NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Single Technology Appraisal (STA)

Aflibercept solution for injection for the first line treatment of wet age-related macular degeneration (AMD) [ID519]

Thank you for agreeing to give us your views on the technology and the way it should be used in the NHS.

Patients and patient advocates can provide a unique perspective on the technology, which is not typically available from the published literature.

To help you give your views, we have provided a template. The questions are there as prompts to guide you. You do not have to answer every question. Please do not exceed the 8-page limit.

About you

Your name: Clara Eaglen and Cathy Yelf

Name of your organisation: Royal National Institute of Blind People (RNIB) and the Macular Society

Are you (tick all that apply):

a patient with the condition for which NICE is considering this technology? No

a carer of a patient with the condition for which NICE is considering this technology? No

an employee of a patient organisation that represents patients with the condition for which NICE is considering the technology? If so, give your position in the organisation where appropriate (e.g. policy officer, trustee, member, etc) Yes

Clara Eaglen, Policy and Campaigns Manager
Cathy Yelf, Head of External Relations

other? (please specify) No

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General comments

1. About Royal National Institute of Blind People (RNIB) and the Macular Society

RNIB is the leading charity in the UK helping people with sight loss maintain independent and fulfilling lives. An increasing focus of our work is on sight loss prevention and access to sight saving treatments. As part of this work we lobby to ensure patients gain access to new, clinically proven treatments as quickly as possible.

The Macular Society is the specialist UK charity for people with macular conditions. We are the largest patient member organisation in the eye care sector with nearly 16,000 members. We offer a range of support and information services for people with central vision loss, their families and carers. We provide information for health professionals, campaign for better services, sponsor research and raise awareness of macular degeneration and its prevention.

Since the remit of both our organisations includes access to treatment, NICE appraisals are of prime interest to us and we have decided to present a joint RNIB/Macular Society submission.

Our response has been informed by:

- discussions with clinicians and patients to examine the treatment of wAMD in the UK and its impact on quality of life
- one to one discussions with clinicians and patients who took part in the clinical trial for the technology under consideration (i.e. aflibercept)
- reading published research

2. Our recommendation:

We call on the NICE Appraisal Committee to recommend aflibercept for the treatment of wet Age-related Macular Degeneration (wAMD). We also ask that the final guidance recognises the importance of rapid access to this treatment.

We strongly believe that aflibercept should be made available on the NHS without restrictions. This will allow clinicians to decide what treatment is best for their patients. This is particularly important as some people with wAMD do not respond to the current NICE approved treatment and another option could mean the difference between saving or losing their sight.

Recommending aflibercept for use on the NHS makes sense not only in terms of the benefits to patients who are given a chance to avoid the mental, physical and social problems associated with blindness. The economic case is just as compelling. Sight loss creates significant costs for the NHS and personal social services, including treatment for depression and sight loss induced falls and the provision of low vision rehabilitation and independent living support services.

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What do patients and/or carers consider to be the advantages and disadvantages of the technology for the condition?

1. Advantages
(a) Please list the specific aspect(s) of the condition that you expect the technology to help with. For each aspect you list please describe, if possible, what difference you expect the technology to make.

We believe the advantages of this treatment are:

- the safe and effective treatment of wAMD
- a less onerous dosing regimen which reduces the burden on patients and carers; the burden on over stretched eye clinics; and helps patients receive timely, optimal care
- a reduction in the risk of endophthalmitis and exposure to antibiotics

These advantages are described in more detail below:

i. Safe and effective treatment for wAMD

Data from the VIEW 2 trial suggests that aflibercept is safe and effective in treating wAMD. It works by preventing new blood vessel growth behind the retina and therefore stops patients losing their central vision in the eye(s) affected by the condition. Trial data also suggests that aflibercept is comparable in safety and efficacy to the current NICE approved treatment ranibizumab.

Aflibercept provides another treatment option for patients with wAMD which is particularly important for those who do not respond to ranibizumab.

ii. Reduction in the burden on patients and carers:

The main advantage of aflibercept is the dosing regimen.

Findings from trial data suggest that patients require one injection per month for three consecutive months, followed by one injection every two months with no requirement for monitoring between injections in the first year. After the first 12 months of treatment, depending on patient outcomes, the treatment interval can be reduced or extended based on the clinical judgement of the doctor.

If patients receive bi-monthly injections for the course of their treatment - after the initial three loading doses - it will:

- Halve, or more, the number of eye clinic appointments they have to attend
  - Patients who currently require, and receive, monthly injections in 1-stop clinics may need only bi-monthly visits
  - Patients in 2-stop clinics currently attend once for assessment and then return for injection if needed
- reduce the amount of time spent at the eye clinic as each appointment can last two hours or more

- reduce the impact on the carer who may have to take time off work in order to drive the patient to the hospital
- resolve transport issues such as long and difficult bus journeys or expensive hospital parking

The patients we spoke to said that although they "did not mind" going to the hospital monthly if it meant saving their sight, attending every other month would be preferable. Less frequent intervals also means that patients are not reminded of their eye condition so often and some reported that this would be helpful.

iii. Reduction in the burden on eye clinics:

The number of patients undergoing intravitreal injection for wAMD is increasing year on year. In addition ranibizumab is becoming licensed and available for more conditions such as diabetic macular oedema and, possible retinal vein occlusion and myopic maculopathy. This is very welcome but there is not doubt that it is adding to the huge burden on eye clinics. Clinicians tell us that bi-monthly injections for wAMD will help them meet this demand.

The current NICE approved treatment for wAMD (ranibizumab) requires patients to be seen monthly for monitoring or injection and many hospitals are running extra clinics in the evenings and at weekends to cope with demand.

iv. Help to improve outcomes by increasing the number of patients who receive timely, optimal care:

We believe that many clinics are currently not able to provide the recommended level of care for their wAMD patients. A survey commissioned by the Macular Interest Group of Vision 2020UK and conducted by the Macular Society (2012) suggests that fewer than half of specialist eye clinics in the UK are meeting national guidelines on treating people with wAMD.

The Royal College of Ophthalmologists recommends that patients should be treated within two weeks of diagnosis and seen monthly after that for further treatment if necessary. However, survey findings suggest that:

- the recommended waiting time for initial treatment is met in only 49.4% of clinics; a further 41.8% of patients wait from two to four weeks for a first appointment; and 8.8% wait more than 8 weeks
- in more than 80% of clinics, patients wait more than the recommended four weeks for follow up appointments

As wAMD can develop very quickly and lead to scarring and permanent sight loss in a short period of time, it is essential that patients receive rapid access to diagnosis and treatment. The time lapses noted in the survey are putting patients' sight at risk. Clinicians advise that treating wAMD patients too infrequently with anti-VEGF agents results in poorer outcomes. Aflibercept's bi-monthly injections will help reduce the burden on eye clinics, help them meet demand to ensure patients get the treatment they require on time and retain their sight.

A summary of the survey findings can be downloaded from the Macular Society's website at:
https://www.surveymonkey.com/sr.aspx?sm=2IdxU2xQhIgm1ZZRmuGl_2flqRbIdKfMGxD6D4gTFDOZU_3d

v. Reduction in the risk of endophthalmitis and exposure to antibiotics

A complication of intravitreal injections is endophthalmitis, a severe inflammation of the interior of the eye. Timely diagnosis and treatment is required to prevent it causing irreversible sight loss. Therefore, the less frequent injections with aflibercept will reduce the risk of endopthalmitis for patients.

Similarly patients receive antibiotics after each injection, so longer injection intervals will reduce the amount of antibiotics they required. This is good in the long term as over exposure to antibiotics can lead to resistance.

(b) Please list any short-term and/or long-term benefits that patients expect to gain from using the technology. These might include the effect of the technology on:
- the course and/or outcome of the condition
- physical symptoms
- pain
- level of disability
- mental health
- quality of life (lifestyle, work, social functioning etc.)
- other quality of life issues not listed above
- other people (for example family, friends, employers)
- other issues not listed above

The short and long term benefits of aflibercept are great - saving sight can not be underestimated. Being diagnosed with wAMD is a sudden and terrible shock. The costs of sight loss are high not only financially but also emotionally and socially.

Loss of central vision means that people are forced to give up active pursuits that promote health, such as walking and cycling. They must abandon fulfilling cultural past-times and leisure activities such as reading, going to the cinema, sewing and DIY. These losses damage quality of life and escalate the risk of mental ill health and social isolation - thus increasing the associated health and social care burden created by wAMD.

In addition, wAMD patients who are not treated optimally or do not respond well to the current NICE approved treatment are at risk of:

- Early retirement from paid employment
- Clinical depression requiring NHS treatment
- Loss of income and dependence on benefits
- Increased costs for visual aids, transport and domestic help
- Increased risk of falls and accidents

- Dependence on carers and spouses, who often have to give up work as well
- Loss of independent mobility
- Loss of confidence and self-esteem
- Social isolation
- Difficulty with activities of daily life including self-administration of medication and maintenance of good quality nutrition

2. Disadvantages
Please list any problems with or concerns you have about the technology. Disadvantages might include:
- aspects of the condition that the technology cannot help with or might make worse
- difficulties in taking or using the technology
- side effects (please describe which side effects patients might be willing to accept or tolerate and which would be difficult to accept or tolerate)
- impact on others (for example family, friends, employers)
- financial impact on the patient and/or their family (for example cost of travel needed to access the technology, or the cost of paying a carer)

All of the patients we have spoken to say that the thought of receiving an injection into their eye had caused anxiety initially. However, they reported that the unpleasant thought was much worse than the reality. The general consensus was that the injections were not a problem if they prevented sight loss. Many patients complimented hospital staff and said they were taken through the process step by step and had received all the necessary information before going through the treatment.

Most did not have any side effects except for temporary floaters and some said they felt pain in their eye when the anaesthetic wore off.

3. Are there differences in opinion between patients about the usefulness or otherwise of this technology? If so, please describe them.

There were no differences in opinion about the usefulness of this technology.

The patients we spoke to as part of this appraisal all welcome aflibercept - they are happy with its safety and efficacy profile and, most importantly, the less onerous dosing regimen.

During the trial, clinicians told us that patients did not complain and kept coming back for their appointments. They felt this meant the treatment was tolerable and although the injections were unpleasant, preserving sight made the experience worth it.

4. Are there any groups of patients who might benefit more from the technology than others? Are there any groups of patients who might benefit less from the technology than others?

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Aflibercept may be beneficial to patients who have not responded to the current NICE approved treatment (ranibizumab).

It is also likely to help people with mobility problems or other difficulties that make it hard to attend hospital appointments.

Comparing the technology with alternative available treatments or technologies NICE is interested in your views on how the technology compares with existing treatments for this condition in the UK.

(i) Please list any current standard practice (alternatives if any) used in the UK.

wAMD is currently treated with ranibizumab. This treatment is injected into the eye at monthly intervals and continued until maximum visual acuity is achieved i.e. the patient's visual acuity is stable for three consecutive months. Patients should then be monitored each month and treated if there is a loss in visual acuity.

We are concerned that some clinics may be using an unlicensed drug - bevacizumab - to treat wAMD. Like the Royal College of Ophthalmologists, we feel NICE and the Medicines and Healthcare Products Regulatory Agency (MHRA) must review the use of this drug in the treatment of wAMD. We also believe it is vital that a national body is identified to take responsibility for risk management and pharmacovigilance to monitor the ongoing usage of bevacizumab in the eye.

(ii) If you think that the new technology has any advantages for patients over other current standard practice, please describe them. Advantages might include:
- improvement of the condition overall
- improvement in certain aspects of the condition
- ease of use (for example tablets rather than injection)
- where the technology has to be used (for example at home rather than in hospital)
- side effects (please describe nature and number of problems, frequency, duration, severity etc)

As stated above, the dosing regimen of aflibercept means that fewer hospital appointments will be required to treat wAMD. This in turn will reduce the burden on hospital clinics (i.e. freeing up capacity) as well as the burden on patients and carers (i.e. fewer hospital visits mean less time spent travelling to and from the hospital, less time spent waiting in the clinic etc).

(iii) If you think that the new technology has any disadvantages for patients compared with current standard practice, please describe them. Disadvantages might include:
- worsening of the condition overall
- worsening of specific aspects of the condition
- difficulty in use (for example injection rather than tablets)

- where the technology has to be used (for example in hospital rather than at home)
- side effects (for example nature or number of problems, how often, for how long, how severe).

We are not aware of any disadvantages relating to this new technology compared with current standard practice.

Research evidence on patient or carer views of the technology
If you are familiar with the evidence base for the technology, please comment on whether patients' experience of using the technology as part of their routine NHS care reflects that observed under clinical trial conditions.

No comment

Are there any adverse effects that were not apparent in the clinical trials but have come to light since, during routine NHS care?

It is difficult to comment as the trial has not reported in full. Aflibercept has only recently received its licence, so there is limited use to date outside of the trial. We are not aware of any adverse effects that were not apparent in the trials.

Are you aware of any research carried out on patient or carer views of the condition or existing treatments that is relevant to an appraisal of this technology? If yes, please provide references to the relevant studies.

RNIB is currently examining service provision for wAMD across the UK. The research will review service provision from the perspective of the clinician, commissioner, patient and carer. It will establish what a high quality wAMD service delivery looks like and consider how to optimise wAMD care and the patient experience. RNIB and the Macular Society hope to use the findings and work with service providers to ensure those most at risk of sight loss receive timely access to diagnosis and treatment. Findings will be published in February 2013.

The Macular Society is jointly (with Bayer) funding a study to evaluate the burden of anti-VEGF therapy on patient and caregivers and to examine the relationship between the caregiver's quality of life (HRQL), caregiver role and burden, the patient's quality of life (HRQL) and the patient's outcome with anti-VEGF therapy. Findings will be published in August 2013.

Availability of this technology to patients in the NHS
What key differences, if any, would it make to patients and/or carers if this technology was made available on the NHS?

A positive recommendation will provide another treatment option for patients with this condition and it will have a less onerous dosing regimen. It would also allow clinicians to decide what treatment is best for each wAMD patient, especially those that have not responded to the current NICE approved treatment ranibizumab.

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What implications would it have for patients and/or carers if the technology was not made available to patients on the NHS?

It will mean that patients who can afford to pay for the treatment privately will be able to do so, while those who can not will be unable to access aflibercept. This could exacerbate health inequalities.

It would also hamper eye clinics who desperately need a solution to help them meet increasing demands and ensure all patients receive optimal treatment for wAMD.

Are there groups of patients that have difficulties using the technology?

People with dexterity problems may find this treatment difficult as they need to take antibiotics post injection. For example, arthritic patients find it hard to squeeze the antibiotic bottle to administer the drug - and this needs to be done four times a day for four days (more or less).

Equality
NICE is committed to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relations between people with particular protected characteristics and others. Please let us know if you think that this appraisal:
- could exclude from full consideration any people protected by the equality legislation who fall within the patient population for which [the treatment(s)] is/are/will be licensed;
- could lead to recommendations that have a different impact on people protected by the equality legislation than on the wider population, e.g. by making it more difficult in practice for a specific group to access the technology;
- could lead to recommendations that have any adverse impact on people with a particular disability or disabilities.

Please tell us what evidence should be obtained to enable the Committee to identify and consider such impacts.

wAMD mainly affects older people and NICE should consider how its decision affect this group of individuals.

Other Issues
Please consider here any other issues you would like the Appraisal Committee to consider when appraising this technology.

We would expect aflibercept to be made available for any eye judged by a qualified clinician to be likely to benefit from the treatment.

Although there is a current NICE approved treatment for wAMD, another treatment option is vital for those who do not respond to the current NICE approved treatment.

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People should have access to available options as one size does not fit all. We would like to remind the Appraisal Committee that if wAMD is not treated it has a huge impact on a person's quality of life. The condition sharply reduces an individual's ability to continue leading an independent, fulfilling life. It leads to loss of central vision needed for activities requiring fine vision such as reading, driving and recognising faces. Peripheral vision is usually retained but the effect on the majority of daily living activities and emotional well-being can nonetheless be severe.

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Appendix: case studies

To assist with our submission, we undertook telephone interviews with a number of patients. Four of these have been included as case studies (see below). In each case we explored the impact of wAMD on the patient's quality of life and their views on current treatment and the new technology.

Out of the four patients we spoke to, two took part in the VIEW 2 trial and received aflibercept and two did not.

Due to the trial design, all patients taking part in VIEW 2 received an intravitreal injection or sham injection each month. Therefore we were unable to explore their experiences of bi-monthly injections. However, we spoke to all four about aflibercept's dosing regimen to get their views on what the new technology would mean to them.

(a) Case studies of patients that took part in the VIEW 2 trial (i.e. received aflibercept)

Name: Patient A
Age: 86
Occupation: retired

Patient A was diagnosed with wAMD in the left eye three years ago and has had cataract surgery in both eyes.

Diagnosis of wAMD occurred after a routine eye test at the local opticians (optometrists). Patient A remembers being referred to the local eye clinic via their GP and being diagnosed with wAMD at the hospital. At the time of diagnosis the consultant explained the eye condition, its treatment and information about the VIEW 2 trial. Patient A was asked if they wanted to take part in the trial, they agreed and signed the relevant papers.

The trial lasted 24 months and involved attending the eye clinic once a month for an injection. Patient A commented that the treatment worked very well and removed most of the fluid at the back of their eye. [Note: although the patient believed they had aflibercept injections each month, some treatments were sham injections due to the trial design].

After the two year trial, the patient received further treatment as an NHS patient to remove the remaining fluid at the back of they eye. They received nine injections of one drug and two of another - they were unable to recall the names of the drugs but we assume one is ranibizumab and the other bevacizumab. Patient A was switched to the second drug (i.e. the second drug as an NHS patient) as the clinician said the first was not effective enough. Patient A has been told that they will only need one more injection at the end of January 2013.

The trial design meant that Patient A had to attend the eye clinic every month, so it was difficult for them to comment on the dosing frequency. However, they felt bi-monthly injections would be beneficial, particularly as they have mobility problems and find it hard to get to the clinic. During the trial a car was supplied to help them get to the hospital, however, after the trial they had to take a bus to receive NHS treatment. The bus takes over an hour to get to the hospital and involves a long walk from the bus stop to the eye clinic. Patient A commented that it was not so bad over warmer months but very difficult in the winter. They also noted that they have "weak legs" which makes walking difficult, so bi-monthly visits would be preferable.

In terms of the actual injection, Patient A said it did not hurt but that they felt pain when the anaesthetic wore off during the night. As this patient has a number of health complications (including a recent heart operation) they were not worried about having an injection in the eye.

Patient A said the care they receive at the hospital is wonderful, that the doctors are very good and that the nurse holds their hand when the injection is administered.

Patient A said wAMD did not affect their quality of life and added that this was because they received rapid treatment for the condition which saved their sight.

They also commented that they had a cataract operation in each eye. The cataract in the right eye was removed immediately but the left one could not be operated on until most of the fluid behind the retina had gone. Patient A commented that the cataract surgery had a big impact on their vision and that they could see much better, even without glasses. So indirectly, aflibercept had a big impact on their vision as it stopped the progress of wAMD and allowed the cataract in the left eye to be removed.

Name: Patient B
Age: 58
Occupation: retired 12 years ago

Patient B was diagnosed with wet AMD in the left eye four years ago.

They first noticed a problem with their sight four years ago during the Christmas period. They thought they needed new glasses and went to the opticians (optometrists) for an eye test. The optician (optometrist) noticed changes at the back of the eye and urgently referred them to the hospital via their GP. The consultant at the hospital diagnosed patient B with wAMD and discussed the condition, its treatment and the VIEW 2 trial in detail.

The consultant put patient B's name forward to take part in the clinical trial (with their agreement) and in March 2009 patient B started treatment with aflibercept. Patient B commented that the process was scary at first as they did not know what would happen. However, after that the process was unpleasant but tolerable if it meant saving their sight.

Patient B said the treatment worked well. They had lost some of their central vision but the treatment helped restore some of their sight. Prior to treatment with aflibercept they would see a large frosted circle in their central vision but the size of the circle reduced following treatment. After the trial, the patient started receiving Lucentis. They are very grateful for the treatment and said that their sight would be terrible without the injections.

They commented that the staff at the local hospital are exceptional and that the macular clinic is marvellous. Patient B also said that their right eye is monitored at each appointment, which puts their mind at rest, as they are worried about getting wAMD in their good eye.

The patient said their right eye has good vision and compensates for the left eye. Therefore, wAMD has a smaller impact on their quality of life compared to having the condition in both eyes. With glasses they can still read and undertake many day to day activities.

In terms of getting to the hospital, Patient B's children (who are both studying at a local university) or other family members take it in turns to transport them to the eye clinic. Patient B mentioned that it depends on who is free. They also mentioned that depending on what tests need to be done (i.e. a fluorocein angiogram) they can be at the eye clinic for over two hours.

In terms of bi-monthly injections, Patient B thought it would be very beneficial. It would be easier for their children/family members to share transport duties and mean less time spent in the clinic. They also commented that some patients at the hospital have to travel very far to get to their appointment, so bi-monthly injections would ease the strain on them.

Finally, Patient B stressed that people should not underestimate the importance of sight. They also felt that any new treatment options should be available to all.

(b) Case studies of patients who did not take part in the VIEW 2 trials

Name: Patient C
Age: 82
Occupation: retired accounts assistant

Patient C was diagnosed with wAMD in the left eye two years ago

Initially their optician (optometrist) spotted the condition and referred them - via their GP - to the local hospital. Patient C waited four weeks for an appointment and when they were finally seen by the consultant (who did not examine them) they were told they had a simple cataract and had to wait for an operation.

The patient's daughter was at the consultation and, as she worked for an optician (optometrist), insisted that the doctor examine her parent's eyes. After examining

patient C, the doctor still insisted that the only problem was a cataract and sent them away.

Patient C's daughter then took her parent to the optician (optometrist) where she worked and asked for a second opinion. The optician (optometrist) suspected wAMD and secured an appointment for Patient C at the hospital within two days.

From then on, patient C experienced excellent care at the hospital and started receiving Lucentis on a monthly basis. According to patient C the hospital staff are friendly; ask them whether they are happy and if they have enough information.

They now attend the clinic every two months for monitoring at a hospital which is 15 miles away (one of their daughters will drive them to the appointment). They then receive Lucentis injections two to three weeks after almost every scan (i.e. treatment every 10 weeks). Treatment takes place at a different hospital which is five miles away and can be reached by bus - patient C attends this appointment on their own. Without the support of their daughters, the trip to the eye clinic for scans would be very difficult and a bi-monthly injection at the local hospital would be much more beneficial.

In terms of the injection, patient C was apprehensive at first, however, they are now used to the treatment. They experience no side effects, other than slight visual disturbance for two to three hours after the injection.

Patient C's eyesight is stable and subjectively they think it has improved a bit. The left eye no longer interferes with the vision in the other eye, which had caused many problems initially. Due to the rapid treatment of their eye condition it is not affecting their quality of life in any real way.

Name: Patient D
Age: 75
Occupation: retired aircraft engineer

Patient D was diagnosed with wAMD four months ago.

Four years ago they had a cataract operation in each eye and had been having annual hospital check ups. About 12 months ago they were "signed off" and told to go for annual sight checks at the optician (optometrist).

In October 2012, they realised something was wrong with their sight while covering over one eye to check their vision. They noticed wavy lines when looking at text on their computer with their left eye and their right eye covered. They searched on internet and self diagnosed with wAMD using an Amsler grid. They commented that they had not previously heard of wAMD.

Following their self diagnosis they tried to see their GP but could not get an appointment. Instead the GP called them to discuss their symptoms and then made

an urgent appointment at the hospital. Four days later patient D attended the eye clinic and was diagnosed with wAMD.

On 22 October 2012 they had a Lucentis injection, received another on 19 November and a third on 17 December. They feel that their vision has improved (although this has not been tested using a snellen chart).

Patient D believes the care they receive at the hospital is excellent. The staff are very friendly, nurses hold their hand during the injection, staff provide a lot of information and make them feel welcome. Patient D is also given a clear eye-patch so they can walk home using vision in two eyes.

In terms of the injection, Patient D is "getting used to it" and said there are no side effects. The injection itself is pain free other than the eye clamp which scraped their cornea once.

The patient's vision in their right eye is 6/6, so they feel that wAMD has not had a huge impact on their lifestyle (as their good eye compensates).

Patient D is concerned about the future as they have been told that the wAMD is likely to spread to the other eye. They live in an isolated area they and might need to move to the city if their vision gets worse, as they would be unable to undertake day to day tasks.

Patient D has a lot of trouble getting to the eye clinic as they live 20 miles away and there is virtually no public transport. At present they get a lift from a neighbour who works at the hospital. They then get a bus back but this stops about four to five miles from their house and they have to walk the rest of the way. Patient D is considering hitchhiking or advertising in the church newspaper for someone to give them a lift. They can cycle to the hospital but it is an 800m ascent on the way back! They are determined not to miss an appointment so will find a way to get to the hospital. A bi-monthly injection would relieve the burden of getting to the hospital on such a regular basis.