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# 从 EURETINA 最新指南看视网膜静脉阻塞 诊疗策略的变化

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**【摘要】** 视网膜静脉阻塞(retinal vein occlusion, RVO)是严重危及视功能的常见疾病,在临床治疗策略和方案上并未完全形成共识,国内至今也未见相关指南和共识发表,近期新的国际指南发布对 RVO 治疗方法和策略有了更为全面、清晰的推荐和建议,了解并解读相关指南可为临床实践提供参考,对规范和指导诊疗提供帮助。

**【关键词】** 视网膜静脉阻塞; 管理; 治疗策略

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## Changes of diagnosis and treatment strategies of retinal vein occlusion according to EURETINA updated guidelines

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**【Abstract】** Retinal vein occlusion (RVO) is one of the most common diseases severely threatening visual acuity. There is not a complete consensus on the clinical treatment strategies and schemes, and no guideline or consensus has been published in China. The publication of the latest international guidelines has provided more comprehensive and clear suggestions and advices for treatment and management strategies for RVO. Reading and understanding those guidelines could provide references for clinical practice, and offer help for standard diagnosis and treatment.

**【Key words】** Retinal vein occlusion; Management; Treatment strategy

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欧洲视网膜专家学会(EURETINA)发布了2019年《EURETINA 视网膜静脉阻塞诊疗指南》,引起眼科医生的极大关注,这是2015年以来首次修订的视网膜静脉阻塞(retinal vein occlusion, RVO)诊疗指南<sup>[1-5]</sup>。该指南的修订基于药物大型临床试验结果和长期的随访资料,形式上采用基本原理-证据-建议的写作结构,对RVO的诊疗策略有了更全面和清晰的建议,涵盖RVO的诊断、检查以及危险因素和全身疾病的控制等内容,为临床医生规范诊疗RVO提供参考依据。

### 1 RVO 病因及致病风险因素的识别和控制

多种病因可引起RVO,有时可能是多因素综合作用的结果<sup>[6]</sup>。RVO临床表现相似,但对治疗的反应和

预后存在差异,复杂性和不确定性是其临床特征之一,部分患者在解除或控制致病风险后病情自行缓解或恢复,也有患者病情反复发作和进展,甚至找不到相关发病因素<sup>[6-7]</sup>。

RVO的眼底表现具有特征性,检眼镜检查或眼底图像即可诊断,但应注意与其他疾病鉴别,如血液病所致的凝血或血液黏滞度异常发生的视网膜出血,表现为双侧性;颈动脉阻塞、海绵窦血栓也可出现类似RVO的临床特征;黄斑部毛细血管扩张症的表现与小分支的RVO表现相似。上述疾病的处理原则是注重病因学治疗,RVO诊断前应排除这些病变<sup>[1]</sup>。

《2019 EURETINA 视网膜静脉阻塞诊疗指南》建议,首诊的RVO患者,须详细询问病史,检测血压、血



积/可检测到的视网膜面积(缺血指数)作为超广角下缺血性视网膜病变的诊断标准仍需在临床实践中验证<sup>[18]</sup>。需注意的是不仅要关注视网膜无灌注区范围,更要关注无灌注区部位,后极部无灌注区发生新生血管的风险较高。位于后极范围的病变,既往 CVOS 诊断标准仍较准确。2019 年新指南再次强调,视盘、视网膜或前节部位一旦出现新生血管,视网膜激光光凝治疗是其标准和核心<sup>[1-5]</sup>,这一原则在抗 VEGF 时代仍适用。缺血型 CRVO 予标准的全视网膜光凝,分支 RVO 的光凝范围位于视网膜无灌注区。

未发生新生血管时是否行预防性视网膜光凝仍有不同意见,国际指南的建议也不尽相同。尽管预防性全视网膜光凝不能阻止虹膜、房角新生血管的发生,但对减少高危患者视网膜新生血管的形成和视网膜 VEGF 因子的释放有积极作用,如无灌注区面积 $\geq 30$ 视盘面积、后极无灌注区面积 $\geq 10$ 视盘面积、1年内无灌注区面积不断扩大、RVO 致病风险因素未能解除并无条件规律随诊的患者等。<sup>[16-17]</sup>2019 年新指南建议在有条件密切随诊(1~2周),或因黄斑水肿正在进行抗 VEGF 治疗的患者至新生血管发生时才用,视网膜光凝,否则可选择预防性光凝。中央 RVO 易引起虹膜、房角新生血管,治疗上更为积极,分支 RVO 发生于视网膜新生血管较少引起新生血管青光眼,预防性光凝的必要性不足<sup>[17,19]</sup>。

抗 VEGF 治疗对于新生血管具有良好的抑制作用,缺血型 RVO 患者一旦发生新生血管,即可进行抗 VEGF 治疗。如条件允许可采用即刻、足量视网膜光凝为主的联合抗 VEGF 治疗,如没条件行视网膜光凝则先行抗 VEGF,通过药物或手术创造视网膜光凝条件。研究显示,抗 VEGF 治疗对 RVO 视网膜无灌注区有缓解作用,但难考以维持,即使反复抗 VEGF 治疗,部分患者仍不能阻止新生血管的发生。缺血性 RVO 患者单独用抗 VEGF 疗法有时不能控制新生血管,但可使新生血管及相关并发症得到有效控制,为避免视网膜光凝的损伤,有学者不推荐预防性光凝。

RVO 病因复杂,治疗效果不同,预后不一,临床上 RVO 的管理和治疗策略在病程的不同时期也不尽相同,新版国际指南对规范诊疗流程、制定治疗决策提供依据,对 RVO 危险因素的排查和控制、黄斑水肿及视网膜有无灌注的治疗提出建议,是 RVO 病程管理的基本内容,值得关注。

**利益冲突** 所有作者均声明不存在利益冲突

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