied. The patients were examined between October 2009 and January 2011; 7 eyes had VMT and 47 eyes had ERM (Table 1, available at http://aaojournal.org). A VMT was defined as a vitreomacular adhesion at the foveal region without an apparent ERM over the entire macular region. All of the cases with VMT were focal VMT, according to the definition of Koizumi et al.[11] The exclusion criteria were: (1) eyes with a history of retinal inflammatory or vascular diseases, such as branch vein occlusion, uveitis, and retinal detachment; (2) eyes with advanced lens opacification or any other ocular diseases that could cause visual disturbances; (3) eyes with strong vitreal traction on the retina that led to either lamellar or pseudomacular holes; (4) eyes in which the center of the fovea could not be determined in the OCT images because of a lack of a bulge-like structure of the IS/OS junction line at the fovea[18]; and (5) cases whose OCT image did not have enough signal intensity for evaluation, that is, average intensity of the OCT signal less than 8/10.

All patients underwent a complete ophthalmologic examination, including best-corrected visual acuity using a Landolt C chart, biomicroscopy of the fundus, fundus photography, and OCT.

Optical Coherence Tomography

The OCT images were obtained with SD OCT (Cirrus HD-OCT, versions 4.5 and 5.1; Carl Zeiss Meditec, Dublin, CA). After dilatation of the pupil, patients were asked to fixate on a target, and 5-line scans with 4 averages were performed both horizontally (length, 9.0 mm) and vertically (length, 6.0 mm). The distance between each scan line was set to be 0.075 mm, or, in some cases, 0.025 mm, to determine the location of foveal bulge. The foveal bulge is a dome-shaped structure of the IS/OS junction line corresponding to the foveal center (Fig 1A, asterisk). If the foveal bulge could not be obtained by the point of fixation, the location of the scan line was shifted and the OCT images were taken repeatedly until the foveal bulge was present in the image.

The CFT was defined as the distance between inner retinal surface and inner border of retinal pigment epithelium (RPE; Fig 1A) and was measured with the built-in scale of the OCT system. The diameter of the highly reflective region was measured in one of the scanned profiles that showed the maximum diameter of the region. For patients who underwent vitrectomy, the OCT images were recorded 6 months after the surgery.

Vitrectomy for Vitreomacular Traction and Epiretinal Membranes

Two of 7 eyes with VMT and 18 of 47 eyes with an ERM underwent 23- or 25-gauge 3-port vitrectomy by 2 experienced

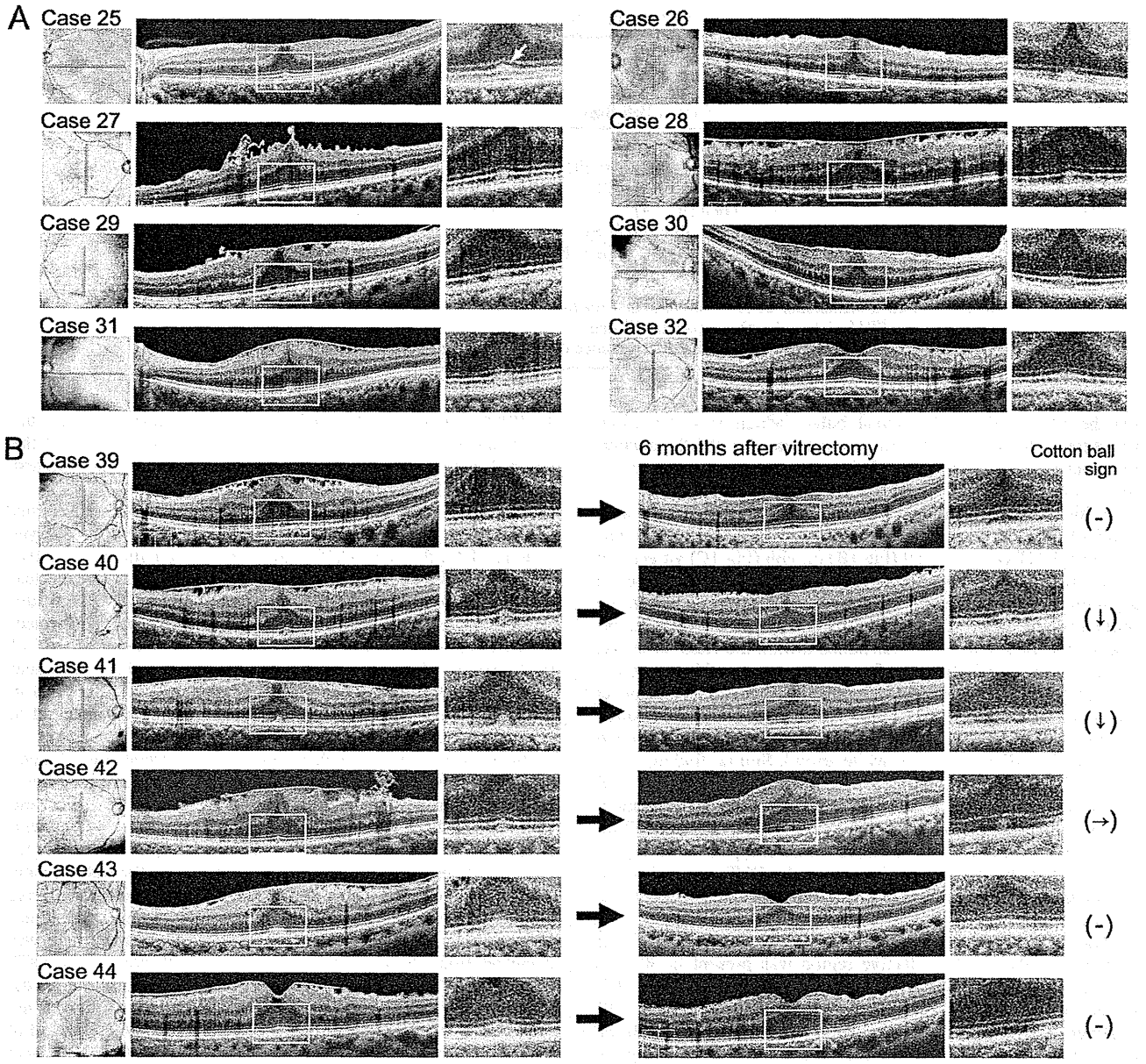

Figure 2. Optical coherence tomography (OCT) images of eyes with an epiretinal membrane (ERM) with the foveal area magnified (*right*). Fundus photographs (*left*) indicate the location of OCT scans. **A**, Optical coherence tomography images of eyes with an ERM. The roundish highly reflective region between inner segment/outer segment junction line and cone outer segment tip line is the cotton ball sign and is identified by a *white arrow* in case 25. **B**, Optical coherence tomography images of eyes with an ERM before and 6 months after vitrectomy. In cases 39, 43, and 44, the cotton ball sign disappeared after surgery. In cases 40 and 41, the cotton ball sign did not disappear, but became more indistinct after the surgery. In case 42, the cotton ball sign was still observed clearly after the surgery. The highly reflective region in cases 25, 40, and 41 appeared roundish, but that in cases 31, 43, and 44 appeared indistinct and diffuse.

surgeons (K.A. and K.W.). During the vitrectomy, a posterior hyaloid detachment was made, and the ERM was removed. The internal limiting membrane was peeled with forceps in all cases. Phacoemulsification with intraocular lens implantation was performed during the same surgery in 17 of the 20 eyes.

Statistical Analysis

Student *t* tests were performed to compare the CFT with the presence of the highly reflective region in cases of ERM before and after surgery. Statistical analysis was performed using Microsoft Office Excel 2007 (Microsoft, Redmond, WA). *P* values <0.05 were taken as statistically significant.

Results

The outer retinal structures detected in the OCT image of normal retinas consisted of (1) the external limiting membrane, (2) the IS/OS junction line, (3) the cone outer segment tip (COST) line,

Table 2. Cotton Ball Sign and Central Foveal Thickness

	Cotton Ball Sign	Central Foveal Thickness (μm)		P
		Mean	*Standard Deviation*	
VMT (n = 7)	Observed	252.0	87.1	
ERM before surgery (n = 47)	Not observed (n = 17)	289.3	96.0	0.0000076*
	Observed (n = 30)	445.7	102.2	
	Total (n = 47)	389.1	124.7	
ERM after surgery (n = 16)	Disappeared (n = 8)	300.0	28.6	0.00033†
	Not disappeared (n = 8)	423.3	59.0	

ERM = epiretinal membrane; VMT= vitreomacular traction.
*t test between ERM with and without cotton ball sign.
†t test between ERM with and without the disappearance of cotton ball sign after vitrectomy.

(4) the RPE, and (5) the foveal bulge, which is a dome-like structure of the external limiting membrane and IS/OS junction line caused by an elongation of the cone outer segments at the fovea (Fig 1A).[18–20]

A highly reflective region was present in all of the eyes with VMT (Table 1, available at http://aaojournal.org). The OCT images of 6 VMT cases without (Fig 1B) or with (Fig 1C) vitrectomy are shown with the foveal images magnified. In all the cases, a separation of the vitreous from the retina occurred except in the limited region around the center of the fovea (Fig 1A, B, arrowheads), and the foveal center was pulled toward the vitreous cavity. In case 1, a roundish, highly reflective region resembling a cotton ball can be seen between the IS/OS junction line and COST line at the center of the fovea. The COST line can be seen to be pulled inward just below the highly reflective region and is separated from the RPE (Fig 1B, case 1, white arrow). Similar findings were observed in cases 2 and 6. In all of the other cases (cases 3, 4, and 7), the highly reflective region was observed at the same location, but its borders were more indistinct than in cases 1, 2, and 6. Two of the eyes with VMT underwent vitrectomy, and the highly reflective region could not be observed in the OCT image obtained 6 months after the vitrectomy (Table 1, available at http://aaojournal.org; Fig. 1C).

The SD OCT examinations of the 47 eyes with an ERM showed that the highly reflective region was present in 30 eyes (63.8%; Table 1, available at http://aaojournal.org). The OCT images of 8 ERM cases without (Fig 2A) or with (Fig 2B) treatment are shown with the foveal images magnified. In all the cases, the epiretinal membrane covered the entire macular region, and the tangential traction elevated the retinal surface at the fovea, leading to a loss of the foveal pit. In case 25, the highly reflective region was observed between the IS/OS junction line and COST line at the center of the fovea (Fig 2A, case 25, white arrow). As in the eyes with VMT, the COST line was pulled inward just below the highly reflective region and was separated from the RPE. The highly reflective region was observed at the same location in all eyes. The regions appeared roundish in some cases (e.g., cases 25, 40, and 41) and indistinct and diffuse in other cases (e.g., cases 31, 43, and 44).

Vitrectomy was performed on 16 eyes with an ERM, and 6 months after surgery, the highly reflective region was not observed in 8 cases, became smaller and more indistinct in 2 cases, or could still be observed in 6 cases (Table 1, available at http://aaojournal.org; Fig 2B).

The diameter of the highly reflective region varied from 96 to 180 μm with a mean 130.4±36.4 μm in the eyes with a VMT and from 80 to 288 μm with a mean of 172.7±65.8 μm in eyes with an ERM. The highly reflective region was always present between the IS/OS junction and COST lines, except for case 41, where the IS/OS junction line was disrupted at the foveal center and the round, highly reflective region penetrated into the outer nuclear layer (Fig 2B).

The mean CFT was 252.0±87.1 μm in eyes with VMT and 389.1±124.7 μm in eyes with an ERM (Table 2). For the 47 eyes with an ERM, the mean CFT of the eyes with the highly reflective region was 445.7±102.2 μm, which was significantly thicker than that in eyes without the highly reflective region at 289±96.0 μm. For the 16 eyes with an ERM for which vitrectomy was performed, the CFT was measured 6 months after surgery. The mean CFT of the 8 eyes in which the highly reflective region did not disappear was 423.3±59.0 μm, which was significantly thicker than that in the 8 eyes in which the highly reflective region disappeared at 300.0±28.6 μm.

In one case (case 5) with a spontaneous vitreous detachment, there was a recovery of the microstructural damage of the photoreceptor layer in the OCT images. Case 5 was a 34-year-old woman who had a sudden decrease of her vision together with floaters in her right eye (Table 1, available at http://aaojournal.org; Fig 3). Her best-corrected visual acuity was 0.6 in the right eye and 1.2 in the left eye. She was referred to the authors' hospital 10 days after the onset of her symptoms, and fundus biomicroscopic examination showed that a thick posterior hyaloid membrane was detached from the posterior pole in her right eye. In the OCT image, there was a clear, highly reflective region, although the vitreomacular traction had been released (Fig 3A). Moreover, the photoreceptor IS/OS junction line seemed to be pulled inward at the foveal center, and there was a local defect of the COST line just beneath the highly reflective region (Fig 3A, white arrow). In the OCT image obtained 30 days after the onset, the highly reflective region was not present, and the photoreceptor structures, including the IS/OS junction and COST lines, appeared normal (Fig 3B, white arrow). The visual acuity also recovered to 1.0 at that time.

Discussion

The SD OCT findings showed that all eyes (n = 7) with VMT and 63.8% of the eyes (30/47) with an ERM have a highly reflective region at the center of the fovea. This region can be roundish in some cases or diffuse and indistinct in other cases, and it was always located between the IS/OS junction and COST lines. This area was termed the *cotton ball sign* after its appearance. Related articles were searched for in PubMed with the following terms: *vitreomacular traction*, *epiretinal membrane*, and *optical coher-*

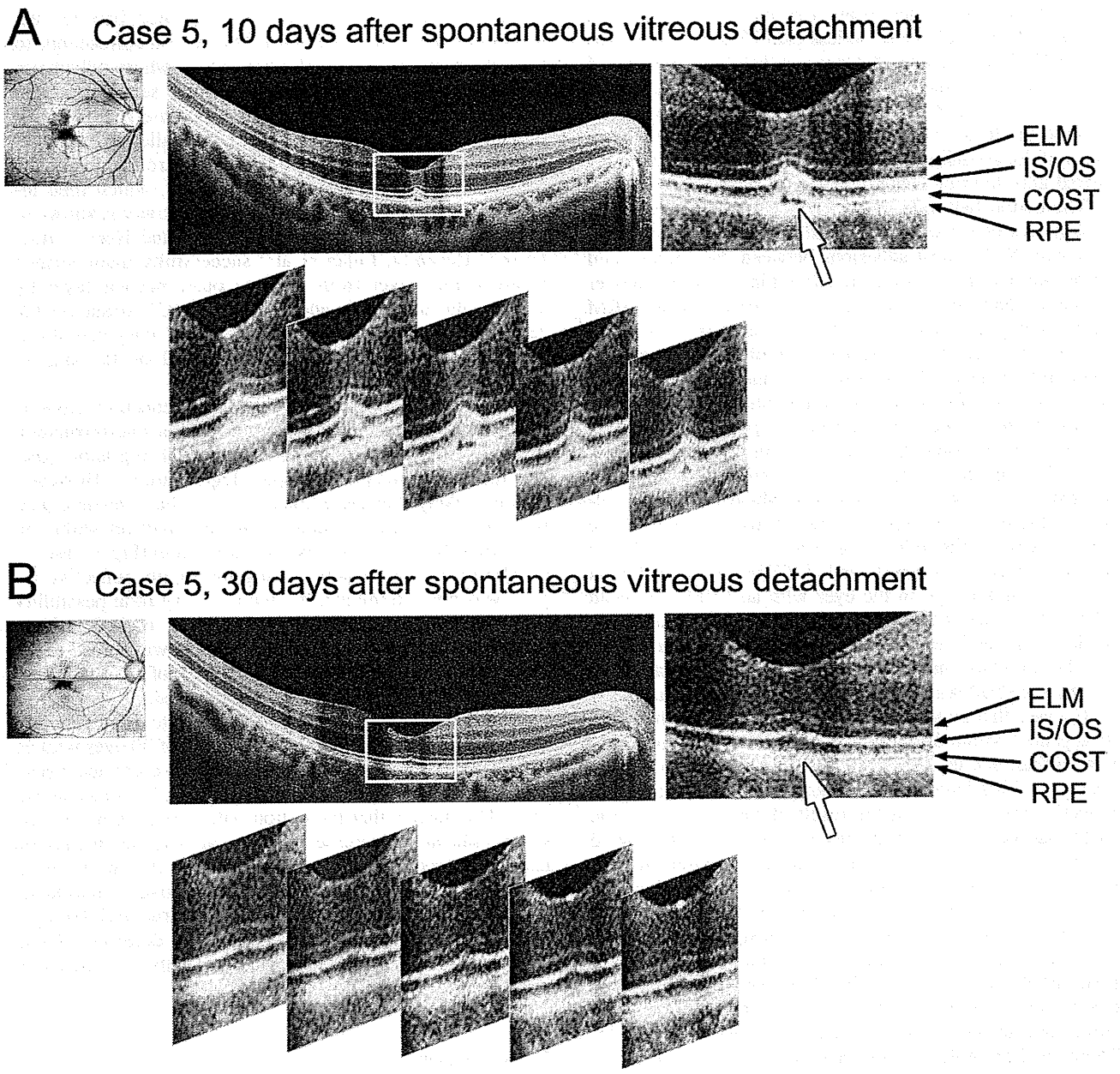

Figure 3. Optical coherence tomography (OCT) images of eyes with vitreomacular traction (case 5) in which a posterior vitreous detachment occurred spontaneously without surgery. Five horizontal OCT scans were obtained with an interscan distance of 20 μm. Five sequential profiles of the foveal region are aligned at the bottom, covering the central region of 80 μm of the fovea. **A,** Optical coherence tomography image obtained 10 days after spontaneous vitreous detachment. A round, highly reflective region (cotton ball sign) is present between the inner segment/outer segment (IS/OS) junction and cone outer segment tip (COST) lines at the foveal center. The center of IS/OS junction line is pulled inward and appears protruded compared with that in a normal OCT image (Fig 1A). The COST line is disrupted just below the highly reflective region (*white arrow*). **B,** Optical coherence tomography image obtained 30 days after the spontaneous vitreous detachment. The cotton ball sign is not present. The protrusion of IS/OS junction line is not distinct, and the COST line is continuous over the entire foveal region (*white arrow*). ELM = external limiting membrane; RPE = retinal pigment epithelium.

ence tomography. These articles were read, and none of them describes the same feature.

Even with the improved OCT instruments with higher spatial resolution, the region easily can be missed if the scanned lines do not pass through the foveal center, the intensity of the OCT signal is not strong enough, or both. Three-dimensional volume scans do not have enough traverse resolution, so OCT should be made with multiple scans with the highest resolution available. The mean diameter of the highly reflective region varied from 96 to 180 μm with a mean of 130.4±36.4 μm in the eyes with VMT and from 80 to 288 μm with a mean of 172.7±65.8 μm in

eyes with an ERM. This means that the distance between each scan line should be set to less than 75 μm in the Cirrus HD-OCT. For example, the consecutive OCT images of case 5 were obtained with 5-line scans with a distance between the scans of 20 μm (Fig 3A, bottom). Moreover, because the fixation point is sometimes shifted upward in cases of longstanding ERM, the OCT scan should be repeated until the true center of the fovea is scanned.

The cotton ball sign in the OCT images seemed to be strongly correlated with the inward traction on the retina. In eyes with VMT, local adhesions between the vitreous and retinal surface causes strong and direct inward traction over the entire depth of the foveal pit.[13,16] However, an ERM causes a tangential shrinkage of the retinal surface, and this leads to an inward retinal displacement of the fovea, regardless of the existence of a posterior vitreous detachment. This continuous tension also affects the photoreceptor layer, leading to mechanical damage of the photoreceptors and deterioration of visual function.[12,14,15] In this study, in eyes with VMT in which direct vitreous traction was present at the fovea, the cotton ball sign was always observed, although there was no apparent inward displacement of the fovea in cases 1 through 5 (Figs 1 and 3) and the CFT was normal, except in cases 6 and 7 (Table 1, available at http://aaojournal.org). In the eyes with an ERM, the mean CFT of the cases with the cotton ball sign was significantly thicker than that in eyes without the cotton ball sign (Table 2). These findings indicate that the continuous inward traction by the ERM was the cause of the cotton ball sign. In 8 of 16 cases that underwent vitrectomy, the cotton ball sign disappeared within 6 months and the CFT was significantly thinner than that in eyes where the cotton ball sign did not disappear. This indicated that disappearance of the highly reflective region was not the result of the removal of the ERM, but was most likely the result of the release of inward traction. It is notable that in cases where the cotton ball sign disappeared after surgery, the foveal pit reappeared because of release of inward traction (Fig 2B, cases 39, 43, and 44). However, in cases where the cotton ball sign did not disappear, the foveal area was still flat or even convex (Fig 2B, cases 40, 41, and 42). These highly reflective regions were observed only at the foveal center, even in cases where the entire macular region was thickened because of the ERM. There are 2 possible reasons for why the cotton ball sign is observed only at the foveal center in the ERM eyes. First, in cases in which the internal limiting membrane became flat because of the tangential traction by the ERM, the inward traction could be applied most strongly to the photoreceptors at the foveal center because of the presence of the foveal pit. Second, the cone photoreceptors at the fovea have an elongated shape and their diameter is much smaller than those at the parafoveal region. This characteristic anatomic structure makes them more susceptible to the minute structural changes that may lead to the increased reflectivity in the OCT.

An ERM usually is associated with macular edema and reduced reflectivity resulting from fluid accumulation; however, an increase in the reflectivity is observed rarely. Then the question arises on why the inward traction affected the reflectivity of the foveal center in the OCT images? The highly reflective region was always located between the IS/OS junction and COST lines. This region corresponds to the outer segment of cone photoreceptors, whose reflectivity is usually low. The photoreceptor outer segments (OSs) contain stacks of membranous discs that are rich in visual pigments, and the OSs are aligned parallel to the light pathway. The authors suggest that the inward traction on the retina changes the alignment of the OSs, which then increases their reflectivity. Directional reflectivity is known to exist in the retinal nerve fiber layer[21,22] and Henle's fiber layer.[23] Recently, Lujan et al[23] successfully distinguished Henle's fiber layer from the true outer nuclear layer by varying the angular incidence of the OCT beam on the retinal plane. The photoreceptor OSs are long cylindrical structures whose reflectivity may depend on the angular incidence of the OCT beam.

The second hypothesis for the highly reflective region is that the continuous inward traction causes microstructural damages to the cone OSs, leading to glial migration, glial scar formation, and photoreceptor degeneration.[24] However, it is not likely that these changes could be reversible and, particularly in case 5, would completely recover within 30 days after the release of mechanical traction (Fig 3, case 5).

The exact mechanism causing the highly reflective region was not determined, but there is very little possibility that this highly reflectivity region is an optical artifact, because it appeared when inward traction was forced to the outer retina, regardless of the existence of an ERM, and disappeared when the traction was released.

The cotton ball sign was present, despite good vision in the patients; 4 of 7 eyes with VMT and 9 of 30 eyes with an ERM with the cotton ball sign had best-corrected visual acuity of 0.8 or better (Table 1, available at http://aaojournal.org). This means that the cotton ball sign does not necessarily indicate a decrease in visual acuity, and it may be used as a predictor of visual impairment that would arise after longstanding inward traction at the fovea. Continuous foveal traction is known to cause microstructural damages in the photoreceptor layer,[12–16] and early detection of this sign may help in the management of these patients in preserving good vision.

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Footnotes and Financial Disclosures

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Selective Abnormality of Cone Outer Segment Tip Line in Acute Zonal Occult Outer Retinopathy as Observed by Spectral-Domain Optical Coherence Tomography

Optical coherence tomography (OCT) plays an important role in the diagnosis of retinal diseases with minimal ophthalmoscopic changes. For example, in eyes with acute zonal occult outer retinopathy (AZOOR),[1-5] an abnormality of the photoreceptor inner segment–outer segment (IS/OS) junction found by OCT was spatially correlated with the region of visual field defect. Recent high-resolution spectral-domain OCT images have shown a thin line between the IS/OS junction and the retinal pigment epithelium. This line has been identified as the cone OS tip (COST) line.[6] However, the pathophysiological interpretation of its appearance has not been established, and the diagnostic value of the COST line has yet to be determined.

We report 2 cases of AZOOR, both of which showed acute central scotoma with an enlarged blind spot. The ophthalmoscopic and angiographic changes were minimal, but electroretinography (ERG) revealed reduced responses in the affected regions. In both cases, the IS/OS junction on the OCT image was normal, but the COST line was not present or appeared indistinct in the region of visual field defect. Our findings suggest that the COST line may be an early indicator of cone photoreceptor dysfunction in eyes with minimal ophthalmoscopic abnormalities.

Report of Cases. Patient 1 (a 24-year-old woman) and patient 2 (a 28-year-old woman) both had sudden unilateral visual disturbances following photopsia. The visual acuities were 0.02 OD and 1.5 OS in patient 1 and 0.15 OD and 1.5 OS in patient 2. Goldmann kinetic perimetry revealed a blind spot enlargement and central scotoma in the right eye of both patients (**Figure 1** and **Figure 2**). The anterior segment and fundus were normal; however, fluorescein angiography showed a slightly mottled hyperfluorescence around the macula in the affected eye of both patients. The full-field scotopic ERGs were normal, but there were phase delays in the photopic 30-Hz ERGs in the affected eyes: 5.7 milliseconds in patient 1 and 8.0 milliseconds in patient 2. In addition, the amplitudes of the photopic b-waves were reduced in both patients. The focal macular ERGs (ER80; Kowa Co, Tokyo, Japan, and Mayo Co, Nagoya, Japan) in the central 15° were almost flat in the affected eye in both patients. Neither patient had systemic disorders such as viral infections or autoimmune diseases.

Spectral-domain OCT (Carl Zeiss Meditec, Dublin, California) showed the IS/OS junction clearly, even in the region of the scotoma. However, the COST line was not detected in patient 1 and appeared indistinct in patient 2 (Figure 1 andFigure 2). Moreover, the bulgelike structure of the IS/OS junction at the fovea (with the foveal bulge indicating a domelike appearance of the IS/OS junction due to an elongated cone OS at the fovea)[7] could not be observed in the affected eyes. The visual disturbances of these patients did not recover, and these abnormalities in the OCT images were observed at all examinations for 50 months in patient 1 and 18 months in patient 2 after the onset.

Comment. To our knowledge, this is the first report of AZOOR where the boundary of the IS/OS junction in the OCT images was well preserved but the COST line was absent or indistinct from the initial examination through the entire follow-up period. Earlier studies demonstrated that a loss or irregularity of the IS/OS junction observed by OCT corresponded well with the visual field defects even at the early stages of AZOOR,[2-5] and the abnormality in the IS/OS junction can improve following recovery of the scotoma. These findings have led to the hypothesis that photoreceptor OS dysfunction is the primary lesion in AZOOR.

The COST line corresponds to the junction between the photoreceptor tips and the apical processes of the retinal pigment epithelium, where photoreceptor OS disc membranes are continuously shed for renewal.[6] Thus, the appearance of the COST line may reflect the normal function of the photoreceptor OSs more closely than the IS/OS junction. In fact, in all of the AZOOR cases we have recently examined, the COST line was always absent in the region of IS/OS abnormalities, suggesting that the abnormality of the COST line may precede that of the IS/OS junction. In our 2 cases, the fundus appeared normal and the IS/OS junction was clearly observed in the region of the COST line abnormality for 50 and 18 months after the onset. The focal macular ERGs, however, were markedly reduced in the affected areas. In the OCT images, the cone photoreceptor dysfunction corresponding to the region of scotoma could be detected only by the abnormality of the COST line.

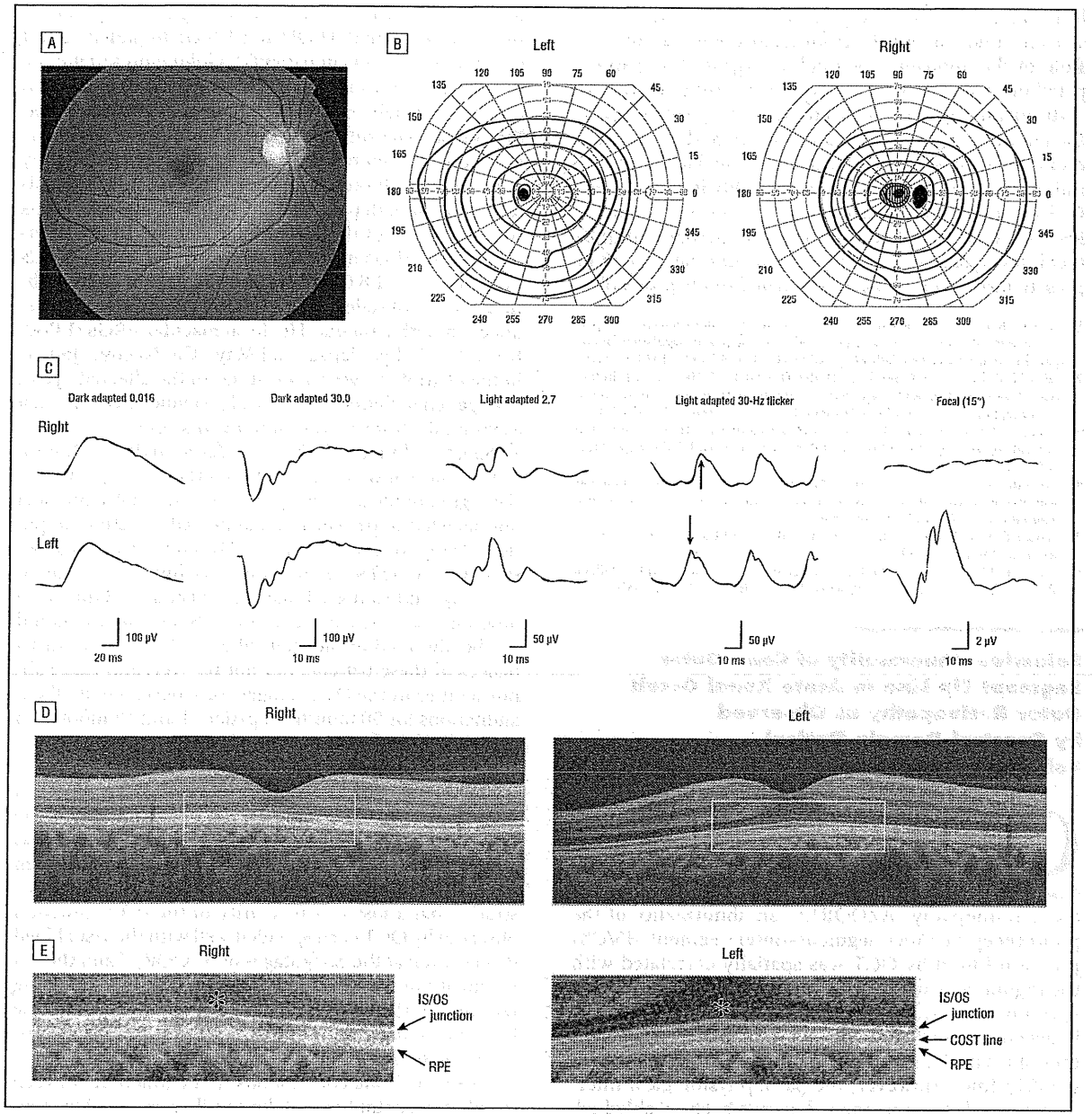

Figure 1. Findings in patient 1. A, Fundus photograph of the right eye showing a normal appearance. B, Goldmann kinetic perimetry showing a blind spot enlargement and central scotoma in the right eye. C, Full-field and focal macular electroretinograms. The latencies of the photopic 30-Hz flicker responses are delayed in the right eye. Arrows indicate the phase difference in light-adapted 30-Hz flicker responses. The focal macular electroretinogram is almost flat in the central 15° of the right eye. Optical coherence tomographic images vertically profiled along the foveola (D) and magnified optical coherence tomographic images in the region of visual field abnormality (E). In the left eye, the inner segment–outer segment (IS/OS) junction, foveal bulge, and cone OS tip (COST) line are clearly observed. In the right eye, the IS/OS junction is clearly observed but the COST line is absent in the macula. The foveal bulge (asterisk) cannot be observed in the right eye. RPE indicates retinal pigment epithelium.

Our findings suggest that the dysfunction of the cone photoreceptor OS could be initially reflected by an absence or indistinctness of the COST line and the absence of the foveal bulge.[5] These changes may be followed by the development of abnormalities in the IS/OS junction in the more advanced stages. However, in our cases, the IS/OS junction remained the same during the entire follow-up period. This may suggest another possibility that our 2 cases constitute a subtype of AZOOR. However, in another case of AZOOR with a blind spot enlargement and relative central scotoma (a 21-year-old woman, data not shown), both the IS/OS and COST lines disappeared in the peripapillary region where visual field disturbance was severe, whereas only the COST line disappeared and the IS/OS line remained normal in the foveal region where the visual field disturbance was milder. These findings support the idea that the visibility of the COST line is more easily affected than that of

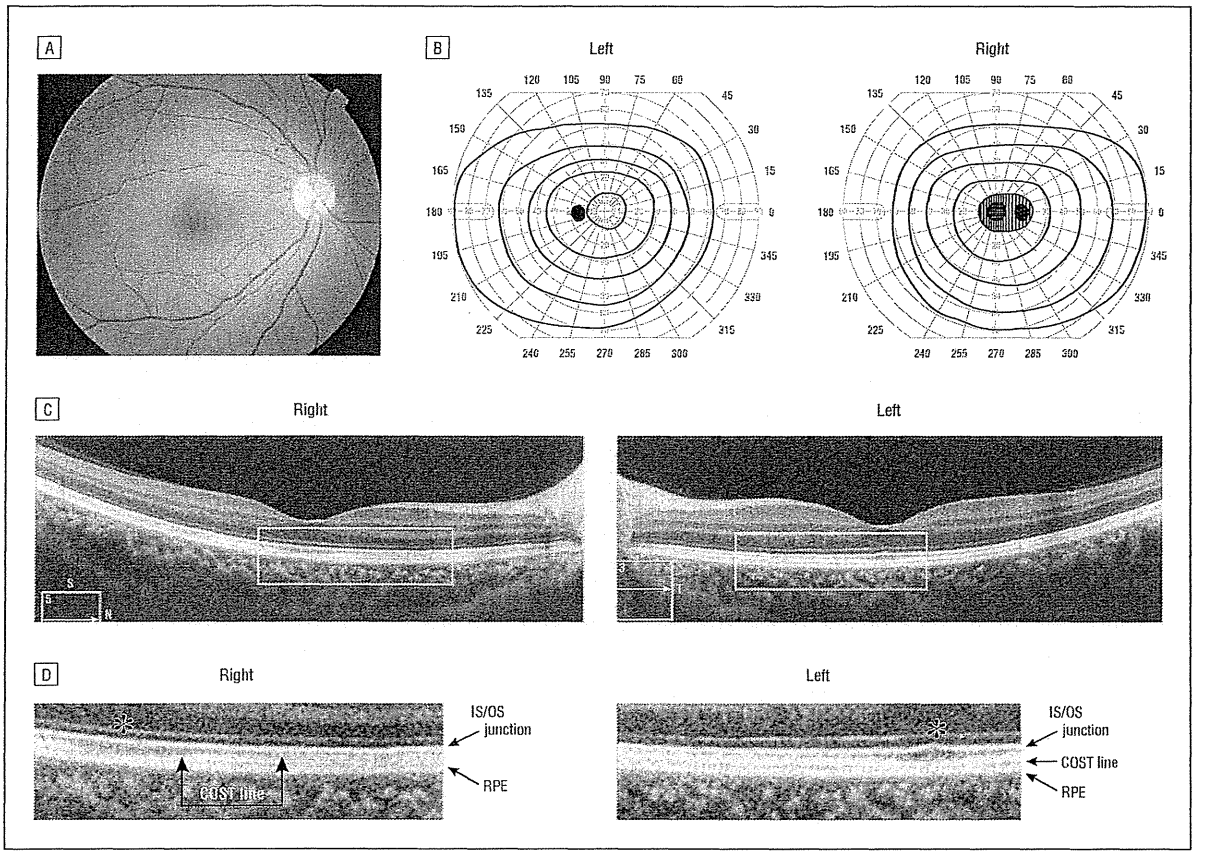

Figure 2. Findings in patient 2. A, Fundus photograph of the right eye showing a normal appearance. B, Goldmann kinetic perimetry showing a blind spot enlargement and central scotoma in the right eye. Optical coherence tomographic images horizontally profiled along the foveola (C), and magnified optical coherence tomographic images in the region of the visual field abnormality (D). In both eyes, the inner segment–outer segment (IS/OS) junction is clearly observed. In the right eye, the cone OS tip (COST) line is partially observed but appeared more indistinct than in the left eye. The foveal bulge (asterisk) cannot be seen in the right eye.

the IS/OS line at an earlier stage by the pathological changes in a typical case of AZOOR. We should note that care should be taken in evaluation of the COST line because its visibility is dependent on the intensity and direction of the laser light that reaches the photoreceptor layer.[6] However, in patients with AZOOR, the COST line and the foveal bulge observed by OCT could help as indicators of early cone photoreceptor dysfunction in cases with minimal ophthalmoscopic and angiographic abnormalities.

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Adult Ovarian Retinoblastoma Genomic Profile Distinct From Prior Childhood Eye Tumor

We report the first case of a woman, previously cured of childhood intraocular retinoblastoma, who developed tumor in the ovary with histological and genomic characteristics suggesting an independent retinoblastoma, not a metastasis.

addition, the duration of treatment to induce retinal reattachment is currently unknown. However, patients with IH have been treated for several months.

Hemangiomas consist histologically of cavernous and capillary vascular networks. The mechanism by which oral propranolol aids in the resolution of exudative retinal detachment in DCH associated with Sturge-Weber syndrome is unknown. It is possible that, similar to IH, there is vasoconstriction of the DCH due to decreased release of nitric oxide, blocking of proangiogenic signals including vascular endothelial growth factor and basic fibroblast growth factor, and apoptosis in proliferating endothelial cells with vascular tumor regression.[5]

To our knowledge, the benefits of propranolol therapy have not been reported in adult hemangioma or for DCH. This is the first reported case of propranolol treatment in an adult with exudative retinal detachment in DCH associated with Sturge-Weber syndrome.

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Oguchi Disease With Unusual Findings Associated With a Heterozygous Mutation in the *SAG* Gene

Oguchi disease is a type of congenital stationary night blindness with an autosomal recessive inheritance pattern. Two causative genes have been reported for Oguchi disease: the *SAG* and *GRK1* genes. Homozygous Oguchi disease is characterized by a golden-yellow discoloration of the fundus that disappears after prolonged dark adaptation, called the Mizuo-Nakamura phenomenon. The International Society for Clinical Electrophysiology of Vision–protocol bright-flash electroretinograms (ERGs), performed after 30 minutes of dark adaptation, are typically electronegative with a severely reduced b-wave and milder reduction of the a-wave.[1,2] After 3 to 4 hours of dark adaptation, both amplitudes recover to nearly normal, especially the a-wave.[2] However, the recovered rod function is rapidly lost after a short light exposure or a single bright white flash.[2,3]

We describe a case of Oguchi disease with unusual findings caused by a putative heterozygous mutation in the *SAG* gene.

Report of a Case. A 40-year-old woman with visual acuity of 20/20 OU had fundus abnormalities and was referred to our institute. She had photophobia but did not report night blindness. There was no autosomal dominant family history. The retina had a golden-yellow appearance (**Figure**, A). The Mizuo-Nakamura phenomenon was observed after 30 minutes of dark adaptation (Figure, B). Sequencing of the *SAG* gene identified a heterozygous mutation of 1147del A at codon 309. No mutation was found in *GRK1*.

The International Society for Clinical Electrophysiology of Vision protocol was used to record the ERGs. The scotopic ERGs after 30 minutes of dark adaptation showed slightly reduced amplitude and delayed implicit time in b-wave (Figure, C). The bright-flash ERG (30 candelas·seconds/m^2) had a positive configuration, although the b:a ratio was lower than normal (Figure, C). The photopic and flicker ERGs performed after 10 minutes of light adaptation were normal (Figure, C). To determine the extent of the rod function recovery, bright-flash ERGs were recorded 4 times at 30-second intervals after 30 minutes of dark adaptation. During the 4 stimuli, the waveform changed from the positive pattern to a negative configuration with a severely reduced b-wave and additional milder reduction of the a-wave, which is characteristic of homozygous Oguchi disease (Figure, D). To our knowledge, this phenomenon has never been reported in normal eyes, in eyes with the typical type of Oguchi disease, or in other cases of Oguchi disease with the same heterozygous *SAG* mutation (Figure, D). The superimposed ERGs elicited by the 4 consecutive flashes show the variation of rod function recovery (Figure, E).

Comment. To our knowledge, this is the first case of Oguchi disease with a distinct fundus appearance and mild electrophysiological abnormalities associated with a putative heterozygous *SAG* mutation. However, we cannot exclude the possibility that another mutation exists in the intron of another allele, which causes the mild phenotype in this patient.

The repetitive-flash ERG protocol was crucial for the diagnosis. It has been reported that double- or triple-flash stimulations after prolonged dark adaption induce ERG alterations in typical patients with Oguchi disease.[3] However, the use of a 30-second interval allowed us to follow the degree of rod function recovery.

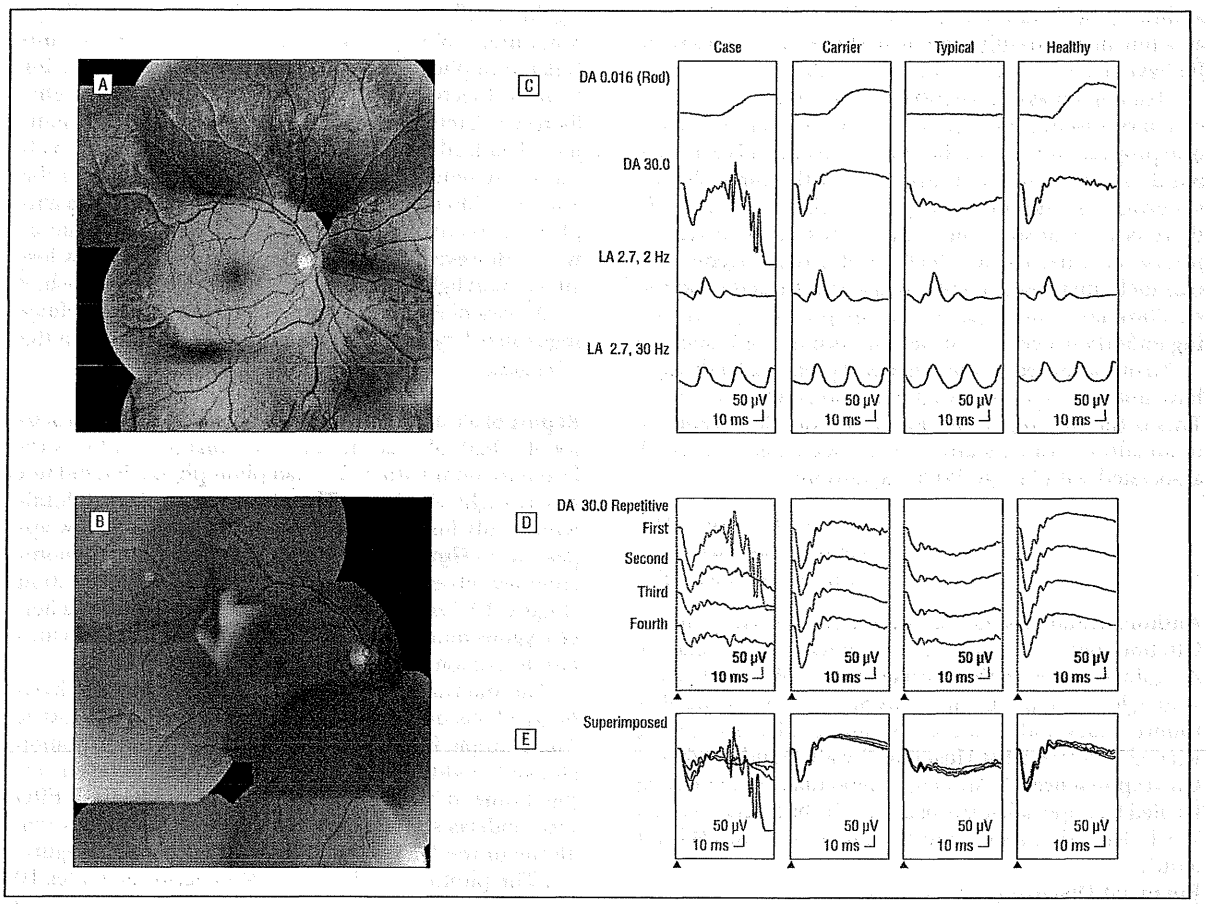

Figure. Fundus photographs showing the Mizuo-Nakamura phenomenon before (A) and after (B) 30 minutes of dark adaptation. C, The electroretinograms (ERGs) recorded according to the International Society for Clinical Electrophysiology of Vision protocol. D, The ERGs elicited by 4 repetitive flashes at interstimulus intervals of 30 seconds. E, Superimposed ERGs elicited by 4 flashes. The ERGs are from our patient with Oguchi disease (case), another patient with Oguchi disease with a heterozygous mutation (carrier), a typical patient with Oguchi disease, and a healthy subject. DA indicates dark adaptation; LA, light adaptation.

Arrestin and rhodopsin kinase act in sequence to deactivate rhodopsin to stop the phototransduction cascade.[4] Results of molecular biological studies have suggested that residual arrestin activity correlates with the severity of the clinical phenotype.[5] However, in our case it was more difficult to determine the relationship between the putative heterozygous mutation of the *SAG* gene and the mild electrophysiological abnormalities in the rod function recovery. A modifying effect of deactivating rhodopsin should be considered.

The time required for the reappearance of the rod function demonstrated in the electrophysiological study and the time required to demonstrate the Mizuo-Nakamura phenomenon were nearly identical. We suggest that the physiological basis for the Mizuo-Nakamura phenomenon may be closely related to the abnormal deactivation of rhodopsin.

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Photoreceptor and Post-Photoreceptoral Contributions to Photopic ERG a-Wave in Rhodopsin P347L Transgenic Rabbits

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Purpose. The a-wave of the photopic electroretinogram (ERG) of macaque monkeys is made up of the electrical activities of cone photoreceptors and post-photoreceptoral neurons. However, it is not known whether the contributions of these two components change in retinas with inherited photoreceptor degeneration. The purpose of this study was to determine the contributions of cones and post-photoreceptoral neurons to the a-wave of the photopic ERGs in rhodopsin Pro347Leu transgenic (Tg) rabbits.

Methods. Ten Tg and 10 wild-type (WT) New Zealand White rabbits were studied at 4 and 12 months of age. The a-waves of the photopic ERGs were elicited by xenon flashes of different stimulus strengths before and after the activities of post-photoreceptoral neurons were blocked by intravitreal injections of a combination of 0.2 to 0.4 mM of 6-cyano-7-nitrouinoxaline-2,3(1H,4H)-dione, disodium (CNQX) and 2 to 4 mM of (±)-2-amino-4-phosphonobutyric acid.

Results. The percentage contribution of the cone photoreceptors to the photopic ERG a-waves increased with increasing stimulus strength, and the percentage ranged from 54% to 75% in 4-month-old WT rabbits. In contrast, the percentage contribution of the cone photoreceptors in 4-month-old Tg rabbits ranged from 32% to 51% ($P < 0.05$). The mean percentage contribution of cone photoreceptors became still smaller at 11% to 48% in 12-month-old Tg rabbits.

Conclusions. These results suggest that the relative contribution of cone photoreceptors to the photopic ERG a-wave is smaller in retinas with inherited photoreceptor degeneration. This indicates that the a-waves of the photopic ERGs in patients with retinitis pigmentosa must consider this lower contribution from the cone photoreceptors. (*Invest Ophthalmol Vis Sci.* 2012;53:1467–1472) DOI:10.1167/iovs.11-9006

The electroretinogram (ERG) is a mass electrical potential change of the retina that is elicited by light stimulation and is easily recorded noninvasively with a corneal electrode.[1] The ERG arises from the neural activity of the different types of retinal cells, and it can be used to perform a layer-by-layer study of retinal function in patients and animals.[2]

The origins of the photopic or light-adapted a-wave of the ERG in macaque monkeys was studied by Sieving et al.[3–5] They injected glutamate agonists and antagonists intravitreally to dissect the retinal circuits. They found that the a-wave of the photopic ERG received contributions not only from the cone photoreceptors but also from post-photoreceptoral neurons (e.g., OFF-bipolar cells and horizontal cells)[3,4] because *cis*-2,3-piperidine dicarboxylic acid (PDA) or kynurenic acid reduced the a-wave amplitude. A later study by Robson et al.[6] showed that the PDA-sensitive post-photoreceptoral a-wave component started at much earlier times of approximately 5 ms in macaques. Frieberg et al.[7] also estimated the time course of the cone photoreceptor response in normal human ERGs using the paired-flash technique, in which an intense "probe" flash was delivered at different times after a "test" flash. Their results showed that the photopic ERG a-wave of the human ERG contains an appreciable postphotoreceptoral component, similar to that reported in monkeys.[3–6]

These studies, which were designed to determine the origins of the photopic ERG a-wave, have been performed primarily on normal macaque monkeys and human eyes.[3–7] It is not known whether the contributions of photoreceptors and post-photoreceptoral neurons are altered in retinas with inherited photoreceptor degeneration (e.g., retinitis pigmentosa [RP]) because the most commonly used RP animals are mice and rats, whose amplitude of photopic ERG a-wave is very small. This makes it difficult to quantify the changes in the a-wave amplitude before and after intravitreal injection of pharmacologic agents.[8–12]

We have recently succeeded in generating a rabbit model of retinal degeneration.[13] This animal has the rhodopsin Pro347Leu mutation, which is one of the major mutations in autosomal dominant retinitis pigmentosa in humans.[14] These animals have a slowly progressive photoreceptor degeneration, as do human RP patients with this mutation,[13,15–18] though it is still unclear whether the retinal degeneration is due to a point mutation of the rhodopsin gene or to an overexpression of rhodopsin in these animals. We believed that this rhodopsin transgenic (Tg) rabbit can be an excellent animal model in which to study the retinal origins of the photopic ERG a-wave in RP because rabbits have a large photopic a-wave. In addition, the large size of the rabbit's eye enabled us to perform reliable intravitreal injections of pharmacologic agents.[15,16,18]

Thus, the purpose of this study was to compare the contributions of cone photoreceptors and post-photoreceptoral neurons with the a-wave of the photopic ERGs between wild-type (WT) and Tg rabbits. To accomplish this we examined the postphotoreceptoral neural activity before and after they were blocked by pharmacologic agents.

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