Age-related Macular Degeneration (AMD)

NHS
Bath and North East Somerset, Swindon and Wiltshire
Clinical Commissioning Group

Diagnostics
- Logmar visual acuity/ Amsler Grid
- Slit Lamp Biomicroscopy
- Fluorescein angiography – optional
- OCT scanning
- ICG angiograpy – optional (if available)

Treatable wet AMD 6/12-6/96

1st line

Drug choice should take into account cost effectiveness and patient preference

Ranibizumab TA 155

Or

Aflibercept TA 294

Or

Brolucizumab TA 672

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

One Intra-vitreal injection monthly until max visual acuity is achieved (usually 3 or more). Once stable the treatment interval may be extended. 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 discount

One Intra-vitreal injection monthly for 3 months. The treatment interval is then extended to two months. Once stable the treatment interval may be extended. 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 discount

One Intra-vitreal injection monthly for the first 3 months. A disease activity assessment is suggested 16 weeks (4 months) after treatment start. In patients without disease activity, treatment every 12 weeks (3 months) should be considered. In patients with disease activity, treatment every 8 weeks (2 months) should be considered. The physician may individualise treatment intervals based on disease activity as assessed by visual acuity and/or anatomical parameters. PAS discount

NICE NG82 states: *Consider switching anti-VEGF treatment for people with late AMD (wet active) if there are practical reasons for doing so, but be aware that clinical benefits are likely to be limited.*

OCT used to assess response to treatment. STOP treatment when visual and anatomic parameters indicate that the patient is not benefiting from continued treatment

If not responding consider doing ICG angiography and PDT

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Diabetic Macular Oedema (DMO) (CRT ≥ 400 micrometers)

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

Prevention: Patients should be counselled on the importance of management of blood sugar, BP, cholesterol and smoking cessation to slow progression of disease

1st line

Drug choice should take into account cost effectiveness and pt preference

Or

Ranibizumab TA 274

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

One Intra-vitreal injection monthly until max visual acuity is achieved (usually 3 or more). Once stable the treatment interval may be extended. 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. PAS discount.

NICE TA346 states that the committee thought that sequential treatment was unlikely to be cost-effective but were unable to make a recommendation due to lack of evidence.

OCT used to assess response to treatment. STOP treatment when visual and anatomic parameters indicate that the patient is not benefiting from continued treatment

Aflibercept TA 346

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

One Intra-vitreal injection monthly for 5 months,. The treatment interval is then extended to two months. Assess visual acuity at 12 months. Once stable the treatment interval may be extended. Monitoring and treatment intervals should be determined by the physician. PAS discount

Use of anti-VEGFs in combination with steroid implants in the same eye is not commissioned or licensed.

1st or 2nd line

Dexamethasone TA 349

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 and/or an increase in retinal thickness, secondary to recurrent or worsening diabetic macular oedema. There is currently no experience of the efficacy or safety of repeat administrations in DMO beyond 7 implants. The SPC for Ozurdex® states that administration to both eyes concurrently is not recommended

Or

2nd line

Fluocinolone TA 301

If treating **chronic** DMO that is insufficiently responsive to available therapies, to be used in an eye with an intraocular (pseudophakic) lens. Single implant, releases fluocinolone for up to 36 months. **May NOT be repeated more frequently than every 36 months** as there are currently no data available demonstrating further benefit from reimplantation. **Patients need to have gained 10 or more ETDRS letters of visual acuity between baseline and month 36 to receive a further implant at month 36 according to the NICE TA301.**
The SPC for Iluvien® states that administration to both eyes concurrently is not recommended.

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Macular Oedema secondary to Central Retinal Vein Occlusion (CRVO)

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Diagnostics
- Logmar visual acuity
- OCT scanning
- Clinician assessment
- Fluorescein angiography - optional

OCT used to assess response to treatment. STOP treatment when visual and anatomic parameters indicate that the patient is not benefiting from continued treatment

1st line

Drug choice should take into account cost effectiveness and patient preference

Ranibizumab TA 283

Recommended as an option for treating visual impairment caused by macular oedema secondary to CRVO.

One Intra-vitreal injection monthly until max visual acuity is achieved (usually 3 or more). Monitoring and treatment intervals should be determined by the physician. The interval between doses should not be shorter than 1 month. If no response after 3 months STOP.

Or

Aflibercept TA 305

Recommended as an option for treating visual impairment caused by macular oedema secondary to CRVO.

One Intra-vitreal injection monthly until max visual acuity is achieved (usually 3 or more). Monitoring and treatment intervals should be determined by the physician. The interval between doses should not be shorter than 1 month. If no response after 3 months STOP.

Or

Dexamethasone TA 229

Recommended as an option for the treatment of macular oedema following CRVO.

Single implant, may be preferred by patients who don't favour monthly injections. Not for young patients or patients with glaucoma. May be repeated after approximately 6 months.
The SPC for Ozurdex states that there is only information concerning the current safety experience of repeat administrations for just over 2 implants in Retinal Vein Occlusion.
The SPC for Ozurdex® states that administration to both eyes concurrently is not recommended.

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Macular Oedema secondary to Branch Retinal Vein Occlusion (BRVO)

NHS
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Clinical Commissioning Group

Diagnostics
- Logmar visual acuity
- OCT scanning
- Clinician assessment
- Fluorescein angiography - optional

Or

1st line

Drug choice should take into account cost effectiveness and patient preference

Ranibizumab
TA 283

Recommended as an option for treating visual impairment caused by macular oedema following BRVO only if PAS discount provided. One Intra-vitreal injection monthly until max visual acuity is achieved (usually 3 or more). Monitoring and treatment intervals should be determined by the physician. If no response after 3 months STOP

Aflibercept
TA 409

Recommended as an option for treating visual impairment in adults caused by macular oedema after BRVO if PAS discount provided.
One Intra-vitreal injection monthly until max visual acuity is achieved (usually 3 or more). Monitoring and treatment intervals should be determined by the physician. If no response after 3 months STOP

2nd line

Dexamethasone
TA 229

OCT used to assess response to treatment. STOP treatment when visual and anatomic parameters indicate that the patient is not benefiting from continued treatment

Recommended as an option for treating macular oedema following BRVO when treatment with laser photocoagulation has not been beneficial, **or** treatment with laser photocoagulation is not considered suitable because of the extent of macular haemorrhage.
Single implant, may be preferred by patients who don't favour monthly injections. Not for young patients or patients with glaucoma. May be repeated after approximately 6 months. The SPC for Ozurdex states that there is only information concerning the current safety experience of repeat administrations for just over 2 implants in Retinal Vein Occlusion.
The SPC for Ozurdex® states that administration to both eyes concurrently is not recommended.

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Choroidal neovascularisation (CNV) associated with pathological myopia

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Diagnostics
- Logmar visual acuity/Amsler grid
- Slit Lamp Biomicroscopy
- Fluorescein angiography - optional
- OCT scanning
- ICG angiograpy – optional

1st line

Drug choice should take into account cost effectiveness and patient preference

Ranibizumab TA 298

Recommended as an option for treating visual impairment due to CNV secondary to pathological myopia.
One single dose intravitreal injection. Additional doses may be administered if visual and/or anatomic outcomes indicate that the disease persists. The interval between doses should not be shorter than 1 month. Monitoring and treatment should be determined by the physician on an individual patient basis taking account of disease activity. Many patients may only need one or two injections during the first year, while some patients may need more frequent treatment.

Or

Aflibercept TA 486

Recommended as an option for treating visual impairment due to CNV secondary to pathological myopia.
One single dose intravitreal injection. Additional doses may be administered if visual and/or anatomic outcomes indicate that the disease persists. The interval between two doses should not be shorter than one month. Monitoring and treatment should be determined by the physician on an individual patient basis taking account of disease activity. Many patients may only need one or two injections during the first year, while some patients may need more frequent treatment.

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Non infectious uveitis

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Diagnostics
- Logmar visual acuity/Amsler grid
- Slit Lamp Biomicroscopy
- Fluorescein angiography - optional
- OCT scanning
- ICG angiograpy – optional

1st line

Dexamethasone
TA 460

Recommended as an option for treating non-infectious uveitis in the posterior segment of the eye in adults, only if there is active disease (that is, current inflammation in the eye) and worsening vision with a risk of blindness. Single implant, but may be repeated after approximately 6 months. Repeat doses should be considered when a patient experiences a response to treatment followed subsequently by a loss in visual acuity and in the clinician's opinion patient may benefit from retreatment without being exposed to significant risk. See SPC for information concerning repeat administrations beyond 2 implants. Administration to both eyes concurrently is not recommended.

2nd line

Fluocinolone
TA 590

Recommended as an option for prevention of relapse in recurrent non-infectious uveitis affecting the posterior segment of the eye. NICE states if the disease has responded well to a dexamethasone implant, clinician could consider using a fluocinolone acetonide implant instead of another dexamethasone implant. Single implant, releases fluocinolone for up to 36 months. There are no data available to support the retreatment of patients with an additional implant Administration to both eyes concurrently is not recommended.

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