Stargardt disease (STGD1) is the most common form of juvenile macular degeneration. The onset of visual symptoms usually occurs in the teenage years with progressive loss of central vision. The prevalence of STGD1 has been estimated at between 1 in 8000 and 1 in 10,000. A number of therapeutic trials for this disease, including those involving small molecule-, gene- and stem cell-based therapies, have recently commenced enrollment, although debate still exists on which small molecule–, gene– and stem cell–based therapies, have recently commenced enrollment, although debate still exists on which small molecule–, gene– and stem cell–based therapies, have recently commenced enrollment, although debate still exists on which small molecule–, gene– and stem cell–based therapies, have recently commenced enrollment, although debate still exists on which small molecule–, gene– and stem cell–based therapies, have recently commenced enrollment, although debate still exists on which small molecule–, gene– and stem cell–based therapies, have recently commenced enrollment, although debate still exists on which
of the same age. The emission spectra of fundus AF in STGD1 patients was similar in shape to normal subjects, there being a broad emission maximum in the 620- to 640-nm range.26 Detection and assessment of abnormal AF patterns by confocal scanning laser ophthalmoscopy (cSLO) have proven helpful for diagnosing ABCA4 disease and allow progression to be monitored.22–25 Several investigators have used cSLO images to assess AF intensities in retinal dystrophies and have shown that patients with ABCA4 disease have elevated AF levels.20,21,24 However, because of inherent variability’s in acquired AF images, even with a strict and standardized imaging protocol, comparisons amongst patients can be challenging.25

We recently reported a novel method, quantitative autofluorescence (qAF), for quantifying AF in images acquired with a cSLO.26 This methodology incorporates a fluorescence reference internal to the imaging device in such a way that the reference is part of the AF image. Analysis then consists of comparing the gray levels (GLs) in the AF image with the GL of the internal reference, accounting thereby for changes in laser power and detector sensitivity. Furthermore, the methodology includes corrections for magnification and optical media density from normative data on lens transmission spectra. This approach when used together with a standardized image acquisition protocol allows reproducible quantification of AF levels in individual patients, interpatient comparison, and monitoring of AF levels longitudinally. It would also permit the comparison of data acquired on different devices at several centers. Here we apply qAF to a cohort of genetically confirmed STGD1 patients and compare the qAF values with normal control subjects.

Materials and Methods

Patients

Patients were prospectively recruited at the Edward S. Harkness Eye Institute, Columbia University. The study cohort consisted of 42 patients (23 females) from 37 families. All patients had a complete dilated eye exam and the clinical diagnosis of STGD1 was confirmed by a retinal specialist (SHT, RTS). Clinical, demographic, and genetic data for all patients are presented in Table 1. All patients had at least one known disease-causing mutation in the ABCA4 gene and 85% had mutations on both chromosomes. Patients were aged between 7 and 52 years (median age: 28.8 years), and had eyes with refractions between −9 and +6 diopters (D) ranging corresponding to control group described below). Thirty-nine patients were of European ancestry and there was one each of African American, Hispanic, and Indian origin. Duration of disease at the time of examination (time since first diagnosis) was 1 to 31 years (median: 6.8 years) and the age at first diagnosis was 4 to 51 years (median: 15.5 years). Control values consisted of previously published data from 277 healthy subjects (374 eyes; age range, 5–60 years).27

Based on color and fundus AF images, patients were assigned to one of three phenotype groups according to the classification of Fishman:26 Fishman I, atrophy, and flecks predominantly restricted to the central region around the fovea; Fishman II, flecks throughout the posterior pole, which often extended anterior to the vascular arcades and/or nasal to the optic disc; and Fishman III, “resorbed” flecks with widespread atrophy of the RPE. The study population included only a few patients with advanced disease: 24 patients were classified as Fishman I, 12 as Fishman II, and six as Fishman III.

The study was carried out with the approval of the Institutional Review Board of Columbia University (IRB-AAA9096), and all patients were enrolled in accordance with the tenets set out in the Declaration of Helsinki. Informed consent was obtained prior to enrollment.

Genotyping

The genotyping microarray (ABCR600; Asper Ophthalmics, Tartu, Estonia),29 which detects all known mutations in the ABCA4 gene (currently 632; Asper Biotech, Inc., www.asperbio.com, in the public domain), was used for initial screening of most patients. Mutations were confirmed by direct Sanger sequencing. In some cases where no mutations were detected by the array, or in more recently recruited patients, the next generation sequencing of the entire ABCA4 open reading frame and adjacent intronic sequences was performed on the Roche 454 platform.30

The four most common mutations found in six or more patients were: G1961E (12 patients from 11 families); L541P/A1038V (eight patients from five families); L2027F (six patients from five families); and P1380L (six patients from six families). Four other mutations were found in two to four patients: R1640W (four patients from three families); Y1557C (two patients from one family); G851D (two patients from one family); and R2030Q (two patients from two families). For the purposes of analyses reported below, we will refer to those eight mutations as the “more common mutations.” In two patients (two families), A1038V was present in a compound heterozygous state with other mutations while not as a complex allele with L541P (Table 1).

Image Acquisition

Autofluorescence images were acquired by three experienced operators (TRB, TD, JPG) using a cSLO device (Spectralis HRA-OCT; Heidelberg Engineering, Heidelberg, Germany) that had been modified by the insertion of an internal fluorescent reference. Pupils were dilated with 1% tropicamide and 2.5% phenylephrine to at least 7 mm in diameter. With room lights turned off, a near-infrared reflectance image (NIR-R; 787 nm) was recorded first. After switching to AF mode (488 nm excitation; beam power <260 μW), the camera was slowly moved toward the patient to allow the patient to adapt to the blue light. Patients were asked to focus on the central fixation light of the device. Alternatively, in cases of pronounced eccentric fixation, an external fixation light was used or the patient was asked to look “straight ahead,” and the orientation of the camera was adjusted to produce a field that was centered on the fovea and included the temporal edge of the disc. The fundus was exposed for 20 to 30 seconds to bleach rhodopsin,26 while the focus and alignment were refined to produce maximum and uniform signal over the whole field. The sensitivity (detector gain) was adjusted so that the GL did not exceed the linear range of the detector (GL < 175).26 Two or more images were then recorded (each of nine frames, in video format) in the high-speed mode (8.9 frames/s) within a 30 × 30° field (768 × 768 pixels). In addition, a horizontal scan through the fovea was recorded by spectral domain optical coherence tomography (SD-OCT).

Usually both eyes of patients were imaged. However, only one eye was imaged in five patients who proved to be challenging (due to photophobia or difficulties in alignment because of unstable or eccentric fixation) and for one patient who had high myopia in one eye (−12 D, study eye: −2 D).

After imaging, all videos were inspected for image quality and consistency in GLs by three of the authors (TRB, TD, JPG). For an imaging session, two videos were selected to generate the AF images for analysis. Only frames with no localized or generalized decreased AF signal (due to eyelid interference or iris obstruction)
Table 1. Clinical, Demographic, and Genetic Data for All STDG1 Patients. Results for qAF and Texture Factor

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</table>

* All subjects were white, except for patients 10, 22, and 36 who were Indian, Hispanic, and black, respectively.
† Bolded data are higher than the upper 95% confidence interval for the mean of healthy subjects.

and no large misalignment of frames (causing double images after alignment) were considered. The images were then aligned and averaged with the system software and saved in “non-normalized” mode (no histogram stretching). Fourteen out of 78 eyes were excluded after inspection of the image, because the quality was not considered sufficient for reliable quantification. To evaluate possible selection bias (e.g., images of eyes with more advanced disease being excluded), we compared visual acuities, and found that there was no difference between those eyes that were included and those that were excluded (Mann-Whitney, z(83) = −0.66, P = 0.51).

To assess reproducibility, a second imaging session was performed only systematically in the second part of the study (21 patients, 32 eyes). The second session was performed after randomly changing the focus and the camera orientation and after repositioning the subject.

**Image Analysis**

Dedicated image analysis written in graphing and data analysis software (IGOR; WaveMetrics, Lake Oswego, OR, USA) was used to determine qAF. The software recorded the mean GLs of the internal reference and from eight circularly arranged segments positioned at an eccentricity of approximately 7 to 9° (Fig. 1). Segments were scaled to the horizontal distance between the fovea and the temporal edge of the optic disc. If the fovea could not be identified, then its position was estimated based on a SD-OCT scan that was registered to an AF or NIR-R image. When a myopic crescent obscured the true edge of the optic disc on AF, a NIR-R image aided in identifying the disc edge (crescent has high reflectance). The software accounted for the presence of vessels and marked atrophy in the segments (see Supplementary Material: “Histogram Anal-
TF

Cideciyan et al.35 introduced a method to quantify small-scale heterogeneity of fundus AF (caused by flecks and small patches of partial atrophy) by defining a texture index as the coefficient of variation (SD/mean signal) when a small aperture was scanned in discrete areas of an AF image. In a photon noise–dominated system, the SD would be expected to increase with variation to decrease. This was verified by quantifying images of uniform fluorescent targets using the cSLO device (Heidelberg Engineering; see Supplementary Material: “Texture Factor”). To obtain a metric for texture that would be independent of the mean signal (qAF), we defined a “texture factor” as $TF = SD/\sqrt{qAF}$, where $qAF$ is the mean value for the area of the segment that does not contain large vessels and SD is the standard deviation of $qAF$ in the same area. To report the $TF$ for one eye, the mean $TF$ was calculated as $TF = \bar{SD}/\sqrt{qAF_0}$, where $\bar{SD}$ was derived from the mean variance ($SD^2$) for the eight segments. We found that $TF$ for the fluorescent targets exhibited little change with $qAF_0$, which is consistent with photon noise limited detection. Thus, if $TF$ is higher than the level observed in targets, the origin of this difference must be due to pathology or to variation in AF in healthy subjects. Since the cohort of STGD1 patients in this study was predominantly white, we compared their $TF$ to those of 83 healthy white subjects (83 eyes; range, 5–58 years). For healthy eyes over 18 years of age, there was no effect of race on $TF$ ($P > 0.23$).

Statistical Analysis

Overall, images of 64 eyes (42 patients) were available for analysis. We used mixed-effects linear regression that accounts for within-subject correlations between eyes and between close family members (e.g., sibling, parent-child; Stata 12.1, College Station, TX, USA) to investigate the relationships between patient characteristics (age, genotype, etc.), $qAF_0$, and $TF$. Models included binary and continuous factors. Continuous factors included age at examination, and disease duration (time since first diagnosis) in years. The binary factors that were examined included sex, eye, and mutation. Comparisons between specific mutations and healthy eyes were conducted for the four most common mutations (at least six patients and eight eyes). For between-genotype analyses, we only considered the eight more common mutations (see “Genotyping” section). The $qAF_0$ data obtained from white STGD1 patients were compared with the confidence intervals of 87 white subjects with healthy eyes (125 eyes).27 For the Indian, Hispanic, and black STGD1 patients, $qAF_0$ was compared with their respective confidence intervals.27

To evaluate the repeatability of the measurements between sessions, we used the method of Bland and Altman34 to compute the coefficient of repeatability (CR, 95% confidence interval) for the differences $log(qAF_0) - log(qAF_0^*)$, where $qAF_0$ and $qAF_0^*$ were the $qAF_0$ in the two sessions. The coefficient of agreement (CA) between the $qAF_0$ of right and left eyes was computed similarly.

Results

Autofluorescence images and color-coded qAF maps for three age-similar STGD1 patients and one healthy subject (Fig. 2) illustrate that the patients had higher qAF values. In these examples, the difference in qAF was greatest between the healthy eye (panel A) and the two STGD1 fundi on the right (patients #2 and #33, panels C and D). Conversely, patient #28 (panel B) had apparent disease confined to the central macula with a smaller elevation of qAF levels consistent with a milder phenotype.

Spatial Distribution

The spatial distribution of qAFs within the ring of segments was calculated as before32 by averaging the normalized distribution measured in both eyes (accounting for mirror-image symmetry) to minimize instrumental nonuniformities.
The spatial distribution for the 22 STGD1 patients for whom two eyes were imaged was similar to that in 97 healthy eyes (Fig. 3). Quantified fundus autofluorescence intensities were highest in the superotemporal quadrant and lowest in the inferonasal quadrant. Overall, there was no significant difference between STGD1 and control groups (mixed-effects linear regression, $\chi^2(1) = 0.04, P = 0.84$), but there was an interaction ($\chi^2(7) = 18.9, P = 0.009$), with STGD1 patients having higher qAF in the temporal segments ($\chi^2(1) = 10.4, P = 0.001$) and lower qAF in the inferior segment ($\chi^2(1) = 3.8, P = 0.05$). These small differences could reflect the natural history of STGD1 or be related to suboptimal area sampling due to eccentric fixation. Overall, the qAF in STGD1 patients can be compared with that in the healthy eyes because of the close similarity of their spatial distributions.

Agreement Between Eyes
The coefficient of agreement for qAF between the two eyes of 22 STGD1 patients was $\pm 13\%$, similar to that observed in healthy eyes ($\pm 15.3\%$). There was no difference between the qAF of left and right eyes (paired $t = 1.3, P = 0.2$).

Repeatability
Between-session repeatability of qAF (mean of two images per session) was evaluated from images of 32 eyes (21 patients). The coefficient of repeatability (for $\log(qAF_2)/\log(qAF_1)$) was $\pm 0.042$ log-qAF-units or $\pm 10.3\%$ of the mean qAF. This was slightly, but not significantly (Brown and Forsythe test, $P = 0.51$), higher than the $\pm 9.4\%$ observed in healthy subjects. The coefficient of repeatability for the TF was $\pm 0.43$ or $\pm 12\%$ of the mean TF.

qAF in STGD1 Patients Versus Healthy Subjects
Stargardt disease eyes exhibited elevated qAF relative to healthy eyes ($P < 0.001$) particularly at younger ages (Fig. 4). Between-subject variability in qAF was greater in STGD1 than in healthy eyes, again predominantly at young ages. Only nine eyes (six patients) had qAF below the upper 95% confidence limit of healthy eyes. For healthy eyes, qAF values increased with age ($P < 0.001$) but in STGD1 eyes, overall, there was no association with age ($P = 0.88$). As reported previously, amongst subjects with healthy eyes qAF was higher in females ($P = 0.01$) and the case for STGD1 patients ($P = 0.009$). For the five pairs of siblings (one twin pair), we found no significant difference in qAF (Wilcoxon paired; $Z_s = 0.4, P = 0.7$).

Genotype-Phenotype Relations (qAF)
Figure 5 shows the qAF levels for patients with different ABCA4 mutations in our sample as a function of age. Comparing each of the four most common mutations separately with healthy eyes, G1961E ($P = 0.001$), L541P/A1038V ($P < 0.001$), L2027F ($P < 0.001$), and P1380L ($P = 0.024$) eyes had qAF that was significantly higher than in healthy eyes.
healthy eyes, when corrected for age. Autofluorescence images from these patients are presented in the Supplementary Material (‘‘AF images of STDG1 patients’’).

A mixed-effects regression of all 64 STDG1 eyes was used to analyze the effects on \(qAF\) of the more common mutations in our cohort. When corrected for age \((P = 0.04)\) and sex \((P = 0.004)\), compared with all other patients who did not have that particular mutation, the mutations L2027F \((P = 0.009)\) and L541P/A1038V \((P = 0.015)\) were associated with higher \(qAF\), while A1038V \((P = 0.06)\); G851D \((P = 0.006)\); and G1961E \((P < 0.001)\) were associated with lower \(qAF\) in this sample.

Texture Factor in STGD1 Patients and Healthy Subjects

As expected, \(TF\) of healthy eyes \((n = 83)\) was higher than that of uniform fluorescent targets \((Fig. 6)\), and increased with age \((P = 0.001)\) when corrected for \(qAF\) \((P = 0.15)\). This suggests that there is an increase in heterogeneity with age in the AF images of healthy subjects; this heterogeneity would be visualized as mottling. For eyes of STGD1 patients, the \(TFs\) in 42 eyes \((27\) patients) exhibited high \(TFs\) above the upper 95% confidence limit \((Fig. 6)\). Among the 42 STGD1 patients, \(TF\) increased slightly with duration of disease \((P = 0.05)\), but not with age \((P = 0.77)\) when corrected for \(qAF\) \((P = 0.22)\). For the five pairs of siblings, there was no significant difference in \(TF\) \((Wilcoxon\) paired, \(Z = 0.9, P = 0.3)\).

Genotype-Phenotype Relations (TF)

When compared separately with healthy eyes, three of the four most common mutations, L541P/A1038V \((P < 0.001)\); L2027F \((P < 0.001)\); and P1380L \((P = 0.008)\) were associated with higher \(TFs\) of the black, Hispanic, and Indian subjects \((open\ circles)\) can be compared with the corresponding upper 95% confidence limits for their different race/ethnicity group \((short\ segments\ of\ solid\ line)\).
TF was higher than expected by chance (Fisher’s exact, \( P = 0.006 \)).

**Phenotype Classifications**

Thirty-four eyes were classified as Fishman I, 20 as Fishman II, and 10 as Fishman III. All three groups had higher \( qAF_8 \) than healthy eyes (\( P < 0.001 \)). In Fishman II, \( qAF_8 \) was higher (\( P < 0.001 \)) than in Fishman I patients (Table 2), but \( qAF_8 \) values of Fishman III patients were not significantly different than those of Fishman I (\( P = 0.07 \)) and II (\( P = 0.10 \)). \( qAF_8 \) was within the normal range for nine of 34 Fishman I eyes, while no Fishman II (0/20) and no Fishman III (0/10) eyes had a \( qAF_8 \) within the normal range (Fisher exact test, \( P < 0.009 \)).

Texture factor of Fishman II and III patients was higher than in healthy subjects (\( P < 0.001 \)), but this effect was slightly less pronounced in Fishman I eyes (\( P = 0.001 \)). Texture factor for Fishman III was higher than for Fishman II (\( P = 0.001 \)), and the latter was higher than for Fishman I (\( P < 0.001 \)). Texture factor was within the normal range for more than half the Fishman I eyes (20 out of 34 eyes), while few Fishman II (2/20) and no Fishman III (0/10) eyes had a \( TF \) within the normal range (Fisher exact test, \( P < 0.001 \)).

The Fishman classification is based on the qualitative assessment of pathological changes in the entire posterior pole. Conversely, \( qAF_8 \) and \( TF \) measures were restricted to the area of the segments (Fig. 1). Thus, to compare \( qAF_8 \) and \( TF \) with the presence of flecks and atrophy in the segments, we applied (consensus of three observers: TRB, TD, SHT) an additional grading scheme that only took into consideration flecks and atrophy within the segments: grade A, no flecks in

![Figure 5](http://tvst.arvojournals.org/)
any segment; grade B, less than five flecks/segment on average; grade C, more than five flecks/segment on average, but the area covered by flecks smaller than that affected by atrophy; and grade D, area of resorbed flecks/atrophy larger than that occupied by flecks. This grading allowed us to better understand the relationship between TF and qAFᵦ. Indeed, when these measures were plotted in a scatter diagram (Fig. 7), a pattern emerged in which grades A through D were well segregated. Grade A and B eyes tended to follow the same relationship as healthy eyes with an increase in qAFᵦ being

Figure 6. Texture factor in one or two eyes of each STGD1 patient (see legend) and healthy subjects (black crosses) as a function of age. Mean (solid black line) and 95% confidence intervals (interrupted line) for the healthy subjects are based on TF data from 83 white subjects (small ✦). The linear fit was $TF = 1.58 + 0.014 \cdot \text{Age}$. ($r^2 = 0.42$, $P = 0.001$). The horizontal (interrupted) line is the mean $TF (1.1; 95\% \text{ confidence interval: } 0.8-1.4)$ associated with uniform fluorescent targets (see Supplementary Material: “Texture Factor”).

Table 2. Fishman Grade: qAF and Texture Factor

<table>
<thead>
<tr>
<th>Fishman Grade</th>
<th>Eyes/Subjects, n</th>
<th>Age, y</th>
<th>Duration, y</th>
<th>qAF, qAF Units</th>
<th>Texture Factor, qAF Units²/₅</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>34/24</td>
<td>33 ± 14*</td>
<td>10 ± 8</td>
<td>458 ± 12*</td>
<td>2.5 ± 0.7*</td>
</tr>
<tr>
<td>II</td>
<td>20/12</td>
<td>21 ± 10*</td>
<td>6 ± 7</td>
<td>684 ± 109*</td>
<td>3.7 ± 1.2†</td>
</tr>
<tr>
<td>III</td>
<td>10/6</td>
<td>28 ± 8</td>
<td>9 ± 5</td>
<td>538 ± 94</td>
<td>5.6 ± 1.8†</td>
</tr>
</tbody>
</table>

Mean ± SD. Same symbols (*) in each column indicated significant differences ($P < 0.001$), accounting for two eyes in some subjects and for family relationships.
accompanied by only a moderate increase in TF. The highest qAF8 values were seen for eyes with numerous flecks (grade C). For grades C and D, qAF8 decreased with increasing TF (Spearman, P = 0.01).

In all 25 grade A eyes (19 patients), the AF image appeared clinically normal in the ring of segments (Fig. 1), with no obvious high AF flecks nor other AF abnormalities. Even so, the qAF8 levels (P < 0.001) and texture (P = 0.02) in these eyes were significantly elevated compared with the healthy eyes (P < 0.001) when corrected for age.

**DISCUSSION**

In keeping with the findings from previous histopathological and AF studies, qAF8 levels were markedly elevated in patients with STGD1. Consistent with the report that lipofuscin is a crucial and early component of the disease process in STGD1, we found that qAF8 levels were increased even in young patients with clinically diagnosed STGD1 (Fig. 4). This observation, together with the sizable differences in qAF8 observed between most STGD1 and control subjects, indicates that qAF may be a meaningful aid to identify patients for ABCA4 genetic screening.

The spatial distribution of the autofluorescence is similar in STGD1 patients and healthy subjects. Highest values are generally found in the superotemporal quadrant and lowest in the inferonasal quadrant. This corresponds with the well-established distribution of rod photoreceptors. The similarity of the spatial distributions facilitates comparisons of STGD1 and healthy eyes.

In this study, we classified all STGD1 patients according to the clinical phenotypes described by Fishman. This classification is based on an assessment of the presence of pigmentary changes, flecks, and atrophy over the entire posterior pole (and the spatial distribution of the flecks). Conversely, since qAF8 and TF only apply to the area defined by the ring of segments (Fig. 1), in addition to Fishman phenotypes we utilized a grading system (A-D) that was restricted to the segment areas. The A through D grading system, as shown in Figure 7, facilitated an interpretation of changes in qAF and TF and may contribute to a better understanding of the natural history of the disease. Despite the cross-sectional nature of the study, we observed an initial increase in qAF followed by a decline in qAF associated with RPE atrophy. This is also reflected in the lack of high qAF8 values at older ages and the decrease in between-subject variability with age. To further understand changes in AF levels and texture with disease progression, it will be necessary to conduct a larger study involving more genotyped patients and longitudinal follow-up. Such a study should also include patients with clinical changes and patients with advanced disease stages.

Only qAF8 for Fishman II patients was significantly elevated compared with the other Fishman groups (Table 2), but all groups had higher levels than healthy subjects. It has previously been noted that some cases of STGD1 can present with high AF in images, wherein structural abnormalities, such as flecks and/or atrophy, are not obvious outside the fovea. This was also the case in this study: all patients assessed as grade A in our classification (25 eyes, 19 patients) presented no flecks or other abnormalities in the ring of segments, but the qAF8 was significantly elevated in that group compared with healthy eyes (P < 0.001).

In addition to qAF8, we used TF to characterize the heterogeneity of fundus AF that depends upon the small-scale variations in lipofuscin distribution. The age-related increase in TF in healthy eyes may reflect RPE cell loss and monolayer thinning and RPE lipofuscin photodegradation. For two-thirds of the STGD1 eyes, TF was significantly higher than in healthy eyes. While more than half of the eyes classified as Fishman I had TFs within the normal range, Fishman II and III generally had levels outside normal limits. Interestingly, 42/64 STGD1 eyes had high TF, and all but two of those also had high qAF8. Conversely, Cideciyan and colleagues reported cases wherein mean AF intensity was within normal limits while AF texture index was elevated. In our cohort, the mutations G851D and P1380L had high AF texture while G1961E was associated with lower AF texture.

Given that STGD1 is a recessive disease and more than 600 disease-causing mutations have been described, compound heterozygosity is very common. Thus, it has been a challenge to determine the contribution of a single mutation to a phenotype and to understand interactions between alleles. In our current cross-sectional study, even though 42 subjects were included in the analysis, only limited genotype-phenotype correlations could be drawn from the data.

While in both the healthy eye and STGD1 patients lipofuscin accumulation begins at birth, our data suggest that the rate in STGD1 is determined, at least in part, by the specific ABCA4 mutation. For example, based on our cross-sectional data, the mutations L2027F and L541P/A1038V seem to confer a faster rate of accumulation, whereas G1961E and G851D seems to confer a slower increase (Fig. 5).

The complex allele L541P/A1038V involves missense mutations in both the exocytoplasmic domain 1 and nucleotide
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that autofluorescent lipofuscin-like material can be detected in photoreceptor inner segment membrane in some patients with STGD1. Perhaps abnormal accretion of bisretinoid lipofuscin in photoreceptor inner and outer segments in the presence of the G1961E mutation is a feature deserving future investigation. A mechanism such as this could explain photoreceptor cell degeneration in the absence of marked lipofuscin accumulation in RPE.

On the operational side, difficulties in properly aligning the fovea in the center of the image caused data to be lost and introduced measurement errors because of image nonuniformities near the edges of the image.13-16 This resulted in part from the limited number of fixation targets available in the cSLO device (Heidelberg Engineering; one central and eight peripheral targets). Addition of intermediate targets in the current system or an improved external fixation (for the fellow eye) may substantially aid image acquisition and shorten the test duration. In this study, images/frames were not included in the analysis if they were of suboptimal quality. Going forward, it will be important to make qAF less operator-dependent. Software-driven feedback could assist image acquisition and standardized computer algorithms could be implemented to select which frames should be used to generate images for AF quantification.

Our approach to measuring texture was simple, yet provided a metric without requiring additional image analysis. In experiments using fluorescent targets we observed that qAF was independent of detector sensitivity as expected, while TF increased with decreasing sensitivity (see Supplementary Material: “Texture Factor”). Since fundus AF levels in STGD1 eyes are high, images are acquired using lower sensitivities than in healthy eyes. This sensitivity effect may explain why grade A STGD1 eyes with qualitatively normal-structured TFs would be overestimated by 3 to 5% with a mean of 12% (see Supplementary Material, p. 8). However, this does not substantially alter our overall conclusion that higher than normal TF values are found in many STGD1 patients. Further efforts at developing metrics to describe pathological and age-related changes are warranted. Inherent limitations of the AF method include the need to bleach the photopigment for approximately 30 seconds with the 488-nm light of the Spectralis to minimize pigment absorption. This light is quite bright (5.1 log photopic trolands) and causes discomfort for some patients (even when gradually implemented). The retinal irradiance during AF imaging is 330 μW/cm² (488 nm, 30’ field; 260 μW beam power), which is below the permissible exposure recommended by the ANSI standards for durations of up to 8 hours (permissible levels are approximately 10 times lower than damage thresholds).55 Overall duration for bleaching and imaging for each eye was typically less than 2 minutes. However, the light exposure safety limits are based on data from healthy subjects and concerns have been raised about the long-term effects of intense retinal illuminations in patients with retinal disorders.56-58 Reducing the beam power of the instrument59 would alleviate patient discomfort but would not reduce the light exposure in our protocol, since duration of bleaching would have to be proportionally increased. Bleaching with an external light source centered on the rod absorption spectrum would reduce the needed exposure by only 15%. An external bleaching light that is gradually
increased in intensity may alleviate patient discomfort and allow better control of the bleaching.

As expected for an inherited disease, qAFs values for the right and left eyes of patients were found to be highly correlated. Similar right-left correspondence between eyes is generally observed clinically in STGD and the size of atrophic RPE lesions in the fellow eyes of patients with STGD1 are reported to be similar. Given the strength of this correlation, measurement of qAF in the eye contralateral to the treated eye, for example, in gene-based or stem cell therapies, could provide useful control data for future clinical trials.

The benefits of using qAF in diseases such as STGD1 are clear. Fundus AF imaging is quicker, easier to perform and cheaper than some other forms of clinical evaluation and provides a quantifiable parameter for assessment of disease status. While exact predictions of genotype-phenotype correlations are made difficult by the genetic and phenotypic heterogeneity observed in ABCA4 disease, qAF provides an additional parameter for the establishment of genotype-phenotype correlations. These correlations will aid both the selection of patients for ABCA4-related clinical trials, as well as the establishment of end-point measures for clinical studies.

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