

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/strategies-for-addressing-complications-in-retinal-vein-occlusion/37666/>

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Strategies for Addressing Complications in Retinal Vein Occlusion

ReachMD Announcer:

This is *Eye on Ocular Health* on ReachMD. On this episode, we'll hear from Dr. Lisa Schocket, who will be discussing complications of retinal vein occlusion and strategies for managing them. Dr. Schocket is an Associate Professor and Chair of the Department of Ophthalmology and Visual Sciences at University of Maryland School of Medicine in Baltimore.

Here she is now.

Dr. Schocket:

So the three reasons why patients lose vision with retinal vein occlusion is, number one, ischemia. So if there's poor blood flow to the central retina or the fovea, we don't really have any great treatment for that. Once the macula or the fovea is really ischemic, we don't have a great way of bringing back vision. For retinal neovascularization, we treat that with laser, and you can lose vision in this scenario because you can develop a vitreous hemorrhage or, rarely, tractional retinal detachment.

The most common reason why people lose vision from vein occlusions is from macular edema or chronic macular edema. We treat macular edema with intravitreal anti-VEGF agents, usually as first line. I typically treat people monthly. I start with a less expensive agent, and if the patient fails that agent, then I move up to maybe something that has proven to last a little bit longer or might be, quote unquote, "a little bit stronger." And then I treat them monthly until the macular edema is gone.

And then I prefer to treat and extend. We know that both branch retinal vein occlusions and central retinal vein occlusions have a higher level of VEGF, and so stopping someone cold turkey or stopping someone totally usually leads to rebound swelling. So, in my opinion, it's better to extend the interval rather than stopping completely. If the patient fails all anti-VEGF agents, I then try intravitreal steroids. I think the intravitreal dexamethasone implant is great. You do need to watch for glaucoma, and I obviously prefer to treat patients with steroids who have already had cataract surgery.

ReachMD Announcer:

That was Dr. Lisa Schocket talking about strategies for effectively managing complications of 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!