Treatment Choices for Wet Age-Related Macular Degeneration (Wet AMD)

Wet age-related macular degeneration (wet AMD) is usually treated with injections of a medicine into the eye. These medicines reduce the activity of abnormal blood vessels beneath the retina and can prevent further loss of vision. In some patients, vision also improves.

The three treatments we most commonly consider are:

- **Eylea 2 mg (aflibercept)**
- **Eylea 8 mg (higher-dose aflibercept)**
- **Vabysmo 6 mg (Faricimab)**

All three are established treatments for wet AMD. Large clinical trials have shown **similar overall visual outcomes when the treatments are given at appropriate intervals**. There is currently no good evidence that one of these medicines consistently produces better vision than the others.

Eylea 2 mg

Eylea 2 mg has been widely used for wet AMD for more than a decade and has a very well-established effectiveness and safety record. Treatment normally starts with injections approximately every four weeks. Once the condition is controlled, the interval between injections can usually be extended. Some patients, however, continue to require injections relatively frequently to keep the disease inactive.

Eylea 8 mg – higher-dose aflibercept

Eylea 8 mg contains the same medicine as conventional Eylea but at a higher dose.

Clinical trials have shown that it produces **similar improvements and preservation of vision to Eylea 2 mg**, while allowing many patients to have injections less frequently.

A large proportion of patients can be treated at intervals of **12–16 weeks**, and some well-controlled patients may eventually reach intervals of **20–24 weeks**.

The principal potential advantage of Eylea 8 mg is therefore **reducing the number of injections and hospital visits while maintaining control of the wet AMD**, rather than producing better vision than conventional Eylea.

Vabysmo (Faricimab)

Vabysmo works in a slightly different way. It blocks VEGF, as Eylea does, but also blocks another pathway called angiopoietin-2 (Ang-2).

Large clinical trials have shown **similar visual results to Eylea 2 mg**. Many patients can subsequently extend treatment to **12- or 16-week intervals**, potentially reducing the number of injections required. Vabysmo is therefore another effective option where reducing treatment frequency is desirable.

How do the treatments compare?

For most patients, the important difference between these treatments is **not the amount of vision gained but how frequently treatment is required**.

Eylea 2 mg has the longest established clinical experience. Eylea 8 mg and Vabysmo have been developed partly to allow longer intervals between injections.

Individual patients respond differently. A medicine that lasts 16 weeks in one patient may only control the disease for 6–8 weeks in another. OCT scans and examination are therefore used to determine the safest treatment interval for each eye. Treatment may also be changed if the response to the initial medicine is inadequate or if its effect does not last sufficiently long.

Infection

All injections into the eye carry a small risk of serious infection inside the eye (**endophthalmitis**).

This is **very uncommon**, generally occurring in only a few patients per several thousand injections. There is currently no convincing evidence of a clinically important difference in infection risk between Eylea 2 mg, Eylea 8 mg and Vabysmo.

Because the risk is associated principally with the injection procedure itself, reducing the total number of injections may also reduce a patient's cumulative exposure to injection-related complications.

You should seek urgent ophthalmic advice following an injection if you develop **increasing pain, redness, light sensitivity or a significant deterioration in vision**.

Inflammation

Non-infectious inflammation inside the eye (**intraocular inflammation**) can occasionally occur following anti-VEGF treatment.

The risk is **low with all three treatments**. Conventional Eylea has a particularly extensive long-term safety record. Clinical trials of Eylea 8 mg have shown a broadly similar overall safety profile.

Inflammation has also been reported with Vabysmo. Rare cases of retinal vasculitis, including occlusive retinal vasculitis, have been reported following its introduction into clinical practice. These complications appear to be uncommon.

Any significant deterioration in vision, new floaters, pain or increasing redness following an injection should therefore be reported promptly.

Which treatment should I have?

There is **no single treatment that is best for every patient**.

For many patients, Eylea 2 mg, Eylea 8 mg and Vabysmo are all reasonable choices. The decision may take into account:

- Previous response to treatment;
- OCT appearance and activity of the wet AMD;
- How long the effect of each injection lasts;
- The number of injections and visits likely to be required;
- Previous inflammation or other eye problems;
- Other medical conditions; and
- Individual patient preference.

Treatment can be changed if the initial medicine does not control the disease adequately or if another treatment is considered more appropriate.

What can treatment achieve?

The primary purpose of treatment is to **control the wet AMD and reduce the risk of further loss of central vision**.

Many patients maintain their vision and some experience an improvement. However, treatment cannot restore retinal tissue that has already been permanently damaged by AMD, and some patients lose vision despite appropriate treatment.

Wet AMD is usually a **long-term condition requiring continued monitoring and, in many cases, repeated injections**.

Further information and evidence

The principal evidence supporting these treatments includes the **VIEW 1 and VIEW 2 trials** for aflibercept 2 mg, the **PULSAR trial** for aflibercept 8 mg, and the **TENAYA and LUCERNE trials** for Faricimab.

Treatment recommendations are also informed by guidance from the **National Institute for Health and Care Excellence (NICE)**, the **Royal College of Ophthalmologists**, and the current UK prescribing information for each medicine.

This information summarises the current evidence and is intended to support, rather than replace, an individual discussion with Mr Tanner. Treatment recommendations may change as further clinical and real-world evidence becomes available.