Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/eye-on-ocular-health/managing-rvo-goals-of-early-intervention/54487/

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Managing RVO: Goals of Early Intervention

Announcer:

You're listening to *Eye on Ocular Health* on ReachMD. On this episode, we'll hear from Dr. Michael Javaheri, who's an Adjunct Clinical Professor of Ophthalmology at the Keck School of Medicine at USC, as well as the Managing Partner and Director of Research for Retina Specialists of Beverly Hills. He'll be discussing the burden of retinal vein occlusion and goals for its management.

Here's Dr. Javaheri now.

Dr. Javaheri:

Retinal vein occlusion is one of the most common retinal vascular diseases we manage, and the burden is significant. Whether it's a branch retinal vein occlusion, central retinal vein occlusion, or hemi retinal vein occlusion, the underlying issue is venous outflow obstruction leading to increased intravascular pressure, vascular leakage, hemorrhage, ischemia, and then macular edema.

The main reason patients lose vision is macular edema. If that edema is not treated effectively and efficiently, the retina can develop chronic structural damage, including photoreceptor disruption, disorganization of the retinal inner layers, and permanent vision loss. In CRVO especially, we also worry about ischemia-driven complications such as neovascularization and neovascular glaucoma, which can be devastating to the patient.

So I do not view RVO as a benign condition. Some BRVO patients may improve spontaneously, but many do not. The goal is to treat early enough to recover vision, dry the macula, and prevent chronic edema from becoming permanent retinal damage.

When I start anti-VEGF therapy in RVO, I'm trying to accomplish three things: improve vision, dry the macula, and eventually reduce treatment burden.

The first goal is visual recovery. I want to see improvement in the best corrected visual acuity, but I also want the patient to function better in real life.

The second goal is an anatomic response on OCT. I am looking at central subfield thickness, intraretinal fluid, subretinal fluid, and whether the foveal contour is normalizing.

The third goal is durability. Once the macula is controlled, how far can I extend the patient safely without recurrent edema? This is where newer agents matter. Historically, retinal vein occlusion patients often needed frequent injections, especially early on due to the high VEGF load. The recent QUASAR data with aflibercept eight milligram is important because it showed that after three or five monthly loading doses, every-eight-week aflibercept eight milligram achieved non-inferior visual acuity gains compared with aflibercept two milligram every four weeks at week 36. That gives us a practical pathway to maintain control with fewer injections.

Announcer:

That was Dr. Michael Javaheri talking about treatment goals for retinal vein occlusion. To access this and other episodes in our series, visit *Eye on Ocular Health* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.

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