Ophthalmology Macular Pathways



- Age related Macular Degeneration
- Diabetic Macular Oedema
- Macular Oedema secondary to Central Retinal Vein Occlusion
- Macular Oedema secondary to Branch Retinal Vein Occlusion
- CNV associated with pathological myopia
- Vitreomacular Traction

Age-related Macular Degeneration (AMD)

Diagnostics to

- · Logmar visual acuity/ Amsler Grid
- Slit Lamp Biomicroscopy
- · Fluorescein angiography optional
- OCT scanning
- ICG* angiograpy optional

Outside of NICE criteria or Dry AMD

Eye Clinic Liaison Officer

Treatable wet AMD 6/12 – 6/96

1st Line

Drug choice takes into account cost effectiveness and patient preference Ranibizumab TA 155 1st line sequential use is not supported; a business case should be submitted if this is required

Or

Aflibercept TA 294

Or

Photodynamic Therapy (PDT) TA 68

If all of the following apply:

- the best-corrected visual acuity is between 6/12 (0.3) and 6/96 (1.2)
- there is no permanent structural damage to the central fovea
- the lesion size is less than or equal to 12 disc areas in greatest linear dimension
- there is evidence of recent presumed disease progression (blood vessel growth, as indicated by fluorescein angiography, or recent visual acuity changes)

Intra-vitreal injection monthly for 3 months 1 injection per month until max visual acuity is achieved (usually 3 or more) then monitoring and treatment intervals should be determined by the physician. The treatment interval should be extended by no more than 2 weeks at a time. PAS must be used.

OCT used to assess response to treatment.

STOP treatment if a person's vision gets worse and there are changes inside the eye which show that treatment isn't working.

If not responding consider doing ICG angiography and PDT

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- the best-corrected visual acuity is between 6/12 (0.3) and 6/96 (1.2)
- there is no permanent structural damage to the central fovea
- the lesion size is less than or equal to 12 disc areas in greatest linear dimension
- there is evidence of recent presumed disease progression (blood vessel growth, as indicated by fluorescein angiography, or recent visual acuity changes)

Monthly appointments for intra-vitreal injection for 3 months THEN

Regular intra-vitreal injection alternate months. Assess visual acuity at 12 months

PAS must be used.

Only in classic with no occult subfoveal choroidal neovascularisation (CNV) and best-corrected visual acuity 6/60 (1.0) or better.

PDT can be useful for specific patients with a rare variant of AMD and those patients with needle phobias

2nd Line

Photodynamic Therapy (PDT) TA 68

TA 68 says PDT is an option. It does not mention second line after failure of anti-VEGF. It is being proposed here for cases that fail who may have a rare variant of AMD.

Only in classic with no occult subfoveal choroidal neovascularisation (CNV) and best-corrected visual acuity 6/60 (1.0) or better. PDT can be useful for specific patients with a rare variant of AMD

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Diabetic Macular Oedema

Prevention: management of blood sugar, BP, cholesterol and smoking cessation

83% Type II diabetes progressing to diabetic retinopathy

29% progressing to Diabetic Macular Oedema

17% progressing to Clinically Significant Macular Oedema

Diagnostics

- Logmar visual acuity/ Amsler Grid
- Slit Lamp Biomicroscopy
- Fluorescein angiography
- OCT scanning
- ICG angiograpy optional
- Fundus autofluorescence useful for accessing previous laser

Eye Clinic Liaison Officer

Treatable

1st Line

Ranibizumab TA 274 1st line or 2nd line sequential use is not supported; a business case should be submitted if this is required

Or

Aflibercept TA 346

Or

to assess response to treatment

OCT used

Untreatable

Macular Laser photocoagulation

If the central retina thickness is 400 micrometres or more when treatment is started.

Intra-vitreal injection monthly for 3 months

1 injection per month until max visual acuity is achieved (usually 3 or more) then monitoring and treatment intervals should be determined by the physician. The treatment interval should be extended by no more than 1 month at a time.

Usually 7 4 2 pattern of injections.

If the central retina thickness is 400 micrometres or more when treatment is started.

Intra-vitreal injection monthly for 5 months, followed by 1 injection every 2 months

After the 1st 12 months, the treatment interval may be extended based on visual and anatomic outcomes and should be determined by the physician.

If no centre involvement or centre involvement with no vision loss > 78 letters

2nd Line

If no improvement with previous therapy

Fluocinolone TA 301

Or 1st/2nd Line

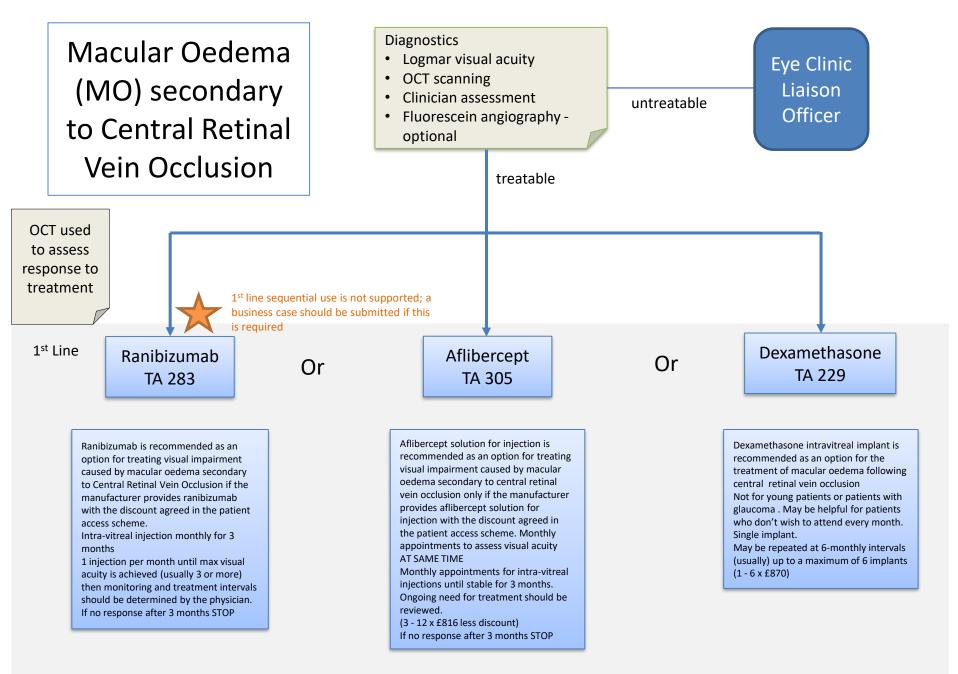
Dexamethasone TA 349

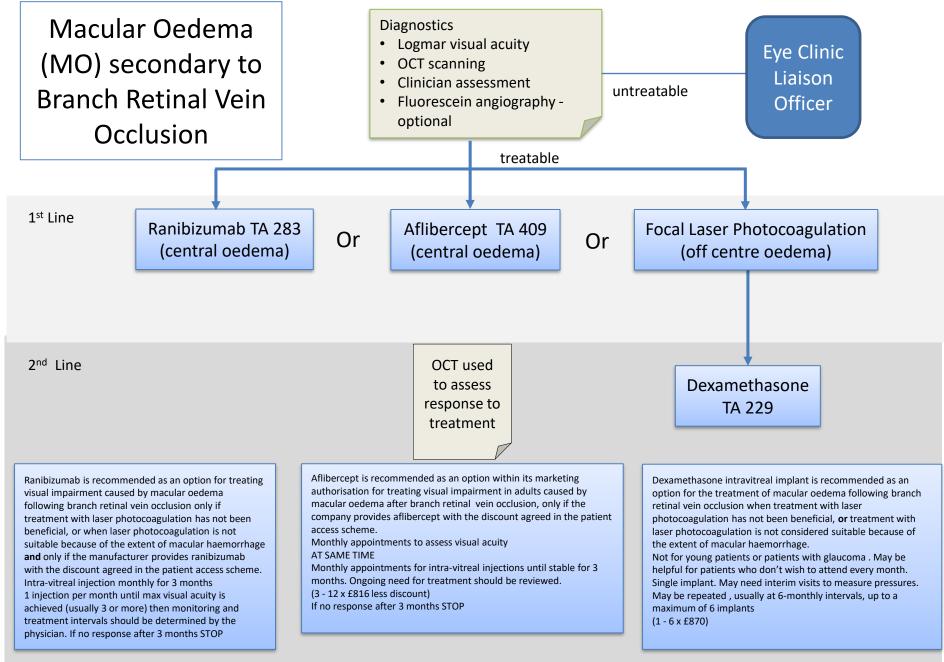
Recommended as an option for treating **chronic DMO** that is insufficiently responsive to available therapies if, used in an eye with an intraocular (pseudophakic) lens **and** supplied with the discount agreed in the patient access scheme. (£5,500 less discount).

NICE have strict criteria for chronic DMO. 36 month duration, but may be repeated after 12 months if deteriorates.

Recommended as an option If to be used in an eye with an intraocular (pseudophakic) lens **and** the DMO does not respond to non-corticosteroid treatment, or such treatment is unsuitable.

Single implant, but may be repeated after approximately 6 months if there is decreased vision (with or without an increased retinal thickness) with recurrent or worsening diabetic macular oedema.





CNV associated with pathological myopia

disease activity.

treatment.

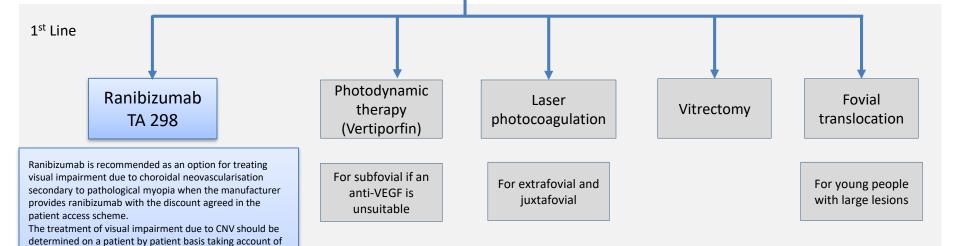
treatment.

Many patients may only need one or two injections during the first year, while some patients may need more frequent

Follow-up visits can be combined with a treatment visit and would not incur any additional costs. However, there are occasions when follow-up visits are done without

Diagnostics

- · Logmar visual acuity/ Amsler Grid
- Slit Lamp Biomicroscopy
- Fluorescein angiography optional
- OCT scanning
- ICG angiograpy optional



Vitreomacular Traction (VMT)

Diagnostics

- Fluorescein angiography optional
- OCT scanning

GASS Biomicrosopic Stage

- 1a} 1b} 50% resolve spontaneously
- 2 >98% closure with early surgery (but waiting times)
- 3 } Vitrectomy with fluid/gas exchange

1st Line

Ocriplasmin TA 297

Ocriplasmin is recommended as an option for treating vitreomacular traction in adults, only if: an epiretinal membrane is not present **and** they have a stage II full-thickness macular hole with a diameter of 400 micrometres or less **and/or** they have severe symptoms.

Single intravitreal injection at a dose of 0.125 mg (£2500 and administration £177)