

Fig. 7. Postoperative fundigram appearance of case two. Mild retinal pigment epithelial atrophy and submacular scar can be noted.

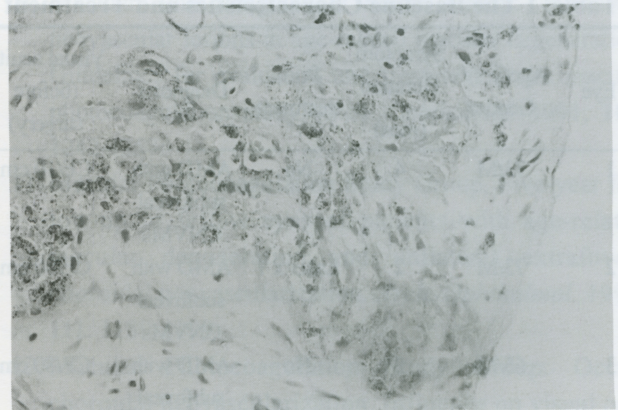


Fig. 9. Histological appearance of CNVM of case one (200x). Section shows neovascular tissue and marked fibroblast proliferation.

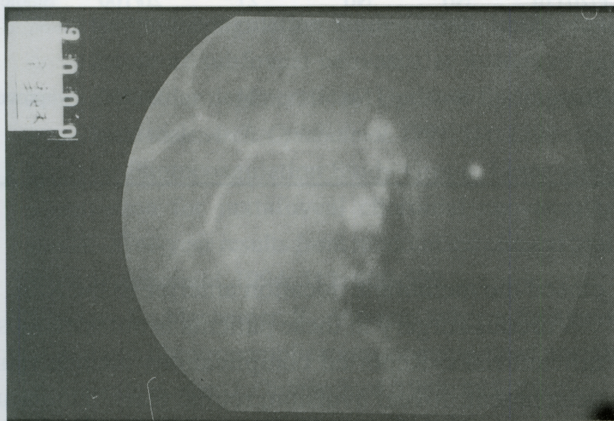


Fig. 8. Postoperative fluorescein angiogram of case two. Mild retinal pigment epithelial atrophy but no CNVMs were found.

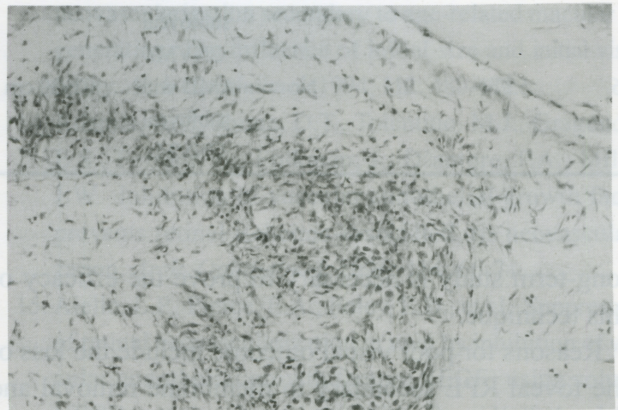


Fig. 10. Histological appearance of CNVM of case two (100x). Section shows neovascular tissue and marked fibroblast proliferation.

DISCUSSION

It is difficult to properly treat of choroidal neovascularization. Referral to an ophthalmologist with special training and experience in managing this condition is appropriate. Ophthalmologists treating patients with AMD should be thoroughly familiar with the eligibility criteria and treatment techniques described in macular photocoagulation study protocols. The subfoveal new choroidal neovascular membranes study (of the MPS⁹⁻¹³) gave 3-year outcomes: 62% of untreated eyes had experienced severe vision loss (6 Snellen lines or more) versus 47% of laser-treated eyes. Median final

visual acuity in the untreated group was 20/500 versus 20/320 for the treated group. There were about 50% recurrent CNVMs following photocoagulation within 2 years. Laser photocoagulation has been shown to be effective in extrafoveal and juxtafoveal lesions, although it is applicable to a minority of patients (2.5%).

The surgical excision of subfoveal neovascular membranes in patients with 20/200 or worse vision has been shown in our study to be a safe and beneficial procedure in the short term in selected patients. Complications have been limited and are controllable. We feel that this technique may be a definite alternative to laser photocoagulation of these membranes; however,