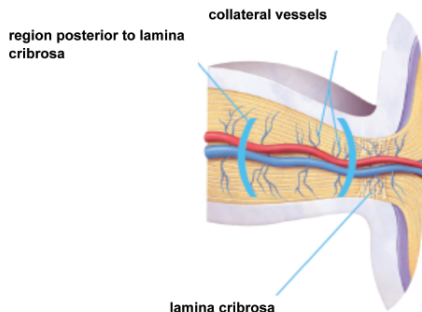


there are two or more central retinal veins. These patients can have occlusion of only one of these veins and have what is called a hemi-central vein occlusion. These often cause less damage than a full central vein occlusion.

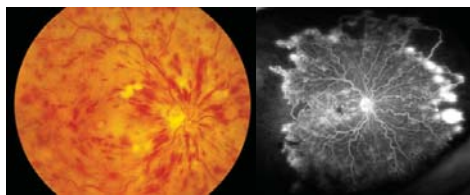


Schematic of central retinal vein occlusion (CRVO) with blockage at the level of the optic nerve.

Most patients who have this problem have risk factors for vascular disease. This may be diabetes, high blood pressure, arteriosclerosis, open angle glaucoma or a condition called thrombophilia. In younger patients, usually under age 40, we check for clotting disorders. We may find an important abnormality that needs to be treated. If there is a family history of strokes or miscarriages or if the patient has autoimmune problems, then the tests are particularly important. Since these problems are stroke-type events, we request that you check with your primary care doctor for a review of your medical condition.

The blockage causes blood to back up in the eye, which causes hemorrhages, swollen retinal veins, and edema or swelling. This often leads to visual loss. If the occlusion is severe, there can also be marked ischemia or closure of the capillaries. This can lead to abnormal vessels in the eye (neovascularization),

hemorrhage into the vitreous, and even abnormal vessels in the front of the eye that can lead to high pressures and glaucoma (rubeosis).

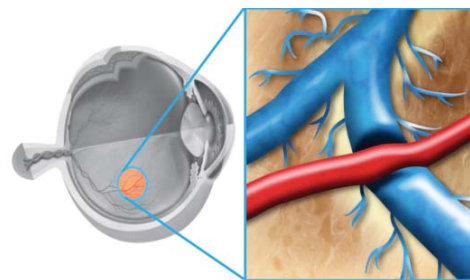


Central retinal vein occlusion: Photograph (left) and fluorescein angiogram (right). Note accumulation of dye in the center of the retina (leakage), and the loss of blood vessels in the peripheral retina.

It has been noted for forty years that some central vein occlusions are severe leading to blindness and complications and others are less severe with some visual loss but maintenance of some vision. Those eyes with severe vein occlusion have blood vessel closure (ischemia) and are more likely to have problems.

What is a Branch Retinal Vein Occlusion (BRVO)?

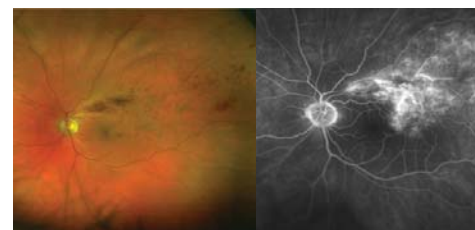
A more localized blockage of the retinal venous system may occur and this is called a branch vein occlusion. The arteries and veins in the back of the eye cross each other like highways on a map. At the places where arteries cross veins, there can be a blockage of the vein. The artery and vein share a common sheath and as the artery thickens with age or hypertension, the vein can be blocked by the thickened artery.



Schematic of branch retinal vein occlusion (BRVO) with compression and blockage of the vein (blue) by a thickened, stiff artery (red).

Most patients who have this problem have risk factors for vascular disease. This may be diabetes, high blood pressure, arteriosclerosis, open angle glaucoma or a condition called thrombophilia. In younger patients, usually under age 40, we check for clotting disorders to see if there is a clotting problem. The yield is not great, but sometimes we find an important abnormality that needs to be treated. If there is a family history of strokes or miscarriages or if the patient has autoimmune problems, then the tests are particularly indicated. Since these problems are stroke-type events, we request that you check with your primary care doctor for a review of your medical condition.

These blockages may not have any symptoms if the occlusion does not involve the macula. If the macula is involved, then there can be swelling of the retinal tissue that can lead to visual loss (macular edema).



Branch retinal vein occlusion: Photograph (left) and fluorescein angiogram (right). Note accumulation of dye in the center of the retina (leakage).

Laser treatment for BRVO has been shown to improve vision compared to the natural course without any treatment. The Lucentis study compared a control group that was treated like the vein occlusion study with a combination of untreated patients if the vision got better and laser treatment if the vision did not get better. In the Lucentis

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treated group, 61.1% got better and in the control group (including laser) only 28.8% improved three lines or more. The percentage of patients seeing 20/40 or better was 64.9 percent for the Lucentis group and 41.7 percent in the sham group. This difference, while significant was not large.

Because the Lucentis shots often require monthly injections, we usually treat with both approaches with the hope of being able to stop the monthly injections.

The most common systemic cause for BRVO is hypertension. It can also be seen in arteriosclerosis and diabetes. Sometimes there is no associated problem.

What treatments are available for Retinal Vein Occlusions (RVO)?

Treatment with Lucentis

There is a new treatment that is effective in improving vision and clearing macular edema in central retinal vein occlusion. It is injection of Lucentis into the eye once a month for at least six months. Lucentis is an antibody against the molecule that causes macular edema and the growth of abnormal vessels (Vascular Endothelial Growth Factor or VEGF).

Vision improvement is rapid and seen, on average, by seven days. Patients were treated with six monthly injections. After six months it may be possible to stop the treatment, but this varies from patient to patient. If the vision is down, we usually restart treatment immediately. If vision is good and there

is no macular edema, observation may be continued.

In CRVO, 48% got significantly better (3 lines on the visual acuity chart) compared to 17% in the control group (observation).

In BRVO, 61% improved by at least three lines compared to 29% in the control group (observation + macular laser).

Treatment with Avastin

There is another anti-VEGF drug called Avastin. This drug is FDA approved for the treatment of cancers and has also been shown to work for macular edema. We prefer to use Lucentis when possible because it is the drug that has been shown to work in large clinical trials, and it is prepared under strict and specific FDA guidelines for use inside the eye.

Treatment with Steroids

Another option of treatment is using intraocular steroid medications. The SCORE trial was a large, multicenter trial that demonstrated a **benefit in CRVO but not in BRVO**. However, there is a significantly-higher risk of glaucoma and cataracts in patients given steroid injections, especially if they need to be repeated.

There is also a long acting steroid implant called Ozurdex, which contains a different steroid, dexamethasone. There is also significant risk of cataract and glaucoma and the duration does not appear to be significantly different than triamcinolone. While we believe that Lucentis is a better, safer choice for most cases, sometimes steroid treat-

ment by itself or in combination with Lucentis may be warranted.

Treatment with Laser

In two large, multicenter clinical trial conducted in the 1990's (the Central Vein Occlusion Study, or CVOS), and the Collaborative Branch Vein Occlusion Study, or BVOS) demonstrated that laser treatment to the macula (the center of vision) demonstrated a **benefit in BRVO but not in CRVO**.

However, laser treatment outside the macula (peripheral or scatter laser) was demonstrated to be effective when abnormal blood vessels grow in the retina or iris (neovascularization). This is a rare but serious complication that can result in bleeding inside the eye (vitreous hemorrhage) and increased eye pressure (neovascular glaucoma).

What are occlusions of the retinal and optic nerve arterioles?

Central Retinal Artery Occlusion:

The arterial circulation of the eye can become occluded just like the venous system. What you see inside the eye is completely different. In a vein occlusion there is edema and hemorrhage. In retinal artery occlusion, the retina turns white.



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Central Retinal Artery Occlusion

Patients with central retinal artery occlusion lose vision suddenly. Unfortunately, the visual loss in central retinal artery occlusion is usually irreversible although there may be some improvement over time.

There is no good treatment of central retinal artery occlusion. Lowering the eye pressure or breathing into a bag have been advocated, but they don't seem to help.

Treating the artery occlusion aggressively like you would a stroke in the brain with TPA (tissue plasminogen activator) has also been tried, but without success.

If you have a central retinal artery occlusion, it is important to figure out why.

Sometimes these problems are caused by emboli from the heart or the carotid artery. Sometimes the blockage is a thrombus that forms in the artery itself with an aggregation of platelets (like the Plavix commercials on TV). Patients with an artery occlusion need to be checked by their doctor and usually have a carotid ultrasound to rule out disease there and an echocardiogram to rule out a clot in the heart. In younger patients there may be a heart condition called patent foramen ovale where there is a hole between the right heart and the left heart and emboli can cross into the arterial circulation. Patients also need to control their cholesterol and high blood pressure if elevated. Usually such patients are treated with aspirin or Plavix.

Branch Retinal Artery Occlusion:

Like in vein occlusions, sometimes only a part of the retina is involved and this is a branch artery occlusion. The same risk factors related to central artery occlusions also apply to branch artery occlusions. Medical evaluation should be undertaken.

There is a unique subset of retinal emboli where the ophthalmologist can actually see flecks of cholesterol in the eye. Sometimes they block the artery and sometimes not. Patients with the plaques in the retina called Hollenhorst plaques after the doctor who first reported them, need to be evaluated to rule out carotid artery disease and hypercholesterolemia.

Ischemic Optic Neuropathy:

Another vascular disease that affects the eye is an occlusion of the choroidal vessels around the optic nerve. This can lead to sudden visual loss and usually affects the upper or lower field of vision. There are no currently proven treatments although steroids and anti-VEGF drugs like Lucentis have been tried.

Ischemic optic neuropathy may be caused by hypertension or arteriosclerosis. It is also associated with temporal arteritis, an inflammatory disease of the arteries of the head. Additional symptoms with temporal arteritis are headaches, difficulty chewing, feeling tired, difficulty getting hands above the head, scalp tenderness, and weight loss. Patients suspected of this condition need blood work, a sed rate and c-reactive protein. Often a biopsy of their temporal artery is needed to confirm the diagnosis. The treatment for temporal arteritis is high dose steroids so it is important to be sure of the diagnosis if treatment is going to be continued for a long time.

Ischemic optic neuritis has also been associated with drugs to treat erectile dysfunction like Viagra. If you are taking these drugs it is important to stop and be evaluated.



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