Abstract

Introduction: The ease of imaging the retinal vasculature, and the evolving evidence suggesting this microvascular bed might reflect the cerebral microvasculature, presents an opportunity to investigate cerebrovascular disease and the contribution of microvascular disease to dementia with fundus camera imaging.

Methods: A systematic review and meta-analysis was carried out to assess the measurement of retinal properties in dementia using fundus imaging.

Results: Ten studies assessing retinal properties in dementia were included. Quantitative measurement revealed significant yet inconsistent pathologic changes in vessel caliber, tortuosity, and fractal dimension. Retinopathy was more prevalent in dementia. No association of age-related macular degeneration with dementia was reported.

Discussion: Inconsistent findings across studies provide tentative support for the application of fundus image analysis in differentiating between dementia subtypes should be investigated using larger well-characterized samples. Future work should focus on refining and standardizing methods and measurements.

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Keywords: Fundus; Dementia; Alzheimer’s disease; Retinal imaging

1. Introduction

Dementia poses a major global medical, economic, and public health challenge [1–3]. Given this worldwide burden there is currently great interest in finding early and easily accessible biomarkers of dementia to ultimately aid prevention. An ideal biomarker for dementia screening should be reliable, predictive, reproducible, noninvasive, simple to perform, and inexpensive [4]. Novel biomarkers, including structural and functional neuroimaging, genetic factors, and biochemical analysis of blood and cerebrospinal fluid, have been examined. Despite this research focus, there remains an ongoing need for sensitive biomarkers for dementia. Increasingly, studies have found evidence that cerebrovascular disease and systemic vascular factors such as type 2 diabetes and hypertension are associated with increased risk of dementia [5,6]. Alzheimer’s disease (AD), the most common form of dementia, is known to...
have a vascular component with small-vessel disease, micro-
infarction, and cerebral amyloid angiopathy contributing to
the pathogenesis [6,7]. Despite the evidence of a vascular
component, difficulties in directly visualizing the cerebral
microvasculature in vivo have hindered efforts to
demonstrate the involvement of cerebral vessels in
dementia.

Anatomically and developmentally, the retina is an exten-
sion of the brain [8]. Because of the homology between the
retinal and cerebral microvasculature [9], the retinal vascula-
lature has potential to be used as a proxy measure whereby
the condition of retinal vessels may reflect the condition of
the cerebral vasculature. This has distinct advantages
because of the ease with which the retina can be noninva-
sively visualized and photographed, offering a “window”
to study brain microvascular and neuronal pathology
[10,11]. Different retinal imaging modalities, such as
fundus camera imaging and optical coherence tomography
(OCT), to measure changes in retinal nerve fiber layer and
retinal ganglion cell loss, and fluorescein angiography
have been applied in the management and research of
systemic diseases. Advancements in retinal imaging
technology have led to promising findings, particularly
OCT where a recent review demonstrated that the
measurement of retinal nerve fiber layer thickness, as a
reflection of axonal loss, provides a promising method to
aid in the diagnosis of various neurodegenerative diseases,
including AD [12]. Although all imaging modalities merit
further study, this review chose to focus on the use of fundus
camera imaging.

Retinal microvascular abnormalities in relation to cogni-
tive dysfunction and dementia have been described in review
articles previously [13–15]. These reviews found evidence to
support the hypothesis that retinal microvascular
abnormalities are associated with dementia [14,15] or
cognitive impairment/dementia both in diabetic patients
and the general population [13]. Retinal abnormalities
were most consistently associated with poorer verbal mem-
ory, information processing speed, and executive function in
population-based samples of middle age and older people
[13]. Heringa et al. [14] reported stronger associations be-
tween retinal microvascular changes and dementia in
cross-sectional studies (odds ratio [OR] range, 1.17–5.57)
than in longitudinal studies where no consistent associations
between retinal morphology and dementia or cognitive
impairment were found (OR and hazard ratio [HR] range,
0.77–1.55). Cheung et al. [15] noted that although various
studies have found an association between retinal vascular
changes and dementia, the results across these studies
were variable. The findings were inconclusive because of
heterogeneity of study design in terms of retinal parameters,
imaging methods, and outcomes. These previous reviews
have examined the extent to which retinal properties relate
to cognitive ability and dementia [13–15]. To our
knowledge, no comprehensive review has been published
on the specific utility of fundus camera imaging as a
method of identifying and measuring a wide range of
retinal changes, specific to dementia and its various
subtypes. For the purposes of this review, we define fundus
imaging as the use of fundus camera photography to
measure, observe, and quantify microvascular retinal
features and abnormalities.

The direct visualization of the retina using fundus imag-
ing offers an opportunity to assess the potential for abnor-
malities and changes in retinal microvasculature to serve
as biomarkers of microvascular pathology in subtypes of
dementia. Fundus photography, with high sensitivity, spec-
ificity, and interexamination and intraexamination
agreement [16], is typically used to determine three different
types of retinal properties: retinopathy, variation in vessel
caliber, and changes in the global geometric branching
network [17]. Furthermore, the digital output from modern
camera systems lends itself to image processing methods
for computer-assisted programs to objectively quantify
important features of the retina and its vasculature with
increasing accuracy and reliability [18]. We aimed to
conduct a systematic review of the literature to examine
the application of fundus camera imaging and analysis in
dementia, including AD, vascular dementia (VaD), frontotem-
poral dementia, and dementia with Lewy bodies.

2. Methods

2.1. Search strategy

Published studies were identified through systematic
searches of the Medical Literature Analysis and Retrieval
System Online (MEDLINE, including work in progress
from 1946), PubMed (from 1950), and the Excerpta Medica
Database (EMBASE, from 1980) for all human studies pub-
lished until March 2016, in all languages. Search filters
included were keyword, title, and abstract information.
The Medical Subject Heading search terms were “retina,”
or “fundus,” or “retinal vasculature,” or “retinal microvascu-
lature,” or “retinal vascular,” or “retinal vessel,” or “retinop-
athy” and in combination with “dementia,” or “Alzheimer,”
or “Lewy bodies,” or “cognition,” or “cognitive”. Articles
with any combination of any of the retinal terms and any de-
mentia or cognition term were reviewed. We also searched
Google Scholar for all studies published before and
including March 2016. References of relevant articles
were hand-searched and a forward citation search was per-
formed to identify further studies.

2.2. Inclusion and exclusion criteria

This review aimed to include all published studies
applying fundus camera imaging to examine the association
between retinal vasculature/retinopathy and any form of de-
mentia. Inclusion criteria were (1) original study; (2) written
in English; (3) assessment of retinal parameters using fundus
imaging; (4) diagnosis of AD, frontotemporal dementia, de-
mentia with Lewy bodies, or VaD; and (5) diagnosis of
dementia based on established criteria such as the National Institute of Neurological, Communicative Disorders and Stroke–Alzheimer Disease and Related Disorders Association [19].

The following studies were excluded: (1) review studies; (2) single-case reports; (3) nonhuman research; (4) non-English language studies; (5) conference presentations or summaries; (6) studies without details of dementia diagnosis criteria; and (7) studies examining retinal integrity through a method other than fundus photography, for example, a laser Doppler instrument or OCT.

2.3. Data extraction

All identified studies were screened by title and abstract by two independent reviewers. Irrelevant and duplicate articles were removed, and the remaining articles were assessed for agreement with the inclusion and exclusion criteria by full-text review (Fig. 1). Data extracted from studies at this stage included title, year of publication, authors, study aim, study type, number of patients and control subjects, mean age, diagnostic criteria, participant selection criteria, method of fundus imaging and image analysis used, results, and conclusions.

2.4. Statistical analysis

Review Manager Software Version 5.3 (Cochrane, Oxford) and R v. 2.15.2 were used for the meta-analysis of continuous and categorical outcomes, calculating the summary estimates including 95% confidence intervals (CIs). Extracted data (means, standard deviations [SD], and sample sizes) were used to calculate the mean difference (MD) using an inverse variance random-effects model. A random-effects generic inverse variance method was used to plot summary odds ratios (sORs) and 95% CIs of adjusted ratios for categorical measures. We tested for heterogeneity between study results with the \( \chi^2 \) test for heterogeneity with an alpha level for significance set at \( P = .05 \). Stratified analysis was carried out on dementia subgroups where possible.

3. Results

One thousand five hundred sixty-six studies were identified in the literature search. One additional study was identified from Google Scholar. Four hundred sixty-nine were duplicates and were therefore removed. The remaining 1098 were screened by title and abstract only. Of these, 59 were considered to be potentially relevant and were assessed by full-text review.

![Flow diagram for manuscript selection](image-url)
<table>
<thead>
<tr>
<th>Study</th>
<th>Study design and total sample size</th>
<th>Dementia outcome number of cases</th>
<th>Mean (SD) age*</th>
<th>Male (%)</th>
<th>Retinal measures</th>
<th>Type of fundus/camera model</th>
<th>Software/grading</th>
<th>One/both eyes</th>
<th>Region measured</th>
<th>Statistical analysis</th>
<th>Additional adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Klaver et al. [20]; Rotterdam Study</td>
<td>Prospective population-based study (n = 1436)</td>
<td>AD (n = 62 incident cases)</td>
<td>No AMD = 80.5 (4.4); stage 1 = 80.0 (4.0); stage 2 = 81.3 (4.5); stage 3 = 82.2 (5.6); stage 4 = 84.5 (4.8)</td>
<td>No AMD = 35.6%</td>
<td>AMD</td>
<td>Topcon TRV-30VT fundus camera, 35° field</td>
<td>Grading of fundus transparencies according to the international classification system</td>
<td>Not reported</td>
<td>Macular area</td>
<td>Cox proportional hazards regression analysis</td>
<td>Age, sex, smoking, atherosclerosis, APOE</td>
</tr>
<tr>
<td>Baker et al. [21]; Cardiovascular Health Study</td>
<td>Population-based cross-sectional study (n = 2211)</td>
<td>AD (n = 99); VaD (n = 111); mixed AD; VaD (n = 49); other types (n = 5)</td>
<td>78</td>
<td>40%</td>
<td>Retinopathy; AVN, FAN, retinal vascular caliber</td>
<td>Canon CR-45UAF, nonmydriatic fundus camera, 45° field</td>
<td>Observer graded. Caliber was measured and summarized</td>
<td>One (50% right, 50% left)</td>
<td>Centered between the OD and macula. Caliber measured one disc diameter from the OD margin</td>
<td>ANCOVA; logistic regression</td>
<td>Age, sex, race, field center, education, internal carotid intimamedia thickness, weight, hypertension, diabetes, smoking, cerebral MRI signs</td>
</tr>
<tr>
<td>Baker et al. [22]; Cardiovascular Health Study</td>
<td>Population-based cross-sectional study (n = 2088)</td>
<td>Dementia (n = 135); AD (n = 86)</td>
<td>With AMD: 80 (4.7), no AMD: 78 (4.2)</td>
<td>AMD: 41%; no AMD: 39.7%</td>
<td>AMD</td>
<td>Canon CR-45UAF, nonmydriatic fundus camera, 45° field</td>
<td>Observer graded. One (50% right, 50% left)</td>
<td>Grading was performed by the superimposition of a circular grid over the macular area</td>
<td>Logistic regression</td>
<td>Age, sex, ethnicity, study center, education, systolic BP, total cholesterol level, diabetes, smoking, APOE, cerebral MRI signs</td>
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<tr>
<td>Qu et al. [23]; AGES-Reykjavik Study</td>
<td>Population-based cross-sectional study (n = 3906)</td>
<td>AD (n = 66); VaD (n = 31); possible AD and VaD (n = 20)</td>
<td>76</td>
<td>42%</td>
<td>Retinopathy; AVN, FAN, 6.3-Megapixel Canon CR6 nonmydriatic camera, 45° field</td>
<td>Observer graded Both</td>
<td>Two images, centered on the OD and the macula</td>
<td>Linear regression; logistic regression</td>
<td>Age, sex, education, visual acuity, depressive symptoms, smoking, hypertension, diabetes, BMI, use of anticoagulants, brain infarcts, load of subcortical and periventricular white matter hyperintensities, cerebral microbleeds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study (Study)</td>
<td>Population-based or case-control study (Study size)</td>
<td>AD cases (controls)</td>
<td>Control:</td>
<td>Control:</td>
<td>CRAE, CRAVE, SIVA &amp; other grading</td>
<td>Retinal vessel measurement system</td>
<td>Observer grading</td>
<td>Centered on:</td>
<td>Logistic regression model</td>
<td>Age, sex, other variables</td>
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<tr>
<td>De Jong et al. [24]. Rotterdam Study</td>
<td>Population-based prospective study (n = 5553)</td>
<td>68</td>
<td>41%</td>
<td>41%</td>
<td>Topcon 20° field, Canon CR-DGi</td>
<td>Retinal Vessel Measurement System</td>
<td>Both</td>
<td>Centered on</td>
<td>Retinal Vessel</td>
<td>Age, sex, systolic BP, antihypertensive medication, serum total cholesterol, serum C-reactive protein, smoking, diabetes mellitus, coronary heart disease, stroke, CRAE/CRAVE adjusted for fellow vessel caliber</td>
<td></td>
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<tr>
<td>Schrijvers et al. [25]. Rotterdam Study</td>
<td>Population-based cross-sectional and prospective study (n = 6078)</td>
<td>69</td>
<td>41%</td>
<td>41%</td>
<td>Retinopathy, Topcon TRV-SOVT, 35° field</td>
<td>Canon CR-1 nonmydriatic camera, 45° field</td>
<td>Both</td>
<td>Centered on</td>
<td>Retinopathy</td>
<td>Logistic regression; Cox proportional hazards models</td>
<td></td>
</tr>
<tr>
<td>Frost et al. [26]. Australian Imaging, Biomarkers and Lifestyle (AIBL) Flagship Study of Ageing</td>
<td>Case-control study (n = 25:123)</td>
<td>71.6 (AD: 72.4)</td>
<td>45% (AD: 48%)</td>
<td>55% (AD: 47%)</td>
<td>CRAE, CRAVE, SIVA, Num1stDB</td>
<td>SIVA</td>
<td>Not reported</td>
<td>Centered on OD; 0.5–1.0 disc diameters or 0.5–2.0 disc diameters away from the disc margin</td>
<td>ANCOVA, receiver-operating characteristic (ROC) curve analysis</td>
<td>Age, sex, hypertension, diabetes, smoking, APOE</td>
<td></td>
</tr>
<tr>
<td>Cheung et al., 2014 Singapore Epidemiology of Eye Disease (SEED) program</td>
<td>Case-control study (n = 136:290)</td>
<td>73.9 (AD: 74.8)</td>
<td>55% (AD: 47%)</td>
<td>55% (AD: 47%)</td>
<td>CRAE, CRAVE, SIVA, Num1stDB</td>
<td>SIVA</td>
<td>Both</td>
<td>Centered on OD; 0.5–1.0 disc diameters or 0.5–2.0 disc diameters away from the disc margin</td>
<td>Independent t test or χ² test; logistic regression</td>
<td>Age, sex, ethnicity, smoking, hypertension, hypercholesterolemia, diabetes, history of myocardial infarction, CRAE/CRAVE adjusted for fellow vessel caliber</td>
<td></td>
</tr>
<tr>
<td>Williams et al. [27]. CASE study</td>
<td>Case-control study (n = 258:322)</td>
<td>76.6 (AD: 80.1)</td>
<td>39% (AD: 37%)</td>
<td>45% (AD: 37%)</td>
<td>Slit-lamp mounted Canon CR-DGi</td>
<td>Observer graded</td>
<td>One grade from worst eye or from only gradable image</td>
<td>6000 µm AREDS grid centered on fovea</td>
<td>Logistic regression</td>
<td>Age, smoking, recent illness, APOE</td>
<td></td>
</tr>
</tbody>
</table>

(Continued)
Table 1

<table>
<thead>
<tr>
<th>Study</th>
<th>Study design and total sample size</th>
<th>Dementia outcome</th>
<th>number of cases Mean (SD) age *</th>
<th>Male (%): Control</th>
<th>AD (%)</th>
<th>Statistical analysis</th>
<th>Additional adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Williams et al. [28]</td>
<td>Case-control study (n = 213:294)</td>
<td>AD (n = 213)</td>
<td>Control: 76.3; AD: 79.6</td>
<td>Control: 40%; AD: 36%</td>
<td></td>
<td>0.5 and 2.0 disc diameters away from the disc margin</td>
<td>Age, sex, mean arterial BP, smoking, hypercholesterolemia, diabetes mellitus, history of cardiovascular disease, cerebrovascular disease, medications (aspirin/clopidogrel, beta blockers, calcium channel blockers, diuretics, nonsteroidal antiinflammatory drugs, thyroxine), CRAE/CRVE adjusted for fellow vessel caliber</td>
</tr>
</tbody>
</table>

Abbreviations: AD, Alzheimer’s disease; AF, asymmetry factor; AMD, age-related macular degeneration; ANCOVA, analysis of covariance; AREDS, Age-Related Eye Disease Study; A VN, arteriovenous nicking; A VR, arteriole-to-venule ratio; AVN, arteriovenous nicking; AV, arteriovenous; BSTD, zone B standard deviation; CRAE/CRVE, central retinal arterial/venular equivalent; FAN, focal arteriolar narrowing; FD, fractal dimension; JE, Junctional exponent deviation; LDR, length to diameter ratio; MRI, magnetic resonance; Num1stB, number of first branching vessels in zone C; OD, optic disc; SD, standard deviation; SIVA, Singapore I Vessel Assessment; VaD, vascular dementia.

*For longitudinal studies age at baseline.
Table 2: Retinal parameters assessed by reviewed studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Klaver, 1991</td>
<td>Age-related macular degeneration (AMD), disease characterized generally by extensive drusen, often associated with pigmentary abnormalities (Coleman et al., 2008*)</td>
</tr>
<tr>
<td>Baker, 2015</td>
<td>Retinopathy, disease of the retina that results in impairment or loss of vision—symptoms include microaneurysms, hemorrhages, hard exudates, and cotton wool spots.</td>
</tr>
<tr>
<td>Qiu, 2009</td>
<td>Focal arteriolar narrowing (FAN), presence of localized areas of arteriolar constriction—definite: arteriole 40 μm in diameter and 250 μm in length, with caliber of constricted vessel 1/2 that of proximal and distal segment; probable: constricted vessel 40 μm in diameter or 250 μm in length, with caliber of constricted vessel not specified.</td>
</tr>
<tr>
<td>Baker, 2016</td>
<td>Arteriovenous nicking, arteriole crossing a venule resulting in the compression of the venule with bulging on either side of the crossing. Definite: tapering or narrowing of the venule on three or four sides of the crossing; probable: narrowing on only two sides of the crossing.</td>
</tr>
<tr>
<td>Frost, 2014</td>
<td>Central retinal arteriolar equivalent caliber (CRAE), measurement of the central retinal arteriolar equivalent single-vessel parent width for the six largest arterioles and venules. Based on the Knudston-Parr-Hubbard formula (Knudston et al., 2003).</td>
</tr>
<tr>
<td>Frost, 2015</td>
<td>Central retinal venular equivalent (CRVE), measurement of the central retinal venular equivalent single-vessel parent width for the six largest arterioles and venules.</td>
</tr>
<tr>
<td>Cheung, 2015</td>
<td>Arteriovenous nicking, arteriole crossing a venule resulting in the compression of the venule with bulging on either side of the crossing. Definite: tapering or narrowing of the venule on three or four sides of the crossing; probable: narrowing on only two sides of the crossing.</td>
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</tr>
<tr>
<td>Study</td>
<td>Dementia outcome</td>
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<tr>
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<tr>
<td>Baker et al. [21]</td>
<td>Dementia</td>
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<td></td>
<td>Mixed AD</td>
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<td></td>
<td>VaD</td>
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<td></td>
<td>AD</td>
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<td>(0.64–2.97)</td>
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<tr>
<td>Baker et al. [22]</td>
<td>Dementia</td>
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<td></td>
<td>AD</td>
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<td></td>
<td>(0.57–1.69)</td>
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<tr>
<td>Qiu et al. [23]</td>
<td>AD</td>
</tr>
<tr>
<td></td>
<td>VaD</td>
</tr>
<tr>
<td>Schrijvers et al. [25]</td>
<td>Dementia</td>
</tr>
<tr>
<td></td>
<td>AD</td>
</tr>
<tr>
<td></td>
<td>(0.71–5.63)</td>
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<tr>
<td>Frost et al. [26]</td>
<td>AD</td>
</tr>
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<td></td>
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<tr>
<td>Cheung et al., 2014</td>
<td>AD</td>
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<tr>
<td>Williams et al. [28]</td>
<td>AD</td>
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<tr>
<td>Williams et al. [27]</td>
<td>AD</td>
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</table>

**Table 3**

Associations between retinal parameters measured using fundus imaging and dementia in cross-sectional studies

**Abbreviations:** a, arteriolar; AD, Alzheimer’s disease; AF, asymmetry factor; AMD, age-related macular degeneration; AVN, arteriovenous nicking; AVR, arteriole-to-venule ratio; BA, branching angle; BC, branching coefficient; CI, confidence intervals; CRAE/CRVE, central retinal arterial/venular equivalent; FAN, focal arteriolar narrowing; FD, fractal dimension; OR, odds ratio; v, venular; VaD, vascular dementia; …, outcome measure not evaluated; =, no association between presence of retinal parameter and outcome measure.

**NOTE.** Results for vessel caliber were recorded in such a way that a negative coefficient means narrowing is associated with dementia, positive coefficient means widening is associated with dementia.

*Measure dichotomized: present versus absent.

†Retinal vessel caliber not measured using CRAE/CRVE; caliber categorized into quintiles, result reported for first quintile; results for FD/tortuosity/BA/BC/AF presented such that a negative coefficient means reduced retinal parameter is associated with AD, positive coefficient means increased retinal parameter associated with AD. Bold values indicate significant associations.
Ten studies met the inclusion criteria. The populations sampled came from the US (2), UK (2), Iceland (1), the Netherlands (3), Australia (1), and Singapore (1). Multiple articles from the same study population were included only if different retinal properties or outcome measures were examined in separate articles. Table 1 describes the characteristics of the studies reviewed.

3.1. Study design and population

The 10 studies included comprised three prospective cohort studies [20,24,25], three population-based cross-sectional studies [21–23], and four case-control studies [10,26–28]. Although several articles had overlapping samples, each article assessed different retinal features. These articles were therefore all included. Across the 10 studies the number of unique participants (i.e., without overlap across studies) was 13,349. The number of dementia cases per article varied from 25 to 655 [24,28]. Table 1 describes the characteristics of the studies reviewed.

3.2. Measurement

Studies assessed retinal parameters through visual grading or with the application of computer-assisted programs. Retinopathy, arteriovenous nicking (AVN), focal arteriolar narrowing (FAN), and age-related macular degeneration (AMD) were visually graded. Definitions and grading of retinopathy differed across studies. Retinopathy was identified by three ophthalmologically trained physicians in the Rotterdam Study by the presence of one or more dot/blot hemorrhages, microaneurysms, or cotton wool spots or evidence of laser treatment for retinopathy [25]. The Cardiovascular Health Study examined images for signs of microaneurysms, retinal hemorrhages, cotton wool spots, hard exudates, macular edema, intraretinal microvascular abnormalities, venous beading, new vessels at the disc or elsewhere, and vitreous hemorrhage [21]. Retinopathy was identified by three certified graders in the AGES-Reykjavik Study on the basis of presences of retinal blot hemorrhages, microaneurysms, soft exudates, and other less common lesions such as hard exudates, macular edema, and optic disc swelling [23]. AMD was identified and graded according to the international classification grading systems [29,30] by Baker et al. [22] and Williams et al. [27].

Quantitative retinal measurements performed using computer-assisted methods included central retinal arterial equivalent (CRAE); central retinal venular equivalent (CRVE); arteriovenous ratio (AVR); SD of vessel width in zone B (BSTD); length to diameter ratio (LDR); curvature tortuosity; bifurcation angle; junctional exponent deviation; fractal dimension (FD); number of first branching arterioles; branching coefficient (BC); and asymmetry factor. Most studies assessed vessel width as continuous variables. See Table 2 for definitions of retinal parameter terminology.

Retinal photographs were taken after pharmacological pupil dilation, except in the Australian Imaging, Biomarkers and Lifestyle Flagship Study of Ageing [26] where images were taken using a nonmydriatic camera in a darkened room and in the Cardiovascular Health Study [21,22] in which images were taken after 5 minutes of dark adaptation. Methods of fundus photography and image analysis varied across studies (see Table 1).

Singapore “I” Vessel Assessment (SIVA) software was used to automatically extract retinal vascular structure and calculate quantitative measures from retinal images in three studies [10,26,28]. Quantitative measurement in the Rotterdam Study [24] was performed using Retinal Vessel Measurement System. The remaining studies used observer grading methods [20–23,25,27].

3.3. Associations between retinal parameters and dementia

Associations between retinal parameters and dementia outcomes are presented in Tables 3 and 4. These tables report results adjusted for demographics and vascular risk factors (details of adjustments are provided in Table 1). Results from cross-sectional and prospective cohort studies are presented separately. Associations of increased retinal parameter values with dementia were indicated by “+,” associations of decreased retinal parameter values with dementia were indicated by “−,” and no statistically significant association between retinal parameters and dementia was indicated by “=” In text both uncorrected and adjusted results are provided where possible.

3.4. Cross-sectional studies: Retinopathy and AMD

3.4.1. Retinopathy

Neither the Cardiovascular Health Study [21] nor the AGES-Reykjavik Study [23] found an association between retinopathy and dementia in uncorrected (OR, 1.34; 95% CI, 0.90–1.99) [data not provided in the Cardiovascular Health Study]) or multivariate-adjusted models (OR, 1.17; 95% CI, 0.62–2.22; OR, 1.35; 95% CI, 0.89–2.04, respectively) in all subjects. In stratified multivariable models, among persons with hypertension, retinopathy was associated with dementia (OR, 2.10; 95% CI, 1.04–4.24). No association was found in those without hypertension [21]. Analyses stratified by diabetes status found an association between retinopathy and dementia in those without diabetes (OR, 1.96; 95% CI, 0.96–4.02). No association was found in those with diabetes (OR, 0.32; 95% CI, 0.07–1.44) [21].

Schrijvers et al. [25] found a significant association between retinopathy and dementia in a population-based sample of individuals aged 55 years and older (age and sex−adjusted OR, 2.04; 95% CI, 1.34–3.09) with a multivariable−adjusted OR = 1.92 (95% CI, 1.24–2.98). sOR of dementia in the presence versus absence of retinopathy was 1.42 (95% CI, 1.15–1.74) (95% CI, 0.62–2.22; OR, 1.35; 95% CI, 0.89–2.04, respectively) in all subjects. In stratified multivariable models, among persons with hypertension, retinopathy was associated with dementia (OR, 2.10; 95% CI, 1.04–4.24). No association was found in those without hypertension [21]. Analyses stratified by diabetes status found an association between retinopathy and dementia in those without diabetes (OR, 1.96; 95% CI, 0.96–4.02). No association was found in those with diabetes (OR, 0.32; 95% CI, 0.07–1.44) [21].

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CI, 1.10–1.85; Fig. 2), with the 95% CI from two studies crossing zero. There was no significant heterogeneity between the three articles ($\chi^2 P = .37$).

The cross-sectional AGES-Reykjavik Study found that those with retinopathy lesions had an increased risk of VaD (age, sex, and education–adjusted OR, 1.98; 95% CI, 1.10–3.56; multivariate-adjusted OR, 1.95; 95% CI, 1.04–3.62) but not AD (age, sex, and education–adjusted OR, 1.20; 95% CI, 0.73–1.98; multivariate-adjusted OR, 1.22; 95% CI, 0.73–2.04) [23]. The Rotterdam Study found increased risk of AD with retinopathy (age and sex–adjusted OR, 1.80; 95% CI, 1.11–2.91; multivariate-adjusted OR, 1.89; 95% CI, 1.15–3.10). The association between retinopathy and VaD (OR, 3.01; 95% CI, 1.26–7.21) did not persist after full adjustment (OR, 2.0; 95% CI, 0.71–5.63) [25]. Retinopathy was not significantly associated with AD or “mixed” AD VaD when assessed separately in the Cardiovascular Health Study (data not reported in study article).

Table 4

<table>
<thead>
<tr>
<th>Study</th>
<th>Dementia outcome</th>
<th>AMD</th>
<th>Retinopathy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>RR (95% CI)</td>
<td>HR (95% CI)</td>
</tr>
<tr>
<td>Schrijvers et al. [25]</td>
<td>Dementia</td>
<td>1.15 (0.89–1.50)</td>
<td>1.11 (1.00–1.22)</td>
</tr>
<tr>
<td></td>
<td>AD</td>
<td>1.15 (0.86–1.55)</td>
<td>1.06 (0.95–1.19)</td>
</tr>
<tr>
<td></td>
<td>VaD</td>
<td>0.90 (0.39–2.11)</td>
<td>1.06 (0.95–1.19)</td>
</tr>
<tr>
<td>De Jong et al. [24]</td>
<td>Dementia</td>
<td>1.05 (0.96–1.16)</td>
<td>1.11 (1.00–1.22)</td>
</tr>
<tr>
<td></td>
<td>AD</td>
<td>1.02 (0.91–1.14)</td>
<td>1.06 (0.95–1.19)</td>
</tr>
<tr>
<td></td>
<td>VaD</td>
<td>1.33 (0.99–1.78)</td>
<td>1.44 (1.10–1.89)</td>
</tr>
<tr>
<td>Klaver et al. [20]</td>
<td>AD</td>
<td>1.5 (0.6–3.5)</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: AD, Alzheimer’s disease; AMD, age-related macular degeneration; CI, confidence interval; CRAE/CRVE, central retinal arterial/venular equivalent; HR, hazard ratio; RR, relative risk; VaD, vascular dementia.

NOTE. Bold values indicate significant associations.
3.4.2. Age-related macular degeneration

Williams et al. [27] found an association between the most advanced cases of AMD (grade 3: geographic atrophy or neovascular AMD) and AD when uncorrected (OR, 2.5; 95% CI, 1.3–5.0) [27]. The association was lost following adjustment for potential confounding variables (age, smoking, APOE, and recent illness) (OR, 1.38; 95% CI, 0.6–3.2). Earlier stages of AMD were not associated with AD in unadjusted (data not provided) or adjusted models (grade 1: OR, 0.65; 95% CI, 0.4–1.1; grade 2: OR, 1.00; 95% CI, 0.5–1.9).

Early AMD (presence of soft drusen/retinal pigment epithelial depigmentation/combination of soft drusen with increased retinal pigment/depigmentation in the absence of exudative AMD/pure geographic atrophy) was not associated with dementia (adjusted for age, sex, ethnicity, study center: OR, 0.77; 95% CI, 0.47–1.27; fully adjusted model: OR, 0.98; 95% CI, 0.57–1.69) or AD (OR, 0.81; 95% CI, 0.45–1.48 and OR, 1.09; 95% CI, 0.57–2.08) [22]. Late AMD was not assessed because of the rarity of these lesion types.

3.5. Longitudinal studies: Retinopathy and AMD

Retinopathy and AMD in relation to incident dementia 2 to 11 years later was examined (see Table 4). Retinopathy was not significantly associated with increased risk of dementia (age and sex–adjusted HR, 1.15; 95% CI, 0.88–1.48; multivariate-adjusted HR, 1.15; 95% CI, 0.89–1.50), AD (age and sex–adjusted HR, 1.12; 95% CI, 0.83–1.50; multivariate-adjusted HR, 1.15; 95% CI, 0.86–1.55), or VaD (age and sex–adjusted HR, 0.97; 95% CI, 0.42–2.23; multivariate-adjusted HR, 0.90; 95% CI, 0.39–2.11) after a follow-up of 11.6 years [25]. Klaver et al. [20] found an increased risk of incident AD after 25.2 months in those with advanced stage AMD (indistinct or reticular drusen with pigmentary irregularities/the presence of either atrophic or neovascular end-stage macular degeneration) at baseline (age and sex–adjusted relative risk [RR], 2.1; 95% CI, 1.1–4.3). However, the association was attenuated following adjustment for smoking and atherosclerosis (RR, 1.5; 95% CI, 0.6–3.5). Risk of AD did not increase for those with earlier AMD in age and sex–adjusted model (RR, 1.0; 95% CI, 0.6–1.9) or following adjustment for smoking and atherosclerosis (RR, 1.0; 95% CI, 0.6–3.5).

3.6. Cross-sectional studies: Retinal vascular caliber, FAN, or AVN

Associations between arteriolar widths and dementia were inconsistent (see Table 3). Using CRAE as a summary measure of vessel caliber, Frost et al. [26] and Cheung et al. [10] found arteriolar narrowing in AD (area under the curve [AUC] = 0.612, SD = 0.082; age, sex, and ethnicity–adjusted OR, 2.02; 95% CI, 1.59–2.58, respectively), whereas Williams et al. [28] found evidence of arteriolar widening in AD (age and sex–adjusted OR, 1.37; 95% CI, 1.08–1.75). However, associations were lost once cardiovascular risk factors were controlled for OR, 1.22; 95% CI, 0.78–1.91 [10] and OR, 1.1; 95% CI, 0.83–1.47 [28].

![Fig. 3. Meta-analysis of Alzheimer’s disease (AD) versus control subjects: CRAE and CRVE. The size of the square denotes the weight attributed to each article, and the horizontal lines represent the 95% confidence interval (CI). A diamond represents the summary mean difference with the width representing the 95% CI. Unadjusted results reported. Abbreviations: CRAE, central retinal arterial equivalent; CRVE, central retinal venular equivalent; SD, standard deviation.](image-url)
Fig. 4. Meta-analysis of Alzheimer’s disease (AD) versus control subjects: Arteriolar fractal dimension (FDa) and venular fractal dimension (FDv). The size of the square denotes the weight attributed to each article. Unadjusted results reported. Abbreviation: SD, standard deviation.

The prospective Rotterdam Study examined associations between retinal vascular calibers and incident dementia, AD (with or without cerebrovascular disease), and VaD [24] (Table 4). Increased risk of dementia with retinal vascular widening was found (age and sex–adjusted HR, 1.09; 95% CI, 1.01–1.18; multivariate-adjusted HR, 1.11; 95% CI, 1.00–1.22) [24]. Stratified analyses revealed the increased risk was driven by the association with VaD (n = 73) (HR, 1.31; 95% CI, 1.06–1.64; multivariate-adjusted HR, 1.44; 95% CI, 1.10–1.89). Venular width was not significantly associated with increased risk of AD in stratified analyses following exclusion of those with cardiovascular disease (n = 47) (HR, 1.16; 95% CI, 0.82–1.64).

Neither study examining the association between AVN and dementia found any significant associations (multivariable-adjusted OR, 1.48; 95% CI, 0.74–2.96) [21] (data not provided).

FAN associations were mixed (see Table 3). Although Qiu et al. [23] failed to find an association of FAN with dementia (data not provided), the Cardiovascular Health Study found a relationship (multivariate-adjusted OR, 1.99; 95% CI, 1.11–3.56) that appeared to be driven by hypertension and diabetes [21]. Those with evidence of FAN were more likely to have “mixed AD VaD” (OR, 3.57; 95% CI, 1.31–9.75) but not AD (OR, 1.38; 95% CI, 0.64–2.97).

3.7. Longitudinal studies: Retinal vascular caliber, FAN, or AVN

Associations between venular caliber and dementia were also mixed (see Table 3). Frost et al. [26] found evidence of narrower venular widths in AD using CRVE (AUC = 0.703, SD = 0.067, P = .0049) and increasing SD of venular widths (AUC = 0.541, SD = 0.081, P = .0089) using BSTDv. Cheung et al. [10] also found that patients with AD (n = 136) had narrower venular calibers measured using CRVE (P < .001; age, sex, and ethnicity–adjusted OR, 2.17; 95% CI, 1.69–2.79; multivariate-adjusted OR, 2.01, 95% CI, 1.27–3.19). Williams et al. [28] did not find a significant difference between CRVE in patients with AD (n = 213) and control subjects (n = 294) (d = 0.006, P = .951) (multivariate–adjusted OR, 0.99; 95% CI, 0.75–1.32, P = .960). Although not wholly consistent, there was a general reduction in venular calibers in AD using CRVE (MD, −10.74; 95% CI, −24.09 to 2.61; Fig. 3) with significant heterogeneity between articles (χ² P < .001). Using venular LDR Frost et al. [26] found no difference in caliber between AD and control subjects (P > .05). The only study using AVR found no significant difference between patients with AD and the control group (P > .05) [26].
3.8. Cross-sectional studies: FD, branching pattern, and geometry

Three articles examined the link between FD and AD [10,26,28], each reporting a reduction in arteriolar and venular FD indicating a sparser network in AD (MD, \(-0.02; 95\% \text{ CI}, -0.03\) to \(-0.01\) (Fig. 4) with no significant heterogeneity between articles (arteriolar FD \(\chi^2 P = .26;\) venular FD \(\chi^2 P = .21\)). Patients with AD demonstrated reduced complexity of the branching pattern in comparison with control subjects with lower arteriolar (AUC = 0.644, SD = 0.075, \(P = .021\)) and venular FDs (AUC = 0.716, SD = 0.074, \(P = .0033\)) [26]. A smaller number of first branching vessels in zone C were found in AD (arteriolar; AUC = 0.675, SD = 0.142, \(P = .022\); venular; AUC = 0.660, SD = 0.121), again indicating reduced complexity of branching [26]. Reduced FD in patients with AD with significant results for venular (\(d = 0.4, P = .001\)); multivariate-adjusted OR per SD decrease, 1.47; 95% CI, 1.17–1.84), arteriolar (\(d = 0.3, P = .002\)); OR, 1.35, 95% CI, 1.08–1.68), and total FD (\(d = 0.4, P < .001\)); OR, 1.54; 95% CI, 1.23–1.93) was also found in the Singapore Epidemiology of Eye Disease study [10]. Likewise, Williams et al. [28] found significantly lower fractal total (\(d = 0.3, P = .001\)), arteriolar (\(d = 0.2, P = .024\)), and venular (\(d = 0.4, P < .001\)) dimensions in AD. Those with lower venular FD (multivariate-adjusted OR per SD increase, 0.77; 95% CI, 0.62–0.97, \(P = .025\)) were more likely to have AD. The association between total and arteriolar FD and AD did not persist in the final models (OR, 0.85; 95% CI, 0.68–1.06, \(P = .141\); OR, 0.92; 95% CI, 0.74–1.14, \(P = .436\)).

Neither study examining branching angle found a difference in arteriolar or venular angle between AD and control groups (\(d = 0.07, P = .521; d = 0.01, P = .922\), respectively) [10] (\(d = 0.006, P = .523; d = 0.04, P = .599\), respectively) [28]. Another measure of circulatory optimality, junctional exponent deviation, also failed to identify an association between AD and branching angles (data not provided) [26]. Higher venular BC values in AD (AUC = 0.55, SD = 0.084, \(P = .035\)), indicating reduced optimality of branching geometry, were found [26]. Further evidence of reduced branching geometry optimality with greater arteriolar and venular asymmetry factor values in AD (AUC = 0.578, SD = 0.081, \(P = .037\); AUC = 0.616, SD = 0.074, \(P = .047\), respectively) was found [26].

Inconsistent associations between tortuosity and dementia were found [10,26,28] (see Table 3). More tortuous arterioles and venules were observed in AD than in control subjects (\(d = 0.2, P < .001\)) in the Singapore Epidemiology of Eye Disease study [10]. Those with higher arteriolar and venular tortuosity were more likely to have AD (multivariable-adjusted OR per SD increase, 1.8; 95% CI, 1.48–2.53; OR, 1.94; 95% CI, 1.48–2.53, respectively). Frost et al. [26] found less tortuous venules (AUC = 0.706, SD = 0.073, \(P = .042\)) in AD with no significant difference in arteriolar tortuosity between patients with AD (\(n = 25\)) and healthy control subjects (\(n = 123\)) (data not provided). Conversely, Williams et al. [28] found lower arteriolar tortuosity in AD (\(d = 0.2, P = .030\), multivariate-adjusted OR, 0.78; 95% CI, 0.63–0.97, \(P = .27\)), and not venules (\(d = 0.07, P = .458\)).

4. Discussion

The aim of this review was to assess the relationship between microvascular changes in the retina and dementia with the use of fundus camera imaging. Despite considerable heterogeneity in both retinal parameters and study design, the cross-sectional studies reviewed found evidence of some consistent cross-sectional associations with dementia. The heterogeneity of retinal measurements in the few longitudinal studies included in this review precluded the comparison of findings across prospective studies.

The most consistent finding was decreased FD in AD [10,26,28]. A decreased FD indicating a sparser branching density has also been observed in stroke [31,32], cognitive dysfunction [33], and hypertension [18]. Pathophysiologically, a less complex retinal microvascular network is a result of retinal vessel rarefaction and collapse, which may cause retinal hypoxia [34]. Destruction and obstruction of the small perforating cerebral vessels have been reported [35] indicating that corresponding pathologic mechanisms are responsible for microvascular changes in the retina and brain. These findings provide evidence for the role of microvascular pathology in the development of dementia. However, the effect sizes reported here are small to medium (\(d = 0.2–0.4\)). In the largest study, the association of arteriolar fractal analysis was lost in the fully adjusted model [28]. Potential differences between arteriolar and venular fractal networks should be assessed using data from larger studies and in different patient populations.

Vessel caliber measurements present conflicting results; both narrower [10,26] and wider arterioles [28] were associated with AD. The finding of narrower venules in AD [10,26] was not replicated by Williams et al. [28]. The prospective Rotterdam Study found wider venular calibers were related to an increased risk of dementia, largely driven by the association with risk of VaD [24]. The association between narrower arteriolar caliber and AD in the Singapore Epidemiology of Eye Disease program study was lost after adjustment for cardiovascular risk factors [10]. Narrower arterioles are strongly associated with hypertension [11,36], which could be responsible for the attenuation in association. Wider retinal venules in VaD could reflect inflammation, cerebral hypoperfusion, and subsequent ischemia, whereas narrower venules in AD may reflect increased venular wall thickness as a result of collagen deposition in cerebral veins [37]. However, evidence has also been reported supporting the involvement of
inflammation in the development of AD [38]. It is possible that opposing changes in diameter caused by inflammation and collagen deposition may decrease the likelihood of detecting meaningful changes and effects. The different mechanisms underlying the association of changes to arteriolar and venular caliber emphasize the importance of analyses according to dementia subtypes and in adjusting for the opposing effect of fellow vessel caliber. Contrasting effects of hypertension causing arteriolar narrowing and ischemia and endothelial dysfunction causing arteriolar widening may lead to spurious associations of vessel caliber with dementia. No association between arteriolar caliber and VaD was found until venular calibers were adjusted for [24]. Most studies adjusted for the opposing effects of fellow vessel caliber [10,24,28]. Frost et al. [26] do not report adjusting for opposing vessel type. Inconsistent associations of vessel caliber could also be attributed to natural variation because of pulsation during the cardiac cycle and by vasomotion with arteriolar and venular caliber found to vary by up to 17% and 11%, respectively [39].

Tortuosity has been proposed as a means of identifying those at risk of microvascular complications by detecting initial vascular changes [28,40]. Results were inconsistent with both increased [10] and decreased tortuosity [26,28] associated with AD. Although the underlying mechanisms for its onset and development remain unclear, retinal tortuosity has been associated with hypertension, retinopathy, cerebral vessel disease, stroke, and ischemic heart disease [18,41–43]. The finding of increased tortuosity in AD is in line with previous findings in stroke, hypertension, and cerebrovascular disease [40,44,45]. Reduced tortuosity has been associated with increasing risk of death from ischemic heart disease possibly resulting from endothelial dysfunction and a widespread impairment of perfusion or oxygenation in the microvasculature [42]. Reduced arteriolar tortuosity has also been found in diabetic retinopathy [17]. The accuracy of tortuosity measurement may be related to the length of the vessel segments [46]. For example, when assessing tortuosity of an entire vessel segment labeled as tortuous, smaller straight (i.e., less tortuous) subsections within the segment may complicate classification by influencing the overall tortuosity of the vessel making it appear less tortuous. All three studies used SIVA to calculate tortuosity where automatically segmented vessels are typically short enough to be classed as either entirely tortuous or nontortuous. Short-term changes in tortuosity in response to environmental effects have also been reported [47]. Tortuosity discrepancies may also be because of differences in race between the studies (Chinese, Indian, and Malay in the Cheung et al. study [10] vs. white Caucasians in Frost et al. [26] and Williams et al. [28]).

Retinopathy lesions including microaneurysms and retinal hemorrhages reflect a breakdown of the retinal blood barrier [48,49]. Results from cross-sectional [23,25] and longitudinal studies [25] suggest that although a marker of microvascular pathology retinopathy is more prevalent in dementia, the onset does not precede the development of dementia. Although retinopathy may reflect underlying cerebral vascular pathology, it is more likely to reflect advanced cerebral microvascular states and as such may not be useful as a diagnostic tool or biomarker for risk of development, as the condition is unlikely to develop before the clinical stages of dementia [25]. The inconsistent findings could reflect the different definitions and grading of retinopathy across studies. Although the three studies mostly used common features for diagnosis, it is noteworthy that the only study failing to identify a significant association used the most comprehensive range of retinopathy signs including intraretinal microvascular abnormalities, venous beading, vitreous hemorrhage, and new vessels at the disc or elsewhere [21]. Neither cross-sectional nor longitudinal associations between AMD and dementia were found [20,22,27].

An additional motivation of this review was to establish whether fundus image analysis could differentiate between dementia subtypes. Most studies meeting the inclusion criteria focused exclusively on AD [10,20,26–28] with limited numbers of VaD across studies (n = 102). The few studies with sufficient numbers for stratified analysis revealed different outcomes by diagnosis: larger venular calibers associated with increased risk of VaD but not with AD [24]; FAN was associated with mixed AD VaD but not with AD [21]; and retinopathy was associated with AD but not with VaD [25] with the opposite finding for Qiu et al. [23]. Although the limited number of cases of VaD (n = 29) could explain the insignificant association in the Rotterdam Study [25], results provide some evidence of the utility of fundus imaging in the differentiation of dementia subtypes. Fundus imaging should be applied to assess the role of microvascular pathology in larger samples of other forms of dementia, particularly VaD.

Accurate and meaningful interpretation of retinal parameters requires not only precise quantification and calculation but also an understanding of potential effects of axial length and ocular refractive error. Dimensional parameters such as CRAE and CRVE are subject to magnification effects and refractive error. The Blue Mountains Eye Study and Beaver Dam Eye Study found an association between myopic refraction and reduced retinal FD and smaller retinal vessel diameters, respectively [50,51]. The Blue Mountains Eye Study found that correcting for refractive error appeared to increase the statistical power to detect associations with retinal vessel caliber [51]. Only one study reviewed adjusted for magnification effects using refractive data [24]. Data on axial length were not included in the reviewed studies. Longer axial length has been associated with the narrowing
of arterioles and venules, increased arteriolar and venular 
BCs, and less tortuous arterioles [52]. Patton et al. [53] like-
wise found an association between increased axial length 
and narrowing of retinal vessels. No effect of axial length 
on AVR, junctional exponents, and bifurcation angles was 
found. Future studies using dimensional measures should 
adjust for refraction and axial length. Dimensionless me-
asures that are not subject to the influence of these effects 
such as AVR, junction exponent, tortuosity, and LDRs 
have been calculated.

Most of the quantitative measurements were assessed and 
calculated using the same semiautomated software, SIVA. 
Despite using the software according to the standardized pro-
tocol to measure common retinal vascular properties in 
similar patient groups, results were inconsistent [10,26,28]. 
Moderate to high intergrader reliability of quantitative 
measurements using SIVA has been reported with 
coefficient of variations ranging from 1.76% for venular 
caliber to 17.66% for venular tortuosity [18]. In addition to 
SIVA, a number of software packages are available (e.g., 
VAMPIRE [54], ARIA [55], IVAN [University of Wisconsin, 
Madison]), each implementing different algorithms for detec-
tion and measurement of retinal vascular features. Although 
the uniformity of quantitative retinal measurement methods 
in the reviewed studies facilitates comparison, additional 
studies using different software and measurement methods 
are required to provide a more comprehensive view of retinal 
vascular status in dementia. Furthermore, a comparison of 
retinal vascular parameters measured using the same fundus 
images with different software packages is required.

Some methodological issues warrant consideration, chiefly 
the limited number and heterogeneity of reviewed studies, 
including design, population, covariates, retinal parameters, 
and outcome measures. The review of the association between 
many retinal parameters and dementia was therefore restricted 
to a descriptive comparison. In addition, studies with negative 
findings may be under-represented because of publication bias. 
The studies reviewed neither report dementia severity nor do 
they include histopathologic confirmation of diagnosis. 
Different levels of disease severity and diagnostic inaccuracy 
could account for some of the inconsistencies between studies. 
Although all used standard clinical diagnosis criteria, studies 
have shown these criteria to routinely fail in accurately differ-
entiating between AD and non-AD dementia [56]. A study of 
15,367 patients found that 16.6% of patients with VaD were 
misdiagnosed with AD [57]. It is possible that the AD samples 
in the studies reviewed include patients with VaD, which would 
introduce variability to the outcomes. Studies also vary in the 
range and breadth of potentially confounding variables 
adjusted for which affects outcomes and their interpretation. 
Participants with ungradable retinal photographs were 
excluded from most studies. Excluded participants were 
more likely to have vascular risk factors [21,22,24]. Because 
of the association of these risk factors with both dementia 
and retinal abnormalities the observed associations may have 
been falsely attenuated as a result of selection bias.

Although not wholly consistent, the findings of this 
review provide evidence to support the hypothesis that 
changes in retinal microvasculature identified using 
fundus imaging are associated with dementia. The mea-
surement of retinal microvasculature, particularly FD, 
using fundus camera imaging appears to offer a promis-
ing means of noninvasively identifying retinal micro-
vascular abnormalities associated with dementia. 
However, the strength of the relation between retinal 
microvascular properties and dementia is modest, which 
limits the prognostic value at the population level. Yet, 
imaging the retinal microvasculature may be used to in-
crease understanding of the mechanisms underlying the 
pathogenesis of dementia, provide enhanced differentia-
tion of dementia subtypes, and as a potential means of 
improving detection of those at an increased risk of de-
mentia. Future research should explore the diagnostic 
and prognostic contribution of combining measures of the 
retinal vasculature with other clinical and imaging 
biomarkers in a multimodal approach, for example, met-
rics derived from retinal OCT. Analysis of combined 
retinal vascular parameters (e.g., vessel calibers, FD, 
and tortuosity), instead of individual markers, may also 
provide increased sensitivity and specificity for different 
subtypes of dementia. In addition, dynamic functional 
measures of retinal microcirculation including flowmetry 
[58], retinal oximetry [59], and dynamic vessel assess-
ments [60] could provide further valuable insights into 
cerebral hemodynamics in dementia. Greater measure-
ment harmonization between studies with a consensus 
on standards for scientific reporting of retinal microvas-
cular changes related to dementia is required. Measures 
taken to optimize image analysis through the introd-
cution of standard operating procedures related to imaging 
techniques, camera systems, and measurement could 
help to reduce the variability and increase the clinical 
utility of retinal imaging. Further studies with common 
objective and standardized retinal measurements are 
required in larger samples of patients with different 
forms of dementia to increase understanding of the spec-
icity of retinal microvascular abnormalities. In addi-
tion, more prospective data are needed to determine the 
most appropriate parameters for application as diag-
nostic tools or biomarkers for risk of development of de-
mentia. These issues need to be addressed before a 
conclusion on the true clinical utility of fundus camera 
imaging in dementia can be reached.

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1. Systematic review: We searched Medical Literature Analysis and Retrieval System Online, Excerpta Medica Database, PubMed, and Google Scholar for all human studies published until March 2016. Studies were systematically evaluated and meta-analysis of pooled results was performed.

2. Interpretation: This is the most comprehensive systematic review focusing specifically on the use of fundus camera imaging in dementia. Significant pathologic changes in retinal parameter were found. Results across studies were inconsistent potentially because of varied methodologies applied and the lack of standardized methods and measurements.

3. Future directions: The potential of fundus camera image analysis in differentiating between dementia subtypes should be the subject of further research of larger well-powered samples of well-characterized dementia types with sufficient numbers for stratified analyses. A particular focus on VaD is warranted because of previous findings of an association of retinal vessel width and major risk factors for VaD, cerebral small vessel disease, and stroke.

References


