



This activity has been accreditation by Optometry Australia for 1.25 clinical CPD hours.



# Navigating the changing geographic atrophy landscape



A guide for  
clinicians 2024



# Learning Objectives

**At the completion of this CPD Activity, participants should be able to:**

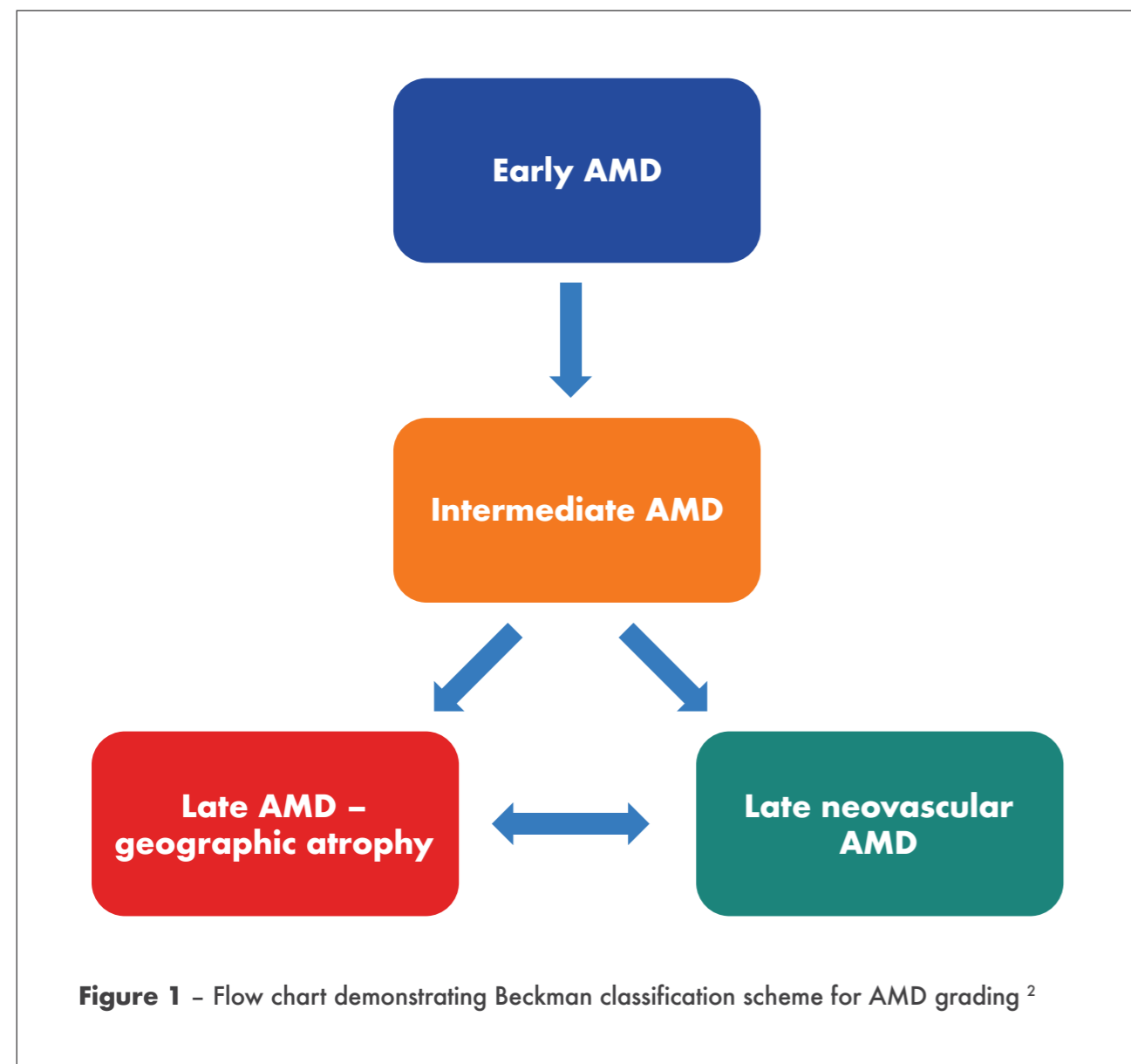
- 1** Describe the prevalence and classification of geographic atrophy.
- 2** Understand the modifiable and non-modifiable risk factors associated with risk of progression to late AMD.
- 3** Describe key imaging techniques to diagnose and manage geographic atrophy.
- 4** Understand the current treatments available for geographic atrophy and how to communicate their risks and benefits with patients.

# Geographic atrophy overview

Geographic atrophy, also known as late “dry” age-related macular degeneration, is a progressive disease of the macula.

It is one of two forms of late-stage age-related macular degeneration (AMD) and results from progressive and irreversible loss of photoreceptors, retinal pigment epithelium (RPE), and choriocapillaris.<sup>1</sup>

In its earlier stages, AMD is characterised by the presence of drusen and/or pigmentary changes. Drusen typically increase in size and number over time. However, drusen regression can also occur which may signal an increased risk of progression to late AMD.<sup>2</sup>

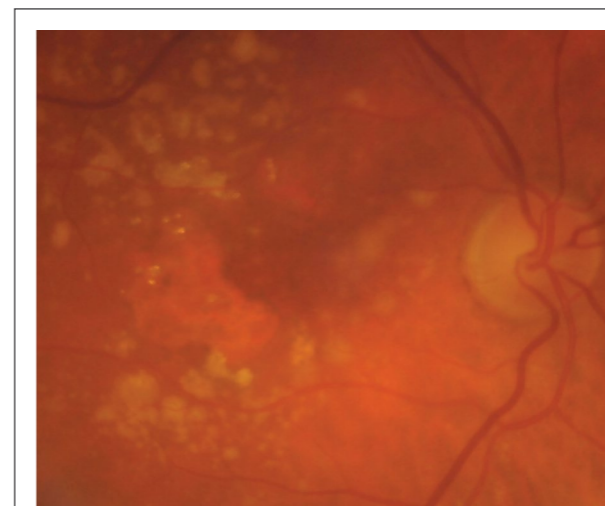


**Figure 1** – Flow chart demonstrating Beckman classification scheme for AMD grading <sup>2</sup>

## Beckman Classification

The current classification for AMD uses the scheme by the Beckman Initiative for Macular Research Classification Committee.<sup>2</sup> This grading system assesses patients over 55 years of age by examining areas within two disc diameters of the fovea. It is designed to estimate the five-year risk of progressing to late-stage AMD based on the clinical findings of drusen and pigmentary abnormalities.<sup>2</sup>

*For more information on the Beckman classification scheme, including hallmark signs of each stage of AMD, please refer to [Centre for Eye Health’s Chairs Reference: AMD](#).*



**Figure 2:** Fundus photography shows areas of geographic atrophy with surrounding large drusen. Image: CFEH.

## Classification of GA

Geographic atrophy (GA) is characterised by the presence of well demarcated areas of complete atrophy of photoreceptors and retinal pigment epithelium of at least 250 µm in diameter.<sup>1,3</sup> GA generally begins in the perifoveal area and can extend to the fovea, presenting as either singular (unifocal) or multiple (multifocal) atrophic lesions.<sup>1</sup>

Geographic atrophy may cause irreversible, severe loss of central vision and is closely associated with older age.<sup>1</sup> Once the fovea is involved, affected individuals experience significant central visual impairment, particularly in activities such as reading, driving, or recognising faces. Currently, there is no cure for geographic atrophy.

## Prevalence

Geographic atrophy affects approximately 5 million people worldwide, with prevalence increasing with age.<sup>4</sup>

In Australia, the overall prevalence of late AMD is estimated to be 0.96%, equating to approximately 75,000 Australians living with GA.<sup>5</sup> This prevalence increases 8-fold from 0.83% among those 70 to 79 years of age to 6.7% among those 80 years or older.<sup>5</sup>





# Risk factors

There are multiple non-modifiable and modifiable risk factors that increase the risk of progression to late AMD. Optometry Australia’s 2024 Clinical Practice Guide for the diagnosis and management of age-related macular degeneration details these risk factors as outlined below.<sup>6</sup>

Non-modifiable risk factors	
<p><b>Age</b> – level of evidence = strong<sup>7</sup> The strongest risk factor for AMD is increasing age. The risk of developing AMD increases more than threefold in those over 75 years compared to those between 65 and 74.<sup>7</sup></p>	<p><b>Family history</b> – level of evidence = strong<sup>7</sup> Family history is well-known as a risk factor for developing AMD.<sup>7</sup> The risk of AMD greatly increases with an affected first-degree relative.<sup>8</sup></p>

Modifiable risk factors				
<p><b>Smoking</b> – level of evidence = strong<sup>7</sup> Tobacco smoking is the strongest modifiable risk factor for AMD.<sup>7</sup> Increasing pack-years of cigarettes smoked is directly linked with an increased risk of AMD and associated with a 5-to-10-year younger age of onset, bilateral disease, and a two-fold increase in risk of developing late AMD.<sup>7,9,10,11</sup> Long-term smoking cessation has been shown to reduce risk of geographic atrophy, and it is estimated that one-third of geographic atrophy cases in smokers, could have been prevented if the individual had never smoked.<sup>12</sup></p>	<p><b>Hypertension</b> – level of evidence = moderate<sup>7</sup> A significant link between hypertension and late AMD has been demonstrated by three case control studies.<sup>7,13</sup></p>	<p><b>Cardiovascular disease</b> – level of evidence = moderate<sup>7</sup> The risk of late AMD is approximately double in those with a history of cardiovascular disease.<sup>7</sup></p>	<p><b>BMI of 30kg/m2 or higher</b> – level of evidence = moderate<sup>7</sup> Being overweight/obese increases the risk of late AMD.<sup>7,14,15</sup></p>	<p><b>Diet</b> – level of evidence = weak<sup>7</sup> MDFA recently undertook a <a href="#">systematic review</a> to evaluate the evidence for the role of dietary patterns, foods, nutrients and supplements in preventing AMD and/or slowing its progression. Diet patterns with consistent intake of omega-3 fatty acid rich foods, lutein, and zeaxanthin may be protective.<sup>7</sup> Furthermore, adherence to the Mediterranean diet has been associated with slowed rates of enlargement of geographic atrophy.<sup>16</sup></p>

# Imaging overview

Imaging techniques of the retina can be used to identify the presence of biomarkers that may indicate more rapid progression and determine the extent of geographic atrophy in the eye.

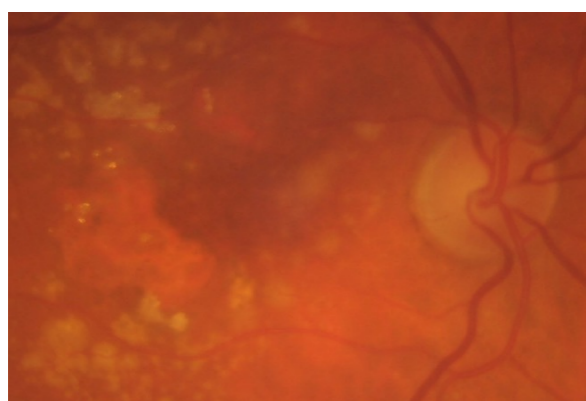
There are primarily three types of imaging techniques commonly used to examine for geographic atrophy: colour fundus photography (CFP), fundus autofluorescence (FAF), and optical coherence tomography (OCT).

OCT is most helpful to identify early atrophy, and risk of GA, while FAF is most helpful for identifying GA lesion progression and to differentiate atrophy related to AMD from atrophy related to inherited retinal disease.

## Colour fundus photography

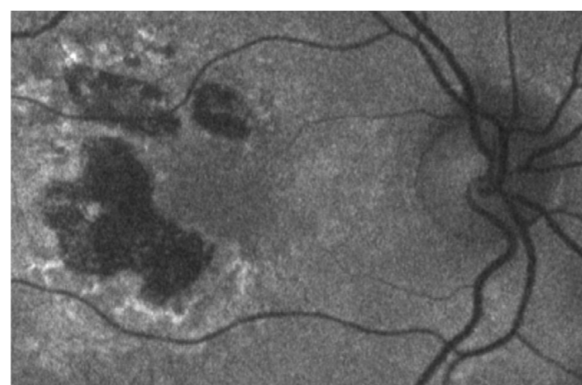
Previously, colour fundus photography (CFP) stood as the gold standard imaging method for capturing geographic atrophy lesions, and remains the imaging modality used for Beckman classifications. It provides a two-dimensional view of the retina, allowing observation of demarcated areas of atrophy, and any regions of thinning.

CFP is often used for monitoring drusen number, size, presence of pigmentary abnormalities and signs of late disease (CNV and GA); however, may be limited by low contrast.



**Figure 3:** Colour fundus photography shows areas of geographic atrophy with surrounding large drusen and some calcific changes. Image: CFEH.

While CFP is still a valuable tool for detecting and grading lesion size, recent technologies surpass CFP in their ability to capture specific clinical features of geographic atrophy.<sup>1</sup>

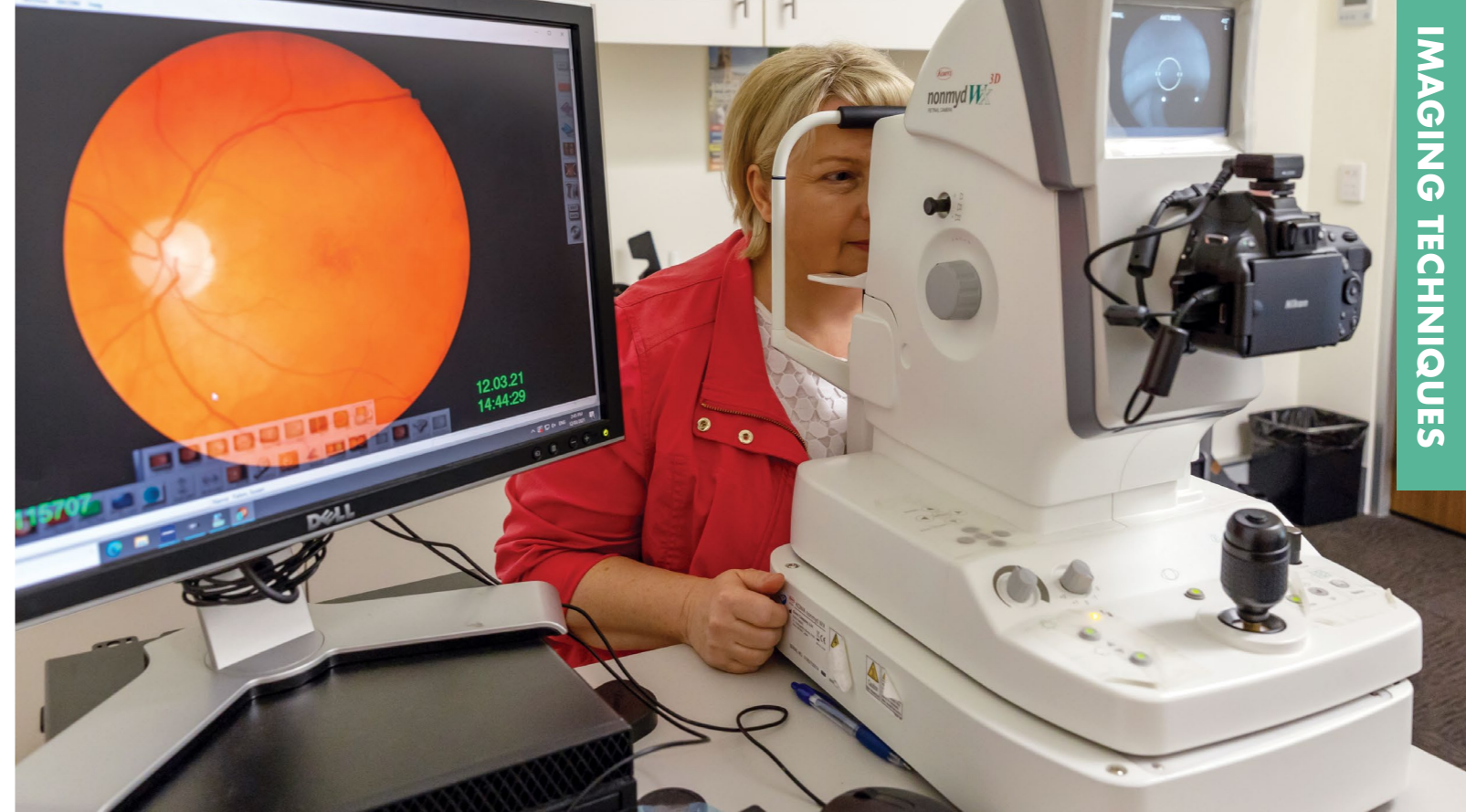


**Figure 4:** Fundus autofluorescence showing areas of geographic atrophy. Image: CFEH.

## Fundus autofluorescence

Fundus autofluorescence (FAF) can show areas of increased lipofuscin accumulation, such as cells in oxidative stress or drusen (as hyper-fluorescent), and areas where the RPE cells have died (hypo-fluorescent). The atrophic region displays a distinct dark area with a lack of fluorescent signal and can help quantify the size of atrophy. Successive scans over time can aid in determining rate of lesion growth. FAF can also be used to communicate findings to patients, where dark or black areas on the scan can be pointed out as areas of vision loss.

Variations in autofluorescent patterns observed through FAF imaging might also serve as potential indicators of lesion growth rate. Studies associate slower growing lesions with FAF images showing minimally hyper-autofluorescent backgrounds, whereas lesions associated with faster progression often display diffuse or 'speckled' hyper-autofluorescent background patterns.<sup>35</sup>



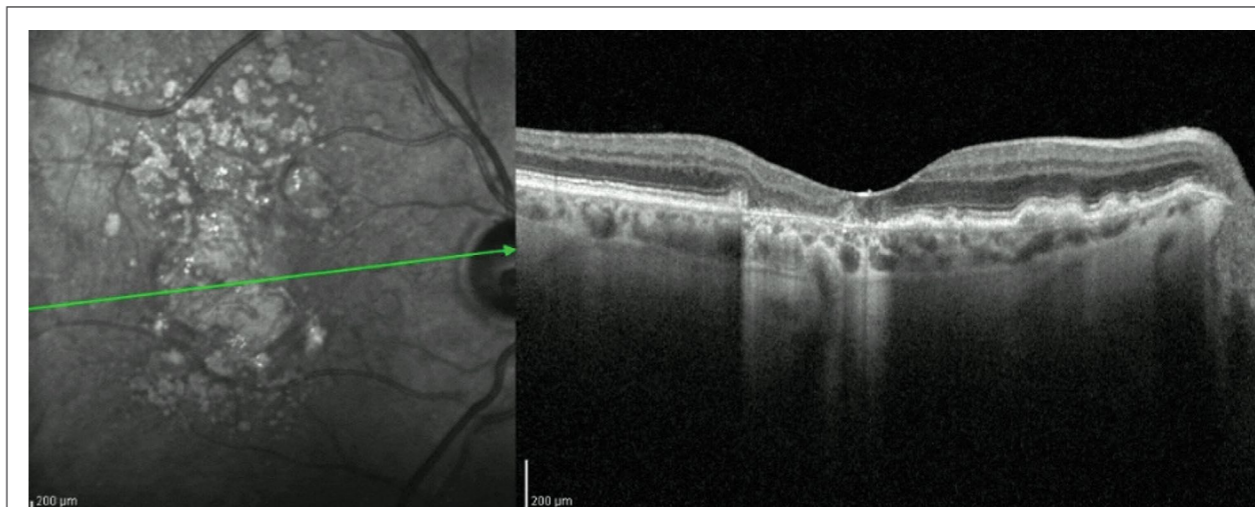
## Optical Coherence Tomography (OCT)

Optical coherence tomography (OCT) allows visualisation of thinning retinal layers through cross-sectional images. OCT allows measurement of the area of RPE and photoreceptor loss.<sup>3</sup>

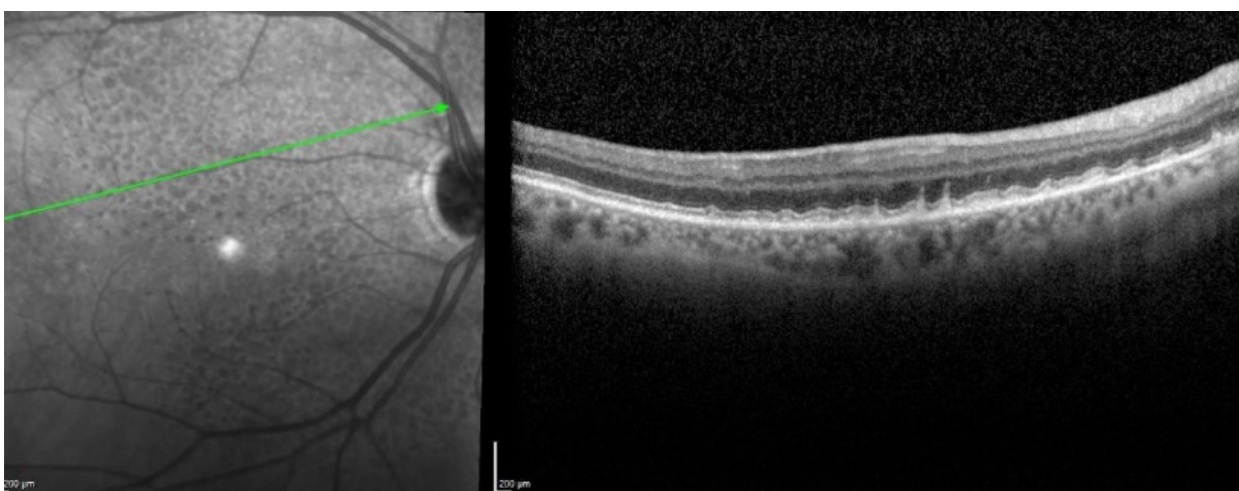
A feature of geographic atrophy in OCT is choroidal hyper-transmission. As a consequence of thinning outer retinal layers, in particular the

RPE, OCT signals penetrate deeper into areas of atrophy, rendering the choroid more discernible in corresponding areas.<sup>17,18,19</sup>

Key OCT clinical biomarkers which signify increased risk of developing GA include reticular pseudodrusen and hyper-reflective foci (discussed below in *prognostic biomarkers*).



**Figure 5:** OCT shows areas of RPE and outer retina loss (increased signal transmission). Image: CFEH.

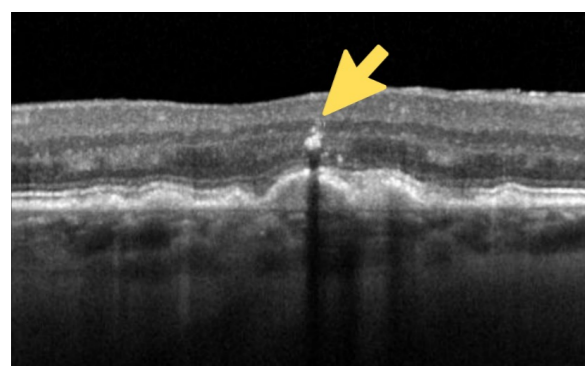


**Figure 6:** OCT line scan showing reticular pseudodrusen above the RPE. They can appear as wavy or conical in shape. Image: CFEH.

### Prognostic biomarkers

Prognostic biomarkers, identified on multimodal imaging, may identify patients at increased risk of developing late-stage AMD. These include:

- Reticular pseudodrusen (RPD) (also known as subretinal drusenoid deposits): They appear as hyper reflective deposits above the RPE, in the subretinal space. RPD have been associated with a 2-to-6-fold increased risk of progression to late AMD. RPD is highly prevalent in late-stage AMD, especially atrophy, and presence of RPD appears to influence the course of disease.<sup>20,21,22</sup>
- Hyper-reflective foci (HRF): HRF have been associated with a 5-fold increased risk of progression to late AMD at 2 years.<sup>23</sup> Hyper-reflective foci appear as a dot-like intraretinal hyper-reflective lesion at the apex of drusen. They typically correspond to pigmentary abnormalities on fundusoscopic examination.



**Figure 7:** Hyper-reflective foci seen on this OCT scan at the apex of an underlying druse. Image: CFEH.



**Figure 8:** Nascent GA identified by the arrow on this OCT line scan. Image: Prof Robyn Guymer CERA

- Nascent geographic atrophy: Nascent geographic atrophy has been found to be a strong predictor of geographic atrophy.<sup>24,25</sup> Nascent GA, also known as incomplete RPE and outer retinal atrophy (iRORA), is defined by the descent of the outer plexiform layer (OPL) and inner nuclear layer (INL), accompanied by a hypo-reflective wedge-shaped band, on OCT imaging.<sup>23</sup>

**If these features are found, a discussion with the patient on the risks of progression to late AMD should take place with an emphasis on the importance of self-monitoring for symptoms of neovascular AMD and the potential need for more frequent reviews.**

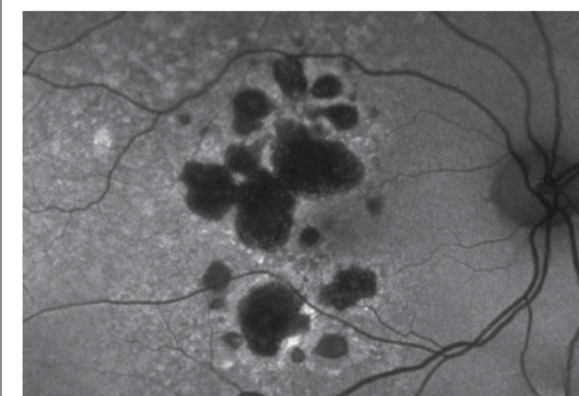
## Features associated with progression of geographic atrophy

Patients with geographic atrophy should be monitored 6-12 monthly, or sooner if any changes are noticed, to check for progression and risk of developing neovascular AMD.<sup>6,26</sup>

*Given the upcoming new treatments for geographic atrophy (GA), it is important for GA patients to undergo longitudinal multimodal imaging to monitor lesion characteristics and progression. This helps identify patients at higher risk of developing subfoveal GA lesions and, consequently, greater central vision loss. If you do not have access to OCT or fundus autofluorescence imaging, then you should refer the patient to a clinician who does.*

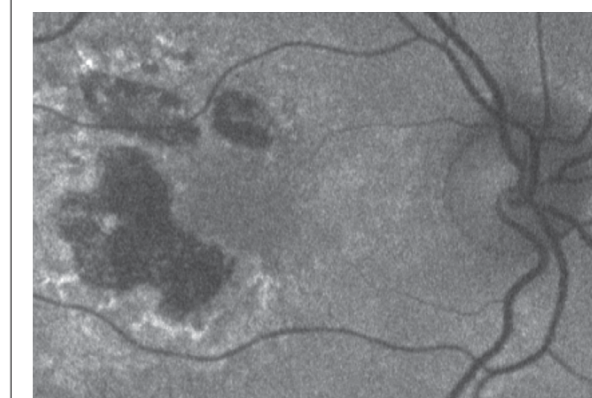
Clinical features that may indicate more rapid progression of GA include:

- Larger lesions. Smaller GA lesions usually grow slower than larger lesions.<sup>1</sup>
- Increased numbers of lesions. Multifocal lesions grow faster than unifocal lesions.<sup>1,27</sup>



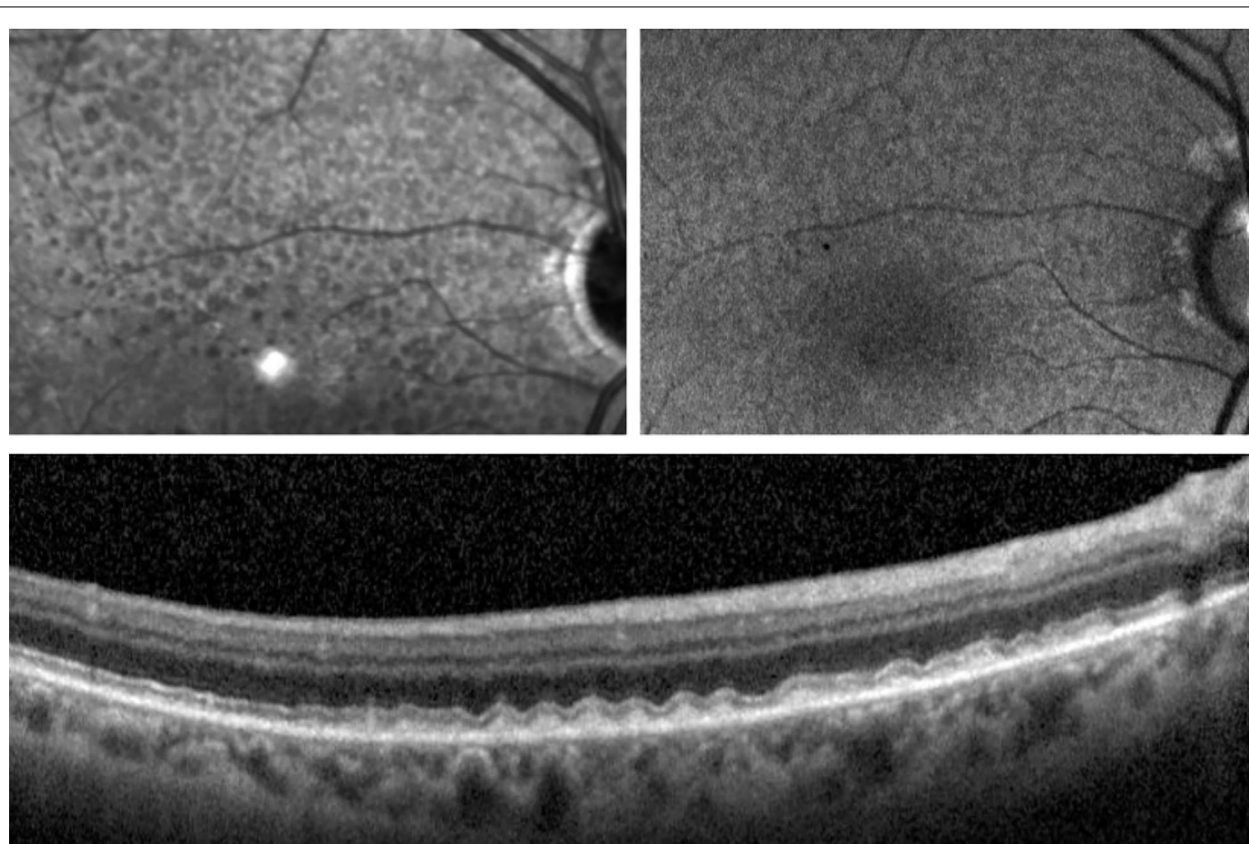
**Figure 9:** Fundus autofluorescence showing multifocal geographic atrophy. Lesions appear as hypo-autofluorescent areas. Image: CFEH.

- Presence of bilateral geographic atrophy, compared to unilateral. Progression is faster in fellow eyes of those with GA.<sup>1,28</sup>
- Shape of lesions. Lesions of irregular shapes have been found to advance faster than circular lesions.<sup>29</sup>



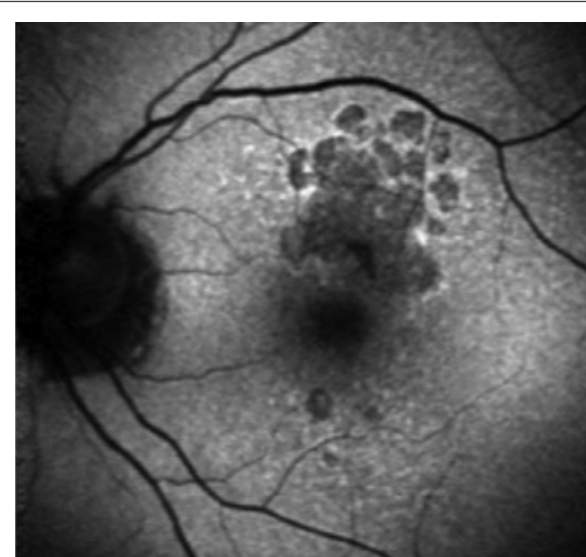
**Figure 10:** Irregular geographic atrophy lesion with surrounding drusen. Image: CFEH.

- Location of lesions. Lesions located outside the fovea showed accelerated growth in comparison to those involving the foveal region.<sup>1,30</sup>
- Direction of lesion growth. Lesion growth toward the periphery, rather than toward the fovea, progress faster.<sup>30</sup>
- Type of drusen. The presence of reticular pseudodrusen (RPD) is associated with more rapid progression of GA, especially in the area of RPD.<sup>31,32,33</sup>



**Figure 11:** Reticular pseudodrusen at the superior macula above the RPE. Image: CFEH.

- Identifying regions with ellipsoid zone disruption on OCT may also predict direction of GA progression.<sup>34</sup>
- Banded and diffuse (particularly “diffuse-trickling”) FAF patterns in the areas surrounding GA lesions usually have a faster growth rate. In FAF imaging, the atrophic area appears more grayish rather than dark black as seen in other GA subtypes and FAF intensity around the atrophy is enhanced.<sup>35</sup>



**Figure 12:** Diffuse-trickling multifocal GA seen on fundus autofluorescence imaging.<sup>35</sup>

### Differential diagnoses

To ensure accurate diagnosis of geographic atrophy, eyecare professionals should be aware of other macular conditions that may masquerade as GA. Variations in drusen appearance (size and distribution), a strong family history (particularly of Mendelian inherited retinal diseases), abnormal background hyper autofluorescence on imaging, and patient age (less than 50 years old) are the primary distinguishing factors that may warrant a second opinion.

The following list is an overview of the most common differential diagnoses for geographic atrophy:

- Best Disease
- Myopic maculopathy
- Inherited retinal disease (i.e. pattern dystrophy, Stargardt disease)

Please refer to [Centre for Eye Health Atlas](#) for more examples of differential diagnoses and what to look for on various imaging modalities.



# Treatments – what’s coming for geographic atrophy?

As per Optometry Australia and RANZCO AMD referral guidelines, current approaches to managing geographic atrophy involve managing modifiable risk factors, regular use of an Amsler grid, prescribing corrective glasses, use of low vision aids, and maintaining regular eye examinations.<sup>6,26</sup>

Recent advancements in clinical trials have shown potential new treatment options for people with geographic atrophy. Two drugs have now been approved for use in the United States: pegcetacoplan and avacincaptad pegol. There are numerous other drugs in the development pipeline for the treatment of geographic atrophy, also mostly targeting the complement pathway.

Both pegcetacoplan and avacincaptad pegol are designed to decrease activity of the body’s complement system. Studies have shown that increased activity of the complement system is involved in the development of atrophic lesions of the macula.<sup>36</sup>

Inhibiting the complement system can help to reduce the growth of the macular lesions, helping to slow progression of late-stage dry AMD.<sup>37,38</sup>

Due to the pending arrival of these treatments in Australia, it is advised that clinicians provide appropriate counselling and/or non-urgent referral to ophthalmology for baseline testing of geographic atrophy in patients interested in new treatments.<sup>26</sup>

## Pegcetacoplan How does the drug work?

When the complement system, and in particular protein C3, becomes overactive it triggers inflammation. This inflammation is thought to lead to or exacerbate the inflammation observed in eyes with geographic atrophy.<sup>36</sup>

C3 is an appealing focal point for prospective treatments due to its position as a point of divergence for three downstream pathways.<sup>36</sup> These pathways are speculated to collectively contribute to the development and/or progression of geographic atrophy.

Pegcetacoplan is a complement inhibitor which specifically targets C3.



TREATMENTS AVAILABLE

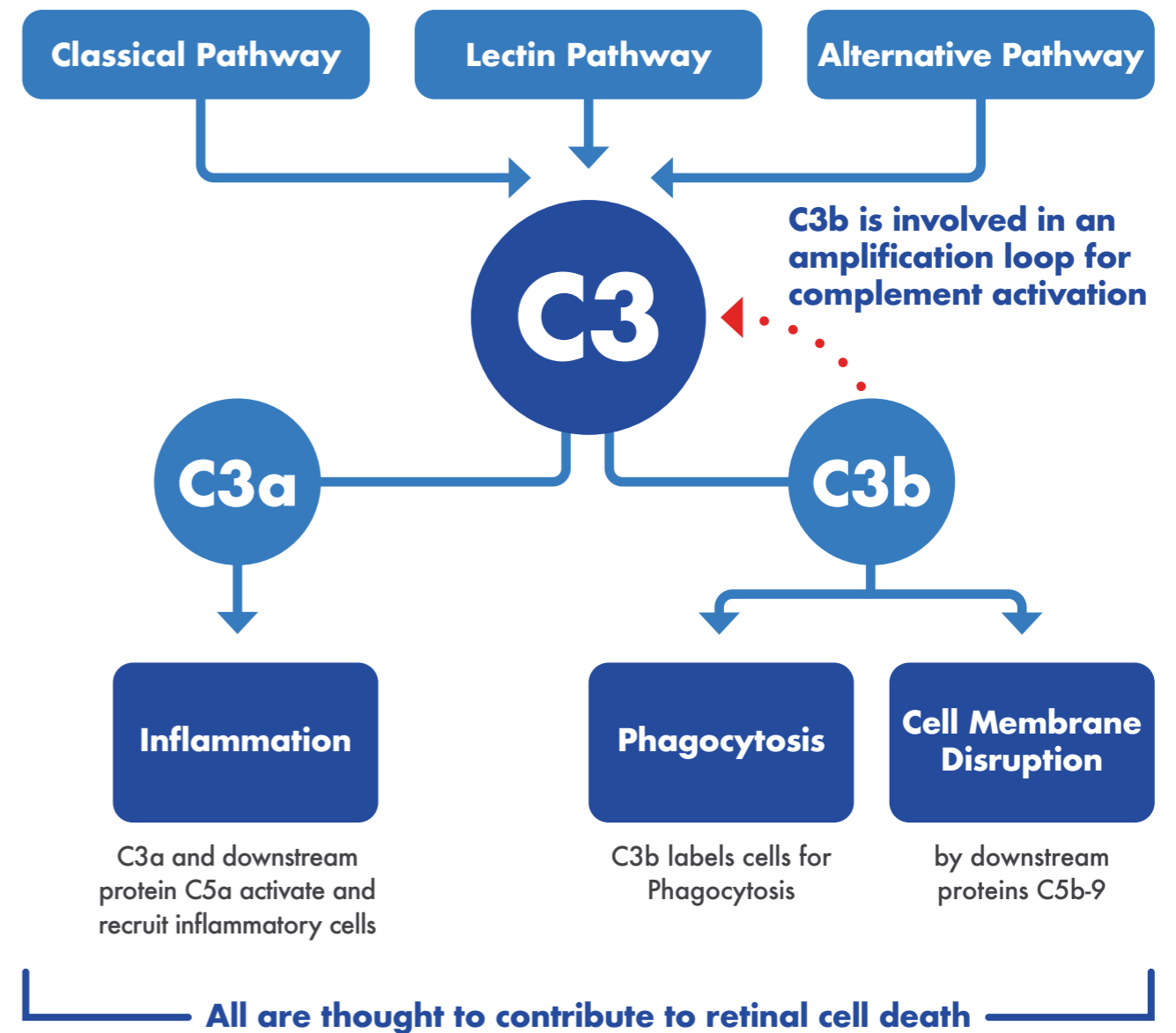
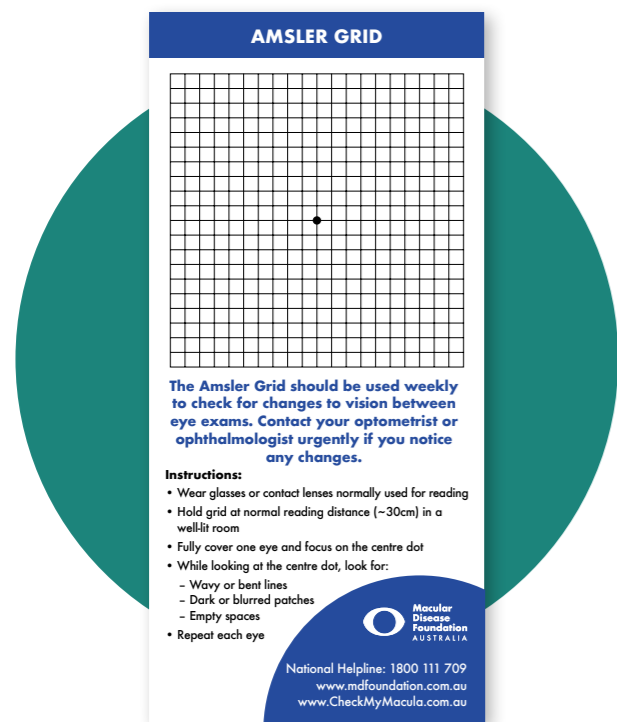
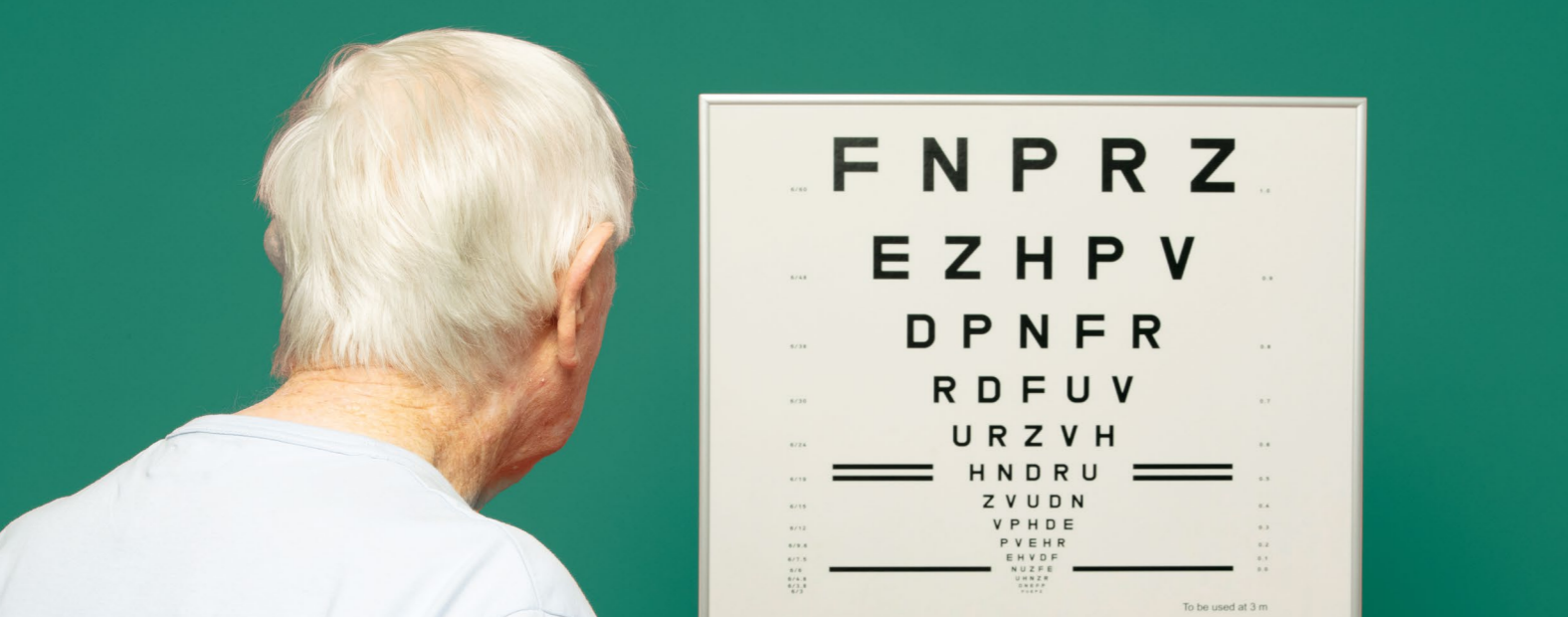


Figure 13: C3 protein involved in the complement cascade.<sup>39</sup>



### Study results

Phase 3 studies (OAKS and DERBY) investigated the safety and efficacy of pegcetacoplan intravitreal injections for treating geographic atrophy over a two-year period.<sup>40</sup> The follow-on GALE extension study is ongoing.

OAKS and DERBY included patients with **both subfoveal and non-subfoveal lesions**. The studies found pegcetacoplan injected into the eye every month or every other month showed a slowing of geographic atrophy lesion growth at 12 months of 16% with monthly injections and 14% with injections every other month.<sup>40</sup>

At 24 months, pegcetacoplan showed a slowing of lesion growth of 21% and 17% with monthly and every other month injections respectively.<sup>40</sup> When looking at pre-specified analysis of the **non-subfoveal group only**, lesion growth slowed by 26% and 23% with monthly and every other month injections respectively.

The GALE extension study 36-month findings showed these beneficial effects seem to increase over time with continuing treatment (injections monthly or every-other-month).<sup>41</sup>

In OAKS and DERBY, pegcetacoplan has not been shown to reduce the size of lesions already present in the eye or show a statistically significant difference in visual acuity, reading speed or mesopic microperimetry between the groups. Patient reported measures showed no day-to-day noticeable difference in vision.

### Adverse events

The clinical trials found the treatment appeared to be generally well tolerated, although it did increase the risk of developing neovascular (wet) AMD in the treated eye. Treatment with pegcetacoplan had serious adverse events including three cases of ischaemic optic neuropathy and four cases of infectious endophthalmitis.

After approval of the treatment, adverse events have continued to be collected. In August 2023, several cases of occlusive vasculitis were reported with the real-world use of pegcetacoplan, with investigation into causality and incidence ongoing.<sup>42</sup> Cases of occlusive vasculitis can result in catastrophic vision loss or even enucleation.

### FDA approval

In February 2023, SYFOVRE™ (pegcetacoplan injection), was approved by the US Food and Drug Administration for the treatment of geographic atrophy secondary to AMD. In 2024 Syfovre was rejected by the European Medicines Agency (EMA) and is currently under re-evaluation. Pegcetacoplan is currently in the process of review by the Therapeutic Goods Administration for use in Australia.

### Avacincaptad pegol

#### How does the drug work?

Avacincaptad pegol targets the C5 protein which is located further down the complement system cascade, compared to the C3 protein.<sup>38</sup> It is thought to play a role in cell membrane disruption which may contribute to retinal cell death.<sup>38</sup>

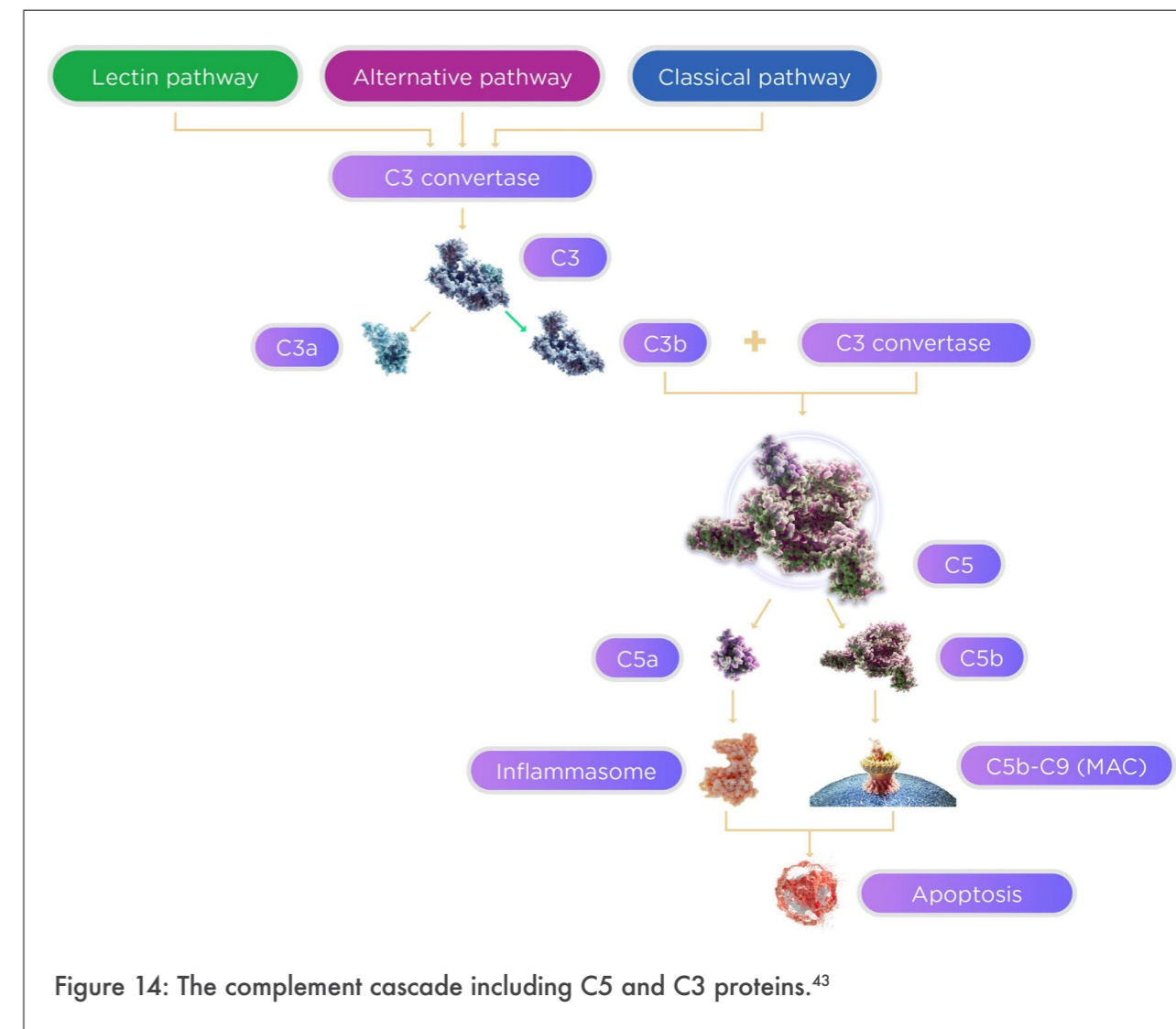


Figure 14: The complement cascade including C5 and C3 proteins.<sup>43</sup>

### Study results

The GATHER2 trial tested the effect of monthly intravitreal injection of avacincaptad pegol compared to sham on participants with **non-subfoveal involved geographic atrophy lesions only** (this is in contrast to OAKS and DERBY which also included sub-foveal).<sup>44</sup> The results showed that monthly intravitreal injection of avacincaptad pegol slowed lesion growth by 14% compared to sham after 12 months.

GATHER2, similar to OAKS and DERBY, found no reduction in lesion size or improvement in visual acuity. GATHER2 participants receiving avacincaptad pegol will have an additional 18 months of treatment and safety monitoring (in addition to the original planned 24-month protocol).

### Adverse events

Similar to OAKS and DERBY, the GATHER2 trial showed that compared with sham, monthly injection of avacincaptad pegol increased development of macular neovascularisation at 12 months. GATHER2 showed the drug was generally well tolerated, with low rates of adverse events similar to that known for intravitreal injections.

Rates of neovascular AMD development in GATHER2 was less than that observed in OAKS and DERBY. This is likely due to the difference in inclusion criteria between the two trials: OAKS and DERBY allowed participants with neovascular AMD in their fellow eye; GATHER2 excluded these people (risk of neovascular AMD is greater for those who have it in their fellow eye).

There has also been a reported case post-trial of a patient who developed retinal vasculitis following injection of avacincaptad pegol.<sup>42</sup>

### FDA approval

In August 2023 IZERVAY™ (avacincaptad 2mg injection) was approved by the US Food and Drug Administration for the treatment of geographic atrophy secondary to AMD.

To stay up to date on the latest research news surrounding geographic atrophy treatments, subscribe to MDFA's quarterly eyecare professional e-newsletter, **Macula Matters**.

The findings from OAKS and DERBY and GATHER2 demonstrate that the treatment is not a cure for GA and only results in a slowing of lesion growth. In the event that there is an approved treatment in Australia, patients need a clear understanding of the treatment's objectives and expected outcomes, emphasising that they will not experience any improvement in their day-to-day vision. This contrasts with anti-vascular endothelial growth factor (anti-VEGF) injections for neovascular AMD, which can improve vision shortly after administration in around one third of eyes.

# Frequently asked questions your geographic atrophy patients may ask

Macular Disease Foundation Australia has put together a series of frequently asked questions your patients with geographic atrophy may ask regarding recent treatment advancements. Please note the information provided is current as of August 2024.

### Q: Are there any treatments for geographic atrophy/dry AMD?

**A: There is currently no available treatment for geographic atrophy in Australia.**

Two new eye injection treatments for geographic atrophy/dry AMD have been approved in the USA.

The treatments are called pegcetacoplan (brand name Syfovre™) and avacincaptad pegol (brand name Izervay™). The treatments are both delivered as an eye injection (intravitreal eye injection), which would be needed indefinitely, every 4 to 8 weeks.

If pegcetacoplan or avacincaptad pegol eye injections do become available in Australia, this doesn't necessarily mean that you will be eligible for treatment, or that the treatment will be suitable for you.

### Q: I've heard/read that eye injection treatments for geographic atrophy/dry AMD have been approved in the United States. Is this true?

**A: Yes.** In 2023, the United States (US) Food and Drug Administration approved two new eye injection treatments for geographic atrophy:

- pegcetacoplan (brand name Syfovre™); and
- avacincaptad pegol (brand name Izervay™).



Both treatments were approved in the United States based on results from clinical trials looking at their effect on slowing the growth of sight-threatening macular lesions.

Slowing lesion growth helps to delay the progression of late-stage dry AMD.

It is important to note, that for both treatments, although the clinical trials found that monthly injections could help to slow progression of dry AMD, the trials did not reduce existing lesion size or improve vision.

The trials also found that some people experienced serious vision-threatening adverse events after treatment including developing neovascular (wet) AMD in the injected eye.

**However, these treatments are currently not available in Australia.**



**Q: Are there any treatments for geographic atrophy/dry AMD approved in Australia?**

**A: No.** There are currently no treatments for geographic atrophy/dry AMD approved for use in Australia.

A drug called pegcetacoplan (brand name Syfovre™) is currently being reviewed by the Therapeutic Goods Administration to assess if it should be approved and registered for use in Australia.

In Australia, the Therapeutic Goods Administration (TGA) assesses different medicines and treatments to help ensure they are safe and effective before registering them and approving them for use.

All medicines registered by the TGA are assessed for safety, quality, and efficacy before they become available to the public. Once the medicine is registered and becomes available, the TGA continues to monitor the medicine to make sure it is safe. If any issues with the medicine emerge, the TGA may suspend or cancel the medicine's registration.

Registration of a medicine with the TGA does not mean that the medicine is funded by the Government under the Pharmaceutical Benefits Scheme (PBS). This funding is dependent on a positive recommendation by the Pharmaceutical Benefits Advisory Committee (PBAC), which must then be approved by the Health Minister.

**Q: How effective are the new eye injection treatments for geographic atrophy/dry AMD?**

**A:** The clinical trials assessing pegcetacoplan eye injections (brand name Syfovre™) and avacincaptad pegol eye injections (brand name Izervay™) found that eye injections every month, or every two months, could help to slow the progression of dry AMD.

However, while the treatment can slow progression of dry AMD, the trials found that neither of the treatments improved vision.

In addition, the trials also found that some people experienced serious adverse events

after treatment including an increasing risk of developing neovascular (wet) AMD and inflammation in the injected eye that could further worsen vision or in rare cases lead to loss of vision.

**At the moment, neither eye injection treatment is approved by the Therapeutic Goods Administration for use in Australia.**

**Q: How do the new eye injection treatments for geographic atrophy/dry AMD work?**

**A:** The two new eye injection treatments for dry AMD (geographic atrophy), pegcetacoplan (brand name Syfovre™) and avacincaptad pegol (brand name Izervay™), both work by inhibiting the complement system, a part of the immune system. Studies have shown that increased activity of the complement system is involved in the development of atrophic lesions of the macula - where small patches of retinal cells gradually die.

This is called geographic atrophy or dry AMD. As the lesions grow, central vision may be affected and people's ability to continue their daily activities, including driving and reading, will be affected.

Inhibiting the complement system helps to reduce the growth of the macular lesions, helping to slow progression of geographic atrophy.

**Q: Are there any risks associated with the new eye injection treatments?**

**A: Yes.** Like many medicines or treatments, there can be side effects or adverse reactions that it is important to be aware of before starting a new treatment.

Some people experienced serious sight-threatening adverse events after treatment including developing neovascular (wet) AMD, infections and inflammation in the injected eye. In the clinical trial assessing pegcetacoplan eye injections there were also cases of sight-threatening inflammation in the injected eye, and a serious optic nerve condition

known as ischaemic optic neuropathy. Since pegcetacoplan has been in clinical use in the United States, there have been rare cases of inflammation affecting the retinal blood vessels ("retinal vasculitis") which can lead to visual loss.

**Q: What is involved in receiving the new eye injection treatments?**

**A:** Pegcetacoplan and avacincaptad pegol are both delivered as intravitreal (eye) injections.

Injecting a needle into your eye might sound scary but eye injections should not be painful.

Your ophthalmologist will use a small eyelid speculum, a type of medical instrument to keep your eyelid open and stop you from blinking. You will not see the needle coming towards your eye.

Your ophthalmologist will then apply a local anaesthetic to numb the eye. They'll also use antiseptic to prevent infection. They will then administer the eye injection using an exceptionally fine needle.

You will usually require some additional scans to monitor your eye/s on the day (e.g. Optical Coherence Tomography or OCT).

The injection can cause some slight discomfort and your vision may be affected for a brief time afterwards.

**Q: Will my vision improve with the new eye injection treatments?**

**A: No.** Both the pegcetacoplan (brand name Syfovre™) and avacincaptad pegol (brand name Izervay™) eye injection clinical trials found that while both treatments can help slow progression of dry AMD, neither of the eye injection treatments improved vision.

It is important to understand that it is not yet known exactly who will benefit most from these new eye injection treatments.

*Please note: the information provided in this document is current as of August 2024.*



# Reference list

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