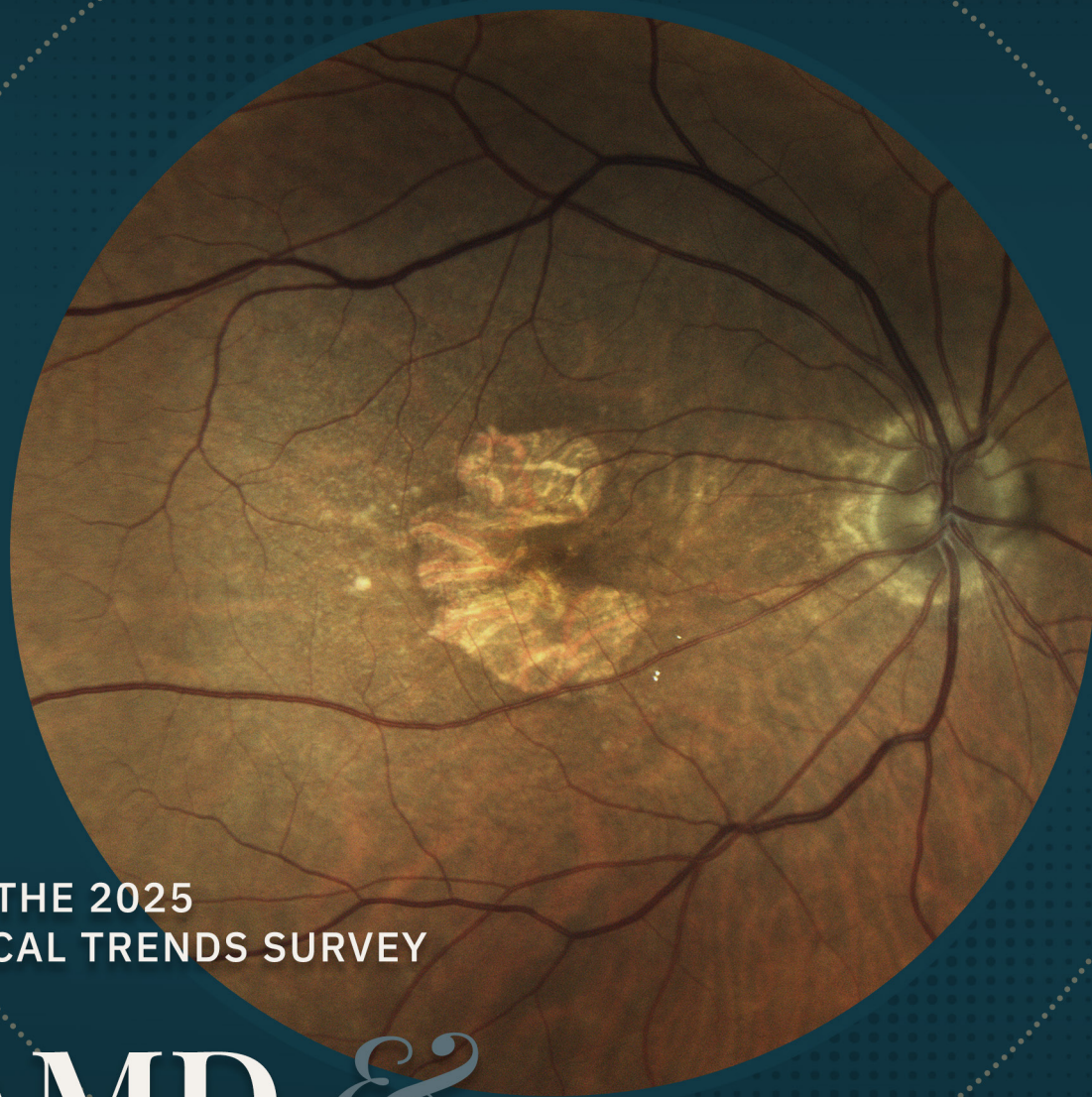


EURETINA • CLINICAL TRENDS SERIES



INSIGHTS FROM THE 2025
EURETINA CLINICAL TRENDS SURVEY

Dry AMD & Geographic Atrophy

BY
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On behalf of the EURETINA Imaging Section

Dry AMD and Geographic Atrophy

In this edition of the EURETINA Clinical Trends Series, Prof. Stela Vujosevic, Chair of the EURETINA Imaging Subspecialty Section, shares expert perspectives on key findings from the 2025 EURETINA Clinical Trends Survey.

Focusing on dry age-related macular degeneration (AMD) and geographic atrophy (GA), this report explores how emerging therapies, advances in multimodal imaging, and evolving biomarkers are transforming the diagnosis, monitoring, and management of retinal disease. The commentary also examines the expanding role of complement inhibition, functional outcome measures, and personalized follow-up strategies aimed at preserving vision and improving quality of life for patients with dry AMD and GA.

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The Shifting Landscape of Dry AMD and Geographic Atrophy

Dry age-related macular degeneration and its advanced form, geographic atrophy, represent a major and growing burden in retinal disease. With the emergence of new therapeutic options and advances in retinal imaging, the management of dry AMD is entering a period of significant clinical evolution.

The 2025 EURETINA Clinical Trends Survey offers valuable insight into how retina specialists are adapting their approach to diagnosis, monitoring, risk stratification, and long-term patient management in this rapidly changing

landscape. The findings reflect a growing emphasis on earlier disease detection, multimodal imaging, individualized monitoring strategies, and the identification of biomarkers associated with progression risk.

As awareness of emerging therapies grows among both clinicians and patients, dry AMD is shifting from a traditionally observational disease toward a more proactive and personalized model of care centered on preserving visual function and quality of life.

Epidemiology

Patient Volume

Understanding patient volume provides important context for interpreting how retina specialists approach dry AMD and GA in routine clinical practice. Survey respondents reported seeing an average of 41 patients with dry AMD per month (**Figure 1**).

■ How many patients do you see monthly, who have dry AMD?

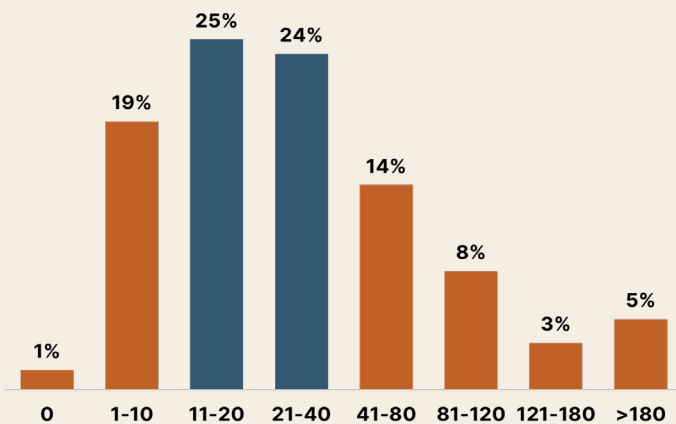


Figure 1. Survey respondents reported seeing an average of 41 patients with dry AMD per month.

The findings highlight the substantial and growing clinical burden of dry AMD in everyday retina practice, with most respondents reporting between 11 and 40 dry AMD patients per month and a relevant proportion managing even higher volumes. This trend reflects increasing clinical attention toward dry AMD in recent years, which is expected to accelerate further as emerging therapies become more widely available.

“Retina specialists are reassessing dry AMD with greater clinical awareness and evolving perspectives on diagnosis, monitoring, and management.”

Importantly, dry AMD is increasingly being viewed through a new clinical lens. The focus is no longer limited to advanced GA but is progressively expanding to include earlier and intermediate stages of disease. This shift is driving earlier diagnosis, closer monitoring, and more personalized follow-up strategies aimed at identifying patients at higher risk of progression before irreversible vision loss occurs.

Several factors are contributing to the growing number of patients seen in referral centers, including advances in multimodal imaging, expanding therapeutic opportunities, and greater patient awareness. In addition, patients at different stages of dry AMD are increasingly seeking specialized retinal evaluation after learning about newly available or emerging treatment options, further contributing to rising clinic volumes.

Disease Stages

Characterizing the distribution of early, intermediate, and GA stages within the dry AMD population is important for understanding disease burden, anticipating monitoring needs, and identifying patients who may become eligible for emerging therapies.

On average, respondents reported that 30% of their dry AMD patients have early dry AMD, 29% have intermediate dry AMD, and 17% have geographic atrophy (**Figure 2**).

■ What percentage of your dry AMD patients have early, intermediate, or GA?

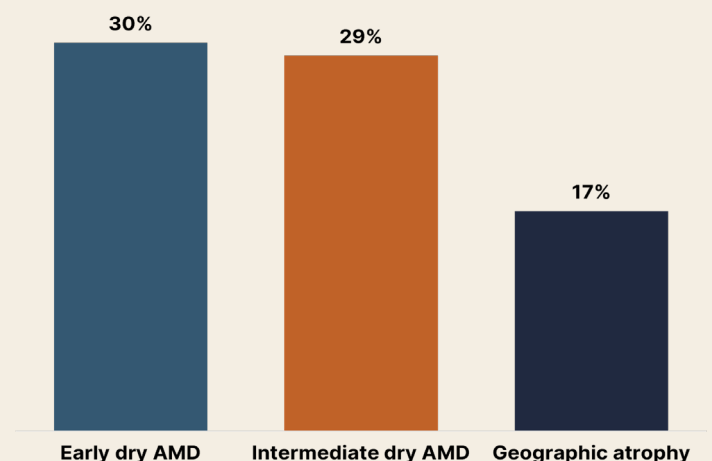


Figure 2. Average patient distribution across dry AMD stages in clinical practice, as reported by survey respondents: 30% early dry AMD, 29% intermediate dry AMD, and 17% geographic atrophy.

Overall, the reported numbers align well with what we commonly see in clinical practice. When discussing disease stage with my patients, I typically describe dry AMD as a continuum of progression, where early, intermediate, and GA stages reflect different degrees of retinal damage and potential for visual impairment.

In the earlier stages, my emphasis is primarily on modification of risk factors, patient education, and the importance of regular check-ups. For patients with intermediate AMD, I generally recommend closer monitoring because of the higher risk of progression to advanced disease. When discussing GA, I explain that it represents a more advanced phase characterized by irreversible retinal cell loss, while also highlighting that emerging therapies may help slow disease progression.

In my experience, the way disease stage is communicated can significantly influence how patients perceive their prognosis, monitoring needs, and treatment expectations. I also inform patients that functional changes and reductions in quality of life may occur even before major visual acuity loss becomes evident. For this reason, I believe continuous monitoring remains essential across all stages of dry AMD.

Diagnosis and Monitoring

Diagnostic Techniques

Accurate diagnosis of dry AMD increasingly relies on a combination of advanced imaging modalities and, to a lesser extent, functional assessments that together provide a more comprehensive understanding of disease stage and progression risk.

Among survey respondents, OCT was nearly universal at the time of diagnosis in patients with suspected dry AMD; used by 96% of clinicians. Fundus photography (65%), fundus autofluorescence (FAF; 56%), and OCT angiography (OCTA; 47%) represented the next most commonly used imaging modalities **(Figure 3)**.

■ What are all the techniques that you use at time of diagnosis in a patient you suspect has dry AMD? (Select all that apply.)

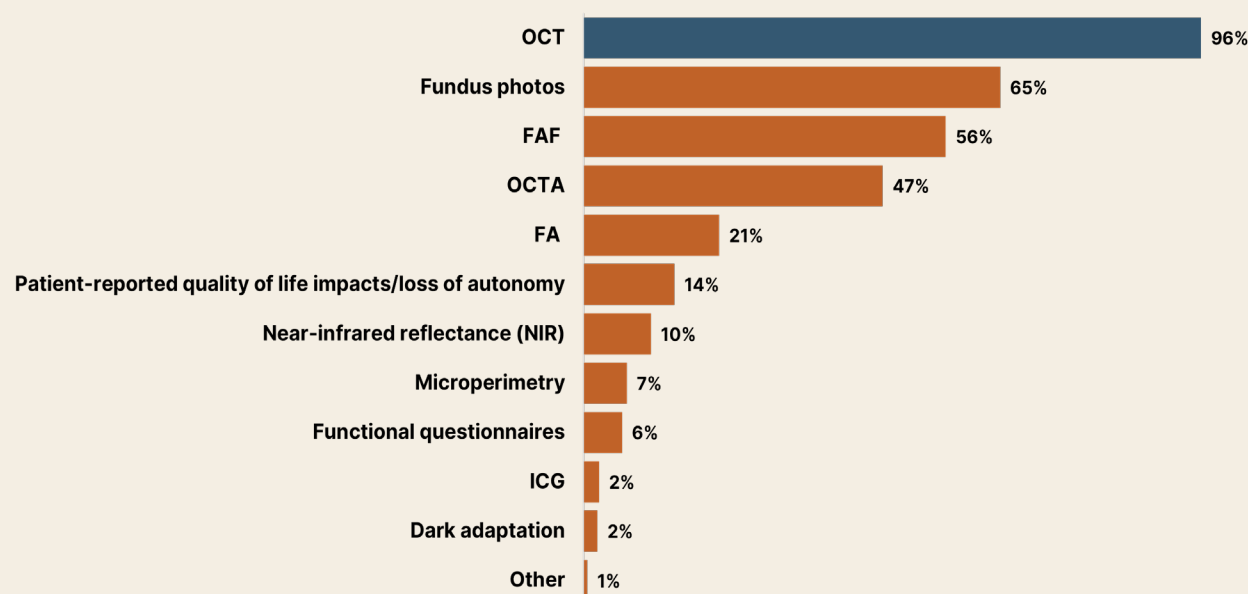


Figure 3. Techniques used at the time of diagnosis of suspected dry AMD, as reported by survey respondents. OCT was the most commonly utilized modality (96%), followed by fundus photography (65%), fundus autofluorescence (56%), and OCT angiography (47%).

“OCT has become the cornerstone for diagnosis, staging, and monitoring of dry AMD.”

These findings reflect the central role of OCT in contemporary dry AMD management. It enables precise visualization of structural biomarkers associated with disease progression, including ellipsoid zone (EZ) disruption, outer nuclear layer (ONL) thinning, and areas of incomplete and complete retinal pigment epithelium and outer retinal atrophy (iRORA and cRORA).

At the same time, multimodal imaging remains essential for achieving a more complete characterization of dry AMD. Color fundus photography continues to play an important role in clinical documentation, longitudinal comparison, and AMD phenotyping, particularly for detecting pigmentary changes and drusen characteristics. Fundus autofluorescence (FAF) offers valuable insight into retinal pigment epithelium (RPE) health and atrophic progression, often revealing areas of dysfunction before complete structural loss appears on OCT. In patients with GA, FAF is particularly useful for assessing lesion margins, progression patterns, and junctional zone activity, especially when interpreted alongside functional testing such as microperimetry.

OCT angiography (OCTA) is also becoming increasingly relevant, both for identifying macular neovascularization and for evaluating choriocapillaris impairment, which may contribute to progression risk stratification. Although fluorescein angiography (FA) is less commonly required in pure dry AMD, it still maintains an important role when conversion to neovascular AMD is suspected or when OCT and OCTA findings are ambiguous.

Overall, dry AMD is a complex and heterogeneous disease, and multimodal imaging allows a more comprehensive structural, vascular, and metabolic assessment than OCT alone.

The survey also highlights the relatively limited use of functional assessments such as microperimetry, dark adaptation testing, and patient-reported outcome measures (PROMS). However, with the advent of new therapies, there is growing recognition that structural findings alone may not fully capture the patient's visual experience or the true functional impact of disease progression.

Hallmarks of Progression

Once dry AMD is diagnosed, clinicians rely on a combination of structural and functional markers to monitor disease progression over time.

Among survey respondents, atrophic lesion growth was the most commonly cited hallmark of progression, selected by 87% of respondents, followed closely by visual acuity loss at 80% (**Figure 4**).

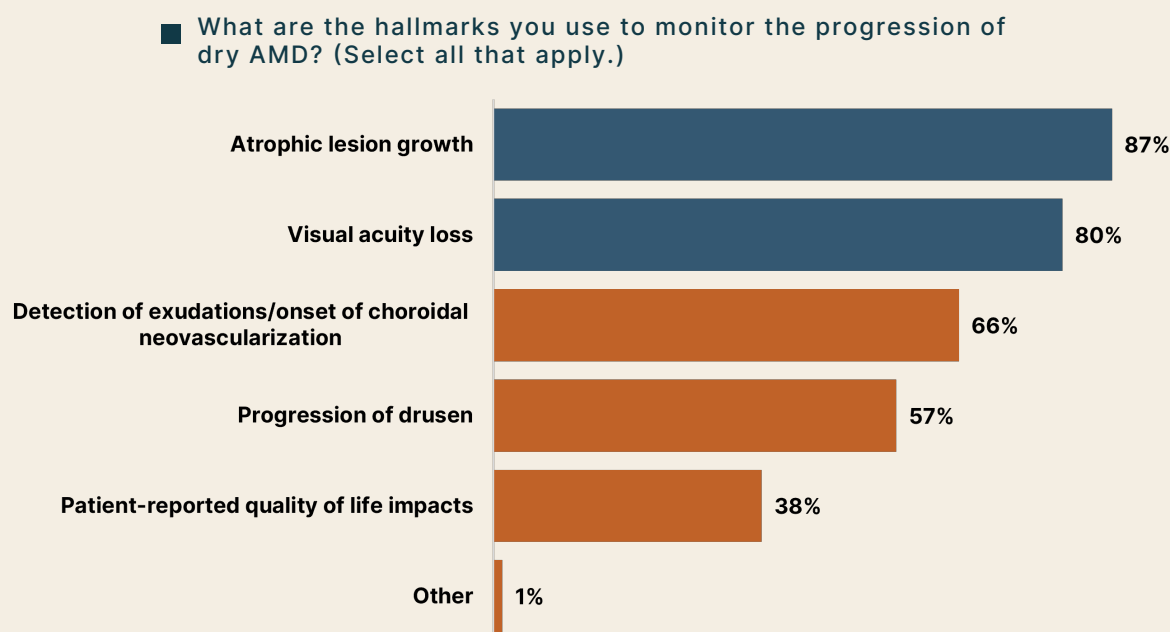


Figure 4. Hallmarks used by survey respondents to monitor dry AMD progression. Atrophic lesion growth (87%) and visual acuity loss (80%) were the most frequently cited indicators.

“Structural and functional changes should be viewed as complementary hallmarks of dry AMD progression.”

These findings highlight the importance of integrating both anatomical and functional assessments when evaluating disease progression and making management decisions. In my opinion, structural progression and functional decline should be considered complementary rather than separate aspects of dry AMD. Selecting the most appropriate endpoints is crucial not only for clinical trial success, but also for ensuring meaningful benefits for patients.

Recent clinical trials investigating therapies for GA, including OAKS, DERBY, and GATHER,^{1,2} have underscored an important discrepancy between anatomical outcomes and functional improvements, demonstrating that slowing atrophic lesion growth does not always directly translate into measurable improvements in visual function or patient experience. Visual acuity, although widely used, often fails to capture subtle or early functional impairment, particularly in the earlier stages of the disease.

As a result, complementary functional assessments such as microperimetry, dark adaptation testing, low-luminance visual acuity, reading speed, and PROMs are becoming more relevant. Importantly, there is currently no single gold-standard functional endpoint for dry AMD, and functional changes may vary according to disease stage, lesion phenotype, and individual patient characteristics.

The survey also highlights the evolving role of PROMs in dry AMD management. PROMs provide direct insight into how patients perceive their vision and its impact on daily life. These measures address challenges related to reading, mobility, driving, low-light adaptation, independence, social interaction, and overall quality of life. These aspects are not fully reflected by anatomical imaging or standard visual acuity measures alone.

Supporting this perspective, recent data from AREDS patients showed that GA lesion area was significantly associated with decline in vision-related quality of life (VRQOL), even after accounting for visual acuity.³ These results reinforce the importance of understanding the relationship between GA subtypes, functional impairment, and patient-centered quality-of-life outcomes, especially as therapeutic strategies continue to evolve.

“The endpoint of patient care, at least for the patients, is the functional outcome and quality of life.”

Ultimately, what matters most to patients is how the disease affects their daily functioning and overall quality of life. To better capture these outcomes, there is a need for validated, disease-specific PROMs that can be consistently integrated into both routine clinical practice and future clinical trials.

OCT Biomarkers for Progression Risk

OCT has become central not only for diagnosing dry AMD, but also for stratifying the risk of progression to GA.

Among survey respondents, autofluorescence patterns were the most commonly used biomarker for assessing progression risk (62%), followed by large drusen size (59%), pigmentary changes (53%), and iRORA/cRORA (53%) (Figure 5).

■ What are OCT biomarkers you rely on to evaluate a patient's risk for progression to GA? (Select all that apply.)

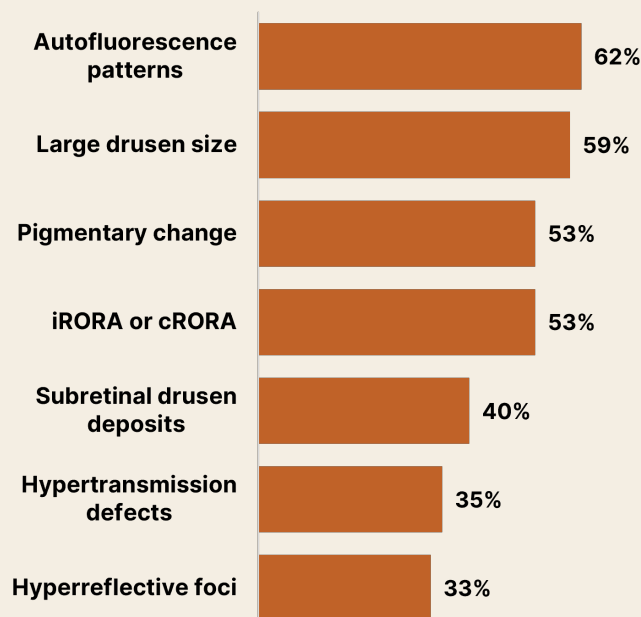


Figure 5. OCT biomarkers used by survey respondents to assess the risk of progression to geographic atrophy. Autofluorescence patterns (62%) were the most commonly selected biomarker, followed by large drusen size (59%), pigmentary changes (53%), and iRORA/cRORA (53%).

FAF patterns, drusen size, and pigmentary abnormalities remain key indicators of disease progression and are widely used in routine practice to help identify patients at higher risk of developing GA.

At the same time, newer OCT-defined features such as iRORA, cRORA, and hypertransmission defects are becoming increasingly used across referral networks as new biomarkers for dry AMD progression, although their interpretation and application may still vary. The CAM classification⁴ has significantly improved the standardization of OCT-defined atrophic features, helping clinicians to detect earlier stages of retinal degeneration before the development of frank GA, which is incredibly helpful.

However, differentiating some intermediate lesions such as iRORA and nascent GA (nGA) can still be challenging in daily clinical practice because these entities may partially overlap morphologically while representing distinct biological stages of disease progression.⁵ In our recent work, we observed that iRORA and nGA may differ not only structurally, but also metabolically.⁶

“Multimodal imaging can provide complementary information beyond structural OCT alone and may help better stratify progression risk in patients with intermediate AMD.”

These observations further support the value of multimodal imaging in dry AMD. Combining OCT with FAF and other imaging modalities provides complementary information beyond structural assessment alone and improves progression risk stratification in patients with intermediate AMD.

Hypertransmission defects are also increasingly recognized as clinically relevant biomarkers because they reflect RPE attenuation and outer retinal loss. Nevertheless, some variability still exists in how these findings are reported and incorporated into management decisions.

As therapeutic options for dry AMD continue to expand, there is a clear shift toward more precise phenotyping and earlier identification of high-risk atrophic changes through standardized OCT terminology and multimodal imaging biomarkers.

Predictors of Fast Disease Progression

Beyond OCT findings, respondents identified a broader set of features that they associate with faster disease progression in dry AMD.

Baseline lesion size was the most commonly cited predictor (64%), followed by FAF pattern (58%), lesion location (57%), multifocality (56%), fellow-eye status (50%), presence of reticular pseudodrusen (41%), and larger low-luminance deficit (13%) (**Figure 6**).

■ **What are predictors for a fast disease progression in a dry AMD patient? (Select all that apply.)**

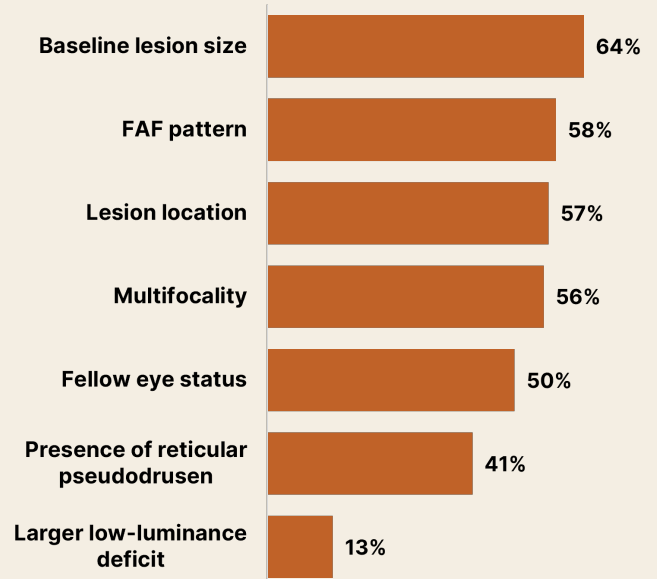


Figure 6. Predictors of rapid dry AMD progression, as reported by survey respondents. Baseline lesion size (64%) was the most commonly cited predictor, followed by FAF pattern (58%), lesion location (57%), and multifocality (56%).

“I prefer to analyze multiple imaging biomarkers together rather than relying on a single predictor.”

In my experience, assessing the risk of progression requires evaluation of multiple imaging biomarkers together rather than relying on a single parameter. When counseling newly diagnosed patients, the features I consider most important include lesion location, particularly non-foveal involvement, irregular FAF patterns, multifocal lesions, reticular pseudodrusen, thin choroid, and a non-circular/irregular lesion shape.

Reticular pseudodrusen and thin choroid are often associated with wider retinal and choroidal dysfunction, while multifocal lesions, non-foveal involvement, and a non-circular lesion morphology may indicate a more aggressive growth pattern and faster atrophic progression over time. Combining these biomarkers provides a more accurate prediction of disease course and supports a more personalized approach to patient counseling and follow-up planning.

In addition, I find it useful to reassess patients at least one more time in order to better understand the speed of the lesion(s) progression.

These predictors also play an important role in guiding practical monitoring strategies. Patients with high-risk features are generally monitored more closely, particularly when the fellow eye is already affected. In these cases, follow-up intervals are often shortened and multimodal imaging, including OCT, FAF, and OCTA, is integrated with functional assessments such as microperimetry whenever available.

As therapeutic options continue to evolve, identifying patients at higher risk of rapid progression is becoming increasingly important not only for clinical management, but also for selecting appropriate candidates for clinical trials and future early-intervention strategies.

Progression to Central GA

While biomarkers and lesion characteristics help identify patients at higher risk of progression, understanding how quickly non-central GA may progress to foveal involvement is important for patient counseling, monitoring strategies, and treatment planning.

Survey respondents reported a wide range of estimates for the time required to progress from non-central GA to central GA, highlighting the significant variability in disease progression observed in clinical practice (**Figure 7**).

■ On average, how long do you believe it takes a patient to progress from first non-central GA to central GA?

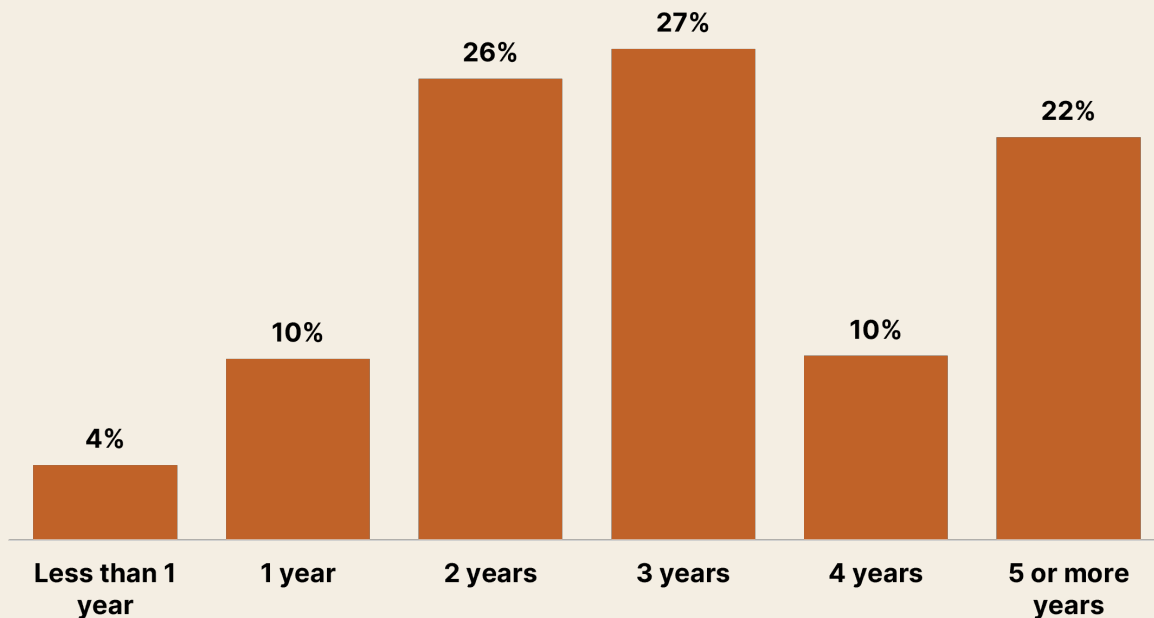


Figure 7. Survey respondents reported substantial variability in their estimates of progression from non-central GA to central GA. While the most common responses (53%) were 2–3 years, a notable proportion (22%) estimated that progression takes more than 5 years.

This variability reflects the complex and heterogeneous nature of dry AMD progression. The rate of progression depends on multiple structural and functional risk factors rather than on a single parameter alone. When discussing GA progression toward the fovea with patients, I typically emphasize that the course of dry AMD can vary considerably from one patient to another. I explain that imaging biomarkers may help estimate the likelihood and rate of progression to central involvement, although predicting an exact timeline for an individual remains challenging.

These conversations are often crucial when considering treatment decisions. In my experience, patients who better understand the risk of central GA progression and

irreversible vision loss are often more willing to consider early intervention strategies aimed at slowing disease progression, even when visual acuity is still relatively preserved. At the same time, it is important to establish realistic expectations by clarifying that current therapies are designed to slow progression rather than restore lost vision.

Understanding the potential timeline to foveal involvement can also help guide follow-up strategies and identify patients who may benefit from earlier intervention.

Monitoring Frequency

Monitoring cadence reflects both the perceived risk of disease progression and the practical realities of clinical practice.

The majority of respondents reported seeing their dry AMD and GA patients every six months (53%), with 22% scheduling follow-up visits every three months, 18% annually, and 7% less frequently than once a year (**Figure 8**).

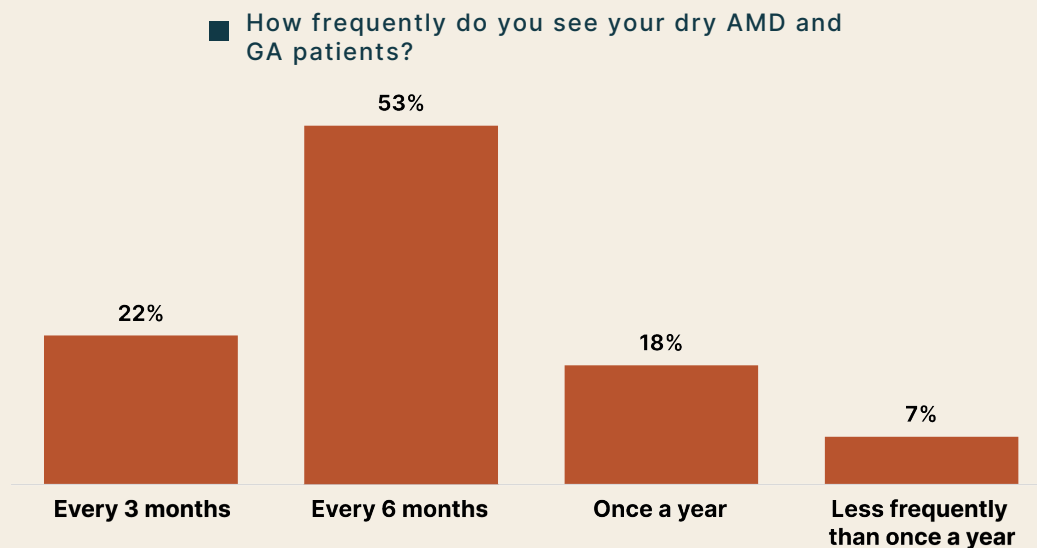


Figure 8. A majority of respondents (53%) see their dry AMD and GA patients every 6 months.

In my opinion, a fixed six-month follow-up interval is unlikely to be appropriate for the entire spectrum of dry AMD and GA. Monitoring strategies should be tailored according to disease stage, imaging biomarkers, functional status, and estimated risk of progression.

Patients with early or stable intermediate AMD can typically be monitored every 6 to 12 months, whereas those with high-risk GA may benefit from closer surveillance. In these patients, multimodal imaging, including OCT, FAF, OCTA, and, when available, functional assessments, may

help identify subtle changes and support more informed management decisions.

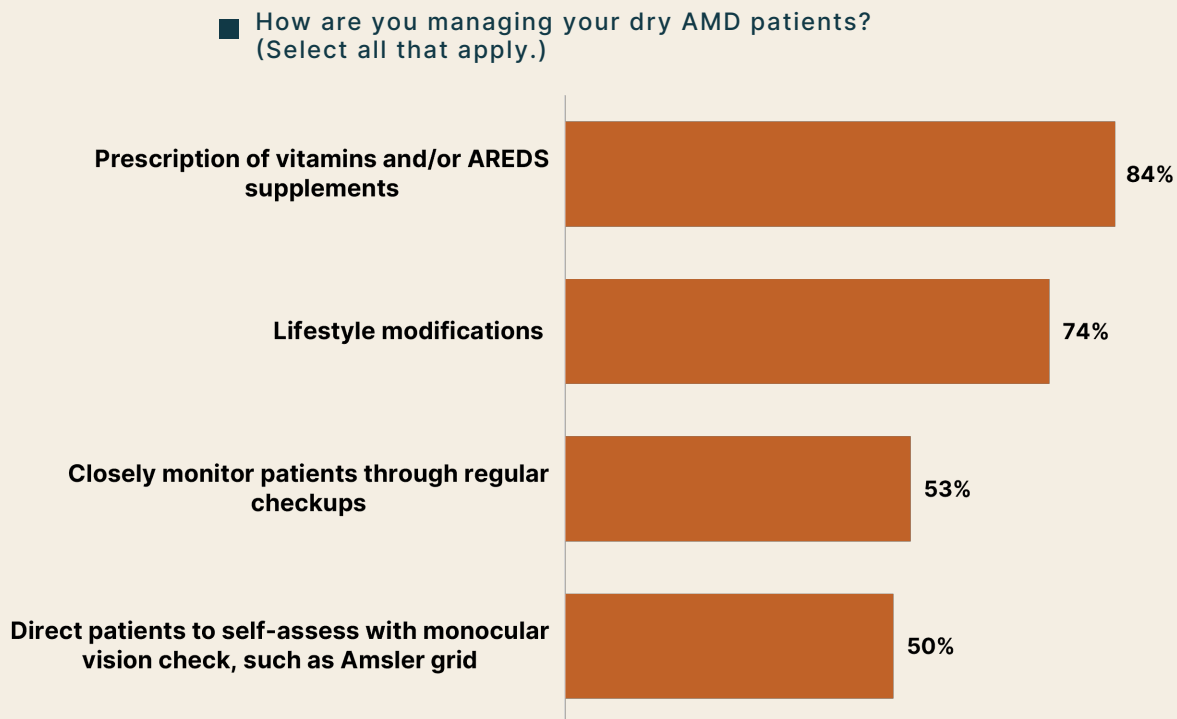
As disease-modifying therapies become more widely available, personalized monitoring strategies will become increasingly important. In particular, complement inhibitor therapy is likely to increase visit frequency, as regular follow-up will be required to monitor treatment response and potential adverse events such as exudative conversion or intraocular inflammation.

Management and Treatment

Current Management of Dry AMD

Before considering emerging GA-specific therapies, it is important to understand how retina specialists currently manage the broader population of patients with dry AMD.

Prescription of vitamins and/or AREDS supplements remains the most common management approach, cited by 84% of respondents, followed by lifestyle modifications and regular clinical monitoring (**Figure 9**).



Only the top four responses are shown; all other responses were selected by 15% or fewer respondents.

Figure 9. Reported management strategies for patients with dry AMD. Vitamins and/or AREDS supplements were the most commonly prescribed intervention (84%), followed by lifestyle modifications and regular clinical monitoring.

For many years, the management of dry AMD has relied primarily on AREDS supplementation and lifestyle modifications. Supporting this approach, a recent post hoc analysis of the AREDS and AREDS 2 studies showed that, among patients with non-central GA, antioxidant supplementation significantly slowed the progression of non-central GA toward the fovea compared to placebo.⁷ The findings also highlight the importance of regular clinical monitoring, which remains a cornerstone of patient care.

Emerging treatments will likely drive the need for closer and more continuous monitoring, increasing interest in home-based technologies such as artificial intelligence (AI)-assisted image analysis, home OCT, remote visual function testing, and digital monitoring platforms. These tools will facilitate early detection of disease progression while reducing the burden of frequent in-office visits. However, their broader adoption will depend on clinical validation, cost-effectiveness, accessibility, seamless integration into routine workflows, and the ability to address privacy and data security concerns.

A CLOSER LOOK

The Role of Photobiomodulation

Survey responses revealed mixed views regarding photobiomodulation (PBM), with most respondents considering the current evidence insufficient to support widespread adoption.

Although studies such as LIGHTSITE III have reported encouraging anatomical and functional outcomes in intermediate dry AMD, uncertainties remain regarding long-term efficacy, patient selection, treatment protocols, and real-world implementation.

Additional prospective studies are needed to better define the role of PBM in dry AMD management.⁸

Parameters for Successful GA Management

Defining successful management of GA remains challenging, particularly in a slowly progressive disease where anatomical and functional outcomes do not always align.

Among the survey respondents, stability of visual acuity (e.g., Snellen acuity) was the most commonly cited parameter of management success (71%), although no single measure emerged as a clear consensus endpoint (**Figure 10**).

- Which of the following do you use as a parameter to define successful GA management? (Select all that apply.)

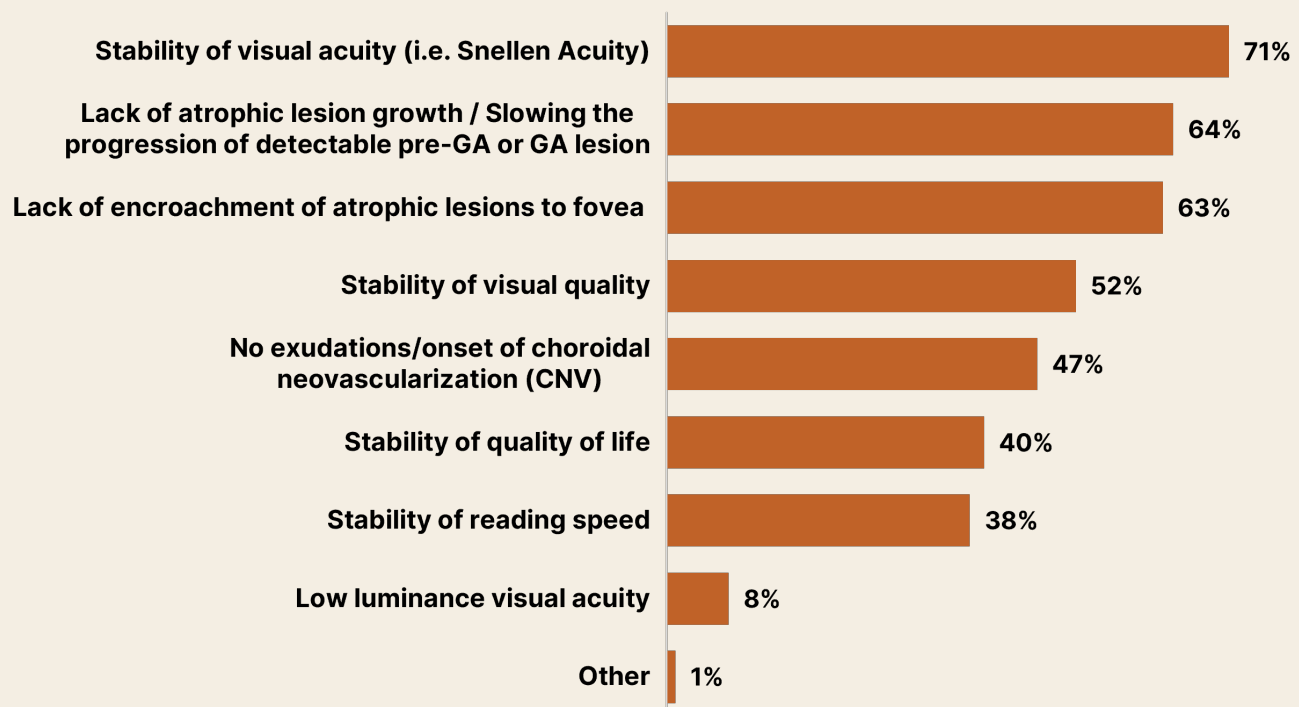


Figure 10. Reported parameters for defining successful GA management. Stability of visual acuity (e.g., Snellen acuity) was the most frequently cited measure of success (71%), although responses were distributed across multiple outcome measures.

Many patients with early GA maintain relatively stable visual acuity until foveal involvement occurs, meaning that reliance on Snellen acuity alone may underestimate both disease progression and its true functional impact. Functional assessments such as reading speed and low-luminance visual acuity are, therefore, gaining importance, as they can detect subtle visual impairment earlier and often better reflect patients' everyday visual experiences.

Reading performance, in particular, may decline before major central visual acuity loss becomes evident and has been associated with reduced independence and overall disease progression. Likewise, low-luminance visual acuity is increasingly recognized as a meaningful functional endpoint, as many patients experience significant visual difficulties in dim lighting conditions despite preserved conventional

visual acuity, and larger low-luminance deficits have been associated with faster BCVA decline and GA progression, potentially reflecting early cone dysfunction.

As therapies increasingly aim to preserve meaningful functional vision rather than simply slow anatomical changes, integrating these measures may provide a more patient-centered definition of therapeutic success. I would also highlight quantitative contrast sensitivity as an emerging functional assessment with growing importance in clinical trials and considerable potential for routine clinical practice.

Together with PROMs, these measures may help bridge the gap between anatomical outcomes and the aspects of vision that matter most to patients.

Anticipated Use of Complement Inhibitors

Complement inhibitors represent the first disease-modifying therapies approved in some regions for GA, and their adoption is expected to evolve rapidly as experience with these agents grows. On average, survey respondents indicated they would treat 37% of their patients with GA with a complement inhibitor if one were available to them.

When considering complement inhibition for patients with GA, it is important to evaluate the overall risk of disease progression alongside lesion features, baseline functional status, fellow eye involvement, age, treatment burden, and patient expectations.

In particular, patients with extrafoveal or foveal-sparing GA, multifocal lesions, reticular pseudodrusen, hyperautofluorescent junctional patterns, or other high-risk imaging biomarkers may benefit most from therapies aimed at slowing progression before central vision is irreversibly affected. Indeed, nearly two-thirds of respondents (65%) identified patients with foveal-sparing GA and a fellow eye with total GA as the group most likely to benefit from complement inhibition therapy. Functional status is equally important, as patients with relatively preserved visual acuity and meaningful residual visual function may have the most

to gain from delaying foveal involvement and maintaining independence for longer.

Recent studies have also shown that lesion phenotype may influence not only anatomical progression but also the trajectory of functional decline. Larger extrafoveal multifocal lesions tend to expand more rapidly, whereas smaller unifocal and subfoveal lesions may be associated with greater deterioration in visual acuity and reading performance over time. These findings underscore the complexity of patient selection and treatment timing.

At the same time, practical considerations remain essential, including the patient's ability to adhere to frequent monitoring visits and intravitreal injections, as well as the potential risk of complications and the overall treatment burden.

Overall, the patients most likely to benefit from complement inhibition are those with earlier-stage GA, preserved central vision, and higher-risk biomarkers suggesting faster progression, where slowing atrophy may translate into meaningful long-term functional benefit and quality-of-life preservation.

Safety Concerns with Emerging GA Treatments

Safety considerations play a central role in decisions about whether and when to initiate emerging GA therapies.

Among survey respondents, conversion to neovascular AMD (nAMD) was the most commonly cited safety concern (51%), more than twice as frequent as any other adverse event (**Figure 11**).

■ Regarding adverse events or side-effects, which is your primary concern with emerging treatments for GA?

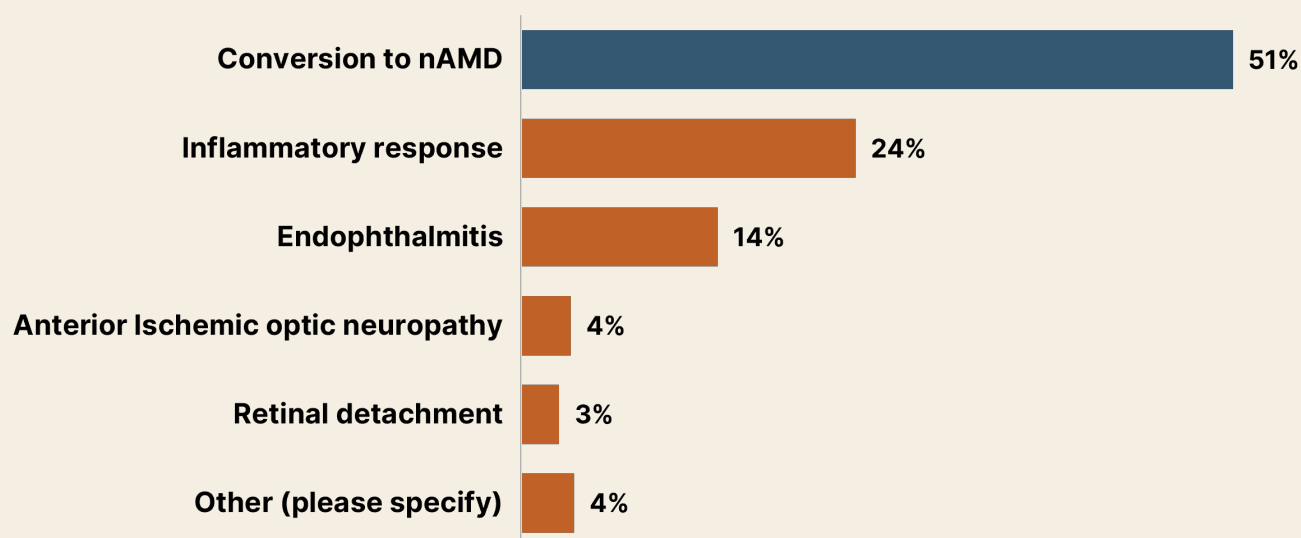


Figure 11. Primary safety concerns regarding emerging treatments for GA, as reported by survey respondents. Conversion to nAMD was the leading concern (51%), cited more than twice as frequently as any other adverse event.

The risk of conversion to nAMD remains one of the primary concerns when considering intravitreal complement inhibition for GA and must be weighed against the benefit of slowing atrophic progression. Clinical trials have consistently demonstrated that complement inhibitors can reduce the rate of GA growth, but treatment decisions should always be considered within the context of the individual patient's disease characteristics, functional status, and risk profile.

“The balance between risks and benefits largely depends on the individual patient profile.”

At the same time, other safety considerations, including intraocular inflammation, endophthalmitis, and complications associated with repeated injections, require ongoing vigilance, even though these events are relatively uncommon. For this reason, careful patient selection, thorough counseling, and close follow-up are essential components of successful treatment.

In my view, the benefits of complement inhibition generally outweigh the associated risks. However, treatment decisions should remain highly individualized and based on a transparent discussion of both the expected benefits and potential safety concerns.

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Meet the Author

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Retina specialist, Head of Ophthalmology Unit-Medical Retina at San Giuseppe Hospital, MultiMedica Group in Milan and assoc/Professor of Ophthalmology at the University of Milan, already qualified as Full Professor in 2020.

Her MD, PhD and Ophthalmology training were performed at the University of Padova, Italy. Medical Retina Fellowship and Reading Centre fellowship were performed at the Moorfields Eye Hospital, London, UK.

She has an extensive global research network collaborations and has been dedicated in increasing and disseminating worldwide the knowledge on imaging biomarkers, structure-function correlations, quality of life and patient reported outcome measures and AI application in retinal diseases and retinal trials. She has been actively involved in training and mentoring young ophthalmologists both in Italy and overseas. She is currently participating in several global working groups and consortiums with the goal to develop and validate novel clinical endpoints and to build global foundation models. She has been participating in numerous clinical trials and research projects, both Italian and international in the role of Principal Investigator.

Gold fellow of the ARVO and the fellow of the EBO; elected member of Diabetic Retinopathy Expert Committee of the EVICRnet, Macula Society, Co-chair of the Imaging Subspecialty Section of the EURETINA, Vice-president of the EAsDEC, scientific committee member of the SISO. Major awards include:

- "The Power List 2022", the Top 100 most influential ophthalmologists in the world by the Ophthalmologist;
- TOP LIST of excellent Women in European Vision Research and Ophthalmology 2021 by the European Vision Institute;
- and Women's Leadership Development in ARVO Program and Gold fellow.

Prof Vujosevic serves as the EIC of Ophthalmic Research, Associate Editor of the AJO Case Reports, and the EBM of the IOVS, JAMA Ophthalmology, RETINA and the Acta Ophthalmologica, and has more than 180 published papers and 8 book chapters.