

IMPROVING CARE OF DIABETIC RETINOPATHY (DR) BEGINS WITH PROPER IDENTIFICATION

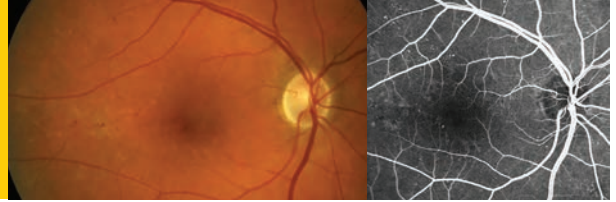
Through early detection, monitoring, and timely referral, you can play a pivotal role in managing your DR patients' vision¹⁻³

The ETDRS-DRSS Severity Scale can help identify and standardize the classification of the clinical features of DR at various stages, allowing for early detection and timely intervention.^{1,4-7}

MILD NONPROLIFERATIVE DR (NPDR) (Level 35)

- Hard exudates, soft exudates, hemorrhages, venous beading, or IRMA, but less extensive than moderate NPDR^{1,4-6}

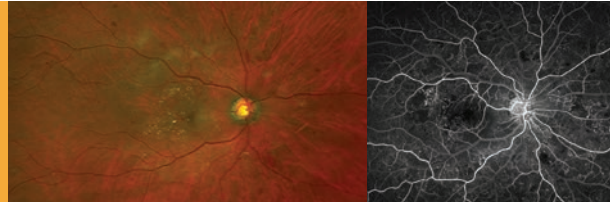
Images captured at different visits.



MODERATE NPDR (Level 43)

- More extensive findings than mild NPDR, but less extensive than moderately severe NPDR^{1,4-6}

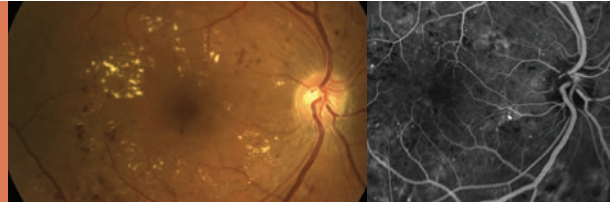
Images captured at different visits.



MODERATELY SEVERE NPDR (Level 47)

- Any of the following^{1,4-6}:
 - Mild IRMA in **4 quadrants**
 - Severe retinal hemorrhages in **2-3 quadrants**
 - Venous beading in **1 or more quadrants**

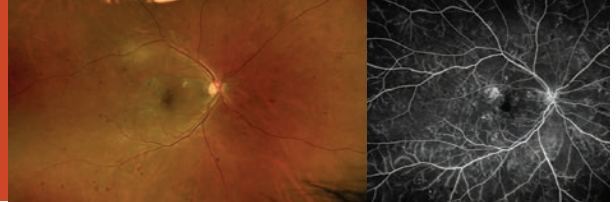
Images captured at different visits.



SEVERE NPDR (Level 53)

- Any of the following (**4-2-1 rule**) and no signs of proliferative disease^{1,4-6}:
 - Severe intraretinal hemorrhages and microaneurysms in **each of 4 quadrants**
 - Definite venous beading in **2 or more quadrants**
 - Moderate IRMA in **1 or more quadrants**

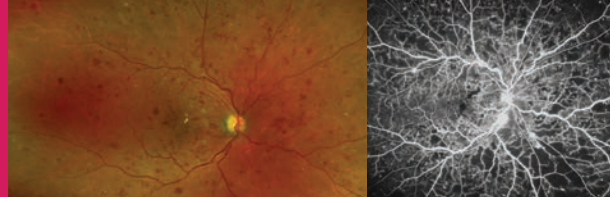
Images captured at different visits.



PROLIFERATIVE DR (PDR) (Level ≥61)

- One or both of the following^{1,4-6}:
 - Neovascularization
 - Vitreous/preretinal hemorrhage

Images captured at different visits.

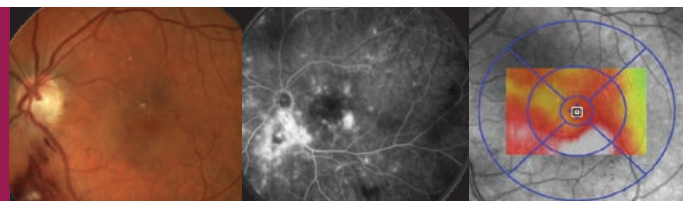


DIABETIC MACULAR EDEMA (DME) can occur at any stage of DR

DME

- Central-involved DME?:
 - Foveal involvement of abnormal intraretinal and/or subretinal fluid
 - Concurrent thickening affecting the 1-mm-diameter central subfield thickness

Images captured at different visits.



Scale is adapted from the Early Treatment Diabetic Retinopathy Study–Diabetic Retinopathy Severity Scale (ETDRS-DRSS), an established grading scale for measuring the severity of DR, as well as the American Academy of Ophthalmology (AAO).

Images courtesy of Dr. Mohammad Rafieetary. Used with permission.

The more you know about emerging clinical science and potential therapies for DR, the better you can help inform your patients about how treatment may be able to help.

THROUGH EARLY DETECTION, MONITORING, AND TIMELY REFERRAL, YOU CAN SET THE COURSE FOR SUCCESS IN DR

*“The clinical signs of diabetic retinopathy can appear early in the natural history of the disease. Unfortunately, individuals may not experience symptoms until relatively late, at which time treatment may be less effective. **The success of appropriate intervention and management strategies depends upon accurate and timely detection of diabetic eye disease.**”⁸*

— AOA Evidence-Based Clinical Practice Guidelines:
Eye Care of the Patient With Diabetes Mellitus

For patients with diabetes mellitus, the frequency of eye exams is determined by several factors, including⁸:

- Type of diabetes
- Duration of disease
- Level of patient adherence to, and understanding of, treatment plan
- Concurrent medical status
- Both nonretinal and retinal ocular findings and symptoms
- Subjective changes in vision



When patients should be seen by a retina specialist, according to AOA guidelines ^{2,3}	
High-risk PDR (with or without macular edema)	Within 24 to 48 hours
PDR	Within 2 to 4 weeks
DME/CSME	Within 2 to 4 weeks
Severe NPDR	Within 2 to 4 weeks

If you see or suspect vision-threatening DR, refer patients to a specialist who can treat DR

Visit YourDRPatients.com for additional information and useful patient resources.

AOA = American Optometric Association; CSME = clinically significant macular edema.

References: 1. Early Treatment Diabetic Retinopathy Study Research Group. Fundus photographic risk factors for progression of diabetic retinopathy. ETDRS report number 12. *Ophthalmology*. 1991;98(5 suppl):823-833. 2. Care of the Patient With Diabetes Mellitus: Quick Reference Guide. American Optometric Association website. <http://bit.ly/2M22OUJ>. Accessed August 28, 2019. 3. Ferrucci S, Yeh B. Diabetic retinopathy by the numbers. *Rev Optom*. June 15, 2016. <http://bit.ly/2KNNJ4E>. Accessed August 28, 2019. 4. Davis MD, Fisher MR, Gangnon RE, et al; for the Early Treatment Diabetic Retinopathy Study Research Group. Risk factors for high-risk proliferative diabetic retinopathy and severe visual loss: Early Treatment Diabetic Retinopathy Study report #18. *Invest Ophthalmol Vis Sci*. 1998;39(2):233-252. 5. Staurengi G, Feltgen N, Arnold JJ, et al. Impact of baseline Diabetic Retinopathy Severity Scale scores on visual outcomes in the VIVID-DME and VISTA-DME studies. *Br J Ophthalmol*. 2018;102(7):954-958. 6. American Academy of Ophthalmology. Preferred Practice Pattern®: Diabetic Retinopathy. <http://bit.ly/2SX3H2D>. Accessed January 17, 2020. 7. Bakri SJ, Wolfe JD, Regillo CD, Flynn HW Jr, Wykoff CC. Evidence-based guidelines for management of diabetic macular edema. *J Vitreoretin Dis*. 2019;3(3):145-152. 8. Eye Care of the Patient With Diabetes Mellitus: Evidence-Based Clinical Practice Guideline. American Optometric Association website. <http://bit.ly/2EBCPG>. Accessed August 28, 2019.

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