Retinal Nerve Fiber Layer Defects in Highly Myopic Eyes with Early Glaucoma

Yugo Kimura, Masanori Hangai, Satosbi Morooka, Kobei Takayama, Noriko Nakano, Masayuki Nukada, Hanako Ohashi Ikeda, Tadamichi Akagi, and Nagahisa Yoshimura

PURPOSE. To compare the retinal nerve fiber layer (RNFL) defects in early glaucomatous eyes between highly and non–highly myopic eyes.

METHODS. Sixty-one highly myopic eyes (< −6.0 diopters [D]) of 61 patients and 55 non–highly myopic eyes of 55 patients with early visual field (VF) defects were studied. The angular locations and widths of the RNFL defects were measured from red-free fundus photographs. The RNFL defect closest to the fovea was designated the “nearest RNFL defect” of each hemisphere.

RESULTS. In total, 131 RNFL defects were found in highly myopic eyes and 82 in non–highly myopic eyes. Twenty-seven (44.3%) of the 61 highly myopic eyes, but only 8 (14.5%) of the 55 non–highly myopic eyes had their nearest RNFL defects between 0° and 10° (P < 0.001). Although the frequencies of paracentral scotomas were comparable between the two groups, the rate of inferotemporal paracentral scotomas was significantly higher in the high myopia group (P = 0.02). The numbers of nearest RNFL defects in the superior hemisphere or extending over both hemispheres were significantly higher in the high-myopia group. Multiple logistic regression analyses showed that high myopia and the nearest RNFL defect involving the papillomacular bundle were significantly associated with paracentral scotomas (odds ratio [OR]: 4.78, P < 0.05, and OR: 5.31, P < 0.001, respectively). High myopia was significantly associated with the nearest RNFL defect involving the papillomacular bundle (OR: 2.95, P < 0.05).

CONCLUSIONS. These findings suggest that highly myopic eyes are more susceptible to papillomacular bundle damage in early glaucoma. (Invest Ophthalmol Vis Sci. 2012;53:6472–6478) DOI:10.1167/iovs.12-10319

Visual field (VF) defects in early glaucoma are usually detected peripherally (e.g., nasal step or arcuate scotomas). Although the paracentral area is usually spared until the end stages of glaucoma, some patients develop paracentral scotomas threatening fixation during early stage glaucoma, and are at greater risk for impaired quality of vision.1–3 Risk factors for developing paracentral scotomas are normal-tension glaucoma (NTG),1,5 low maximum untreated IOPs,6 frequent disc hemorrhage,8 systemic factors,6 and high myopia.7–9

Myopia is highly prevalent in East Asia10–12 and is a risk factor for glaucoma.13 In advanced glaucoma, higher myopia has been associated with significantly higher frequencies of cecocentral scotomas located just temporal and inferior to the fixation point.14,15 However, VF defects characteristic of high myopia have not been properly studied in early glaucoma,16 and whether highly myopic eyes are at greater risk for impaired paracentral vision during early glaucoma is unknown.

Atypical retinal nerve fiber layer (RNFL) defects, including papillomacular bundle defects, are found in highly myopic eyes with primarily moderate-to-severe VF defects. Longer axial length, larger optic disc, and NTG are risk factors for papillomacular bundle defects.7 Whether or not the frequency of such RNFL defects is greater in patients with highly myopic eyes in early-stage glaucoma remains unknown. Because the RNFL defects often precede the VF defects17–19 RNFL defects are useful indicators of the locations of early glaucomatous damage.20 Measurement of the angular location and size of RNFL defects should allow quantitative comparison of RNFL defects between eyes with and without high myopia.21–23

We have investigated the rate of papillomacular bundle defects in highly myopic eyes compared with non–highly myopic eyes during early-stage glaucoma by determining the angular locations and widths of RNFL defects in highly and non–highly myopic eyes with early-stage glaucoma.

METHODS

Participants

Medical records of patients who were examined at the Glaucoma Clinic of the Department of Ophthalmology, Kyoto University, Kyoto, Japan from October 2007 to April 2011 were reviewed. All participants underwent complete ophthalmic examinations, including best-corrected visual acuity (BCVA) with a 5-meter Landolt chart, refraction, slit-lamp biomicroscopy, IOP measurements with a Goldmann applanation tonometer, gonioscopy, axial length measurements by partial laser interferometry (IOL master; Carl Zeiss Meditec, Dublin, CA), dilated biomicroscopic examination, stereoscopic color optic disc photography (with a 3-Dx simultaneous stereo disc camera; Nidek, Gamagori, Japan), red-free fundus photography with a Heidelberg Retina Angiogram 2 (HRA2; Heidelberg Engineering, Heidelberg, Germany), Heidelberg Retina Tomography 2 (HRT 2; Heidelberg Engineering), and standard automated perimeter (SAP) using the Swedish interactive threshold algorithm standard 24-2 with a Humphrey Visual Field Analyzer (Carl Zeiss Meditec). The refractive error was converted to

From the Department of Ophthalmology and Visual Sciences, Kyoto University Graduate School of Medicine, Kyoto, Japan.

Supported in part by grants from Grant-in-Aid for Scientific Research (20592038) from the Japan Society for the Promotion of Science (JSPS).

Submitted for publication June 2, 2012; revised August 15, 2012; accepted August 15, 2012.

Disclosure: Y. Kimura, None; M. Hangai, NIDEK (F, C, S), Topcon (F, C), Heidelberg Engineering (R), Santen (I); S. Morooka, None; K. Takayama, None; N. Nakano, None; M. Nukada, None; H.O. Ikeda, None; T. Akagi, None; N. Yoshimura, NIDEK (F, C, S), Topcon (F, C), Heidelberg Engineering (R), Canon (F)

Corresponding author: Masanori Hangai, Department of Ophthalmology and Visual Sciences, Kyoto University Graduate School of Medicine, 54 Kawahara-cho, Shogoin, Sakyo-ku, Kyoto 606-8507, Japan; hangai@kuhp.kyoto-u.ac.jp.
RNFL Defects in Glaucoma and High Myopia

Definition of Visual Field Defects

To investigate the relationship between the locations of RNFL defects and patterns of VF defects in eyes with early glaucoma, glaucomatous VF defects were classified as paracentral or nonparacentral scotomas as previously reported, with modifications. Paracentral scotoma was defined as a glaucomatous VF defect in one hemifield outside of the central 10° of fixation with at least one point at P less than 1% lying on the outer 10° of fixation. The number of eyes with paracentral scotoma with abnormal test points at P less than 1% within the central 5° in each quadrant (superior temporal, superior nasal, inferior temporal, and inferior nasal) or hemisphere (superior and inferior) were also counted.

Optic Disc Measurements with HRT 2

Heidelberg Retina Tomography 2 (HRT 2) images were obtained from undilated pupils. The area of the optic disc was measured in all eyes by using the built-in HRT 2 software (Heidelberg Engineering, Heidelberg, Germany) according to published techniques. The measurement was included in analysis only if the SD of the mean topographic image was less than 5% of the normal reference values confirmed by at least two

the spherical equivalent refractive error. The IOP of each eye was taken from the average IOP of the last three examinations.

All procedures adhered to the tenets of the Declaration of Helsinki, and the study was approved by the institutional review board and ethics committee of Kyoto University Graduate School of Medicine.

The inclusion criteria were BCVA of greater than or equal to 20/20 in Snellen equivalents, normal anterior chamber, normal open angle by gonioscopy, presence of RNFL defects on red-free fundus photographs consistent with the glaucomatous appearance of the optic disc (i.e., diffuse or localized neuroretinal rim thinning on stereoscopic color fundus photographs), and early VF defects (mean deviation < -6 dB) that were consistent with the glaucomatous optic disc appearance. The exclusion criteria were hazy media, evidence of vitreoretinal diseases or pathologic myopic fundus changes (e.g., patchy chorioretinal atrophy, lacquer crack lesions, intrachoroidal cavitation, an abrupt change in the scleral curvature temporal to the optic disc, or choroidal neovascularization), and previous ocular surgery. Patients with diabetes mellitus, poorly controlled hypertension, or other systemic disease, or neurological diseases that might cause VF defects or RNFL damage were also excluded. When both of a patient's eyes were eligible, one eye was randomly selected for analysis.

Eyes with refractive errors less than –6.0 diopter (D) were assigned to the high-myopia group and those with refractive errors greater than or equal to –6.0 D to the non-high-myopia group.

Optic Disc Measurements with HRT 2

Heidelberg Retina Tomography 2 (HRT 2) images were obtained from undilated pupils. The area of the optic disc was measured in all eyes by using the built-in HRT 2 software (Heidelberg Engineering, Heidelberg, Germany) according to published techniques. The measurement was included in analysis only if the SD of the mean topographic image was
less than 40 μm. An experienced examiner, masked to the other findings, outlined the optic disc margin manually while viewing fundus color photographs. Magnification errors were corrected by the HRT2 software using the patient’s refractive error and corneal curvature.

**Measurements of Optic Disc Ovality**

To define tilted disc, the degree of tilting is customarily estimated by the disc ovality index, which is the ratio of the minimum to the maximum optic disc diameter. An examiner examined color fundus photographs of the optic disc taken at a 45° viewing angle and plotted 14 points along the disc margin. Software developed by our group automatically drew an ellipse along the contour of the optic disc to determine centers of gravity and maximum and minimum diameters of each optic disc. Disc ovality indexes were calculated as the ratios of the minimum to the maximum diameters.

**Statistical Analyses**

Differences in continuous values between groups were determined by unpaired *t*-tests or Mann-Whitney *U* tests. The effect of age was offset by analysis of a covariance model that included age as the covariance factor. Differences in categorical variables were evaluated by *χ*² tests. The Kolmogorov-Smirnov test was used to determine whether the angular locations of RNFL defects were normally distributed. Cohen’s *κ* coefficient was calculated to estimate interobserver agreement for highly myopic eyes, and the ICC for non–highly myopic eyes. Eight eyes with high myopia and six eyes with non–high myopia were also excluded after random selection of their fellow eye in patients with two eligible eyes. Ten eyes with high myopia and four without high myopia were excluded because group discussion did not reach agreement as to the presence of RNFL defects. Finally, data from 61 eyes of 61 patients with high myopia and 55 eyes of 55 patients with non–high myopia were analyzed.

Patient demographics and optic disc characteristics are shown in Table 1. Age, spherical equivalent refractive error, and axial length differed significantly between eyes with and without high myopia. Sex distribution, mean IOP during follow-up, mean deviation (MD) and PSD did not differ significantly between the groups. The high-myopia group had significantly lower ovality indices. Disc area did not differ significantly between the groups.

**Retinal Nerve Fiber Layer Defect Measurements**

Interevaluator agreement, as represented by the Cohen *κ* value, for the number of RNFL defects was 0.80 for all eyes, 0.78 for highly myopic eyes, and 0.81 for non–highly myopic eyes. The ICC for the angular location was 0.93 for all eyes, 0.94 for highly myopic eyes, and 0.93 for non–highly myopic eyes. The ICC for the angular width was 0.85 for all eyes, 0.89 for highly myopic eyes, and 0.85 for non–highly myopic eyes. These findings indicate good reliability in the detection and measurement of RNFL defects.

A total of 131 RNFL defects were found in eyes with high myopia and 82 in eyes without high myopia. After adjustment for age and MD, the mean number of RNFL defects per eye was significantly higher, the mean angular location of all RNFL defects significantly lower, and the total width of the RNFL defects significantly larger in the high-myopia group than in the non–high-myopia group (Table 2).

**Frequency Distribution and Angular Location and Width of Nearest RNFL Defects**

The frequency distributions according to the angular locations (in 10° steps) of the nearest retinal nerve fiber layer defects were plotted separately for high-myopia and non–high-myopia groups (Fig. 2). The angular locations of the non–high-myopia group were normally distributed (P = 0.20), with a peak angular location between 21° and 30° (17 of 55 eyes, 30.9%). The angular locations of the high-myopia group were not

---

**Table 1. Subject Demographics and Optic Disc Characteristics**

<table>
<thead>
<tr>
<th></th>
<th>High Myopia (n = 61)</th>
<th>Non–High Myopia (n = 55)</th>
<th><em>P</em> Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>44.7 (11.3)</td>
<td>55.5 (12.8)</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Female/Male</td>
<td>36/25</td>
<td>39/16</td>
<td>0.14†</td>
</tr>
<tr>
<td>Spherical equivalent (D)</td>
<td>−8.8 (2.3)</td>
<td>−2.0 (2.2)</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Axial length (mm)</td>
<td>27.1 (1.3)</td>
<td>24.5 (1.2)</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Mean follow-up IOP (mm Hg)</td>
<td>15.9 (2.4)</td>
<td>15.5 (2.4)</td>
<td>0.27*</td>
</tr>
<tr>
<td>MD (dB)</td>
<td>−3.5 (1.5)</td>
<td>−3.1 (1.7)</td>
<td>0.09*</td>
</tr>
<tr>
<td>PSD (dB)</td>
<td>4.8 (2.2)</td>
<td>5.3 (2.5)</td>
<td>0.19*</td>
</tr>
<tr>
<td>Disc area (mm²)</td>
<td>2.3 (0.82)</td>
<td>2.5 (0.5)</td>
<td>0.99*</td>
</tr>
<tr>
<td>PPA area (mm²)</td>
<td>2.1 (1.4)</td>
<td>0.83 (0.8)</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Ovality index</td>
<td>0.78 (0.12)</td>
<td>0.83 (0.08)</td>
<td>0.03*</td>
</tr>
</tbody>
</table>

Decimal values are expressed as the mean with SD in parentheses.

* Unpaired *t*-test.
† *χ*² test.
normally distributed ($P < 0.001$) and peaked between $0^\circ$ and $10^\circ$. Twenty-seven of 61 (44.3%) highly-myopic eyes and 8 of 55 (14.5%) non–highly-myopic eyes had nearest RNFL defects between $0^\circ$ and $10^\circ$ ($P < 0.001$). The number of eyes with nearest RNFL defects involving the papillomacular bundle (i.e., those within $20^\circ$ of the reference line) was significantly higher ($P = 0.002$) in highly myopic (34 eyes, 55.7%) than in non-highly-myopic (15 eyes, 27.2%) eyes.

Figure 3 shows examples of cases with high myopia, in which the nearest RNFL defect involved the papillomacular bundle. After adjustment for age and MD, the mean angular locations of the nearest RNFL defects were significantly lower in the eyes with high myopia (Table 3). In contrast, the mean widths of the nearest RNFL defects did not differ significantly between the two groups (Table 3). The proportion of nearest RNFL defects involving the papillomacular bundle was significantly larger in high myopia (Table 3).

### Abnormal Paracentral Points and Nearest RNFL Defects in Eyes with Paracentral Scotomas

Paracentral scotomas were found in 29 (47.5%) eyes with high myopia and 28 (50.9%) eyes without high myopia ($P = 0.72$). In eyes with paracentral scotoma, the mean number of VF test points at $P$ less than 1% per eye did not differ significantly ($P = 0.46$) between high (mean number = 1.77) and non–high myopia (mean number = 1.50) groups. However, comparison of the locations of the abnormal test points at $P$ less than 1% showed that the number of eyes with abnormal test points in the inferior temporal quadrant was significantly higher ($P = 0.02$) in the high-myopia group (Table 4).

The number of nearest RNFL defects in the superior hemisphere, but not that in the inferior hemisphere, was significantly higher in the high-myopia group (Table 5). Nearest RNFL defects extending over both hemispheres were rare in eyes without high myopia (7.1%) but were significantly more frequent in eyes with high myopia (41.3%).

### Univariate and Multivariate Analyses

Nearest RNFL defects located within the papillomacular bundle were significantly associated with the presence of paracentral scotoma in both univariate ($P < 0.01$) and multivariate (odds ratio [OR]: 5.56, 95% confidence interval [CI]: 2.17–14.2, $P < 0.001$) logistic regression analyses. High myopia was also significantly associated with the presence of a paracentral

| Table 2. Comparison of All RNFL Defects between High Myopia and Non–High Myopia |
|---------------------------------|-----------------|----------------|-----------------|---------|
| Mean number of RNFL defects per eye | 2.1 (1.1) | 1.5 (0.8) | $<0.001$ | 0.006 |
| Angular location of each RNFL defect (degrees) | 24.4 (20.0) | 35.4 (17.9) | $<0.001$ | 0.008 |
| Angular width per RNFL defect (degrees) | 21.2 (11.9) | 21.1 (11.0) | 0.51 | 0.958 |
| Total angular width per eye (degrees) | 45.4 (24.4) | 31.4 (17.4) | $<0.001$ | 0.02 |

* Mann-Whitney $U$ test.
† Analysis of covariance.

**TABLE 2. Comparison of All RNFL Defects between High Myopia and Non–High Myopia**

Decimal values are expressed as the mean with SD in parentheses.

Figure 2. Frequency distributions of the angular locations (degrees) of the nearest RNFL defects in eyes with high and non–high myopia. *$P < 0.01$ ($\chi^2$ test). The number of eyes in which the nearest RNFL defect was detected within the corresponding range was plotted for each angular location.
scotoma in multivariate logistic regression analysis (OR: 3.08, 95% confidence interval [CI]: 1.14–8.33, \( P = 0.03 \)). High myopia and tilted disc were significantly associated with nearest RNFL defects located within papillomacular bundle on both univariate (high myopia, \( P = 0.001 \); tilted disc, \( P = 0.01 \)) and multivariate (high myopia, OR: 3.72, 95% CI: 1.64–8.45, \( P = 0.002 \); tilted disc, OR: 2.73, 95% CI: 1.13–6.61, \( P = 0.03 \)) logistic regression analyses.

**DISCUSSION**

The frequency distribution profile of the angular locations of the nearest RNFL defects differed significantly between eyes with and without high myopia; 44.3% and 55.7% of highly myopic eyes had their nearest RNFL defects in the central region (≤10°) and over the papillomacular bundle region (≤20°), respectively, versus 14.5% and 27.2% of non–highly myopic eyes. Therefore, measurement of the angular locations of RNFL defects was useful to demonstrate the unusual distribution profile of early glaucomatous RNFL damage in eyes with high myopia.

The frequency distribution of the angular locations of RNFL defects in eyes without high myopia has been previously reported. Lee et al.\(^2\) showed that RNFL defects detected on red-free photographs were most commonly found in the 7 to 11 o’clock sectors. Leung et al.\(^29\) reported that the RNFL measured by Cirrus HD-OCT (Carl Zeiss-Meditec) was thinnest in the inferotemporal meridians between 72° and 90°. The results from our non–high myopia group are nearly consistent with those of these earlier studies. The high frequency of papillomacular bundle defects, therefore, appears to be characteristic of highly-myopic eyes.

Although the angular locations of the RNFL defects differed significantly between eyes with and without high myopia, the rate of paracentral scotomas in early glaucomatous eyes did not, nor did the mean number of abnormal points at \( P < 1\% \) affecting the 4 paracentral points in eyes with paracentral scotomas. However, paracentral scotomas were found in the inferior temporal quadrant significantly more often in the eyes with high myopia. Araie et al.\(^14\) and Mayama et al.\(^15\) reported that higher myopia was significantly associated with VF damage just temporal and inferior to the fixation point in advanced glaucomatous eyes. Our results agree with theirs, and we further suggest that these lower cecocentral VF defects develop more frequently in highly myopic eyes than in non–highly myopic eyes, even in early stage glaucoma.

Nearest RNFL defects located in the superior hemisphere and/or extending over both hemispheres were found more

**TABLE 3. Comparison of Angular Location and Width of Nearest RNFL Defects**

<table>
<thead>
<tr>
<th></th>
<th>High Myopia (( n = 61 ))</th>
<th>Non-High Myopia (( n = 55 ))</th>
<th>( P ) Value</th>
<th>( P ) Value Adjusted for Age and MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angular location (degree) of nearest RNFL defects, mean (SD)</td>
<td>14.9 (19.0)</td>
<td>28.9 (18.3)</td>
<td>&lt;0.001*</td>
<td>0.003‡</td>
</tr>
<tr>
<td>Angular width (degree) of nearest RNFL defects, mean (SD)</td>
<td>22.9 (12.0)</td>
<td>22.2 (12.0)</td>
<td>0.71*</td>
<td>0.98‡</td>
</tr>
<tr>
<td>Nearest RNFL defects involving papillomacular bundle, number (%)</td>
<td>34 (55.7)</td>
<td>14 (25.5)</td>
<td>&lt;0.001‡</td>
<td>NA</td>
</tr>
</tbody>
</table>

Decimal values are expressed as the mean with SD in parentheses.

* Mann-Whitney U test.
† \( \chi^2 \) test.
‡ Analysis of covariance.
frequently in the high-myopia group in the current study. Multiple logistic regression analysis indicated that papillomacular bundle defects were significantly associated with paracentral scotomas. Therefore, a higher rate of papillomacular bundle defects involving the superior hemisphere appears to be related to a higher frequency of inferotemporal paracentral scotomas in highly myopic eyes.

An inferior paracentral scotoma can significantly affect a patient’s quality of life, and it is important to detect these abnormalities. RNFL defects are often detected earlier than VF defects, and detection of superior papillomacular bundle defects could be useful to predict development of inferotemporal paracentral scotomas.

Seven of the highly myopic eyes without papillomacular bundle defects in the present study had paracentral scotomas, while 12 highly myopic eyes with papillomacular bundle defects lacked paracentral scotomas. Thus, the paracentral scotomas detected by SAP and papillomacular bundle defects did not completely match. A possible reason for this discordance is that RNFL defects that do not involve the papillomacular bundle can also cause paracentral scotomas, particularly in the nasal paracentral points. Another possibility is that because RNFL defects precede VF defects, these mechanisms would be worthwhile.

The present study has limitations. Detection of RNFL defects can be affected by a tessellated fundus. We used red-free photography, which is better than color fundus photography for detecting RNFL defects, even in eyes with tessellated fundus, and our interobserver agreement for detection and measurement of RNFL defects was acceptable. Second, we did not match the ages of the eyes with and without high myopia. We included eyes with early VF defects because we believed that matching the severity of glaucoma would be more important for the purpose of this study. However, intergroup differences in RNFL defect measurements remained significant even after adjustment for age.

Greater attention should be paid to searching for RNFL defects involving the papillomacular bundle in highly myopic eyes with early VF defects. Papillomacular bundle defects are less evident than inferotemporal and superotemporal RNFL defects, and because it is not practical to perform VF testing for all patients with high myopia as a screening for glaucoma in general eye clinics, detection of RNFL defects will let us know that the patient requires VF testing and monitoring for progressive RNFL damages and VF defects. Detection of papillomacular bundle defects and/or paracentral scotoma also provides an opportunity to select or add SAP10-2 testing, to consider more frequent VF testing, and to consider changes in the level of treatment, improving overall care for these patients.

In conclusion, papillomacular bundle defects and inferotemporal paracentral scotomas were more frequent in highly myopic than in non-high myopic early glaucomatous eyes. The papillomacular bundle defects were associated with paracentral scotomas. Multiple logistic regression analyses confirmed high myopia as a risk factor for papillomacular bundle defects and paracentral scotomas. Longitudinal studies are needed to development/enlargement of PPA occurred in children with myopic shift. Their findings indicated that the lamina cribrosa, though to be a principal site of glaucomatous damages, also shifts to the nasal direction in eyes with a tilted disc. This myopic tilting of the optic disc may generate tensile stretch of the temporal side of the lamina cribrosa and the RGC axons in the papillomacular bundle. The significant association between tilted discs and papillomacular bundle defects in our study may support this speculation. The following two recent studies showed focal lamina cribrosa defects associated with VF defects in eyes with glaucoma and in eyes with pathologic myopia: Kiumehr et al. reported that focal lamina cribrosa defects detected in eyes with glaucoma spared the temporal and nasal 45° sectors, but Ohno-Matsui et al. reported that 31.6% of lamina cribrosa defects (acquired optic nerve pits) found in high myopia were located along the temporal edge of the lamina cribrosa, indicating that this area may be susceptible to mechanical stress in high myopia. Further studies regarding these mechanisms would be worthwhile.

**Table 4. Number of Eyes with Abnormal Visual Field Points at P Less than 1% Affecting At Least One Paracentral Point in Each Quadrant and Hemisphere in Eyes with and without High Myopia**

<table>
<thead>
<tr>
<th>Quadrant</th>
<th>High Myopia (n = 29)</th>
<th>Non–High Myopia (n = 28)</th>
<th>P Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superior nasal</td>
<td>26 (89.7%)</td>
<td>23 (82.1%)</td>
<td>0.46</td>
</tr>
<tr>
<td>Superior temporal</td>
<td>9 (31.0%)</td>
<td>14 (50.0%)</td>
<td>0.18</td>
</tr>
<tr>
<td>Inferior nasal</td>
<td>7 (24.1%)</td>
<td>3 (10.7%)</td>
<td>0.18</td>
</tr>
<tr>
<td>Inferior temporal</td>
<td>9 (31.0%)</td>
<td>2 (7.1%)</td>
<td>0.02</td>
</tr>
</tbody>
</table>

**Table 5. Number of Eyes with Nearest RNFL Defects in the Superior, Inferior, and across Both Hemispheres in Eyes with Paracentral Scotoma**

<table>
<thead>
<tr>
<th>Hemisphere</th>
<th>High Myopia (n = 29)</th>
<th>Non–High Myopia (n = 28)</th>
<th>P Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superior hemisphere</td>
<td>16 (55.2%)</td>
<td>4 (14.3%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Inferior hemisphere</td>
<td>25 (86.2%)</td>
<td>26 (92.9%)</td>
<td>0.67</td>
</tr>
<tr>
<td>Across both hemispheres</td>
<td>12 (41.3%)</td>
<td>2 (7.1%)</td>
<td>0.003</td>
</tr>
</tbody>
</table>

Values indicate the number (%) of eyes with nearest RNFL defects in each location. * χ² test.
determine the progression of these central vision-threatening RNFL defects in highly myopic eyes.

References


