ASTIGMATISM IN CANDIDATES OF CATARACT SURGERY AND ITS RELATIONSHIP WITH CORNEAL OPTICAL POWER, AXIAL LENGTH, SEX AND PATIENT AGE

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Abstract - This study was conducted to define the prevalence and types of corneal astigmatism in relation with corneal optical power, axial length, sex and patient age. 641 cataract patients were included in a descriptive study. Complete eye examinations were performed. The data were analyzed by standard procedures including analysis of variance, Chi square test and multiple linear regression models. With the rule, astigmatism was 55.6% in younger cases and against the rule astigmatism was 43.7% in older cases (P < 0.0001). Against the rule astigmatism was 55.8% in older males and 34.6% in older females (P < 0.0001). There was 0.023 diopter decrease in kpel for each year increase in age 1 (P < 0.0001). Axial length in males was 23.57 ± 1.46 mm and females was 23.35 ± 1.76 mm (P < 0.05). For second degree model to show relationship between astigmatism and axial length R² was 0.019 and 0.05. By increasing axial length up to 26 mm corneal power decreased, but further increase in axial length led to corneal power increase. For each diopter increase in corneal power there was 0.1  diopter increase in net astigmatism (P < 0.0001). In corneal powers less than 45.5 diopter there was no change between direction of astigmatism, but in corneal powers more than 45.5 diopter with the rule astigmatism was decreased (P < 0.01). Younger cases had more with the rule astigmatism and older cases had more against the rule astigmatism. Against the rule astigmatism was more common in older males than in older females. With the rule astigmatism ratio shifted to ATR astigmatism ratio with age but there was no change in against the rule astigmatism ratio with age. Males had 0.22 mm axial length more than females. There was significant relationship between axial length and net astigmatism. Abnormal size eyes had more astigmatism. Emmetropization mechanism of cornea did not work for eyes longer than 26 mm. Myopia was related to axial length. Second degree model was more failed to show relationship between astigmatism and axial length.


Key Words: Preoperative astigmatism, axial length, corneal optical power

MATERIALS AND METHODS

The study was performed from January to December 1997. 641 cases with normal intracocular pressure who had been scheduled for cataract surgery in Farabi Eye Hospital participated in the study regardless of age, sex and race. None of them had previous eye surgery, eye diseases or any systemic disorder affecting eyes. Preoperative examinations included visual acuity measurement using E chart, slit lamp examinations and applanation tonometry by Haag Streit devices, indirect fundoscopy by Topcon and keratometry by standard Javal keratometer.

A scan sonography was done by Kidek US 2500 to calculate IOL power and axial length measurement. The velocity of ultrasound was assumed to be 1550 m/s as has been used by Olsen (5).

All of the patients had normal IOP (14-16 mmHg) therefore we excluded it as a criterion. All the clinical and paraclinical data were obtained by ophthalmology assistants and well-trained optometrist respectively, under close supervision of the author. Astigmatism was defined as greater than 0.5 diopter difference between the highest and the lowest corneal meridian. With the rule astigmatism (WTR) was defined when the greatest corneal power lied between 30° of the vertical meridian, and against the rule astigmatism (ATR) when it was within 30° of the horizontal one, and the remainder were defined as oblique astigmatism.

For comparative purposes we chose the kpel advocated by Naeser (6) which takes into account both the direction and amount of astigmatism as a single unit. Kpel = M (Sin 2α - Cos 2α)

INTRODUCTION

Despite its importance of Medical Sciences, astigmatism has not been studied in candidates of cataract surgery in our country.
Kpol is the keratometric polar value of net astigmatism in diopter, where M is the difference between the highest and the lowest corneal meridian in diopter and α is the meridian of greatest corneal power. Using M (Sin 2α) for the vertical component and M (Cos 2α) for the horizontal component. All meridians of greatest corneal power were included in the calculation of the polar value regardless of the amount of astigmatism. By definition WTR astigmatism in this field exists when the greatest corneal power meridian lies between 45° and 135° which leads to positive value for Kpol and ATR astigmatism when it lies at less than 45° or more than 135° which makes Kpol value negative. In oblique astigmatism the greatest corneal meridian lies somewhere in between. When the greatest corneal meridian lies at 45° and 135°, Kpol is zero (Fig. 1).

Statistical analysis was performed with standard procedures including comparing mean data between two or more groups (analysis of variance), Chi square test and multiple linear regression models.

RESULTS

295 cases (46%) were females and 346 cases (54%) were males. Mean age of females was 65 years (R = 3.94 years). Mean age of males was 62.9 years (R=4.98 years). (P=0.067).

The degree of astigmatism is shown in table 1. The difference between the mean degree of is astigmatism in males and females was 0.14 D. (P = 0.1). Distribution of astigmatic direction with respect to sex and age the mean degree of is shown in tables II and III and IV. The mean age was 61.27 years in cases with WTR astigmatism and 66.22 years in those with ATR astigmatism. The difference between the mean ages of the two groups was 4.94 years (P < 0.0001).

Relation between direction of astigmatism and age

There was a significant difference between cases of WTR astigmatism and ATR astigmatism with respect to age. Younger cases had more WTR, and older cases had more ATR astigmatism. The difference between males and females with respect to direction of astigmatism was more significant in cases of older than 65 years, in other words ATR astigmatism was more common in older males than older females P < 0.0001.

By controlling the sex factor with increasing the age there is a significant shift towards ATR astigmatism which coincides with decrease in Kpol. (Fig 2).

With increasing each year in age the Kpol decreases by 0.023 D per year, approaching negative polar value or ATR astigmatism (P<0.0001).

Relation between axial length, gender and age

The mean eye axial length was 23.57 ± 1.46 mm and 23.35 ± 1.76 in males and females respectively, so that in the males, the axial length was 0.22 mm more than females (One-tail t-test. P=0.037).

Our study did not show any relation between age and axial length, which is against the results obtained by other investigators (1). Our findings may be due to our smaller sample size which will be repeated in the future. (two tail t-test: P=0.5).

Relation between net astigmatism, corneal power and axial length

Net astigmatism showed statistically significant relationship with corneal power, so that for each diopter increase in corneal power, we had 0.1 diopter increase in astigmatism (P<0.0001) (astigmatism = -3.64 + 0.11 power).

There was a significant relationship between axial length and the degree of astigmatism regardless of direction P=0.0001. (net astigmatism = -1.42 + 0.11 DIA -0.16 female = 0 male = 1).

As shown in Table 3, when we move from the center of X axis (horizontal) which is the site of more spherical eyes toward both extremities, the ratio of abnormal size eyes (short < 22 mm or long > 24 mm) to normal size eyes increases. It means abnormal size
eyes have more astigmatism than normal size eyes. This 
concept has been confirmed also by previous studies 
(1).

Fig. 2. Relationship of Kpol with age.
Note: Kpol decreases with increasing age. (leads to negative values or ATR astigmatism)

Change of astigmatism by axial length could be 
shown by different models. In the first degree model, 
R² (correlation coefficient) was 0.019 and 0.03 and in 
the second degree model, R² was 0.037 and 0.049 for 
males and females, respectively.

As shown in Figure 4A and 4B, the second degree 
model is more suitable for demonstrating the relation 
et astigmatism and axial length which is consistent with 
the finding that the R² of the second degree model is 
greater than R² first degree model.

Relation between axial length and corneal power

As shown is Figure 4A and 5B by increasing A.P 
diameter up to about 26 mm, corneal power decreases, 
but further increase in diameter leads to increase in 
corneal power. Again second degree model is more 
fitted to show this relationship. R²=0.2 and 0.016 for 
first degree model in males and females. R²=0.3 and 
0.18 for second degree model in males and females.

R² second degree model > R² first degree model

Relation between corneal power, age and sex

Corneal power relationships with age and sex were 
analyzed in two models. In a simple model, corneal 
power was related to both age and sex (P = 0.0001) and 
(P = 0.031) respectively. But in a multiple model we 
could not find any relationship with age (P=0.11).

This finding may indicate that the above relation of 
corneal power with age is not a real one and could be 
due to difference in distribution of age between males 
and females (controlling variables).

Fig. 3. Relationship between axial length and astigmatism.
Note: as we move from the center of X axis to both 
extremes, astigmatism or the ratio of abnormal size eyes 
to normal size eyes increases.

Table 1. Distribution of degree of net astigmatism among the 
cases.

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid percent</th>
<th>Cum percent</th>
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<tbody>
<tr>
<td>0.05-0.5</td>
<td>109</td>
<td>26.8</td>
<td>37.5</td>
<td>26.8</td>
</tr>
<tr>
<td>0.5-1</td>
<td>203</td>
<td>31.5</td>
<td>37.6</td>
<td>61.7</td>
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<tr>
<td>1-1.5</td>
<td>114</td>
<td>17.7</td>
<td>18.8</td>
<td>80.1</td>
</tr>
<tr>
<td>1.5-2</td>
<td>44</td>
<td>6.8</td>
<td>7.2</td>
<td>87.3</td>
</tr>
<tr>
<td>2-2.5</td>
<td>27</td>
<td>4.2</td>
<td>4.4</td>
<td>91.3</td>
</tr>
<tr>
<td>2.5-3</td>
<td>16</td>
<td>2.5</td>
<td>2.6</td>
<td>94.4</td>
</tr>
<tr>
<td>3-3.5</td>
<td>13</td>
<td>2.0</td>
<td>2.1</td>
<td>96.5</td>
</tr>
<tr>
<td>3.5-4</td>
<td>16</td>
<td>2.5</td>
<td>2.6</td>
<td>99.2</td>
</tr>
<tr>
<td>&gt; 4</td>
<td>5</td>
<td>8</td>
<td>8</td>
<td>100</td>
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<tr>
<td>Missing</td>
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<td>5.1</td>
<td>missing</td>
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</tbody>
</table>

Table 2. Distribution of astigmatism direction with response to 
sex

<table>
<thead>
<tr>
<th>Direction</th>
<th>Oblique</th>
<th>ATR</th>
<th>WTR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>51</td>
<td>94</td>
<td>144</td>
<td>293</td>
</tr>
<tr>
<td></td>
<td>(19.2%)</td>
<td>(31.9%)</td>
<td>(48.8%)</td>
<td>(100.0%)</td>
</tr>
<tr>
<td>Male</td>
<td>65</td>
<td>151</td>
<td>346</td>
<td>661</td>
</tr>
<tr>
<td></td>
<td>(23.6%)</td>
<td>(43.6%)</td>
<td>(53.5%)</td>
<td>(100.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>122</td>
<td>245</td>
<td>540</td>
<td>641</td>
</tr>
<tr>
<td></td>
<td>(19.0%)</td>
<td>(38.2%)</td>
<td>(42.7%)</td>
<td>(100.0%)</td>
</tr>
</tbody>
</table>

Chi square = 0.00852
Note: WTR astigmatism is more common in females, ATR 
astigmatism is more common in the males.
Oblique astigmatism is the same in both sexes.
Fig. 4A. Relationship between net astigmatism and axial length (first degree model).

Note: The degree of net astigmatism increases with increasing axial length. The relationship can not be shown at neither extreme.

Relation between axial length and direction of astigmatism

We could not find any relationship between axial length and direction of astigmatism. (Regression $P = 0.91$ Chi square comparing DIA $> 23$ mm DIA $< 23$ mm P=0.89).

Relation between corneal power and direction of astigmatism

The relationship between corneal power and direction of astigmatism is shown in Table 5. Powers less than 45.5 diopter, there is not a significant difference between different direction groups, but with powers greater than 45.5 diopter WTR astigmatism dominated (Chi square $P=0.01$). We were not able to find any change in ATR astigmatism with increasing age (95% CI = -0.009 to 0.0052) but the degree of WTR astigmatism showed 0.013 diopter decrease per year. (95% CI = -0.006 to 0.021).

Fig. 5A. Relationship between corneal power and axial length: (first degree model)

By increasing axial length up to 26 mm, corneal power decreases; this model is unable to show increase in corneal power by increasing the axial length more than 26mm.

| Table 3. Distribution of astigmatic direction with respect to age. |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                 | Total           | Oblique         | ATR             | WTR             | Frequency       | age group      |
| Rel             | Rel             | Rel             | Rel             | Rel             | Relative        | Absolute       | Rel             | Rel             |
| 100%            | 153             | 17.6%           | 27              | 24.0%           | 41              | 55.6%          | 48              | < 65 year       |
| 100%            | 286             | 14.3%           | 41              | 43.7%           | 125             | 42%            | 120             | > 65 year       |
| 100%            | 439             | 13.3%           | 68              | 37.8%           | 166             | 46.7%          | 2.5             | Total           |

P = 0.0023
Note: In the younger cases WTR astigmatism, and ATR astigmatism is more common.
**DISCUSSION**

A small degree WTR astigmatism is common in early life (3) although it may change in different sex and age groups. In our cases, WTR astigmatism was more common in females and younger age and ATR astigmatism in males and older ones. WTR astigmatism decreases with age and shifts to ATR astigmatism, but there is no change in ATR astigmatism with age. Our findings are compatible with the data obtained in the other studies (3,7), although they have shown that there changes take place more slowly in females than in males. In the present study in corneal powers less than 45.5 diopters we found no difference between the of directions of astigmatism, but in corneal powers of more than 45.5 diopters, WTR astigmatism was dominant. In a previous study (8) females have been shown to have steeper corneas than males, but no relation between corneal astigmatism and sex has been detected yet. For comparative purposes we chose k PCP which takes into account both the amount of astigmatism and its direction (6). Our data showed that k PCP decreases with age, means taking negative values and shifting to ATR astigmatism as in Figure 2. This concept has been noted also by Nimm-Pedersen (1), but ATR astigmatism has not shown any change with age. Our results showed that men have 0.22 mm axial length more than females.
The same results have been obtained by other authors too (9).

We found no relation between corneal power and age or sex, which is in contrast with dominance of steeper corneal powers in females, and increase in corneal powers by age to compensate for decrease in axial length by age, to keep the patient emmetropic (8).

We were not able to show any relation between axial length and age, although it has been shown to decrease with age in both males and females (0.13 mm per year) (1). Our results may be due to smaller sample size. We found no relation between axial length and direction of astigmatism by using k pol (P=0.99).

Pedersen found that WTR astigmatism increases with increasing axial length (1). As shown in Figure 3, if we move far from normal size eyes towards abnormal size eyes, whether short or long, the amount of astigmatism increases, in other words abnormal size eyes have more astigmatism, the concept being consistent with the data obtained by Pedersen (1).

We might be able to say that k pol values whether positive or negative are more dependent on the direction rather than amount of astigmatism, but their absolute values depend on both direction and amount of astigmatism. It is interesting to note that some authors have suggested that the shape of cornea depends on the size of the eyes (10). Jackson noted that hyperopic eyes shift towards ATR astigmatism with age whereas myopic eyes shift more to WTR astigmatism. Because it is now known that the size of the eye is actively regulated (11) the shape of the cornea may also be actively regulated as suggested by Pedersen (1).

We found that each diopter increase in corneal power may lead to 0.1 diopter increase in net astigmatism which contrasts with Pedersen's idea (1). This finding is statistically significant but its clinical significance is to be determined.

In a previous study it was found that a 1 mm change in axial length corresponds to an average change of 0.4D in the optical power of the cornea (12). Pedersen also showed that a 1 mm change in axial length corresponds to a change of 0.37 diopter in corneal optical power with no change in males and females (1).

Our findings showed that by increasing axial length up to 26 mm, corneal power decreases. This finding may be explained by emmetropization mechanism suggested by Gravenor (13) which keeps the corneal power compatible with axial length to maintain emmetropia. But further increase in axial length, leads to increases in corneal power. The last point may be due to the fact that high axial length eyes are out of control of emmetropization mechanism of the cornea, although this point needs more investigation. We found a more significant relationship between axial length and corneal power with net astigmatism. This concept has also been also shown by Pedersen (1). That is why second degree model IOL calculation formulas are more predictive than first degree ones, especially for hyperopic and myopic eyes (5).

Considering significant relationship between axial length and corneal astigmatism, one can find a relationship between myopia and total astigmatism, by relating axial length to myopia and corneal astigmatism to total astigmatism. This concept as noted by Stephen et al (14) is important when we want to treat a patient with myopia and corneal astigmatism. This fact accounts for the reduction in total astigmatism achieved by treating only the spherical component of myopia as postulated by Loewenstein (15).

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REFERENCES


