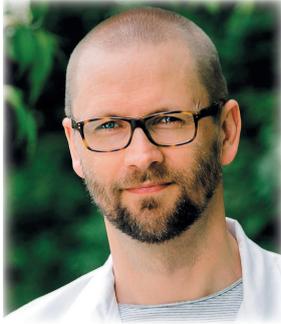




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Scandinavian perspectives on **ensuring medical retina care** in the time of **COVID-19**

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Ophthalmological clinics in Scandinavia vary in their experience with managing the COVID-19 pandemic. Herein, we present a summary of learning points to aid clinical decision-making regarding COVID-19 following a virtual meeting organized by Bayer AB on June 17, 2020.



Disinfection and masks



A waiting room in times of Covid-19

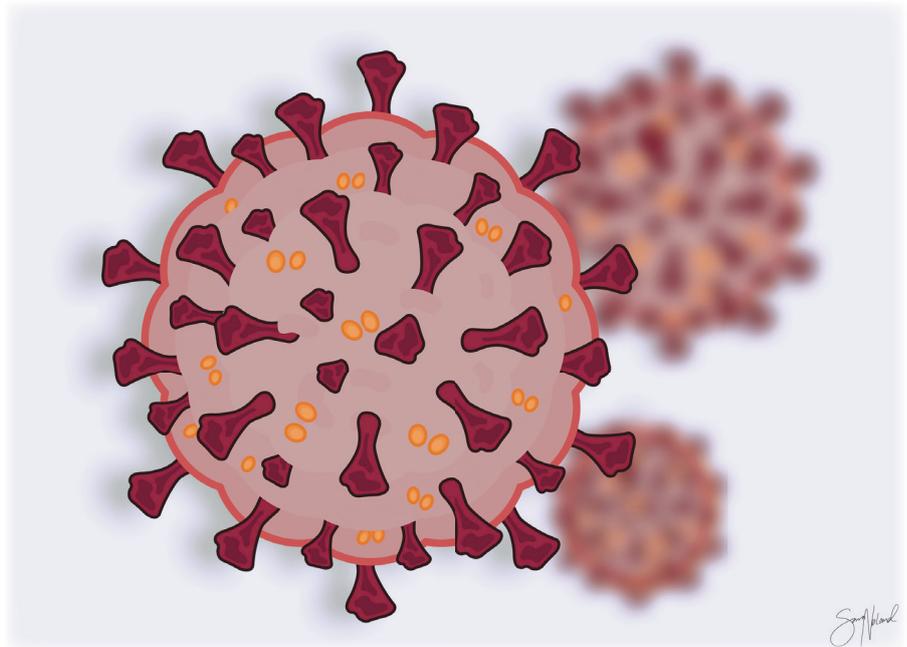
The coronavirus outbreak has hindered the management of patients with retinal diseases. In the initial months of the pandemic, we estimate that 10–20% of our patients were reluctant to attend treatment because they recognized that their advanced age and co-morbidities would increase the lethality of COVID-19. The consequence of delayed intravitreal injections (IVI) is loss of

vision, and the extent of this problem can only be evaluated once the patients return for a follow-up.

Methods to minimize exposure to COVID-19 among healthcare personnel and patients include triage, personal protective equipment (PPE), a reduced number of patients, and social distancing in waiting areas.

Some clinics inform patients in writing about the benefits and risks of continuing IVI treatment during the pandemic, emphasizing the need for preventive care. Alternative forms of patient counseling, such as phone calls and virtual meetings, are also encouraged. There is no consensus in Scandinavia on the use of PPE. Although PPE practices differ, protective plexiglass shields have been installed on slit lamps throughout the region.

Furthermore, various measures have been taken to rationalize IVI and reduce the time patients spend in the clinic. These include post-poning visual acuity assessments, clinical examinations, and imaging for patients with stable clinical courses; scheduling IVI for the next six months; and aiming for fixed treatment



SARS-CoV-2. Illustration: Sara T. Nøland

regimens instead of a treat-and-extend approach. Additionally, to achieve less crowded facilities, some clinics are offering IVI outside normal office hours. By employing these measures, many clinics have successfully managed their IVI load.

Among patients with retinal vascular diseases, neovascular age-related macular degeneration and central retinal vein occlusion are typically prioritized, as the risk of vision loss with these conditions is higher if left untreated compared to patients with diabetic macular edema and branch retinal vein occlusion.

Suggestions for how to prepare for another wave of COVID-19:

- Triage patients before they visit the clinic
- PPE: stockpile supplies and establish national guidelines for usage
- Install protective shields on slit lamps
- Reduce the number of patients in waiting areas
- Standardize letters to patients, optimize communication, utilize virtual or telephone patient counseling, and translate information into the patient's native language
- Post-poner non-urgent appointments
- Minimize the number of clinical examinations (e.g., visual acuity testing, optical coherence

tomography, angiography, and tonometry) unless critical to decision-making

- Use fixed injection intervals for stable clinical courses
- Diabetic macular edema: post-poner anti-vascular endothelial growth factor therapy treatment for four months unless associated with severe non-proliferative diabetic retinopathy or proliferative diabetic retinopathy
- Retinal vein occlusion: prioritize central retinal vein occlusion; post-poner branch retinal vein occlusion for three months
- Optimize patient flow and consider virtual patient consultations and mobile injection units

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Split lamp with shield



Patient letter

Photo of Oystein Kalnes Jorsted: Moment Studio

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