NEW ARMD SEVERITY SCALE. WHAT IS IT USED FOR?

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It will be easy for readers to recall the recent publication of a new diabetic retinopathy classification, proposed by the authors of the AREDS (Age-related eye disease study) in the form of a new scale to assess the risk of progression of patients to advanced ARMD (1,2). It is important to understand that it not only a matter of classifying patients but rather to be able to evaluate the risk they are under. With the advent of new treatments, we have been capable of altering the course of this disease. Photodynamic therapy, intra-vitreous triamcynolone and the new anti-angiogenics soon to enter the market have allowed to mitigate at least in part the catastrophic consequences of this disease.

However, the challenge we face in the next few years is the prevention of ARMD, but that involves several requirements. First, a better knowledge of the pathogeny of the process. Recent discoveries about the genetic factors involved in this disease, which point to the participation of the supplement system, and other discoveries about the involvement of several growth and oxidative stress factors, constitute important advances in this area. Second, we must be able to foresee which patients with the initial symptoms of the disease are more likely to suffer loss of vision and therefore be the target of preventive treatments. This is important because to perform preventive treatment on a process which, in its initial forms, affects over 50% of people over 65, represents a health expense making this average hardly effective from the cost viewpoint. In this regard, the new classification of the AREDS study can be of great help to better determine which patients may need preventive therapy. Third, it is necessary to have efficient treatments at hand; to date, the only treatment which has proved its efficiency is the supplement of megadoses of antioxidants, as demonstrated by the AREDS study (3). At this point we must remember that in our country we don’t have formulations in the market supplying the dosages which proved effective in said study. A new AREDS study has been initiated to assess the usefulness of lutein and Omega-3 fatty acid supplementation in addition to said antioxidants. It will be interesting to see the results of this research because it will clarify not only the role played by these two substances in the prevention of ARMD but also will confirm or cast doubts upon the results of the AREDS-1 study which was not without some methodological shortcomings.

New preventive techniques are being explored. One of the most interesting ones is the use of Anecortave acetate under the Tenon every six months in the contralateral eye of patients who have already developed advanced ARMD in one of their eyes (4). The effect of this substance on the matrix metal proteinases, one of the elements having an early participation in the formation of choroidal neovascularization, renders its use logical, at least from the theoretical point of view.

As regards the new classification, it must be pointed out that in fact two classifications have been developed (1,2): one is more complex and is mainly designed for following up patients in clinical trials (1). The other simplified classification can help us at least to give better information (in lieu of a straightforward answer) to the question: «will the same happen in the other eye?».

This simplified classification determines five levels which quantify the risk of progression within five years of eyes with initial forms of ARMD to more advanced forms.

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The scale aggregates risk elements existing in the retina of both eyes. «One point» is added for the presence of one or more large drusen (of at least 125 microns or, in other words, equivalent to the diameter of a retinian vein at the level of side of the papilla). If this type of drusen is present in both eyes, the score will be «two points». If there aren’t any large drusen in none of the eyes, but we find middle-sized drusen (of at least 65 microns), «one point» is added. Similarly, one point is added for the presence of alterations of the pigmented skin when present in one eye and «two points» if bilateral. Advanced ARMD in one eye scores two points and the above factors are assessed only in the contralateral eye. The total sum ranges between 0-4 points, equivalent to a risk quantified as follows: 0 points equals a risk within 5 years of 0.5%; one point equals 3%; 2 points equals 12%; 3 points equals 25% and 4 points equals 50% risk.

In the simplified scale, the value given to the existence of an advanced ARMD in one eye is counterbalanced by the importance given in the complex nine-level scale (1). A further inconvenience of this scale is that it uses the drusen size for practical reasons instead of the total area of drusen, a value having a greater predictive risk capability (1). Yet a third inconvenience is that it doesn’t take into account other systemic risk factors such as arterial hypertension, tobacco addiction, cataract surgery, genetic predisposition or body mass index (5).

Therefore, even though this scale can (and probably will) be improved in the future, in the light of the new discoveries it can be a very useful tool to assess the patients with higher risk of ARMD progression.

REFERENCES