BLUE FIN VISION®

PATIENT INFORMATION

Intravitreal Triamcinolone Injection

Steroid injection for cystoid macular oedema that has not responded to drops

Given only after a full course of topical treatment has failed

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To achieve the immeasurable, you must measure everything.

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Consultant Ophthalmic Surgeon and Medical Director

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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 injection of triamcinolone, a steroid, 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 steroid 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 Triamcinolone Is

Triamcinolone is a corticosteroid, the same family of medicine as the steroid drops you have already been using, but delivered directly into the eye as a small depot of fine crystals rather than as a drop.

Cystoid macular oedema after lens surgery is driven by inflammation, and steroid addresses that inflammation at its source. Because the depot dissolves slowly, a single injection can act for weeks to months, which is its principal advantage over drops.

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 steroid needed in only one eye.

Licensed and Unlicensed Use

> **This is an important point about your consent**
>
> Intravitreal triamcinolone is widely used for macular oedema, but its use in this way is generally outside the terms of a United Kingdom marketing authorisation, and the preparation used may be an unlicensed or specially prepared product.
>
> This is described as off-label or unlicensed use. It is lawful and long established in ophthalmology, and it means a doctor is using a well understood 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 used 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.

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 anti-VEGF

An anti-VEGF injection is the alternative injectable treatment and is described in a separate Blue Fin Vision® leaflet. It carries a lower risk of raised pressure and of cataract, but for oedema of this particular type steroid is generally the more effective option. 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 and carries a lower risk of pressure rise, but delivers less drug to the macula and is generally less effective.

A slow-release steroid implant

Longer-acting steroid implants exist and are licensed for some causes of macular oedema. They last longer than triamcinolone but carry the same pressure and cataract risks over a longer period, and are usually reserved for oedema from other causes.

Doing nothing further

Where the effect on your vision is modest, continued observation with scanning is a legitimate choice.

Are You a Steroid Responder?

A proportion of people respond to steroid, in any form, with a rise in the pressure inside the eye. This is called a steroid response, and it is the single most important thing to establish before an intravitreal steroid injection.

> **Your drops have already given us information**
>
> Because you have been using steroid drops for months, we already know something about how your eye responds to steroid, and your pressures during that period are reviewed before the injection is offered. A patient whose pressure rose noticeably on drops is more likely to respond to a depot injection that cannot be stopped once given.
>
> This is one reason the six month rule has a clinical benefit as well as a proportionality one: the eye has already been tested.

If you have glaucoma, ocular hypertension, or a known steroid response, an intravitreal steroid injection may still be possible, but it changes the balance of risk and may make anti-VEGF the better choice. Tell your surgeon if any of these apply to you or to close family members.

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 triamcinolone is injected through the white of the eye, a few millimetres behind the edge of the cornea, using a 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 for a day or so, mainly from the antiseptic. A red patch where the needle passed is common and fades over one to two weeks.

> **Floaters after a steroid injection are different**
> Triamcinolone is a suspension of fine crystals rather than a clear solution, so most patients see a cloud of small dark spots or a shifting haze for the first days to weeks while the drug disperses. This is expected and is not a complication. A sudden shower of new floaters with flashing lights or a shadow is a different matter and is covered under Warning Signs.

Vision is blurred for several hours and often for a day or two longer than after an anti-VEGF injection because of the drug particles themselves. Use any drops prescribed exactly as instructed, and do not rub the eye.

How Well Does It Work?

Intravitreal triamcinolone is effective for refractory cystoid macular oedema and typically produces a reduction in macular thickness within weeks. It is generally the more effective of the two injectable options for oedema of this type.[6]

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.

The effect is not necessarily permanent. As the depot dissolves, oedema can return, and some patients need a further injection or a different approach. That is a property of the treatment rather than a failure of it.

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. Steroid carries specific additional risks that anti-VEGF does not.

Raised pressure inside the eye

This is the most important risk specific to steroid. A systematic review of pressure after intravitreal steroid found clinically significant rises in a substantial minority of eyes, typically developing over the weeks following injection.[7] Most are controlled with drops, but a small number of patients need longer term treatment or, rarely, glaucoma surgery.

Unlike a drop, an injected depot cannot be stopped. If your pressure rises, it is managed while the steroid dissolves rather than by withdrawing the drug, which is why the monitoring described in the next section is not optional.

Cataract

Steroid inside the eye accelerates cataract formation. If you still have your natural lens, this is a significant consideration and cataract may develop or progress over the following months to years. Most patients receiving this treatment for oedema after lens surgery already have an artificial lens implant, in which case this risk does not apply to them.

Infection inside the eye

Endophthalmitis is the most serious complication of any intravitreal injection, reported after approximately 1 in 2 000 injections.[8] It requires urgent treatment and can cause permanent loss of vision. A sterile inflammatory reaction to the drug crystals can also occur and can be difficult to distinguish from infection early on, which is why any increasing pain or redness must be assessed rather than assumed to be the drug.

Bleeding, retinal tear and detachment

A red patch on the surface of the eye is common and harmless. Bleeding inside the eye is uncommon. Retinal tear and detachment are rare but recognised, and the warning signs apply for life after any intraocular procedure.

Drug in the visual axis

Occasionally the crystals settle where they interfere with vision for longer than usual. This almost always resolves as the drug dissolves.

Pressure Monitoring After Treatment

Because a pressure rise usually develops over weeks rather than immediately, a single check on the day is not sufficient.

What we commit to

Your pressure is measured before the injection, on the day, and at scheduled reviews over the months that follow while the steroid is active. If your pressure rises, treatment is started promptly and continued until the depot has dissolved and the pressure has returned to baseline.

This monitoring is part of the treatment rather than an optional extra, and it is included in your fee. If you cannot attend the review appointments, tell us before the injection rather than afterwards, because the monitoring is the reason this treatment can be offered safely.

If The Oedema Returns

Recurrence as the depot dissolves is common enough to be expected rather than surprising. Your scan at each review establishes whether fluid is returning before your vision changes.

Options then include a further injection, a longer-acting steroid implant, a switch to anti-VEGF, reinstating topical treatment, or continued observation. Where oedema recurs repeatedly, your surgeon will reconsider whether another condition is driving it rather than simply repeating treatment. 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.

Item	Fee
Consultation, scanning and diagnostic assessment	£325
Intravitreal triamcinolone injection	See current published price
Pressure monitoring and scheduled reviews	Included

Current pricing is maintained online and may change, so please refer to **our published price list**. You will receive a written quotation before proceeding.

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?
- Did my pressure rise while I was using steroid drops?
- Why steroid rather than anti-VEGF for my eye?
- Is this use of the drug within its licence, and if not, what does that mean?
- What is my individual risk of a pressure rise, and how will it be monitored?
- Do I still have my natural lens, and what does that mean for cataract risk?
- What happens if the oedema comes back when the drug wears off?

> **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, and a depot injection cannot be undone once given. 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.

Mr Mfazo Hove

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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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