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Fluid Foundations: How Location Impacts Outcomes in nAMD

Dr. Goldberg:
As retina specialists, we've been trained not to tolerate retinal fluid in patients with neovascular age-related macular degeneration. Given observations from studies with second-generation agents, the question is: should that still be the case? I'm Roger Goldberg, and I'm joined today by Ehsan Rahimy. Ehsan, thanks so much for being here.

Dr. Rahimy:
Roger, thanks for having me today. Your question about fluid tolerance is a great one and a very relevant one. PAT survey data as recently as 2024 showed that close to 62% of US physicians would not tolerate subretinal fluid and would actually reduce their treatment intervals in recently diagnosed patients with neovascular AMD on a treat-and-extend regimen. There's a fear of worse visual outcomes, which can happen with long-term fluid fluctuations in our patients.

However, we do know that not all fluid is bad. There have been some important clinical trials. One study that I think we're all familiar with is the FLUID study, which is published in Ophthalmology in 2019. And Guymer and colleagues found that similar best corrected visual acuity outcomes between complete intraretinal fluid and subretinal fluid resolution versus intraretinal fluid resolution with some residual extrafoveal subretinal fluid were observed. So, in such situations, patients are able to extend their treatment intervals a little bit further out by tolerating a little bit more subretinal fluid.

Also, we have the longer-term, follow-up results from the CATT study. We saw 5-year outcomes that showed patients with really any type of foveal pathology—be it foveal atrophy, scar, CNV, but also intraretinal fluid at the foveal center —all resulted in worse visual outcomes.

Dr. Goldberg:
Ehsan, that was a great summary. Thanks so much.

Let me show you some cases and ask you to predict or give me your thoughts about what type of fluid this is and how worrisome it is. Here's the first case of pigment epithelial detachment with intraretinal fluid. What are your thoughts on this one?

Dr. Rahimy:
I think we'd all agree, intraretinal fluid is bad. We're going to want to treat this side particularly aggressively and get it as dry as possible. So I will treat this eye aggressively until all the intraretinal fluid is resolved.

Dr. Goldberg:
Agreed. And I would strive to maintain a dry retina and not have that yo-yoing back and forth. And I think that's what some of the next-generation agents allow us to explore a little bit more fully.

Here's a case of a pigment epithelial detachment with serous subretinal fluid. And let's say the patient's treatment-naïve here.

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Dr. Rahimy:
I'm still going to treat this side. The goal is to get the retina dry. But I wouldn't be surprised here if the visual acuity is relatively well preserved. So assuming I can't get it completely dry, there's a little bit of subretinal fluid, I'll be able to tolerate and attempt extension at that point.

Dr. Goldberg:
Okay. And now let me show you a case. Let's say there was no subretinal or intraretinal fluid, just a case of what we call nonexudative macular neovascularization. Are you treating these patients yet? Or just watching them carefully?

Dr. Rahimy:
I think it depends on the patient. If they're already receiving treatment in their fellow eye, my patients tend to want to be aggressive, especially if this is their better-seeing eye. If a patient is also symptomatic with this, I'm more inclined to treat.

Dr. Goldberg:
I agree with that.

Here's a subtype of subretinal fluid called SHRM, or subretinal hyperreflective material. I think we know that this is, again, like hemorrhage, a more aggressive phenotype and something we have less tolerance for within that subcategory of subretinal fluid.

Here's another version of a kind of a subretinal hyperreflective material. But what do you see there on the infrared image?

Dr. Rahimy:
It's concerning for hemorrhage, and I think all of us have zero tolerance for blood, so we're going to inject until this patient has the hemorrhage resolved.

Dr. Goldberg:
Agreed. And finally, I'll just show one case of intraretinal fluid overlying a scar. I think that fluid can be safely observed because that's nonfunctional retina there. What do you think?

Dr. Rahimy:
I agree with you. If this can be safely observed.

Dr. Goldberg:
Excellent. Thanks so much.

And I'd just end by saying, overall, we want to dry the retina as much as possible, and our second-generation agents may be able to reduce what has traditionally been persistent fluid. I'd encourage you all to join us next episode where we dive further into the data with second-generation treatments. Ehsan, thank you for being here.

Dr. Rahimy:
Thanks for having me, Roger.

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