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. . .and vision rehabilitation

This month is the American Optometric Association's Save Your Vision Month and a time to "remind Americans of all ages about how important regular eye examinations are for maintaining healthy vision and overall good health" (*http://www.aoa.org/x5072.xml*). In keeping with the spirit of that statement, I am ever mindful that "refractive error has been identified . . .as the leading cause of visual impairment in the developed world and a leading cause of blindness in the developing world. . ."[1] The U.S. Centers for Disease Control and Prevention (CDC) reported, in fact, that "the nearly two thirds of adults with diabetes who have visual impairment can be adequately corrected with the prescription of eyeglasses or contact lenses."[2] For those whose sight cannot be corrected by conventional eyeglasses and contact lenses, there should be, and are, public service awareness campaigns addressing their concerns, like those below.

Last month, Prevent Blindness America (*http://www.healthfinder.gov/library/nho/nho.asp?year=2007*) and this month, the American Academy of Ophthalmology (Eye M.D. Observances 2007[3]), both designated AMD/Low Vision Awareness as the topic(s) for their respective public service campaigns. I am certainly very pleased to see the juxtaposition of these 2 topics, as macular degeneration is one of the leading causes of visual impairment of (white) adults in the U.S., as well as worldwide.[4] I would, however, encourage all future public awareness campaigns from the entire ophthalmic community to include low vision awareness with any of the other topical areas (such as glaucoma, cataracts, and diabetic eye disease), which can result in diminished vision. These initiatives are not only directed to the public but should also serve to remind the ophthalmic community of the continuum of eye and vision care, which in some cases goes beyond diagnosis and medical or surgical intervention, to include vision rehabilitation. Regrettably, all too often, low vision awareness appears in isolation, as a topic unto itself; the artificial separation of this treatment option does not support the need in a practitioner's mind for the complete care of a patient.

In January 2007, I had the opportunity to address the topic of low vision awareness in the same forum as other ophthalmic presentations, at the Alcon-sponsored Informed Educators Meeting, with some 150 participants. Notably, I was the first presenter, rather than the last (which is often the case with this topic), and I spoke only about the concept of rehabilitation as a treatment option, not about how to evaluate and prescribe for the visually impaired population. This was by design, as it stressed the need for the participants to think about vision rehabilitative services as they were listening to the other topics, which included recent advances in cataract and glaucoma treatment. I think the presentation accomplished just that, raising the awareness of the need for eye care providers to think about vision rehabilitative services as a treatment option along the continuum of care. The charge to this international audience was then to think in terms of what percentage of people with various conditions causing visual impairment could be helped through nutritional, medical, or surgical intervention. And even if the percentage of favorable outcomes (however that may be measured) is considered to be good, for any given patient one must determine if that treatment is *enough* to improve the functioning of that individual. Beyond that, this audience was asked to decide how to care for the rest of the patients for whom the treatment may not have been as therapeutically successful. All of this presupposes that patients are cared for holistically and that time is taken for good communications with patients (specifically by asking the right questions), then knowing where vision rehabilitative services can be obtained and, lastly, by advising the patient of that rehabilitative option in more than a casual manner.

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There is no question that for some of those who suffer from an ocular disorder that can lead to a visual impairment, advances in our understanding of proper nutrition and environmental awareness, and medical and/or surgical intervention, will continue to improve visual outcomes. But even in the best

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of circumstances, there will be those who do not benefit. As an example, a recent article pointed out that for patients with dry AMD ". . . even if all people at high risk fully complied with the daily regimen [Age-Related Eye Disease Study supplement formulation], more than 200,000 people each year in the United States would develop late AMD."[5] Therefore, there "is the continued need for low vision rehabilitative assistance for those whose vision does not get better, (or) for those whose vision gets better but whose improvement does not allow the sight necessary for specific tasks. . .."[6] For these patients, and for others who are disabled or handicapped by a visual impairment, all those in the ophthalmic community would undoubtedly best serve their patients by simply remembering. . .*and vision rehabilitation*.

References

1. Congdon NG, Friedman DS, Lietman T. Important causes of visual impairment in the world today. *JAMA* 2003;290(15):2057-60.
2. Unmet need: CDC study finds many diabetes patients need vision correction. *AOA News* December 18, 2006;45(8):9.
3. Eye M.D. observances 2007. *Ophthalmology* 2007;114(1).
4. The Eye Disease Prevalence Research Group: causes and prevalence of visual impairment among adults in the United States. *Arch Ophthalmology* 2004;122:477-85.
5. The Complications of Age-Related Macular Degeneration Prevention Trial (CAPT) Research Group. Laser treatment in patients with bilateral large drusen. *Ophthalmology* 2006;113(11):1974-86.
6. Freeman PB. With a little help from my friends. *Optometry* 2006;77(12):575-6.