

# Treatment of diabetic eye disease

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It is now well recognised that whilst good systemic control of diabetes may initially lead to worsening of retinopathy, it will ultimately reduce the severity of eye disease.<sup>1,2</sup> Diabetic retinopathy remains a major global health problem, however. Screening programmes are able to detect eye disease at a potentially treatable stage. Once detected, it is essential that treatment is available. The benefit of adequate, timely laser treatment is well recognised.<sup>3</sup>

In this issue, Bailey *et al.*<sup>4</sup> report the clinical outcomes of the National Diabetic Retinopathy Laser Treatment Audit. What it shows is that the battle against diabetic eye disease is far from won. Good laser treatment is time-consuming and difficult. The clinical infrastructure needs to support frequent, systematic review of these patients to detect those who fail to respond. Any opportunity for treatment must be taken – the paper by West *et al.*,<sup>5</sup> also in this issue, reports the results of laser during cataract surgery. Developments in indirect laser delivery systems and small-incision cataract surgery have made this treatment easier.

The national audit has shown that significant numbers of eyes fail to respond to laser alone. Vitreoretinal surgery has long been the 'last chance saloon' for diabetic eyes. Over the years, both the type of customer and the saloon's menu have changed – the indications for surgery have evolved together with improvements in surgical techniques. On the one hand the threshold for early intervention has been lowered, and on the other hand eyes previously thought inoperable have become treatable. Studies have teased out the benefits of surgery in subgroups of patients and provided a better understanding of the timing of surgery.<sup>6</sup>

Several surgical principles have stood the test of time: clear blood from the visual axis; isolate vitreoretinal fibrovascular adhesions to reduce the risk of progressive retinal traction; and reduce the stimulus for further neovascularisation. Perhaps the most important lesson of all, however, is that inappropriate or inadequate surgery is far worse than no surgery. It is not a condition to be tackled by the 'occasional' vitreoretinal surgeon; however

tempting it may be simply to remove blood from the vitreous, other vitreoretinal pathology must be managed at the same time. It is easy to forget the patient behind the eye. Those with complex retinopathy also have complex emotional and social problems. Young patients with 'roller-coaster retinopathy' can cycle between good vision and blindness, suffering repeated surgical episodes for vitreous haemorrhage, retinal detachment, cataract and glaucoma. They may spend several years of their lives in a planning blight, not knowing whether they will be able to resume work and provide for their dependants. More than anything such patients need support and time to talk.

Vitreoretinal surgery will retain a role in the management of diabetic retinopathy for the foreseeable future. The skills of the surgeon are not enough in this disease: the age-old role of the doctor as counsellor and supporter are needed every bit as much.

## References

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