



PATIENT INFORMATION

YAG Vitreolysis

Laser treatment for selected vitreous floaters
A treatment suitable for a minority of the patients who ask for it

To achieve the immeasurable, you must measure everything.

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Version 1.0 | August 2026

Contents

About This Leaflet
What Are Floaters?
New Floaters Are Assessed Before Anything Else
Why Most Floaters Are Left Alone
Am I Suitable For Vitreolysis?
Who Is Not Suitable
What The Evidence Shows
Your Alternatives
What The Laser Does
Your Assessment
On The Day
After Your Treatment
How Well Does It Work?
Risks and Side Effects
If It Does Not Work
Warning Signs
The Long Term
Costs
Questions Worth Asking
Where We Operate
Your Clinical Team
References

How to use this leaflet

This leaflet is written to be read before your appointment. Rather more of it than usual is about who should not have this treatment, because suitability is the decisive issue in vitreolysis and most patients who ask about it are not suitable.

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

About This Leaflet

This leaflet is for patients troubled by vitreous floaters who are considering YAG vitreolysis, a laser treatment that breaks up a floater inside the eye.

Floaters are extremely common and almost always harmless. For most people they become less intrusive with time and need no treatment at all.

An honest starting position

Vitreolysis is a treatment for a specific kind of floater in a specific kind of eye. It is not a general treatment for floaters, and it is not suitable for most of the patients who ask about it.

The evidence base is considerably smaller than for most of the procedures we perform, and the benefit reported in trials is partial rather than complete. We think you should know both of those things before, rather than after, a consultation.

The UK evidence position

The National Institute for Health and Care Excellence has reviewed this procedure and concluded that the published evidence on its safety and efficacy is inadequate in quality and quantity, and that it should only be used in the context of research.² We state this at the outset rather than in a footnote, because it is the most important external fact about the treatment.

Insufficient evidence is not the same as evidence of no benefit

NICE did not conclude that vitreolysis does not work. It reviewed randomised trials and case series, identified improvement in quality of life and reduction in visual disturbance as key efficacy outcomes, and acknowledged that the procedure may provide a less invasive alternative to vitrectomy. Its conclusion was that the evidence is not yet strong enough to establish safety and efficacy with confidence.

Published studies do show symptomatic benefit in selected patients. What remains uncertain is how reliably that benefit occurs, in which patients, and how safe the procedure is over the long term. One of the weaknesses NICE identifies is that studies have reported patient selection poorly, including the type, size and position of the floater treated.

That distinction matters for you, because a single discrete Weiss ring sitting well clear of the retina and lens is a different clinical proposition from floaters in general.

This assessment is about evidence rather than about cost. It is not a judgement on whether the NHS should fund the procedure, and it does not mean the treatment has been found too expensive to provide.

Healthcare professionals are expected to take NICE guidance fully into account when exercising their clinical judgement. NICE also states that its guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with that patient.

Your consultant will therefore recommend treatment only where the characteristics of your floater, your eye and your symptoms make the possible benefit sufficient to justify both the known risks and the evidential uncertainty.

What that means for your decision

The uncertainty is part of what you are deciding about, alongside the risks. If you would not accept a treatment whose evidence base a national body has judged insufficient, that is an entirely reasonable position and you should not have this procedure.

NICE also recommends, in its own words, that the procedure be done by retinal specialists experienced in laser surgery and with expertise in managing vitreoretinal disease. Who would perform your treatment, and their relevant experience, is set out under Your Clinical Team so that you can weigh that for yourself.

Your named Blue Fin Vision® consultant examines your eye, decides with you whether treatment is appropriate, obtains your consent and performs any laser personally. An assessment that ends in a recommendation not to treat is a successful assessment, and in this pathway it is the most common outcome.¹

What Are Floaters?

The centre of the eye is filled with a clear gel called the vitreous. With age, the gel changes consistency, and strands of collagen within it clump together and cast shadows on the retina. Those shadows are what you see as floaters: specks, threads, cobwebs or a ring drifting across your vision.

Eventually the vitreous separates from the retina altogether, which is called a posterior vitreous detachment. This is a normal event, and it often produces a sudden increase in floaters, sometimes including a distinct ring-shaped floater called a Weiss ring where the gel detached from the optic nerve.

Floaters move with the eye, drift when the eye stops, and are most noticeable against a bright uniform background such as a white wall or the sky. They are more common in people who are short-sighted and after cataract surgery.³

New Floaters Are Assessed Before Anything Else

This comes before any discussion of treatment

A sudden increase in floaters, particularly with flashing lights, can indicate a retinal tear. A shadow or curtain spreading across the vision can indicate a retinal detachment. Both require same-day assessment and neither is treated with vitreolysis.

Every patient presenting with floaters at Blue Fin Vision® has a dilated examination of the whole peripheral retina before anything else is discussed.

This matters because a patient who arrives asking about laser treatment for floaters may in fact have a retinal tear that needs urgent treatment. Discussing an elective laser before excluding that would be the wrong order in which to think.

If a tear is found, it is treated on its own merits, usually with retinal laser, and that is covered in a separate leaflet.

Why Most Floaters Are Left Alone

Three things happen to floaters over time, and all of them work in your favour.

- They settle. Floaters drift downwards out of the visual axis, so the same floater becomes less noticeable.
- They disperse. The clumps that cast the shadow gradually break up on their own.
- You stop noticing them. Over time many people become substantially less aware of an established floater, through a combination of movement or dispersal of the opacity and neurological adaptation to a stable, unchanging shadow.

This is why patience is genuinely a treatment rather than a way of avoiding one. Many patients become substantially less troubled over subsequent months without any intervention at all.

Time is the first-line treatment

At Blue Fin Vision® we normally wait at least six months after an uncomplicated posterior vitreous detachment before considering elective vitreolysis. This is our own conservative selection policy rather than a universal rule, though it matches the entry criteria used in the main sham-controlled trial of the procedure.⁴ Treating earlier risks intervening in an eye that would have improved by itself.

Am I Suitable For Vitreolysis?

Suitability depends on what the floater is, where it sits, and what kind of eye it sits in. All three must be favourable.

The features that make treatment possible

- A single, discrete, well-defined floater, most typically a Weiss ring, rather than diffuse haze or innumerable small specks.
- A floater sitting well away from the retina, so that laser energy is not delivered close to it.
- A floater sitting well away from the natural lens, for the same reason.
- A floater that can be clearly visualised and tracked at the laser, which is not always possible even when it is visible on examination.
- Symptoms that are genuinely functional, meaning the floater interferes with reading, driving or work, rather than being simply present.
- A stable posterior vitreous detachment, usually of at least six months' standing.

An artificial lens changes one part of the calculation

In an eye that has already had cataract surgery there is no natural lens to damage, so the risk of causing a cataract with the laser does not arise and the safe working distance towards the front of the eye is greater. That can make some floaters technically more suitable for treatment.

It does not remove the retinal risks, the pressure-related risks, or any of the other hazards of the procedure. A pseudophakic eye is not a safe eye, it is an eye with one fewer hazard.

Who Is Not Suitable

This section is longer than the one before it, and deliberately so.

- Patients with diffuse floaters, vitreous haze or many small specks rather than one discrete opacity. Laser treats a target; it cannot clear a fog.
- Patients whose floater lies close to the retina. The margin for error is measured in millimetres and the consequence of error is a retinal burn or tear.
- Patients whose floater lies close to the natural lens, where treatment risks causing a cataract.
- Younger, short-sighted patients with fine strand-like floaters and no posterior vitreous detachment. These are the patients most troubled by floaters and least suitable for this treatment, which is an uncomfortable but important truth.
- Patients whose floaters have been present only a short time, in whom natural improvement has not yet had a chance.
- Patients with retinal disease, previous retinal detachment, significant glaucoma or an eye that cannot be examined adequately.
- Patients whose symptoms cannot be explained by a discrete opacity that can be safely targeted. In that situation, treating the visible floater may not address the visual difficulty that brought you to clinic.

Saying no is the usual answer

If you have been told elsewhere that your floaters can be lasered and we do not agree, the disagreement will be about whether your particular floater can be treated safely and usefully, not about whether the symptom is real. Being unsuitable for vitreolysis does not mean your floaters are imaginary or trivial.

What The Evidence Shows

We think you are entitled to know how strong the evidence for this treatment is, because it is weaker than for most of what we do.

The best available randomised evidence is a small trial comparing YAG vitreolysis with a sham procedure in patients with a Weiss ring. Treated patients reported a significant improvement in floater-related symptoms compared with the sham group, though the improvement was partial rather than complete and the study was small.⁴

Larger case series report that a proportion of appropriately selected patients are substantially improved, that results are considerably better for a Weiss ring than for other floaters, and that patients with diffuse floaters do poorly.⁵

Longer-term follow-up of that same trial cohort, in which 35 of the original 52 patients were reviewed at an average of 2.3 years, reported three delayed retinal tears.⁶ That is one of the reasons national assessment of the procedure has been cautious about drawing long-term safety conclusions from short-term studies.

The national position, restated

NICE has concluded that this evidence is insufficient in quality and quantity to establish safety and efficacy with confidence, and recommends that it should only be used in the context of research.² We repeat that here because it belongs alongside the trial result rather than separately from it. It is a statement about the strength of the evidence, not a finding that the treatment does not work.

The realistic expectation is meaningful improvement in a well-selected eye, not the disappearance of every floater. Reported complete resolution rates are low, and partial improvement is the more common result.

If a provider tells you the procedure reliably eliminates floaters, that claim is not supported by the published evidence.

Your Alternatives

Observation and neuroadaptation

The default, and for most patients the correct one. It carries no procedural risk whatsoever, and the natural history is favourable. Reassurance that the retina is healthy is itself therapeutic for many patients, because much of the distress caused by floaters comes from uncertainty about what they mean.

Practical measures

Sunglasses in bright conditions, adjusting screen brightness and background contrast, and moving the eye to shift a floater out of the visual axis all reduce day-to-day intrusion without treating anything.

Vitrectomy

Surgical removal of the vitreous gel is the definitive treatment for floaters and is far more effective than laser. It is also a considerably larger intervention, carrying risks of retinal detachment, cataract in an eye that still has its natural lens, and infection inside the eye.

For a patient with severe, genuinely disabling floaters who is unsuitable for laser, vitrectomy may be the more appropriate discussion. Where that applies, your care remains within Blue Fin Vision® through our vitreoretinal service.

Doing nothing, permanently

Choosing to live with floaters is a legitimate decision and, for most people, the one with the best balance of benefit and risk.

What The Laser Does

A YAG laser delivers very short, high-energy pulses focused precisely on the floater. The energy converts the collagen into gas, which then dissolves, so the opacity is fragmented or vaporised rather than removed from the eye.

Nothing is taken out. The material is broken into pieces small enough that they no longer cast a noticeable shadow. Some smaller fragments may remain visible, and they usually settle over the following weeks.

Treatment is performed at a slit lamp microscope with a contact lens on the eye, in the clinic rather than an operating theatre.

Your Assessment

Your assessment establishes whether treatment is possible, not merely whether floaters are present.

- A dilated examination of the whole peripheral retina in both eyes, to exclude a tear or other pathology.
- Assessment of the floater itself: whether it is discrete, how large it is, and how mobile.
- Its distance from the retina and from the natural lens, which determines whether treatment can be delivered safely.
- Whether a posterior vitreous detachment is complete, and how long ago it occurred.
- Whether your eye is phakic, meaning it still has its natural lens, or pseudophakic.
- Optical coherence tomography and retinal imaging where they will change the plan.
- An honest discussion of how much your floaters actually limit your daily activities.

Not every floater that is visible on examination can be visualised well enough at the laser to be treated safely. Occasionally that only becomes apparent at the treatment appointment itself, and in that situation treatment is abandoned rather than attempted.

On The Day

Treatment is performed in the clinic and takes a few minutes to around half an hour, depending on the floater. You go home afterwards.

- Eat and drink normally and take your usual medication unless told otherwise.
- Drops widen the pupil, which takes twenty to thirty minutes, and anaesthetic drops numb the surface of the eye.
- A contact lens is placed gently on the eye so the floater can be seen and the laser focused accurately.
- You will see bright flashes and may notice small dark shapes or bubbles appearing as the floater is treated.
- Most patients feel nothing. The treatment is not painful.
- Your eye pressure is checked before you leave.

Your pupil remains dilated and your vision blurred for several hours, so do not drive yourself home.

After Your Treatment

Vision is blurred for a few hours from the drops. You may notice new small floaters or dark specks immediately afterwards, which are fragments of the treated opacity and gas bubbles.

- Anti-inflammatory drops are sometimes prescribed for a short period.
- There are no restrictions on normal activity, reading or screens once your vision has settled.
- Your pressure is rechecked and your retina re-examined at follow-up.

The result is judged over weeks

Fragments settle and disperse over the following weeks, so the appearance immediately after treatment is not the result. Equally, an eye that is no better at three months is unlikely to improve substantially later.

How Well Does It Work?

In a well-selected eye with a single discrete Weiss ring, a substantial proportion of patients report meaningful improvement. In a poorly selected eye, the procedure is at best ineffective and at worst harmful, which is the whole reason for the length of the suitability sections in this leaflet.

More than one session is sometimes required. Where a first session produces no meaningful benefit at all, a second is unlikely to, and repeated attempts on an unresponsive floater are not in your interest.

What success looks like

Success in this treatment usually means a floater that no longer interrupts reading or driving, not an eye in which nothing can be seen against a white wall. Patients who define success as the complete absence of any floater are usually disappointed, whatever the technical result.

Risks and Side Effects

Vitreolysis is not a trivial procedure and its risks are the reason selection matters so much.

Raised eye pressure

Pressure can rise in the hours after treatment, which is why it is checked before you leave. Most rises are short lived and treated with drops. Rarely, the rise can be substantial or prolonged, and refractory open-angle glaucoma has been reported after vitreolysis, including cases presenting weeks or months later.⁷ That is why a pressure check at follow-up matters even if the eye feels entirely normal.

New or different floaters

Fragmenting one large floater can produce several smaller ones. Most settle, but some patients find the new pattern no better than the original, and occasionally worse.

Damage to the natural lens

If the floater lies close to the lens, laser energy can cause a focal cataract, which may require cataract surgery. This risk does not apply if you already have an artificial lens, and it is a principal reason why phakic eyes are treated more conservatively.

Retinal damage, tear and detachment

Laser energy delivered close to the retina can cause a burn, a tear or, rarely, a retinal detachment. This is the most serious risk of the procedure and the reason a floater sitting close to the retina is not treated at all.

Bleeding and inflammation

Small haemorrhages within the vitreous can occur and usually clear. Mild inflammation is uncommon and settles with drops.

No benefit

A proportion of treated patients notice no improvement. Since this is elective treatment of a symptom rather than of a disease, an unsuccessful vitreolysis leaves you with the original floater plus the risk you have already taken.

If It Does Not Work

If the floater is unchanged or your symptoms persist, your consultant will reassess whether the original floater was in fact the cause of your symptoms, whether a further session is justified, and whether vitrectomy should now be discussed.

Sometimes the honest conclusion is that no further treatment is appropriate. That is a legitimate endpoint, and it is better arrived at deliberately than through repeated sessions in the hope of a different result.

Warning Signs

Seek same-day assessment

A sudden new shower or substantial increase in floaters. New or markedly increasing flashes of light. A shadow or curtain spreading across any part of your vision. Sudden loss or deterioration of vision. Increasing pain in the eye.

Do not assume that new floaters after vitreolysis must be fragments of the treated one. They may be, but a retinal tear presents in exactly the same way and cannot be distinguished without examination.

If you cannot reach us, attend an eye casualty department and tell them you have had YAG vitreolysis and on what date.

The Long Term

Treating one floater does not prevent new ones. The vitreous continues to change with age, and further floaters can develop in either eye.

The warning signs above remain relevant for life. If you develop new floaters, flashes or a visual field defect months or years from now, they should be assessed on their own merits rather than attributed to previous treatment.

Costs

Vitreolysis undertaken for floaters is not normally covered by private medical insurance, because it is treatment of a symptom rather than of a sight-threatening condition. The assessment that excludes retinal pathology may be covered where symptoms are new.

Item	Fee
Consultation and diagnostic assessment	£325
YAG vitreolysis, per session	See current published price

Current pricing is maintained online and may change, so please refer to [our published price list](#). Your written quotation will make clear whether a second session, if one is recommended, is charged separately.

You will not be sold treatment because you have paid for an assessment

Your consultation fee is for the consultant assessment, including the dilated retinal examination, and is payable whether or not treatment is recommended.

Because most patients assessed for vitreolysis are not suitable, it is worth stating plainly that paying for the assessment does not commit you to anything. We would far rather tell you no at the assessment than proceed with a procedure unlikely to help you.

Questions Worth Asking

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

- Has my whole retina been examined, and is there any tear or other pathology?
- What kind of floater do I have, and is it a discrete opacity or diffuse?
- How far is it from my retina and from my natural lens?
- Do I still have my natural lens, and how does that change my risk?
- How long have my floaters been present, and could they still improve on their own?
- What is the realistic chance of meaningful improvement in my eye?
- How many sessions might I need, and what does a further session cost?
- What happens if the treatment makes my floaters different rather than better?
- Would vitrectomy be a better option for me, and if not, why not?

Taking your time

Once retinal tear, retinal detachment and other acute pathology have been excluded, treatment of an established benign floater is not urgent, and delay costs nothing except patience. Waiting allows natural improvement, and any decision to treat is better made after the eye has settled. 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 YAG vitreolysis varies by site, and we will confirm where your appointment is held when it 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

Further information about our structure of care is published at bluefinvision.com/advantage.

Your Clinical Team

Blue Fin Vision® is a consultant-led practice. Your assessment and your treatment are performed by a named Blue Fin Vision® consultant ophthalmic surgeon, who examines your retina, decides with you whether treatment is appropriate, obtains your consent and remains responsible for your care. This document is authored and clinically governed by our Medical Director.

NICE recommends, in its own words, that this procedure be done by retinal specialists experienced in laser surgery and with expertise in managing vitreoretinal disease.²

Your surgeon is a consultant ophthalmic surgeon with extensive experience of argon retinal laser treatment, and the dilated peripheral retinal examination that precedes any vitreolysis is the same assessment used in that work. Vitreoretinal expertise sits within the same practice, as set out below. You are entitled to ask directly about the experience of whoever would perform your treatment, and we will answer.

Where vitrectomy or other vitreoretinal care becomes appropriate, your care remains within Blue Fin Vision®. Professor Mahmut Dogramaci, Consultant Vitreoretinal Surgeon, provides that cover within the same practice, so a discussion about surgery does not mean being discharged into an external waiting list.

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Consultant Ophthalmic Surgeon, Founder and Medical Director, Blue Fin Vision®

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

Author and medical reviewer: Mr Mfazo Hove MBChB MD FRCOphth CertLRS. Version 1.0, August 2026. Review date: August 2027. Produced in accordance with the guidance of the General Medical Council and the professional standards of The Royal College of Ophthalmologists. The text of this document is original to Blue Fin Vision®.

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