

Classic CNV

Classic CNV is characterized by well-demarcated hyperfluorescence in early phases on FA and late leakage that obscures the boundaries of the lesion ([Fig. 8](#)).

As defined by Donald Gass, classic CNV lies between the neurosensory retina and the RPE (type II CNV) ([10](#)).

Angiographic classic CNV appears as a lacy or bicycle-wheel pattern.

Depending on its location, it can be classified as extrafoveal (>200 microns from the foveal center) ([Fig. 9](#)), juxtafoveal (1-199 microns from the foveal center) ([Fig. 10](#)) or subfoveal (involving the foveal center) ([Fig. 11](#)).

Sometimes, a feeder vessel can be localized ([Fig. 12](#)).

Another typical feature is the presence of a hyperpigmented rim, hypofluorescent on FA, surrounding the CNV ([Fig. 12](#)).

On occasion, classic CNV can be associated to loculated fluid ([Fig. 13](#)).

In loculated fluid, dye pooling is well-demarcated in a confined space of a localized sensory retinal detachment or within intraretinal cystic spaces.

It was a common finding in patients with new subfoveal CNV in the Macular Photocoagulation Study (MPS) and may confuse the treating physician as to the boundary of the lesion ([11](#)).

Depending on their sizes, classic CNV can be classified as small ([Fig. 9-11](#)) or medium ([Fig. 14](#)) or large ([Fig. 15](#)).

Importantly, larger classic CNV are associated to a poorer visual prognosis since they represent long-term duration of the pathological disorder.

Classic CNV is an emergency and it requires early treatment to halt the progression of the disease.

Without treatment, CNV tend to enlarge and irreversible fibrosis appears ([Fig. 16](#)).

In the last decade of the last century, the advent of photodynamic therapy (PDT) with verteporfin promoted a classification of the lesions depending on the percentage of classic CNV.

Thus, predominantly classic lesions were defined as having 50% or more of the total lesion size comprised of classic CNV ([Fig. 17](#)).

On the other hand, minimally classic lesions were characterized by classic CNV occupying less than 50% of the total lesion size ([Fig. 18](#))([12](#)).

The best results with PDT in wet AMD patients were obtained in the treatment of predominantly classic lesions.

Nowadays, in the antiangiogenic therapy era, this classification has lost popularity among ophthalmologists since lesion composition does not seem to be as relevant as it was with PDT.

Lesion components associated with neovascular AMD that can obscure the boundaries of CNV include changes that block fluorescence, such as blood, fibrous tissue, RPE hyperplasia, or RPE redundancy (from an RPE tear).

Likewise, CNV can be obscured by greater fluorescence from staining or pooling.

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