HAND-IN-HAND

Guiding Your Patients With Dry AMD

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astellas

BRISBANE INTERACTIVE

DISCLOSURES

Speaking & Publication Honoraria: Astellas, Carl Zeiss Meditec, Mivision

Patients lose more than just vision

require assistance with daily activities[1]

report difficulty reading[2]

lose confidence driving at night[1]

In 1.6 years after diagnosis, **67% of people** with GA lose their ability to drive[3]

QUESTION #1

What percentage of patients with Geographic Atrophy (GA) and no CNVM do you personally monitor with no regular ophthalmology review?

(i) 0-25%

(ii) 26-50%

(iii) 51-75%

(iv) 76-100%

WHAT IS AMD ?

Acquired later in life, progressive degenerative condition affecting photoreceptors and RPE[4]

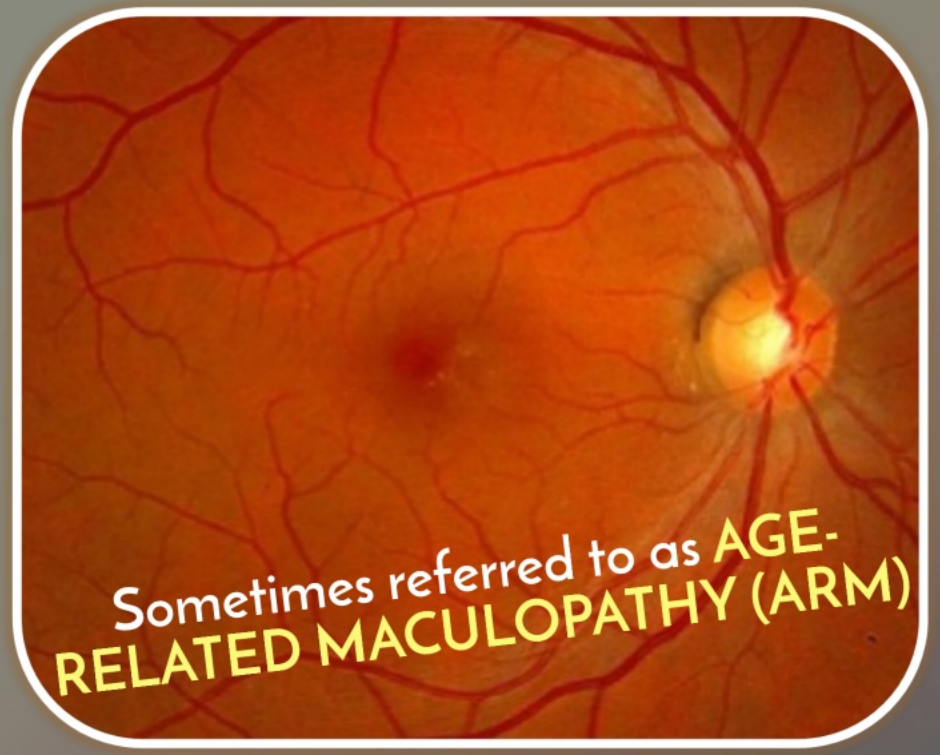
Build up of proteinaceous and lipid deposits under the macula (**DRUSEN**)[4]

Dysregulation of immune responses via complement system causes further damage to photoreceptors and RPE[4]

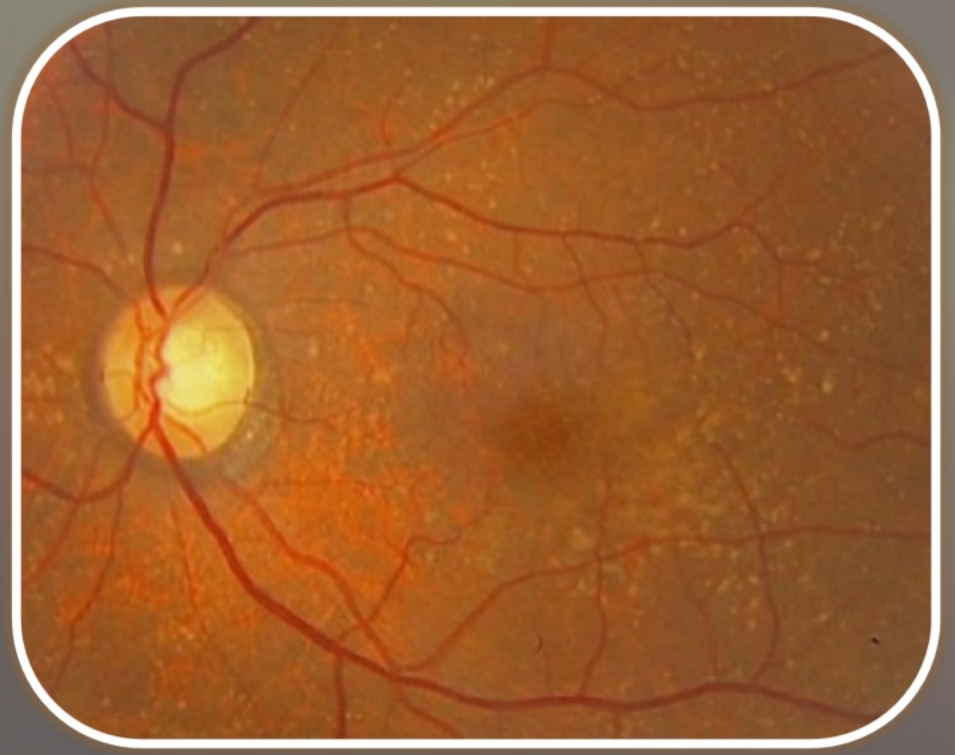
Can ultimately cause loss of photoreceptors and RPE (**geographic atrophy**) or development of abnormal blood vessels (**CNVM**)[4]

AMD CLASSIFICATION

AREDS Category 1 (No or Normal Ageing Changes)
No drusen / a few hard drusen
No RPE abnormalities



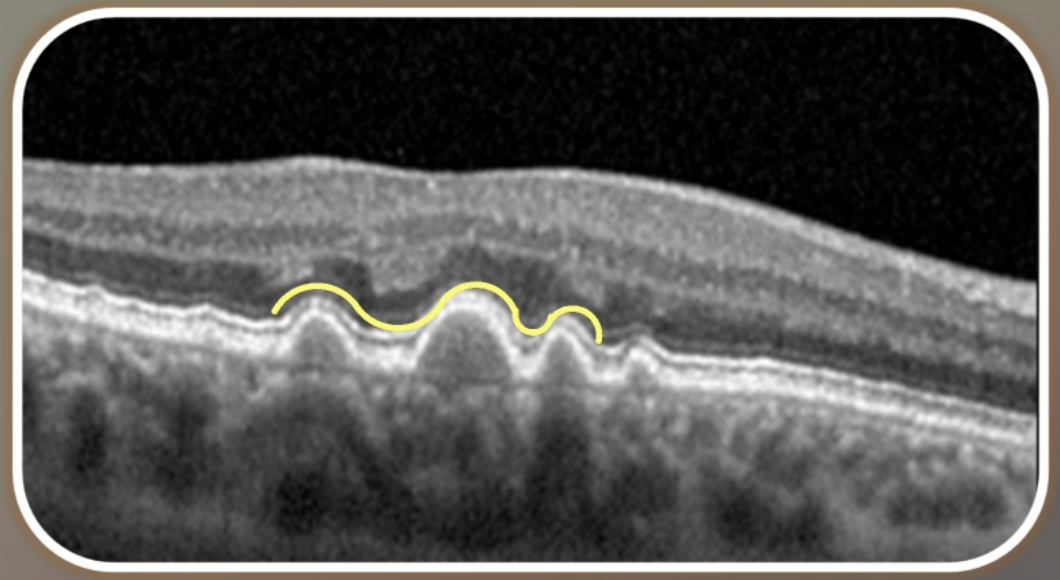
AREDS Category 2 ("Early" AMD)
Several hard drusen
OR a few intermediate drusen (63-124um)
No RPE abnormalities

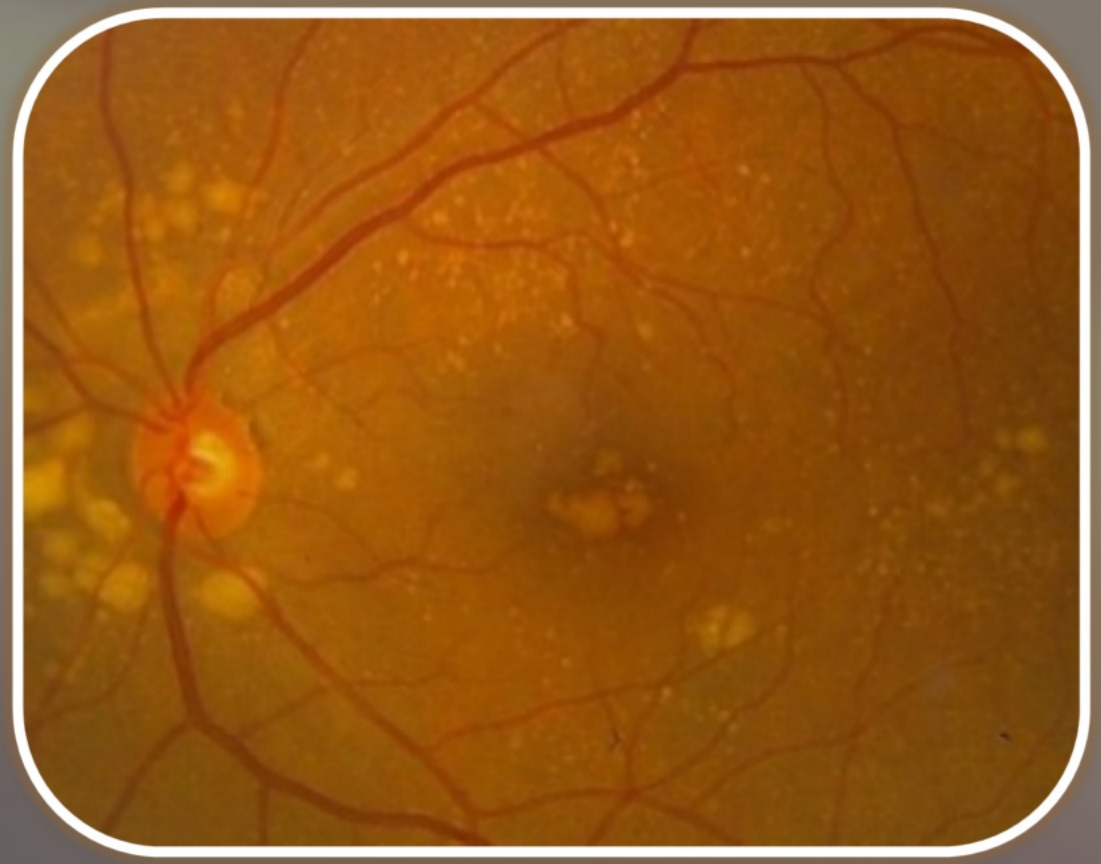


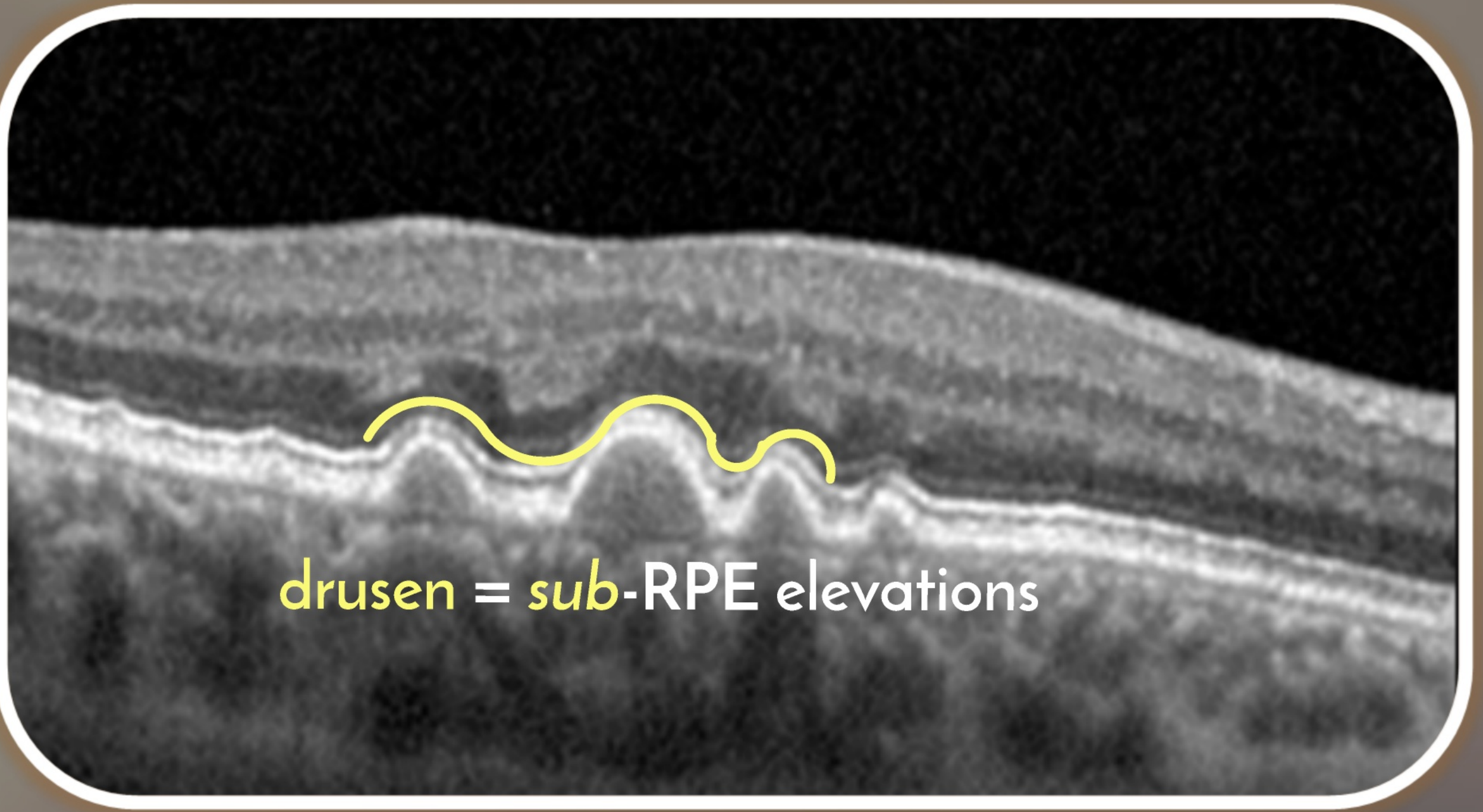
AMD CLASSIFICATION

AREDS Category 3 ("Intermediate" AMD)

Many intermediate-sized drusen
OR > 1 large drusen (>125μm diameter),
OR non-centre involving GA
RPE abnormalities

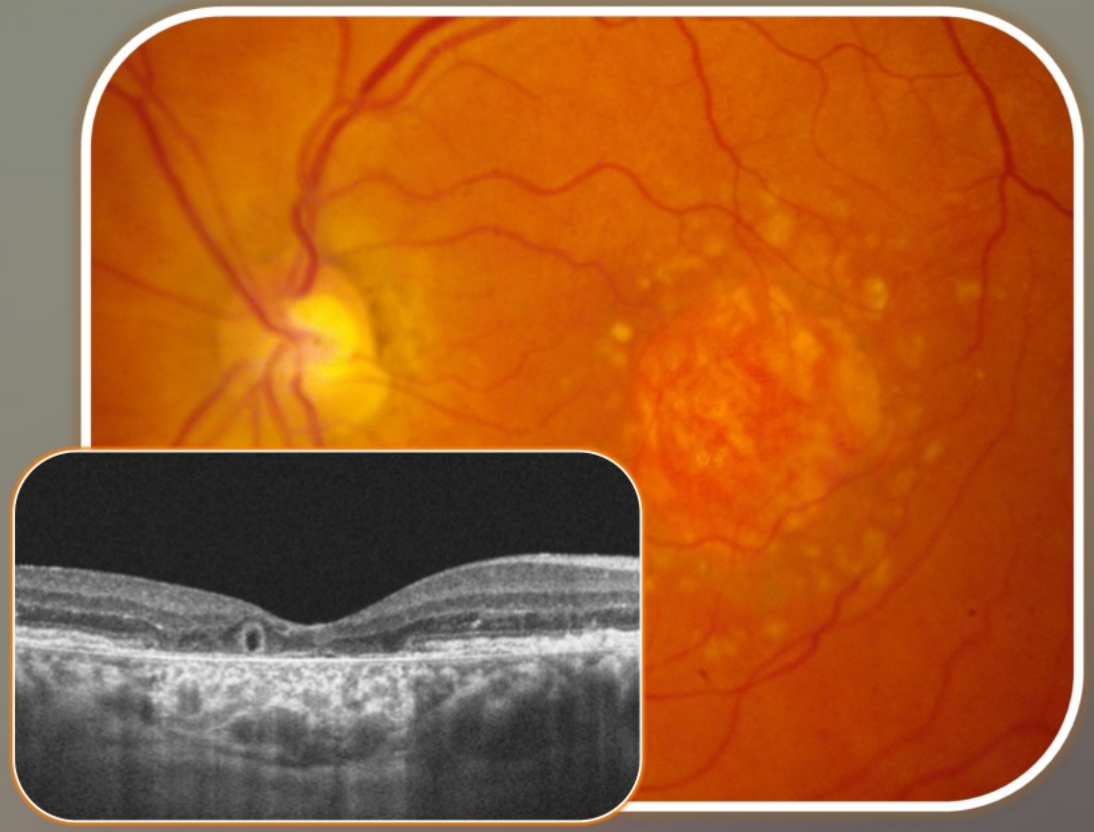




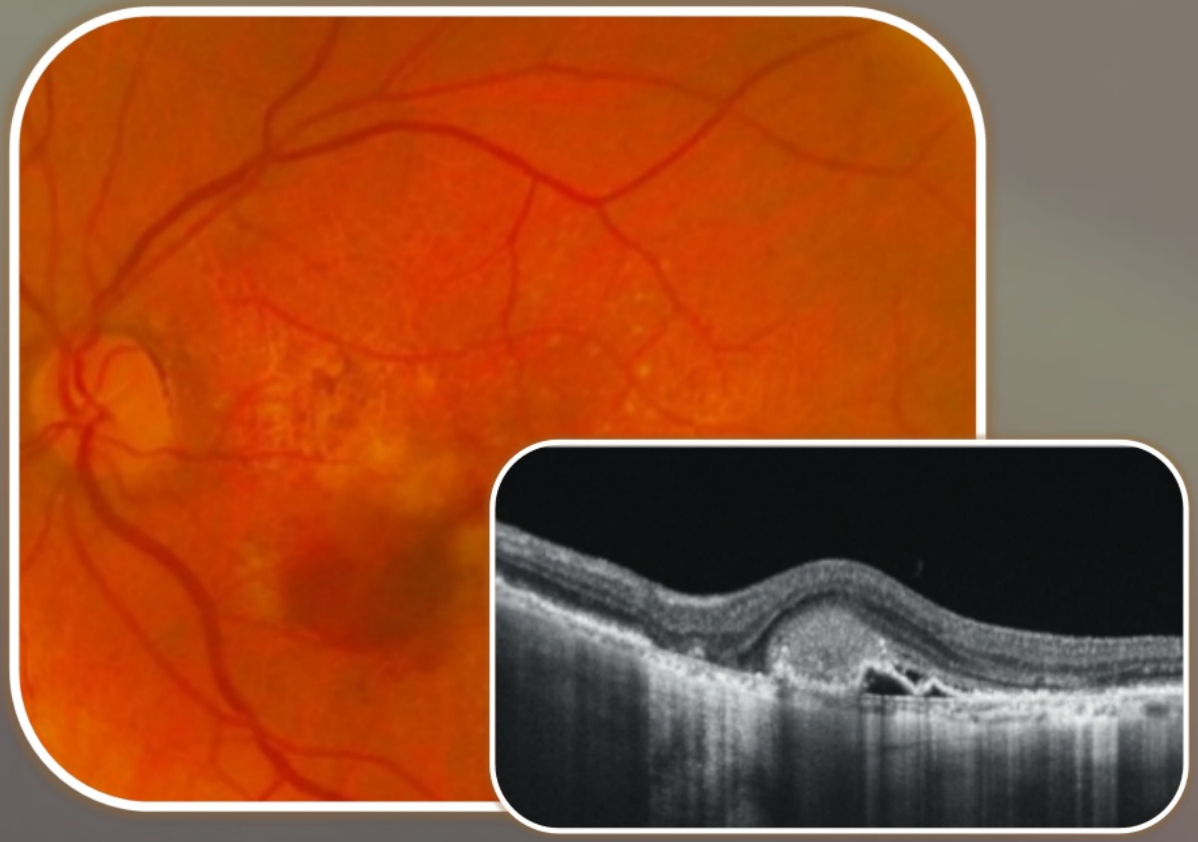

drusen = *sub*-RPE elevations

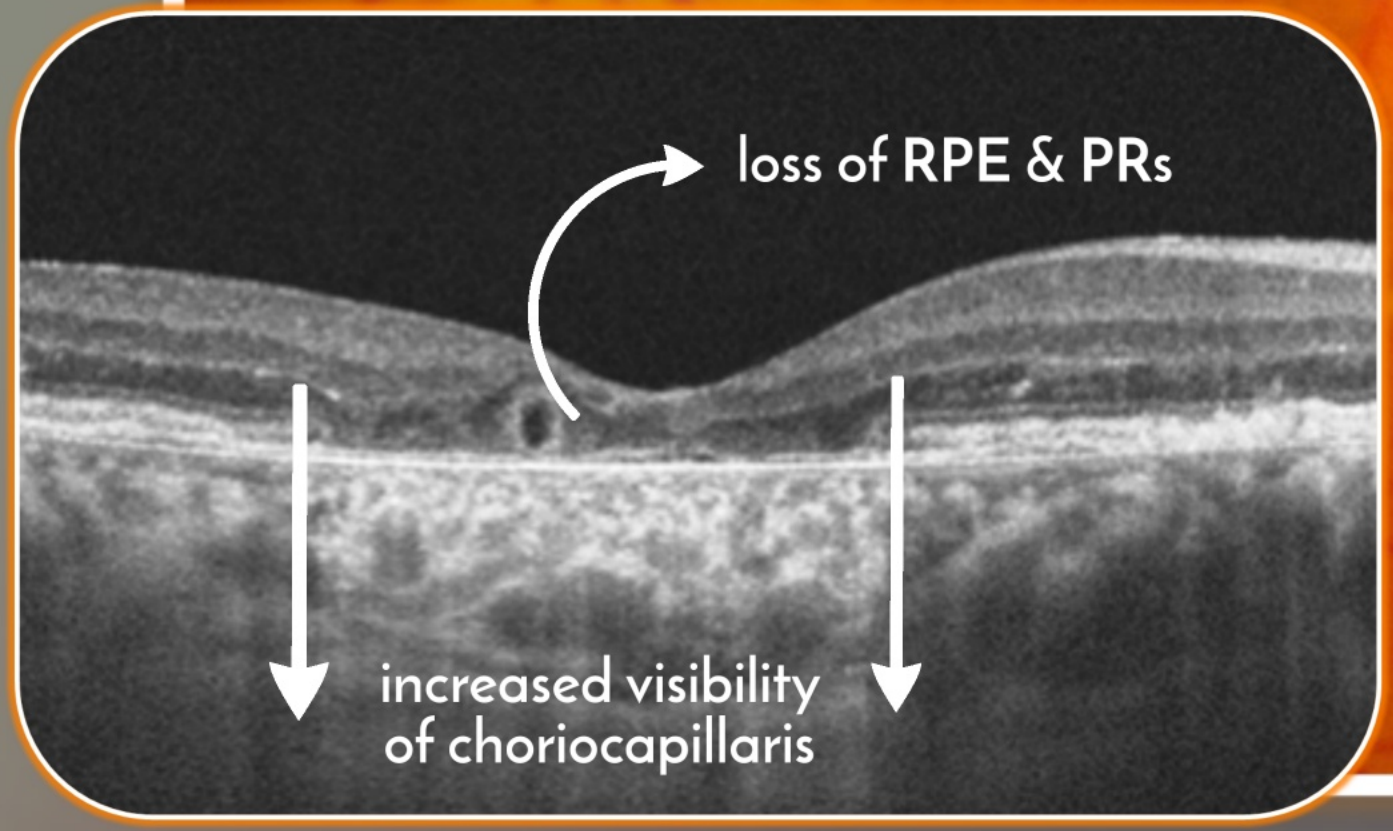
AMD CLASSIFICATION

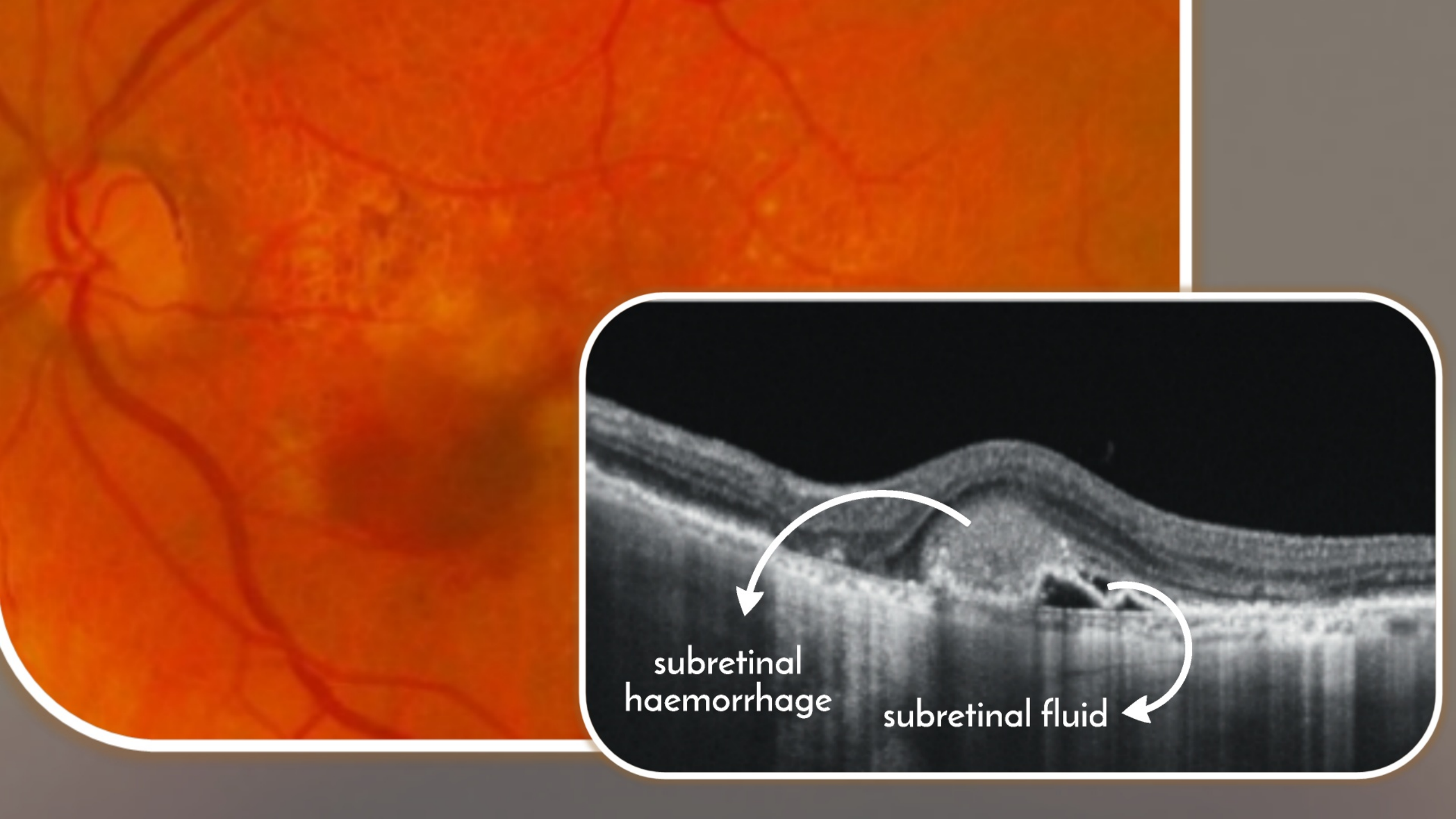
AREDS Category 4 ("Late" AMD)
Centre-involving GA (usually >175um)



AREDS Category 4 ("Late" AMD)
Choroidal neovascularisation




loss of RPE & PRs
increased visibility
of choriocapillaris


subretinal
haemorrhage
subretinal fluid

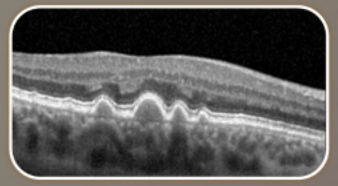
WHY GRADE AMD?

Know risk of progression to late-stage disease over 5 years [5]

- **Normal:** <1%
- **Early AMD:** 1.3%

every 1-2 years

- **Intermediate AMD:** up to 27% *every 6-12 months*



Many intermediate-sized drusen
OR > 1 large drusen (>125µm diameter),
OR non-centre involving GA

Set appropriate **review** periods and management options

OXIDATIVE STRESS

GENETICS

PATHOGENESIS

IMMUNE (COMPLEMENT) SYSTEM

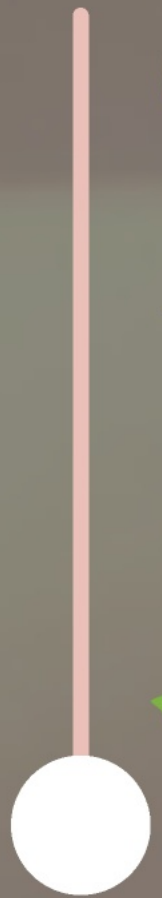
GENETICS

52 common known gene variants associated with AMD risk (eg. *CFH, ARMS2/HTRA1*)[6]

Phenotypic presentation more prevalent with age

- 288 million people worldwide will have AMD by 2040[7]
- greater proportion of late-stage disease due to aging population[7]
- approximately 5 million people worldwide with GA[7]

OXIDATIVE STRESS



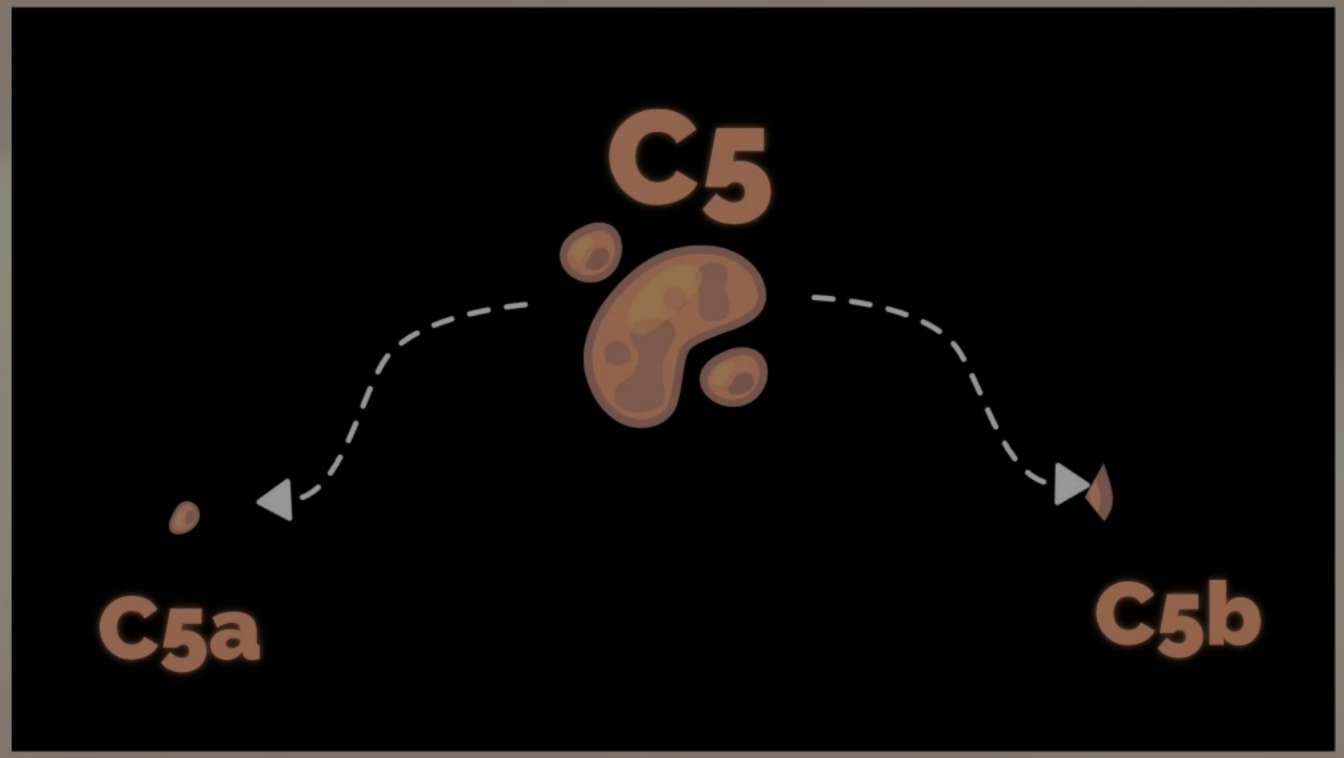
Age[8]

UV exposure[8]

Smoking[8]

Diet & Lifestyle[8]

PROGENESIS



IMMUNE (COMPLEMENT) SYSTEM

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BRISBANE INTERACTIVE

BREAKING BAD NEWS

(1) Educate and empower your patients

- Amsler grid
- AREDS2 anti-oxidant supplements (The 5Ws)
- Diet & lifestyle

(2) Try a "Positive-Negative-Positive" approach

BREAKING BAD NEWS

(3) . . . But ultimately, bad news is bad news no matter what . . .

- Be honest
- Allow time and preparation
- Support person
- Titrate your information (second appt, reliable external resources)

QUESTION #2

Which of the following techniques do you routinely perform for your AMD patients, new and returning? Please select all that apply.

(i) SD-OCT
(ii) Colour fundus photography
(iii) Fundus autofluorescence (FAF)
(iv) OCT-angiography (OCT-A)
(v) VFT 10-2
(vi) I don't perform any of these techniques

HOW TO MONITOR AMD

(1) Colour fundus photography

(2) SD-OCT

(3) Fundus autofluoresence (FAF)

(4) Red-free imaging

(5) OCT-Angiography (OCT-A)

(6) Visual Acuity (to some degree . . .)

HOW TO MONITOR AMD

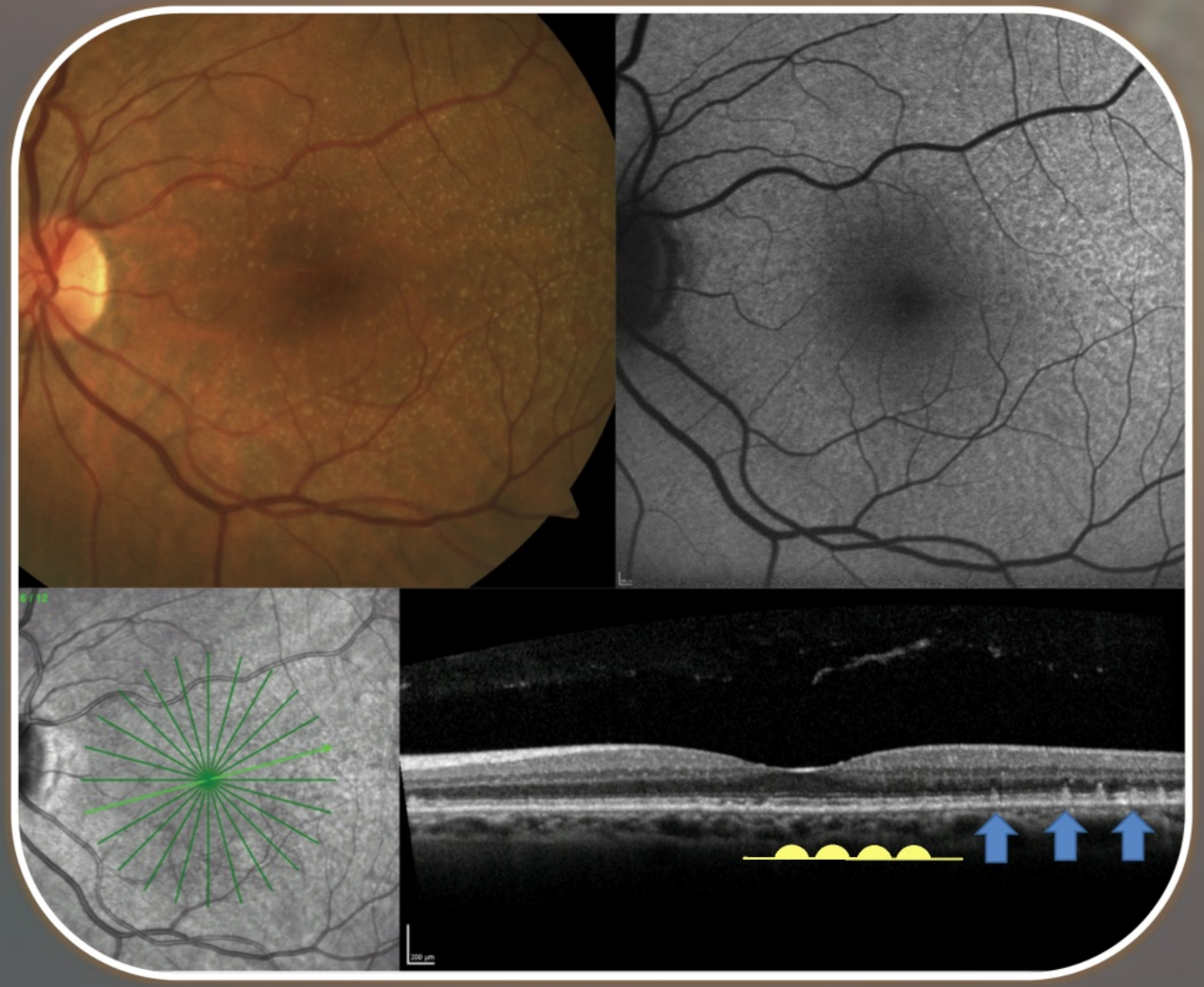
(2) SD-OCT

- useful for detecting subtle RPE changes and drusen (early AMD)
- can demonstrate advanced AMD very clearly (GA/exudation from CNVM)
- recognised high-risk OCT-based biomarkers for progression of dry AMD, especially to GA

HOW TO MONITOR AMD

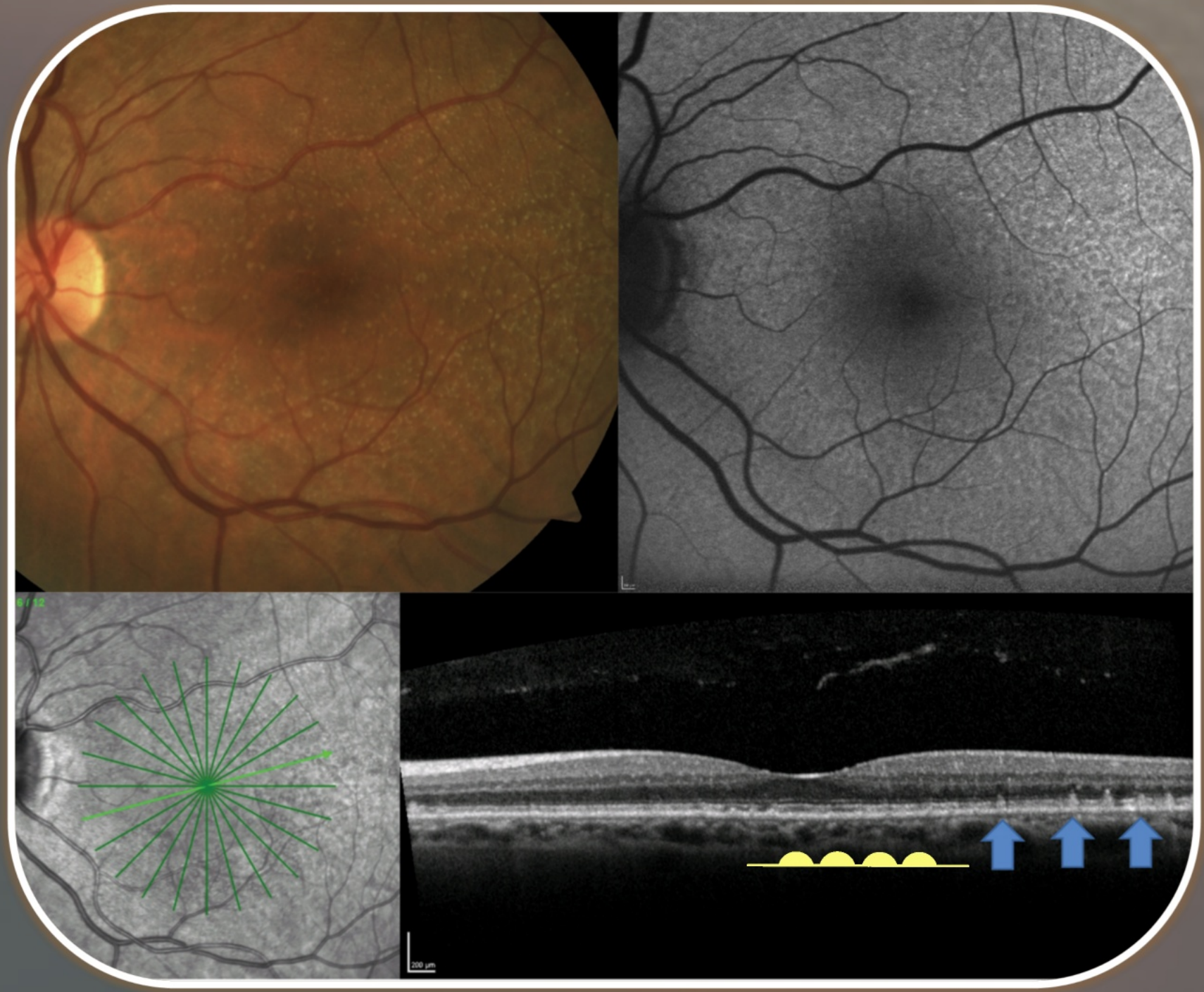
(2) SD-OCT (potential high-risk features)

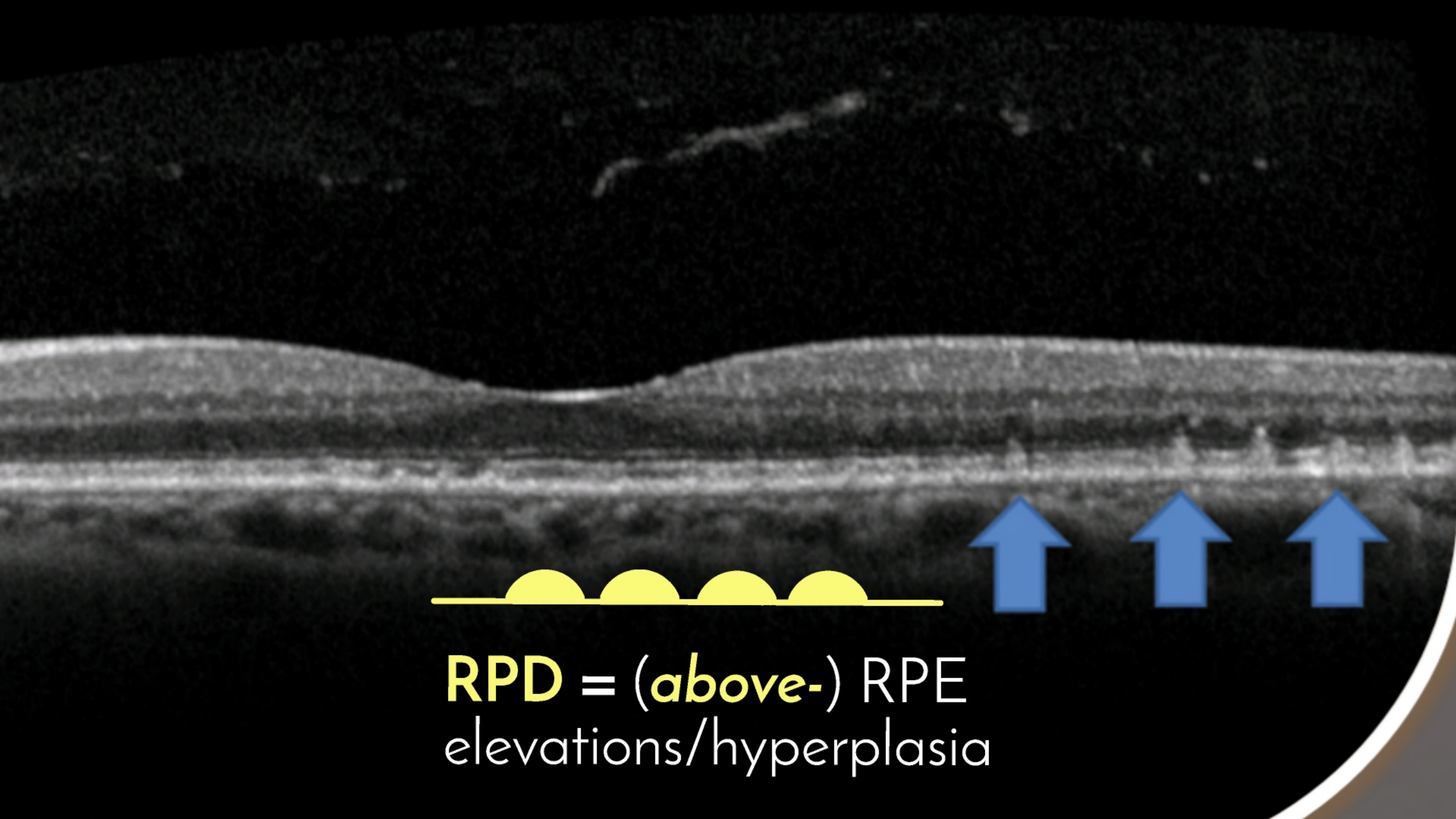
- reticular pseudodrusen



al

rusen

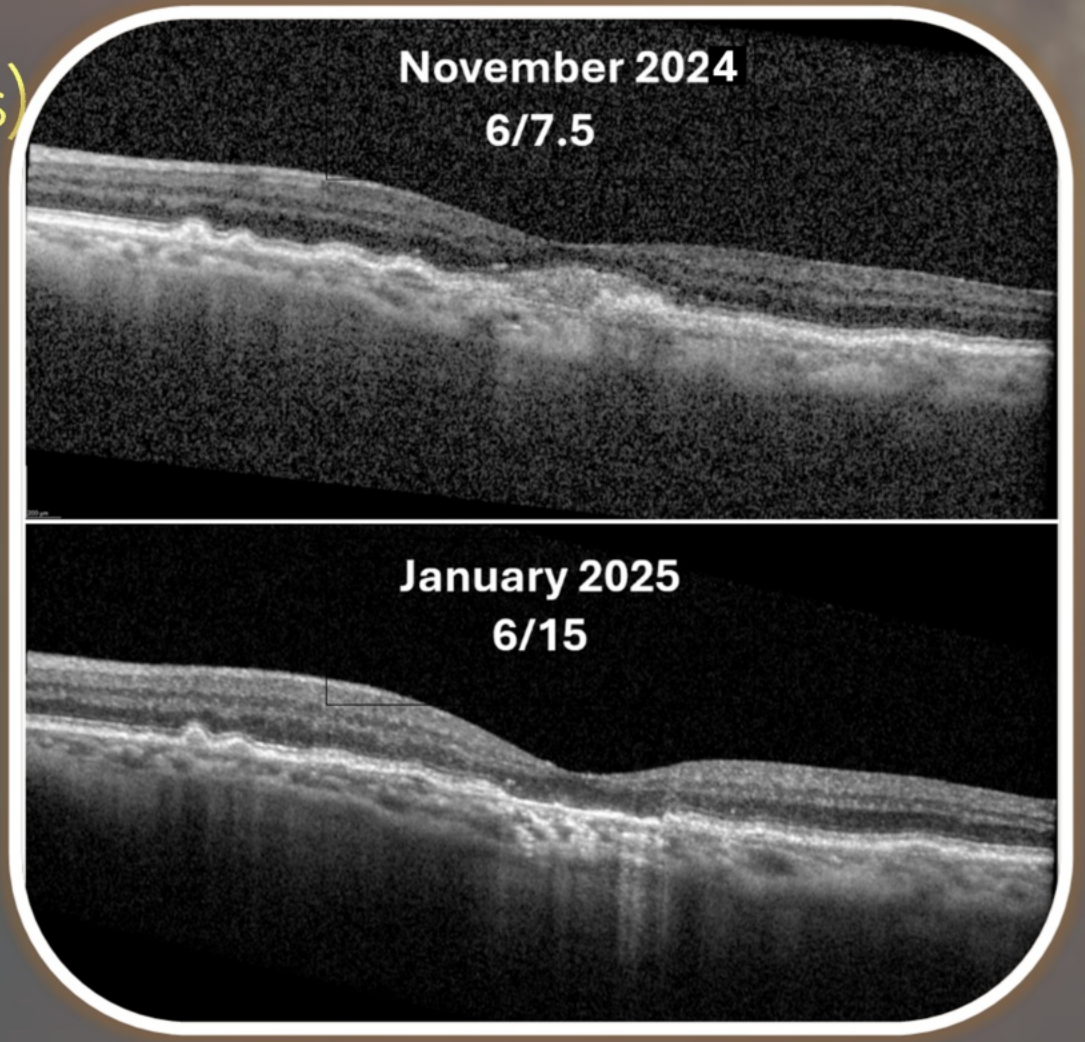



RPD = (above-) RPE
elevations/hyperplasia

HOW TO MONITOR AMD

SD-OCT (potential high-risk features)

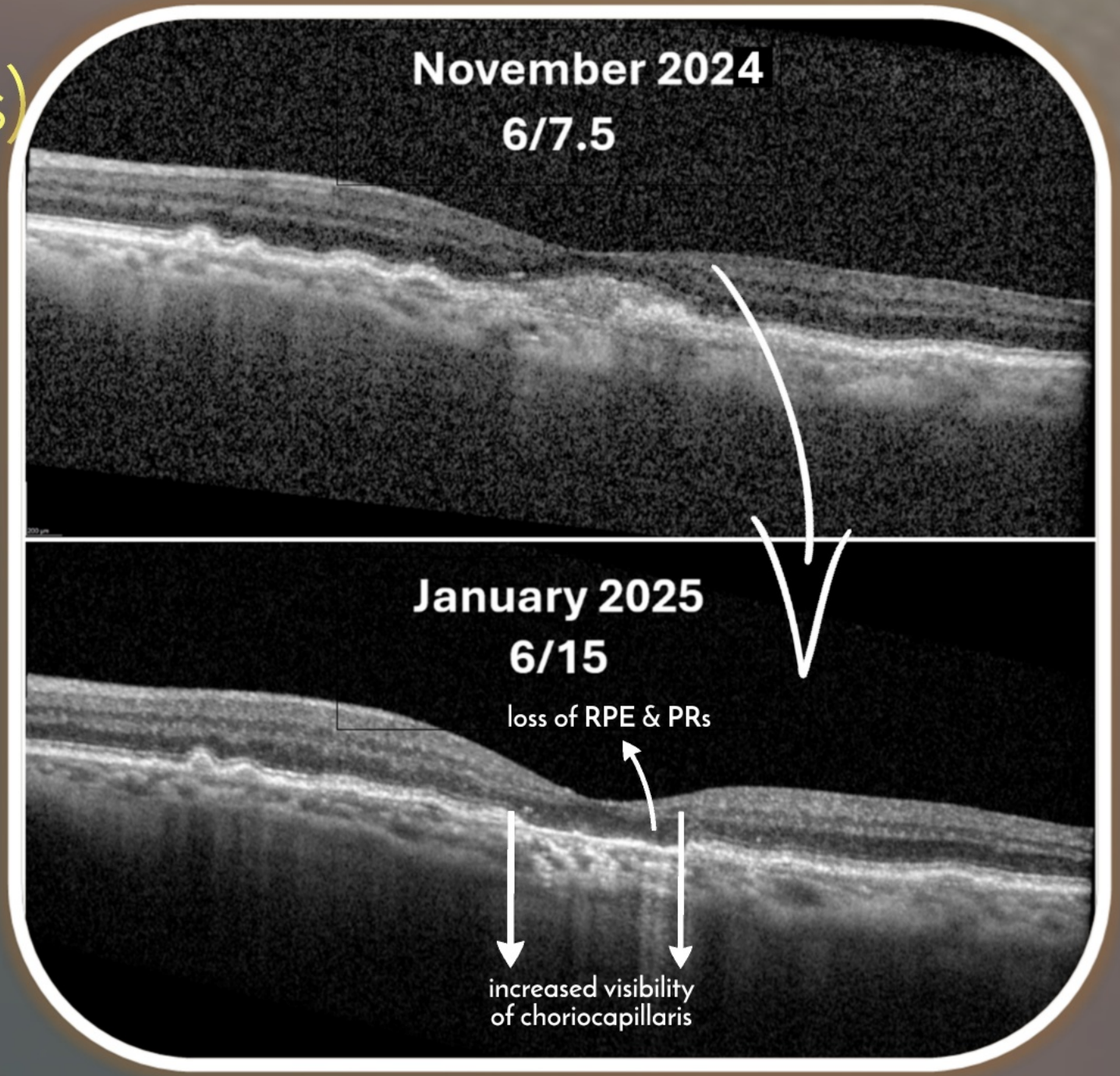
- high-volume drusen
- collapse of drusenoid or fibrovascular PEDs



n-risk features)

n

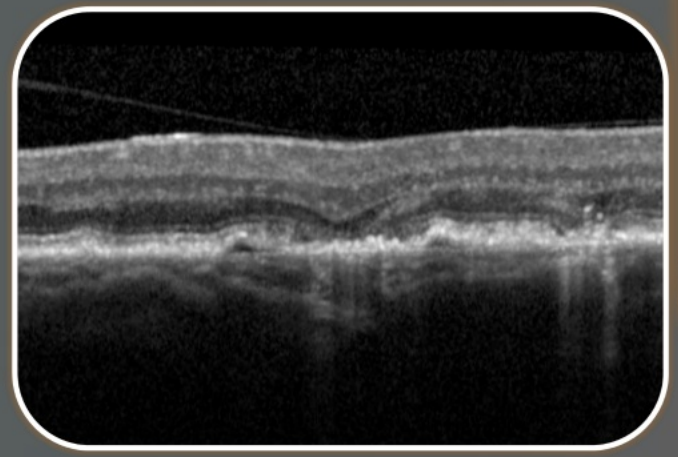
id
Ds

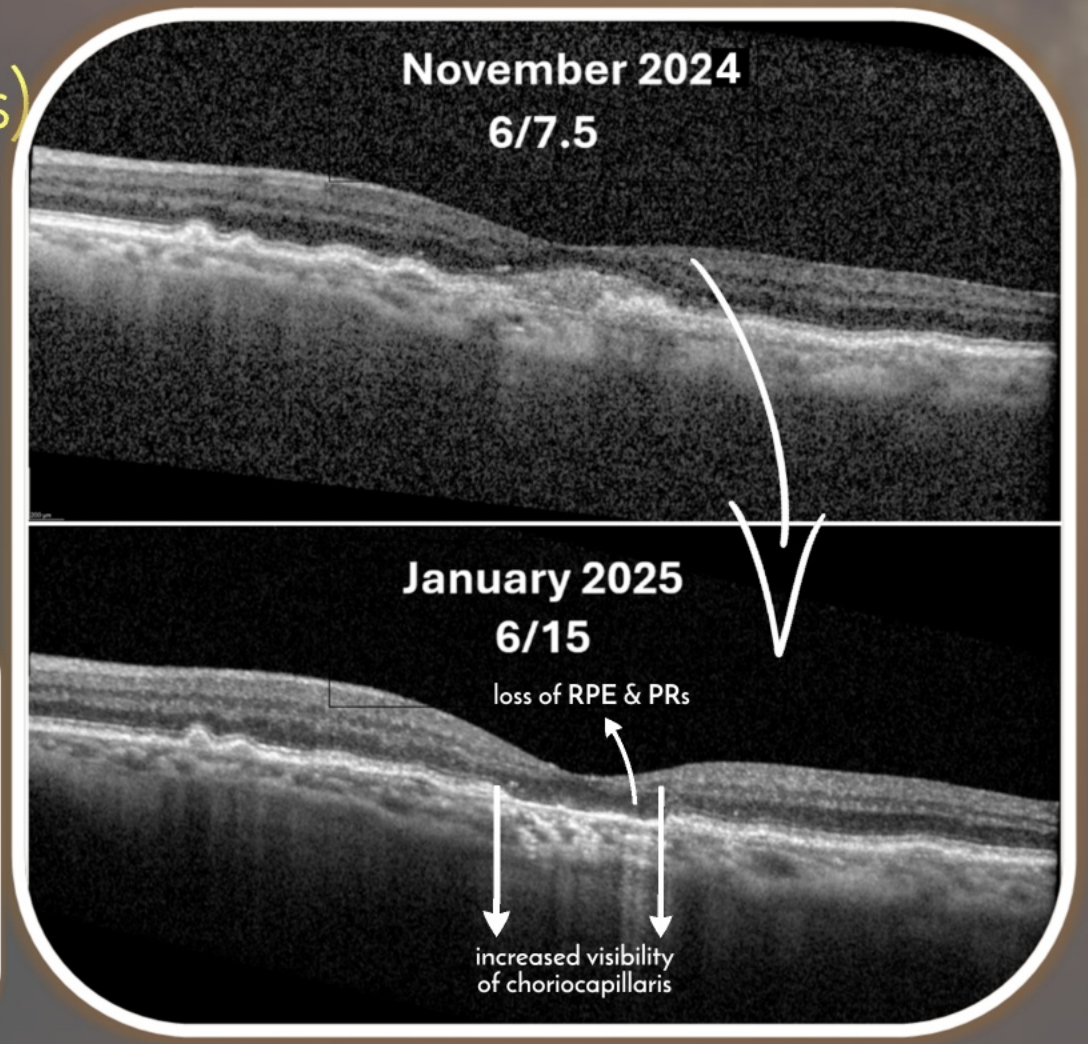


HOW TO MONITOR AMD

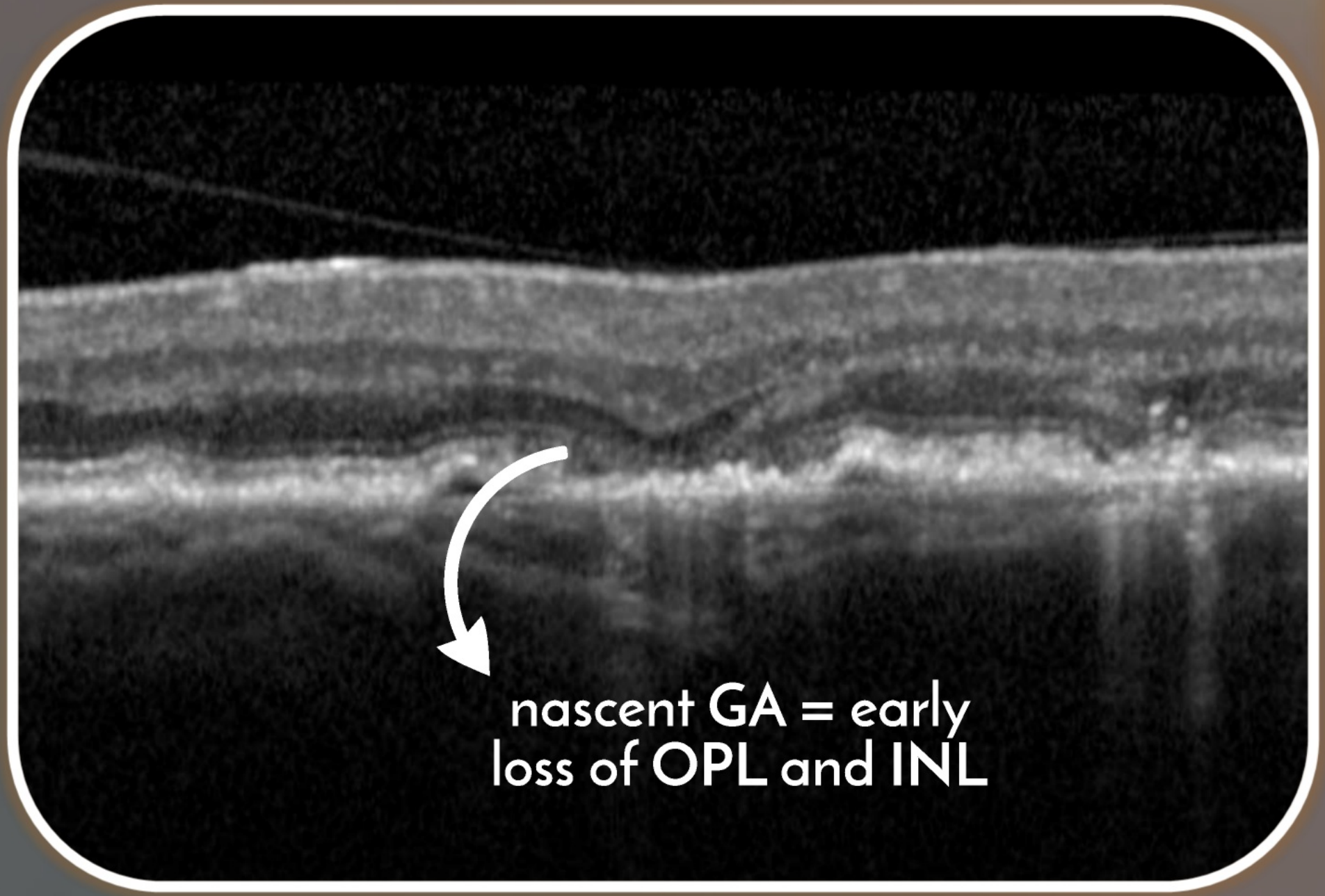
SD-OCT (potential high-risk features)

- high-volume drusen
- collapse of drusenoid or fibrovascular PEDs
- nascent GA





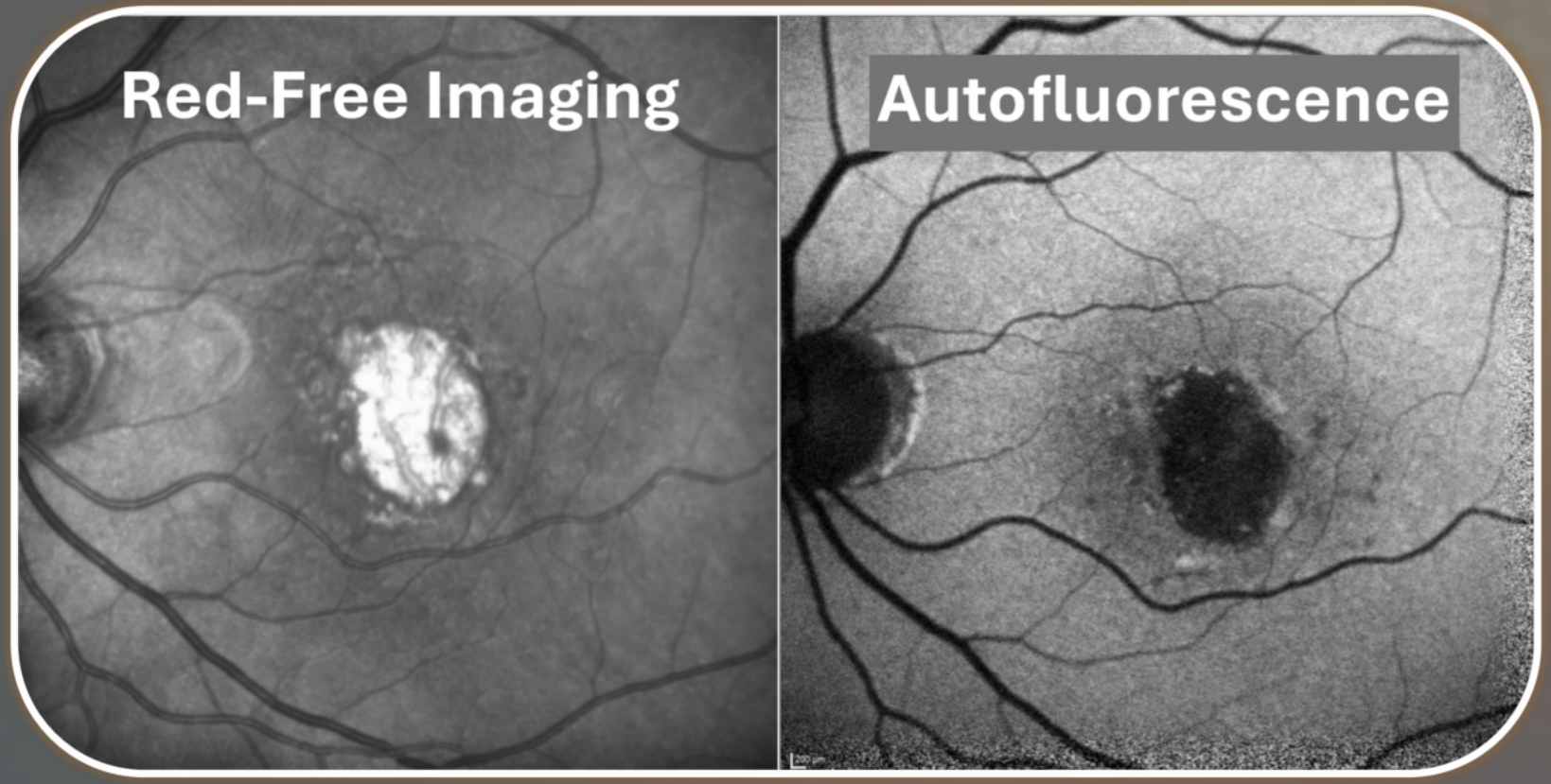
GA



HOW TO MONITOR AMD

(3) Fundus autofluoresence (FAF)

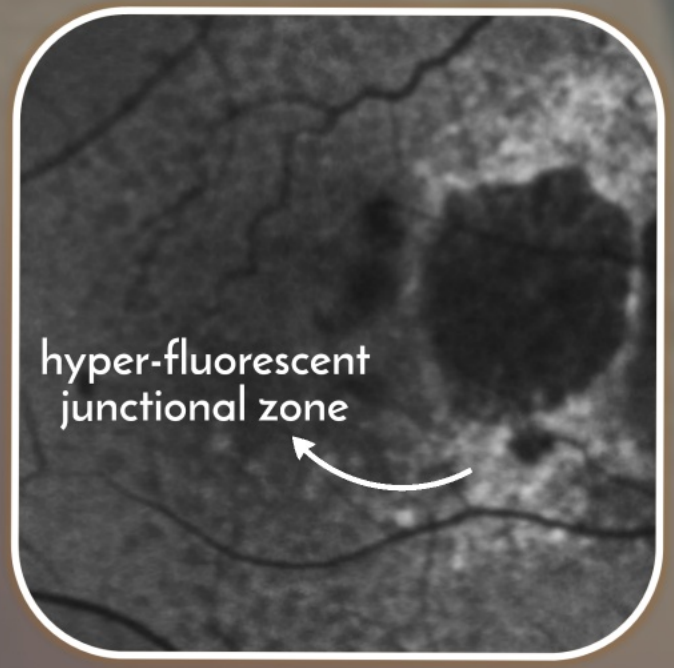
(4) Red-free imaging

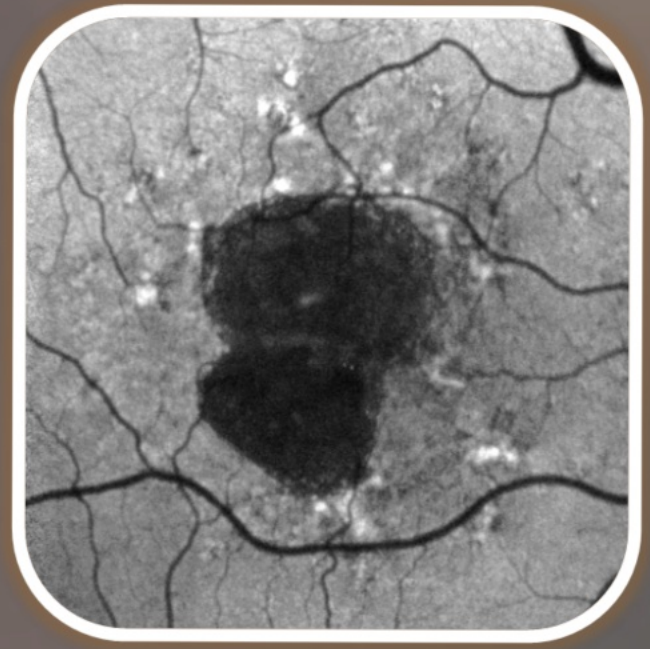


HOW TO MONITOR AMD

(3) Fundus autofluorescence (FAF)

- can better delineate edges of GA
- useful for measuring area of GA and progression to fovea
- hyperfluorescent junctional zone associated with higher risk of GA progression[9]



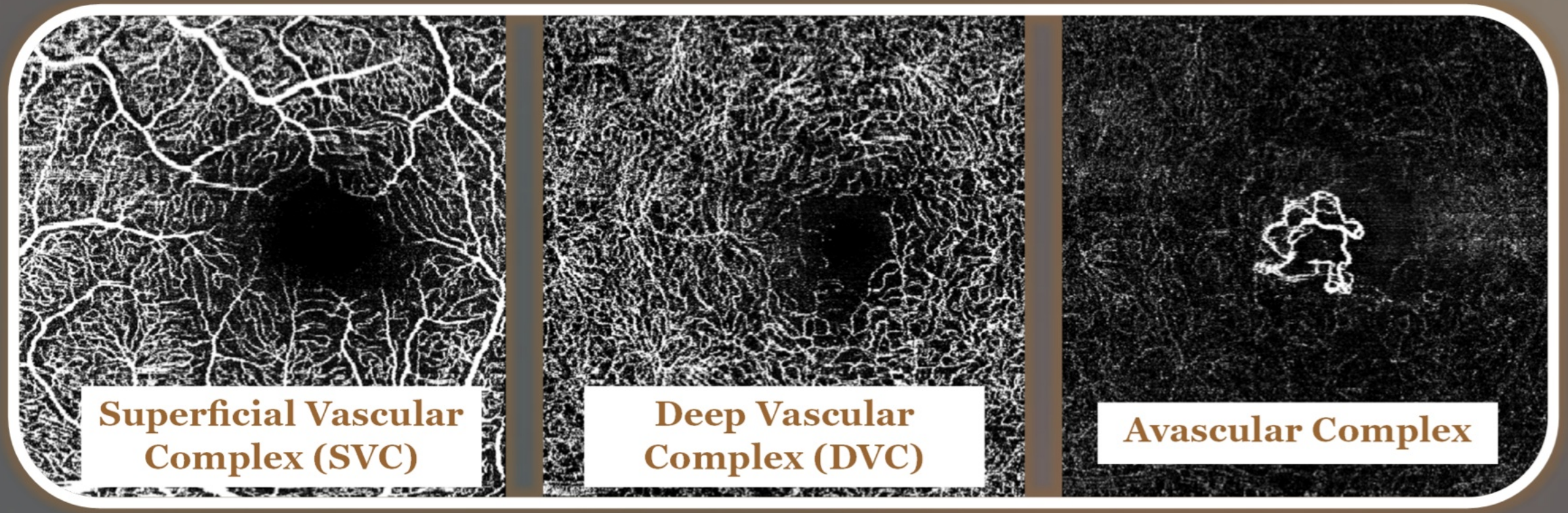


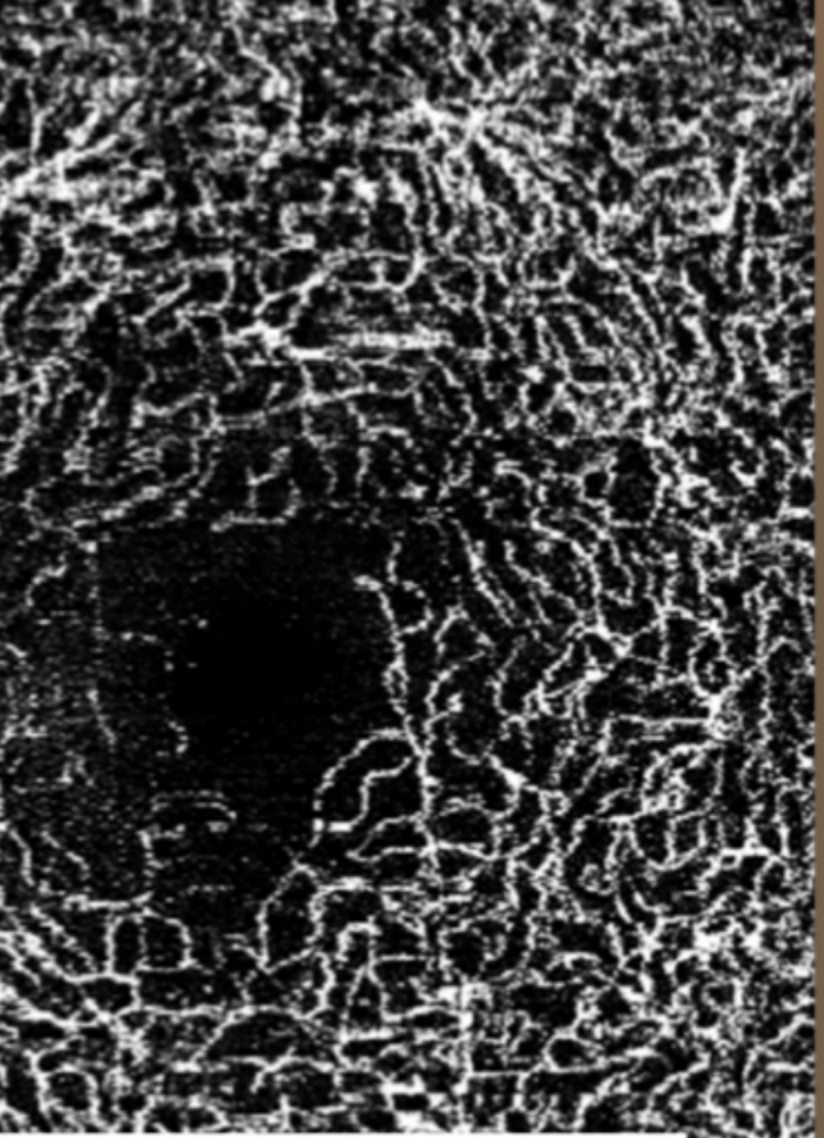
- **Optometry Australia Clinical Practice Guide:** recommended clinical imaging for AMD patients (or referral to optometry colleague or opthalmologist for these tests)[10]

Table 6: Recommended ocular imaging of a patient with AMD	
Colour Fundus Photography (CFP)	**Key indications:** CFP is often used for monitoring drusen number, size, presence of pigmentary abnormalities and signs of late disease (MNV and GA); however, may be limited by low contrast, especially in the presence of imaging artifacts with small pupils, and/or ocular media opacities.
Optical Coherence Tomography (OCT)	**Key indications:** same as with CFP, but invaluable for identifying signs of late neovascular AMD (such as retinal fluid) or early signs of atrophic AMD (such as nascent geographic atrophy [nGA]) not seen on CFP. Can also be used for improved three-dimensional visualisation of drusen extent.
Fundus Autofluorescence (FAF)	**Key indications:** FAF provides better demarcation of areas of GA than CFPs[63,64], so it is especially useful for measuring the size and extent of atrophic lesions.

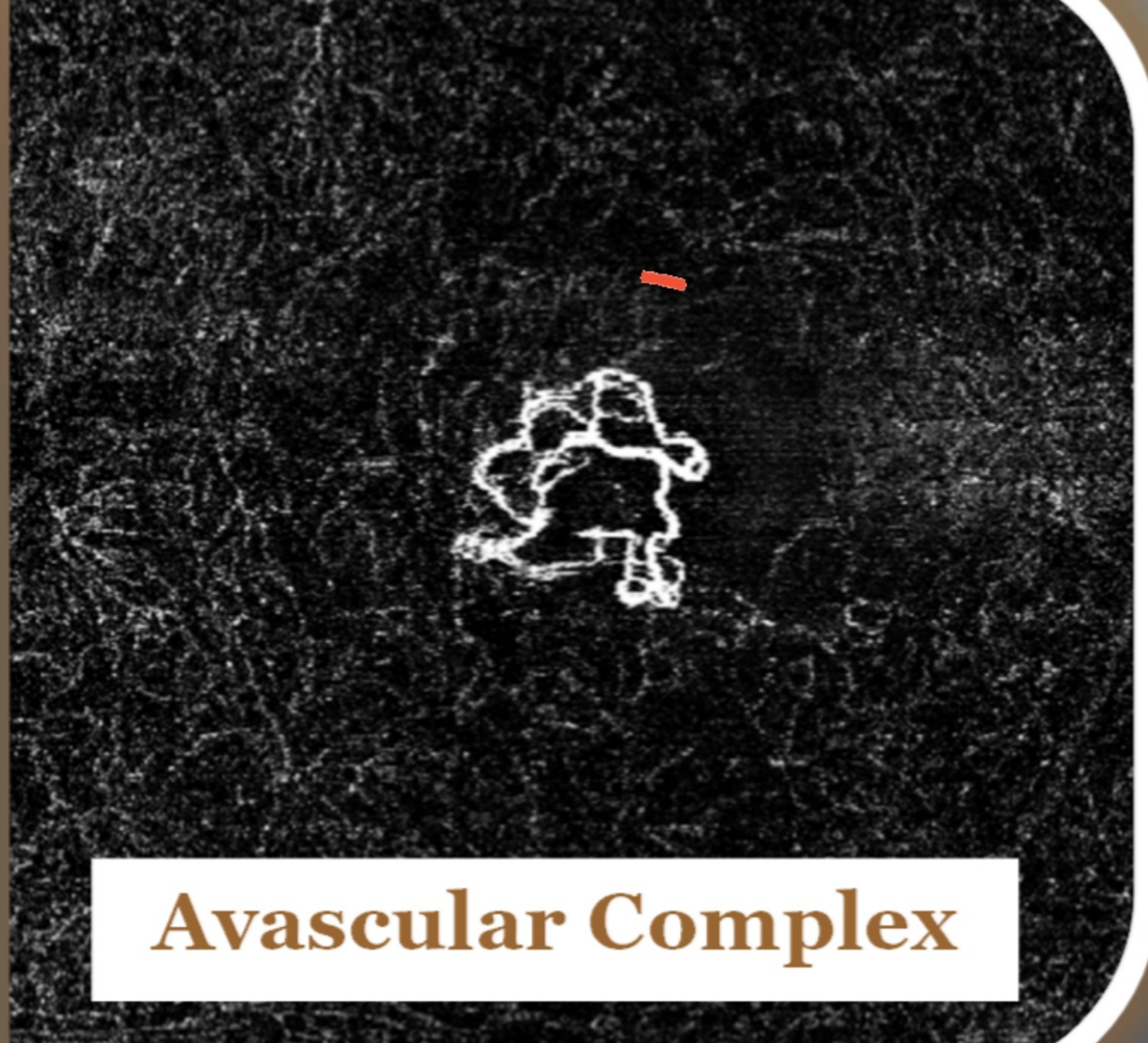
HOW TO MONITOR AMD

(5) OCT-Angiography (OCT-A)





Vascular
ex (DVC)



Avascular Complex

HOW TO MONITOR AMD

Some imaging is better than no imaging! (eg. colour fundus photography only)

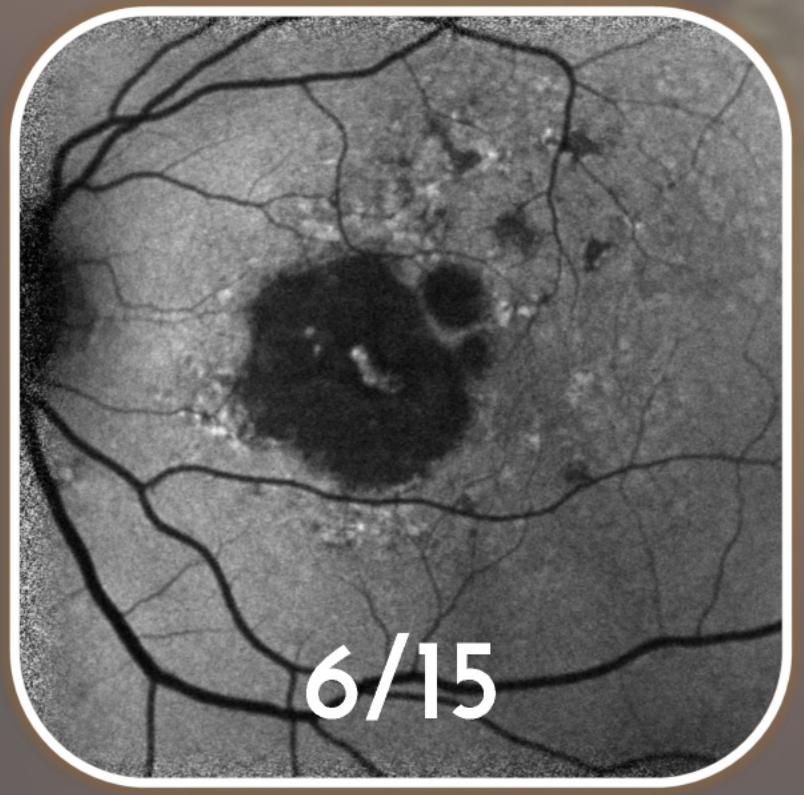
Call a friend - consider sending to a colleague with SD-OCT and/or autofluorescence if more detailed monitoring is required

If sending to an ophthalmologist for diagnostic imaging / baseline assessment (eg. lack of equipment, consideration for GA treatments), consider mentioning a collaborative care plan

HOW TO MONITOR AMD

(6) Visual Acuity

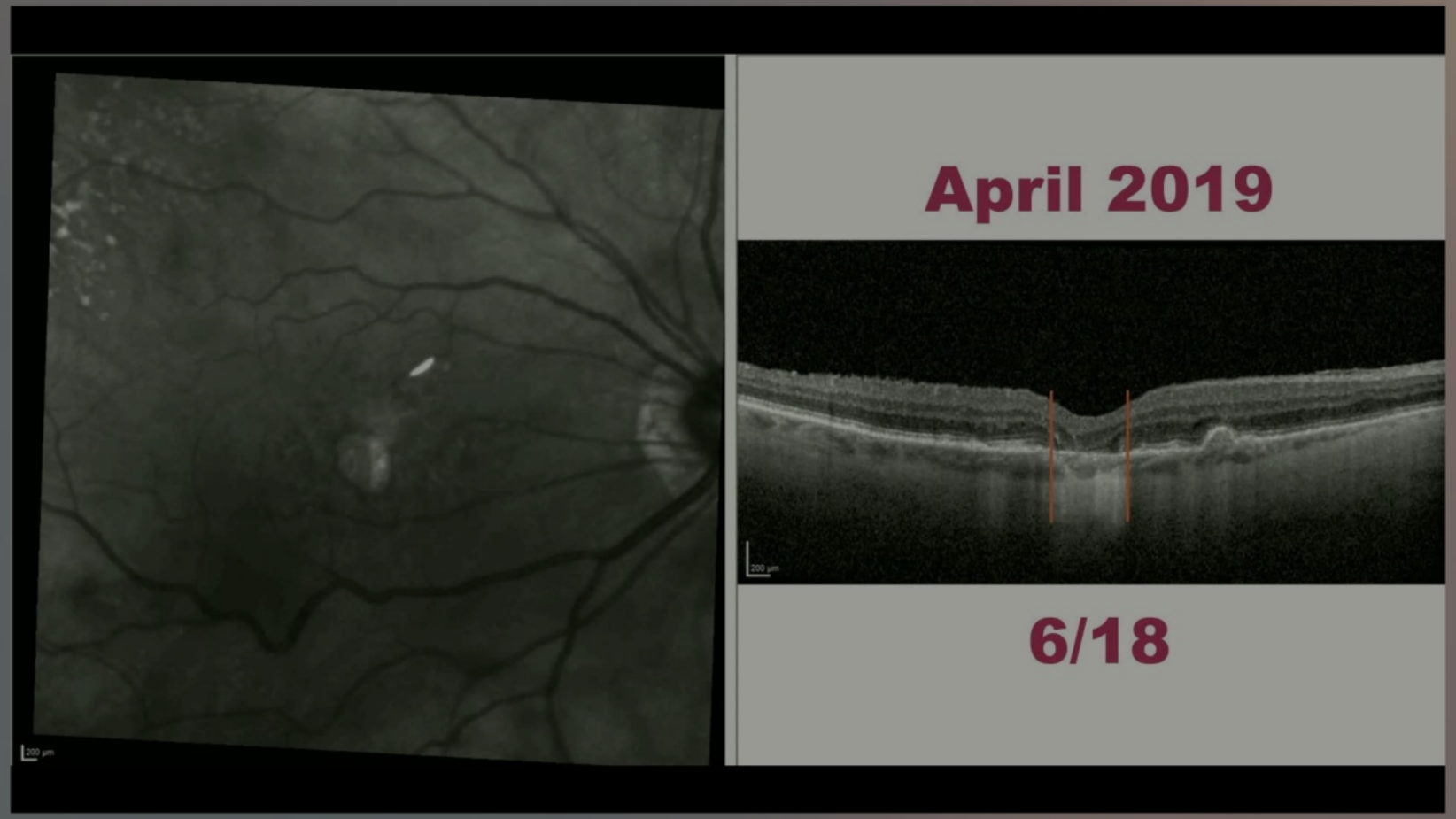
- beware over-estimation of visual function
- eccentric viewing

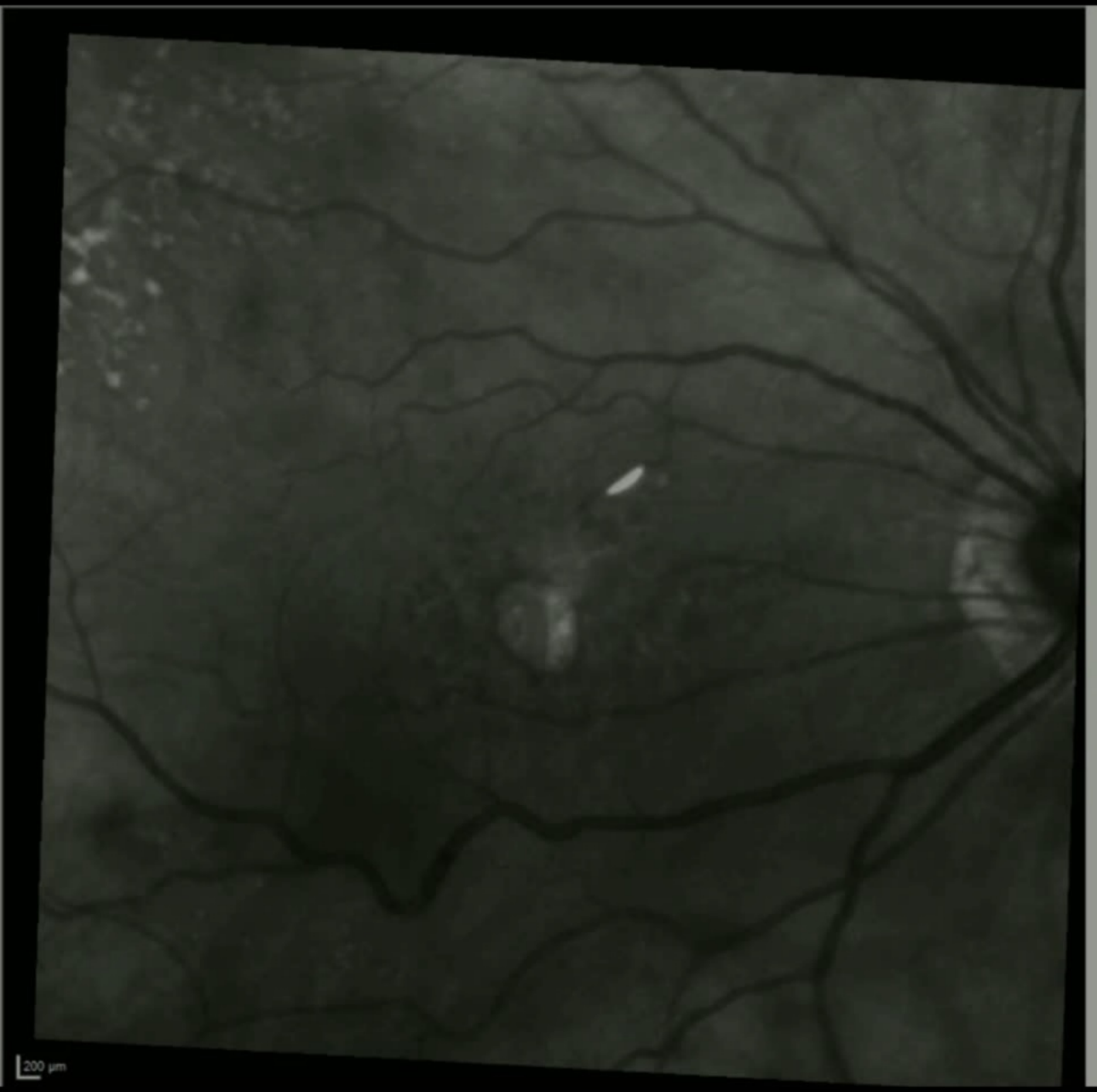


CASE

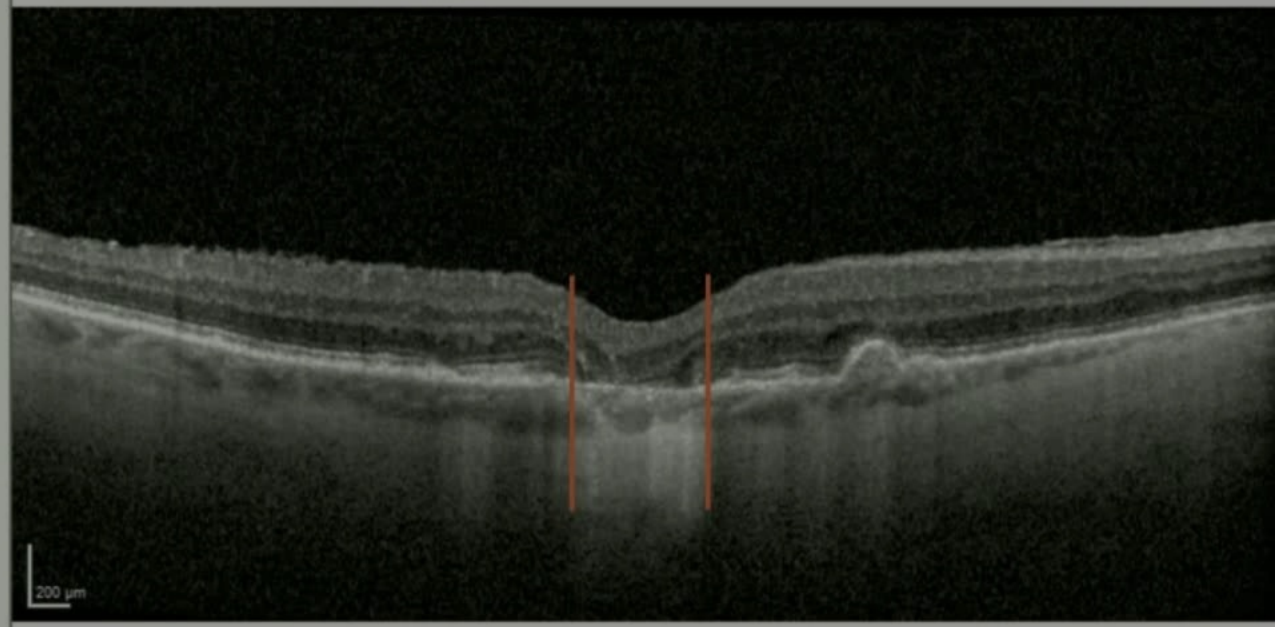
83yo Mr BF - patient since 2015

RE:





April 2019



6/18

QUESTION #3

When do you refer your dry AMD patients to private ophthalmology? Please select all that apply.

(i) When VA deteriorates
(ii) When patient requests referral
(iii) When patient is borderline for driving standards
(iv) At first diagnosis for baseline scans and discussion with ophthalmologist
(v) When patient is classified as intermediate dry AMD (non-centre involving GA/>1 large drusen (>125um diameter)
(vi) Evidence of GA development or progression
(vii) When patient is classified as late AMD (centre-involving GA/CNVM concern)
(viii) Never

WHEN TO REFER

(1) Newly-diagnosed dry AMD if uncertain about diagnosis and/or limited imaging modalities in practice

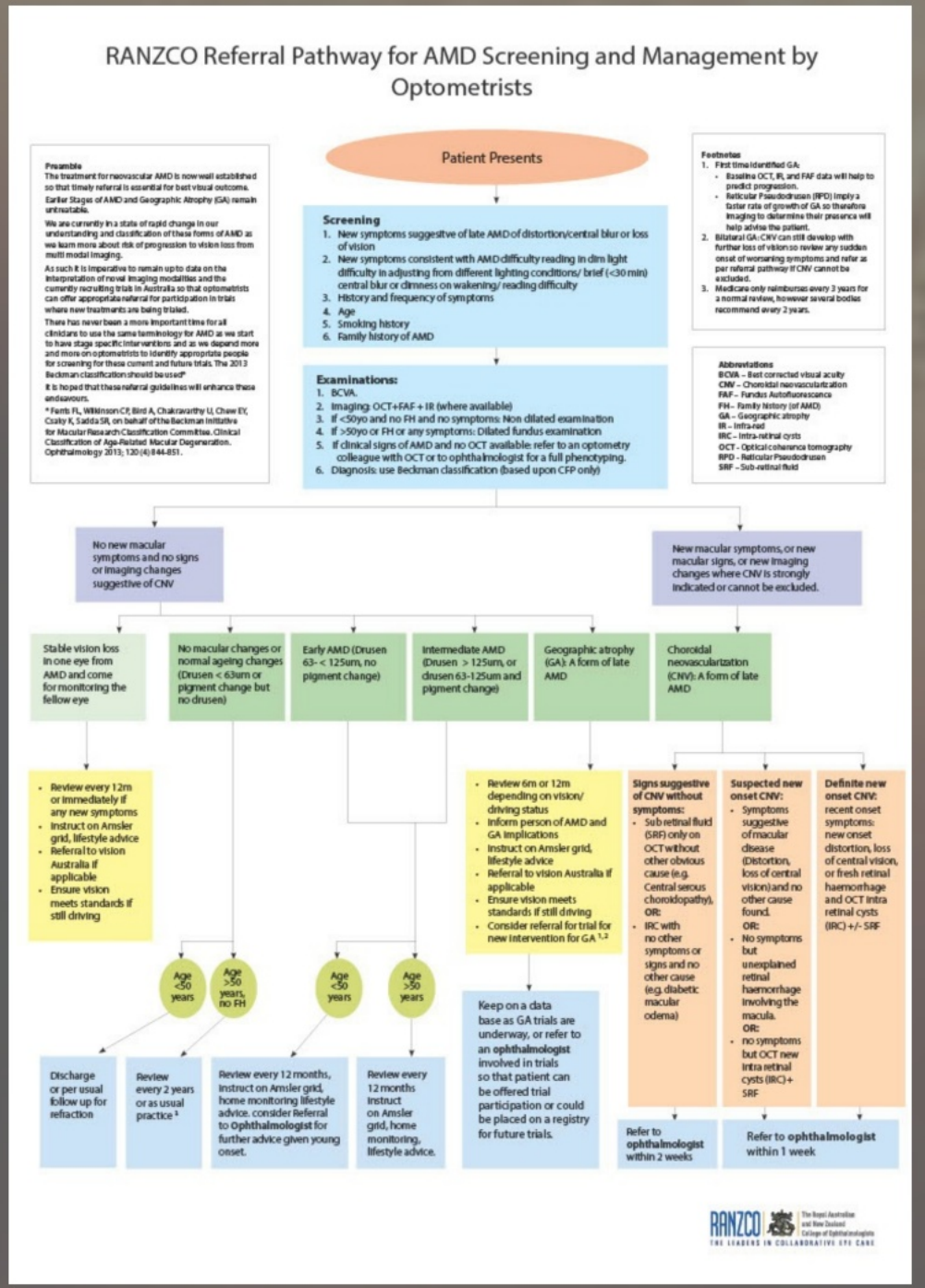
(2) Query new CNVM (or recurrent disease prior to next injection)

(3) Possible progression of dry AMD on diagnostic imaging

(4) Potential candidates for intravitreous GA treatments (when available)

(5) Sudden changes in VA or new-onset distortion on Amsler grid

WHEN TO REFER



RANZCO Referral Pathway for AMD Screening and Management by Optometrists

Preamble
The treatment for neovascular AMD is now well established so that timely referral is essential for best visual outcome.
Earlier Stages of AMD and Geographic Atrophy (GA) remain untreatable.
We are currently in a state of rapid change in our understanding and classification of these forms of AMD as we learn more about risk of progression to vision loss from multi modal imaging.
As such it is imperative to remain up to date on the interpretation of novel imaging modalities and the currently recruiting trials in Australia so that optometrists can offer appropriate referral for participation in trials where new treatments are being trialed.
There has never been a more important time for all clinicians to use the same terminology for AMD as we start to have stage specific interventions and as we depend more and more on optometrists to identify appropriate people for screening for these current and future trials. The 2013 Beckman classification should be used*
It is hoped that these referral guidelines will enhance these endeavours.
* Ferris FL, Wilkinson CP, Bird A, Chakravarthy U, Chew EY, Csaky K, Sadda SR, on behalf of the Beckman Initiative for Macular Research Classification Committee. Clinical Classification of Age-Related Macular Degeneration. Ophthalmology 2013; 120(4):844-851.

Patient Presents

Screening
1. New symptoms suggestive of late AMD of distortion/central blur or loss of vision
2. New symptoms consistent with AMD difficulty reading in dim light difficulty in adjusting from different lighting conditions/ brief (<30 min) central blur or dimness on wakening/ reading difficulty
3. History and frequency of symptoms
4. Age
5. Smoking history
6. Family history of AMD

Examinations:
1. BCVA.
2. Imaging: OCT+FAF + IR (where available)
3. If <50yo and no FH and no symptoms: Non dilated examination
4. If >50yo or FH or any symptoms: Dilated fundus examination
5. If clinical signs of AMD and no OCT available: refer to an optometry colleague with OCT or to ophthalmologist for a full phenotyping.
6. Diagnosis: use Beckman classification (based upon CFP only)

Footnotes
1. First time identified GA:
   - Baseline OCT, IR, and FAF data will help to predict progression.
   - Reticular Pseudodrusen (RPD) imply a faster rate of growth of GA so therefore imaging to determine their presence will help advise the patient.
2. Bilateral GA: CNV can still develop with further loss of vision so review any sudden onset of worsening symptoms and refer as per referral pathway if CNV cannot be excluded.
3. Medicare only reimburses every 3 years for a normal review, however several bodies recommend every 2 years.

Abbreviations
BCVA – Best corrected visual acuity
CNV – Choroidal neovascularization
FAF – Fundus Autofluorescence
FH – Family history (of AMD)
GA – Geographic atrophy
IR – Infra-red
IRC – Intra-retinal cysts
OCT - Optical coherence tomography
RPD - Reticular Pseudodrusen
SRF – Sub-retinal fluid

No new macular symptoms and no signs or imaging changes suggestive of CNV

New macular symptoms, or new macular signs, or new imaging changes where CNV is strongly indicated or cannot be excluded.

Stable vision loss in one eye from AMD and come for monitoring the fellow eye

- Review every 12m or immediately if any new symptoms
- Instruct on Amsler grid, lifestyle advice
- Referral to vision Australia if applicable
- Ensure vision meets standards if still driving

No macular changes or normal ageing changes (Drusen < 63um or pigment change but no drusen)

Age <50 years

Discharge or per usual follow up for refraction

Age >50 years, no FH

Review every 2 years or as usual practice [1]

Early AMD (Drusen 63- < 125um, no pigment change)

Age <50 years

Review every 12 months, instruct on Amsler grid, home monitoring lifestyle advice. consider Referral to **Ophthalmologist** for further advice given young onset.

Intermediate AMD (Drusen > 125um, or drusen 63-125um and pigment change)

Age >50 years

Review every 12 months instruct on Amsler grid, home monitoring, lifestyle advice.

Geographic atrophy (GA): A form of late AMD

- Review 6m or 12m depending on vision/ driving status
- Inform person of AMD and GA implications
- Instruct on Amsler grid, lifestyle advice
- Referral to vision Australia if applicable
- Ensure vision meets standards if still driving
- Consider referral for trial for new intervention for GA [1,2]

Keep on a data base as GA trials are underway, or refer to an **ophthalmologist** involved in trials so that patient can be offered trial participation or could be placed on a registry for future trials.

Choroidal neovascularization (CNV): A form of late AMD

Signs suggestive of CNV without symptoms:
- Sub retinal fluid (SRF) only on OCT without other obvious cause (e.g. Central serous choroidopathy), OR:
- IRC with no other symptoms or signs and no other cause (e.g. diabetic macular edema)

Refer to **ophthalmologist** within 2 weeks

Suspected new onset CNV:
- Symptoms suggestive of macular disease (Distortion, loss of central vision) and no other cause found. OR:
- No symptoms but unexplained retinal haemorrhage involving the macula. OR:
- no symptoms but OCT new intra retinal cysts (IRC)+ SRF

Refer to **ophthalmologist** within 1 week

Definite new onset CNV:
recent onset symptoms: new onset distortion, loss of central vision, or fresh retinal haemorrhage and OCT intra retinal cysts (IRC) +/- SRF

RANZCO
The Royal Australian and New Zealand College of Ophthalmologists
THE LEADERS IN COLLABORATIVE EYE CARE

Keep on a data base as GA trials are underway, or refer to an **ophthalmologist** involved in trials so that patient can be offered trial participation or could be placed on a registry for future trials.

GA progression data is NOT transferrable between machines.

Consider early baseline referrals to ophthalmology for patients who may be interested or suitable for GA treatments in the future (progression data established)

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astellas

BRISBANE INTERACTIVE

QUESTION #4

Which of the following are part of your regular management plan for a NEW dry AMD patient? Please select all that apply.

(i) Grading of AMD
(ii) Amsler grid use
(iii) AREDS2 anti-oxidant supplement recommendation
(iv) Diet and lifestyle

QUESTION #5

Which of the following referrals are part of your regular management plan for a NEW dry AMD patient? Please select all that apply.

(i) Referral to an ophthalmologist
(ii) Referral to patient support services (eg. Macular Disease Foundation)
(iii) Referral to a low vision service on indication (eg. Vision Australia)
(iv) Referral to GP for psycholog referral/other

HOW CAN WE HELP NOW?

1 Refer to low vision support services (and check back in!)

Vision Australia

Quantum
Reading • Learning • Vision

Guide Dogs

QUT Health Clinics

EYE CONNECT

Macular Disease Foundation AUSTRALIA

HOW CAN WE HELP NOW?

2 Ensure your patient is receiving adequate social support

- Disability (Blind) Pension (not income-tested) - up to $1000-$1100 per person per fortnight
- Taxi subsidy scheme (TSS) - half-price taxi trips (up to $30)
- Vision Impairment Travel Pass (VITP) - free public transport

HOW CAN WE HELP NOW?

3 Check in with your patient's mental and psychological welfare

- document their hobbies and social interests, follow-up on these
- support from family and friends
- Charles Bonnett Syndrome

HAND-IN-HAND

Guiding Your Patients With Dry AMD

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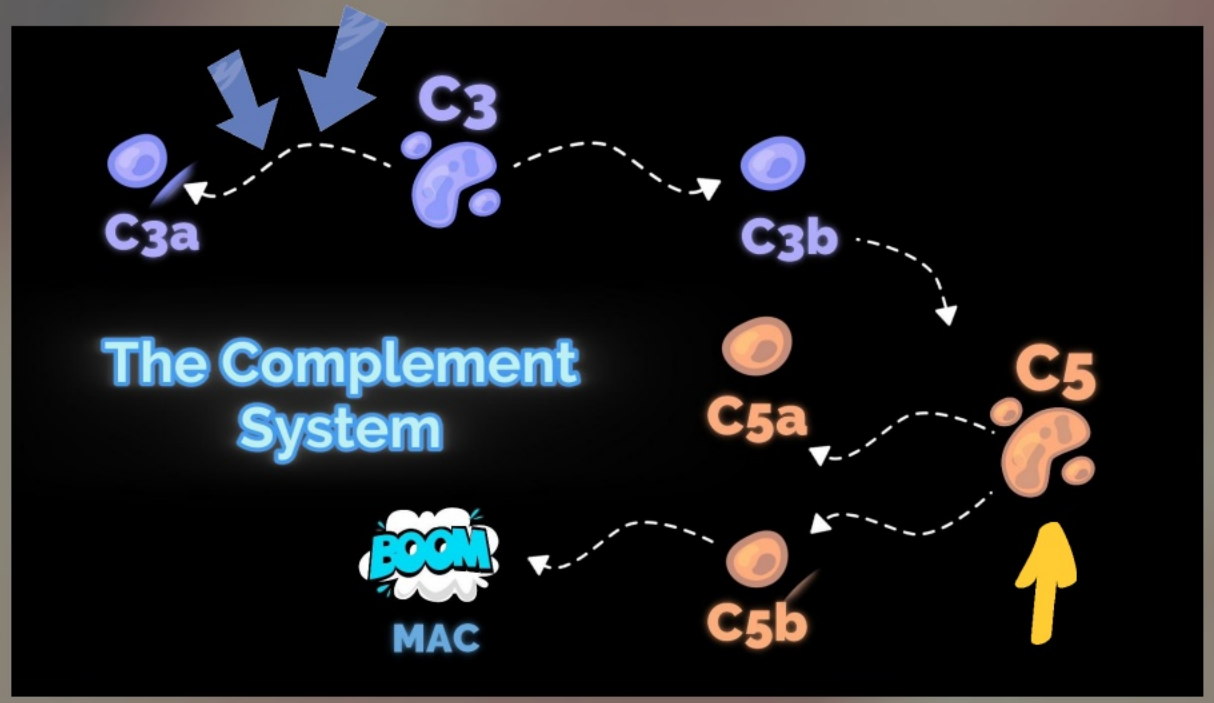
BRISBANE INTERACTIVE

GA TREATMENTS

FDA approved intravitreal complement inhibitors [11]

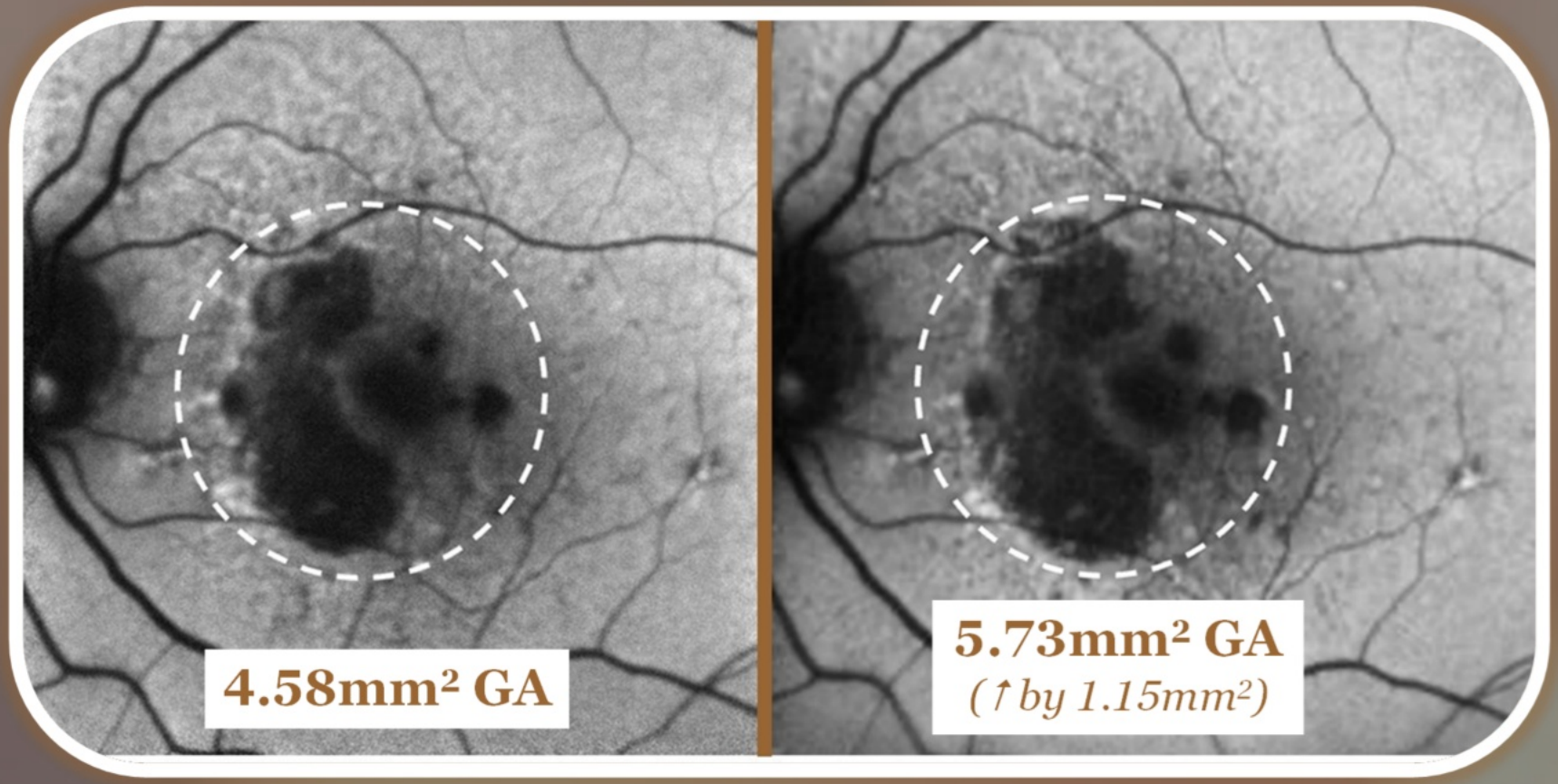
Avacincaptad pegol is a
C5 inhibitor

Pegcetacoplan is a
C3 & C3b inhibitor



RISK FOR GA PROGRESSION

GA grows at approximately **0.53 to 2.6 mm2/year** (0.2-1 disc areas)[12]



RISK FOR GA PROGRESSION

larger baseline size of GA

extrafoveal GA (>250-300um from fovea)

NB. GA tends to progress to periphery faster than to fovea ("foveal sparing")

multifocal GA

presence of reticular pseudodrusen (RPD)

hyper-fluorescence in junctional zone on FAF

impaired choroidal blood flow on OCT-A

disruption to photoreceptor layer on SD-OCT

fast historical rate of GA enlargement

GA in fellow eye

Adapted from Guymer, 2023[13]

GA TREATMENTS

Do not stop or reverse GA but can **SLOW** progression (by up to 14 to 25% in Phase 3 clinical trials)[14-15]

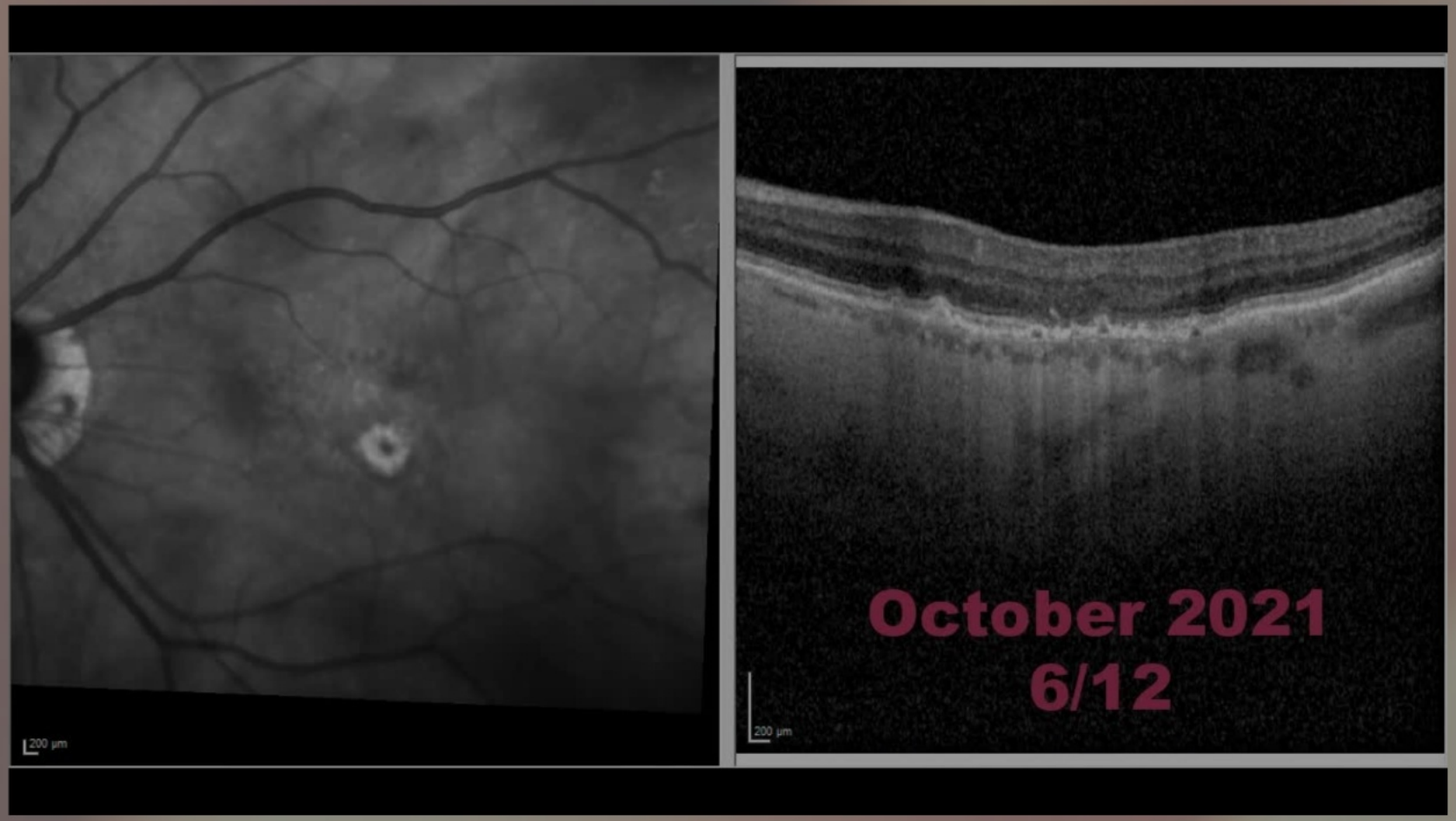
Selection criteria not fully defined but likely need to see some historical evidence of progression (consider early ophthalmology referral)

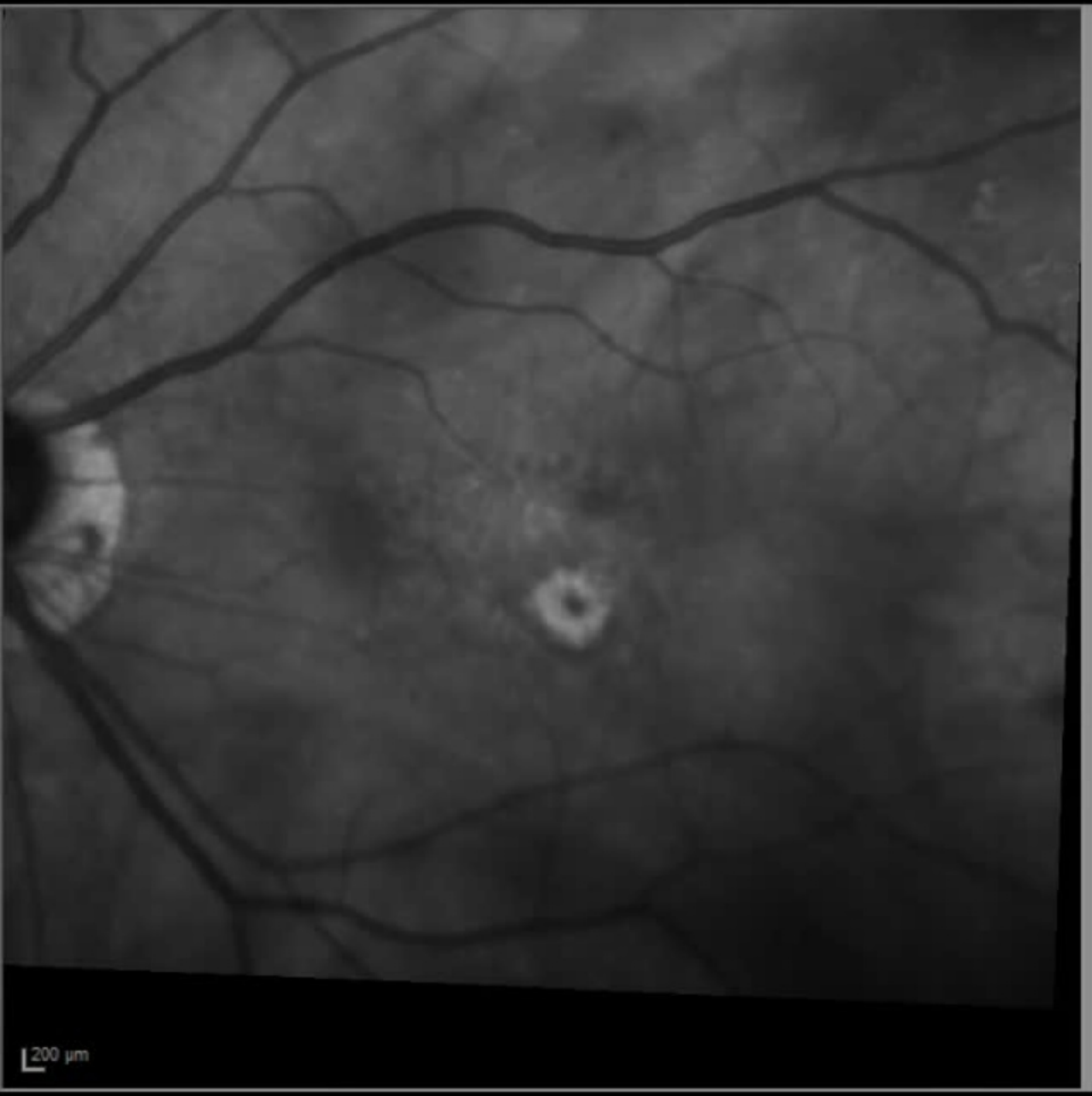
Most likey to be beneficial for

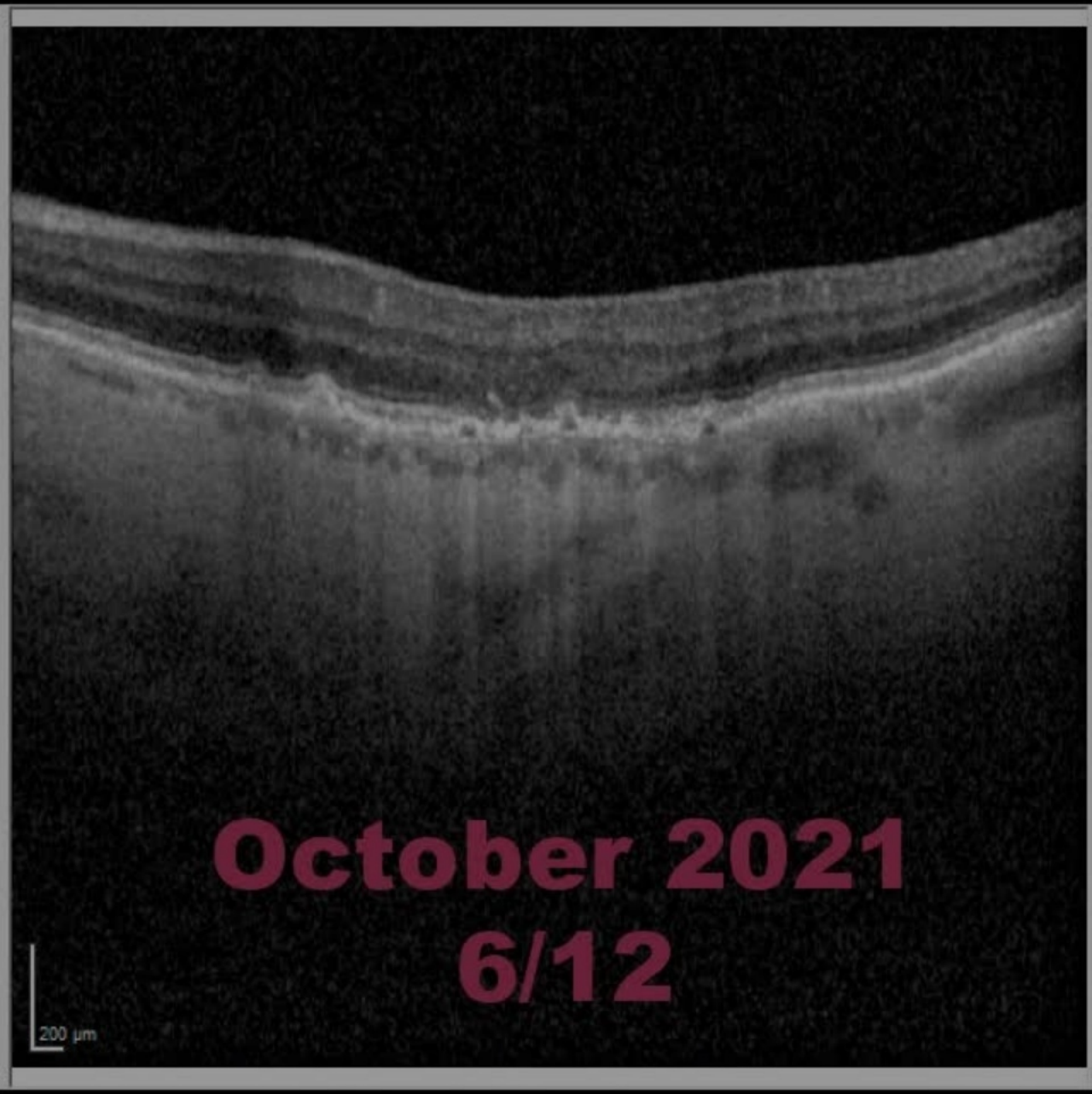
- extrafoveal GA (slower decline in VA)
- history of aggressive-growing GA
- patients who have already lost vision in one eye from GA

83yo Mr BF - patient since 2015

- RE 6/45 from centre-involving GA
- LE




200 µm

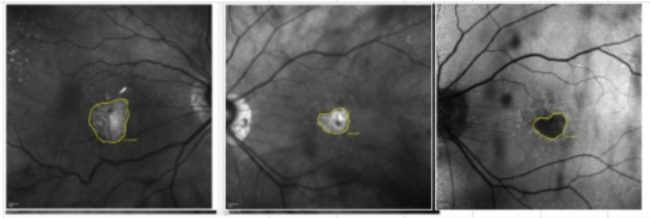
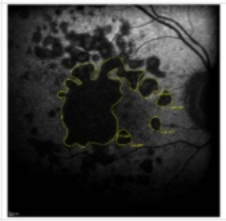
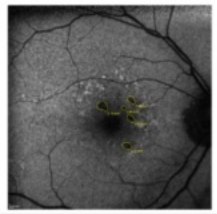
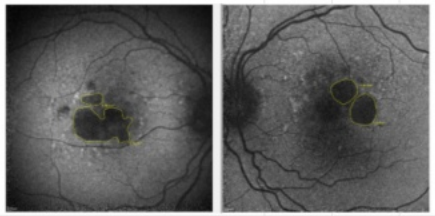

October 2021
6/12
200 µm

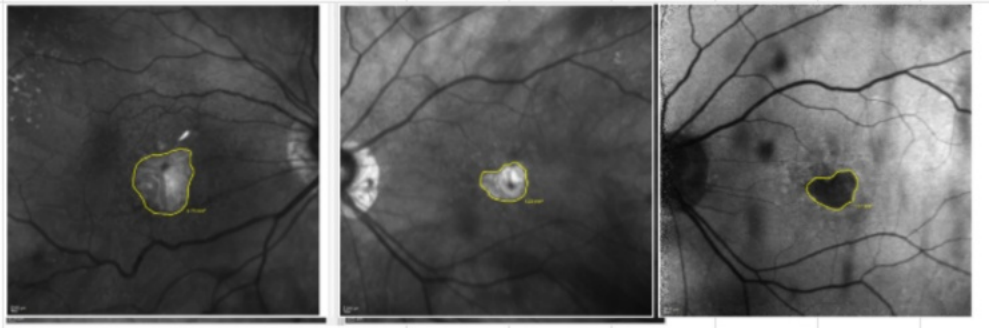
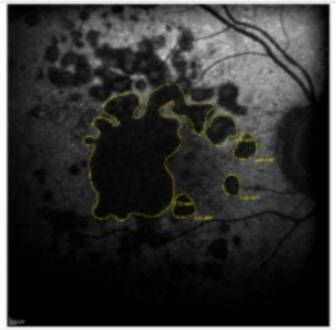
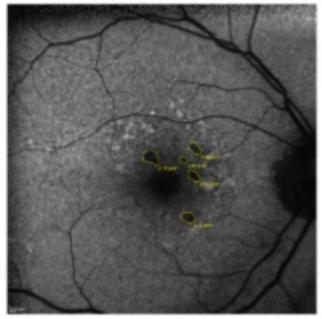
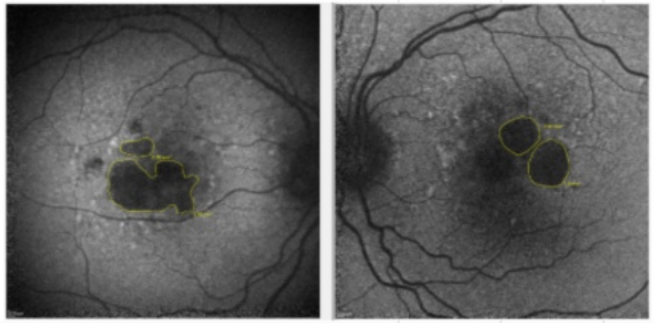
GA TREATMENTS

Currently monitoring potential candidates for GA treatments in practice

GA TREATMENTS

Currently monitoring potential candidates for GA treatments in practice

CLINICAL NOTES	GA AREA	FAF
Concurrent glaucoma R 6/24 L 6/15 DROPPED TO 6/30 IN NOVEMBER 2024	R 2.73mm2 L 1.23mm2	
HM in contralateral eye from CNV Enlarging centre-threatening GA in good eye (6/12)	R 9.17mm2	
Lost vision in LE (CF) RE 6/7.5	R 0.45mm2	
R>L GA VA R 6/18 L 6/7.5	R 3.33mm2 L 2.09mm2	

	CLINICAL NOTES	GA AREA	FAF
3	Concurrent glaucoma R 6/24 L 6/15 DROPPED TO 6/30 IN NOVEMBER 2024	R 2.73mm2 L 1.23mm2	
4	HM in contralateral eye from CNV Enlarging centre-threatening GA in good eye (6/12)	R 9.17mm2	
5	Lost vision in LE (CF) RE 6/7.5	R 0.45mm2	
6	R>L GA VA R 6/18 L 6/7.5	R 3.33mm2 L 2.09mm2	

REFERENCES

1. Patel PJ, Ziemssen F, Ng E, et al. Burden of illness in geographic atrophy: a study of vision-related quality of life and health care resource use. Clin Ophthalmol. 2020;14:15-28.
2. Singh RP, Patel SS, Nielsen JS, Schmier JK, Rajput Y. Patient-, caregiver-, and eye care professional-reported burden of geographic atrophy secondary to age-related macular degeneration. Am J Ophthalmic Clin Trials. 2019;2(1):1-6.
3. Chakravarthy U, Bailey CC, Johnston RL, et al. Characterizing disease burden and progression of geographic atrophy secondary to age-related macular degeneration. Ophthalmology. 2018;125(6):842-849.
4. Girgis S, Lee LR. Treatment of dry age-related macular degeneration: A review. Clin Exp Ophthalmol. 2023;51(8):835-852.
5. Age-Related Eye Disease Study Research G. A randomized, placebo-controlled, clinical trial of high-dose supplementation with vitamins c and e, beta carotene, and zinc for age-related macular degeneration and vision loss: Areds report no. 8. Archives of Ophthalmology 2001; 119: 1417-36.
6. Figueiredo I, Farinha C, Barreto P et al. Nutritional Genomics: Implications for Age-Related Macular Degeneration. Nutrients 2024; 16:4124
7. Wong WL, Su X, Li X, et al. Global prevalence of age-related macular degeneration and disease burden projection for 2020 and 2040: a systematic review and meta-analysis. Lancet Glob Health. 2014; 2:106-116
8. Mares J. A., Voland R. P., Sondel S. A., et al. Healthy lifestyles related to subsequent prevalence of age-related macular degeneration. Archives of Ophthalmology. 2011;129(4):470–480
9. Bearelly S, Khanifar AA, Lederer DE, Lee JJ, Ghodasra JH, Stinnett SS, Cousins SW. Use of fundus autofluorescence images to predict geographic atrophy progression. Retina. 2011 Jan;31(1):81-6.
10. Optometry Australia. Clinical Practice Guide for the Diagnosis and Management of Age-related Macular Degeneration Australia: 2024. Available from: https://www.optometry.org.au/wp-content/uploads/Professional_support/Guidelines/2024-AMD-Clinical-Practice-Guide-v11-Compressed-Copy.pdf
11. Garg A, Nanji K, Tai F, et al. The effect of complement C3 or C5 inhibition on geographic atrophy secondary to age-related macular degeneration: A living systematic review and meta-analysis. Surv Ophthalmol. 2024;69(3):349-361.
12. Fleckenstein M, Mitchell P, Freund KB, et al. The progression of geographic atrophy secondary to age-related macular degeneration. Ophthalmology. 2018; 125:369-390.
13. Guymer RH. Treating Geographic Atrophy -- Are We Ready? A Call to Image. Ophthalmology Retina 2023; 7: 1-3.
14. Heier JS, Lad EM, Holz FG OAKS and DERBY study investigators. Pegcetacoplan for the treatment of geographic atrophy secondary to age-related macular degeneration(OAKS and DERBY): two multicentre, randomised, double-masked, sham-controlled, phase 3 trials. Lancet. 2023;402(10411): 1434–1448
15. Khanani AM, Patel SS, Staurenghi G, et al. Efficacy and safety of avacincaptad pegol in patients with geographic atrophy (GATHER2): 12-month results from a randomised, double-masked, phase 3 trial. Lancet. 2023;402(10411):1449-1458.

HAND-IN-HAND

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BRISBANE INTERACTIVE

QUESTION #6

In accordance with Optometry Australia's Clinical Practice Guide for the Diagnosis and Management of Age-related Macular Degeneration, what are the recommended imaging techniques for geographic atrophy (GA) diagnosis and monitoring?

(i) SD-OCT, colour fundus photography and fundus autofluorescence

(ii) SD-OCT and colour fundus photography

(iii) Fundus red-free photography only

(iv) Fundus photography through iPhone at slit lamp

QUESTION #7

67% of people with geographic atrophy (GA) lose their ability to drive within how many years?

(i) 1.6 years

(ii) 5 years

(iii) 10 years

(iv) 20 years

TAKE HOME MESSAGES

1. Recgonise the important role optometrists play in educating and supporting patients (both clinical and psychological)
2. Use all available multi-modal imaging (colour fundus photography, autofluorescence, SD-OCT) to monitor AMD
3. Ensure your patients are accessing all support services available to them (eg. low vision aides, support programs)
4. GA treatments may become available in Australia in the future - refer patients who may be suitable or interested

QUESTION #8

A 60-year-old patient presents with minor vision changes. You note the following changes: the right macula has 2 large soft drusen (>125 µm), and the left macula has non-centre involving RPE changes. You diagnose intermediate (Category 3) dry AMD.

What is the risk of progression to late-stage AMD in the next 5 years?

(i) Up to 27% in both eyes

(ii) Up to 10% in both eyes

(iii) 10% in the right eye, 50% in the left eye

(iv) Up to 50% in both eyes

QUESTION #9

After reviewing retinal and OCT images, you recommend diet, lifestyle changes, and support options. This patient expresses their desire to do everything possible to protect their vision.

Which of the following would be an appropriate next step?

(i) Refer to private ophthalmology for baseline scans for future GA treatments

(ii) Advise nothing can be done and review when vision changes

(iii) Review annually

HAND-IN-HAND

Guiding Your Patients With Dry AMD

THANK YOU!

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UNDERSTANDING AMD

REAL LIFE EXPERIENCE

PROVIDING SUPPORT

THE FUTURE

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