SCIENTIFIC ARTICLE

Changes in retinal nerve fiber layer thickness after spinal surgery in the prone position: a prospective study

Baran Gencer a, *, Murat Côşar b, Hasan Ali Tufan a, Selçuk Kara a, Sedat Arikan a, Tarik Akman b, Hasan Ali Kiraz c, Arzu Taskiran Gomez a, Volkan Hancı d

a Department of Ophthalmology, Canakkale Onsekiz Mart University, Canakkale, Turkey
b Department of Neurosurgery, Canakkale Onsekiz Mart University, Canakkale, Turkey
c Department of Anesthesiology and Reanimation, Canakkale Onsekiz Mart University, Canakkale, Turkey
d Department of Anesthesiology and Reanimation, Dokuz Eylül University, İzmir, Turkey

Received 19 August 2013; accepted 13 March 2014
Available online 30 April 2014

KEYWORDS
Retinal nerve fiber layer thickness;
Prone position;
Spinal surgery;
Intraocular pressure

Abstract

Background and objectives: Changes in ocular perfusion play an important role in the pathogenesis of ischemic optic neuropathy. Ocular perfusion pressure is equal to mean arterial pressure minus intraocular pressure. The aim of this study was to evaluate the changes in the intraocular pressure and the retinal nerve fiber layer thickness in patients undergoing spinal surgery in the prone position.

Methods: This prospective study included 30 patients undergoing spinal surgery. Retinal nerve fiber layer thickness were measured one day before and after the surgery by using optical coherence tomography. Intraocular pressure was measured by tonopen six times at different position and time-duration: supine position (baseline); 10 min after intubation (Supine 1); 10 (Prone 1), 60 (Prone 2), 120 (Prone 3) min after prone position; and just after postoperative supine position (Supine 2).

Results: Our study involved 10 male and 20 female patients with the median age of 57 years. When postoperative retinal nerve fiber layer thickness measurements were compared with preoperative values, a statistically significant thinning was observed in inferior and nasal quadrants (p = 0.009 and p = 0.003, respectively). We observed a statistically significant intraocular pressure decrease in Supine 1 and an increase in both Prone 2 and Prone 3 when compared to the baseline. Mean arterial pressure and ocular perfusion pressure were found to be significantly lower in Prone 1, Prone 2 and Prone 3, when compared with the baseline.

* A part of this study was presented at the 46th National Congress of Turkish Ophthalmology Society, October 2012, Antalya, Turkey.
** Corresponding author.
E-mail: barangencer@gmail.com (B. Gencer).

http://dx.doi.org/10.1016/j.bjane.2014.03.005
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Conclusions: Our study has shown increase in intraocular pressure during spinal surgery in prone position. A statistically significant retinal nerve fiber layer thickness thinning was seen in inferior and nasal quadrants one day after the spinal surgery.

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Introduction

Postoperative vision loss (POVL) is a rare but serious complication that may develop after non-ocular surgeries. It most commonly occurs after spinal surgery. The etiology of POVL has been identified as posterior ischemic optic neuropathy (PION), anterior ischemic optic neuropathy (AION) and central arterial occlusion, respectively. A multi-center study demonstrated that male gender, obesity, use of Wilson frame, long duration of anesthesia, excess blood loss and low ratio of colloids administration are the independent risk factors for peroperative ION development after spinal surgery. Changes in ocular perfusion play an important role in the pathogenesis of ischemic optic neuropathy. Ocular perfusion pressure (OPP) is calculated by the subtraction of intraocular pressure (IOP) from mean arterial pressure (MAP). Several studies have demonstrated that spinal surgery in the prone position causes an IOP elevation. It has been speculated that as a result of IOP elevation in the prone position, OPP reduces (in patients where MAP remains stable or reduces) and may lead to AION.

Although IOP changes during spinal surgery in prone position have been well demonstrated, there is no study evaluating the effect of these changes on the optic nerve. Retinal nerve fiber layer thickness (RNFLT) is an important objective marker for early period changes due to optic nerve damage, which in turn is caused by ischemic optic neuropathy and sudden increase in IOP.

In this prospective study, we aimed to determine the early period RNFLT changes in patients undergoing spinal surgery in the prone position and the factors affecting these changes.
Materials and methods

The study was performed with informed patient consent, and conducted under a protocol approved by the local Ethics Committee of Çanakkale Onsekiz Mart University (26.04.2012, 050-99-79) and in accordance with the ethical standards stated in the 1964 Declaration of Helsinki. Participants for the study were enrolled from consecutive patients who underwent spinal surgery between May and November 2012, and whose physical states were I-III in accordance with American Society of Anesthesiologists (ASA).

One day before the surgery, the patients underwent a full ophthalmic examination including visual acuity, slit-lamp exam, IOP measurement using Goldmann applanation tonometry and fundus examination. Patients under 18 year and patients with spherical values ±5 dioptre and/or cylindrical values ±3 dioptre refractory error, glaucoma, uveitis, history of eye surgery, optic nerve anomaly, history of allergy to topical anesthesia, or measurement quality below 5/10 on optic coherence tomography (OCT) were excluded.

The RNFLT were measured one day before and after the surgery by using OTI Spectral OCT/SLO (Ophthalmic Technologies Inc. (OTI), Toronto, Ontario, Canada). OCT scans were made after placing a 3.4mm diameter circular ring around the optic nerve head on image of the confocal scanning laser ophthalmoscopy. The patients’ RNFLT maps were evaluated together with normative RNFLT ratios. The average RNFLT measurements for temporal, superior, nasal and inferior quadrants were collected (Fig. 1).

No premedication was given before anesthesia. Anesthesia was induced with 2 μg/kg fentanyl, and 2.5 mg/kg propofol. Tracheal intubation was facilitated with 0.6 mg/kg rocuronium, and the lungs were mechanically ventilated at 0.5 FiO₂. Anesthesia was maintained with sevoflurane, and remifentanyl 0.15–0.2 μg/kg/min. Additional rocuronium was administered as required. After topical anesthesia (right eye 0.5% proparacaine hydrochloride, 0.5% Alcaine, Alcon) IOP measurements were taken for six times with Tono-Pen AVIA applanation tonometer (Reichert Inc., Depew, NY): before premedication in the supine position (baseline); 10 min after intubation (Supine 1); 10 min (Prone 1), 60 min (Prone 2), 120 min (Prone 3) after being turned to prone position and 10 min after the patient was turned to supine position (Supine 2). Prone position cushions were used to stabilize the patients’ heads in prone position.

Systolic blood pressure (SBP), diastolic blood pressure (DBP), MAP, heart rate (HR), end-tidal carbon dioxide (ET-CO₂) and oxygen saturation (SatO₂) were also recorded simultaneously with IOP measurements. OPP was calculated using the MAP-IOP formula. The anesthesia, prone position and surgery durations were also noted. The amount of blood and liquids given to the patient was measured against blood loss and urine output during the operation to calculate liquid balance ([liquid balance = (given blood + fluids) – (lost blood + urine)]. Preoperative and postoperative hemoglobin (Hb) and hemocrit (Htc) levels were recorded. In the recovery room, the patients were asked whether they had any vision loss or discomfort in their eyes.

![Figure 1](image_url) The comparison of the retinal nerve fiber layer thickness measurements obtained by spectral domain, one day before and after the operation.
Power analysis

The main focus of our study was to determine postoperative RNFLT. The sampling size was determined following a study by Hong et al., where inferior quadrant RNFLT average was reported as 139.9 ± 11.8 μm. The patient number required to determine an average reduction in inferior quadrant RNFLT (with 5% of normal values, 0.05x error and 80% power) was calculated as 30. The sample size was determined by a power calculator.

Statistical analyses

Statistical analyses were performed using the Statistical Package for Social Sciences (SPSS), version 15.0, for Windows (SPSS, Chicago, IL). The Shapiro–Wilk normality test was used to examine the compatibility between the measured variables and the normal distribution. The Wilcoxon test was used to compare pre- and postoperative RNFLT measurements. During the operation the changes in IOP and hemodynamic parameters measured at six different times were later evaluated using the Friedman test. Pairwise comparisons were performed using the Wilcoxon and Mann–Whitney U test. The relationship between RNFLT changes and parameters showing significant changes during the operation were examined using the Spearman correlation test. The data were shown as median (minimum–maximum), and the level of significance was accepted as p < 0.05.

Results

A total of 32 patients underwent spinal surgeries between May and November 2012. Among them, 30 patients were included in our study, while two patients were excluded due to tilted disk. There were 10 male and 20 female patients, with an average age of 54.9 ± 13.4 years. The patient characteristics and properties relating to the operation are summarized in Table 1.

Preoperative and postoperative median values of superior, temporal, inferior and nasal quadrant RNFLT measurements are given in Table 2. There was no significant difference between postoperative and preoperative measurements for superior and temporal quadrants (p > 0.05). However, a statistically significant thinning was observed in inferior (p = 0.009) and nasal quadrants (p = 0.003) (Table 2).

The patients’ IOP and hemodynamic measurements are summarized in Table 3. When compared to the baseline, a reduction in IOP was seen at Supine 1 (p < 0.001).

A statistically significant IOP elevation was observed in Prone 2 (p < 0.001) and Prone 3 (p = 0.01) when compared to baseline values. Hemodynamic changes showed that SBP, DBP and MAP were significantly lower at Prone 1 (p = 0.02, p = 0.03, p = 0.01), Prone 2 (p < 0.001 for all) and Prone 3 (p = 0.001 for all) when compared to baseline. Average OPP values were significantly lower than baseline at Prone 1 (p = 0.01), Prone 2 (p < 0.001) and Prone 3 (p = 0.004). Heart rates were significantly lower at Prone 2 (p = 0.01) and Prone 3 (p = 0.01) when compared to baseline. At all times, SpO2 values were significantly higher when compared to baseline (Supine 1 and Prone 2; p < 0.001, Prone 1 and Supine 2; p = 0.001, Prone 3; p = 0.005). Calculated liquid balance for all patients was positive, and average values were 1325 (550–3000) mL. Preoperative and postoperative average Hb values were 13.2 (11–16.3) g/dL and 11.1 (8.1–14.1) g/dL, respectively; while Htc values were 39.3 (33.8–48.7) g/dL and 34.2 (25–43.1) g/dL. The reductions in postoperative Hb and Htc values were statistically significant (p < 0.001 for both).

No significant correlation was found between the amount of RNFLT thinning and patients age, BMI, anesthesia duration, blood loss, and administered colloid amount, changes of IOP and OPP during the operation (p > 0.05) (Table 4).

Discussion

This prospective study aimed to examine changes in RNFLT and factors affecting those changes in patients who underwent spinal surgery in the prone position. When we evaluated the changes in RNFLT measured by SD-OCT, we observed a thinning in the inferior and nasal quadrants on the first postoperative day compared to preoperative
measurements. We observed a significant increase in IOP in the prone position while there was a significant decrease in hemodynamic factors. However, we did not find any correlation between the changing of all parameters during the operation and the RNFL thinning.

POVL, occurring after spinal surgery in the prone position is a serious complication which has been linked, in order of decreasing frequency, to posterior ION, anterior ION and central artery occlusion, but its etiology is still not well understood. It has been proposed that IOP elevation in the prone position reduces ocular perfusion, especially in cases whose MAP remains stable, thereby causing anterior ION or central retinal arterial occlusion.

The first study investigating IOP changes in spinal surgery in the prone position was carried out by Cheng et al. They observed a significant IOP elevation at the beginning (27 ± 2 mmHg) and at the end (40 ± 2 mmHg) of the operation in the prone position when compared with baseline values (19 ± 1 mmHg) measured in the supine position. However, they did not investigate intraoperative IOP changes. In another study evaluating patients who underwent spinal surgery, it was found that the average IOP values in the supine position after anesthesia induction were 11.5 mmHg, while in the prone position at the beginning and at the end of surgery IOP values were 23.5 mmHg and 30.5 mmHg, respectively. They determined that in the prone position, these values were significantly higher than in the supine position. In various studies using healthy volunteers, IOP values in the prone position were found to be significantly higher than in the sitting position.

To the best of our knowledge, this study is the most comprehensive study till date investigating IOP changes in the prone position. IOP was measured in the prone position at the 10th, 60th and 120th minutes of operation. We found that IOP was highest at the 60th minute, and it reduced slightly at the 120th minute, which was still significantly higher than baseline values. While our study on IOP changes during the operation has a variation curve similar to other studies, any differences may be linked to erroneous high measurements due to excessive eyelid opening or pressure on the globe.

Spectral domain OCT provides reliable and repeatable measures of the nerve fiber layer of the optic nerve at the level of 7–15 μm. These properties have led it to becoming the most important diagnostic tool for early diagnosis and follow-up for disorders involving the front part of the visual pathway. In a previous study, interoperator (intraclass correlation coefficient (ICC), 0.87; CV, 2.8%) and intraoperator (ICC, 0.94 and 0.95; CV, 1.28% and 1.26%, respectively, for operator A and operator B) agreement have been found for average RNFL thickness measurements using OTI Spectral OCT/SLO.

This study is the first in the literature to evaluate RNFL changes following spinal surgery in the prone position. On the first postoperative day, a significant thinning was

<table>
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<th>Table 3</th>
<th>Intracocular pressure, blood pressure (systolic, diastolic, mean), ocular perfusion pressure and heart rate measurements during operation.</th>
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<tr>
<td></td>
<td>IOP (mmHg)</td>
</tr>
<tr>
<td>Baseline (n = 30)</td>
<td>15 (7-20)</td>
</tr>
<tr>
<td>Supine 1 (n = 30)</td>
<td>10 (5-24)&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Prone 1 (n = 30)</td>
<td>14.5 (6-31)</td>
</tr>
<tr>
<td>Prone 2 (n = 30)</td>
<td>19 (10-37)&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Prone 3 (n = 18)</td>
<td>15 (11-35)&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Supine 2 (n = 30)</td>
<td>15.5 (9-32)</td>
</tr>
</tbody>
</table>

Variables are shown as the median (range). IOP, intraocular pressure; SBP, systolic blood pressure; DBP, diastolic blood pressure; MAP, mean arterial pressure; OPP, ocular perfusion pressure; HR, heart rate.

<sup>a</sup> p < 0.05, compared with baseline value, Wilcoxon signed ranks test.

<table>
<thead>
<tr>
<th>Table 4</th>
<th>The correlations between inferior and nasal quadrants’ retinal nerve fiber layer thickness changes and patients variables.</th>
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</thead>
<tbody>
<tr>
<td>Variables (n = 30)</td>
<td>Inferior quadrant change</td>
</tr>
<tr>
<td></td>
<td>r²</td>
</tr>
<tr>
<td>Age</td>
<td>−0.13</td>
</tr>
<tr>
<td>BMI</td>
<td>−0.02</td>
</tr>
<tr>
<td>Anesthesia duration</td>
<td>0.22</td>
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<tr>
<td>Blood loss</td>
<td>0.07</td>
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<tr>
<td>Colloid infusion</td>
<td>−0.09</td>
</tr>
<tr>
<td>IOP change (Prone 2 — baseline)</td>
<td>0.25</td>
</tr>
<tr>
<td>OPP change (Prone 2 — baseline)</td>
<td>−0.14</td>
</tr>
</tbody>
</table>

<sup>a</sup> Spearman’s rank correlation.

BMI, body mass index; IOP, intraocular pressure; OPP, ocular perfusion pressure.
observed in the inferior and nasal quadrants. While there was a significant rise in IOP in the prone position, there was a significant decrease in hemodynamic factors. However, no significant correlation was found between patients' age, BMI, anesthesia duration, blood loss or given colloids, IOP or OPP changes and thinning in RNFL. Similarly, Fortune et al. showed that acute IOP increase caused RNFL thinning in rat eyes, and this thinning returned to normal values after a month. Piette et al. found that acute IOP increase caused by suction in LASIK patients, which resulted in a statistically significant thinning of RNFLT, and even after IOP values returned to normal this thinning remained. In another study, all GDx parameters except for symmetry showed statistically significant reduction on the first postoperative day in patients who underwent coronary artery bypass operation. By the 5th postoperative day, superior/nasal ratio parameters returned to normal values, however, by the first postoperative month the inferior ratio values were still under normal values. This study supports our results showing that the inferior quadrant retinal nerve fibers are more sensitive.

Although the number of patients in our study is comparable to similar studies, low patient number is the most important limitation. Another limitation was the lack of long-term follow-ups. The progress of RNFLT changes was not evaluated in this study.

In conclusion, spinal surgical interventions in the prone position lead a significant inferior and nasal quadrants thinning in RNFL at the early postoperative period even though patients do not suffer from vision loss. But there was not found any significant correlation between the amount of RNFLT thinning and changes of IOP during the operation in this study. Larger controlled studies with longer follow-up will be required to fully determine the role of prone position on RNFLT changes.

Conflicts of interest

The authors declare no conflicts of interest.

References