Central retinal artery occlusion (CRAO) should be regarded similar to stroke because of comparable etiology, potentially concurrent cerebral ischemia, and disabling consequences.1 Mostly its cause is cardiac or arterio-arterial embolization, and vasculitis accounts for 4% of cases. There is no generally agreed treatment regimen. Studies investigating intra-arterial or intravenous thrombolysis have yielded inconsistent results.2–4

Ocular color-coded duplex sonography (OCCS) allows direct examination of the central retinal artery. Only few studies report on its value.5,6 Next to Doppler evaluation, B-mode may reveal a hyperechoic structure within the occluded artery, the so-called retrobulbar spot sign (Figure). It may help discriminate vasculitic from embolic occlusion, as it does not seem to occur in vasculitis.7 On the other hand, a spot sign is only found in a proportion of embolic CRAO. It has been suggested that it may represent a calcified portion of the embolus.8

Following this suggestion, we hypothesised that the spot sign is associated with arterio-arterial embolization and designed this prospective study. In a subset of patients receiving intravenous thrombolysis, we evaluated its influence on treatment results.

Results
OCCS confirmed occlusion in all 46 patients with CRAO (mean age 69.8±10.9 years; range 45–88; 60% male).
The etiology of CRAO was classified as embolism from LAA in 27 patients and CE in 10 (Table 1). Fifty-nine percent of LAA patients displayed a spot sign (4/5 patients with ipsilateral carotid stenosis ≥70% [NASCET] or occlusion; 10/19 stenosis <70%; 2/3 aortic arch disease) compared with only 20% in CE (1/8 in atrial fibrillation; 0/1 fibroelastoma; 1/1 endocarditis). This difference was statistically significant (P<0.05). A spot sign was found in 0/5 vasculitis cases and in 3/4 patients with undetermined cause.

Eleven patients underwent thrombolysis (Table 2; median symptom onset to treatment time 4.25 h; range 1.75–10.5). All 4 patients with spot sign negative CRAO had significant visual improvement (visual acuity ≥0.6) and restored blood flow. The 7 patients with spot sign positive CRAO had persisting visual impairment ≤0.02 (significant with P<0.05), and all arteries remained occluded. Symptom to treatment time was slightly longer in patients without a spot sign (5.75 versus 4.51 h). Intracranial hemorrhage was not detected in any of the patients.

The spot sign persisted in all 21 initially spot sign–positive cases (follow-up ultrasound between 14 h and 90 days; median 69 h).

**Discussion**

Our study shows that transbulbar sonography is reliable for detection of CRAO. The retrobulbar spot sign, overall found in 51% of cases with embolic CRAO, is more likely found in LAA than in CE, whereas none of our patients with vasculitis displayed a spot sign. These findings support the hypothesis of the spot sign reflecting a calcified portion of the embolus. Altmann et al previously discussed its calcified nature on basis of their findings of persistence of the retrobulbar spot sign in a series of patients' median follow-up of 17 months.

Thrombolytic treatment repeatedly showed promise in previous studies, but effectiveness has not been confirmed in a larger trial. In a summary of reported cases, Biousse et al found visual improvement in 48.5% of IV-treated and 34.9% of IA-treated patients, which may be an improvement compared with the natural course.

A prospective randomized multicenter trial on intra-arterial tissue-type plasminogen activator was stopped because of lack of efficacy and a higher rate of adverse events. A small randomized trial (n=16) on intravenous tissue-type plasminogen activator found improved visual acuity in 25% of patients, versus none after placebo.

For the first time, we correlated treatment effects with the occurrence of a spot sign. We found relevant treatment effects only in spot sign–negative CRAO. Although the number of patients was small, the observed effect was statistically significant. These results are plausible in the light of the presumed calcified nature of the spot sign, resulting in a much smaller likelihood to respond. Our results indicate that sonographic identification of the presence or absence of a spot sign may help identify patients more likely to benefit from thrombolytic treatment. A calcified embolus being present in ≈50% of embolic CRAO may be one major reason for limited treatment effects in previous studies. We suggest to include OCCS in future studies to improve awareness of a potential subgroup being less susceptible to tissue-type plasminogen activator.
The main reason for exclusion from thrombolysis was time window limitation, with the majority of patients presenting later than 12 h from symptom onset. This emphasizes that emergency awareness and referral to specialized centers need to be improved.9

In conclusion, this study shows that OCCS is valuable for initial diagnosis, etiologic workup, and prognostic assessment. Ultrasound may help identify patients more likely to benefit from thrombolytic treatment.

None.

References


Retrobulbar Spot Sign Predicts Thrombolytic Treatment Effects and Etiology in Central Retinal Artery Occlusion

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