

MOST PATIENTS AT THE NEW YORK EYE CANCER CENTER KEEP THEIR VISION AFTER EYE PLAQUE RADIATION THERAPY

In 2006, Dr. Finger discovered that intraocular injections of *anti-VEGF* drugs could slow radiation-related vision loss! He found it worked both after eye plaque and external beam radiation therapy. Since that time, Dr. Finger was awarded a US patent 7,553,486 for its use against radiation vascular damage and has published his 10-year experience saving vision after eye plaque treatment for choroidal melanoma (In 2015 - The European Journal of Ophthalmology). Herein, he explains how he has improved this technique.



WHAT IF I LIVE FAR AWAY FROM MY EYE CANCER SPECIALIST?

Patients who live far away or cannot travel for treatment are typically co-managed by their local retinal specialist. Dr. Finger has found that most retina specialists can offer injections, but don't necessarily have extensive experience with radiation retina damage. Therefore, it may be necessary return to *The New York Eye Cancer Center* every 4 or 6 months to reevaluate how often, how much, and which type of *anti-VEGF* medication should be used.

The bottom line is that, in Dr. Fingers' published 10-year experience, more than 80% of patients who needed anti-VEGF therapy maintained close to their pre-treatment vision.

Visit Dr. Fingers' result page to see the average patients' vision after eye plaque therapy for intraocular melanoma visit: <https://eyecancer.com/our-approach/doctor-reported-outcomes/>



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**THE NEW YORK
EYE CANCER
CENTER:
HOW WE USE
ANTI-VEGF
TREATMENTS TO
SAVE OUR
PATIENTS'
VISION**



ANTI-VEGF THERAPY AS A GAME-CHANGER

Before anti-VEGF therapy, about 50% of patients treated with radiation eye plaques lost most of their vision. However, in 2006, Dr. Finger discovered that injections of *anti-VEGF* medications could suppress radiation retina damage and usually prolong useful vision for many years.

Dr. Finger said:

"I was amazed after treating the first patient with radiation optic nerve damage. Instead of watching the optic nerve turn white and the vision deteriorate, the swelling and hemorrhages cleared, and the vision returned to 20/20."

Over the next 14 years, Dr. Finger learned more and more about anti-VEGF treatment of intraocular radiation damage. He discovered that early treatment resulted in greater preservation of the retina and optic nerve. However, he found that treatments merely *suppressed* the damage and that (like hypertension, diabetes, and most chronic medical problems) patients had to be treated continuously in order to maintain their vision. In addition, as the years went by, most patients would need increased doses or more frequent injections to remain stable. Lastly, when most patients stopped therapy (due to poor compliance or choice), radiation damage almost always progressed and good vision was permanently lost.

WHAT IS THE "BEST DRUG" FOR ANTI-VEGF THERAPY?

In 2006, only *bevacizumab* was available for intraocular injection. Since then, *ranibizumab* and *afilbercept* have become available for treatment of radiation macular edema and vascular occlusion. But, it is not as simple one versus the other. Dr. Finger says: "some patients respond better to certain drugs; other patients require "high-dose" treatments; and some patients have even found that adding steroid can be helpful to make anti-VEGF therapy more effective."

The bottom line is that treatment must be tailored to the patient. But, in general, Dr. Finger has found that more or more-frequent medication are required over time.

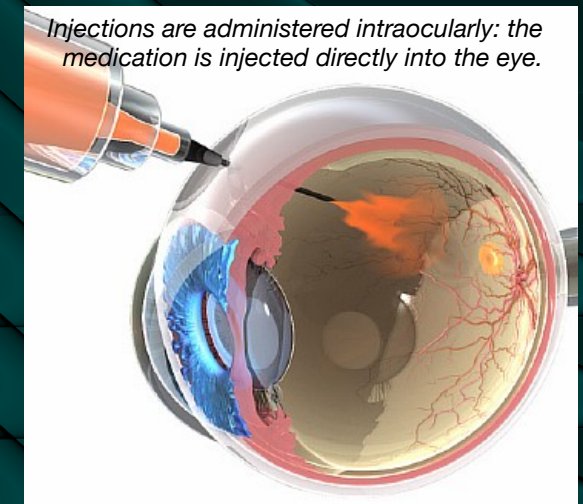
At **The New York Eye Cancer Center**, Dr. Finger makes treatment decisions based on a combination of the patients' vision, the appearance of the macular retina, measurements with optic coherence tomography (OCT), and fluorescein angiography.

WHEN DOES DR. FINGER START ANTI-VEGF TREATMENT?

When Dr. Finger started (1986), there was no treatment for radiation retina damage. Most became legally blind in the affected eye. In an effort to save his patients' vision, Dr. Finger discovered intraocular anti-VEGF treatment.

Dr. Finger believes the old saying, "above all: do no harm." So, the **FIRST** patients treated with anti-VEGF treatment were already losing their vision. After watching these patients' vision stabilize, and in consideration of both safety and improvement, Dr. Finger started to treat patients that had only experienced "distortions" in their vision. Later, the threshold increased to patients with early signs of central radiation retina damage. and now patients who have greatest risk of developing radiation side effects can begin anti-VEGF therapy.

Now, 14 years after treating the first patient with anti-VEGF medications for radiation retinopathy and optic neuropathy, Dr. Finger knows that treatment is effective.



Speak with your doctor about the standard risks associated with intraocular injection.

