THE ROYAL VICTORIA EYE AND EAR HOSPITAL DUBLIN

LOOKING AFTER THE NATION'S EYES AND EARS SINCE 1897

Clinical Guideline for the treatment of

SUSPECTED MACULAR NEOVASCULARISATION

DESCRIPTION

Macular neovascularization is an invasion by vascular and associated tissues into the outer retina, subretinal space, or sub-RPE space in varying combinations.

HOW TO ASSESS

EXAMINATION

1. Complete ophthalmic exam.
2. Assess for signs of inflammation, posterior uveitis, chorioretinal lesions.
3. OCT macula both eyes, and consider optos colour photos/autofluorescence if indicated.
4. Some disturbance at level of retinal pigment epithelium (RPE) should be present in cases of neovascular AMD (nAMD) – e.g. pigment epithelium detachment (PED), subretinal hyperreflective material (SRHM) etc. Cystoid macular oedema (CMO) symmetrically around fovea in absence of RPE disturbance should raise suspicion of alternative diagnosis such as inflammatory CMO, pseudophakic CMO etc.

TREATMENT

Suspected nAMD, myopic choroidal neovascular membrane (CNV)

- Direct appointment with MR service within 2 weeks. Give information leaflet re
- Intravitreal Injections to patient as likely they will be offered same day injection at MR appointment.

If >2DD (disc diameters) of subretinal haemorrhage present and involving fovea and <2 weeks since onset:

- discuss with VR re possible surgical intervention.

Suspected inflammatory CNV and inflammatory CMO (Toxoplasma, PIC etc):

- Refer to uveitis service.

Pseudophakic CMO:

- Refer back to surgeon who performed cataract surgery or to general consultant on-call if not available.

FOLLOW-UP

Patients currently or previously under the care of any retinal consultant at RVEEH should be referred back to that consultant's service in the first instance.