Canadian Retina Society (CRS) Position Statement on Intravitreal Injections and the Management of Retinal Diseases during the COVID-19 Crisis

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The Executive of the CRS has reviewed recommendations from local, national and international Medical and Ophthalmology groups regarding the management of patients and the risks to health care workers during this COVID crisis. The CRS provides the following commentary. These comments and recommendations are based on the "conditions on the ground" that exist today at the time of this writing.

It is clear that eye care providers are facing a difficult challenge in balancing their Hippocratic Oath, as doctors, to provide critical care to those under their care at risk of vision loss with the risk of disease and death to their patients and the global community. Several Ophthalmologists have already died from COVID-19. The global concern about the rapid consumption of personal protective equipment (PPE) for front line health care workers and ICU staff is a valid reason for reducing or stopping provision of certain non-essential medical services. It is clear that governing bodies SHOULD be helping to define what should be considered ESSENTIAL office-based and surgical services and should provide comment and suggestions as to how to mitigate risk while providing these services. ***An essential service is defined as a medical service, which, if withheld, will result in permanent loss of life, or function of limb or organ.*** We each have a responsibility to our patients and to the global community to limit the spread of COVID-19. No one can say, with any certainty, how long these care restrictions will need to be in effect and so plans will need to be regularly re-evaluated.

The American Society of Retinal Specialists (ASRS) has provided guidance in defining how retinal ***surgical cases*** should be categorized, defining emergent, urgent and non-urgent case types. They indicated that emergent cases should be operated on within 24 hours, urgent cases within 1 week and non-urgent retinal cases within 3 months, as longer delays would lead to permanent and irrecoverable vision loss in the affected eyes. The presence of monocularity is an obviously important cofactor in these designations. **The CRS fully endorses the recommendations of the ASRS for management of retinal surgical cases (Appendix A).**

Suggestions for the management of retinal disease patients requiring intravitreal anti-VEGF agent injections mandates similar categorization and clear and evidence-based decisions on

optimal treatment algorithms. These treatments are ***essential services*** as if these retinal diseases are left untreated or are undertreated, irreversible vision loss is likely to occur.

The Canadian Retina Society suggests the following during the COVID-19 crisis:

1. That only urgent, time sensitive retinal patients are brought in for examination and treatment visits.
2. That all eyecare providers and staff maintain social distancing and use optimal available PPE.
3. That appointments are staggered and numbers of patients significantly decreased to ensure limited waiting room exposure for patients. We should strive to have far fewer patients in our waiting rooms. We strongly suggest there be at least 2 meters between seated patients. We suggest at least a 50% reduction in daily patient visits in order to maintain the principles of social distancing.
4. This should be coupled with improved “office flow” so that patients spend significantly less time in the office or hospital environment awaiting their examinations and treatments. This may mean adjusting or decreasing what diagnostic testing or other services are done on each patient to limit eyecare provider and patient exposure.
5. That patients be asked to limit conversation.
6. That patient caregivers and accompanying persons be restricted from office entry unless it is deemed essential to providing the care. This is done to limit the number of people in the waiting room area.
7. That proper cleaning of examination room equipment is completed between patients.
8. That, under the current circumstances, all injecting ophthalmologists should do their best to extend intervals to the maximal tolerated. The optimal injection schedule must be individualized for each patient. We recommend progressively extending responsive patients by at least two weeks and we suggest consideration of extending intervals beyond what we have accepted as the maximal limits in the past.
9. That retinal specialists and staff do their best to directly communicate with their retinal patients to alleviate patient concerns, eliminate unnecessary visits and provide reassurance and guidance.

Appendix A

ASRS Releases Guidelines to Help Retina Practices Navigate COVID-19 Pandemic

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Today, the ASRS is releasing detailed guidelines to help retina practices reduce risk and help assure the health and safety of patients and medical personnel during the COVID-19 pandemic. The guidelines define what constitutes an essential visit and provide a means to categorize emergent, urgent and non-urgent cases for the purposes of negotiating for limited operating room access during these unprecedented times.

After receiving multiple inquiries from members, ASRS offers the following guidance for identifying those retinal surgery indications that, if not done in a certain timeframe, will result in severe vision loss. Such designations include: 1) Emergent (within 24 hours), 2) Urgent (within one week), and 3) Non-urgent, non-elective (within 3 months). For emergent surgical indications, the risk of permanent vision loss without immediate intervention is high and access to the operating room is vital. For urgent surgical indications, the risk of severe and permanent vision loss without immediate surgery is not as high and treatment can be delayed for up to a week. For the non-urgent, non-elective indications, surgery can be delayed for up to 3 months without significant risk to further vision loss. It is possible that, in following non-urgent, non-elective patients that their condition can worsen and the urgency increase. It is important that retina specialists are judicious with their use of the emergent and urgent designations. Many factors must be considered in assessing the need for and urgency of surgery and strict guidelines cannot be made.

Examples of emergent surgical indications include:

1. Acute retinal detachment – macula attached
2. Acute retinal detachment – macula detached in a monocular patient
3. Retained lens fragments with elevated intraocular pressure not controlled medically
4. Acute endophthalmitis with severe vision loss
5. Open globe injury with or without an intraocular foreign body
6. Expulsive choroidal hemorrhage
7. Dense vitreous hemorrhage in monocular patient
8. Massive macular subretinal hemorrhage
9. Exposed/infected scleral buckle or other ocular implant

Examples of urgent surgical indications include*:

1. Retinal detachment – macula detached
2. Retained lens fragment with medically controlled intraocular pressure
3. Vitreous hemorrhage in which a retinal tear or detachment is suspected

* These indications should be considered emergent if the patient is monocular or extenuating circumstances arise.

Examples of non-urgent, non-elective surgical indications include:**

1. Macular hole

2. Dislocated intraocular implant lens
3. Diabetic vitreous hemorrhage with no macula-threatening retinal detachment
4. Retained silicone oil
5. Macular epiretinal membrane/Vitreomacular traction

** These indications should be considered urgent/emergent if the patient is monocular or extenuating circumstances arise.