

Current treatments in diabetic macular oedema: systematic review and meta-analysis

John Alexander Ford,¹ Noemi Lois,² Pamela Royle,³ Christine Clar,⁴ Deepson Shyangdan,³ Norman Waugh³

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¹Department of Population Health and Primary Care, Faculty of Medicine and Health Sciences, Norwich Medical School, University of East Anglia, Norwich, UK
²Centre for Vascular and Visual Sciences, Queens University, Belfast, UK
³Warwick Evidence, Division of Health Sciences, Warwick Medical School, Coventry, UK
⁴Researcher in Systematic Reviews, Berlin, Germany

Correspondence to

Dr John Alexander Ford;
john.ford@uea.ac.uk

ABSTRACT

Objectives: The aim of this systematic review is to appraise the evidence for the use of anti-VEGF drugs and steroids in diabetic macular oedema (DMO) as assessed by change in best corrected visual acuity (BCVA), central macular thickness and adverse events

Data source: MEDLINE, EMBASE, Web of Science with Conference Proceedings and the Cochrane Library (inception to July 2012). Certain conference abstracts and drug regulatory web sites were also searched.

Study eligibility criteria, participants and interventions: Randomised controlled trials were used to assess clinical effectiveness and observational trials were used for safety. Trials which assessed triamcinolone, dexamethasone, fluocinolone, bevacizumab, ranibizumab, pegaptanib or aflibercept in patients with DMO were included.

Study appraisal and synthesis methods: Risk of bias was assessed using the Cochrane risk of bias tool. Study results are narratively described and, where appropriate, data were pooled using random effects meta-analysis.

Results: Anti-VEGF drugs are effective compared to both laser and placebo and seem to be more effective than steroids in improving BCVA. They have been shown to be safe in the short term but require frequent injections. Studies assessing steroids (triamcinolone, dexamethasone and fluocinolone) have reported mixed results when compared with laser or placebo. Steroids have been associated with increased incidence of cataracts and intraocular pressure rise but require fewer injections, especially when steroid implants are used.

Limitations: The quality of included studies varied considerably. Five of 14 meta-analyses had moderate or high statistical heterogeneity.

Conclusions and implications of key findings: The anti-VEGFs ranibizumab and bevacizumab have consistently shown good clinical effectiveness without major unwanted side effects. Steroid results have been mixed and are usually associated with cataract formation and intraocular pressure increase. Despite the current wider spectrum of treatments for DMO, only a small proportion of patients recover good vision ($\geq 20/40$), and thus the search for new therapies needs to continue.

ARTICLE SUMMARY

Article focus

- To review the evidence for triamcinolone, dexamethasone, fluocinolone, bevacizumab, ranibizumab, pegaptanib and aflibercept in the treatment of diabetic macular oedema.

Key messages

- The anti-VEGFs ranibizumab and bevacizumab have consistently shown good clinical effectiveness in the short term without major unwanted side effects.
- Steroid results have been mixed and are usually associated with cataract formation and IOP increase.

Strengths and limitations of this study

- A robust, detailed review of the literature has been undertaken and, when appropriate, data have been combined in meta-analysis.
- The quality of studies included varied considerably.

INTRODUCTION

Diabetic macular oedema (DMO) is a complication of diabetic retinopathy and a leading cause of blindness. The prevalence of DMO is likely to increase with more people suffering from diabetes.¹ Increasing DMO has significant implications for patients, healthcare providers and wider society. Laser has been the mainstay of treatment, but recently antivascular endothelial growth factor (anti-VEGF) drugs and steroids have been introduced as potential alternatives to laser photocoagulation.

Burden of disease

Diabetic retinopathy is present at the time of diagnosis of diabetes mellitus in 0–30% of individuals.² The incidence is estimated to be 2.3/100 person-years for the overall diabetic population and 4.5 for patients on insulin therapy.³ There is good evidence that progression to DMO is associated with

duration of disease,^{4–7} poor glycaemic control⁸ and, in type 2 diabetes, the need for insulin,⁹ though the need for insulin therapy is more a marker for duration and poor control.

The number of people with DMO is likely to increase as diabetes becomes more common. Some reports have suggested a decrease in progression to severe visual loss between 1975–1985 and 1986–2008 in a combined population of types 1 and 2.¹⁰ Regular screening for retinopathy and better glycaemic control are thought to have reduced the progression to severe visual loss. Diabetic retinopathy is associated with a reduced quality of life. Compared with all diabetic complications, blindness was perceived to be the third worst health state after a major stroke and amputation.¹¹

In the USA, the presence of DMO at diagnosis is associated with 29% additional costs within the first 3 years compared with individuals without retinopathy at diagnosis.¹² In 2010, the estimated healthcare costs for DMO in England were £92 million, with £65.6 million being spent on hospital treatment and related costs.¹³

Visual impairment results in increased welfare costs, early retirement and costs of home help and carers.¹⁴ In England in 2010 (total population 52.23 million), the estimated population with diabetes was 2.34 million; the above social costs were estimated to be £11.6 million for DMO.¹³

Overview of pathophysiology

DMO is caused mainly by disruption of the blood-retinal barrier. The complex pathway that leads to this disruption has been previously described in this journal.¹⁵ Sustained hyperglycaemia causes a multifactorial cascade of physiological processes, involving increased permeability, cytokine activation, altered blood flow, hypoxia and inflammation. Vascular endothelial growth factor-A (VEGF-A) is a major contributor to the inflammatory process and, in particular, to angiogenesis and permeability.¹⁶ Hypoxia caused by microvascular disease stimulates the release of VEGF-A to aid perfusion. There are six major isoforms of VEGF-A: 121, 145, 165, 183, 189 and 206. In addition to causing widespread microvascular injury, there is now evidence that hyperglycaemia results in preceding neuronal dysfunction, which may contribute to visual loss.¹⁷

Overview of current treatments

Laser photocoagulation has been the mainstay of treatment for DMO. The landmark Diabetic Retinopathy Study¹⁸ and the Early Treatment Diabetic Retinopathy Study (ETDRS)^{19–20} demonstrated its clinical effectiveness. However, although laser photocoagulation was clearly effective in preserving vision, it was less successful in restoring it, once lost. Furthermore, patients with perifoveal ischaemia are not amenable to this form of therapy. In ETDRS, although laser was shown to reduce the risk of moderate visual loss (a loss of three ETDRS lines) by 50%, visual acuity improved in only 3% of patients.²⁰ However, in some recent trials, laser has

improved the proportion of patients with more than or equal to 10 letters by 7–31%.^{21–24} In addition, laser is not without side effects. Foveal burns, visual field defects, retinal fibrosis and laser scars have been reported.²⁵ Over the following decade it became apparent that certain patients suffered severe visual loss despite aggressive treatment.²⁶

Steroids and anti-VEGF drugs are newer treatments in DMO. Intravitreal corticosteroids have potent anti-inflammatory effects. Triamcinolone (Kenalog) is not licensed for eye use but has been used to treat DMO for over 10 years. Triamcinolone (Trivaris), recently, was licensed for eye use. The development of intravitreal implants has allowed sustained release formulations. Fluocinolone acetonide (Iluvien, Alimera Sciences) and dexamethasone (Ozudex, Allergan) are implants that have been introduced recently.

Anti-VEGF agents have shown efficacy compared with laser. Bevacizumab (Avastin, Genentech/Roche) is a monoclonal antibody that targets all VEGF isoforms. Although being developed for colorectal cancer, it is widely used off-label, as an intravitreal treatment for macular oedema of different aetiologies. Ranibizumab (Lucentis, Genentech/Roche) is a fragment of the bevacizumab antibody (molecular weight of ranibizumab 48.4 kDa compared with 149 kDa for bevacizumab). It was designed specifically for use in the eye. Ranibizumab is considerably more expensive than bevacizumab (the estimated cost of ranibizumab is \$2000/dose compared with \$50 for bevacizumab).²⁷ Pegaptanib (Macugen, Eyetech Pharmaceuticals/Pfizer) is a PEGylated aptamer, with a high affinity to the VEGF isoform 165, and was approved for the treatment of exudative AMD in 2004. Aflibercept (Regeneron/Bayer HealthCare) is a recent addition to the anti-VEGF class that targets all forms of VEGF-A and placental growth factor.

Aim of the review

The aim of this review is to provide clinicians with an up-to-date overview of current intraocular drug treatments for DMO. It is hoped that the information contained herein will assist clinicians to present their patients with the best evidence supporting each treatment, including possible complications. In addition, this review may be helpful to policy makers. The review focuses on the current evidence for the use of anti-VEGF drugs and steroids to treat DMO, as assessed by change in best corrected visual acuity (BCVA) (mean and proportion with more than two lines improvement), central macular thickness (CMT), as determined by optical coherence tomography (OCT), and their adverse events.

EVIDENCE ACQUISITION

A systematic literature search was performed. The databases searched included MEDLINE, EMBASE, Web of Science with Conference Proceedings and the Cochrane

Library. The dates searched were from the inception of each database until July 2012.

The search terms combined the following key words:

ranibizumab or lucentis or bevacizumab or avastin or pegaptanib or macugen or aflibercept or vegf trap-eye or steroid* or corticosteroid* or dexamethasone or fluocinolone or triamcinolone or anti-VEGF* or anti-vascular endothelial growth factor*

AND

DMO or diabetic macular edema or diabetic retinopathy or diabetic maculopathy

AND

(masked or sham or placebo OR control group or random*) OR (systematic review or meta-analysis) OR (risk or safety or adverse or harm or pharmacovigilance or side-effect* or precaution* or warning* or contraindication* or contra-indication* or tolerability or toxic)

The meeting abstracts of the Association for Research in Vision and Ophthalmology, the American Diabetes Association (2002–2012) and the European Association for the Study of Diabetes were searched from 2002 to 2012.

In addition, the web sites of the European Medicines Agency and the US Food and Drug Association were searched for data on registration status and safety. Clinicaltrials.gov and the EU Clinical Trials Register were searched in July 2012 for data on ongoing research.

Full details of the searches are shown in appendix 1.

Randomised controlled trials (RCT) were used to evaluate clinical effectiveness. Safety was assessed through both RCTs and observational studies.

RCTs were included provided that they (1) addressed the use of triamcinolone, dexamethasone, fluocinolone, bevacizumab, ranibizumab, pegaptanib or aflibercept in patients with DMO, (2) had a minimum follow-up of 6 months and (3) had a minimum of 25 eyes per study arm. Studies were excluded if they (1) evaluated laser only, (2) assessed the effect of the aforementioned treatments in macular oedema due to other retinal diseases (instead of DMO), (3) used only a single dose, (4) were combined with a surgical intervention or (5) published studies in languages other than English. There were no exclusions based on drug dose. Trials were excluded if they evaluated combined drug treatment with surgery or systemic treatment.

Search results were screened by two independent authors (JF and PR/DS). Data were extracted by one author (CC) and checked by a second (JF). Data extracted included inclusion/exclusion criteria, baseline demographics, BCVA expressed as a change in logMAR/ETDRS letters or proportion of participants with more than two or three lines BCVA improvement, CMT and adverse events. Risk of bias was assessed using the Cochrane risk of bias tool.

Studies were assessed for similarity in study population, interventions (dose and frequency), outcomes and

time to follow-up, with a view to including similar studies in a meta-analysis. Conference abstracts were excluded from the meta-analysis because their quality and detailed methodology were not clear. A difference of 6 months was allowed between study follow-ups because of the potential heterogeneity from disease progression and differences in the number of doses prescribed. If salient data were not reported, such as SDs, data were sought by personal communication with authors. Data were analysed using Review Manager software. If data from multiple time-points were available, the primary end-point data were used. Data were entered by one author (JF) and double-checked by a second (DS). Mean differences were calculated for change in BCVA and CMT and ORs were calculated for proportion of participants with more than two lines improvement. The 95% CIs were calculated for all outcomes. Statistical heterogeneity was measured through I^2 scores. A score of less than 30% was considered as low heterogeneity, a score of more than 70% was considered as high heterogeneity and scores between 30% and 70% were considered as moderate. A random effects model was used throughout. The random effects model assumes variability between studies and therefore models uncertainty into the meta-analysis. Fixed assumes no variability. Generally speaking, the random effects model results in wider CIs.

RESULTS

The literature search identified 430 unique articles for possible inclusion, as shown in figure 1. In total, 328 articles were excluded on the basis of title and abstract, leaving 102 full papers to be read. Fifty-one of these articles were excluded; the reasons for their exclusion are summarised in table 1. Fifty-one articles from 29 studies met the inclusion criteria and were included in the review; these are described in tables 3–16. Seven studies were suitable for meta-analysis.

Study quality

The quality of the included studies was, in general, good as is shown in table 2. (Note that the meeting abstracts were not quality assessed, owing to the lack of details reported on the methods.) Most studies adequately described sequence generation, except in three studies where it was unclear.^{28–30} However, allocation concealment was poorly described throughout, with only eight reports addressing this issue appropriately.^{31–38} Reporting of masking also varied. A number of studies masked patients using sham injection or sham laser.^{21 24 29 31 33 36 38 39 40} Various studies reported that masking of patients was impossible. Assessors, where reported, were masked. In two studies, incomplete outcomes were not addressed.^{31 41} Baseline characteristics were consistent within study treatment arms. Administration of laser followed the ETDRS protocol, or a modified version, in all studies that described laser administration.^{21–24 28 30 33 34 42 43} Two studies, both

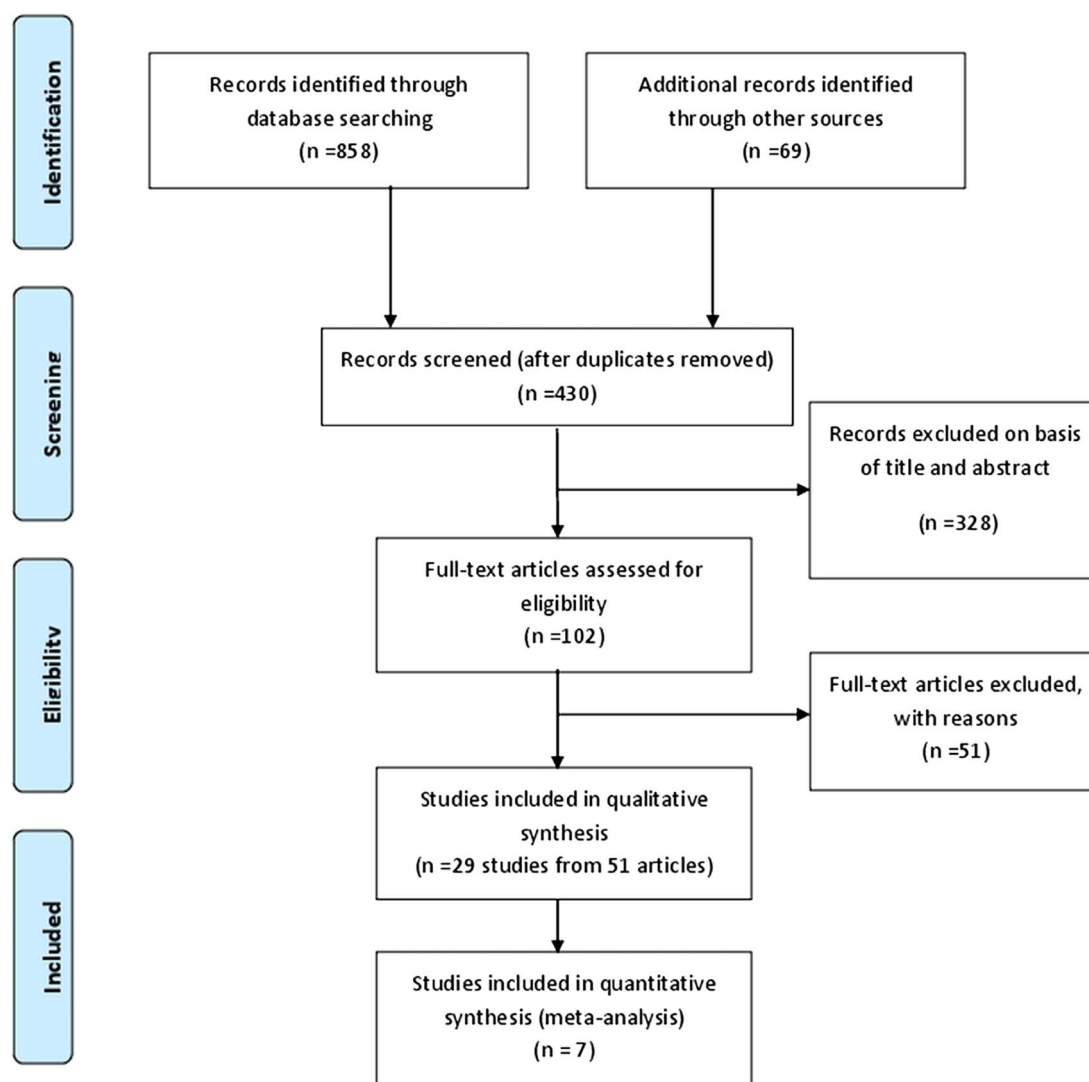


Figure 1 PRISMA flow diagram.

available only as meeting abstracts, did not report the laser administration details.^{44 45}

Intravitreal anti-VEGFs

The characteristics of all published studies including design, inclusion/exclusion criteria, intervention, outcomes and their timing are shown in [tables 3–8](#). Safety data for each drug are shown in [tables 9–16](#).

Ranibizumab

Nine RCTs have evaluated ranibizumab as a potential new treatment for patients with DMO ([tables 3 and 8](#)); seven were sponsored by industry, and two were led by independent investigators ([table 7](#)).^{21 46} READ-2 was the first large RCT (n=126).^{28 47} It compared ranibizumab (0.5 mg) alone, and ranibizumab in combination with laser and laser alone. At 6 months, BCVA had improved significantly in the ranibizumab alone group compared with laser alone or ranibizumab plus laser. Addition of laser to ranibizumab did not provide additional BCVA

gain. REVEAL (n=396) compared ranibizumab (0.5 mg) with ranibizumab plus laser and laser alone.⁴⁸ At 12 months, both ranibizumab arms resulted in a statistically significantly better improvement in BCVA compared to laser alone. The addition of laser did not confer further benefit.

Within the past 2 years, the results of RESOLVE,³⁶ RESTORE²⁴ and RISE and RIDE³⁸ have been published in peer-reviewed journals. RESTORE (n=345) randomised similar groups as the READ-2 study (ranibizumab (0.5 mg) alone, laser alone and ranibizumab plus laser); outcomes were evaluated at 12 months. Ranibizumab improved mean BCVA, with laser providing no additional benefit. Two-year extended follow-up suggested that these results continued.⁴⁹ RESOLVE (n=151) compared two doses of ranibizumab (0.3 and 0.5 mg) with sham injection. The greatest improvement in BCVA at 12 months was in the 0.3 mg group (11.8 letter gain) compared to the 0.5 mg group (8.8 letter gain) or sham injection (1.4 letter loss). In this study, rescue laser was

Table 1 List of excluded studies

Study	Reason
Active comparator trials	
Cho <i>et al</i> ⁸⁷	Single dose
DRCRN 2010 (Googe <i>et al</i>) ⁸⁸	<6 months f/u
Faghihi <i>et al</i> ⁸⁹	Single dose
Figuerola <i>et al</i> ⁹⁰	Single dose
Isaac <i>et al</i> ⁹¹	Single dose
Paccola <i>et al</i> ⁹²	Single dose
Prager <i>et al</i> ⁹³	<25 pts per arm
Ozturk <i>et al</i> ⁹⁴	Non-RCT
Marey and Ellakwa ⁹⁵	<6 months
Shahin and El-Lakkany ⁹⁶	Single dose
Pegaptanib	
Loftus <i>et al</i> ⁹⁷	Quality of life data
Ranibizumab	
Ferrone and Jonisch ⁹⁸	<25 pts per arm
Bevacizumab	
Solaiman <i>et al</i> ⁹⁹	Single dose
DRCRN—Scott <i>et al</i> ¹⁰⁰	<25 pts per arm
Lee ¹⁰¹	Non-RCT
Isaac <i>et al</i> ⁹¹	Single dose
Triamcinolone	
Audren <i>et al</i> ¹⁰²	Single dose (dosing study)
Audren <i>et al</i> ¹⁰³	Single dose
Avitabile ¹⁰⁴	Mixed RVO and DMO
Bandello <i>et al</i> ¹⁰⁵	Case report+PDR
Bonini <i>et al</i> ¹⁰⁶	Single dose injection technique
Cellini <i>et al</i> ¹⁰⁷	Single injection PSTI
Cardillo <i>et al</i> ¹⁰⁸	Single injection PSTI
Chung <i>et al</i> ¹⁰⁹	Single injection PSTI
Dehghan <i>et al</i> ¹¹⁰	Single dose
DRCRN—Chew <i>et al</i> ¹¹¹	<25 pts per arm
Gil <i>et al</i> ¹¹²	<25 pts per arm
Entezari <i>et al</i> ¹¹³	<6 months
Hauser <i>et al</i> ¹¹⁴	Single dose
Jonas <i>et al</i> ¹¹⁵	Single dose
Joussen <i>et al</i> ¹¹⁶	Study protocol
Avci and Kaderli ¹¹⁷	Anaesthetic technique
Kang <i>et al</i> ¹¹⁸	Single dose
Kim <i>et al</i> ¹¹⁹	Single injection and CME
Lam <i>et al</i> ¹²⁰	Single injection
Lee ¹²¹	Single injection
Maia <i>et al</i> ¹²²	Single dose
Massin <i>et al</i> ¹²³	Single dose
Mohamed <i>et al</i> ¹²⁴	Post hoc analysis
Nakamura <i>et al</i> ¹²⁵	Single dose
Spandau <i>et al</i> ¹²⁶	Single dose
Tunc ¹²⁷	<6 months
Verma <i>et al</i> ¹²⁸	Single dose
Wickremasinghe <i>et al</i> ¹²⁹	Single dose
Yalcinbayir <i>et al</i> ¹³⁰	Single dose
Dexamethasone	
Haller <i>et al</i> ¹³¹	<6 months
Haller <i>et al</i> ¹³²	<25 pts per arm
Kuppermann <i>et al</i> ¹³³	Mixture of macular oedema causes
Boyer <i>et al</i> ¹³⁴	Non-randomised
Fluocinolone	
Campochiaro <i>et al</i> ¹³⁵	<25 pts per arm
Diclofenac	
Elbendary ⁷¹	<35 pts per arm

CME, cystoid macular edema; DMO, diabetic macular oedema
PDR, proliferative diabetic retinopathy; PSTI, posterior subtenon injection; RVO, retinal vein occlusion.

allowed after 3 months of treatment, if BCVA had decreased by 10 letters or more, or if the investigator considered the macula not to be flat as assessed by OCT. Only 4.9% of the ranibizumab group required rescue laser, compared with 34.7% in the sham injection group.

READ-2 and RESTORE were suitable for pooling through meta-analysis and, when doing so, it was found that ranibizumab statistically significantly improved mean BCVA compared with laser (figure 2). In regard to the proportion of patients gaining more than or equal to 15 letters, individual trials showed a statistically significant difference between laser and ranibizumab but when these two trials were pooled using a random effects model, the result was no longer statistically significant. When a fixed effects model was used, the result was statistically significant (figure not shown). Adding laser to ranibizumab did not add any significant benefit (figure 3). In fact, the mean change in BCVA and the proportion of patients with more than 15 letter gain favoured, although not statistically significantly so, ranibizumab alone compared with ranibizumab plus laser. This was probably a chance effect.

RISE (n=377) and RIDE (n=382) were identical in design. The study arms are similar to those in the RESOLVE study, 0.3 or 0.5 mg ranibizumab compared with sham. In the RISE study, the proportion of patients with 15 or more letter gain was greatest in the 0.3 mg group at 24 months, whereas in the RIDE study this was greatest in the 0.5 mg group. In the DRCRN trial (n=854), Elman and colleagues compared ranibizumab (0.5 mg) plus prompt (within 3–10 days post ranibizumab) or deferred (≥24 weeks) laser with sham injection plus prompt laser, or triamcinolone (4 mg, Trivaris) plus prompt laser (table 8). At 1 year, both ranibizumab groups reported greater gains in mean BCVA change than triamcinolone or laser alone. Interestingly, at 2 years (n=628), the proportion of patients with 10 or more letter gain was not statistically significantly different between ranibizumab plus prompt laser and laser alone groups, but was statistically significant in the ranibizumab plus deferred laser compared with laser alone comparison. The reason for this is not clear.

READ-3 (n=152) has been published in abstract form and compared monthly injections of intravitreal ranibizumab high dose (2.0 mg) and low dose (0.5 mg).⁵⁰ At 6 months, there was no statistically significant difference in BCVA between groups.

One study (n=63), published in abstract form, was identified which directly compared monthly injections of ranibizumab (0.5 mg) with bevacizumab (1.5 mg).⁵¹ At 48 weeks, the authors found no statistically significant difference between bevacizumab and ranibizumab.

RESTORE, READ-2 and DRCRN (12 month data used) were suitable for pooling through meta-analysis to compare ranibizumab plus laser and laser alone (figure 4). Ranibizumab plus laser resulted in a statistically significantly greater change in mean BCVA, proportion of patients with more than 15 letter gain and CMT reduction versus laser alone.

Table 2 Study quality

Study (author and year)	Adequate sequence generation	Allocation concealment	Masking	Incomplete outcome data addressed	Free of selective reporting	Free of other bias (eg, similarity at baseline, power assessment)	Funder
<i>Anti-VEGFs</i>							
Ranibizumab READ-2 Study ^{28 47}	Unclear	Unclear	Unclear	Yes (91.3% completion)	Yes	Comparison groups similar at baseline; power analysis not mentioned	Juvenile Diabetes Research Foundation, Genentech Inc
RESOLVE Study (Massin <i>et al</i>) ³⁶	Yes	Yes	Yes (patients and outcome assessors)	Yes (82% completion in sham arm, 90.2% with ranibizumab)	Yes	Comparison groups similar at baseline; power analysis unclear	Novartis Pharma, Switzerland
RESTORE Study (Mitchell <i>et al</i>) ²⁴	Yes	Unclear	Yes (patients, outcome assessors)	Yes (87.3–88.3% completion)	Yes	Comparison groups similar at baseline; power analysis carried out (power adequate for VA changes)	Novartis Pharma, Switzerland
RISE and RIDE (Nguyen <i>et al</i>) ³⁸	Yes	Yes	Yes (patients, treating physician masked to assigned dose of ranibizumab)	Yes (2 year study completed by 83.3% of patients in RISE and by 84.6% in RIDE)	Yes	Comparison groups similar at baseline; ITT analysis; power analysis carried out (power adequate for primary endpoint)	Genentech Inc
Bevacizumab BOLT Study (Michaelides <i>et al</i>) ^{23 52}	Yes	Unclear	Partial (outcome assessors, not patients)	Yes (97.5% completion)	Yes	Comparison groups similar at baseline (except laser group had longer duration of clinically significant DMO); power analysis carried out (power adequate for VA changes)	Moorfields Special Trustees, National Institute for Health Research
Faghihi <i>et al</i> ⁵³	Yes	Unclear	Yes (patient)	Yes (100% completion)	Yes	Comparable groups at baseline	Not specified
Lam <i>et al</i> ³⁵	Yes	Yes	Yes (patients and technicians assessing BCVA, OCT and IOP)	Yes (92.3% follow-up at 6 months)	Yes	Comparison groups similar at baseline; power analysis carried out (power adequate for CMT changes)	Supported in part by the Action for Vision Eye Foundation Hong Kong (charity)

Continued

Table 2 Continued

Study (author and year)	Adequate sequence generation	Allocation concealment	Masking	Incomplete outcome data addressed	Free of selective reporting	Free of other bias (eg, similarity at baseline, power assessment)	Funder
Pegaptanib Cunningham <i>et al</i> / Adamis <i>et al</i> ^{39 57}	Yes	Unclear	Yes (patients and outcome assessors)	Yes (95% completion)	Yes	Comparison groups similar at baseline; acknowledge lack of power to detect differences between doses of pegaptanib	Eyetech Pharmaceuticals Inc, New York, and Pfizer Inc, New York
Sultan <i>et al</i> ⁴⁰	Yes	Unclear	Yes (patients and outcome assessors)	Yes (69.9–73.8% completion)	Yes	Comparison groups similar at baseline; power analysis carried out (power adequate for VA changes)	Pfizer Inc, New York
Aflibercept Da Vinci <i>et al</i> ^{30 58}	Unclear (predetermined randomisation scheme)	Unclear	Yes (patients)	Yes (85% completion)	Yes	Comparison groups similar at baseline, power calculation completed	Regeneron Pharmaceuticals, Inc, New York
Steroids Dexamethasone Haller <i>et al</i> ⁶⁹	Yes	Unclear	Yes (patients to dexamethasone dose, outcome assessors)	Yes (92% completion)	Yes	Comparison groups similar at baseline; power analysis carried out, but study not powered to detect differences in subgroups	Oculex Pharmaceuticals Inc
Fluocinolone FAME Study (Campochiaro <i>et al</i>) ^{29 60}	Unclear	Unclear	Partial (patients, masking of outcome assessment not mentioned)	Yes (drop-out rate 19.0–22.7%)	Yes	Comparison groups similar at baseline; power analysis not mentioned	Alimera Sciences Inc, Atlanta, Georgia; Psivida Inc, Watertown, Massachusetts
Pearson <i>et al</i> ⁴³	Yes	Unclear	Third party masked design (patient and investigator not masked)	No losses to follow-up	Yes	Demographic characteristics were similar between implant and SOC groups; power calculation done, study adequately powered	Bausch & Lomb Inc, Rochester, New York

Continued

Table 2 Continued

Study (author and year)	Adequate sequence generation	Allocation concealment	Masking	Incomplete outcome data addressed	Free of selective reporting	Free of other bias (eg, similarity at baseline, power assessment)	Funder
Triamcinolone DRCR Network 2008 ^{22 61 63 64}	Yes	Unclear	Partial (patients to triamcinolone dose, outcome assessors not formally masked but generally not aware of participant's study group)	Yes (81–86% completion)	Yes	Comparison groups similar at baseline; power analysis carried out (power adequate for VA changes)	Cooperative agreement from the National Eye Institute, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health, Department of Health and Human Services
Gillies <i>et al</i> /Sutter <i>et al</i> ^{82 136–138}	Yes	Yes	Yes (patients, outcome assessors)	Yes (91% completion intervention, 83% control)	Yes	Comparison groups similar at baseline (but limited demographic data); power analysis carried out (power adequate for VA changes)	Sydney Eye Hospital Foundation and Juvenile Diabetes Research Foundation, New York
Gillies <i>et al</i> ⁸³	Yes	Yes	Yes (patients, outcome assessors)	Yes (84.5% completion)	Yes	Power analysis carried out (power adequate for VA changes)	National Health and Medical Research Council, Canberra, Australia, and the Sydney Eye Hospital Foundation
Lam <i>et al</i> ⁸⁴	Yes	Yes	Partial (outcome assessors)	No losses to follow-up	Yes	Comparison groups similar at baseline; power analysis carried out (power adequate for CMT changes)	Action for Vision Foundation, Hong Kong
Ockrim <i>et al</i> / Sivaprasad <i>et al</i> ^{42 62}	Yes	Unclear	Unclear	Yes (94% completion)	Yes	Comparison groups similar at baseline; power analysis carried out (power adequate for VA changes)	Special Trustees of Moorfields Eye Hospital

Continued

Table 2 Continued

Study (author and year)	Adequate sequence generation	Allocation concealment	Masking	Incomplete outcome data addressed	Free of selective reporting	Free of other bias (eg, similarity at baseline, power assessment)	Funder
<i>Active comparator trials</i>							
Ahmadieh <i>et al</i> ³¹	Yes	Yes	Yes (patients and outcome assessors)	Unclear	Yes	CMT lower in control group at baseline ($p<0.05$), other baseline values similar; power analysis carried out (power adequate for CMT changes)	Not reported
DRCR Network ^{21 46}	Yes	Unclear	Yes (patients, except deferred laser group; outcome assessors); masking discontinued after the first year	Yes (1 year completion for 91–95% of eyes)	Yes	Comparison groups similar at baseline; power analysis carried out (power adequate for VA changes)	Cooperative agreement from the National Eye Institute, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health and Human Services; Ranibizumab provided by Genentech, triamcinolone provided by Allergan Inc; companies also provided funds to defray the study's clinical site costs
Lim <i>et al</i> ⁵⁵	Yes	Unclear	Yes (investigators only)	Yes (7.5% drop out after enrolment)	Yes	Groups similar at baseline. The bevacizumab group received more injections	Not reported
Soheilian <i>et al</i> ^{37 41}	Yes	Yes	Yes (patients and outcome assessors)	Unclear (36 week completion for 76–88%)	Yes	CMT significantly lower and VA significantly better in MPC group at baseline, other baseline values similar; power analysis carried out (power adequate for VA changes)	Ophthalmic Research Centre, Labbafinejad Medical Center, Tehran

MPC, macular photocoagulation.

Table 3 Ranibizumab trials

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
READ-2 Study (Nguyen <i>et al</i>) ^{28 47} USA Multicenter Design: 3-arm RCT Follow-up: 6 months, 2-year extension (no relevant outcomes as IVR received by all groups by that time, no safety outcomes for 2-year data)	N: 126 eyes of 126 patients Inclusion criteria: ≥ 18 years, type 1 or 2 DM, DMO, BCVA 20/40-20/320, CMT ≥ 250 μ m, HbA1c $\geq 6\%$ within 12 months before randomisation; expectation that scatter laser photocoagulation not required for 6 months Exclusion criteria: contributing causes to reduced BCVA other than DMO, focal/grid laser within 3 months, intraocular steroid within 3 months, intraocular VEGF antagonist within 2 months Age: 62 years Sex: 52–69% female Diabetes type: not reported HbA1c: 7.39–7.77% Baseline VA: ETDRS letter score 24.85–28.35 Baseline CMT: excess foveal thickness 198.75–262.52 μ m Comorbidities: not reported	Group 1 (IVR, n=42 eyes): IV injections of 0.5 mg ranibizumab at baseline, 1, 3 and 5 months Group 2 (L, n=42 eyes): focal/grid laser at baseline and 3 months if CMT ≥ 250 μ m Group 3 (IVRL, n=42 eyes): IV injections of 0.5 mg ranibizumab at baseline and 3 months, followed by focal/grid laser treatment 1 week later Regimen for all groups: after 6 months, patients could receive IV injections of ranibizumab no more than every 2 months or focal/grid laser no more than every 3 months if CMT ≥ 250 μ m Laser Modified ETDRS protocol was used	At 6 months BCVA (ETDRS):		
			BCVA (letters)	p Value	
			IVR	+7.24	0.0003 vs L
			L	–0.43	
			IVRL	+3.80	NS vs IVR or L
			Plus ≥ 3 lines		
			IVR	22%	<0.05 vs L
			L	0	
			IVRL	8%	
			CMT (OCT):		
READ-3 Study (Do <i>et al</i>) USA ⁵⁰ Design: phase 2, 2-arm RCT Follow-up: 6 months	N: 152 eyes Inclusion criteria: NR Exclusion criteria: NR Age: NR Sex: NR Diabetes type: NR HbA1c: NR Baseline VA: Mean BCVA Snellen equivalent 20/63 in the 2.0 mg group and 20/80 in the 0.5 mg group Baseline CST (central subfield thickness): 432 μ m in the 2.0 mg group and 441 μ m in the 0.5 mg group Comorbidities: NR	Group 1 (IVR2.0, n=NR): monthly injections Group 2 (IVR0.5, n=NR): monthly injections After month 6, eyes evaluated and additional ranibizumab injections given on an as needed basis if DMO still present on OCT.	CMT (μ m)		
			IVR	–106.3	p Value
			All <0.01 vs baseline, NS for elimination of $\geq 50\%$ excess foveal thickness between groups		
			L	–82.8	
			IVRL	–117.2	
			At 6 months: BCVA		
			Mean BCVA letters gain		
			IVR2.0	+7.46	NR
			IVR0.5	+8.69	NR
			CST reduction		
			IVR2.0	–163.86 μ m	NR
			IVR0.5	–169.27 μ m	NR

Continued

Table 3 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
RESOLVE Study (Massin <i>et al</i>) ³⁶ Multicenter international Design: 3-arm placebo-controlled RCT Follow-up: 12 months	N: 151 eyes of 151 patients Inclusion criteria: >18 years, type 1 or 2 DM, clinically significant DMO, BCVA 20/40–20/160, HbA1c <12%, decreased vision attributed to foveal thickening from DMO, laser photocoagulation could be safely withheld in the study eye for at least 3 months after randomisation Exclusion criteria: unstable medical status, panretinal laser photocoagulation performed within 6 months before study entry, previous grid/laser photocoagulation except patients with only mild laser burns at least 1000 µm from the centre of the fovea performed >6 months previously Age: 63–65 (range 32–85) years Sex: 43.1–49% female Diabetes type: 96.1–98% type 2 DM HbA1c: 7.3–7.6 (range 5.3–11.1) % Baseline VA: ETDRS letter score 59.2–61.2 SD9.0–10.2 Baseline CMT: 448.9–459.5 SD102.8–120.1 µm Comorbidities: not reported	Group 1 (IVR0.3, n=51 eyes): 0.3 mg (0.05 ml) IV ranibizumab, 3 monthly injections (dose up to 0.6 mg, see below) Group 2 (IVR0.5, n=51 eyes): 0.5 mg IV (0.05 ml) ranibizumab, 3 monthly injections (dose up to 1.0 mg, see below) Group 3 (C, n=49 eyes): sham treatment, 3 monthly injections Regimen for all groups: after month 1, the injection dose could be doubled if CMT remained >300 µm or was >225 µm and reduction in retinal oedema from previous assessment was <50 µm; once injection volume was 0.1 ml it remained that for subsequent injections; if treatment had been withheld for >45 days, subsequent injections restarted at 0.05 ml; 68.6% of dose doubling with ranibizumab, 91.8% with sham; 34.7% of rescue laser photocoagulation in sham group, 4.9% in ranibizumab group	At 12 months BCVA (ETDRS):		
			IVR0.3	BCVA (letters) +11.8 SD6.6	p Value <0.0001 vs C
			IVR0.5	+8.8 SD11.0	<0.0001 vs C
			C	–1.4 SD14.2	
			Change ≥ 10 letters		
			IVR0.3	Gain 72.5%	<0.0001 vs C
				loss 0	
			IVR0.5	Gain 49%	0.001 vs C
				loss 9.8%	
			C	Gain 18.4%	
RESTORE Study (Mitchell <i>et al</i>) ^{24 49}	N: 345 eyes of 345 patients Inclusion criteria: ≥18 years, type 1	Group 1 (IVR, n=116 eyes): 0.5 mg IV ranibizumab plus sham laser	At 12 months BCVA (ETDRS):		
			CMT (OCT):		
			IVR0.3	CMT (µm) –200.7 SD122.2	p Value <0.0001 vs C
			IVR0.5	–187.6 SD147.8	<0.0001 vs C
			C	–48.4 SD153.4	

Continued

Table 3 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)
Multicenter international <i>Design:</i> 3-arm RCT <i>Follow-up:</i> 12 months	or 2 DM, HbA1c $\leq 10\%$, visual impairment due to DMO (eligible for laser treatment), stable medication for management of diabetes, BCVA ETDRS letter score 39–78 <i>Exclusion criteria:</i> concomitant eye conditions that could affect VA, active intraocular inflammation or infection, uncontrolled glaucoma in either eye, panretinal laser photocoagulation within 6 months or focal/grid laser photocoagulation within 3 months prior to study entry, history of stroke, hypertension <i>Age:</i> 62.9–64.0 SD8.15–9.29 years <i>Sex:</i> 37.1–47.7% female <i>Diabetes type:</i> 86.4–88.8% type 2 DM <i>HbA1c:</i> not reported <i>Baseline VA:</i> ETDRS letter score 62.4–64.8 SD9.99–11.11 <i>Baseline CMT:</i> 412.4–426.6 SD118.01–123.95 <i>Comorbidities:</i> not reported	(median injections 7 (range 1–12), median sham laser treatments 2 (range 1–5))	<i>BCVA (letters)</i> <i>p Value</i>
		<i>Group 2 (IVRL, n=118 eyes):</i> 0.5 mg IV ranibizumab plus active laser (median injections 7 (range 2–12), median laser treatments 1 (range 1–5))	<i>IVR</i> +6.1 SD6.43 <i>IVRL</i> +5.9 SD7.92 <i>L</i> +0.8 SD8.56
		<i>Group 3 (L, n=111 eyes):</i> laser treatment plus sham injections (median sham injections 7 (range 1–12), median laser treatments 2 (range 1–4))	<i>BCVA change categories</i> Plus ≥ 10 : 37.4% Loss ≥ 10 : 3.5%
		<i>Regimen for all groups:</i> 3 initial monthly injections, followed by retreatment schedule; 1 injection per month if stable VA not reached; Laser retreatments in accordance with ETDRS guidelines at intervals no shorter than 3 months from previous treatment	Plus ≥ 10 : 43.2% Loss ≥ 10 : 4.2% Plus ≥ 10 : 15.5% Loss ≥ 10 : 12.7%
			<i>CMT (OCT):</i>
			<i>CMT (μm)</i> –118.7 SD115.07
			<i>p Value</i> 0.0002 vs L
			<i>IVR</i> –128.3 SD114.34
			<i>IVRL</i> –61.3 SD132.29
			<i>L</i>
REVEAL Study (Ohji and Ishibashi) ⁴⁸ Japan Multicenter <i>Design:</i> phase III double-masked RCT <i>Follow-up:</i> 12 months	<i>N:</i> 396 patients <i>Inclusion criteria:</i> NR <i>Exclusion criteria:</i> NR <i>Age:</i> 61.1 years <i>Sex:</i> NR <i>Diabetes type:</i> 98.7% with type 2 diabetes <i>HbA1c:</i> 7.5% <i>Baseline VA:</i> 58.6 letters <i>Baseline CMT:</i> 421.9 μm <i>Comorbidities:</i> NR	<i>Group 1 (IVR 0.5 + sham laser, n=133):</i> day 1, month 1, 2 and pro-renata thereafter based on BCVA	<i>At 12 months</i> <i>BCVA:</i>
		<i>Group 2 (IVR 0.5+ active laser, n=132):</i> day 1, month 1, 2 and pro-renata thereafter based on BCVA	<i>Mean average change from baseline to months 1–12</i> +5.9 +5.7 +1.4
		<i>Group 3 (sham injection + active laser, n=131):</i> day 1, month 1, 2 and pro-renata thereafter based on BCVA	<i>p Value</i> vs laser <0.0001 vs laser <0.0001
		Active/sham laser photocoagulation performed according to ETDRS guidelines at ≥ 3 month intervals	<i>Mean change from baseline to month 12 in BCVA and CRT</i> +6.6; –148.0 μm +6.4; –163.8 μm +1.8; –57.1 μm
			<i>IVR+sham laser</i> <i>IVR+laser</i> <i>Laser+sham</i>
			<i>IVR+sham laser</i> <i>IVR+laser</i> <i>Laser+sham</i>

Continued

Table 3 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
RISE Study (Brown <i>et al</i> / Nguyen <i>et al</i>) ^{38 139} USA Multicenter Design: 3-arm double-blind sham-controlled RCT Follow-up: 24 months	N: 377 eyes of 377 patients Inclusion criteria: ≥ 18 years, type 1 or 2 diabetes, BCVA 20/40–20/320, DMO CMT ≥ 275 μ m Exclusion criteria: prior vitreoretinal surgery, recent history (within 3 months of screening) of panretinal or macular laser in the study eye, intraocular corticosteroids or antiangiogenic drugs, those with uncontrolled hypertension, uncontrolled diabetes (HbA1c $>12\%$), recent (within 3 months) cerebrovascular accident or myocardial infarction Age: 61.7–62.8 SD8.9–10.0 (range 21–87) years Sex: 41.6–48% female Diabetes type: type 1 or 2 HbA1c: 7.7% SD 1.4–1.5; $\leq 8\%$ (65–68.3%); $>8\%$ (31.7%–35%) Baseline VA: Mean ETDRS letter score 54.7–57.2; $\leq 20/200$ (7.9–13.6%); $>20/200$ but $<20/40$ (72.4–72.8%); $\geq 20/40$ (13.6–19.7%) Baseline CMT: 463.8–474.5 μ m Comorbidities: History of smoking 46.4–51.2%	Group 1 (IVR0.3, n=125 eyes): 0.3 mg IV ranibizumab Group 2 (IVR0.5, n=125 eyes): 0.5 mg IV ranibizumab Group 3 (C, n=127 eyes): sham injection Regimen for all groups: monthly injections; need for macular rescue laser assessed monthly starting at month 3	At 24 months BCVA:		
			Plus ≥ 15 letters	p Value	
			IVR0.3	44.8%	<0.0001 vs C
			IVR0.5	39.2%	$=0.0002$ vs C
			C	18.1%	
			Loss of <15 letters		
			IVR0.3	97.6%	$=0.0086$ vs C
			IVR0.5	97.6%	$=0.0126$ vs C
			C	89.8%	
			Snellen equivalent of 20/40 or better		
			IVR0.3	60%	<0.0001 vs C
			IVR0.5	63.2%	<0.0001 vs C
			C	37.8%	
RIDE study (Boyer <i>et al</i> / Nguyen <i>et al</i>) ^{38 140} USA Multicentre Design: 3-arm double-blind sham-controlled RCT Follow-up: 24 months	N: 382 eyes Inclusion criteria: ≥ 18 years, type 1 or 2 diabetes, BCVA 20/40–20/320 and DMO CMT ≥ 275 μ m Exclusion criteria: prior vitreoretinal surgery, recent history (within 3 months of screening) of	Group 1 (IVR0.3, n=125 eyes): 0.3 mg IV ranibizumab Group 2 (IVR0.5, n=127 eyes): 0.5 mg IV ranibizumab Group 3 (C, n=130 eyes): sham injection Regimen for all groups: Patients	At 24 months BCVA:		
			More than 15 letters	p Value	
			IVR0.3	33.6%	<0.0001 vs C
			IVR0.5	45.7%	<0.0001 vs C
			C	12.3%	
			Mean BCVA gain (letters)		
			IVR0.3	+12.5 SD14.1	<0.0001 vs C
			IVR0.5	+11.9 SD12.1	<0.0001 vs C
			C	+2.6 SD13.9	
			CFT:		
			Mean change from baseline		
			IVR0.3	–250.6 SD212.2	<0.0001 vs C
			IVR0.5	–253.1 SD183.7	<0.0001 vs C
			C	–133.4 SD209.0	

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Table 3 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
	panretinal or macular laser in the study eye, intraocular corticosteroids or antiangiogenic drugs, those with uncontrolled hypertension, uncontrolled diabetes (HbA1c >12%), recent (within 3 months) cerebrovascular accident or myocardial infarction	were eligible for rescue macular laser starting at month 3		Less than 15 letters	
			IVR0.3	1.6%	>0.05 vs C
			IVR0.5	3.9%	<0.05 vs C
			C	8.5%	
	(HbA1c >12%), recent (within 3 months) cerebrovascular accident or myocardial infarction			Snellen equivalent of 20/40 or better	
	Age: 61.8–63.5 (range 22–91) years		IVR0.3	54.4%	=0.0002 vs C
	Sex: 37–49.1% female		IVR0.5	62.2%	<0.0001 vs C
	Diabetes type: type 1 or 2		C	34.6%	
	HbA1c: 7.6 SD1.3–1.5; ≤8% (65.8–67.5%); >8% (32.5–34.2%)		IVR0.3	Mean BCVA gain (letters)	
	Baseline VA: Mean ETDRS letter score 56.9–57.5		IVR0.5	+10.9 SD10.4	<0.0001 vs C
	Baseline CMT: 447.4–482.6 µm		C	+12.0 SD14.9	<0.0001 vs C
	Comorbidities: history of smoking 33.6–51.6%		CMT:	+2.3 SD14.2	
				Mean change from baseline	p Value
			IVR0.3	–259.8 SD169.3	<0.0001 vs C
			IVR0.5	–270.7 SD201.6	<0.0001 vs C
			C	–125.8 SD198.3	

Injections are intravitreal unless otherwise noted. BCVA, best corrected visual acuity; C, control; CMT, central macular thickness; CSME, clinically significant macular oedema; DDS, dexamethasone; DIL, dexamethasone followed by laser; DM, diabetes mellitus; DMO, diabetic macular oedema; DP, diastolic pressure; DR, diabetic retinopathy; HR QoL, health-related quality of life; IOP, intraocular pressure; IV, intravitreal; IVB, intravitreal bevacizumab; IVP, intravitreal pegaptanib; IVR, intravitreal ranibizumab; IVT, intravitreal triamcinolone; IVTL, intravitreal triamcinolone plus laser; IVVTE, intravitreal VEGF Trap Eye; L, laser; MLT/MPC, macular laser therapy/macular photocoagulation; NEI VFQ-25, National Eye Institute Visual Function Questionnaire-25; NPDR, non-proliferative diabetic retinopathy; NR, not reported; OCT, optical coherence tomography; PDR, proliferative diabetic retinopathy; PRP, panretinal photocoagulation; RCT, randomised controlled trial; SOC, standard of care; SP, systolic pressure; SRFA, fluocinolone; VA, visual acuity; VEGF, vascular endothelia growth factor.

Table 4 Bevacizumab studies

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
BOLT Study (Michaelides <i>et al</i> /Rajendram <i>et al</i>) ^{23 52 85} UK Design: 2-arm RCT Follow-up: 12 months	N: 80 eyes of 80 patients Inclusion criteria: ≥18 years, type 1 or 2 DM, BCVA in the study eye 35–69 ETDRS letters at 4 m (≥6/60 or ≤6/12), center-involving clinically significant DMO with CMT ≥270 µm; media clarity, papillary dilation and cooperation sufficient for adequate fundus imaging; a least 1 prior macular laser therapy; IOP <30 mm Hg; fellow eye BCVA ≥3/60; fellow eye received no anti-VEGF in past 3 months and no expectation of such therapy Exclusion criteria: (ocular for study eye) macular ischemia, macular oedema due to causes other than DMO, coexistent ocular disease affecting VA or DMO, any treatment for DMO in prior 3 months, PRP within 3 months prior to randomisation or anticipated, PDR, HbA1c >11%, medical history of chronic renal failure; any thromboembolic event within 6 months prior to randomisation, unstable angina, evidence of active ischemia on ECG; major surgery within 28 days of randomisation or planned; participation in an investigational drug trial; systemic anti-VEGF or pro-VEGF treatment within 3 months of enrolment; pregnancy, lactation; intraocular surgery within 3 months of randomisation; aphakia; uncontrolled glaucoma; significant external ocular disease Age: 64.2 SD8.8 years Sex: 31% female Diabetes type: 90% type 2 DM, 10% type 1 DM HbA1c: 7.5–7.6 SD1.2–1.4% Baseline VA: ETDRS letter score 54.6–55.7 SD8.6–9.7 Baseline CMT: 481–507 SD121–145 µm Comorbidities: 19% mild NPDR (level 35), 46% moderate NPDR (level 43), 19% moderately severe NPDR (level 47), 13% severe NPDR (level 53), 3% moderate PDR (level 65), 79–88% phakic	Group 1 (MLT, n=38 eyes): modified ETDRS macular laser therapy; reviewed every 4 months up to 52 weeks; retreatment performed if clinically indicated by ETDRS guidelines (median 4 laser treatments)	At 24 months BCVA (ETDRS):	BCVA. mean (SD)	p Value
		Group 2 (IVB, n=42 eyes): 1.25 mg (0.05 ml) IV bevacizumab at baseline, 6 and 12 weeks; subsequent IVB injections (up to 52 weeks) guided by an OCT-based retreatment protocol (median 13 injections) Laser modified ETDRS protocol, retreatment by ETDRS guidelines	MLT IVB MLT IVB MLT IVB	–0.5 (10.6) +8.6 (9.1)	0.005 vs MLT
				BCVA gain categories (letters) gaining ≥10: 7% losing >15: 4% gaining ≥10: 49% losing >15: 32% CMT (µm, quartiles) –118 SD171 –146 SD122	0.001 vs MLT 0.004 vs MLT
Lam <i>et al</i> ⁸⁵ Hong Kong Design: 2-arm RCT	N: 52 eyes of 52 patients Inclusion criteria: ≥18 years, type 1 or 2 DM, clinically significant DMO (slit-lamp biomicroscopy, ETDRS criteria; leakage confirmed by fluorescein	Group 1 (IVB1.25, n=26 eyes): 1.25 mg bevacizumab (0.05 ml) Group 2 (IVB2.5, n=26 eyes): 2.5 mg bevacizumab (0.1 ml)	At 6 months BCVA (ETDRS chart):		

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Table 4 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
Follow-up: 6 months	angiography, CMT ≥ 250 μm on OCT), BCVA ≥ 1.3 ETDRS logMAR units; only patients with diffuse DMO recruited <i>Exclusion criteria:</i> macular oedema due to reasons other than diabetes, significant media opacities, macular ischemia of ≥ 1 disk area, vitreomacular traction, PDR, aphakia, glaucoma or ocular hypertension, previous anti-VEGF treatment, intraocular surgery except uncomplicated cataract extraction (but > 6 months prior), focal DMO, any laser procedure within previous 4 months, subtenon or intravitreal triamcinolone injection within 6 months, pregnancy <i>Age:</i> 65.3 SD8.9 years <i>Sex:</i> 46.2% female <i>Diabetes type:</i> not reported <i>HbA1c:</i> 7.5 SD1% <i>Baseline VA:</i> 0.61 SD0.29 logMAR <i>Baseline CMT:</i> 466 SD127 μm <i>Comorbidities:</i> not reported	<i>Regimen for all groups:</i> 3 monthly IV injections, topical 0.5% levofloxacin 4x/day for up to 2 weeks after each injection	<i>BCVA (logMAR)</i>		
			IVB1.25	0.11 SD0.31 (+5.5 letters)	0.018 vs baseline, NS vs IVB2.5
			IVB2.5	0.13 SD0.26 (+6.5 letters)	0.003 vs baseline
			<i>CMT (OCT)</i> IVB1.25	<i>CMT (μm)</i> 96	<i>p Value</i> 0.002 vs baseline, NS vs IVB2.5
			IVB2.5	74	0.013 vs baseline
			Subgroups: ► For patients with previous DMO treatment (mainly laser): no significant reduction in CMT at 6 months (452 μm at baseline to 416 μm at 6 months, $p=0.22$); no significant improvement in BCVA (0.66 logMAR at baseline to 0.56 logMAR at 6 months (+5 letters), $p=0.074$)		

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Table 4 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
Faghihi <i>et al</i> ⁶³ Iran Design: 2-arm RCT Follow-up: 6 months	N: 80 eyes of 40 patients Inclusion criteria: Bilateral non-tractional CSME, 10/10> V.A≥1/10, Controlled blood pressure. Exclusion criteria: Advanced or advanced active PDR, significant cataract, glaucoma, history of recent vascular accident (eg, MI, CVA), Previous treatment of CSME or PDR, or pharmacotherapy for CSME, macular ischemia and uncontrolled hypertension Age: 57.7±8 years Sex: 27.5% females Diabetes type: NR HbA1c: 8.42±1.82 g/dl Baseline VA: 0.326–0.409 (SD 0.279–0.332) Baseline CMT: 277 um–287 um (SD 78–98) Comorbidities: not reported	Group 1 (IVB, n=40 eyes): 1.25 mg bevacizumab Group 2 (IVB+MPC, n=40 eyes): 1.25 mg bevacizumab Regimen for all groups: Eyes examined every 2 months and if evidence of CSME IVB was injected. Mean of the number of IVB injections in IVB group and IVB+MPC group were 2.23±1.24 and 2.49±1.09, respectively	At 6 months Mean change in BCVA (ETDRS chart):	BCVA (logMAR)	p Value
			IVB	0.138	<0.05 vs baseline
			IVB+MPC	0.179	<0.05 vs baseline
			► no statistically significant difference between the two groups		
			CMT (OCT):		
			IVB	CMT (µm) –39	<0.05 vs baseline
			IVB+MPC	–39	<0.05 vs baseline
			► No statistically significant difference between the two groups		

BCVA, best corrected visual acuity; C, control; CMT, central macular thickness; CSME, clinically significant macular oedema; DDS, dexamethasone; DIL, dexamethasone followed by laser; DM, diabetes mellitus; DMO, diabetic macular oedema; DP, diastolic pressure; DR, diabetic retinopathy; HR QoL, health-related quality of life; IOP, intraocular pressure; IV, intravitreal; IVB, intravitreal bevacizumab; IVP, intravitreal pegaptanib; IVR, intravitreal ranibizumab; IVT, intravitreal triamcinolone; IVTL, intravitreal triamcinolone plus laser; IVVTE, intravitreal VEGF Trap Eye; L, laser; MLT/MPC, macular laser therapy/macular photocoagulation; NEI VFQ-25, National Eye Institute Visual Function Questionnaire-25; NPDR, non-proliferative diabetic retinopathy; NR, not reported; OCT, optical coherence tomography; PDR, proliferative diabetic retinopathy; PRP, panretinal photocoagulation; RCT, randomised controlled trial; SOC, standard of care; SP, systolic pressure; SRFA, fluocinolone; VA, visual acuity; VEGF, vascular endothelia growth factor.

Table 5 Pegaptanib and aflibercept studies

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
Pegaptanib Cunningham <i>et al</i> / Adamis <i>et al</i> ^{89 57} USA Design: 4-arm phase II RCT Follow-up: 36 weeks	N: 172 eyes of 172 patients Inclusion criteria: ≥18 years, type 1 or 2 DM, DMO involving the center of the macula with corresponding leakage from microaneurysms, retinal telangiectasis, or both; clear ocular media, BCVA letter scores between 68 and 25 in the study eye and at least 35 in the fellow eye; IOP ≤23 mm Hg, focal photocoagulation could be safely deferred for 16 weeks; no ECG abnormalities, no major serological abnormalities Exclusion criteria: history of panretinal or focal photocoagulation; neodymium:yttrium–aluminum–garnet laser or peripheral retinal cryoablation in previous 6 months; any ocular abnormality interfering with VA assessment or fundus photography; vitreoretinal traction; vitreous incarceration; retinal vein occlusion involving the macula; atrophy/scarring/fibrosis or hard exudates involving the center of the macula; history of intraocular surgery within previous 12 months, myopia of ≥8 diopters, axial length of ≥25 mm, likelihood of requiring panretinal photocoagulation within following 9 months; cataract surgery within 12 months; active ocular or periocular infection; previous therapeutic radiation to the eye, head, or neck; known serious allergies to fluorescein dye; HbA1c ≥13%, pregnancy Age: 61.3–64.0 SD9.3–10.1 years Sex: 45–55% female Diabetes type: 5–10% IDDM HbA1c: 7.1–7.7 SD1.2–1.6 Baseline VA: letter score 55.0–57.1 SD9.1–11.5 Baseline CMT: 423.2–476.0 μm Comorbidities: not reported	Group 1 (IVP0.3, n=44 eyes): 0.3 mg IV pegaptanib (90 μl) (median 5 injections (range 1–6)) Group 2 (IVP1, n=44 eyes): 1 mg IV pegaptanib (90 μl) (median 6 injections (range 3–6)) Group 3 (IVP3, n=42 eyes): 3 mg IV pegaptanib (90 μl) (median 6 injections (range 1–6)) Group 4 (C, n=42 eyes): sham injection (median 5 injections (range 1–6)) Regimen for all groups: injections at baseline, week 6 and week 12; thereafter, additional injections administered every 6 weeks at the discretion of the investigators if judged indicated (maximum of 6 injections up to week 30); laser photocoagulation allowed after week 13 if judged indicated by the study-masked ophthalmologist (25% for IVP0.3, 30% for IVP1, 40% for IVP3, 48% for C)	At 36 weeks BCVA:		
			IVP0.3	BCVA (letters)	p Value
			IVP1	+4.7	0.04 vs C
			IVP3	+4.7	0.05 vs C
			C	+1.1	NS vs C
				–0.4	
				Plus ≥10 letters	
			IVP0.3	34%	0.003 vs C
			IVP1	30%	
			IVP3	14%	
			C	10%	
			CMT (OCT):		
				CMT (μm, 95% CI)	p Value
			IVP0.3	–68.0 (–118.9 to –9.88)	0.02 vs C
			IVP1	–22.7 (–76.9 to +33.8)	NS vs C
			IVP3	–5.3 (–63.0 to +49.5)	NS vs C
			C	+3.7	
			► Subgroups: of 16 participants with retinal neovascularisation at baseline, 8 of 13 (62%) in the pegaptanib groups and 0 of 3 in the sham group had regression of neovascularisation at 36 weeks		

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Table 5 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)			
Sultan <i>et al</i> ⁴⁰ Multicenter international Design: 2-arm placebo-controlled RCT Follow-up: 2 years (primary efficacy endpoint at 1 year)	N: 260 eyes of 260 patients Inclusion criteria: ≥ 18 years, type 1 or 2 DM, DMO involving the center of the macula not associated with ischemia, CMT ≥ 250 μ m, BCVA letter score 65–35, IOP ≤ 21 mm Hg, clear ocular media Exclusion criteria: any abnormality other than DMO affecting VA assessment, vitreomacular traction; yttrium–aluminium–garnet laser, peripheral retinal cryoablation, laser retinopexy for retinal tears, focal or grid photocoagulation within prior 16 weeks; panretinal photocoagulation < 6 months before baseline or likely to be needed within 9 months; significant media opacities; intraocular surgery in prior 6 months; pathological high myopia; prior radiation in region of study eye; history of severe cardiac or peripheral vascular disease, stroke in prior 12 months, major surgery in prior 1 month, treatment in prior 90 days with any investigational agent or with bevacizumab for any nonocular condition, HbA1c $\geq 10\%$ or signs of uncontrolled diabetes, hypertension, known relevant allergies; pregnant or lactating Age: 62.3–62.5 SD9.3–10.2 years Sex: 39–46% female Diabetes type: 6.3–7.5% type 1 DM, 92.5–93.7% type 2 DM HbA1c: 42.5–45.9% $< 7.6\%$, 54.1–57.5% $> 7.6\%$ Baseline VA: letter score 57.0–57.5 SD8.1–8.9 Baseline CMT: 441.6–464.6 SD135.5–148.5 μ m Comorbidities: not reported	Group 1 (IVP, n=133 eyes): 0.3 mg IV pegaptanib sodium (mean number of injections 12.7 SD4.6) Group 2 (C, n=127 eyes): sham injection (mean number of injections 12.9 SD4.4) Regimen for all groups: injections every 6 weeks up to week 48 (9 injections); at investigator determination (ETDRS criteria), laser photocoagulation could be performed at week 18, with possible repeat treatment at a minimum of 17 weeks later (maximum 3 treatments per year) (laser treatments in 25.2% of IVP group and 45% of C group); in year 2, injections as judged necessary	At 1 year			
			BCVA (ETDRS):			
			IVP			
			C			
			BCVA (letters)			
			+5.2			
			+1.2			
			Plus ≥ 10 letters			
			IVP			
			36.8%			
			C			
			19.7%			
			Retinopathy:			
			Increase in degree by ≥ 2 steps			
			IVP			
			4.1%			
			C			
			12.4%			
			Decrease in degree by ≥ 2 steps			
			IVP			
			10.2%			
			C			
			3.1%			
			CMT (OCT):			
			IVP			
			$\geq 25\%$: 31.7%			
			C			
			$\geq 50\%$: 14.6%			
			C			
			$\geq 25\%$: 23.7%			
			C			
			$\geq 50\%$: 11.9%			
			At 2 years			
			BCVA (ETDRS):			
			IVP			
			+6.1			
			C			
			+1.3			
			Plus ≥ 10 letters			
			IVP			
			38.3%			
			C			
			30%			
			Retinopathy:			
			Increase in degree by ≥ 2 steps			
			IVP			
			6.3%			
			C			
			13.8%			
			Decrease in degree by ≥ 2 steps			
			IVP			
			16.3%			
			C			
			3.8%			
			CMT (OCT):			
			IVP			
			$\geq 25\%$: 40.4%			
			C			
			$\geq 50\%$: 19.2%			
			$\geq 25\%$: 44.6%			
			$\geq 50\%$: 26.1%			

Continued

Table 5 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
			QoL: ► <i>NEI VFQ-25</i> : between group differences not significant at 54 weeks; at 102 weeks, significantly greater improvement in composite score and subscales distance vision activities, social functioning and mental health with pegaptanib ► <i>EQ-5D</i> : no significant differences between groups in EQ-5D scores at weeks 54 or 102		
<i>Aflibercept</i>					
DA VINCI 2010 (Do et al) ^{30 58}	N: 221 eyes of 221 patients	Trial of VEGF Trap-Eye (VTE), randomised on a 1 : 1:1 : 1:1 basis	At 6 months		
Multicenter	<i>Inclusion criteria</i> : aged >18 years and diagnosed with type 1 or 2 diabetes mellitus, with DMO involving the central macula defined as CRT (>250 µm in the central subfield. Participants were required to have BCVA letter score at 4 m of 73–24. Women of childbearing potential were included only if they were willing to not become pregnant and to use a reliable form of birth control during the study period	Group 1 (IVVTE1, n=44 eyes): IVVTE, 0.5 mg every 4 weeks	IVVTE1	BCVA (letters)	p Value
<i>Design</i> : 5-arm phase II RCT	<i>Exclusion criteria</i> : history of vitreoretinal surgery; panretinal or macular laser photocoagulation or use of intraocular or periocular corticosteroids or antiangiogenic drugs within 3 months of screening; vision decrease due to causes other than DMO; proliferative diabetic retinopathy (unless regressed and currently inactive); ocular inflammation; cataract or other intraocular surgery within 3 months of screening; laser capsulotomy within 2 months of screening; aphakia; spherical equivalent of >8 diopters; or any concurrent disease that would compromise visual acuity or require medical or surgical intervention during the study period: active iris neovascularisation, vitreous hemorrhage, traction retinal detachment, or preretinal fibrosis involving the macula; visually significant vitreomacular traction or epiretinal	Group 2 (IVVTE2, n=44 eyes): IVVTE, 2 mg every 4 weeks	IVVTE2	+8.6	0.005 vs L
<i>Follow-up</i> : 24 weeks		Group 3 (IVVTE3, n=42 eyes): IVVTE, 2 mg for 3 initial months then every 8 weeks	IVVTE3	+11.4	<0.0001 vs L
		Group 4 (IVVTE4, n=45 eyes): IVVTE, 2 mg for 3 initial months then as needed	IVVTE3	+8.5	0.008 vs L
		Group 5 (L, n=44 eyes): laser photocoagulation	L	+10.3	0.0004 vs L
		Laser modified ETDRS protocol	L	+2.5	
				plus ≥ 10 letters	
			IVVTE1	50%	NR
			IVVTE2	64%	NR
			IVVTE3	43%	NR
			IVVTE3	58%	NR
			L	32%	NR
				CMT(µm)	
			IVVTE1	–144.6	0.0002 vs L
			IVVTE2	–194.5	<0.0001 vs L
			IVVTE3	–127.3	0.007 vs L
			IVVTE3	–153.3	<0.0001 vs L
			L	–67.9	
			At 12 months		
				BCVA (letters)	p Value
			IVVTE1	+11.0	≤0.0001 vs L
			IVVTE2	+13.1	≤0.0001 vs L
			IVVTE3	+9.7	≤0.0001 vs L
			IVVTE3	+12.0	≤0.0001 vs L

Continued

Table 5 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)	
	membrane evident biomicroscopically or on OCT; history of idiopathic or autoimmune uveitis; structural damage to the center of the macula that is likely to preclude improvement in visual acuity after the resolution of macular oedema; uncontrolled glaucoma or previous filtration surgery; infectious blepharitis, keratitis, scleritis, or conjunctivitis; or current treatment for serious systemic infection: uncontrolled diabetes mellitus; uncontrolled hypertension; history of cerebral vascular accident or myocardial infarction within 6 months; renal failure requiring dialysis or renal transplant; pregnancy or lactation; history of allergy to fluorescein or povidone iodine; only 1 functional eye (even if the eye met all other entry criteria); or an ocular condition in the fellow eye with a poorer prognosis than the study eye	L	–1.3	
	Age: 60.7–64.0 years (SD 8.1–11.5)	IVVTE1	40.9%	0.0031 vs L
	Sex: % female 35.6–47.6%	IVVTE2	45.5%	0.0007 vs L
	Diabetes type: percentage of type 2, 88.6–97.7%	IVVTE3	23.8%	0.1608 vs L
	HbA1c: 7.85–8.10 (SD 1.71–1.94)	IVVTE3	42.2%	0.0016 vs L
	Baseline VA: 57.6–59.9 (SD 10.1–12.5)	L	11.4%	
	Baseline CMT: 426.1–456.6 µm (SD 111.8–152.4)	IVVTE1	57%	0.0031 vs L
	Comorbidities: history of any cardiac disease was twice as common in the VEGF Trap-Eye groups compared with the laser group	IVVTE2	71%	0.0007 vs L
		IVVTE3	45%	0.1608 vs L
		IVVTE3	62%	0.0016 vs L
		L		
		IVVTE1	–165.4	<0.0001 vs L
		IVVTE2	–227.4	<0.0001 vs L
		IVVTE3	–187.8	<0.0001 vs L
		IVVTE3	–180.3	<0.0001 vs L
		L	–58.4	

BCVA, best corrected visual acuity; C, control; CMT, central macular thickness; CSME, clinically significant macular oedema; DDS, dexamethasone; DIL, dexamethasone followed by laser; DM, diabetes mellitus; DMO, diabetic macular oedema; DP, diastolic pressure; DR, diabetic retinopathy; HR QoL, health-related quality of life; IOP, intraocular pressure; IV, intravitreal; IVB, intravitreal bevacizumab; IVP, intravitreal pegaptanib; IVR, intravitreal ranibizumab; IVT, intravitreal triamcinolone; IVTL, intravitreal triamcinolone plus laser; IVVTE, intravitreal VEGF Trap Eye; L, laser; MLT/MPC, macular laser therapy/macular photocoagulation; NEI VFQ-25, National Eye Institute Visual Function Questionnaire-25; NPDR, non-proliferative diabetic retinopathy; NR, not reported; OCT, optical coherence tomography; PDR, proliferative diabetic retinopathy; PRP, panretinal photocoagulation; RCT, randomised controlled trial; SOC, standard of care; SP, systolic pressure; SRFA, fluocinolone; VA, visual acuity; VEGF, vascular endothelial growth factor.

Table 6 Dexamethasone and fluocinolone studies

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
Dexamethasone Callanan <i>et al</i> ⁴⁴ Design: 2-arm RCT Follow-up: 12 months	N: 253 eyes of 253 patients Inclusion criteria: diffuse DMO, CMT $\geq 275 \mu\text{m}$, BCVA ≥ 34 and ≤ 70 letters Exclusion criteria: not reported Age: not reported Sex: not reported Diabetes type: not reported HbA1c: not reported Baseline VA: not reported Baseline CMT: not reported Comorbidities: not reported	Group 1 (DIL, $n=126$ eyes): dexamethasone IV implant followed by laser photocoagulation after 1 month (mean 1.6 implants; 78.6% completion) Group 2 (L, $n=127$ eyes): laser alone (79.5% completion) Regimen for all groups: if needed, patients were retreated with the dexamethasone implant at months 6 or 9, and with laser at months 4, 7 and 10; mean 2.2 laser treatments per patient Laser protocol not reported	At 12 months BCVA:		
			DIL L	Plus ≥ 10 letters (%) 28 24	p Value NS vs L
Haller <i>et al</i> ⁶⁹ USA Multicenter Design: 3-arm RCT Follow-up: 6 months (180 days), primary outcome 3 months (90 days)	N: 171 eyes of 171 patients Inclusion criteria: ≥ 12 years, DMO persisting for ≥ 90 days after laser treatment or medical therapy, BCVA by ETDRS between 20/40 (67 letters) and 20/200 (35 letters) due to clinically detectable DMO; analysis includes only eyes with DMO associated with DR Exclusion criteria: history of vitrectomy in the study eye; use of systemic, periorcular, or intraocular steroids within 30 days of enrolment; moderate or severe glaucoma in the study eye; poorly controlled hypertension (SP > 160 mm Hg or DP > 90 mm Hg); poorly controlled diabetes (HbA1c $> 13\%$) Age: 62.9–63.8 years SD10.2–12.0 Sex: 45.6–49.1% female Diabetes type: not reported HbA1c: 7.3–7.6% Baseline VA: letter score 54.4–54.7 SD9.96–11.88 Baseline CMT: 417.5–446.5 μm SD123.7–155.9 Comorbidities: 19–21% prior cataract extraction	Group 1 (DDS350, $n=57$ eyes): 350 μg dexamethasone IV drug delivery system, implanted into the vitreous cavity Group 2 (DDS700, $n=57$ eyes): 700 μg dexamethasone IV drug delivery system, implanted into the vitreous cavity Group 3 (C, $n=57$ eyes): no treatment Regimen for all groups: eyes demonstrating a VA loss of ≥ 5 letters could be treated with any other therapy (including laser photocoagulation and IV triamcinolone) ($n=4$ with photocoagulation or IV triamcinolone in the C group, $n=2$ in the DDS350 group, none in the DDS700 group)	At 90 days BCVA (ETDRS):	Plus ≥ 10 letters	p Value
			DDS350 DDS700 C CMT (OCT): DDS350 DDS700 C	21% (graph) 33% 12% CMT (μm) –42.57 SD95.96 –132.27 SD160.86 +30.21 SD82.12	NS vs C 0.007 vs C NS ($p=0.07$) vs C <0.001 vs C
			At 180 days BCVA (ETDRS):	Plus ≥ 10 letters	p Value
			DDS350 DDS700 C	20% (graph) 33% (graph) 23% (graph)	NS vs C NS vs C

Continued

Table 6 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
Fluocinolone FAME Study (Campochiaro <i>et al</i> /Campochiaro <i>et al</i>) ^{29 60} Multicenter international Design: 3-arm placebo-controlled RCT Follow-up: 24 months; abstract with 36 month outcomes	N: 956 eyes of 956 patients Inclusion criteria: DMO, CMT $\geq 250 \mu\text{m}$ despite at least 1 prior focal/grid macular laser photocoagulation treatment, BCVA ETDRS letter score between 19 and 68 (20/50–20/400) Exclusion criteria: glaucoma, ocular hypertension, IOP $> 21 \text{ mm Hg}$, taking IOP lowering drops; laser treatment for DMO within 12 weeks of screening, any ocular surgery in the study eye within 12 weeks of screening; ocular or systemic steroid therapy; active ocular infection; pregnancy Age: 62.5 SD9.4 years Sex: 40.6% Diabetes type: 6.6% type 1 DM, 92% type 2 DM, 1.4% uncertain HbA1c: 7.8 SD1.59% Baseline VA: ETDRS letter score 53.4 SD12.23 Baseline CMT: 469.0 SD164.78 μm Comorbidities: 47.1% cataract at baseline, 62.7–67.4% phakic	Group 1 (0.5, n=375 eyes): intravitreal insert releasing 0.2 $\mu\text{g/day}$ fluocinolone acetonide (FA) (2, 3, or 4 treatments received by 21.3, 1.9 and 0.3%) Group 2 (SRFA0.5, n=393 eyes): intravitreal insert releasing 0.5 $\mu\text{g/day}$ fluocinolone acetonide (2, 3, or 4 treatments received by 22.6, 2.5 and 0.3%) Group 3 (C, n=185 eyes): sham injection (2, 3, or 4 treatments received by 19.5, 2.7 and 1.6%) Regimen for all groups: patients could receive rescue focal/grid laser therapy any time after the first 6 weeks for persistent oedema (35.2–36.7% in FA groups, 58.9% control group, $p < 0.001$); treatments were allowed every 3 months for persistent or recurrent oedema; patients eligible for another FA insert at 1 year if ≥ 5 letter reduction in BCVA or $> 50 \mu\text{m}$ CMT increase from best status	At 24 months BCVA (ETDRS):		
			SRFA0.2	BCVA (letters)	p Value
			SRFA0.5	+4.4	0.02 vs C
			C	+5.4	0.017 vs C
				+1.7	
				Plus ≥ 15	p Value
			SRFA0.2	letters (%)	
				29	0.002
			SRFA0.5		SRFA vs C
			C	29	
				16	
			Subgroups: ► BCVA benefits only in pseudophakic eyes (cataract surgery before or during the study), in phakic eyes, BCVA letter score was reduced by 5 (high dose) and 9 (low dose) from baseline at 24 months		
			CMT (optical coherence tomography):		
			SRFA0.2	CMT (μm)	p Value
			SRFA0.5	–167.8	0.005 vs C
				–177.1	< 0.001 vs C
			C		
				–111.3	
			► effect maintained at 36 months		
			At 36 months		
				Plus ≥ 15	p Value
			SRFA0.2/0.5	letters	
				28.7%	0.018
			C		SRFA vs C
				18.9%	

Continued

Table 6 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
Pearson <i>et al</i> ⁴³ USA Multicenter Design: 2-arm RCT Follow-up: 36 months	N: 196 patients Inclusion criteria: persistent or recurrent unilateral or bilateral DMO with retinal thickening involving fixation of ≥ 1 disc area in size, ETDRS visual acuity of ≥ 20 letters (20/400) to ≤ 68 letters (20/50) and ≥ 1 macular laser treatment in the study eye more than 12 weeks prior to enrolment Exclusion criteria: Ocular surgery within 3 months prior to enrolment, uncontrolled IOP within the past 12 months while on ≥ 1 antiglaucoma medication, IOP of ≥ 22 mm Hg at screening while on ≥ 1 antiglaucoma medication, peripheral retinal detachment in the area of implantation or media opacity precluding diagnosis of status in the study eye Age: 61.4–62.7 years Sex: 41.7–42% female Diabetes type: 62.3–70% on insulin HbA1c: not reported Baseline VA: not reported Baseline CMT: not reported Comorbidities: not reported	Group 1 (SRFA, n=127): 0.5 mg sustained release fluocinolone acetonide intravitreal implant Group 2 (SOC, n=69): standard of care—either repeat laser or observation Laser ETDRS protocol	At 3 years		
			BCVA:		
			SRFA SOC	Gain ≥ 15 letters	p Value
				31%	NS
			SRFA SOC CMT:	Loss ≥ 15 letters	NS
				20%	
			SRFA SOC CMT:	17%	NS
				14%	
				Mean change in baseline CMT	p Value
			SRFA SOC	–86	NS
				–110	

BCVA, best corrected visual acuity; C, control; CMT, central macular thickness; CSME, clinically significant macular oedema; DDS, dexamethasone; DIL, dexamethasone followed by laser; DM, diabetes mellitus; DMO, diabetic macular oedema; DP, diastolic pressure; DR, diabetic retinopathy; HR QoL, health-related quality of life; IOP, intraocular pressure; IV, intravitreal; IVB, intravitreal bevacizumab; IVP, intravitreal pegaptanib; IVR, intravitreal ranibizumab; IVT, intravitreal triamcinolone; IVTL, intravitreal triamcinolone plus laser; IVVTE, intravitreal VEGF Trap Eye; L, laser; MLT/MPC, macular laser therapy/macular photocoagulation; NEI VFQ-25, National Eye Institute Visual Function Questionnaire-25; NPDR, non-proliferative diabetic retinopathy; NR, not reported; OCT, optical coherence tomography; PDR, proliferative diabetic retinopathy; PRP, panretinal photocoagulation; RCT, randomised controlled trial; SOC, standard of care; SP, systolic pressure; SRFA, fluocinolone; VA, visual acuity; VEGF, vascular endothelia growth factor.

Table 7 Triamcinolone studies

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)				
DRCR Network 2008 (Ip et al/Beck et al/Bressler et al) ^{22 61 63 64} USA Multicenter Design: 3-arm RCT Follow-up: 2 years, additional 3 year follow-up	N: 840 eyes of 693 patients Inclusion criteria: >18 years, type 1 or 2 DM, study eye: (1) BCVA (E-ETDRS) between 24 and 73 (20/320 and 20/40), (2) retinal thickening due to DMO involving the center of the macula main cause for visual loss, (3) CMT ≥250 μm, (4) no expectation of scatter photocoagulation within 4 months Exclusion criteria: any prior treatment with IV corticosteroids, peribulbar steroid injection within prior 6 months, photocoagulation for DMO within prior 15 weeks, panretinal scatter photocoagulation within prior 4 months, pars plana vitrectomy, history of open-angle glaucoma or steroid-induced IOP elevation requiring IOP-lowering treatment, and IOP ≥25 mm Hg Age: 63 SD9 years Sex: 49% female Diabetes type: 95% type 2 DM, 5% type 1 DM HbA1c: 7.9 SD1.8% Baseline VA: ETDRS letter score 59 SD11 (~20/63) Baseline CMT: 24 SD130 μm Comorbidities: 21% pseudophakic, 2% ocular hypertension, 7% mild NPDR, 13% moderate NPDR, 40% moderately severe NPDR, 11% severe NPDR, 23.5% mild to moderate, 3% high risk PDR	Group 1 (IVT1, n=256 eyes): 1 mg IV triamcinolone (3.5 treatments)	At 2 years BCVA (E-ETDRS):				
		Group 2 (IVT4, n=254 eyes): 4 mg IV triamcinolone (3.1 treatments)	IVT1	BCVA (letters) –2 SD18		0.02 vs L	
		Group 3 (L, n=330 eyes): focal/grid photocoagulation (2.9 treatments)	IVT4	–3 SD22		NS vs IVT4	
		Regimen for all groups: retreatment protocol: where indicated, retreatment was performed within 4 weeks after the follow-up visit and no sooner than 3.5 months from the time of last treatment; eyes were generally retreated unless: (1) little or no oedema involving the center of the macula present and CMT ≤225 μm, (2) VA letter score ≥79 (20/25 or better), (3) substantial improvement in macular oedema since last treatment (eg, ≥50% decrease in CMT), (4) clinically significant adverse effect from prior treatment, (5) additional treatment deemed futile (<5 letter improvement in VA letter score or lack of CMT reduction) and (6) for laser group, complete focal/grid photocoagulation already given, with no areas identified for which additional treatment was indicated	L	+1 SD17		0.002 vs L	
			IVT1	BCVA gain categories		0.03 vs L, NS vs IVT4	
				+10 or more: 25%			
				+9 to –9: 50%			
				–10 – more: 26%			
				+10 or more: 28%		0.01 vs L	
				+9 to –9: 44%			
				–10 or more: 28%			
				+10 or more: 31%			
				+9 to –9: 50%			
				–10 or more: 19%			
				Subgroups:			
				► Similar results when considering only pseudophakic eyes or eyes with minimal cataract no substantially different results based on baseline VA, baseline CMT, history of focal/grid photocoagulation for DMO			
		► 3 year results consistent with 2 year results for BCVA and CMT					
		CMT (OCT):					
			CMT (μm)		p Value		
		IVT1	–86 SD167		<0.001 vs L,		
		IVT4	–77 SD160		NS vs IVT4		
		L	–139 SD148		<0.001 vs L		
		Progression of retinopathy:					
			2 years	3 years	p Value		
		IVT1	29%	35%			
		IVT4	21%	30%	<0.05 vs L		
		L	31%	37%			

Continued

Table 7 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)
Gillies <i>et al</i> Sutter <i>et al</i> ^{32 136–138} Australia <i>Design</i> : 2-arm placebo-controlled RCT <i>Follow-up</i> : 2 years, additional 3-year follow-up	<i>N</i> : 69 eyes of 43 patients <i>Inclusion criteria</i> : patients with persistent (≥3 months after adequate laser treatment) DMO involving the central fovea, BCVA in the affected eye ≤6/9 <i>Exclusion criteria</i> : uncontrolled glaucoma, loss of vision due to other causes, systemic treatment with >5 mg prednisolone (or equivalent) daily, intercurrent severe systemic disease, any condition affecting follow-up or documentation <i>Age</i> : 62.4–69.6 <i>SD</i> 9.2–12.5 years <i>Sex</i> : 52% female <i>Diabetes type</i> : not reported <i>HbA1c</i> : 7.63–8.28 <i>SD</i> 1.12–1.41 <i>Baseline VA</i> : ETDRS letter score 60.5–61.3 <i>SD</i> 11.9–13.2 <i>Baseline CMT</i> : 439–444 <i>SD</i> 101–125 µm <i>Comorbidities</i> : 25% pseudophakic	protocol as used in prior DRCR.net protocols <i>Group 1 (IVT, n=34 eyes)</i> : 4 mg (0.1 ml) IV triamcinolone acetonide (mean 2.6 injections over 2 years) <i>Group 2 (C, n=35 eyes)</i> : placebo injection (subconjunctival saline injection) (mean 1.8 injections over 2 years) <i>Regimen for all groups</i> : retreatment considered at each visit as long as treatments were at least 6 months apart (retreatment if VA decreased ≥5 letters from previous peak value and persistent CMT >250 µm), if no improvement after 4 weeks, further laser treatment was applied (n=1 laser treatment in intervention group, n=16 in placebo group, p=0.0001) <i>Laser</i> ETDRS protocol	<i>At 2 years</i> <i>BCVA (ETDRS)</i> : <i>IVT</i> <i>C</i> <i>IVT</i> <i>C</i> <i>CMT (OCT)</i> : <i>IVT</i> <i>C</i> <i>BCVA (letters)</i> <i>p Value</i> 0.01 vs C <i>CVA gain categories</i> +10 or more: 21% +9 to –9: 70% –10 or more: 9% +10 or more: 12% +9 to –9: 62% –10 or more: 25% <i>CMT (µm)</i> –125 <i>p Value</i> 0.009 vs C, difference between groups 59 µm (95% CI 15 to 104) –75

Continued

Table 7 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
Gillies <i>et al</i> ⁸³ Australia Design: 2-arm RCT Follow-up: 24 months	N: 84 eyes of 54 patients Inclusion criteria: DMO involving the central fovea, CMT ≥ 250 μm , BCVA 17–70 letters (~20/40–20/400), laser treatment could be safely delayed for 6 weeks without significant adverse effects Exclusion criteria: uncontrolled glaucoma, controlled glaucoma but with a glaucomatous visual field defect, loss of vision resulting from other causes, systemic treatment with >5 mg prednisolone (or equivalent) daily, retinal laser treatment within 4 months, intraocular surgery within 6 months, concurrent severe systemic disease, any condition affecting follow-up or documentation Age: 65.4–66.9 SD8.9–9.5 years Sex: 38.1–47.6% female Diabetes type: not reported HbA1c: 7.81–8.02 SD1.44–1.63% Baseline VA: letter score 55.2–55.5 SD11.3–12.5 Baseline CMT: 482.1–477.4 SD122.7–155.5 μm Comorbidities: not reported	Group 1 (IVTL, n=42 eyes): 4 mg (0.1 ml) IV triamcinolone acetate followed by laser treatment (at least 1 retreatment in 2nd year in 69%) Group 2 (L, n=42 eyes): sham injection followed by laser treatment (at least 1 retreatment in 2nd year in 45%) Regimen for all groups: retreatment with injection followed by laser at discretion of chief investigator, with at least 6 weeks between treatments; no retreatment if: (1) investigator considered the macula nearly flat and CMT <300 μm ; (2) VA was ≥ 79 letters (20/25) or VA had improved by ≥ 5 letters compared with the best VA after treatment or baseline acuity; (3) laser treatment was considered by the investigator as inappropriate or had no potential for improvement	At 24 months BCVA (ETDRS):		
			ITL	BCVA (letters)	p Value
			L	+0.76	NS vs L
			IVTL	–1.49	
				BCVA gain categories	
				+10 or more: 36%	0.049 vs L
				+9 to –9: 31%	
			L	–10 or more: 33%	
				+10 or more: 17%	
				+9 to –9: 59%	
				–10 or more: 24%	
			Subgroups:		
			► BCVA outcome not significantly affected by cataract surgery		
			CMT (OCT):		
			IVTL	CMT (μm)	p Value
			L	–137.1	NS vs L
				–109.6	

Continued

Table 7 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
Kim <i>et al</i> ^{A5} Korea Design: 2-arm RCT Follow-up: 3 years	N: 86 eyes of 75 patients Inclusion criteria: diffuse DMO Exclusion criteria: not reported Age: not reported Sex: not reported Diabetes type: not reported HbA1c: not reported Baseline VA: not reported Baseline CMT: not reported Comorbidities: not reported	Group 1 (IVT, n=38 eyes): 4 mg IV triamcinolone (1.88 additional treatments, completion 68.1%) Group 2 (IVTL, n=48 eyes): macular laser photocoagulation 4 weeks after 4 mg IV triamcinolone (0.92 additional treatments, completion 77.1%) Regimen for all groups: additional treatment possible, criteria not mentioned Laser protocol not reported	At 3 years BCVA: not reported Outcomes related to DMO:	No DMO recurrence 3.9% 24.3% Time DMO not present 10.33 months 19.88 months	p Value 0.028 vs IVT 0.027 vs IVT
Lam <i>et al</i> ^{B4} Hong Kong Design: 3-arm RCT Follow-up: 6 months (2 years planned)	N: 111 eyes of 111 patients Inclusion criteria: >18 years, type 1 or 2 DM, clinically significant DMO (ETDRS), CMT ≥250 μm Exclusion criteria: macular oedema due to causes other than diabetic maculopathy, signs of vitreomacular traction, proliferative diabetic retinopathy, aphakia, history of glaucoma or ocular hypertension, macular ischemia, any laser procedure within 3 months, ocular surgery within 6 months, significant media opacities Age: 64.7–67.2 SD8.2–10.3 years Sex: 42–59% female Diabetes type: not reported HbA1c: not reported Baseline VA: ETDRS logMAR 0.64–0.72 SD0.34–0.36 Baseline CMT: 385–424 SD91–108 μm Comorbidities: 66–84% phakic eyes	Group 1 (IVT, n=38 eyes): 4 mg IV triamcinolone (no retreatments) Group 2 (IVTL, n=36 eyes): 4 mg IV triamcinolone followed by grid laser photocoagulation (ETDRS) (laser treatment once the macular oedema had reduced to <250 μm at the foveal center or at 1 to 2 months after injection, whichever was earlier) Group 3 (L, n=37 eyes): grid laser photocoagulation (n=3 retreatments) (no retreatments) Regimen for all groups: in case of recurrence or persistence of macular oedema, retreatment offered according to study group, at intervals no less than 4 months Laser ETDRS protocol	At 6 months BCVA (ETDRS): BCVA improvement –0.7 SD 10.7 log MAR Plus ≥15 letters: 5% –1.1 SD 10.8 log MAR Plus ≥15 letters: 3% –1.6 SD 11.5 log MAR Plus ≥15 letters: 5% CMT (OCT): CMT (μm) 342 SD124 (–54) 307 SD181 (–116) 350 SD169 (–35)	p Value NS between groups p Value NS between groups, <0.01 vs baseline <0.01 vs baseline	

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Table 7 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
Ockrim <i>et al</i> /Sivaprasad <i>et al</i> ⁶² UK Design: 2-arm RCT Follow-up: 1 year	N: 88 eyes of 88 patients Inclusion criteria: clinically significant DMO persisting ≥ 4 months, ≥ 1 previous laser treatment, BCVA 6/12–3/60, VA in fellow eye $\geq 3/60$, duration visual loss < 24 months Exclusion criteria: significant macular ischemia, baseline IO > 23 mm Hg, glaucoma, coexistent renal disease, loss of VA due to other causes, previous vitrectomy, intraocular surgery within 3 months of study entry, previous inclusion in other DR trials, inability to return to follow-up, inability to give informed consent Age: 62.3–64.8 SD7.5–10.1 years Sex: 28.9–34.9% female Diabetes type: 97.8–100% type 2 DM HbA1c: 7–7.8 IQR6.5–8.7% Baseline VA: ETDRS letter score 53.0–54.6 SD13.3–14.2 Baseline CMT: 410.4–413.4 SD127.8–134.1 μm Comorbidities: 17.8–19.5% PDR, 13.3–18.6% pseudophakia, 15–17.8% posterior vitreous detachment	Group 1 (IVT, $n=43$ eyes): 4 mg IV triamcinolone (mean number of IVT injections 1.8 (range 1–3)) Group 2 (L, $n=45$ eyes): ETDRS laser photocoagulation (mean number of grid laser sessions 2.1 (range 1–3)) Regimen for all groups: patients retreated at 4 and 8 months if they had persistent macular oedema Laser ETDRS protocol	At 12 months BCVA (ETDRS): IVT L IVT L CMT (optical coherence tomography): IVT L	BCVA (letters) –0.2 +1.7 Plus ≥ 15 letters 4.8% 12.2% CMT (μm) –91.3 –63.7	<i>p</i> Value NS vs L NS vs L NS vs L

BCVA, best corrected visual acuity; C, control; CMT, central macular thickness; CPL, control plus laser; CSME, clinically significant macular oedema; DDS, dexamethasone; DIL, dexamethasone followed by laser; DM, diabetes mellitus; DMO, diabetic macular oedema; DP, diastolic pressure; DR, diabetic retinopathy; HR QoL, health-related quality of life; IOP, intraocular pressure; IV, intravitreal; IVB, intravitreal bevacizumab; IVP, intravitreal pegaptanib; IVR, intravitreal ranibizumab; IVT, intravitreal triamcinolone; IVTL, intravitreal triamcinolone plus laser; IVVTE, intravitreal VEGF Trap Eye; L, laser; MLT/MPC, macular laser therapy/macular photocoagulation; NEI VFQ-25, National Eye Institute Visual Function Questionnaire-25; NPDR, non-proliferative diabetic retinopathy; NR, not reported; OCT, optical coherence tomography; PDR, proliferative diabetic retinopathy; PRP, panretinal photocoagulation; RCT, randomised controlled trial; RDL, ranibizumab plus deferred laser; RPL, ranibizumab plus laser; SOC, standard of care; SP, systolic pressure; SRFA, fluocinolone; TPL, triamcinolone plus laser; VA, visual acuity; VEGF, vascular endothelial growth factor.

Table 8 Trials assessing more than one drug

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)
Ahmadiéh <i>et al</i> ³¹ Iran <i>Design</i> : 3-arm placebo-controlled RCT <i>Follow-up</i> : 24 weeks	<i>N</i> : 115 eyes of 101 patients <i>Inclusion criteria</i> : eyes with clinically significant DMO unresponsive to previous macular laser photocoagulation (last session >3 months prior) <i>Exclusion criteria</i> : visual acuity $\geq 20/40$; history of cataract surgery within past 6 months; prior intraocular injection or vitrectomy, glaucoma or ocular hypertension; PDR with high-risk characteristics; vitreous hemorrhage; significant media opacity; presence of traction on the macula; pregnancy; serum creatinine ≥ 3 mg/100 ml; monocular patients <i>Age</i> : 59.7 SD8.3 years (range 39–74) <i>Sex</i> : 50.5% female <i>Diabetes type</i> : not reported, 27.6–33.3% on insulin <i>HbA1c</i> : 9.35–10.06% <i>Baseline VA</i> : not reported <i>Baseline CMT</i> : not reported <i>Comorbidities</i> : (percentage of eyes) 13.9% history of cataract surgery, 81.7% NPDR, 4.3% early PDR, 13.9% regressed PDR; no iris neovascularisation	<i>Group 1 (IVB, n=41 eyes)</i> : bevacizumab 1.25 mg (0.05 ml) <i>Group 2 (IVB/IVT, n=37 eyes)</i> : combined bevacizumab (1.25 mg (0.05 ml)) and triamcinolone (2 mg (0.05 ml)), followed by two injections of bevacizumab alone <i>Group 3 (C, n=37 eyes)</i> : sham injection <i>Regimen for all groups</i> : 3 consecutive IV injections at 6-week intervals	<i>At 24 weeks BCVA (Snellen chart)</i> : BCVA (logMAR), 95% CI p Value –0.18 (–0.29, –0.08) (+9 letters (4, 14.5)) 0.01 vs C, NS vs IVB/IVT –0.21 (–0.30, –0.12) (+10.5 letters (6, 15)) 0.006 vs C –0.03 (–0.08, 0.14) (+1.5 letters (–7, 4)) CMT (OCT): CMT (μ m), 95% CI p Value –95.7 (–172.2, –19.3) 0.012 vs C, NS vs IVB/IVT –92.1 (–154.4, –29.7) 0.022 vs C 34.9 (7.9, 61.9)
ATEMD Oliveira Neto <i>et al</i> ⁶⁶ Multicenter <i>Design</i> : 3-arm RCT <i>Follow-up</i> : 6 months <i>Note</i> : only 48.3% completion	<i>N</i> : 120 eyes of 120 patients <i>Inclusion criteria</i> : DMO, BCVA 20/40–20/400, CMT ≥ 275 μ m <i>Exclusion criteria</i> : PDR, laser photocoagulation in previous 3 months, no IV corticosteroid or anti-VEGF in previous 3 months <i>Age</i> : not reported <i>Sex</i> : not reported <i>Diabetes type</i> : not reported <i>HbA1c</i> : not reported <i>Baseline VA</i> : not reported <i>Baseline CMT</i> : not reported <i>Comorbidities</i> : not reported	<i>Group 1 (IVB, n=NR eyes)</i> : 1.25 mg (0.05 ml) of IV bevacizumab <i>Group 2 (IVT, n=NR eyes)</i> : 4 mg (0.1 ml) of IV triamcinolone acetate <i>Group 3 (IVB/IVT, n=NR eyes)</i> : 1.25 mg (0.05 ml) of IV bevacizumab plus 4 mg (0.1 ml) of IV triamcinolone acetate <i>Regimen for all groups</i> : monthly injections	<i>At 6 months BCVA</i> : ► no significant difference between groups (between 1.7 and 2.3 lines gained in the different groups in 2010 report (n=18)) <i>CMT (OCT)</i> : ► CMT reduced in all 3 groups (between 17 and 33% reduction in the different groups in 2010 report (n=18)); no significant difference between groups

Continued

Table 8 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
DRCR Network 2010 (Elman <i>et al</i>) ^{21 46} USA Multicenter Design: 4-arm placebo-controlled RCT Follow-up: 1–2 years; 2 years extension (Elman) ⁴⁶ for consenting patients	N: 854 eyes of 691 patients Inclusion criteria: ≥18 years, type 1 or 2 DM; study eye: (1) BCVA letter score 78–24 (20/32–20/320), (2) definite retinal thickening due to DMO assessed to be main cause of visual loss, (3) retinal thickness measured on time domain OCT ≥250 µm in central subfield (2 study eyes per patient could be included if both were eligible at study entry) Exclusion criteria: (1) treatment for DMO within the prior 3 months, (2) panretinal photocoagulation within the prior 4 months or anticipated need for panretinal photocoagulation within the next 6 months, (3) major ocular surgery within the prior 4 months, (4) history of open-angle glaucoma or steroid-induced IOP elevation, requiring IOP-lowering treatment, (5) IOP ≥25 mm Hg; systolic pressure >180 mm Hg, diastolic pressure >110 mm Hg; myocardial infarction, other cardiac event requiring hospitalisation, cerebrovascular accident, transient ischemic attack, treatment for acute congestive heart failure within 4 months before randomisation Age: median 62–64 years (25th, 75th centile 55–58, 69–70) Sex: 41–46% female Diabetes type: 6–9% type 1 DM, 89–92% type 2 DM, 2–3% uncertain HbA1c: median 7.3–7.5% (25th, 75th centile 6.5–6.7, 8.3–8.6) Baseline VA: letter score 63 SD12 (~20/63 SD2.4 lines) Baseline CMT: 405 SD134 µm Comorbidities: 60–67% prior treatment for	Group 1 (CPL, n=293 eyes): sham injection plus prompt (within 3–10 days after injection) focal/grid photocoagulation Group 2 (RPL, n=187 eyes): 0.5 mg IV ranibizumab plus prompt focal/grid photocoagulation Group 3 (RDL, n=188 eyes): 0.5 mg IV ranibizumab plus deferred (≥24 weeks) focal/grid photocoagulation Group 4 (TPL, n=186 eyes): 4 mg IV triamcinolone plus prompt focal/grid photocoagulation Regimen for all groups: Baseline treatment 0.5 mg IV ranibizumab and 4 mg preservative free triamcinolone; study treatment every 4 weeks up to 12 weeks, then retreatment algorithm: 16 to 20 weeks, monthly retreatment unless 'success' criteria were met (visual acuity letter score ≥84 (20/20) or OCT central subfield thickness <250 µm); 24–48 weeks, patients subdivided (according to predefined criteria) into 'success', 'improvement', 'no improvement' or 'failure';	At 1 year BCVA (E-ETDRS Visual Acuity Test):		
			CPL	BCVA (letters) +3 SD13	p Value
			RPL	+9 SD11	<0.001 vs CPL
			RDL	+9 SD12	<0.001 vs CPL
			TPL	+4 SD13	NS vs CPL
			CPL	BCVA gain categories (letters)	
				+10 or more: 28%	
				+9 to –9: 59%	
			RPL	–10 or more: 13%	<0.001 vs CPL
				+10 or more: 50%	
			RDL	+9 to –9: 45%	<0.001 vs CPL
				–10 or more: 4%	
			TPL	+10 or more: 47%	<0.001 vs CPL
				+9 to –9: 51%	
				–10 or more: 3%	
				+10 or more: 33%	NS vs CPL
				+9 to –9: 52%	
				–10 or more: 14%	
			Subgroups:		
			► BCVA results in TPL group substantially better for pseudophakic eyes than for phakic eyes (comparable to results for RPL and RDL groups) (p not reported)		
			► No difference in results according to prior treatment for DMO, baseline VA, baseline CMT, baseline level of retinopathy, focal or diffuse oedema		
			CMT (OCT):	CMT (µm)	p Value
			CPL	–102 SD151	
			RPL	–131 SD129	<0.001 vs CPL
			RDL	–137 SD136	<0.001 vs CPL

Continued

Table 8 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)
	DMO; 61–68% with NPDR, 26–36% with PDR or PDR scars	'improvement' group continued treatment, other groups treated at investigator discretion; alternative treatment permitted if eye met criteria for 'failure' or 'futility'. In the case of retreatment, ranibizumab could be given as often as every 4 weeks, and triamcinolone every 16 weeks (with sham injections as often as every 4 weeks). Retreatment for focal/grid laser (after ≥13 weeks from previous treatment) if there was oedema involving or threatening the center of the macula and if complete laser had not been given; retreatment algorithms facilitated by web-based real-time data entry system. Median number of drug injections before 1 year visit was 8–9 for ranibizumab, 3 for triamcinolone, and 5 sham injections. Retreatment between 1 and 2 years (Elman 2011): median injections 2 in RPL group, 3 in RDL group; in TPL group 68% of eyes received at least 1 injection; at least one focal/grid laser sessions between 1 and 2 years: 51% CPL, 40% RPL, 29% RDL, 52% TPL	TPL Subgroups: ► pattern of CMT decrease similar for groups with CMT <400 and ≥400 µm at baseline ► Significantly more patients with severe NPDR or worse improved by 2 levels or more in the ranibizumab groups (28%, no significant change in the other groups) <i>At 2 years (expanded results, Elman 2011)</i> <i>BCVA (E-ETDRS Visual Acuity Test):</i> CPL (n=211) RPL (n=136) RDL (n=139) TPL (n=142) BCVA gain categories (letters) CPL RPL RDL TPL CMT (OCT): CPL RPL RDL TPL
			-127 SD140 BCVA (letters) +3 SD15 +7 SD13 +9 SD14 +2 SD19 +10 or more: 36% +9 to -9: 52% -10 or more: 13% +10 or more: 44% +9 to -9: 49% -10 or more: 7% +10 or more: 49% +9 to -9: 48% -10 or more: 3% +10 or more: 41% +9 to -9: 40% -10 or more: 19% CMT (µm) -138 SD149 -141 SD155 -150 SD143 -107 SD145
			<0.001 vs CPL p Value 0.03 vs CPL <0.001 vs CPL NS vs CPL NS vs CPL 0.01 vs CPL NS vs CPL p Value 0.003 vs CPL 0.01 vs CPL NS vs CPL

Continued

Table 8 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
Jorge <i>et al</i> ⁵¹ Brazil Design: Prospective RCT Follow-up: 24 and 48 weeks (to date, 73% and 56% of patients completed 24 and 48 weeks, respectively)	N: 63 eyes of 47 patients Inclusion criteria: Refractory center-involving DMO Exclusion criteria: NR Age: NR Sex: NR Diabetes type: NR HbA1c: NR Baseline VA: NR Baseline CMT: NR Comorbidities: NR	Laser Modified ETDRS protocol as used in prior DRCR.net protocols Group 1 (IVB 1.5 mg, n=NR): injections at baseline and monthly if CSFT (central subfield thickness) measured by SDOCT (spectral domain OCT) >275 µm Group 2 (IVR 0.5 mg, n=NR): injections at baseline and monthly if CSFT >275 µm	At 48 weeks		
			BCVA		
				Mean BCVA reduction from baseline (logMAR)	p Value
			IVB1.5	−0.21	vs baseline <0.05 at all-time points vs IVR0.5: no significant difference at all time-points
			IVR0.5	−0.21	vs baseline <0.05 at all time-points vs IVB1.5: no significant difference at all time-points
			CSFT		
				Mean CSFT reduction from baseline	p Value
			IVB1.5	−129.6 µm	vs baseline <0.05 at all-time points vs IVR0.5 no significant different at all-time points
			IVR0.5	−137.9 µm	vs baseline <0.05 at all-time points vs IVB1.5 no significant different at all-time points
			At 12 months		

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Table 8 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
Lim <i>et al</i> ⁶⁵	N: 111 eyes of 105 patients	Group 1 (IVB/IVT, n=36):	BCVA (logMAR)	<i>p</i> Value	
Korea	<i>Inclusion criteria:</i> eyes with clinically significant	IV injection of 1.25 mg (0.05 ml) IVB at 0 and 6 weeks and IV injection of 2 mg (0.05 ml) IVT at 0 weeks. Mean number of addition injection 1.28	IVB/IVT IVB IVT	−0.15 −0.16 −0.16	0.088 (between groups)
Design: 3-arm RCT	DMO based on ETDRS and DMO with central macular thickness of at least 300 µm by optical coherence tomography (OCT)	Group 2 (IVB, n=38): IV injection of 1.25 mg (0.05 ml) IVB at 0 and 6 weeks. Mean number of injections 2.54.	IVB/IVT IVB IVT	CMT (µm) −199 −17s9 −200	<i>p</i> Value 0.132 (between groups)
Follow-up: 12 months	<i>Exclusion criteria:</i> unstable medical status, including glycemic control and blood pressure; any previous treatment for DMO, including intravitreal, sub-Tenon injection or macular photocoagulation, history of vitreoretinal surgery, uncontrolled glaucoma; proliferative diabetic retinopathy with active neovascularisation, previous panretinal photocoagulation, presence of vitreomacular traction, history of systemic corticosteroids within 6 months, contraindications for bevacizumab or triamcinolone acetonide Age: 60.4 SD 7.4 (range 48–70) years Sex: 52% female Diabetes type: NR HbA1c: 7.2 SD 1.2–7.4 SD1.2 Baseline VA: 0.62 SD 0.23–0.65 SD 0.28 logMAR Baseline CMT: 447 SD 110–458 SD 92 µm Comorbidities: NR	Group 3 (IVT, n=37): IV injection of 2 mg (0.05 ml) IVT at 0 weeks. Mean number of injections 1.04 Unclear if rescue laser was available IVB injections were repeated if CMT appeared >300 µm on OCT in at least 6 weeks in all three groups			

Continued

Table 8 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)		
Soheilian <i>et al</i> ^{87 41 54 141} Iran <i>Design</i> : 3-arm RCT <i>Follow-up</i> : 36 weeks (Soheilian 2007 reports 12 week results of the same trial, these were not considered here)	N: 150 eyes of 129 patients <i>Inclusion criteria</i> : eyes with clinically significant DMO (ETDRS criteria) <i>Exclusion criteria</i> : previous panretinal of focal laser photocoagulation, prior ocular surgery or injection, history of glaucoma or ocular hypertension, VA \geq 20/40 or <20/300, iris neovascularisation, high risk PDR, significant media opacity, monocularly, pregnancy, serum creatinine \geq 3 mg/dL, uncontrolled DM Age: 61.2 SD6.1 years Sex: 47.3% female <i>Diabetes type</i> : not reported <i>HbA1c</i> : not reported <i>Baseline VA</i> : 0.55–0.73 SD0.26–0.28 logMAR <i>Baseline CMT</i> : 300–359 SD118–149 μ m <i>Comorbidities</i> : 94% NPDR, 6% early PDR	<i>Group 1 (IVB, n=50 eyes)</i> : IV injection of bevacizumab 1.25 mg (0.05 ml) (retreatment IVB 14 eyes) <i>Group 2 (IVB/IVT, n=50 eyes)</i> : IV injection of combined bevacizumab (1.25 mg (0.05 ml)) and triamcinolone (2 mg (0.05 ml)), followed by two injections of bevacizumab alone (retreatment IVB/IVT 10 eyes) <i>Group 3 (MPC, n=50 eyes)</i> : focal or modified grid laser (retreatment MPC 3 eyes) <i>Regimen for all groups</i> : Retreatments performed at 12 week intervals as required	At 36 weeks BCVA (Snellen chart):		
			IVB	BCVA (logMAR), SD	<i>p Value</i>
			IVB/IVT	–0.28 SD0.25 (+14 SD12.5 letters)	0.053 vs IVB/IVT or MPC
			MPC	–0.04 SD0.33 (+2 SD16.5 letters)	NS vs MPC
				+0.01 SD0.27 (–0.5 SD13.5 letters)	
			IVB	Snellen line changes	NS between groups
				+2 lines or more: 37%	
			IVB/IVT	stable within 2 lines: 59.3%	
				–2 lines or more: 3.7%	
			MPC	+2 lines or more: 25%	
				stable within 2 lines: 54.2%	
				–2 lines or more: 20.8%	
				+2 lines or more: 14.8%	
				stable within 2 lines: 66.7%	
				–2 lines or more: 18.5%	
			CMT (OCT):	CMT (μ m), SD	<i>p Value</i>
			IVB	–56 SD140	0.044 vs baseline, NS between groups
			IVB/IVT	–5 SD113	
			MPC	–8 SD67	

Continued

Table 8 Continued

Study	Participants and baseline values	Intervention	Outcome (change from baseline at study end)
			Subgroups: ▲ larger CMT reduction in subgroup with ≥ 400 μm at baseline (36 weeks: IVB -27.2 SD34.8%, IVB/IVT -8.8 SD35.9%, MPC -15.1 SD14.6%, $p < 0.001$ vs baseline in IVB and MPC groups only)
	BCVA, best corrected visual acuity; C, control; CMT, central macular thickness; CSME, clinically significant macular oedema; DDS, dexamethasone; DIL, dexamethasone followed by laser; DM, diabetes mellitus; DMO, diabetic macular oedema; DP, diastolic pressure; DR, diabetic retinopathy; HR QoL, health-related quality of life; IOP, intraocular pressure; IV, intravitreal; IVB, intravitreal bevacizumab; IVP, intravitreal pegaptanib; IVR, intravitreal ranibizumab; IVT, intravitreal triamcinolone; IVTL, intravitreal triamcinolone plus laser; IVVTE, intravitreal VEGF Trap Eye; L, laser; MLT/MPC, macular laser therapy/macular photocoagulation; NEI VFQ-25, National Eye Institute Visual Function Questionnaire-25; NPDR, non-proliferative diabetic retinopathy; NR, not reported; OCT, optical coherence tomography; PDR, proliferative diabetic retinopathy; PRP, panretinal photocoagulation; RCT, randomised controlled trial; SOC, standard of care; SP, systolic pressure; SRFA, flucocinolone; VA, visual acuity; VEGF, vascular endothelial growth factor.		

Adverse events are shown in tables 9 and 16. Conjunctival haemorrhages were higher in the ranibizumab arms compared with laser (RESTORE) or no treatment (RESOLVE). In the RESOLVE, RISE and RIDE studies, a considerably higher incidence of intraocular pressure (IOP) increase was reported in the ranibizumab arm compared to control. This increase in IOP was not demonstrated in the RESTORE study. There were no consistent differences in systemic adverse events between ranibizumab and laser or placebo.

Bevacizumab

Eight RCTs investigating the use of bevacizumab in DMO were identified (tables 4 and 8). One RCT, the BOLT study ($n=80$), randomised patients to laser therapy or 1.25 mg intravitreal bevacizumab.^{23 52} At 24 months, the mean changes in BCVA and the proportion of patients who gained 10 ETDRS letters or more was statistically significantly higher in the bevacizumab arm than in the laser arm. Faghihi *et al*⁵³ ($n=80$) compared 1.25 mg bevacizumab (average 2.23 injections per patient) with 1.25 mg bevacizumab plus a single laser treatment (average 2.49 injections per patient). After 6 months, the authors found both treatments to be effective at improving BCVA, but neither treatment was found to result in a greater benefit.

Lam *et al*⁵⁵ ($n=52$) compared two doses of bevacizumab (1.25 and 2.5 mg) in patients with diffuse DMO. Patients with focal DMO associated with localised retinal thickening were excluded. At 6 months, following 3 initial monthly injections (no treatment in the remaining 3 months), both groups showed a statistically significantly increased mean BCVA compared with baseline vision, but there was no difference between doses.

Four trials have investigated the combination of bevacizumab and triamcinolone. Ahmadi *et al*⁵¹ ($n=115$) compared combined bevacizumab (three 1.25 mg injections at 6 week intervals) plus triamcinolone (2 mg baseline injection only, Triamhexal) with bevacizumab alone (three 1.25 mg at 6 week intervals) and sham injection in patients who had DMO unresponsive (definition not reported) to previous laser (last session more than 3 months previously). The combination arm and bevacizumab alone arm improved mean BCVA more than the sham injection. For BCVA, the combination of bevacizumab plus triamcinolone was non-statistically significantly better than bevacizumab alone.

Soheilian *et al*^{57 41} ($n=150$) compared combined bevacizumab (1.25 mg) plus triamcinolone (2 mg) with bevacizumab alone and laser alone in patients who were laser naïve. At 36 weeks, bevacizumab alone improved BCVA more than either combination therapy or laser, although the difference was not statistically significant. Extended follow-up at 24 months showed that there was no statistically significant difference between groups for BCVA; however, the direction of effect favours the bevacizumab and combination arms more than the laser.⁵⁴

Table 9 Ranibizumab safety data

	READ-2 study ^{28 47}	RESOLVE study ³⁶	RESTORE study ²⁴	RISE study ³⁸	RIDE study ³⁸
<i>Number of patients</i>	IVR: n=42; L: n=42; IVRL: n=42	IVR0.3: n=51; IVR0.5: n=51; C: n=49	IVR: n=116; IVRL: n=118; L: n=111	IVR0.3: 125; IVR0.5: 126; C: 123	IVR0.3: 125; IVR0.5: 124; C: 127
Ocular adverse events					
Eye pain	NR	IVR0.3: n=9 (18%); IVR0.5: n=9 (18%); C: n=10 (20%)	IVR: n=13 (11%); IVRL: n=10 (8%); L: n=12 (11%)	IVR0.3: 26%; IVR0.5: 21%; C: 19%	IVR0.3: 8%; IVR0.5: 12.9%; C: 7.1%
Conjunctival hyperaemia	NR	NR	IVR: n=9 (8%); IVRL: n=6 (5%); L: n=6 (5%)	NR	NR
Conjunctival haemorrhage	NR	IVR0.3: n=10 (20%); IVR0.5: n=13 (25%); C: n=7 (14%)	IVR: n=8 (7%); IVRL: n=10 (8%); L: n=0	IVR0.3: 54%; IVR0.5: 52%; C: 32%	IVR0.3: 40.8%; IVR0.5: 50%; C: 31.5%
IOP increase	NR	IVR0.3: n=6 (12%); IVR0.5: n=15 (29%); C: n=1 (2%)	IVR: n=1 (<1%); IVRL: n=1 (<1%);	IVR0.3: 20%; IVR0.5: 14%; C: 2%	IVR0.3: 15.2%; IVR0.5: 18.5%; C: 11%
Vitreous haemorrhage	IVR: n=1 (2%); L: n=4 (10%); IVRL: n=3 (7%)	IVR0.3: n=1 (2%); IVR0.5: n=0; C: n=0	NR	IVR0.3: 3.2%; IVR0.5: 3.2%; C: 13%	IVR0.3: 0.8%; IVR0.5: 2.4%; C: 15%
Substantial worsening of DMO	L: n=1 (2%)		NR	NR	NR
Retinal ischaemia	NR	IVR0.3: n=0; IVR0.5: n=1 (2%); C: n=0	NR	NR	NR
Retinal artery occlusion	NR	IVR0.3: n=0; IVR0.5: n=1 (2%); C: n=0	NR	NR	NR
Endophthalmitis	NR	IVR0.3: n=1 (2%); IVR0.5: n=1 (2%); C: n=0	NR	IVR0.3: 0.8%; IVR0.5: 0; C: 0	IVR0.3+IVR0.5: 1.2%; C: 0%
Retinal detachment	NR	IVR0.3: n=0; IVR0.5: n=0; C: n=1 (2%)	NR	IVR0.3: 0.8%; IVR0.5: 0; C: 0.8%	IVR0.3+IVR0.5: 0.4%; C: 0%
Neovascularisation	NR	NR	NR	IVR0.3: 0; IVR0.5: 0; C: 0.8%	IVR0.3: 0.8%; IVR0.5: 0.8%; C: 5.5%
Traumatic cataract	NR	NR	NR	IVR0.3: 0.8%; IVR0.5: 0.8%; C: 0	IVR0.3+IVR0.5: 0.4%; C: 0%
Uveitis	NR	NR	NR	NR	IVR0.3+IVR0.5: 0.4%; C: 0%
Macular oedema	NR	NR	NR	IVR0.3: 16.8%; IVR0.5: 20.6%; C: 21.1%	IVR0.3: 19.2%; IVR0.5: 13.7%; C: 20.5%
Retinal exudates	NR	NR	NR	IVR0.3: 19.2%; IVR0.5: 17.5%; C: 20.3%	IVR0.3: 16%; IVR0.5: 15.3%; C: 11%

Continued

Table 9 Continued

	READ-2 study ^{28 47}	RESOLVE study ³⁶	RESTORE study ²⁴	RISE study ³⁸	RIDE study ³⁸
Retinal haemorrhage	NR	NR	NR	IVR0.3: 12.8%; IVR0.5: 12.7%; C: 20.3%	IVR0.3: 15.2%; IVR0.5: 22.6%; C: 18.9%
Cataract	NR	NR	NR	IVR0.3: 16.8%; IVR0.5: 11.9%; C: 14.6%	IVR0.3: 20%; IVR0.5: 23.4%; C: 23.6%
Vitreous detachment	NR	NR	NR	IVR0.3: 13.6%; IVR0.5: 11.1%; C: 15.4%	IVR0.3: 8.8%; IVR0.5: 12.9%; C: 15%
Ocular hyperemia	NR	NR	NR	IVR0.3: 15.2%; IVR0.5: 11.1%; C: 10.6%	IVR0.3: 3.2%; IVR0.5: 3.2%; C: 7.9%
Vitreous floaters	NR	NR	NR	IVR0.3: 12.8%; IVR0.5: 14.3%; C: 5.7%	IVR0.3: 7.2%; IVR0.5: 8.1%; C: 3.1%
Eye irritation	NR	NR	NR	IVR0.3: 10.4%; IVR0.5: 9.5%; C: 6.5%	IVR0.3: 5.6%; IVR0.5: 5.6%; C: 3.1%
Foreign body sensation in eyes	NR	NR	NR	IVR0.3: 12.8%; IVR0.5: 7.1%; C: 4.1%	IVR0.3: 8%; IVR0.5: 2.4%; C: 5.5%
Systematic adverse events					
Arterial thromboembolic events	Stroke in 1 pt (2%) in IVRL group- not related to study drug	IVR0.3: n=0; IVR0.5: n=3 (6%); C: n=2 (4%)	IVR: n=6 (5%); IVRL: n=1 (<1%); L: n=1 (<1%)	IVR0.3: 3.2% (n=1 stroke); IVR0.5: 7.9% (n=5 strokes); C: 7.3% (n=2 strokes)	IVR0.3: 1.6% (stroke), 5.6% (heart attack); IVR0.5: 2.4% (stroke), 2.4% (heart attack); C: 1.6% (stroke), 5.6% (heart attack)
Hypertension	NR	IVR0.3: n=4 (8%); IVR0.5: n=5 (10%); C: n=5 (10%)	IVR: n=9 (8%); IVRL: n=6 (5%); L: n=9 (8%)	Serious IVR0.3: 0.8%; IVR0.5: 3.2%; C: 0.8%	Serious IVR0.3: 1.6%; IVR0.5: 1.6%; C: 0%
Non-ocular haemorrhage	NR	IVR0.3: n=1 (2%); IVR0.5: n=1 (2%); C: n=0	IVR: n=1 (<1%); IVRL: n=0; L: n=1 (<1%)	NR	NR
Proteinuria	NR	NR	IVR: n=1 (<1%); IVRL: n=1 (<1%); L: n=0	NR	NR
Deaths	1 (2%) due to CVA in IVRL group	NR	IVR: n=2 (2%); IVRL: n=2 (2%); L: n=2 (2%)	IVR0.3: 2.4%; IVR0.5: 4%; C: 0.8%	IVR0.3: 3.2%; IVR0.5: 4.8%; C: 1.6%

C, control; DMO, diabetic macular oedema; IOP, intraocular pressure; IVR, intravitreal ranibizumab; IVRL, intravitreal ranibizumab plus laser; L, laser; NR, not reported.

Table 10 Bevacizumab safety

	BOLT study^{23 52}	Lam <i>et al</i>³⁵	Faghihi <i>et al</i>⁶³
<i>Number of patients</i>	MLT: n=38; IVB: n=42	IVB1.25, n=26; IVB2.5, n=26	IVB1.25 n=40 IVB 1.25 plus MLT n=40 Not reported
Ocular adverse events			
Loss of _15 or _30 ETDRS letters	MLT: n=1 transient, 3 at 24 month analysis; IVB: n=4 transient	No significant ocular events (IOP increase, retinal tear, retinal detachment, endophthalmitis); no significant difference in change in cataract scores between groups	
Vitreous haemorrhage	MLT: n=1; IVB: n=0		
Eye pain/irritation/watering during or after injection	MLT:n=0; IVB: n=8		
Red eye after injection	MLT: n=0; IVB: n=8		
Endophthalmitis	NR		
Transient IOP increase	≥30 mm Hg—MLT: 0; IVB: n=4 ≥45 mm Hg—MLT: n=1; IVB: n=1		
Floaters after injection	MLT: n=0; IVB: n=2		
Corneal epithelial defect	MLT:n=0; IVB:n=1		
Vitreomacular traction with macular oedema	MLT: n=1; IVB: n=0		
Systematic adverse events			
Anaemia	MLT: n=1; IVB: n=0	No systematic adverse effects (1 patient in 1.25 mg group with foot gangrene requiring amputation due to worsening diabetic neuropathy, considered unrelated to treatment)	
Vomiting after FFA	MLT: n=1; IVB: n=0		
Uncontrolled hypertension	MLT:n=0; IVB: n=1		
Polymyalgia rheumatica	MLT:n=0; IVB: n=1		
Intermittent claudication	MLT:n=0; IVB: n=1		
Gastroenteritis	MLT:n=0; IVB: n=1		
Fall	MLT:n=2; IVB: n=0		
Urinary tract infection	MLT:n=0; IVB: n=1		
Chest infection	MLT:n=0; IVB: n=1		
Headaches, dizziness, tiredness	MLT:n=1; IVB: n=0		
Bell palsy	MLT:n=1; IVB: n=0		
Admission for diabetic foot ulcer	MLT:n=1; IVB: n=1		
Admission for cholecystectomy	MLT:n=0; IVB: n=1		
Admission for fall/loss of consciousness	MLT:n=1; IVB: n=0		
Angina—hospital admission	MLT:n=1; IVB: n=0		
Cerebrovascular accident	MLT:n=1; IVB: n=0		
Myocardial infarction	MLT:n=0; IVB: n=2		
Coronary artery bypass graft	MLT:n=0; IVB: n=1		
Dyspnea, chest pain—admitted for hospital observation	MLT:n=0; IVB: n=1		
Death	NR		

ETDRS, Early Treatment Diabetic Retinopathy Study; FFA, fundus fluorescein; IOP, intraocular pressure; IVB, intravitreal bevacizumab; MLT, macular laser therapy; NR, not reported.

Table 11 Pegaptanib safety

	Cunningham <i>et al</i> /Adamis <i>et al</i> ^{39 57}	Sultan <i>et al</i> ⁴⁰
Number of patients	IVP0.3, n=44 eyes; IVP1, n=44 eyes; IVP3, n=42 eyes	IVP, n=133 eyes; C, n=127 eyes
Ocular adverse events		
Eye pain	Pegaptanib: 31%; C: 17%	IVP: 11.1%; C: 7%
Vitreous haemorrhage	Pegaptanib: 22%; C: 7%	IVP: 6.3%; C: 7.7%
Punctuate keratitis	Pegaptanib: 18%; C: 17%	IVP: 11.8%; C: 6.3%
Cataract	Pegaptanib: 13%; C: 10%	IVP: 8.3%; C: 9.2%
Eye discharge	Pegaptanib: 11%; C: 10%	NR
Conjunctival haemorrhage	Pegaptanib: 10%; C: 0%	IVP: 22.2%; C: 14.1%
Vitreous opacities	Pegaptanib: 9%; C: 5%	NR
Blurred vision	Pegaptanib: 7%; C: 5%	NR
Other vitreous disorder	Pegaptanib: 7%; C: 0%	NR
Other visual disturbance	Pegaptanib: 7%; C: 0%	NR
Culture-negative endophthalmitis	Pegaptanib: n=1	NR
IOP increase	NR	IVP: 17.4%; C: 6.3%
Retinal haemorrhage	NR	IVP: 6.3%; C: 10.6%
Retinal exudates	NR	IVP: 6.3%; C: 5.6%
Conjunctivitis	NR	IVP: 5.6%; C: 4.2%
Lacrimation increased	NR	IVP: 5.6%; C: 2.8%
Diabetic retinal oedema	NR	IVP: 11.1%; C: 17.6%
Macular oedema	NR	IVP: 9.7%; C: 11.6%
Systemic adverse events		
Non-ocular hypertension	NR	IVP: 13.9%; C: 9.9%
Cardiac disorders	NR	IVP: 6.9%; C: 5.6%
Deaths	NR	IVP: n=4

IOP, intraocular pressure; IVP, intravitreal pegaptanib; NR, not reported.

Lim *et al*⁵⁵ (n=111) also evaluated the combination of bevacizumab plus triamcinolone when compared with bevacizumab alone or triamcinolone alone. At 12 months, the authors found no statistically significant difference between groups for BCVA or CMT.

The Efficacy Study of Triamcinolone and Bevacizumab Intravitreal for Treatment of Diabetic Macular Oedema (ATEMD) study, currently only published in abstract form, compared combined therapy with bevacizumab (1.25 mg) and triamcinolone (4 mg) with each of these alone.⁵⁶ At 6 months, they found no statistically significant difference between groups. One study comparing bevacizumab with ranibizumab is discussed above.⁵¹ No bevacizumab trials were suitable for meta-analysis because treatment arms were not comparable among included studies.

Adverse events are shown in tables 10 and 16. There was a low frequency of adverse events reported in the included trials. A higher incidence of mild anterior chamber reaction was reported in bevacizumab groups compared with controls. The incidence of IOP increase was comparable between bevacizumab and laser. Soheilian *et al*^{37 41} were the only authors to report the incidence of lens opacity. No patients in the bevacizumab alone group were found to have lens opacities but in four patients (8%) in the bevacizumab plus triamcinolone group, this finding was observed over the 36-week follow-up period.

Pegaptanib

Two studies have evaluated pegaptanib in DMO and both compared it with sham injection (table 5). Cunningham *et al*^{39 57} compare three doses of pegaptanib (0.3, 1 and 3 mg) and sham injection in laser-naïve patients (n=172). At 6 months, patients in the 0.3 and 1 mg groups performed statistically significantly better than those in either the 3 mg or sham groups. Six injections (median) were administered in the 0.3 and 1 mg groups, whereas only five (median) injections were administered in the 3 mg group.

The second trial (n=260), reported by Sultan and colleagues in 2011, compared pegaptanib (0.3 mg) and sham injection. At 2 years, the pegaptanib group showed a statistically significantly greater improvement in mean BCVA compared with sham.⁴⁰ However, there was no statistically significant difference in the proportion of patients with an improvement of 10 letters or more. Patients were allowed rescue laser at the assessors' discretion (25.2% of patients in the pegaptanib group and 45% of patients in the sham group received rescue treatment). In regard to meta-analysis, data were only available to combine these trials for the proportion of patients with more than 15 letter gain. Although neither trial individually demonstrated a statistically significant difference favouring pegaptanib over sham (figure 5), when pooled together in meta-analysis, a statistically significant difference was found in favour of pegaptanib (OR 1.94, 95% CI 1.01 to 3.71).

Table 12 Aflibercept safety

	DA VINCI 2010 ^{30 58}
Number of patients	IVVTE (all doses) n=175, laser n=44
Ocular adverse events	
Conjunctival hemorrhage	At 6 months: Laser 18.2%, IVVTE 18.9% At 12 months: Laser 18.2%, IVVTE 26.9%
IOP increase	At 6 months: Laser 2.3%, IVVTE 9.7% At 12 months: Laser 2.3%, IVVTE 9.7%
Eye pain	At 6 months: Laser 4.5%, IVVTE 8.6% At 12 months: Laser 4.5%, IVVTE 13.7%
Ocular hyperaemia	At 6 months: Laser 4.5%, IVVTE 6.3% At 12 months: Laser 4.5%, IVVTE 7.4%
Vitreous floaters	At 6 months: Laser 4.5%, IVVTE 5.1% At 12 months: Laser 4.5%, IVVTE 6.9%
Endophthalmitis	At 6 months: Laser 0%, IVVTE 1.1% At 12 months: Laser 0%, IVVTE 1.1%
Uveitis	At 6 months: Laser 0%, IVVTE 0.6% At 12 months: Laser 0%, IVVTE 0.6%
Diabetic retinal oedema	At 6 months: Laser 2.3%, IVVTE 0% At 12 months: Laser 2.3%, IVVTE 4.6%
Visual acuity reduced	At 6 months: Laser 2.3%, IVVTE 0% At 12 months: Laser 2.3%, IVVTE 0%
Vitreous hemorrhage	At 6 months: Laser 2.3%, IVVTE 0% At 12 months: Laser 6.8%, IVVTE 0%
Corneal abrasion	At 6 months: Laser 0%, IVVTE 0.6% At 12 months: Laser 0%, IVVTE 4.6%
Retinal tear	At 6 months: Laser 0%, IVVTE 0.6% At 12 months: NR
Systematic events	
Hypertension	At 6 months: Laser 6.8%, IVVTE 9.7% At 12 months: Laser 0%, IVVTE 1.7%
Myocardial infarction	At 6 months: Laser 0%, IVVTE 1.1% At 12 months: Laser 0%, IVVTE 1.7%
Cerebrovascular event	At 6 months: Laser 0%, IVVTE 1.1% At 12 months: Laser 2.3%, IVVTE 1.7%
Death	At 6 months: Laser 0%, IVVTE 1.7% At 12 months: Laser 2.3%, IVVTE 4%

IOP, intraocular pressure; IVVTE, intravitreal vascular endothelial growth factor Trap Eye.

Adverse events for pegaptanib are shown in table 11. There was a higher incidence of eye pain compared to control (31% vs 17%).^{39 57} Cataract formation was similar between the pegaptanib and control groups. There was a higher incidence of IOP increase in the pegaptanib arm compared to control (17.4% vs 6.3%).⁴⁰

Other anti-VEGF

Aflibercept has been evaluated in the Da Vinci study (n=219)^{30 58} (table 5). Four regimens of aflibercept (0.5 mg 4 weekly, 2 mg 4 weekly, 2 mg monthly for 3 months, then every 8 weeks, and 2 mg monthly for 3 months followed by treatment as required) were compared with laser. At 6 months, all aflibercept arms had a statistically better BCVA and CMT change than the laser arm. The regimen that resulted in the greatest BCVA gain and CMT reduction was 2 mg every 4 weeks; however, statistical significance between aflibercept arms was not reported. One year extended follow-up showed

that all aflibercept arms were found to have a statistically significantly better BCVA compared to laser.⁵⁸

Adverse events are shown in table 12. There was a higher incidence of IOP increase and eye pain in the aflibercept group compared with laser. Other adverse events were too infrequent to draw meaningful conclusions. The incidence of cataracts was not reported.

Steroids

Dexamethasone

Two included trials assessed the use of dexamethasone to treat DMO (table 6): Haller 2010 (full text available)⁵⁹ and Callanan (available to date only in an abstract form).⁴⁴ Haller 2010 (n=171) compared two doses of dexamethasone, administered as an intravitreal implant (350 and 700 µm) through a 20-gauge trans-scleral incision, with no treatment. At 90 days only, the 700 µm group showed a statistically significantly higher proportion of patients with 10 or more letter gain

Table 13 Dexamethasone safety

	Callanan <i>et al</i> ⁴⁴	Haller <i>et al</i> ⁵⁹
<i>Number of patients</i>		
<i>Ocular adverse events</i>		
IOP elevation	DIL: 20% (p<0.001); 1% ≥10 mm HgL: 1.6% ; 0% ≥10 mm Hg	
Cataract	NR	NR
Anterior chamber cells	NR	DDS350: 29.1%; DDS700: 26.4%; C: 1.8%
Anterior chamber flare	NR	DDS350: 27.3%; DDS700: 20.8%; C: 8.8%
Vitreous haemorrhage	NR	DDS350: 20%; DDS700: 22.6%; C: 5.3%
Eye pain	NR	DDS350: 18.2%; DDS700: 9.4%; C: 3.5%
Vitreous disorder	NR	DDS350: 20%; DDS700: 15.1%; C: 3.5%
Increased IOP	NR	DDS350: 14.5%; DDS700: 9.4%; C: 0%
Conjunctival haemorrhage	NR	DDS350: 14.5%; DDS700: 7.5%; C: 0%
Vitreous floaters	NR	DDS350: 7.3%; DDS700: 17%; C: 0%
		No significant differences in: reduced VA, eye irritation, abnormal sensation in eye, macular oedema, eye pruritus, retinal hemorrhage, DR, nonocular events

Dil, dexamethasone followed by laser; DDS, dexamethasone; IOP, intraocular pressure; NR, not reported.

compared to no treatment (33% compared with 12%, p=0.007). The 350 µm group showed a non-statistically significant improvement compared with laser alone (21% compared with 12%). At 180 days, there was no statistically significant difference between either the dexamethasone group or no treatment group. The treatment effect appeared to peak at 3 months.

The second trial, by Callanan and colleagues (n=253), compared dexamethasone (dose not reported) plus laser with laser alone. Although a greater improvement in mean BCVA was seen at 1–9 months in the dexamethasone plus laser group compared with laser alone, there was no statistically significant difference at 12 months. A mean of 1.6 implants were used over the 12 month period.

These trials were not suitable for meta-analysis since one study is only available in abstract form.

Adverse events are shown in table 13. In the 350 and 700 µm groups compared with no treatment, there was a higher incidence of anterior chamber cells (29.1/26.4% compared with 1.8%), anterior chamber flare (27.3/20.8% compared with 8.8%), vitreous haemorrhage (20/22.6% compared with 5.3%) and increased IOP (14.5/9.4% compared with 0%). However, there was no statistically significant difference in cataract formation between groups at 12 months.⁵⁹ Callanan *et al*⁴⁴ reported an increase in IOP in the dexamethasone plus laser group compared with laser alone (20% compared with 1.6%).

Fluocinolone

Two trials assessed fluocinolone implant for DMO (table 6). The FAME study (n=956) compared two doses of fluocinolone (0.2 and 0.5 µg/day) with sham injection in patients with at least one prior laser treatment.²⁹

Approximately 25% of patients in each group had more than one prior laser treatment. At 24 months, both doses of fluocinolone showed a statistically significant improvement in mean BCVA compared to sham. There was a modest difference between fluocinolone groups. Rescue laser was given after the first 6 weeks for persistent oedema and was allowed every 3 months. A range of 35–37% of patients in the fluocinolone group and 59% in the sham injection group required rescue laser. Extended follow-up at 36 months showed that both the fluocinolone arms continued to result in a statistically significant benefit compared with sham.⁶⁰

Pearson *et al*⁴³ (n=196) compared fluocinolone (0.59 mg) with standard of care, either laser or no treatment. At 3 years, there was no statistically significant difference in the proportion of patients with 15 letter gain or more (31% fluocinolone compared with 20% standard of care) between groups and the proportion of patients losing 15 letters or more in the fluocinolone group (17% compared with 14%). Increased incidence of cataracts may have contributed to this difference.

These trials were not suitable for meta-analysis.

Adverse events are shown in table 14. Pearson and colleagues reported a higher incidence of cataracts at 3 years in the fluocinolone group compared with standard of care (55.9% compared with 21.7%). In the extended report of the FAME study, there was a considerably higher incidence of cataract surgery in phakic eyes in the 0.2 and 0.5 µg/day fluocinolone groups (80% and 87.2% compared with 27.3%) and increased IOP at any point (37% and 46% compared with 12%).

Following the demonstration in the FAME trial that a lower dose was about as good as higher ones, the higher doses are unlikely to be used.

Table 14 Fluocinolone safety

	FAME study (Campochiaro <i>et al</i>) ^{29 60}	Pearson <i>et al</i> ⁴³
<i>Number of patients</i>		
<i>Ocular adverse events</i>		
IOP at 12 months	NR	NR
Progression of cataract	NR	NR
Cataract	NR	SRFA: 55.9%; SOC: 21.7%
Transient vitreous floaters	NR	NR
Transient subconjunctival haemorrhage	NR	NR
Cataract surgery	SRFA0.2: 41.1% (74.9% of those without cataract surgery at baseline, 80% at 36 months); SRFA0.5: 50.9% (84.5% of those without cataract surgery at baseline, 87.2% at 36 months); C: 7% (23.1% of those without cataract surgery at baseline, 27.3% at 36 months)	NR
Glaucoma	SRFA0.2: 1.6%; SRFA0.5: 2.3%; C: 0.5%	NR
Increased IOP	SRFA0.2: 3.2%; SRFA0.5: 3.3%; C: 0%	SRFA: 69.3%; SOC: 11.6%
IOP >30 mm Hg at any point during 36 months	SRFA0.2: 18.4%; SRFA0.5: 22.9%; C: 4.3%	NR
Trabeculectomy	SRFA0.2: 2.1%; SRFA0.5: 4.8%; C: 0%	NR
Other glaucoma surgery	SRFA0.2: 1.3%; SRFA0.5: 1.3%; C: 0.5%	NR
Trabeculectomy	SRFA0.2: 0.8%; SRFA0.5: 2.3%; C: 0%	NR
Vitreous haemorrhage	NR	SRFA: 40.2%; SOC: 18.8%
Abnormal sensation in eye	NR	SRFA: 37%; SOC: 11.6%
Macular oedema	NR	SRFA: 34.6%
Eye pain	NR	SRFA: 26.8%; SOC: 15.9%
Eye irritation	NR	SRFA: 22%; SOC: 10.1%
Increased lacrimation	NR	SRFA: 22%; SOC: 8.7%
Photophobia	NR	SRFA: 21.3%; SOC: 21.7%
Blurred vision	NR	SRFA: 21.3%; SOC: 15.9%
Vitreous floaters	NR	SRFA: 21.3%; SOC: 8.7%
<i>Systemic adverse events</i>		
Serious cardiovascular events	SRFA0.2: 12%; SRFA0.5: 13.2%; C: 10.3%	
Pruritus	NR	SRFA: 38.6%; SOC: 21.7%
Deaths	NR	NR

IOP, intraocular pressure; NR, not reported; SOC, standard of care; SRFA, fluocinolone.

Triamcinolone

Ten trials evaluating triamcinolone were identified (tables 7 and 8). All trials evaluated intravitreal administration of triamcinolone, but there were no trials evaluating posterior or anterior subtenon injections. Two trials used Trivaris,^{21 61} two trials used Kenacort,^{32 33} one trial used Kenalog,⁶² one trial used Triamhexal³¹ and four trials did not report the type of triamcinolone used.^{34 3745 56} Three doses were assessed in the included studies (1, 4 and 8 mg) and triamcinolone has been combined with laser or bevacizumab.

Ip and colleagues (n=840) were the only authors to evaluate triamcinolone 1 mg (Trivaris).^{22 61 63 64} They found a statistically significant improvement in mean BCVA at 2 years in the laser group compared with the triamcinolone group and no significant difference between 1 compared with 4 mg.

Several trials compared 4 mg intravitreal triamcinolone. Ip and colleagues (n=840) found that laser therapy resulted in a greater improvement in mean BCVA at 2 years compared to 4 mg triamcinolone (Trivaris).^{22 61 63 64} Lam *et al*³⁴ (n=111) found no

Table 15 Triamcinolone safety

	DRCR Network 2008 (Ip <i>et al</i> /Beck <i>et al</i> / Bressler <i>et al</i>) ^{22 61 63 64}	Gillies <i>et al</i>/Sutter <i>et al</i>^{32 136–138}	Gillies <i>et al</i>³³	Kim <i>et al</i>⁴⁵	Lam <i>et al</i>³⁴	Ockrim <i>et al</i>/ Sivaprasad <i>et al</i>^{42 62}
<i>Number of patients</i>						
Ocular adverse events						
	At 2 years (or 3 years when indicated)	At 2 years	–	Not reported	–	At 12 months
IOP ≥30 mm Hg	IVT1: n=22; IVT4: n=53; L: n=3	NR	NR		NR	IVT: IOP significantly higher than in L group (18.2 mm Hg, range 12–26 mm Hg); no cases of glaucoma
IOP >22 mm Hg	NR	NR	NR		IVT: 37% (p=0.002 vs L); IVTL: 36% (p=0.002 vs L); L: 5%	NR
IOP ≥10 mm Hg from baseline	IVT1: n=41; IVT4: n=85; L: n=12	NR	NR		NR	NR
IOP ≥5 mm Hg	NR	IVT: 68% (p=0.007 vs C); C: 10%	NR		NR	NR
IOP lowering medication used	IVT1: n=31; IVT4: n=76; L: n=25	IVT: 44% (p=0.0002 vs C); C: 3%	IVTL: 64% (p<0.001); L: 24%		NR	NR
Cataract surgery	IVT1: 23% (of those phakic at baseline, 46% by 3 years (p<0.001 between all groups); IVT4: 51% (of those phakic at baseline, 83% by 3 years); L: 13% (of those phakic at baseline, 31% by 3 years)	IVT: 56% (of phakic eyes over 3 years, p<0.001 vs C); C: 8% (of phakic eyes over 3 years)			NR	NR
Ptosis	NR	NR	NR		NR	NR
Retinal detachment	IVT1: n=2; IVT4: n=4; L: n=2	NR	NR		None	NR
Retinal vein occlusion	IVT1: n=1; IVT4: n=2; L: n=3	NR	NR		NR	NR
Retinal artery occlusion	IVT1: n=0; IVT4: n=0; L: n=1	NR	NR		NR	NR
Anterior ischemic optic neuropathy	IVT1: n=1; IVT4: n=0; L: n=0	NR	NR		NR	NR
Vitrectomy	IVT1: n=26; IVT4: n=19; L: n=31	NR	NR		NR	NR
Open angle glaucoma	IVT1: n=2; IVT4: n=7; L: n=2	NR	NR		NR	NR
Glaucoma filtering surgery	IVT1: n=0; IVT4: n=2; L: n=0	NR	NR		NR	NR
Laser trabeculoplasty	IVT1: n=0; IVT4: n=1; L: n=0	IVT: n=2; C: n=0	IVTL: n=1		NR	NR
Ciliary body destruction	IVT1: n=0; IVT4: n=1; L: n=0	NR	NR		NR	NR

Continued

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Table 15 Continued

	DRCR Network 2008 (Ip <i>et al</i> /Beck <i>et al</i> / Bressler <i>et al</i>) ^{22 61 63 64}	Gillies <i>et al</i> /Sutter <i>et al</i> ^{32 136–138}	Gillies <i>et al</i> ³³	Kim <i>et al</i> ⁴⁵	Lam <i>et al</i> ³⁴	Ockrim <i>et al</i> / Sivaprasad <i>et al</i> ^{42 62}
Endophthalmitis	IVT1: n=0; IVT4: n=;0 L: n=0	(Infectious) IVT: n=1; C: NR	(Culture-negative) IVTL: n=1		None	(sterile) IVT: n=1
Pseudoendophthalmitis	IVT1: n=0; IVT4: n=;0 L: n=0	NR	NR		NR	NR
Chemosis	NR	NR	NR		NR	NR
Percentage of increase in cataract scores	NR	NR	NR		IVT:+1.0 SD1.1 (p=NS vs L); IVTL:+1.3 SD1.9 (p=NS vs L); L: +0.5 SD0.9	NR
Ocular hypertension (>21 mm Hg)	NR	NR	NR		NR	NR
Cataract progression	NR	NR	Phakic eyes, progression by ≥2 AREDS grade, IVTL: 64% (p<0.001); L: 11% (p<0.001)		NR	NR
Corneal decompensation	NR	IVT: NR; C: n=1	NR		NR	NR
Cataract surgery	NR	NR	IVTL: 61% (p<0.001); L: 0%		NR	IVT: n=2; L: n=1
Vitreous haemorrhage	NR	NR	NR		IVTL: n=1	
Lens opacity	NR	NR	NR		NR	Significantly greater change in lens opacity in IVT group than in L group (1.9)
Deaths	N=33, unrelated to study treatment	IVT: n=1; C: n=2	IVTL: n=2; L: n=1		NR	NR

CPL, control plus laser; IOP, intraocular pressure; NR, not reported; IVT, intravitreal triamcinolone; IVTL, intravitreal triamcinolone plus laser; RDL, ranibizumab plus deferred laser; RPL, ranibizumab plus laser; TPL, triamcinolone plus laser.

Table 16 Safety data in trials assessing more than one drug

	Ahmadieh ³¹	ATEMD 2011 (Oliveira Neto <i>et al</i>) ⁵⁶	DRCR Network 2010 (Elman <i>et al</i> ,) ^{21 46}	Lim <i>et al</i> ⁵⁵	Soheilian <i>et al</i> ^{37 41}
<i>Number of patients</i>					
<i>Ocular adverse events</i>					
Mild anterior chamber reaction	IVB: 19.5% (n=8 eyes), resolved after 1 week of no treatment; IVB/IVT: 18.9% (n=7 eyes), resolved after 1 week of no treatment	NR	NR	NR	IVB: 20% (n=10 eyes), resolved after 1 week; IVB/IVT: 18% (n=9 eyes), resolved after 1 week
Marked anterior chamber reaction	IVB: n=1 (topical corticosteroid and cycloplegic drops)	NR	NR	NR	IVB: n=1 (topical corticosteroids and cycloplegic drops);
Progression of fibrous proliferation	IVB: n=1 with no sign of retinal traction	NR	NR	NR	IVB: n=1 with no sign of retinal traction;
Vitreous haemorrhage	IVB/IVT: n=1 after third injection (excluded from study)	NR	NR	NR	NR
IOP rise	IVB: 23, 22 and 28 mm Hg at 6, 12 and 18 weeks (anti-glaucoma drops)	NR	IOP elevation more frequent with triamcinolone + PL	IVB/IVT: 8.3% IVT: 10.8%	NR
IOP ≥10 mm Hg from baseline	NR	NR	CPL: n=16; RPL: n=10; RDL: n=5; TPL: n=70	NR	NR
IOP ≥30 mm Hg from baseline	NR	NR	CPL: n=3; RPL: n=2; RDL: n=4; TPL: n=46	NR	NR
Initiation of IOP lowering treatment at any visit	NR	NR	CPL: n=9; RPL: n=5; RDL: n=4; TPL: n=41	NR	NR
Iris neovascularisation	None	NR	NR	NR	NR
Lens opacity	None	NR	NR	NR	Severe lens opacity IVB/IVT: n=4 eyes; MPC: n=1 eye
Endophthalmitis	NR	NR	CPL: n=1; RPL: n=1; RDL: n=1; TPL: n=0	NR	None
Pseudoendophthalmitis	NR	NR	CPL: n=1; RPL: n=0; RDL: n=0; TPL: n=1	NR	NR
Ocular vascular event	NR	NR	CPL: n=1; RPL: n=1; RDL: n=0; TPL: n=2	NR	NR
Retinal detachment	NR	NR	CPL: n=0; RPL: n=0; RDL: n=1; TPL: n=0	NR	None
Vitrectomy	NR	NR	CPL: n=7; RPL: n=0; RDL: n=3; TPL: n=0	NR	NR
Vitreous haemorrhage	NR	NR	CPL: n=15; RPL: n=3; RDL: n=4; TPL: n=2	NR	None

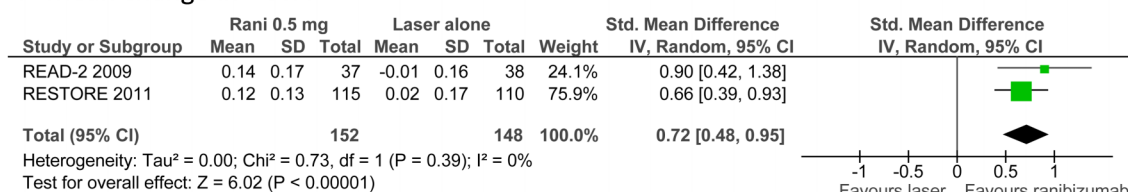
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Table 16 Continued

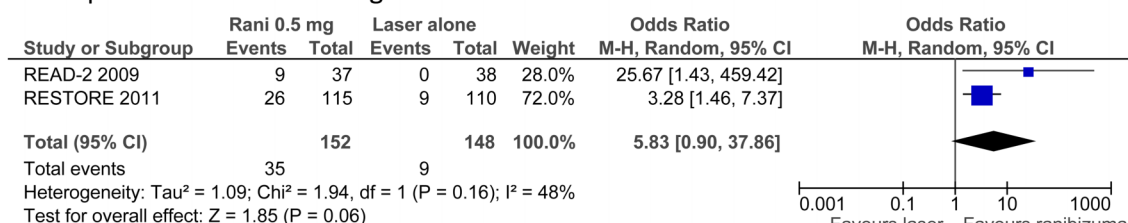
	Ahmadieh ³¹	ATEMD 2011 (Oliveira Neto <i>et al</i>) ⁵⁶	DRCR Network 2010 (Elman <i>et al</i> ,) ^{21 46}	Lim <i>et al</i> ⁵⁵	Soheilian <i>et al</i> ^{37 41}
Cataract surgery	NR	NR	CPL: n=11 (of those phakic at baseline); RPL: n=6 (of those phakic at baseline); RDL: n=8 (of those phakic at baseline); TPL: n=19 (of those phakic at baseline)	NR	NR
Glaucoma surgery	NR	NR	NR	NR	NR
Retinal neovascularisation	NR	NR	NR	NR	IVB: n=4 (all resolved); MPC: n=3 eyes (2 resolved)
Development of early PDR	NR	NR	NR	NR	IVB: n=1; IVB/IVT: n=4; MPC: n=3
Progression to high-risk PDR	NR	NR	NR	NR	IVB: n=4; IVB/IVT: n=3; MP: n=3
Ocular hypertension (≥23 mm HG)	NR	NR	NR	NR	IVB/IVT: 16% (n=8 of eyes), controlled medically in all except 1 that progressed to neovascular glaucoma
Systemic adverse events					
Acute myocardial infarction		N=1, considered not to be related to the study drug	No specific systemic adverse events that could be attributed to chance		No significant blood pressure increase, no thromboembolic events
Deaths	C: n=1	N=1, considered not to be related to the study drug	CPL: n=8; RPL: n=5; RDL: n=3; TPL: n=2		IVB/IVT: n=2; MPC: n=2

C, control; CPL, control plus laser; DMO, diabetic macular oedema; IOP, intraocular pressure; IVB, intravitreal bevacizumab; IVR, intravitreal ranibizumab; IVRL, intravitreal ranibizumab plus laser; IVT, intravitreal triamcinolone; L, laser; NR, not reported; PDR, proliferative diabetic retinopathy; RDL, ranibizumab plus deferred laser; RPL, ranibizumab plus laser; TPL, triamcinolone plus laser.

2.1 Mean change in BCVA



2.2 Proportion with >15 letter gain



2.3 CMT

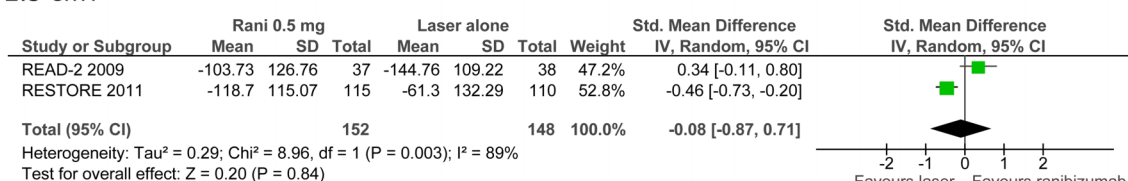
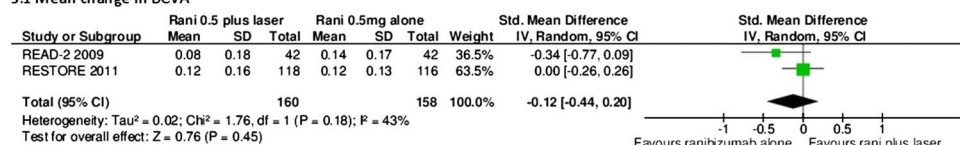


Figure 2 Ranibizumab 0.5 mg alone versus laser alone. (A) Mean change in best corrected visual acuity. (B) Proportion with >15 letter gain. (C) central macular thickness.

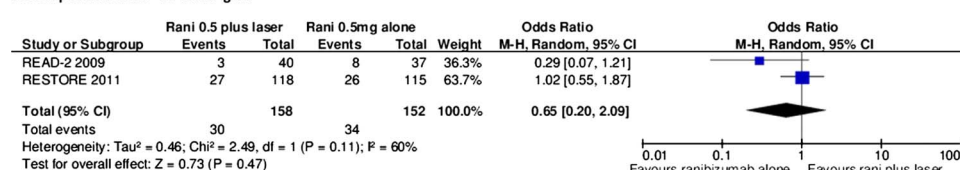
statistically significant difference between laser and triamcinolone at 6 months (triamcinolone type not reported). When these two trials were pooled through meta-analysis, the treatment effect favoured laser but the differences were not statistically significant (figure 6). Ockrim *et al*⁶² ($n=88$) compared 4 mg intravitreal triamcinolone (Kenalog) with laser alone. At 12 months, they

found no statistically significant BCVA improvement between the triamcinolone and laser groups. Gillies *et al*³² ($n=69$) compared 4 mg of triamcinolone (Kenacort) with sham injection. Mean BCVA improved statistically significantly with triamcinolone at 24 months compared with sham injection (3.1 letter gain compared with 2.9 letter loss, $p=0.01$).

3.1 Mean change in BCVA



3.2 Proportion with >15 letter gain



3.3 CMT

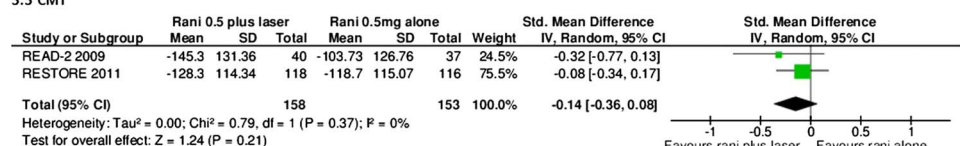
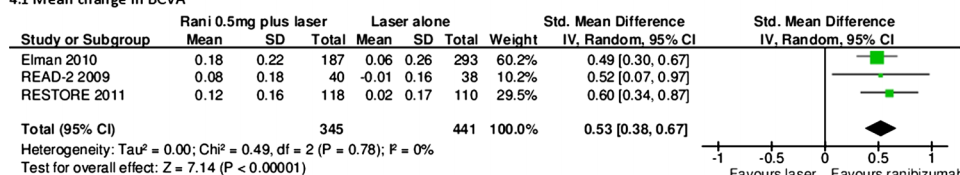
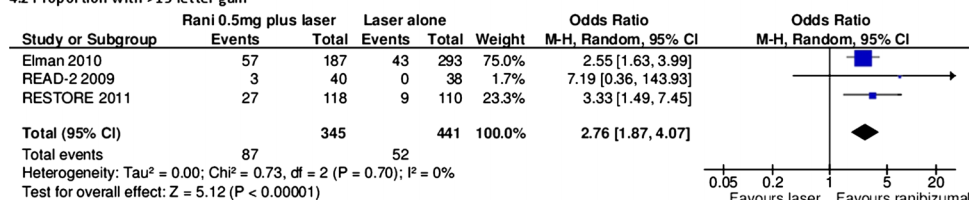


Figure 3 Ranibizumab 0.5 mg plus laser versus ranibizumab 0.5 mg alone. (A) Mean change in best corrected visual acuity. (B) Proportion with >15 letter gain. (C) central macular thickness.

4.1 Mean change in BCVA



4.2 Proportion with >15 letter gain



4.3 CMT

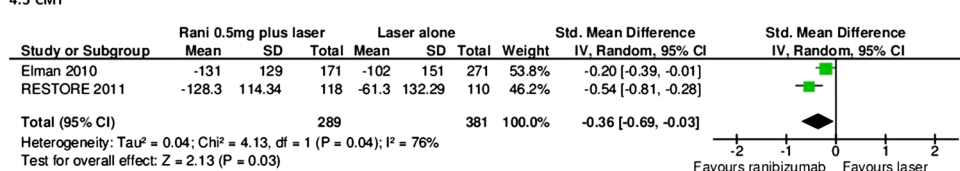


Figure 4 Ranibizumab 0.5 mg plus laser versus laser alone. (A) Mean change in best corrected visual acuity. (B) Proportion with >15 letter gain. (C) Central macular thickness.

Lam *et al*³⁴ (n=111) compared triamcinolone 4 mg alone with 4 mg of triamcinolone plus laser or laser alone. At 6 months, the authors found no difference in BCVA between any of the groups. Elman *et al*²¹ (n=854) compared 4 mg of triamcinolone (Trivaris) plus laser with ranibizumab plus prompt (within 3–10 days) or deferred (more than 24 week) laser and laser alone. At 2 years, they found a statistically significant difference in mean BCVA between ranibizumab plus prompt/deferred laser compared with laser alone (7 letter gain/9 letter gain compared with 3 letter gain), but no difference with triamcinolone plus laser compared with laser alone (2 letter gain compared with 3 letter gain). Neto *et al*⁶⁶ (n=120) compared 4 mg triamcinolone alone (triamcinolone type not reported) with 4 plus 1.25 mg bevacizumab. At 6 months, they found no statistically significant difference between groups.

The Elman and Lam studies were suitable for meta-analysis, which showed non-statistically significant improvements in mean BCVA and the proportions of patients with more or equal than 15 letter gain in the triamcinolone plus laser group compared with laser alone (figure 7).

Adverse events are shown in tables 15 and 16. Triamcinolone was associated with consistently higher incidences of IOP increase and cataracts. Gilles and colleagues reported a cataract rate of over 50% by 3 years in patients treated with triamcinolone.

Other pertinent studies

Only one study in abstract form directly compared bevacizumab with ranibizumab.⁵¹ Bevacizumab and ranibizumab have been compared through an indirect comparison of five trials.⁶⁵ There was no evidence of a difference between the drugs; however, wide credible intervals meant that the superiority of either drug could not be excluded.

Two-year results of the CATT (Comparison of AMD Treatment Trials) and 1 year results of the IVAN (Inhibit VEGF in Age-related choroidal Neovascularisation), recently published, have demonstrated a good safety profile of anti-VEGF therapies when used to treat patients with age-related macular degeneration.^{66 67} The CATT study randomised 1208 patients with AMD to monthly or as required injection of either ranibizumab or bevacizumab. At 1 year, the mean BCVA was similar in

5.1 Proportion with >15 letter gain

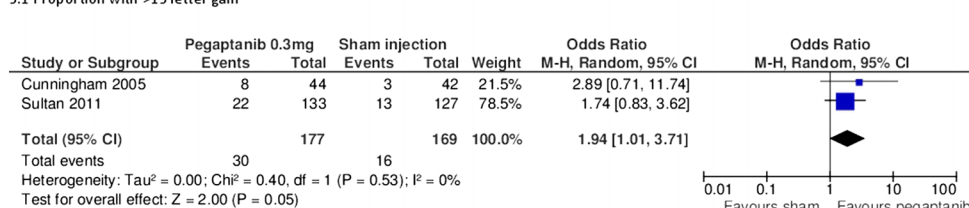


Figure 5 Pegaptanib 0.3 mg versus sham injection. (A) Proportion with >15 letter gain.

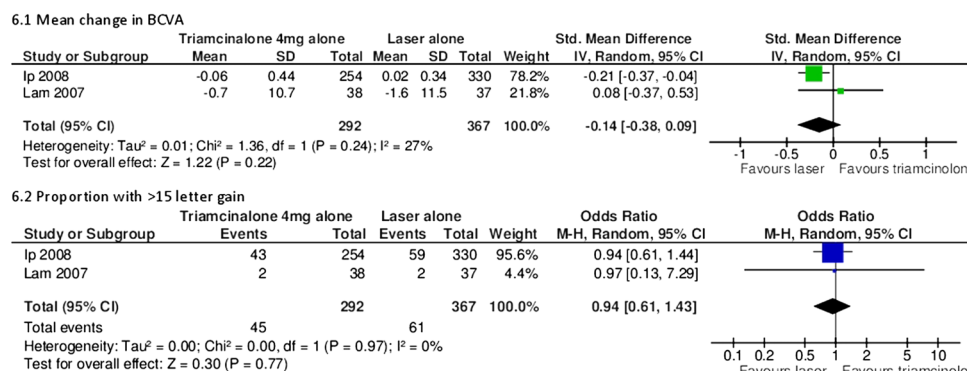


Figure 6 Triamcinolone 4 mg versus laser alone. (A) Mean change in best corrected visual acuity. (B) Proportion with >15 letter gain.

both groups (8 letter gain in bevacizumab and 8.5 in ranibizumab). Over 2 years, the rates of deaths, myocardial infarction and stroke did not differ between the ranibizumab and bevacizumab treatment groups. However, there was a higher rate of serious adverse events in the bevacizumab group compared with the ranibizumab group. This increased event rate was driven mainly by hospitalisations (RR 1.29, 95% CI 1.01 to 1.66). However, the hospitalisations were not caused by known adverse events of bevacizumab. Arteriothrombotic events and heart failure occurred in less than 2% of participants in the IVAN, and they were more often observed in the ranibizumab group than in the bevacizumab group ($p=0.03$). Further data from other ongoing clinical trials may provide more insight on the safety or anti-VEGF treatment and possible differences on this respect among available drugs.

Campbell *et al*⁶⁸ conducted a population-based nested case-control study of 91 378 older adults with a history of physician-diagnosed retinal disease. The authors found that neither ranibizumab nor bevacizumab was associated with significant risks of ischaemic stroke, acute myocardial infarction, congestive heart failure or venous thromboembolism.

A recent systematic review specifically assessing adverse events in anti-VEGF drugs found a low incidence of

serious (below 1 in 100) and non-serious ocular events (below 1 in 500) from ranibizumab, bevacizumab and pegaptanib.⁶⁹

Fung *et al*⁷⁰ used an internet-based survey of clinicians to assess the safety of bevacizumab. The survey covered over 5000 patients and found that bevacizumab was associated with an infrequent incidence of adverse events (all less than 0.21%).

One study, which assessed diclofenac, did not meet the inclusion criteria (follow-up for only 12 weeks).⁷¹ The authors randomised 32 patients to either intravitreal diclofenac or triamcinolone and found that both diclofenac and triamcinolone reduced CMT, but a statistically significant visual improvement was observed only in the triamcinolone group.

Sfikakis *et al*⁷² undertook a 30-week randomised cross-over trial comparing infliximab and placebo. The study failed to meet our inclusion criteria (only 11 patients included). The authors found that infliximab resulted in a 28.6% improvement in vision compared with 4.3% with placebo. The improvement seen with placebo could be due to a 'carry over effect', seen in cross-over trials.

The Fenofibrate Intervention and Event Lowering in Diabetes (FIELD) trial was primarily a study to see if the lipid-lowering agent fenofibrate could reduce macrovascular and microvascular events in type 2 diabetes.⁷³

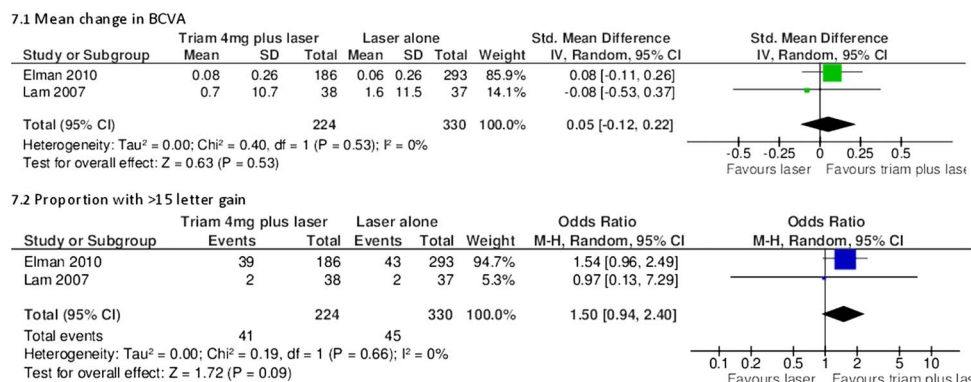


Figure 7 Triamcinolone 4 mg plus laser versus laser alone. (A) Mean change in best corrected visual acuity. (B) Proportion with >15 letter gain.

However, a substudy within FIELD recruited 1012 patients to a retinopathy study. The primary outcome in the main study was need for laser therapy (3.4% on fenofibrate vs 4.9% on placebo), but the substudy used retinal photography to assess progression of retinopathy or development of macular oedema. The HR at 6 years for DMO was 0.69 (95% CI 0.54 to 0.87) in the fenofibrate group compared to placebo.

Ruboxistaurin is another oral agent which has been assessed for the treatment of DMO. Aiello and colleagues randomised 686 patients to receive placebo or one of three doses of ruboxistaurin.^{74 75} There was no statistically significant difference in delay to sight-threatening DMO in any ruboxistaurin group compared to placebo. The authors suggest that differences in laser treatment between groups may have contributed to the non-significant finding.

Assessment of heterogeneity within meta-analysis

Heterogeneity was assessed methodologically and statistically. Methodological heterogeneity was assessed by comparing the study population, interventions, outcome measures and follow-up. Studies that were not methodologically comparable were excluded from the meta-analysis. For example, bevacizumab trials were not pooled because Soheilian *et al*⁸⁷ included patients who were laser naïve and Ahmadiéh *et al*⁸¹ included patients who were unresponsive to laser. Some analyses were also excluded because sufficient details were not reported in the studies. For example, several studies failed to report SDs.^{35 39}

Statistical heterogeneity was assessed through I^2 scores. High statistical heterogeneity was found in two analyses (2.3 and 4.3). Therefore, these results should be interpreted with due caution. Moderate heterogeneity was found in three analyses (2.2, 3.1 and 3.2). Low heterogeneity was found in the remaining eight analyses.

Ongoing trials

There are numerous ongoing studies listed in appendix 2. The most salient studies include a study to compare ranibizumab and bevacizumab (Schmidt-Erfurth), a study investigating rescue ranibizumab treatment for patients who have failed on bevacizumab (Chaudhry), a study evaluating two algorithms for ranibizumab, 'treat and extend' and 'as required' (RETAIN), further studies of Trap-eye (VIVID and VISTA) and trials which are examining the use of NSAIDs, such as diclofenac and nepafenac (NEVANAC and Soheilian).

DISCUSSION

It appears that anti-VEGF treatment is effective in DMO, especially ranibizumab and bevacizumab. Meta-analysis of available short-term data (up to 2 years) suggests that ranibizumab is superior to laser and that adding laser to ranibizumab treatment does not confer additional benefit. Steroid treatment has demonstrated mixed success and, almost uniformly, increased the incidence

of cataracts and IOP. The licence for fluocinolone takes note of this and it is positioned as a treatment when others have failed.

Strengths and limitations of the review

There are a number of strengths of this review. A robust systematic review methodology was used. Reliability was improved by excluding trials with small sample sizes or short follow-up. Since a number of trials included similar intervention arms, consistent treatment effects further improve reliability. Validity was improved by assessing the quality of trials using the Cochrane risk of bias tables. Including abstracts from ARVO provided up-to-date results. Pooling results through meta-analysis provided further evidence. The random effects model was used throughout to allow for heterogeneity among studies.

This review, however, has limitations. Although the inclusion of abstracts provides more up-to-date results, the studies contained in these abstracts could not be assessed for risk of bias and should therefore be interpreted with caution. In addition, reporting of quality assessment criteria was variable. Allocation concealment was especially poorly reported. There was only one study which compared different anti-VEGFs⁵¹ and none that compared steroids (fluocinolone vs dexamethasone vs triamcinolone). Therefore, it is difficult to assess the effectiveness within drug classes. As with any meta-analysis, questions of heterogeneity arise. Follow-up periods varied among studies. A difference of 6 months was allowed for studies to be pooled for meta-analysis, but this could have still resulted in heterogeneity. High statistical heterogeneity was found in a quarter of the analyses. Furthermore, because of the low number of trials included, publication bias could not be assessed by funnel plot analysis. The manufacturers funded most of the trials for ranibizumab, pegaptanib, dexamethasone and fluocinolone, whereas trials for bevacizumab and triamcinolone were generally funded by non-pharmaceutical organisations. Generally, the non-commercial studies had smaller numbers, perhaps because of the funding restraints.

It is important to note that there may be differences in laser treatment protocol between studies. This applies to trials which combine drug treatments with laser or include laser as a comparator. All studies referred to the ETDRS protocol^{19 20} or a modified version of it. In the ETDRS, once a diagnosis of clinically significant macular oedema was made, an angiogram was obtained to identify 'treatable lesions'. 'Treatable lesions' included discrete points of retinal hyperfluorescence or leakage (most of these are often microaneurysms), areas of diffuse leakage within the retina related to microaneurysms, intraretinal microvascular abnormalities, diffusely leaking retinal capillary bed and retinal avascular zones. In the ETDRS protocol, treatment of lesions closer than 500 microns from the centre of the macula was not required initially; however, if vision was less than 20/40 and the oedema and leakage persisted, treatment up to 300 microns from the centre of the macula was

recommended unless there was capillary dropout; in the latter case, treatment was not recommended as it may lead to further loss of perifoveal capillaries.

However, in routine clinical practice, clinicians generally use lighter and less intense treatment than specified in the ETDRS protocol.⁷⁶ In addition, some centres do not use fluorescein angiography (unlike the ETDRS study¹⁹) to guide treatment. The exact adherence to the ETDRS protocol within studies is unclear. For example, in the BOLT study, a modified ETDRS protocol was used. One of the aims of the protocol was 'not darkening/whitening of microaneurysms', which is not consistent with the ETDRS protocol.

Interpretation of the results

The anti-VEGF drugs appear to be clinically effective in treating DMO in short-term studies (up to 2 years). Ranibizumab has the most robust evidence base and has shown superiority compared to laser and sham injection in all trials and meta-analyses, except for the proportion of patients with 10 or more letter gain in the DRCR.net study published by Elman *et al*⁴⁶ at 2 years follow-up. Adding laser to ranibizumab conferred no benefit. Bevacizumab has also been shown to be superior to laser. Three doses have been used (1.25, 1.5 and 2.5). The higher dose does not appear to add further benefit, and most studies in the literature use 1.25 mg. The addition of triamcinolone to bevacizumab did not provide further benefits. Pegaptanib has only been compared to sham injection. Mean change in BCVA favoured pegaptanib, but only through meta-analysis did the proportion of patients with more than 15 letter gain favour pegaptanib. Further published data are required before drawing conclusions on aflibercept. However, although the anti-VEGF drugs are a significant advance, they fail to improve BCVA by 10 or more letters in half or more patients, and so they do not provide a complete answer to DMO.

Steroid treatments have inconsistent results and are undoubtedly associated with increased IOP and cataract. The effects of dexamethasone appear to peak at 3 months. At 6 months, there was no significant difference compared with laser. This might imply that earlier retreatment is needed if the beneficial effect is to be maintained, but increasing the number of treatments would very likely increase the associated complications, especially with the relatively large needle size. The addition of laser did not appear to add further benefit. There was no significant difference in cataract formation at 6 months with dexamethasone compared to observation, but it is likely that a higher incidence of cataracts would be seen with longer follow-up. Significantly more patients suffered increased IOP in the dexamethasone group compared with observation. Fluocinolone has been shown to be effective compared with sham injection (FAME);^{29 60} however, when compared to standard of care (laser or observation at clinician's discretion), there was no significant difference in the proportion of

patients with a 15 letter or more gain. Both studies reported higher incidence of cataract formation in the fluocinolone group, with over 80% at 3 years at the higher dose. Results for triamcinolone are inconsistent. Ip *et al*⁶¹ found that laser was more effective, while others have found no statistically significant difference. Triamcinolone combined with laser, however, seemed to have similar efficacy as ranibizumab combined with laser in pseudophakic eyes.^{21 46} Triamcinolone is more effective than sham injection. Triamcinolone has consistently been associated with increased incidence of cataract and raised IOP.

Steroids and laser therapy may affect CMT in a different manner from anti-VEGF drugs. For example, when ranibizumab alone is compared with ranibizumab plus laser, it appears to be more effective in terms of mean change in BCVA and proportion of patients with more than 15 letter gain. However, ranibizumab plus laser is more effective at reducing CMT. Furthermore, when triamcinolone plus laser is compared with ranibizumab plus laser, the latter appears to be more effective in terms of change in BCVA and proportion of patients with more than 15 letter gain, but triamcinolone plus laser is more effective at reducing CMT. The reasons for this are unclear. There is a weak correlation between CMT and BCVA. However, the long-term benefits of reducing CMT are currently unknown.

No large observational studies were identified that compared anti-VEGF drugs. Using an internet-based survey, Fung *et al*⁷⁰ found the incidence of adverse events in bevacizumab to be low. One small outbreak of sterile endophthalmitis was reported with a single batch of bevacizumab in Canada, emphasising the need for sterility when preparing aliquots.⁷⁷ Curtis *et al*⁷⁸ carried out a very large retrospective cohort study in 146 942 patients aged 65 and over with age-related macular degeneration (AMD). Their aim was to examine cardiovascular outcomes in patients treated with the four options: photodynamic therapy (PDT), pegaptanib, bevacizumab and ranibizumab. The authors reported that one of their comparisons showed an increase in overall mortality and stroke risk with bevacizumab compared to ranibizumab, with HRs of 0.86 (95% CI 0.75 to 0.98) and 0.78 (0.64 to 0.96), respectively. However, owing to the very large cost differences between bevacizumab and ranibizumab, the authors noted that selection bias might be operating, with poorer people (with poorer health) more likely to be treated with bevacizumab. They therefore carried out another analysis using only ophthalmological clinics which used only one drug, to avoid selection bias. This analysis showed no significant difference: overall mortality HR for ranibizumab 1.10 (95% CI 0.85 to 1.14); MI 0.87 (0.53 to 1.14); stroke 0.87 (0.61 to 1.24).

Gower *et al*⁷⁹ analysed 77 886 anti-VEGF injections from Medicare data (46% ranibizumab and 54% bevacizumab). Results have only been published in abstract form. The authors found an increased risk of overall mortality and cerebrovascular events in the bevacizumab

group (HR 1.11 99% CI 1.01 to 1.23 and 1.57, 1.04 to 2.37, respectively). There was no statistically significantly increased risk in the ranibizumab group. The authors acknowledge that a limitation of the study is a failure to adjust for important confounding factors (such as smoking, hypertension and hyperlipidaemia). Considering the cost difference, it is likely that patients treated with bevacizumab would have been in a lower socioeconomic class and therefore at high risk of mortality and vascular disease.

Implications for clinicians

The anti-VEGF drugs appear to be a significant advance in the treatment of DMO and are regarded now as the treatment of choice for patients affected by this condition. Studies assessing the effectiveness of steroids have reported mixed results. The high rates of cataract and increased IOP are a drawback. Triamcinolone combined with laser may be a good option for pseudophakic patients and may be more cost-effective than treatment with ranibizumab. However, the need for fewer administrations, potentially one every 3 years with fluocinolone, is advantageous. From an administration perspective, some patients might prefer infrequent steroid injections with a sizeable risk of cataract, and a small, but existent, risk of glaucoma, to frequent anti-VEGF injections, even if the potential gain may not be fully comparable. Steroids may also be considered for patients who do not adequately respond to anti-VEGFs. Currently, the role of laser in the treatment of DMO is debatable. Short-term data from available trials have demonstrated the superiority of anti-VEGF with regard to laser treatment but have failed to demonstrate a benefit of combining both treatment approaches. It is possible that some ophthalmologists may still opt to offer laser treatment to patients with very focal areas of leakage.

Currently, there is more evidence for the effectiveness of ranibizumab and bevacizumab than for pegaptanib and VEGF-trap eye. The results of direct head to head trials of ranibizumab and bevacizumab are awaited. Bevacizumab is not licensed for intraocular use but costs considerably less than other forms of therapy. Ranibizumab is licensed and more expensive, but its use is supported by large manufacturer-funded trials demonstrating its clinical effectiveness. In the UK, the General Medical Council recommends that unlicensed medications should only be prescribed if 'an alternative, licensed medicine would not meet the patient's needs' and there is 'a sufficient evidence base and/or experience of using the medication to demonstrate its safety and efficacy'.⁸⁰ The FDA says that when using a drug 'off-label', clinicians 'have the responsibility to be well informed about the product, to base its use on firm scientific rationale and on sound medical evidence, and to maintain records of the product's use and effects'.⁸¹ Patients should be fully aware of the use of any unlicensed medication and consent to any safety or efficacy uncertainties.

The place of intravitreal steroids needs consideration now that we have the anti-VEGFs drugs, as does the role of laser. The anti-VEGFs drugs may now be the first-line treatment in place of laser, with laser being used selectively for focal lesions, and in sequence after anti-VEGF therapy once the retinal thickness has been reduced. However, it should be noted that about half of the patients do not get good results with anti-VEGFs. In RESTORE, only 50% of patients had gains in VA of 10 or more letters. So the anti-VEGFs are 'game-changers', but their impact should not be overestimated.

In those who do not respond to anti-VEGFs or laser, there remains a place for steroids, despite their high adverse effect rates. The European licence for fluocinolone recognises this, by stating that it should be used when other therapies have not had sufficient effect.⁸² The commonest adverse effect is cataract, but that is very common in people with diabetes, and many are already pseudophakic when treatment of DMO is required.

Vitreoretinal surgery for the treatment of DMO was not included in our review. Laidlaw reviewed the literature and only found evidence for vitrectomy when there were signs of clinical or OCT traction.⁸³ However, even in these cases, the evidence was not strong.

Implications for policy makers

In the UK, the National Institute of Health and Clinical Excellence (NICE) has recently made the decision not to recommend ranibizumab for the treatment of DMO.⁸⁴ NICE concluded that ranibizumab, although clinically effective, was not cost-effective compared to laser therapy. Bevacizumab is less than a tenth of the cost of ranibizumab but is unlikely to be licensed. This beckons the question as to whether policy makers should recommend cheaper unlicensed medications over a more expensive licensed alternative when their efficacy and side effects appear to be similar.

Unanswered questions

Several unanswered questions remain. Studies evaluating the effectiveness of ranibizumab compared with bevacizumab are needed. Although the anti-VEGFs are clinically effective and a major step forward in the management of DMO, it has to be noted that they have little effect in a large number of patients. Generally speaking, the proportion of patients who have demonstrated 10 or more letter gain using anti-VEGFs is between 30% to 50% in the trials that demonstrate the greatest effectiveness. Most of these patients would not achieve the 20/40 visual acuity required for driving. More effective treatments, or combinations of treatments, are required.

There is a lack of specific evidence for the use of anti-VEGF drugs or steroids in patients with macular ischaemia secondary to DMO. A number of trials excluded patients with macular ischaemia.^{23 34 35 40 53 62} The RESTORE trial included patients with macular

ischaemia and undertook a subgroup analysis.²⁴ The authors compared patients with (n=34) and without (n=35) macular ischaemia at baseline. They found that those without macular ischaemia responded better to ranibizumab (mean average change in BCVA at 12 months 7.2 letters gain compared with 6.3 letters). Larger trials are needed to assess the use of anti-VEGF drugs and steroids in patients with macular ischaemia.

The duration of treatment is as yet uncertain. Most of the included studies use a retreatment protocol based on clinical need or OCT results. For example, in the BOLT study, patients received a median of nine injections of bevacizumab over 24 months.^{23 85} However, it is not yet known for how frequent long-term maintenance injections will be needed and whether laser treatment in sequence could potentially reduce the number of anti-VEGF injections required. Other treatment strategies to apply laser, such as using laser power at subthreshold levels, may prove more effective.⁸⁶ Future trials should use active comparators which are used in routine clinical practice and avoid placebo-controlled trials.

CONCLUSION

This review evaluated current treatments for DMO. Undoubtedly, the use of anti-VEGFs heralds a new era for patients who suffer from DMO. Currently, the anti-VEGFs ranibizumab and bevacizumab have consistently shown good clinical effectiveness without major unwanted side effects. Steroid results have been mixed and are usually associated with cataract formation and IOP increase. Based on the short-term data available, adding laser therapy to anti-VEGFs does not appear to confer additional benefit.

Despite the current wider spectrum of treatments for DMO, only a small proportion of patients recover good vision ($\geq 20/40$), and thus the search for new therapies to prevent and manage DMO needs to be continued.

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APPENDIX 1: METHODS OF THE LITERATURE SEARCH

Searches for clinical trials

Ovid MEDLINE 1948-week 2 July 2012 and Ovid MEDLINE(R) In-Process and Other Non-Indexed Citations 11 July 2012

1. Diabetic Retinopathy/dt (Drug Therapy)
2. Macular Edema/dt (Drug Therapy)
3. (diabet* adj2 macular adj (edema or oedema)).tw.
4. (diabet* adj2 maculopathy).tw.
5. (diabet* adj2 retinopathy).tw.
6. 1 or 2 or 3 or 4 or 5
7. (ranibizumab or lucentis or bevacizumab or avastin or pegaptanib or macugen or aflibercept or vegf trap-eye or steroid* or corticosteroid* or dexamethasone or fluocinolone or triamcinolone or anti-VEGF* or anti-vascular endothelial growth factor*).tw.
8. exp Vascular Endothelial Growth Factor A/
9. exp Fluocinolone Acetate/
10. exp Triamcinolone/
11. 7 or 8 or 9 or 10
12. 6 and 11
13. randomised controlled trial.pt.
14. controlled clinical trial.pt.
15. (masked or sham or placebo or control group or random*).tw.
16. 13 or 14 or 15
17. 12 and 16
18. (case reports or editorial or letter or review).pt.
19. 17 not 18
20. limit 19 to humans

EMBASE 1947–2012 week 27

1. (ranibizumab or lucentis or bevacizumab or avastin or pegaptanib or macugen or aflibercept or vegf trap-eye or dexamethasone or fluocinolone or triamcinolone or anti-VEGF* or anti-vascular endothelial growth factor*).m_title.
2. (diabetic macular edema or diabetic macular oedema or diabetic retinopathy or diabetic maculopathy).m_title.
3. 1 and 2
4. random*.tw.
5. 3 and 4

Cochrane Central Register of Controlled Trials, Issue 7 of 12, July 2012

Ranibizumab or lucentis or bevacizumab or avastin or pegaptanib or macugen or aflibercept or vegf trap-eye or steroid* or corticosteroid* or dexamethasone or fluocinolone or triamcinolone or anti-VEGF* or anti-vascular endothelial growth factor* in Record Title and diabetic macular edema or diabetic macular oedema or diabetic retinopathy or diabetic maculopathy in Record Title

Web of Science—with Conference Proceedings (updated 12 July 2012)

Title=(ranibizumab or lucentis or bevacizumab or avastin or pegaptanib or macugen or aflibercept or vegf trap-eye or steroid* or

corticosteroid* or dexamethasone or fluocinolone or triamcinolone or anti-VEGF* or anti-vascular endothelial growth factor*) AND Title=(diabetic macular edema or diabetic macular oedema or diabetic retinopathy or diabetic maculopathy) AND Title=(random*)

Searches for systematic reviews

Ovid MEDLINE(R) Daily Update 11 July 2012, Ovid MEDLINE(R) In-Process and Other Non-Indexed Citations 11 July 2012

1. Diabetic Retinopathy/dt (Drug Therapy)
2. Macular Edema/dt (Drug Therapy)
3. (diabet* adj2 macular adj (edema or oedema)).tw.
4. (diabet* adj2 maculopathy).tw.
5. (diabet* adj2 retinopathy).tw.
6. 1 or 2 or 3 or 4 or 5
7. (ranibizumab or lucentis or bevacizumab or avastin or pegaptanib or macugen or aflibercept or vegf trap-eye or steroid* or corticosteroid* or dexamethasone or fluocinolone or triamcinolone or anti-VEGF* or anti-vascular endothelial growth factor*).tw.
8. exp Vascular Endothelial Growth Factor A/
9. exp Fluocinolone Acetonide/
10. exp Triamcinolone/
11. 7 or 8 or 9 or 10
12. 6 and 11
13. (systematic review or meta-analysis or pubmed or medline).tw.
14. meta-analysis.pt.
15. cochrane.af.
16. 13 or 14 or 15
17. 12 and 16

Cochrane Database of Systematic Reviews and Technology Assessments Database, Cochrane Library July Issue, 2012

Ranibizumab or lucentis or bevacizumab or avastin or pegaptanib or macugen or aflibercept or vegf trap-eye or steroid* or corticosteroid* or dexamethasone or fluocinolone or triamcinolone or anti-VEGF* or anti-vascular endothelial growth factor* in Record Title and diabetic macular edema or diabetic macular oedema or diabetic retinopathy or diabetic maculopathy in Record Title

Searches for safety and adverse events

Ovid MEDLINE(R) Daily Update 11 July 2012, Ovid MEDLINE(R) In-Process and Other Non-Indexed Citations 11 July 2012 ; EMBASE 1980–2012 week 27

1. (ranibizumab or lucentis or bevacizumab or avastin or pegaptanib or aflibercept or vegf trap-eye or macugen or dexamethasone or fluocinolone or triamcinolone or anti-VEGF* or anti-vascular endothelial growth factor*).m_title.
2. (diabetic macular edema or diabetic macular oedema or diabetic retinopathy or diabetic maculopathy).m_title.
3. 1 and 2
4. (risk or safety or adverse or harm or pharmacovigilance).tw.
5. (side-effect* or precaution* or warning* or contraindication\$ or contra-indication* or tolerability or toxic*).tw.
6. 4 or 5
7. 3 and 6

Searches of the annual meeting abstracts (for trials, reviews and safety studies)

- ▶ ARVO (Association for Research in Vision and Ophthalmology) (2002–2012)
- ▶ ADA (American Diabetes Association) (2002–2012)
- ▶ EASD (European Association for the Study of Diabetes) (2002–2012)

Other searches

Web sites of the following

- ▶ Drugs@FDA: FDA Approved Drug Products

- ▶ European Medicines Association
- ▶ ClinicalTrials.gov
- ▶ EU Clinical Trials Register
- ▶ National Institute for Health and Clinical Excellence

APPENDIX 2: ONGOING TRIALS IN CLINICALTRIALS.GOV

- ▶ Schmidt-Erfurth and colleagues are comparing ranibizumab and bevacizumab in DME (NCT00545870)
- ▶ TRIASTIN study is comparing ranibizumab, triamcinolone and sham injection (NCT00682539)
- ▶ Maturi and colleagues are comparing bevacizumab plus dexamethasone with bevacizumab alone (NCT01309451)
- ▶ IBeTA study (Jorge and colleagues) is comparing bevacizumab (1.5 mg) plus laser, triamcinolone (4 mg) plus laser with laser alone (NCT00997191)
- ▶ Chaudhry and colleagues are evaluating ranibizumab in patients who have failed with 3–6 injections of bevacizumab (NCT01253694)
- ▶ MIDME study (Pfizer) is comparing pegaptanib 0.3 mg with sham injection (NCT01175070)
- ▶ Figueira and colleagues are comparing pegaptanib plus laser with laser alone (NCT01281098)
- ▶ RESPOND (Novartis) is comparing ranibizumab (0.5 mg) alone with ranibizumab plus laser or laser alone (NCT01135914)
- ▶ RETAIN (Novartis) study is comparing two different ranibizumab algorithms; 'treat and extend' versus as needed (NCT01171976)
- ▶ RED-ES (Novartis) is comparing ranibizumab with laser in patients with visual impairment due to DME (NCT00901186)
- ▶ READ 3 study (Do and colleagues) are comparing two doses of ranibizumab 0.5 and 2 mg (NCT01077401)
- ▶ VIVID-DME and VISTA DME studies (Bayer) are comparing aflibercept with laser. (NCT01331681 and NCT01363440)
- ▶ Gillies and colleagues are comparing bevacizumab with dexamethasone (NCT01298076)
- ▶ Soheilian and colleagues are performing a phase I study looking at the use of diclofenac compared with bevacizumab in DME (NCT00999791)
- ▶ López-Miranda and colleagues are comparing the use of bevacizumab before and after laser therapy (NCT00804206)
- ▶ NEVANAC study is comparing triamcinolone alone with triamcinolone plus nepafenac (NSAID) (NCT00780780)
- ▶ Elman and colleagues are comparing laser alone, laser combined with an intravitreal injection of triamcinolone, laser combined with an intravitreal injection of ranibizumab, or intravitreal injection of ranibizumab alone (NCT00444600)
- ▶ BRDME (Schlingemann and colleagues) study is comparing the use of bevacizumab and ranibizumab in the treatment of patients with DME (OCT central area thickness > 275 µm) (NCT01635790)
- ▶ Wiley and colleagues are comparing bevacizumab and ranibizumab in patients with DME in at least one eye (NCT01610557)
- ▶ Protocol T study (Wells and colleagues) is comparing effectiveness of a aflibercept, bevacizumab and ranibizumab for DME (NCT01627249)
- ▶ Allergan-funded study comparing safety and efficacy of 700 µg dexamethasone implant against 0.5 mg ranibizumab in patients with DME (NCT01492400)
- ▶ Pfizer-funded study comparing effectiveness of 0.3 mg pegaptanib against sham injection (NCT01100307)
- ▶ Allergan-funded study comparing safety and efficacy of an intravitreal dexamethasone implant (700 and 350 µg) against sham in patients with DME (NCT00168389)
- ▶ Allergan-funded study comparing safety and efficacy of an intravitreal dexamethasone implant (700 and 350 µg) against sham in patients with DME (NCT00168337)