Peripheral Defocus with Single-Vision Spectacle Lenses in Myopic Children

Zhi Lin*, Aldo Martinez†, Xiang Chen*, Li Li‡, Padmaja Sankaridurg§, Brien A. Holden†, and Jian Ge¶

ABSTRACT

Purpose. To determine the impact of wearing single-vision spectacle lenses (SVLs) on the refractive errors at the periphery of the retina in myopic eyes of Chinese children.

Methods. Twenty-eight children (8 to 15 years) were divided into two groups: one (n = 17) comprising children with low myopia (spherical equivalent between 0.75 D and 3.00 D inclusive) and the other (n = 11), with moderate myopia (spherical equivalent between −3.25 D and −6.00 D inclusive). Cycloplegic autorefraction from right eyes was measured at the fovea and at 20, 30, and 40° in the temporal and nasal visual fields. Measurements were taken on each subject both while uncorrected and while wearing SVLs.

Results. Hyperopic peripheral defocus was found with SVLs in both the low and moderate myopia groups. However, the increase in relative peripheral hyperopic defocus when wearing spectacle correction, when compared with the uncorrected state was statistically significant for the moderate myopia group only. In the moderate myopia group, relative peripheral hyperopic defocus when wearing spectacle correction was statistically significantly greater vs. the low myopia group at 40° in the nasal field and at both 30 and 40° in the temporal field (p < 0.038). An increase in astigmatism with correction was observed for J45 (p < 0.05) was also seen in eyes with moderate myopia, but this was limited to the nasal field.

Conclusions. Previous investigators have suggested that peripheral hyperopic defocus may play a role in the development and progression of myopia. We have shown that SVLs used to correct myopia can result in increased hyperopic defocus at the peripheral retina in the eyes of Chinese children. The magnitude of this increase tends to escalate with increasing refractive error and eccentricity, especially in cases with moderate levels of myopia.

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Key Words: myopia, peripheral defocus, single-vision spectacle lenses, children

The prevalence of myopia is higher in Asian populations in comparison with other populations1–3; in addition, its prevalence has been increasing over the past few decades.4–7 Despite the intense efforts undertaken, the reasons for development and progression of myopia remain unknown.5,8 To date, there has been no intervention found to be truly efficacious in preventing or retarding the progression of myopia.2,9

The idea that peripheral refractive error can alter on-axis refractive development in humans was first suggested in 1971.10 Since then, several studies have suggested that peripheral defocus may play an important role both in myopia onset and myopia progression. Smith et al.11 found that peripheral defocus can influence eye growth and refractive development in infant monkeys. Mutti et al.12 suggested that relative (hyperopic) peripheral refractive error may be a risk factor for the onset and progression of myopia in children and that traditional spectacle lens designs do nothing to reduce or eliminate peripheral hyperopic defocus. Despite these and other studies supporting the notion that peripheral refractive error plays an important role in the control of eye growth, to our knowledge, no study has reported the relationship between the wearing of single vision spectacle lenses (SVLs) for the correction of myopia and its impact on peripheral retinal defocus in children. This study aims to investigate the effects of SVLs on peripheral refractive error in a group of Chinese myopic children.

METHODS

The study conformed to the tenets of the Declaration of Helsinki and was approved by the institutional ethics committee of...
TABLE 1.
Front base curve of both spherical and spherocylindrical lenses in diopters (D) used in this study

<table>
<thead>
<tr>
<th>Lens power (D)</th>
<th>Base curve (D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spherical lenses</td>
<td></td>
</tr>
<tr>
<td>−1.00</td>
<td>+4.27</td>
</tr>
<tr>
<td>−1.50</td>
<td>+4.27</td>
</tr>
<tr>
<td>−2.00</td>
<td>+3.70</td>
</tr>
<tr>
<td>−2.50</td>
<td>+3.98</td>
</tr>
<tr>
<td>−3.00</td>
<td>+3.70</td>
</tr>
<tr>
<td>−3.50</td>
<td>+3.13</td>
</tr>
<tr>
<td>−4.00</td>
<td>+2.84</td>
</tr>
<tr>
<td>Spherocylindrical lenses</td>
<td>+3.41</td>
</tr>
</tbody>
</table>

To ensure both stabilized accommodation and adequate pupil size for central and peripheral autorefraction, an anticholinergic cycloplegic agent was used. One to 2 min after instillation of oxybuprocaine 0.4%, a single drop of tropicamide 1% was instilled in each eye. A second drop of tropicamide 1% was added after an additional 5 min. Refraction measurements commenced 20 min after instillation of the second tropicamide dose.

Data analysis was performed using SPSS 15.0 statistical software (Chicago, IL). Spherocylindrical refractive errors were converted into power vector form (M, J180, and J45) using the conventional formulas for astigmatic decomposition before analysis. The relative peripheral refractive error (RPRE) was calculated to analyze the amount of change of the peripheral refractive power with respect to the foveal values. To analyze whether differences existed in the amount of peripheral refractive shift relative to the central refractive shift with SVLs between eyes with low and moderate myopia, the relative change of peripheral defocus (RCPD) was computed according to Eq. 1.

\[
\text{RCPD}_i = (M_{ic} - M_{iu}) - (M_{uc} - M_{uu})
\]

Where, M is the mean spherical equivalent error measured at the eccentricity denoted by suffix i (where i represents −40, −30, −20, 20, 30, or 40°). Suffix 0° denotes measurement taken at the foveal/on-axis direction. Suffix c indicates corrected condition (with SVLs), and suffix u indicates uncorrected condition. The aforementioned variables were analyzed between conditions as a function of eccentricity for each refractive error group using a one-way analysis of variance with a level of significance set at p < 0.05.

RESULTS

The mean age of the 28 children who took part in this study was 12.5 ± 2.0 years (range 9 to 15 years). No differences in age existed between children with low myopia (12.7 ± 2.1 years) and children with moderate myopia (12.3 ± 2.0 years) (p > 0.05). The mean M ± SD was −2.30 ± 0.42 D (range −1.48 to −2.89 D) in the low myopia group and −4.27 ± 0.65 D (range −3.27 to −5.27 D) in the moderate myopia group. The overall results (M, J180, J45, and RPRE) from the low myopia and moderate myopia groups are summarized in Tables 2 and 3, respectively.

Spherical Equivalent (M)

Mean M from both low myopia and moderate myopia groups in the uncorrected and corrected states is shown in Fig. 1. In uncorrected low myopic eyes, myopic defocus was found at five of the six off-axis positions (T20, T30, T40, N20, and N30), whereas hyperopic defocus was found at N40 (0.44 ± 1.27 D). Similarly, in uncorrected moderate myopic eyes, myopic defocus was present at all off-axis positions. However, with spectacle correction, hyperopic defocus was found in all the six off-axis positions in both groups.

Relative Peripheral Refractive Error

The RPRE as a function of eccentricity and correction state in both low and moderate myopic eyes is shown in Fig. 2. In low myopic eyes with SVLs, relative hyperopic defocus increased...
TABLE 2.
Results for mean M, \(J_{180}\), and \(J_{45}\) and relative peripheral refractive error RPRE (mean ± standard deviation) for 17 low myopic eyes at seven different eccentricities

<table>
<thead>
<tr>
<th></th>
<th>Temporal field (nasal retina)</th>
<th>Central</th>
<th>Nasal field (temporal retina)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(-40^\circ)</td>
<td>(-30^\circ)</td>
<td>(-20^\circ)</td>
</tr>
<tr>
<td>Uncorrected M</td>
<td>-0.57 ± 0.98</td>
<td>-1.30 ± 0.63</td>
<td>-1.94 ± 0.75</td>
</tr>
<tr>
<td>(J_{180})</td>
<td>-1.21 ± 0.35</td>
<td>-0.77 ± 0.20</td>
<td>-0.36 ± 0.37</td>
</tr>
<tr>
<td>(J_{45})</td>
<td>-0.08 ± 0.27</td>
<td>-0.09 ± 0.20</td>
<td>-0.02 ± 0.19</td>
</tr>
<tr>
<td>RPRE</td>
<td>1.73 ± 1.00</td>
<td>1.01 ± 0.66</td>
<td>0.36 ± 0.67</td>
</tr>
<tr>
<td>Corrected M</td>
<td>1.90 ± 0.93</td>
<td>1.02 ± 0.70</td>
<td>0.35 ± 0.65</td>
</tr>
<tr>
<td>(J_{180})</td>
<td>-1.12 ± 0.35</td>
<td>-0.74 ± 0.23</td>
<td>-0.46 ± 0.41</td>
</tr>
<tr>
<td>(J_{45})</td>
<td>-0.12 ± 0.37</td>
<td>-0.10 ± 0.23</td>
<td>-0.06 ± 0.16</td>
</tr>
<tr>
<td>RPRE</td>
<td>1.99 ± 0.96</td>
<td>1.11 ± 0.75</td>
<td>0.45 ± 0.69</td>
</tr>
</tbody>
</table>

TABLE 3.
Results for mean M, \(J_{180}\), and \(J_{45}\) and relative peripheral refractive error RPRE (mean ± standard deviation) for 11 moderate myopic eyes at seven different eccentricities

<table>
<thead>
<tr>
<th></th>
<th>Temporal field (nasal retina)</th>
<th>Central</th>
<th>Nasal field (temporal retina)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(-40^\circ)</td>
<td>(-30^\circ)</td>
<td>(-20^\circ)</td>
</tr>
<tr>
<td>Uncorrected M</td>
<td>-1.74 ± 1.14</td>
<td>-2.66 ± 1.40</td>
<td>-3.35 ± 1.36</td>
</tr>
<tr>
<td>(J_{180})</td>
<td>-1.29 ± 0.32</td>
<td>-0.77 ± 0.19</td>
<td>-0.19 ± 0.34</td>
</tr>
<tr>
<td>(J_{45})</td>
<td>-0.28 ± 0.31</td>
<td>-0.26 ± 0.30</td>
<td>-0.10 ± 0.29</td>
</tr>
<tr>
<td>RPRE</td>
<td>2.53 ± 1.31</td>
<td>1.61 ± 1.47</td>
<td>0.92 ± 1.26</td>
</tr>
<tr>
<td>Corrected M</td>
<td>3.40 ± 1.39</td>
<td>2.14 ± 1.39</td>
<td>1.05 ± 1.17</td>
</tr>
<tr>
<td>(J_{180})</td>
<td>-1.16 ± 0.30</td>
<td>-0.77 ± 0.17</td>
<td>-0.60 ± 0.23</td>
</tr>
<tr>
<td>(J_{45})</td>
<td>-0.53 ± 0.54</td>
<td>-0.34 ± 0.33</td>
<td>-0.04 ± 0.23</td>
</tr>
<tr>
<td>RPRE</td>
<td>3.49 ± 1.40</td>
<td>2.23 ± 1.41</td>
<td>1.14 ± 1.17</td>
</tr>
</tbody>
</table>

FIGURE 1.
Spherical equivalent (M) in diopters along the horizontal field in uncorrected and corrected eyes with low myopia and moderate myopia. Error bars indicate 1 ± standard deviation.

FIGURE 2.
Relative peripheral refractive error (RPRE) along the horizontal field in uncorrected and corrected eyes with low myopia and moderate myopia. Error bars indicate 1 ± standard deviation.
slightly with eccentricity, but it was not statistically significant (p > 0.05). On the other hand, in moderate myopic eyes with SVLs, the relative hyperopic defocus also increased with eccentricity and was statistically significant at 40° (p = 0.03) on the nasal field only. Although the mean RPRE values in the uncorrected state were not different (p > 0.05) between both refractive groups, in the corrected state, moderate myopic eyes had significantly more relative hyperopic defocus at T40° (p = 0.007), T30° (p = 0.03), and N40° (p = 0.038) than low myopic eyes.

Relative Change of Peripheral Defocus

In respect of the RCPD, in all six off-axis positions, there was a significant difference between low and moderate myopic eyes (p < 0.05, all positions) (Fig. 3). The relative change in low myopic eyes was less than that in moderate myopic eyes, with moderately myopic eyes exhibiting more hyperopic defocus.

Astigmatism (J180 and J45)

The mean results of J180 and J45, from both low myopia and moderate myopia groups in the uncorrected and corrected states are shown in Figs. 4 and 5, respectively. The mean levels of J180 (on and off-axis) were similar between low and moderate myopic eyes in both uncorrected and corrected conditions (p > 0.05). There was an effect on astigmatism with correction in both myopic groups. On-axis, there was a reduction in the mean values of central J180 (p < 0.05) with correction in both low and moderate myopic eyes. Off-axis, J180 (absolute) values increased at 20° temporal field with correction only in moderate myopic eyes by 0.41 D (p < 0.05), and they tend to decrease with correction in both low and moderate myopic eyes for most eccentricities but did not significantly decrease with correction in both low and moderate myopic eyes at the other eccentricities (p > 0.05). In contrast to on-axis values, off-axis J180 values did not decrease significantly with correction as a function of eccentricity in either group (p > 0.05).

DISCUSSION

Our results are in agreement with previously published reports that demonstrate relative hyperopia in the horizontal retinal periphery of uncorrected myopic eyes. However, the relative hyperopia observed in our study population was higher than that reported from a group of (mostly white) myopic children (+0.80 ± 1.29 D, 30° nasal field) with a similar age range (6 to 14 years) and myopic refractive error (−2.84 ± 2.09 D). It is well known that the prevalence of myopia in children is higher in Chi-
ne population in comparison with a white population, and the annualized progression of myopia is also greater in the Chinese population. Thus, the increased relative peripheral hyperopia observed in our population may provide some evidence of ethnic differences in eye shape or distortion in myopic Chinese children and consequently provide us with an alternate explanation for the differences seen in progression of myopia in children from different ethnicity.

It has been hypothesized that peripheral hyperopia provides a stimulus for axial elongation and progression of myopia as measured at the fovea. Also, studies in infant monkeys showed that deprivation in the retinal periphery despite clear images at the fovea can produce axial myopia at the fovea. Our data show that when uncorrected, the myopic eye experiences absolute myopic defocus along the horizontal visual field. However, when corrected with SVLs, the myopic eye experiences absolute hyperopic defocus at the periphery, which may be associated with the progression of myopia. More importantly, when the magnitude of hyperopic defocus was compared between corrected vs. uncorrected states, it was seen the correcting SVLs increased the amount of hyperopic defocus in eyes with moderate myopia. Calver et al. using trial lenses to correct adults with low myopia did not find differences in peripheral mean spherical equivalent error between corrected and uncorrected state of myopia. Although our results concur with Calver et al. for the low myopic group, we found a significant increase in hyperopic defocus with SVLs for the moderately myopic group. This increase was present at all the peripheral angles that were assessed and was as expected due to higher powered negative lenses being prescribed for moderate myopic eyes. Given these results, the question then asked is to whether correction with SVLs is likely to accelerate myopia progression. Smith et al. suggested that prescribing lenses that impose hyperopic defocus in the periphery could effectively promote axial elongation and suggested it may be possible to slow the progression of myopia in children by prescribing lenses that correct central refractive errors and at the same time increase the curvature of field of the image plane, thus either correcting for any peripheral hyperopia or actually imposing myopic defocus in the periphery. Because of the cross-sectional nature and the methodology adopted in this study, we are unable to draw any inferences on the effect of hyperopic defocus with SVLs on progression of myopia. Studies considering the peripheral refractive error state of stable myopic eyes vs. progressive myopic eyes with SVLs or a longitudinal study monitoring the progression of myopia with or without interventions will shed more light on this issue. However, despite the lack of the evidence for efficacy in terms of control of progression of myopia, it could be argued that a correcting lens that reduces or eliminates hyperopic defocus may have inherent advantages over the present form of spectacles in optimizing aspects of peripheral visual performance such as detection acuity. Wang et al. demonstrated that grating detection acuity depends strongly on optical blur in the periphery, and Whatham et al. demonstrated that contrast sensitivity at peripheral retinal locations improved with correction of peripheral refractive errors.

In agreement with previous data, asymmetry was observed in the peripheral refraction with the temporal retina being more hyperopic in comparison with nasal retina. Also, astigmatism increased with an increase in eccentricity in the uncorrected myopic eyes. These findings have been suggested to be the result of the combined effects of the cornea, crystalline lens, and retina. Correction with SVLs had a small impact on the magnitude of J in both the low and moderate myopic eyes; however, J increased with eccentricity, especially in moderate myopic eyes. One possible explanation for this increase is the pantoscopic tilt induced by spectacle lenses. We rule out misalignment of the spectacle lenses as a possible explanation for this increase as the methodology adopted in the study involved the use of appropriate head turn to ensure that the spectacle plane was always at right angles to the visual axis. Furthermore, for the farthest peripheral angle measured in the study, i.e., 40° the rays passed approximately 15 to 20 mm from the lens center and therefore was not subject to increased astigmatism and other aberrations.

In conclusion, our results provide evidence that correction of SVLs induced absolute hyperopic defocus on the retinal periphery of low and moderate myopic eyes. Although the effect of this induced hyperopia on the progression of myopia at the fovea remains to be assessed, it is reasonable to suppose that improving on the designs of the existing optical interventions may confer additional benefits.

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