Transcript Details
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nAMD and RVO: Understanding the Impact on Patient Lives and the Need for Timely Diagnosis and Referral

Announcer:
Welcome to CME on ReachMD. This activity is part of a special series titled “Time is Vision in Neovascular Age-Related Macular Degeneration and Retinal Vein Occlusion” and is provided in partnership with the National Eye Institute of the National Institutes of Health, of the U.S. Department of Health and Human Services, along with Prova Education. It’s supported by an independent educational grant from Regeneron Pharmaceuticals. To view this activity or others in the series, please visit EyeHealthAcademy.org/TimeIsVision

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Dr. Chew:
Nearly 2 million individuals in the United States are living with age-related macular degeneration. Another 1.6 million have retinal vein occlusion, or RVO, and these numbers are increasing. We’ve had many advances in treatment, but are we doing all we can to prevent vision loss in our patients?

This is CME on ReachMD. I’m Dr. Emily Chew, and joining me for today’s discussion are Drs. Neil Bressler, Joseph Coney, and Steven Ferrucci. Welcome.

Dr. Bressler:
Emily, thank you for having me.

Dr. Coney:
Thank you for having me.

Dr. Ferrucci:
Thanks for having me.

Dr. Chew:
First, let me start off by saying that diabetic retinopathy is another retinal disease with a concerning increase in prevalence. Other educational activities on that specific topic can be found at EyeHealthAcademy.org.

Today we’re talking about AMD and retinal vein occlusions, or RVO. Joe, what do you know about the increasing prevalence of AMD and RVO?

Dr. Coney:
Emily, thank you for that question. You know, unfortunately, both of these conditions, there’s an increase in both macular degeneration and retinal vascular disease because they’re both linked to aging. It’s been reported that nearly 200 million people have been diagnosed with macular degeneration, and 11 million people will have either moderate or severe loss. And that’s mostly because of the advancing disease in the dry form, and unfortunately, the devastating neovascular component. Retinal vein occlusion is also increasing because of the aging and also because of the risk factors that we have, which are high blood pressure, heart disease, kidney disease, obesity, and things of the like. So as the population continues to increase, both of these will be a problem because they both cause substantial loss of vision. I think the most important thing is that we have good therapies that can address the vision earlier in order to have better visual outcomes.

Dr. Chew:
Well, thank you. Thank you very much, Joe.

Considering available randomized clinical data on AMD, Steve, what do we know about the treatment of AMD and patient outcomes?

Dr. Ferrucci:
In regards to treatment of AMD, there are more available options now compared to when I started practice in the mid '90s. Back then, we could often do nothing but sit back and idly watch as our patients lost vision. But dry AMD, the AREDS [Age-Related Eye Disease Study], and the AREDS2 study showed us a specific combination of vitamins, including lutein and zeaxanthin, could help slow the progression and reduce the risk of vision loss in those patients with intermediate or worse AMD by approximately 25%. Therefore, I recommend the use of vitamins in appropriate patients, as well as frequent monitoring and other lifestyle changes, such as no smoking, maintaining healthy weight, and a healthy diet with green leafy vegetables.

When it comes to wet or neovascular AMD, we are now in the era of serial anti-VEGF injections. Data shows us that treated patients have better vision than those untreated, and baseline VA at the start of treatment is the best predictor for final vision. Therefore, the better the vision at the start of treatment, the better it will be at the end. However, multiple studies tell us that patients are often diagnosed with AMD too late. As an example, only 36% of patients had visual acuity of 20/40 or better at the time of diagnosis, according to the CATT trial data. I think the bottom line is that we need to do better in diagnosing AMD earlier, especially wet AMD, and making sure those that need treatment receive it promptly. Time is vision, so the sooner a patient is diagnosed and treated if needed, with as little delay as possible, the better off the patient will be in the long run.

Dr. Chew:
Thank you, Steve. That really is really important. This time is indeed vision. I picked up on the point that visual acuity at diagnosis is very important. I was part of the AREDS Home Study group that showed that telemonitoring with a home device improved early diagnosis, and patients in the device arm actually had a smaller drop in visual acuity than those who were not.

So, Neil, what are your thoughts on this home monitoring?

Dr. Bressler:
You know, I think it's very important. We have excellent treatments right now to get excellent outcomes. But they require frequent monitoring once we start treatment, and even before we start treatment, it requires us to identify these patients, ideally before they've lost a lot of vision. Now, some patients will suddenly come in with a hemorrhage and lose a lot of vision, and we can't help that, but there are many patients with the neovascular form of macular degeneration who start with just a little vision loss, and if we could just improve our ability to monitor them, identify those patients, and bring them in while their visual acuity is still 20/25 or 20/40, we have a much better chance of ending up with good vision after treating them.

Dr. Chew:
Let's turn our attention now to RVO, which is a little different given its acute onset. What do the data tell us, Joe?

Dr. Coney:
Well, Emily, I think this is very similar to what we see in AMD. Both of these diseases, people can have a rapid decrease in visual acuity when there's a problem. Just like AMD, when there's neovascularization that affects the central part of the eye, in a vein occlusion, once the blockage occurs, people can also have a significant decrease in vision. The average time people normally present to us is approximately 3 months. I think we learned a lot from some of our national clinical trials, which we tried to interpret in our own clinical data, in our own clinical lives in our practice, which is somewhat tough.

So, if we look at CRUISE, for example, which is a randomized, multicenter trial, a pivotal trial which led to the approval of ranibizumab for the treatment of macular edema secondary to retinal vein occlusions. These individuals received aggressive therapy for the first 6 months. They either received a 0.3-mg dose or 0.5-mg dose every single month. The second phase of the study was an observation group, where they were able to receive treatment on an as-needed basis, or PRN basis we call it, based on certain criteria. But individuals that did not receive an injection between month 6 and month 7, 50% of these individuals lost vision and had a recurrent swelling and needed current therapy. Two-thirds of these individuals within the next 6 months, needed treatment in order to maintain those same visual gains. If you look at the sham arm – the one that did not receive therapy until 6 months – they had a rapid decrease in the OCT, which we normally see in most of our trials, but the visual gains were actually stunted.

So we know that by delaying therapy, you don't get the same visual gains, at least what we see in the CRUISE study. And we see this in other trials as well. I think this is a testament to show that earlier treatment normally does better.

One other thing that we know from the clinical trials is that by delaying therapy from the time of onset, you also can actually decrease

the level of neovascularization. Even if you increase it by 30 days or more, you increase the rate of neovascularization as well as increasing additional adjunct therapy that needed to actually treat those eyes.

Dr. Crews:
So indeed, time really is vision. In our last few moments, I'd like to pose this question to each of you. What actually should we be taking to improve early diagnosis of neovascular AMD and RVO? Steve, why don't you go first.

Dr. Ferrucci:
Sure, thanks Emily. As an optometrist, I feel our primary job is to detect patients who have converted from dry to wet AMD and get those patients treated as soon as possible. Therefore, I strongly feel that any dry AMD patient that presents with reduced vision or metamorphopsia should be assumed to have wet AMD until proven otherwise. The best way to do this is with OCT or OCT angiography, where one can evaluate the macula for any signs of fluid, leakage, or active CNVM [choroidal neovascular membranes]. If you're unable to ascertain with certainty that there is no fluid, an indication of conversion from wet to dry disease, or do not have an OCT available, these patients should promptly be referred to a retinal specialist for advanced imaging and further evaluation.

Dr. Crews:
Thank you. And you, Joe?

Dr. Coney:
Well, I think one of the most important things that we should look at is earlier detection, so if optometrists, for example, see anyone with a vein occlusion disease, I think early referral to a retina specialist is important. You know, studies have shown that even in eyes that have poor visual acuity, we're able to salvage those eyes, and 70% of the time we can have visual acuity better than 20/70. Wide-field angiography, I think, is really important. Anecdotally, we don't have all the answers in terms of how to treat these eyes when they don't have macular edema and when they don't have neovascularization, but we have a significant amount of information that tells us that anti-VEGF medications can delay the onset of neovascularization, although it cannot prevent it. So if we do additional testing, look into periphery in eyes that we may not have a good idea of what's going on, if we see eyes that could be sick and more prone to having more complications, we may be able to save these eyes and halt the disease process.

Dr. Chew:
So early diagnosis and these diagnostic tools are very important for our armamentarium. And how about you, Neil? What thoughts do you have?

Dr. Bressler:
You know, Emily, I think it's all about patient education. Patient education when you first diagnose that the person needs anti-VEGF treatment for the neovascular form of macular degeneration, or for macular edema from a central vein occlusion, to tell them we probably need to monitor them almost every month for the first year or 2. And that may be shocking to them, but we say that's what we want to do to get excellent outcomes. And then the education doesn't stop there. You want to continue that education with each and every visit they have. So I actually use the time when I'm injecting them, month after month after month, to reinforce that they're doing well. They still need to come back. And maybe after 4 or 5 injections, they tell me, "I'm getting a little tired of this," and I say, "Don't get tired of it. We're doing all we can to save your vision, and it's critical that you keep coming back." So education in the beginning to monitor them, education during the times that you're treating them.

I've put together a video for patients to help them understand the importance of early as well as continued treatment, and you can find it at EyeHealthAcademy.org/TimeIsVision.

Dr. Chew:
Well, thank you, Neil. That really is important. Patient education and their expectations need to be completely – really, really an important aspect for them to be thinking about and bringing them back. So these are important steps that we should all be taking for our patients.

Well, that's all the time we have for today. I'd like to thank the audience for listening and to thank Drs. Bressler, Coney, and Ferrucci for joining me today. It was a pleasure having all of you with me. Thank you so much.

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