

Behavioral Ophthalmology - Round Two

In a previous guest editorial in this journal¹ I commented on the rediscovery of pseudo-convergence insufficiency by pediatric ophthalmologists and the implications it held for a common ground between ophthalmologists and optometrists in the diagnosis and treatment of functional vision disorders. I was pleasantly surprised to see this concept elaborated in a new clinical text entitled, *Decision Making in Pediatric Ophthalmology*. In his section on "Abnormal Amplitudes of Convergence," Malcolm L. Mazow, M.D.,² essentially describes what optometrists working in vision therapy have labeled as a "skills" case, choosing to call it "convergence insufficiency syndrome." The key observations by Mazow are that patients with subjective nearpoint complaints may have constricted fusional convergence and/or divergence ranges at near with ostensibly normal phorias and convergence nearpoints, and often have abnormal accommodation as the precipitating factor for the abnormal vergence. As an aside, Mazow probes the concept of non-organic pseudomyopia and the harm done by the inappropriate prescribing of minus lens optical corrections in his section on "Abnormal Amplitudes of Accommodation."³

As much as I enjoyed reading Mazow's passages, I was astounded when I turned the page and read about the "Evaluation of Asthenopia in Childhood," by Andrea Cibis Tongue, M.D.⁴ Tongue first identifies the importance of the relationship between the break and the recovery values on fusional vergence testing. Secondly,

she reviews the clinical testing of accommodative facility (that's right folks, "accommodative facility") with +/- 2.00 lens flippers. Tongue concludes, "Patients with accommodative insufficiency may benefit from orthoptics and/or the wearing of plus lenses for near. Orthoptic exercises include work with plus/minus flipper lenses while reading."

I thought that this was enough enjoyment for one train ride home, but Tongue's sole reference for her section on asthenopia in childhood caught my eye. It was listed as: Rosner J, Rosner J. *Pediatric Ophthalmology*. My good colleague, Marty Bimbaum, had a chuckle over this and speculated on the extent of Freudianism behind the renaming of Rosner's book, *Pediatric Optometry*. Was this a subliminal message that, as purported by some of our peers, ophthalmology was attempting to reinvent behavioral/functional optometry and claim it for its own? First contact lenses, then dispensing, and now vision therapy?

Incidentally, I have no qualms about ophthalmology entering into the field of vision therapy. I see a parallel between this development and the evolution of contact lenses. When optometrists first began to fit contact lenses, ophthalmologists warned the public of the dangers inherent in putting a piece of plastic on one's eye. There were no landmark studies that convinced ophthalmologists of the efficacy of contact lenses. Rather the clinical success of optometrists and the demand by the public for this modality drove most ophthalmologists into contact lens fitting. Did the encroachment

of ophthalmology into contact lenses have a negative impact on the field?

To date the medical community has waged a purposeful campaign to discredit vision therapy. I suspect that as ophthalmology enters this arena in an effort to broaden its range of clinical services, the concerns about VT being "educational" or "experimental" in nature will fall by the wayside. The acceptance of vision therapy for reimbursement by third party providers will not be heralded through landmark studies. It will arrive quietly through the insidious adoption of behavioral philosophy by ophthalmology in response to the public's demand for efficacious treatment. The new text, *Decision Making in Pediatric Ophthalmology* is a harbinger of the revolution. I welcome it.

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REFERENCES

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