OCT angiography: redefining standards

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BACKGROUND

The advent of optical coherence tomography (OCT) revolutionized retinal imaging by providing a fast, simple, and noninvasive method to assess retinal structure at a microscopic level1,2. Since its debut more than two decades ago, the technology behind OCT has evolved drastically, with profound improvements in speed, resolution and imaging depth. The explosive growth of OCT in clinical practice was noted after the commercial introduction of the Stratus OCT by Carl Zeiss Meditec (Jena, Germany). With the emergence of spectral-domain (SD) OCT systems, higher scanning speeds and eye tracking have led to higher-resolution cross-sectional images of the retina that cannot be obtained by any other noninvasive diagnostic technique3. SD-OCT has improved the quality of clinical decision making4, hence becoming an invaluable tool for any retinal specialist.

With enhance depth imaging (EDI) and swept-source (SS) OCT systems, better penetration and improved signal strength in the choroid have facilitated a qualitative and quantitative assessment of this structure4. However, even the most advanced structural OCTs do not provide an adequate visualization of the choriocapillaries, rendering it necessary to call upon angiography systems – fluorescein angiography (FA) and indocyanine green angiography (ICGA).

Both FA and ICGA are invasive imaging techniques that require intravenous injection of a dye – fluorescein or indocyanine green, respectively. Although generally safe, side effects like nausea, vomiting or even severe allergic reactions may develop in a minority of patients, thus limiting its repeated use5,7. Furthermore, given its dynamic nature, ICGA and FA are time-dependent, with an initial, intermediate and late phase6. FA has been adopted as the gold standard for in vivo evaluation of the retinal circulation because the architecture of the blood vessels, the blood flow and leakage from damaged/diseased retinal capillaries can be evaluated easily8. However, not all the capillary networks can be appraised with FA8,10. Fluorescein spreads through the fenestrations of the choriocapillaries, rendering it difficult to accurately assess this vascular layer8. To overcome this issue, ICGA is usually performed whenever a good visualization of the choroidal anatomy is needed (e.g. exudative age-related macular degeneration, namely in polypoidal choroidal vasculopathy or occult choroidal neovascularization)12. Nevertheless, ICGA is neither available nor routinely performed in many institutions throughout the world.

OPTICAL COHERENCE TOMOGRAPHY ANGIOGRAPHY

OCT angiography (OCTA) is a revolutionary imaging technique that allows noninvasive, three-dimensional visualization of the retinal and choroidal vasculature via motion contrast imaging12,13. Angio-OCT is capable of detecting endoluminal flow by mapping erythrocyte movement over time and comparing sequential OCT B-scans at a given crosssection12. The split-spectrum amplitude-decorrelation angiography (SSADA) algorithm and the motion correction tool are two patented primary technologies developed to improve the signal-to-noise ratio of flow detection and to remove unavoidable saccadic artifacts, respectively14,15. These technologies have significantly improved the quality of the vascular images, thus enabling the in vivo acquisition of high-speed, dyeless, microvascular angiograms, representing a true extension of capabilities from SD-OCT1,13. The inherent advantages of OCTA appear to be the ability to optically dissect and visualize flow in various layers of the retina, the high obtainable resolution and the freedom and safety of frequent examinations because of not having to use an injected dye6.

By using the en face OCT technology, layer segmentation is automatically generated to identify areas of interest, such as the superficial and deep retinal vascular plexuses or the choriocapillaries (Fig 1). The superficial vascular plexus, located in the ganglion cell layer (GCL) and nerve fiber layer (NFL) is exposed at a thickness of 60 μm from the internal limiting membrane (ILM). Although anatomically distinct,
the two deep plexuses, located in the inner nuclear layer (INL) and outer plexiform layer (OPL), cannot be individualized and are thus seen as one single vascular plexus (Fig 1B).

The parameters for the deep plexuses are defined with reference to the inner plexiform layer (IPL) in a 50 μm thick scan. To evaluate the choriocapillaries, segmentation is performed at the level of Bruch’s membrane.

CLINICAL APPLICATIONS

Recently, the 70 kHz Avanti RTVue XR equipped with the AngioVue software (Optovue, Fremont, CA, USA) has become commercially available, facilitating a widespread clinical access to OCTA. While still in a germinial stage, descriptive studies on the clinical applications of OCTA are beginning to materialize. Exudative age-related macular degeneration and other causes of choroidal neovascularization (CNV); diabetic retinopathy (DR); retinal vein occlusions (RVO) and glaucoma are some of the finest examples.

An unrivaled visualization of the CNV net is now possible with OCTA. The morphology (tree-like, glomerular, fragmented), the presence of a fibrovascular capsule, afferent feeder trunk and peripheral anastomosis can be clearly assessed. Furthermore, the non-invasive nature of the technique allows for a convenient lesion monitoring through sequential examinations during and after treatment (Fig 2).

In RVO, OCTA may show capillary dropout and focal non-perfusion as dark areas (similar to FA), foveal ring disruption, increased foveal avascular zone (FAZ) and collaterals, both in the superficial and in the deep vascular plexuses (Fig 3).

In patients with DR, OCTA shows a foveal avascular zone (FAZ) larger than in healthy subjects (normal FAZ ~500 μm) and according to Lumbroso et al this is an early
sign of DR that appears before the inception of microaneurysms. As clearly depicted in Figure 4, a loose network with large and sparse meshes can be easily appreciated, even in patients with mild nonproliferative DR. Microaneurysms appear as focally dilated saccular or fusiform capillaries on OCT angiograms of the superficial and/or deep capillary plexus (Fig 4). Retinal non-perfused areas are seen as lesions with no or sparse capillaries on OCT angiograms (Fig 4). Ishibazawa et al.15 have concluded from a pilot study with OCTA in diabetic retinopathy that this new imaging technique may be clinically useful to evaluate the microvascular status and therapeutic effect of treatments for DR. Neovascularization at the optic disc or posterior pole can also be imaged and clearly discernible with OCTA.16,17

OCTA of the optic nerve head of healthy subjects shows a very dense vascular network around the disc that cannot be detected in FA (Fig 5). Jia et al.18 have found that this network is greatly attenuated in glaucomatous discs. Further studies are needed to determine its correlation with the rate of progression and whether disc perfusion can be used as a prognostic indicator.

CONCLUSION

This path-breaking imaging modality is redefining our understanding of several vascular disorders by conveying detailed, depth-resolved information on the retinal and choroidal vascular networks, both at a structural and functional level. Although far from perfect, the technology behind OCTA may very well be the future gold standard of retinal and choroidal imaging.

REFERENCES

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