From the Director

Hello again. I hope this past year has been a good one for you and that our monthly NLVSG sessions have helped to make it so. We are pleased to have again received funding from Genentech, Inc., and we are expecting to soon hear from the National Eye Institute about their support, as well. This means the program is paid for through 2007, with lots of good information and fellowship ahead.

We are very happy to welcome our newest affiliate, the Macular Disease Society from the United Kingdom. This connects an additional 154 live support groups to our project. It looks like we may have to call ourselves the International Low Vision Support Group from now on! Don Curran, who is on the Society’s board of directors, will be our guest in March, so we look forward to learning more about our friends from across the pond at that time.

This newsletter is mostly a summary of what I learned at the annual meeting of the American Academy of Ophthalmology, held November 11-14 in Las Vegas. It should bring you right up to date on the latest research and developments.

Best wishes for a happy holiday season!

Dan Roberts
Summary of News from the 2006 Meeting of the American Academy of Ophthalmology

Day 1

Out of many choices of symposiums and courses offered, I decided to spend my entire first day at the AAO meeting in Las Vegas with a room full of ophthalmologists who are interested in promoting awareness of the importance of low vision rehabilitation. And I'm glad I did. We listened to a total of 12 presentations by doctors who are concerned not only with understanding and treating macular degeneration, but who believe in encouraging low vision rehabilitation training following diagnosis.

These are the men and women who say, "You have macular degeneration. Now here is where you can find resources and get the education and experience to help you deal with it." Their numbers are few right now, but interest in low vision rehabilitation is growing in the practice of ophthalmology. And the more we insist upon that kind of necessary treatment, the more caring professionals we will see entering that field.

Later that evening, I met with the developers of a new computerized test for early detection of blood vessel development in dry AMD patients. The test, which can be self-administered, is called “Preferential Hyperacuity Parimeter” (PHP). Developed by Notal Vision, it appears to be more effective than current early detection methods. MD Support is, therefore, considering the PHP device as a possible focal point of its upcoming initiative to establish periodic screening exams in retirement centers and low vision libraries, beginning with affiliates of the NLVSG.

Other sessions presented information about current research developments, which we have been reporting on here monthly.

Day 2

On the second day, I listened to 90 minutes of reports on recent research in the areas of antiangiogenic drug therapy for wet AMD,
including Genentech's MARINA and PIER studies of ranibizimab (Lucentis) and Alcon's progress on the anecortave acetate (Retaane 15 mg) trials. Nothing particularly new was presented, but some interesting findings were discussed:

Elias Reichel, M.D. reported that in the MARINA trials, there was improvement at all visual acuity levels, but there was not a big difference if the patient's baseline vision was either low or excellent. This "floor-to-ceiling" effect is not unusual with this kind of study, but it is useful information for patient communicating with patients about expectations.

Nancy Holekamp, M.D., discussed key anatomic endpoints in the MARINA trials, in particular, the total lesion area over time (no growth of the lesion area was noted in the treated patients), the mean area of leakage (the amount of decrease was statistically significant) and the mean foveal retinal thickness (treated eyes showed a significant thinning of the retina). The bottom line is that all anatomic outcomes from the trial favored Lucentis, and the treatment is so effective over a long period of time without any signs of toxicity, there is no indication that anything in lieu of Lucentis should be used to treat wet AMD.

Peter Kaiser, M.D., reported on subgroup analysis of Genentech's PIER study. The primary endpoint was met, showing a difference of 16 letters visual acuity between the treated group and the sham group. Further, the dosing regimen was effective, but the visual acuity benefit was not as robust when injections went from monthly to quarterly. The persistence of monthly injections may depend upon who has dry lesions and who has wet lesions at the 5th month. The dry lesion group did better than the wet lesion group with quarterly dosing. This data is pointing toward better prediction of dosage outcomes for individual patients.

Jason Slakter, M.D., reported that Alcon's anecortave acetate has shown weak anti-angiogenic activity, but the method of treatment (injection outside of the eyeball) gives it the chance to have an effect over a longer period of time. This, he said, justifies continuing the study in the face of the impressive Lucentis results.
Melissa Brown, M.D., M.N., M.B.A. (Center for Value-Based Medicine) addressed the question, "On what basis can doctors compare pharmacologic treatments for wet AMD?" She suggested value-based analysis, looking at both quality of life and cost, and starting with an examination of the evidence. In a comparison of several current interventions, she noted that Lucentis shows the highest percentage in quality of life, but highest in cost. Still, Lucentis--at approximately $50,000 per quality of life year--is within commonly accepted parameters in the field of medicine.

John Thompson, M.D., reported no significant difference in three dose levels of Acuity Pharmaceutical's bevasiranib, an anti-VEGF small interfering RNA drug with the ability to turn off genes that cause wet AMD. Results indicate that treatment with direct VEGF inhibitors may be necessary initially before treatment with bevasirinab. Hopefully, a Phase III study will show effectiveness as long term treatment.

That afternoon, I attended several scientific poster sessions, three of which revealed that intravitreal treatment with bevacismumab (Avastin) for wet AMD and pathologic myopia is showing no systemic adverse events and that the off-label drug is showing success in inhibiting neovascularization and improving visual acuity. The general conclusion is that re-treatment is needed at 2-3 month intervals. The study titles were:

Finally, a poster session of particular interest to AMD patients reported that "no significant association between regular systemic use of anti-inflammatory drugs (aspirin, acetaminophen or NSAIDs) and the odds of developing advanced AMD in one eye of patients with extensive intermediate or large drusen, or in the study eye of patients with advanced AMD in their fellow eye." In short, regular use of anti-inflammatory drugs may not lead to wet AMD.

**: DAY 3**

After spending several hours wandering among dealers' and organizational booths at the AAO meeting, I would like to tell you
about some products and one service that grabbed my attention. I have no commercial attachment--just thought you would like to know about them.

**AMIGO Electronic magnifier (from Enhanced Vision)**

A brand new slim and light portable digital magnifier (3.5-14x) with a 6.5 inch tilt-screen for viewing anything from recipe cards to prescription labels. It includes a stand that allows you to write beneath it, and it connects to your TV for increased magnification. See it at www.enhancedvision.com or call 888-811-3161. This company is also the maker of the MAX portable magnifier and the Merlin CCTV that you are probably familiar with. The price of AMIGO is high, but it’s competitive with similar, less effective devices.

**MacuScope for early detection of pigment density changes in the macula**

Low pigment density (the amount of yellow in your macula) can be an early indication of future problems that might be forestalled with proper nutrition. The MacuScope is a diagnostic device you might want to tell your doctor about, since it is not for personal use. I had my remaining good eye tested and was found to have "zero" pigment density, meaning I may need to increase my consumption of lutein and zeaxanthin. Both of these antioxidants are important for protecting the macula against the harmful effects of blue light. Your doctor can learn about the MacuScope on the Internet at www.macuscope.com. It is one of several good attempts at diagnosing AMD early, before it is too late to start preventative measures.

**Co-Pay Relief**

Finally, here is an organization (not a product) that you might like to be acquainted with. It is a patient assistance program of the Patient Advocacy Foundation, and it provides co-payment assistance to insured Americans who financially and medically qualify. Learn more about it at www.copays.org or call them at 866-
512-3861. I found them to be very caring and helpful folks.

That's it from AAO 2006: a brief summary that certainly doesn’t cover everything there was to learn, but the news that matters most to our senior low vision community.

Next Month

"Doc Talk"

With Janet Sunness, M.D. Medical Director, Hoover Rehabilitation Services for Low Vision and Blindness, Greater Baltimore Medical Center, Baltimore, Maryland.

This free monthly newsletter is also available by email in “text-only” format.

To begin receiving it, contact Dan Roberts at director@mdsupport.org