



PATIENT INFORMATION

Intravitreal Anti-VEGF Injection

*Treatment for cystoid macular oedema that has not responded to drops
Given only after a full course of topical treatment has failed*

To achieve the immeasurable, you must measure everything.

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How to use this leaflet

This leaflet is for the small number of patients whose cystoid macular oedema has not resolved with drops. Most patients with this condition never reach this stage.

It forms part of your informed consent alongside the discussion you will have with your consultant and the consent form you sign.

About This Leaflet

This leaflet is for patients being considered for an intravitreal anti-VEGF injection to treat cystoid macular oedema that has persisted despite a full course of topical treatment.

An intravitreal injection means an injection of medication into the vitreous, the clear gel that fills the inside of the eye, so that the drug acts directly on the retina.

At Blue Fin Vision®

Your named Blue Fin Vision® consultant ophthalmic surgeon confirms the diagnosis on scanning, establishes that topical treatment has genuinely failed, obtains your consent and performs the injection personally.

An assessment that ends in a recommendation not to inject is a successful assessment.

The General Medical Council requires that the person performing your treatment is the person who obtains your consent, and that you are given the information you need to decide.¹

What Is Cystoid Macular Oedema?

The macula is the central part of the retina and is responsible for detailed vision, reading and recognising faces. Cystoid macular oedema, usually shortened to CMO, means that fluid has collected within the layers of the macula in small cyst-like spaces.

It is the most common reason for vision to be less good than expected after otherwise uncomplicated cataract or lens surgery, and it typically appears a few weeks to a few months afterwards. When it follows cataract surgery it is sometimes called Irvine-Gass syndrome.

A large United Kingdom database study of more than 80 000 eyes found that macular oedema after cataract surgery occurred in approximately 1 to 2 per cent of eyes overall, with higher rates in patients with diabetes, previous retinal vein occlusion, uveitis or an epiretinal membrane.²

It is usually temporary and usually treatable

Most cystoid macular oedema settles with drops. The great majority of patients never need an injection, and this leaflet exists for the small minority in whom the fluid does not resolve with the standard treatment.

How it is diagnosed

CMO is diagnosed and monitored with optical coherence tomography, a scan that produces a cross-sectional image of the macula in a few seconds without drops or discomfort. The scan shows the fluid directly, measures the thickness of the macula in microns, and allows each subsequent visit to be compared against your own previous measurements rather than against an impression.

Every treatment decision described in this leaflet is made from those measurements. Nothing here is decided on symptoms alone.

Why Drops Come First

The first-line treatment for cystoid macular oedema after lens surgery is a combination of topical steroid and topical non-steroidal anti-inflammatory drops. The combination works better than either drop used alone, and it is well tolerated.³

This is why injections are so rarely needed here

In our practice the combination of topical steroid and non-steroidal anti-inflammatory drops resolves cystoid macular oedema in the overwhelming majority of patients. Cases requiring an intravitreal injection are genuinely exceptional.

If you have been given this leaflet, it is because your oedema has not followed that usual course, not because injection is a routine part of the pathway.

A full course means a full course

Drops are continued and tapered over months rather than weeks, and the response is measured with repeated scans. Oedema that is improving on scanning is not treated as refractory simply because vision has not yet recovered, because the scan changes before the vision does.

Stopping treatment early, or tapering too quickly, is a common reason for oedema to appear resistant when it is not. Where a patient has relapsed after stopping drops, the correct next step is usually to reinstate and taper more slowly rather than to escalate to an injection.⁴

The Six Month Rule

Blue Fin Vision® applies a clear threshold before any intravitreal injection is offered for cystoid macular oedema.

We do not inject until topical treatment has genuinely failed

An intravitreal injection is not offered until you have completed at least six months of appropriate topical steroid and non-steroidal anti-inflammatory treatment, and optical coherence tomography confirms that significant oedema persists despite it.

This is a floor rather than a target. Meeting it does not mean an injection will be recommended: it means the question can properly be asked.

The reason is proportionality. An intravitreal injection is an intraocular procedure carrying a small but real risk of serious complications, and it should not be used to shorten a course of drops that would have worked given time.

When we would act sooner

The rule is not absolute. Where vision in the affected eye is severely reduced and deteriorating, where the fellow eye is poorly sighted, or where an underlying condition such as diabetic maculopathy or retinal vein occlusion is driving the oedema rather than the surgery, earlier treatment may be appropriate. In that situation the oedema is not simply post-surgical and is managed on its own terms.

Your surgeon will tell you which of these situations applies to you, and why.

Before Any Injection Is Offered

Three questions are answered before an injection is considered, and a yes to the first alone is not sufficient.

- Is significant oedema still present on scanning, rather than only on symptoms?
- Has appropriate topical treatment genuinely been completed, at the right intensity and for long enough?
- Is the oedema the reason your vision is limited, rather than something else such as posterior capsule opacification, residual refractive error, dry eye or another retinal condition?

Treating the wrong cause produces a technically successful injection that does not improve the vision, which is the most avoidable disappointment in this pathway.

What Anti-VEGF Treatment Is

VEGF stands for vascular endothelial growth factor, a naturally occurring protein that makes blood vessels leaky and encourages abnormal new vessels to grow. Anti-VEGF drugs block its action.

In cystoid macular oedema the small blood vessels at the macula leak fluid into the retina. Reducing that leakage allows the fluid to be reabsorbed and the macula to return towards its normal thickness.

The drug is delivered by injection because drops cannot reach the back of the eye in useful concentration, and tablets would expose the whole body to a drug that is only needed in one eye.

Licensed and Unlicensed Use

This is an important point about your consent

Anti-VEGF drugs are licensed in the United Kingdom for conditions including wet age-related macular degeneration, diabetic macular oedema and macular oedema following retinal vein occlusion. Their use for cystoid macular oedema following cataract or lens surgery is outside the terms of that licence.

This is described as off-label use. It is lawful and common in ophthalmology, and it means that a doctor is using an established medicine for a purpose the licence does not specifically cover, on the basis of published evidence and clinical judgement.

General Medical Council guidance requires that where a medicine is prescribed outside its licence, the doctor is satisfied there is sufficient evidence or experience to support it, records the reasons, and explains this to the patient.⁵ We tell you rather than leaving it in the small print, because a patient consenting to an injection is entitled to know the regulatory basis on which it is being given.

Your Alternatives

Continuing or restarting topical treatment

Where drops have been stopped early, tapered too quickly, or not used at the intensity intended, reinstating them properly is often the right next step rather than escalating.

Intravitreal steroid

An injection of triamcinolone, a steroid, is the alternative injectable treatment for refractory cystoid macular oedema and is described in a separate Blue Fin Vision® leaflet. Steroid tends to be more effective than anti-VEGF for oedema of this particular type, but carries a higher risk of raised eye pressure and, in an eye that still has its natural lens, of cataract. Your surgeon will explain which is more appropriate for your eye.

Periocular steroid injection

Steroid can also be injected around the outside of the eye rather than into it. This avoids entering the eye but delivers less drug to the macula.

Doing nothing further

Some long-standing cystoid macular oedema resolves slowly on its own, and some patients function well despite persistent fluid. Where the effect on your vision is modest, continued observation with scanning is a legitimate choice, and the fluid does not usually cause permanent damage in the short term.

On The Day

The injection is performed in a clean treatment room or theatre environment. It takes a few minutes and you go home the same day.

- Eat and drink normally and take your usual medication unless told otherwise.
- Anaesthetic drops numb the surface of the eye, and an antiseptic solution is applied to the eye and eyelids. The antiseptic is the part most patients find sharp or stinging.
- A small clip holds the eyelids open. This feels strange rather than painful.
- The medication is injected through the white of the eye, a few millimetres behind the edge of the cornea, using a very fine needle.
- The injection itself takes a few seconds. Most patients feel pressure rather than pain.
- Your eye is checked afterwards and you are given written instructions before you leave.

Your vision will be blurred immediately afterwards, so do not drive yourself home. Please tell us in advance if you take anticoagulant or antiplatelet medication, although this rarely prevents the injection from going ahead.

After Your Injection

Your eye may feel gritty or scratchy for a day or so, mainly from the antiseptic rather than the injection itself. Simple lubricating drops help.

- A red patch on the white of the eye where the needle passed is common and harmless, and fades over one to two weeks.
- You may see floaters or small dark shapes for a day or two, which are tiny air bubbles or drug in the vitreous.
- Vision is blurred for several hours and usually recovers by the following day.
- Use any drops prescribed exactly as instructed, and do not rub the eye.

You can return to normal activities the next day, and there is no restriction on reading, screens or exercise. Avoid swimming for a week.

How Many Injections?

Anti-VEGF has a limited duration of action, so a single injection is rarely the whole treatment. A course is usually planned as a small number of injections at monthly intervals, with the response measured on scanning before each one.

Every injection is a decision

We do not commit in advance to a fixed number of injections. Each is decided on the scan in front of us, so treatment stops when the fluid has resolved rather than when a predetermined course has been completed, and it stops equally when repeated injections are not producing benefit.

How Well Does It Work?

Anti-VEGF treatment can reduce macular thickening and improve vision in refractory cystoid macular oedema, and the published evidence supports its use where topical treatment and steroid have not succeeded.⁶

The evidence base is smaller and less consistent than for the licensed indications, and the response is generally less predictable than for oedema treated with steroid. Some eyes respond well, some partially, and some not at all.

Improvement in the scan usually precedes improvement in vision, sometimes by weeks. Where oedema has been present for a long time before treatment, some structural change at the macula can be permanent and vision may not return fully even when the fluid resolves. This is one of the reasons the condition is monitored rather than ignored.

Risks and Side Effects

Intravitreal injection is a very common ophthalmic procedure with a good safety record, but it involves entering the eye and it is not risk free.

Infection inside the eye

Endophthalmitis is the most serious complication. Published series report it after approximately 1 in 2 000 injections.⁷ It requires urgent treatment and can cause permanent loss of vision. The antiseptic preparation before your injection exists specifically to reduce this risk, and the warning signs later in this leaflet exist to catch it early.

Raised pressure inside the eye

A transient rise in pressure immediately after injection is usual and settles within minutes to hours. Sustained rises are uncommon with anti-VEGF, and less likely than with steroid injection.

Bleeding and discomfort

A red patch on the surface of the eye is common and harmless. Bleeding inside the eye is uncommon. Discomfort for a day or two is usual.

Retinal tear or detachment

Rare, but recognised. The warning signs of flashes, a shower of floaters or a shadow apply for life after any intraocular procedure, not only in the first week.

Cataract

Injury to the natural lens is rare, and most patients receiving this treatment for post-surgical oedema already have an artificial lens implant.

Systemic effects

A small amount of drug reaches the bloodstream. Large studies in the licensed indications have not established a clear excess of cardiovascular events, but if you have had a recent stroke or heart attack you should tell your surgeon, because it may affect the choice of treatment.

If The Oedema Does Not Improve

If scanning shows no useful reduction in macular thickness after an adequate trial, further injections of the same drug are unlikely to help and we will say so rather than continuing.

The next steps may include switching to intravitreal steroid, reconsidering whether another condition is driving the oedema, further retinal investigation, or accepting the current vision with continued monitoring. Care remains within Blue Fin Vision® throughout.

Warning Signs

Contact us the same day

Increasing pain in the eye rather than settling discomfort. Increasing redness. Deteriorating vision. Marked sensitivity to light. A sudden increase in floaters, flashing lights, or a shadow across your vision.

These can indicate infection, raised pressure or a retinal problem, all of which are treated more successfully when seen early. If you cannot reach us, attend an eye casualty department and tell them you have had an intravitreal injection and when.

Mild grittiness, a red patch on the white of the eye and a few floaters in the first days are expected and settle without treatment. The distinction that matters is between symptoms that are settling and symptoms that are worsening.

Costs

Treatment of cystoid macular oedema is medically indicated, and private medical insurance commonly provides cover, subject to your policy terms and prior authorisation. The drug cost is normally itemised separately from the procedure fee.

Item	Fee
Consultation, scanning and diagnostic assessment	£325
Intravitreal anti-VEGF injection	See current published price
Drug cost	Quoted separately, by agent

Current pricing is maintained online and may change, so please refer to [our published price list](#). You will receive a written quotation before proceeding, confirming the procedure fee, the drug cost and the expected number of injections in the first instance.

Questions Worth Asking

You are entitled to clear answers to these questions, from us or from any provider you are considering.

- How much fluid is present on my scan, and how has it changed?
- Have I completed a genuinely adequate course of drops?
- Is the oedema definitely what is limiting my vision?
- Why anti-VEGF rather than a steroid injection for my eye?
- Is this use of the drug within its licence, and if not, what does that mean?
- How many injections do you expect, and how will you decide when to stop?
- What happens if my scan does not improve?
- What are the warning signs I should act on, and who do I call?

Taking your time

Unless your vision is deteriorating rapidly, there is time to consider this. Cystoid macular oedema that has already been present for six months rarely changes materially in the week you take to decide. Blue Fin Vision® does not use time-limited pricing or pressure of any kind.

Where We Operate

Blue Fin Vision® works across the sites below. Governance, protocols and measurement pathways do not vary by postcode. Availability of intravitreal injection varies by site, and we will confirm where your treatment is performed when your appointment is arranged.

Site	Address
The Harley Street Eye Centre	22A Harley Street, London W1G 9BP
Weymouth Street Hospital	42-46 Weymouth Street, London W1G 6NP
Phoenix Hospital Chelmsford	Essex Healthcare Park, West Hanningfield Road, Chelmsford CM2 8HN
One Hatfield Hospital	3 Hatfield Avenue, Hatfield, Hertfordshire AL10 9UA
Chase Lodge Hospital	Page Street, Mill Hill, London NW7 2ED
London Eye Diagnostic Centre	25 Harley Street, London W1G 9QW. Insured patients
Abbey Wood Hospital	The Cottage, Bostall Hill, Abbey Wood, London SE2 0GD. Blue Fin Vision® services starting soon

Your Clinical Team

Blue Fin Vision® is a consultant-led practice. Your assessment, your injection and your follow-up are performed by a named Blue Fin Vision® consultant ophthalmic surgeon, who obtains your consent and remains responsible for your care. Injections are not delegated.

Where vitreoretinal expertise or ongoing medical retina care is required, your care remains within Blue Fin Vision®. Professor Mahmut Dogramaci, Consultant Vitreoretinal Surgeon, provides that cover within the same practice, so you are not discharged into an external waiting list for a problem identified here.

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Mr Mfazo Hove is a Consultant Ophthalmic Surgeon with experience spanning more than 57 000 procedures. He completed 6.5 years of specialist training at Moorfields Eye Hospital and served as a consultant at the Western Eye Hospital, Imperial College Healthcare NHS Trust, from 2017 to 2022. He has published six consecutive years of outcome data through the National Ophthalmology Database, with a posterior capsule rupture rate in cataract and lens surgery of approximately 0.2 per cent.

Document control

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