GEOGRAPHIC ATROPHY (GA):

Diagnosis Quick Reference Guide

SEE GA DIFFERENTLY

Geographic atrophy (GA) is an advanced form of dry age-related macular degeneration (AMD) that causes irreversible vision loss.[1] Imaging can be used to visualize GA lesions, whether for diagnostic or monitoring purposes. Lesion patterns can be predictive of slower or faster progressing disease.[2]

This guide is intended as a quick reference on key imaging and assessments that may aid in diagnosing and monitoring GA, and on sharing information on GA with your patients and retinal specialist partners. For more detailed information about imaging and the GA disease state, please see the back of this guide for a QR code that links to SeeGADifferently.ca.

Considerations for Diagnosing and Monitoring GA

Retinal Imaging Can Help With GA Diagnosis

OCT is helpful in assessing GA lesion features[2]

- What to look for[2]:
  - Choriocapillaris layer loss
  - Presence of choroidal hypertransmission
  - Evidence of overlying photoreceptor degeneration

FAF is helpful for assessing lesion size and monitoring disease progression[2]

- What to look for[2,3]:
  - Areas of hypoautofluorescence with sharply demarcated borders
  - Patterns of hyperautofluorescence surrounding atrophic lesions such as focal, patchy, banded, diffuse, or diffuse-trickling

CFP was widely used in large epidemiologic studies and disease classification systems for GA[2]

- What to look for[2]:
  - Drusen, as well as depigmentation
  - Hypopigmented GA lesions with sharply demarcated areas and increased visibility of choroidal vessels

Functional Visual Assessments

Visual acuity often does not provide a complete assessment of visual function. A decline in visual function can lead to a reduced quality of life.[4–6] It is important to inquire about:

- Trouble performing daily activities (reading, driving, hobbies, etc.)[4,6,7]
- Difficulty with low-light vision, night vision, or driving in low-light conditions[2]
- Decreased contrast sensitivity[8]

Lesion Characteristics Can Help Predict Progression

GA is a heterogenous disease, and characteristics of its lesion patterns can be predictive of slower or faster progressing disease.[2,9]

Lesion Size

Slower Progression	Faster Progression
	
Small Baseline Lesions	Large Baseline Lesions

Location

Slower Progression	Faster Progression
	
Foveal	Non-foveal

Focality

Slower Progression	Faster Progression
	
Unifocal	Multifocal

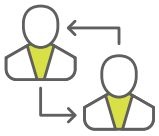
Lesion size, location, and focality may be predictive of the rate of lesion progression in GA. GA progression is faster in lesions that are larger, outside of the fovea, or multifocal.[2]

Patient Discussion and Education

Educate your patients on what they may experience throughout their GA journey.

- Explain the irreversible impact GA may have on vision
- Emphasize the importance of regular monitoring and follow-up appointments[9]

Partnering With Your Eye Care Colleagues



Collaborative multidisciplinary care is increasingly important.[9]

Discuss with your retinal specialist partner:

- Which patients to refer, and where they are in their course of disease
- What information to share—consider discussing previous imaging scans, changes in functional vision, patient history, and any other clinically helpful information and considerations
- How you can collaborate to monitor potential disease progression

Use your smartphone camera to scan this QR code or visit www.SeeGADifferently.ca to learn more.

CFP = colour fundus photography; FAF = fundus autofluorescence; OCT = optical coherence tomography; RPE = retinal pigment epithelium.

References: 1. Anegondi N, et al. *Ophthalmology*. 2025;132(4):420-430. **2.** Fleckenstein M, et al. *Ophthalmology*. 2018;125(3):369-390. **3.** Yung M, Klufas MA, Sarraf D. *Int J Retina Vitreous*. 2016;2:12. **4.** Carlton J, Barnes S, Haywood A. *Br Ir Orthopt J*. 2019;15(1):133-141. **5.** Sivaprasad S, et al. *Ophthalmol Ther*. 2019;8(1):115-124. **6.** Singh RP, et al. *Am J Ophthalm Clin Trials*. 2019;2(1):1-6. **7.** Patel PJ, et al. *Clin Ophthalmol*. 2020;14:15-28. **8.** Lindblad AS, et al. *Arch Ophthalmol*. 2009;127(9):1168-1174. **9.** Regillo CD, et al. *Clin Ophthalmol*. 2024;18:325-335.

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