UPDATED 22 September 2020

Medical Retinal Management Plans during COVID-19

This guidance has been developed by the RCOphth COVID-19 Review Team in response to the pandemic and may be subject to change.

The Royal College of Ophthalmologists (RCOphth) has produced guidance as a pragmatic approach to maintain care for those patients who need it while deferring care for those patients who can wait. Individual eye departments may institute their own guidelines.

For patients already under review by the hospital eye service

Wet AMD patients

As capacity has improved in Medical Retina services in most NHS Trusts, consider moving patients to pre-pandemic protocols. In most cases, this would be treat and extend protocols or individualised treatment regimens. It may be helpful to start with patients who previously could be maintained on a greater than 8 weekly interval as an initial cohort. For patients whose visual acuity has decreased by > 10 letters during the lockdown, consider moving them to an appropriate individualised dosing to stabilise or improve the visual acuity.

In rare situations, where Medical Retina services are still constrained by capacity issues, maintain all patients on 8 weekly anti-VEGF therapy* with no clinic review unless they mention a significant drop in vision at their injection visit. Such patients may need OCT and VA assessments and management changed, if deemed appropriate.

* please note bevacizumab is not recommended as an 8 weekly fixed dose anti-VEGF therapy but may be considered in a treat and extend protocol along with NICE approved anti-VEGF therapies

DMO

Defer anti-VEGF injections and review in clinic after 4 months. Exceptions are eyes with severe NPDR and active PDR that may require anti-VEGF agents and PRP. Virtual review with OCT and wide field colour photography is the preferred option to review these patients.

BRVO

Defer review in clinic by 4 months.

CRVO

For patients with macular oedema due to CRVO who have had at least 6 injections, consider PRP if required. Otherwise, review in clinic in 4 months.

Inherited retinaldiseases

Delay review by 6 months or longer.

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CSCR

Delay review by 6 months or longer.

Uveitis

Consultant decision on a case-by-case basis, on whether a review is required within 4 months. Most cases should be deferred by 4 months. Patients on immunosuppression should be managed virtually with blood tests done in local GP practice and following the specific Academy of Medical Royal Colleges guidance.

PRP Laser

Complete PRP but with appropriate PPE i.e. surgical masks and breathguard. If feasible, do one more extensive PRP laser to delay need for a second PRP session.

PDT laser for CSCR

Delay by 6 months or longer.

For new patients

Wet AMD

Consider implementing your pre pandemic protocols for diagnosis and treatment of new wet AMD patients. New wet AMD cases may be confirmed by OCT and OCTA. Fundus fluorescein angiography is not mandated if wet AMD is confirmed by OCT and OCTA.

If services remain constrained by capacity issues, diagnosis to be confirmed with OCT and OCTA, if available. Confirmed new wet AMD cases should be treated with a loading phase of 3 injections of anti-VEGF and then continue on 8 weekly with no clinic review. Consent is taken on the day of first injection.

DMO

Defer treatment for 6 months unless associated with R3. R3 patients should be treated with PRP.

BRVO

Defer review in clinic by 4 months.

CRVO

Provide a loading phase of 6 anti-vegf injections at 4 week intervals if visual impairment due to macular oedema and then review in clinic. If in the opinion of the clinician that there is no hope of visual improvement an alternative approach is an extensive PRP laser to reduce the risk of rubeotic glaucoma. However, visual outcomes are likely to be poorer with this approach.

Inherited retinaldiseases

Delay appointments for 6 months or longer then see in clinic.

UPDATED 22 September 2020

CSCR

Delay appointments for 6 months or longer then see in clinic.

Uveitis

Consultant case-by-case basis decision on whether to review or not. Patients on immunosuppression should be managed virtually with blood tests done in local GP practice and following the specific Academy of Medical Royal Colleges guidance.

Patients on clinical trials

Largely individual trust research departments will govern this but, as a general principle, it is recommended that observational studies are suspended. Drug trials where the patient would come to harm if the study stopped should continue for patients already on trials but recruitment of new patients should be suspended. Visual acuity measurements may need to be subjective as opposed to objective refracted best-corrected visual acuity measurements if optometry staff are not available.

RCOphth COVID-19 REVIEW TEAM

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