

Conferencias y Simposios

SEIS VOCES EN 10 MINUTOS

C) Actualización en complicaciones crónicas

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Retinopatía

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La retinopatía diabética (RD) es la causa más frecuente de nuevos casos de ceguera evitable en adultos entre 20 y 74 años; se estima que más de un tercio de los pacientes con diabetes mellitus (DM) tiene algún grado de RD y la misma correlaciona con el tiempo de duración de la diabetes y el control glucémico (1).

La complicación ocular relacionada con diabetes representa a nivel mundial el 35,6% en alguna de sus manifestaciones, siendo 7,24% formas proliferativas (PDR), 7,48% edema macular diabético (EMD) y 11,72% compromiso grave de pérdida de agudeza visual (2).

Otras formas de enfermedad ocular son: glaucoma secundario a panfotocoagulación u otra cirugía ocular o neovascular por invasión de neovasos al segmento anterior del iris, cataratas: aguda de la hiperglucemia, transitoria y reversible o senil.

Dentro los 5 años del inicio de la DM1 y al diagnóstico en la DM2 debe realizarse la evaluación por el oftalmólogo avezado en diagnosticar la forma clínica de la enfermedad ocular mediante biomicroscopía con pupila dilatada; como métodos complementarios, la retinofluoresceínografía (RFG) permite evaluar lesiones vasculares iniciales, áreas de no perfusión, isquémicas, microaneurismas intrarretinales y neovascularización, y la tomografía ocular computada (OCT) mostrará la estructura de la retina, características del edema macular e interfase vitreoretiniana.

El control de la RPT consistirá en lograr los objetivos metabólicos, tratando de alcanzar y sostener valores de hemoglobina glicosilada A1C, tensión arterial, lípidos, no fumar y control oftalmológico: anual si no hay RPT, semestral si hay RPT leve/moderada, trimestral si es severa, y considerar panfotocoagulación (PFC) temprana y uso precoz anti factor de crecimiento endotelial vascular (VEGF). Si hay RPT proliferativa corresponde PFC extensa + antiVEGF y considerar cirugía precoz. Los VEGF están indicados (bevacizumab, ranibizumab y aflibercept) en edema macular diabético.

Todo paciente con DM que se someta a cirugía de cataratas debe ser evaluado por el retinólogo, ya que ésta podría desencadenar o empeorar una retinopatía de base, la cual se tratará con inyecciones de antiVEGF; una vez estabilizado se procederá a resolver la catarata.

Cuando la indicación del tratamiento electivo con cirugía ocular, panfotocoagulación o AntiVEGF se establece por enfermedad ocular del paciente, un valor de A1C superior a 8% no es contraindicación para realizar el mismo (3).

Finalmente, un punto importante a destacar teniendo en cuenta que nuestros pacientes probablemente tengan indicación de aspirina por el riesgo cardiovascular (RCV), no hay contraindicación para uso en pacientes con retinopatía, incluso proliferativa (4).

Palabras clave: retinopatía; diabetes; controles.

Bibliografía

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SIX VOICES IN 10 MINUTES

C) Update on chronic complications

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Retinopathy

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Diabetic Retinopathy (DR) is the most frequent cause of new cases of preventable blindness in adults between 20 and 74 years old; it is estimated that more than a third of the patients with Diabetes Mellitus (DM) have some degree of diabetic retinopathy and the same correlation with the duration of diabetes and glycemic control (1).

Eye complications related to Diabetes represent, worldwide, a 35.6% in any of its manifestations, being a 7.24% proliferative diabetic retinopathy (PDR), a 7.48%, diabetic macular edema (DME) and an 11.72%, severe compromise of visual acuity loss.

Other forms of eye disease are: Glaucoma, following Panretinal photocoagulation or another ocular surgery, or neovascular glaucoma, caused by neovessels invasion to the anterior segment of the iris; Cataracts: acute of hyperglycemia, transitional and reversible or senile.

Within 5 years of the beginning of T1D and at diagnosis of T2D, an experienced ophthalmologist should make an evaluation and diagnose the clinical form of the ocular disease with a Biomicroscopy with dilated pupils; as complementary methods, fluorescein angiography of the retina allows for evaluation of initial vascular injuries, non-perfusion areas, ischemic, intraretinal microaneurysms and neovascularization and the Optical Coherence Tomography (OCT) will show the structure of the retina, characteristics of the Macular Edema and the vitreoretinal interface.

Retinopathy control will try to achieve the metabolic objectives, reach and sustain the values of HbA1c, blood pressure, lipids and not smoking and the ophthalmological control: annually if there is no Retinopathy, six-monthly if the Retinopathy is mild/moderated; quarterly if severe, in which case early Panretinal photocoagulation (PRP) should be considered, as should the early use of anti-vascular endothelial growth factor (VEGF); if there is proliferative Retinopathy, we need extended PRP and anti-VEGF, and early surgery should be considered. The VEGF indicated (bevacizumab, ranibizumab and aflibercept) are in the Diabetic Macular Edema.

Every patient with DM that will undergo cataracts surgery must be evaluated by a retina specialist, since the surgery could unchain or worsen basal retinopathy, which will be treated with anti-VEGF injections. Once it is stabilized, the next step will be to deal with the cataract.

When the indication for the elective treatment with ocular surgery, Panretinal photocoagulation or anti-VEGF is established because the patient has an ocular disease, the level of A1C higher than 8% is not a contraindication to perform the procedure. (3)

Finally, an important aspect to highlight, taking into account that our patients probably have an aspirin indication for cardiovascular risk (CVR), is that there is no contraindication for patients with retinopathy, even if it is proliferative (4).

Key words: retinopathy; diabetes; controls.

Bibliography

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