

Sight loss not routine part of old age

A key issue for people over 70 is to maintain and preserve vision enabling them to see well enough to continue living independently as they age in their own homes. Threats to sight must be taken seriously and patients over 70 should be encouraged to have a comprehensive eye examination every year.

The big three in threats to sight for older people are cataracts, diabetic retinopathy, and age-related macular degeneration (ARMD). Early intervention is crucial to outcomes for diabetic retinopathy and ARMD.

Of course, poor vision in any patient requires prompt intervention, and with outpatient waiting times long, general practitioners should consider referring these people to an optometrist as a first step. For example, if the patient has cataracts, the optometrist is capable of assessing the opacity under the local DHB criteria and referring to the hospital only if it is clinically justified. Appropriate prioritization means that those who are likely to have surgery, as they meet the required criteria, will be referred, and the others will remain managed in the community instead of waiting on a

list for an appointment that will not lead to surgery.

Assessment of cataracts can be difficult. Often, while a patient may appear to have marked cataracts when viewed with a direct ophthalmoscope, they may still be achieving surprisingly good vision. Rapid myopic shifts in patients with developing cataracts are not uncommon meaning increasing distance vision problems. To ensure safety, it is important that their glasses continue to be fitted with an appropriate corrective lens until surgery is indicated.

Refractive information can be a useful guide as to the rate of development of a cataract and, as such, act as an indicator of when the surgical option may become a necessity. It is not a good idea to rely solely on the results of pinhole vision.

The optometrist can also measure contrast sensitivity or use some similar measure to assess how much disability is being caused by veiling glare from a cataract.

Most importantly, though, the optometrists will look at the rest of the eye to see if there are other pathologies or changes that may be causing the blurred vision or may compromise the health of the eye or the outcome of cataract surgery.

The most obvious co-morbidities would be age-related macular degeneration (ARMD) and glaucoma. Both these conditions will be identified through a routine optometric consultation.

Optometrists have the skills, knowledge and technology to detect and assess eye pathology and see themselves as part of the team looking after the patient's overall eye care.

Optometrists can play an important role in ensuring patients with cataracts and other pathologies receive the most appropriate and timely attention.

Optometrists can also assist your management of patients with red eye, watery eyes, headaches, diabetes, and loss of vision from macular degeneration.

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Case study - Bill

A 52 year old male presented to an optometrist for a routine eye examination upon the recommendation of his GP. He had worn over-the-counter spectacles for most close work for the last 6 years. He considered his distance vision to be excellent, and reported no eye problems apart from the blurred near vision. Upon further questioning it was determined his grandfather had had poor vision and an aunt had glaucoma.

His unaided vision was R 6/6, L6/9 and with a small hyperopic correction, 6/6 was achieved for both eyes. A reading prescription consistent with his age gave N5 near acuity at 40 cm and as his working distance on his computer was 60cm, a different near prescription was indicated for this task.

Examination with biomicroscope of the anterior eye was unremarkable apart from some fine pigmentary deposits on the endothelium of the cornea. His media were clear. Direct ophthalmoscopy revealed a cup-to disc ratio of 0.7 in right eye, and 0.8 in left eye and normal macula. Upon dilation, indirect ophthalmoscopy detected no peripheral abnormalities but did show subtle notching of the rim of the optic disc, especially in the LE. Intraocular pressures were R17mmHg, L18mmHg measured with applanation tonometry. Automated threshold visual fields were performed and detected a repeatable nasal step scotoma in left eye.

Normal tension glaucoma (NTG) was confirmed upon referral to an ophthalmologist and the patient is now on glaucoma treatment with the aim of reducing intraocular pressure to minimise further damage to optic nerve.

Normal tension glaucoma is also known as low tension glaucoma or normal pressure glaucoma. In this type of glaucoma, the optic nerve is damaged even though intraocular pressure (IOP) is not excessively high. The mechanism is unclear as to why some people's optic nerves are damaged even though they have what is considered to be "normal" (between 10-22 mm Hg) pressure levels. NTG accounts for approximately 25-30% of all glaucoma cases in the U.S. Studies have shown a higher prevalence in Japanese people compared to Europeans.

Normal tension glaucoma is usually detected after an examination of the optic nerve and visual field testing. Currently, ophthalmologists treat normal tension glaucoma by keeping eye pressures as low and stable as possible with medication, laser surgery, or filtering surgery. Regular eye examinations are the best means of ensuring early detection.

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