THE ROYAL COLLEGE OF OPHTHALMOLOGISTS'

COLLEGE STATEMENT

Statement from The Royal College of Ophthalmologists on the rapid review of the technology appraisal of the use of intravitreal ranibizumab in patients with diabetic macular oedema (DMO)

The National Institute of Clinical Excellence (NICE) has completed a rapid review of the previous technology appraisal of the use of intravitreal ranibizumab in patients with diabetic macular oedema. The new guidance document on ranibizumab for diabetic macular oedema, (TA274), published on 27th February 2013[1], recommends that patients with DMO can be commenced on ranibizumab therapy in one or both eyes provided they have central retinal thickening greater than 400 microns measured on OCT at the start of treatment and if ranibizumab is provided by the manufacturer through the new patient access scheme which was agreed in 2012. The Royal College of Ophthalmologists welcomes this guidance which offers another treatment option for patients with severe diabetic macular oedema.

There are several points to note in this new guidance document:

1. The 400 micron retinal thickness rule only applies at the start of therapy. If retinal thickening reduces to below 400 microns after therapy, repeat injections can be given for recurrences of thickening even if the recurrences do not cause retinal thickening greater than 400 microns. Some patients who have had very long standing visual loss and chronic oedema may have very little to gain from ranibizumab therapy. It may be reasonable not to commence ranibizumab therapy in eyes with very severely damaged retinal structure or function even if they satisfy the 400 micron rule.

2. Laser photocoagulation can still be used; either in conjunction with ranibizumab therapy or prior to ranibizumab therapy especially in laser naïve eyes with focal and diffuse oedema. The decision to use laser photocoagulation for DMO greater than 400 microns should be made by a retinal specialist experienced in evaluating and performing macular laser photocoagulation for DMO.

3. Ranibizumab was found to be more cost effective for treatment of central retinal thickening greater than 400microns but published evidence indicates that there will be a proportion of patients who, despite treatment, will have persistent thickening and/ or worsening vision. It is necessary to use pragmatic retreatment algorithms, similar to those developed from DRCR.net trials, to guide decision making on when to retreat and when to withhold injections[3].

4. It is still important for all ophthalmologists who manage patients with DMO to optimise other important factors such as glycaemic control and hypertension.

5. It is recognised that implementation of this guidance may be challenging for some ophthalmic departments especially with the need to deliver more capacity for intra vitreal injections. It is important that business planning is undertaken early to meet these greater demands on service delivery in the months to come. A costing tool has been provided along with the NICE guidance TA274.[2]

It is envisaged that ophthalmologists and their healthcare institutions will follow the NICE guidance on ranibizumab of DMO and will be able to offer more hope of visual stability and improvement to their patients with DMO.

References

1) http://guidance.nice.org.uk/TA274

2) http://guidance.nice.org.uk/TA274/CostingTemplate/xls/English

3) http://www.google.co.uk/search?q=simplified+retreatment+protocol+I+dme&rlz=1T4ADRA_enGB462GB464&hl=en-GB&gbv=2&gs_l=heirloom-hp.12...4468.9859.0.11250.22.22.0.0.0.0.141.2126.14j8.22.0...0.0...1c.1.J5y_duQNaBQ&oq=simplified+retreatment+protocol+I+dme

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