

OEP

CLINICAL CURRICULUM NEWS

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Auditing a Clinical Curriculum Course

It is a little known fact that anyone who has already taken a Clinical Curriculum Course can audit that course at any time for a small audit fee of \$495. This is true for ODs as well as therapists. After a few years in practice a refresher is nice. Or, if you did the course, and you have a therapist you want to send, taking the course again with your therapist can create a bond between doctor and therapist which puts you both on the same level of understanding regarding the procedures. This special offer is possible on a space available basis only.

Shadow a Doctor

If you will be attending a Clinical Curriculum Course in any of our US sites, it is possible to visit with the doctor in his office before the course starts. If this is something you or your therapist would be interested in, watching therapy in action or sitting with the instructor while he does exams, just call Theresa or Karen, 800 447 0370, to make the arrangements. Please make sure you make the appropriate arrangements with Karen or Theresa first. There might be circumstances that would preclude your visit, so please make prior arrangements.

Consultation Corner

By: Rob Lewis, O.D.

Christy, then a 25 year old young woman, (The names have been changed to protect the innocent) came to our office 08-30-04. She came because she heard that we could “help someone with a blind eye.” She said she had never done any vision therapy, but had been patched as a child and has worn glasses of some kind for much of her life.

The glasses prescription she was wearing was -1.00 with both the right eye and left eyes. Her entering visual acuity was 20/30- with her right eye and 20/200 “because she knew what the E was” with her left. As you will see, the -1.00 O.U. was probably prescribed as a balance lens for her “blind eye”. Retinoscopy and refraction showed:

O.D. -1.00 20/20
O.S. +7.25 20/100±

At the time of this exam there was no measurable stereo.
Aspheric soft contact lenses were prescribed:

O.D. -0.75 20/20
O.S. +6.50 20/100±

After 18 weeks of VT, her refractive status had remained stable, her acuity had improved to 20/60 through her left eye and she was able to complete phoria measurements with 2/1 XO for distance viewing and 6/6 XO for near.

At the conclusion of her formal VT (so far), she was able to see 20/20 through her right eye and 20/50+ through her left. She had float and appropriate projection with the Keystone Basic Binocular Test, she had 400 arc seconds of randot stereo at near—all while wearing her contacts: -1.25 OD and +6.00 OS.

At the present time, two years post VT, Christy's findings and visual status remain much the same. What has changed is that she is now reading for enjoyment. Before VT, she would buy books because she knew they were valuable, but the information in them was not accessible to her at all.

Now she is reading a great deal and believes a new world is open to her.

There are three major points to consider here.

- 1) Christy was 25 years old, well past what some call the critical period. Although the critical period has never been true, the idea that age is a significant variable still creeps into people's thinking and can become a barrier to adults receiving the benefits of therapy.
- 2) The diagnosis is not the reason for therapy. Although Christy certainly had dense amblyopia, her improved visual skill following therapy has made it possible for her to read with increased fluency and facility so she is able to read as a way of learning and enjoyment. Reading has become a way of solving problems rather than being a problem.
- 3) Visual acuity is not the answer. When I begin a therapy program for a patient diagnosed with amblyopia, I expect to see each patient develop roughly equal acuity, stereopsis, and grace in movement. In Christy's case, we have randot stereopsis, grace in movement, and increased reading ability. When viewed from that perspective the outcome is enormously positive. If measured from an acuity improvement bias, the results are less compelling.

Christy is aware of how much positive change has taken place so far. Left as it is, this case is a huge success, but there is more that can be done should she choose to.

Bernell Discount

Bernell corporation has extended a discount to all Clinical Curriculum Course Attendees. It is good for a 10% discount on all BC materials and 5% discount on non BC materials. There is no discount on software. When ordering materials from Bernell, please give the code GE 208.

Treasures From the Vault

"Treasures From the Vault" is where we will drag out *oldies but goodies* from past newsletters that are as important now as when they were first printed. From the August 2000 Clinical Curriculum Newsletter comes this treasure:

Question: There seem to be different ways to perform static retinoscopy (#4). I have talked with several of the teachers at our school and we each seem to have learned slightly different methods. I've checked Borish, Bennett & Rabbetts and some OEP publications, but can't find anywhere in exact steps, what I should be doing. My understanding is that you can either: (1) Use a large target with +1.50 diopter lenses in front of each eye and scope like this to reveal any hyperopia or the least amount of myopia, by relaxing the accommodative system, or (2) Use one line bigger than their best visual acuity, remove the +1.50 diopter lens on the first eye, scope the other eye with the +1.50 in place. When you scope the second eye then the lens situation is reversed. Please help me understand your views and let me know your preferred way to do the #4 finding.

Answer Paul Harris: You are very correct in your perception that there is no clear single method for doing retinoscopy. We have modified the basic procedure to give us more insights into how the person actually performs.

On a conceptual basis, we view fogging (the use of plus on the eye that is not being scoped) as a non-medicinal form of cycloplegia. Since we want the patient to be more actively involved or “connected” to the distance target, we want them to do this with the possibility that they may be able to see the target clearly. As they select the distance target to be that from which they are deriving meaning, we do not want them fogged. Fogging causes them to go passive and we want to see them actively involved in seeing.

Yes, with fogging it is possible in some situations to get more plus or less minus to be revealed. However, the feeling is that this has been artificially produced and is not the type of insight that has lots of use clinically.

Now let’s consider the type of target we use for retinoscopy. Since I would like the person to be dynamically and actively involved with the target, I want something that is near threshold visual acuity. If the visual acuity is 20/20 (6/6) then 20/30 (6/9) or 20/40 (6/12) is all right to use as a target. In Behavioral Vision Care (BVC) we talked about how poor most of our retinoscopy targets really are. Having some type of dynamic changing target that required sustained attention would be better. How long does a person of average intelligence need to look at 5 letters to know them? A film, television, or a slide projector where the person was given the controls so that they could change the slide when ready to view another would be best.

I hope this clarifies the procedure. To be clear, here is an example. Let's assume a person who reads 20/20 (6/6) and is about +1.00 on the #7 finding. I use the 20/40 (6/12) line with full room illumination. I start the procedure with plano in each eye. I find my neutral in the right eye with +2.50. I remove my working lens in the right eye, leaving + 1.00 in the right eye. I now move over to the left eye. Again, while doing the left eye, the right eye has the + 1.00, not the +2.50 which would include the fog. I now find neutral on the left at +2.50. I then take out the + 1.50 working lens and record + 1.00 OU on the number 4 finding.

If I end up with any lens greater than the "rules of throw out", which are related to the refractive finding, then I may come back and re-scope the right eye. For example, if the person has +6.00 refraction with both eyes, I start with nothing in the phoropter. I scope the right eye and get neutral at +7.50. I take out the working lens and leave +6.00 in the right eye while I go do the left. I may then decide to come back to redo the right eye after I have done the left eye. This time I will be scoping the right eye with +6.00 over the left.

Done this way the finding is a dynamic, not a static distance retinoscopy. Most of what you will find in the literature is about static retinoscopy. I hope this answers your questions.

Additional Insights Rob Lewis: I remember my days as a student quite well. One of the most baffling things for me was the way in which I was taught about retinoscopy. It seemed to be a route to a thing called the *prescription*. This was especially true when it came to the #4 finding (called static retinoscopy). At the time, it seemed to me that the retinoscopy must match the subjective and when it did, the examiner had done a good job of retinoscopy because it agreed with what the patient told me was the clearest lens, and two *tests* had produced consistent data.

My undergraduate experience was in physics. I learned to believe my data and I learned to trust in my ability to observe. As I began to see my own patients, my data and the patient's subjective did not always agree well. If what I saw with my retinoscope was correct, either the patient was wrong about his or her own vision or what I understood about the relationship of the retinoscopy findings to the other findings was in error. As time passed, I began to realize that retinoscopy did not depend on other findings for its validity. It was not a measure of the *refraction*, but seemed to be an indicator of what the patient's visual system was doing. It was at this time that I began to be aware that *static* was an unusual word to use to describe what seemed to be a dynamic process. This was true, even though I was still using a streak retinoscope and a plus fogging technique for the #4 finding, both of which tend to obscure a good deal of available information.

John Streff, O.D., one of my mentors, told me that in retinoscopy (and the rest of the exam as well) the examiner brings his or her visual system to bear on the visual system of the patient. This is what all forms of retinoscopy have in common. The patient's response that we observe through retinoscopy evokes an answering response in the examiner. It is possible to observe this response in the examiner even when the examiner has little awareness that it occurs. As each examiner becomes more in tune with their own visual system, they will be increasingly aware of the patient as well. This continues to happen in my case. Each technique of retinoscopy offers an avenue through which the examiner can gain insight into the vision of a patient. In this sense, it could be said that there is one retinoscopy technique applied at differing distances with differing targets to gain insight into the patient's responses to the differing situations. For example:

- 1) Does the patient remain engaged with the task or let it go (fight or flight)?
- 2) Where does the patient place identification to deal with the target?
- 3) What is the symmetry and stability of the visual response?

I do not believe it is reasonable for a person learning the techniques and theories of our profession to be asked to learn and understand all of the subtlety of every retinoscopy technique at first. As a clinician becomes more skillful and improves his or her understanding, each probe of the visual system becomes integrated into a developing understanding of the needs for each individual patient. It is interesting to me that Paul and I developed our general approach in isolation from each other, and yet there is almost no difference in the way we do retinoscopy. Distance retinoscopy provides the starting point of the *analytical* sequence we both use. It is an anchor point for me.

I believe the best way to begin to learn retinoscopy is as a part of the exam sequence, related to the other findings. Paul described an excellent approach in his note to you. Both he and I use it. With retinoscopy seen in this perspective, the entire examination sequence becomes a natural way of looking at where the patient is and developing an understanding of where they can be.

Contact Information

You are reminded to contact OEP if you change your address, phone number or your email address. In order for us to supply accurate information for referrals, we need up-to-date contact information. Our web site listing also needs to be kept accurate and notifying us of any changes allows us to be current. Either email Theresa at TheresaKrejciOEP@verizon.net or call 1 800 447 0370 with your current contact information.