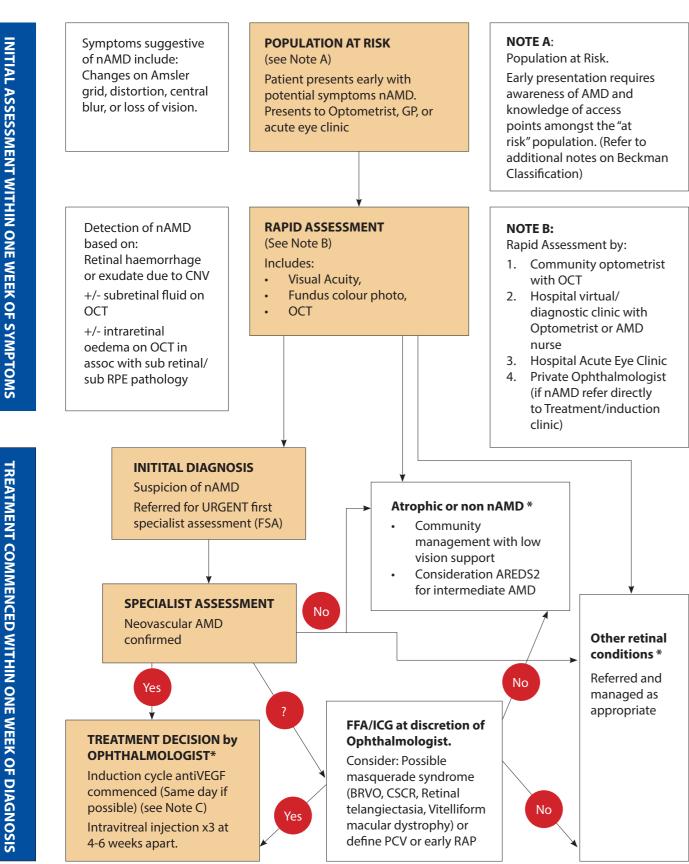
## NZ National guidelines for management of neovascular AMD





## **OPHTHALMOLOGIST** NOTE C: **TO ESTABLISH &** Injectors: Ophthalmologist **MANAGE** or suitably trained, DHB **Ongoing REVIEW by** approved and credentialed Treatment plan Ophthalmologist\* injector in accordance with • Team supervision **RANZCO** guidelines & delegation of **Care Co-ordination:** responsibilities to track treatment and Assessment as schedule appointments needed OCT on each visit FFA/ICG as required **Adequate response:** Continue treatment Treat and Extend protocol Inadequate/suboptimal response:\* 4,6,8,10,12 week Review diagnosis. Consider FFA/ICG or strict PRN protocol Switch to 2nd line antiVEGF Suboptimal Inadequate/ response:\* suboptimal response:\* Adequate response: **Further** Continue treatment Further treatment futile treatment T/E protocol at clinician's with retinal structural with antiVEGF @ discretion. ie damage including: 4,6,8,10,12 week treatment offers Subfoveal fibrosis benefit, reducing Outer retinal atrophy or strict PRN protocol **DISCHARGE** if good RPE Rip involving fovea progression of referral system with scotoma. robust re-entry Patient declining pathway. This requires further treatment. a good rapid access system to return Ongoing REVIEW by ophthalmologist\* **DISCHARGE** to community care with Stable for 12 months without treatment or atrophic AMD: **DISCHARGE** to post treatment low vision support. Provide education surveillance: optometrist or GP regarding second eye. with intermittent ophthalmology as required\*

## \*Low vision rehabilitation (LVR).

Any patient with  $\leq$  6/12 vision may benefit from LVR.

\*Indicates possible referral points for Low Vision rehabilitation if appropriate at multiple points in the pathway. LVA may be hospital or community based

Refer to MDNZ and Blind Foundation (if eligible) for support and information