EDITORIAL

(... sort of)

THE DISTANCE PRESCRIPTION

Dear Irwin,

I have been disturbed for a long time regarding the general belief that the objective retinoscopy and subjective findings, per se, indicates the true and proper distance prescription. The thinking is that once the "refractive error" is determined, the formula for the optimal distance lenses is determined. Consequently, I perceive that routine cycloplegic refraction is creeping in as a major tool in optometry. Of course, the supposed ease of performing the objective and subjective refraction is part of what drives opticianry's contention that they should be able to refract and prescribe. And, indeed, with the increased scope of practice I know that some optometrists are delegating the "refraction" to assistants.

I have never believed that the standard refraction always constituted the true prescription. I have long been convinced that there was a range of lenses (both sphere and cylinder) that could permit standard acuity. In some cases this range is very small and there is little choice. In many more cases there is some latitude. It requires various observations during the objective and subjective phases of testing to determine this sensitivity and a good deal of professional judgment to come to the most useful prescription for the patient. These factors are particularly important in cases of anisometropia.

Recently I examined a young lady who had undergone five surgical procedures for strabismus. The ophthalmologist has given up on surgery since the eye now exhibits very little lateral movement of any kind. He wrote a note to the parents disputing an occupational therapist's contention that "her poor eye movements affect her performance in many daily activities." (Roughly quoted.) The physician stated that although her eye movements were abnormal, she could still do many things. They have also been patching vigorously for an amblyopia (20/30).

It was interesting to me that the ophthalmologist's closing comments in this note were that his responsibility now was to ensure the health of her eyes and to ensure that her refractive error was properly corrected. She was wearing OD +2.50 DS, OS +1.50-1.00 x 180. She was referred to me because she complains of not being able to see the board unless she moves to the front of the class. Her teachers and parents concurred that she works very slowly, and is falling behind in school, although all feel that she has adequate intelligence. My examination revealed that her glasses provide little improvement in distant or near acuity, and there was indeed a moderate anisometropia.

I prescribed +0.75 DS, OU. The feedback from teachers has been almost immediate and very positive. She can see the board and her work is going better. While vision therapy is indicated, we haven't yet started.

Maybe there are other lenses that would do as well or better, but it seems that the ophthalmologist's "refractive error" prescription was not the best choice. I do not know if you have had similar experiences or if you even feel that the distance Rx can be modified in these ways. As I said, I have never accepted the distance subjective as the gold standard for the optimal prescription. I realize that this may go against much of the conventional thinking, but I frequently see such conventional thinking as a dead end.

I would like to know your thoughts on this issue. I would also like to know what you think it would take to get the profession to reconsider this standard. Don't bother telling me that I should write up this case and submit it for publication as you always do. I will grant you that it should be done. Yes, an individual case is of value, but it is also anecdotal. Maybe it should be in the literature for the record, but by itself it is merely an interesting report.

I think it would take a campaign. Several articles by several different people appearing in several different journals and relatively closely spaced might generate more response, especially if the point was repeatedly made that the "refractive status" was not the criteria for the optimal distance prescription. This would need to be followed up with some other efforts and ultimately a researcher would investigate the concept.

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Irwin B. Suchoff, O.D., D.O.S.

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Have any thoughts or ideas on the subject?

Sincerely,
Greg

Hi Greg,

I like your ideas on the optimal distance correction. You raise many good points, especially about the fact that the determination is often trivialized, and thus eye care practitioners of both ilks are increasingly delegating the task to less qualified people, which paves the way for opticians wanting to "refract." By the way, how did you arrive at the +0.75's for your patient? It seems a rather drastic departure from the "refractive status" to me. And yes, I have run across similar situations with patients. It's interesting that when I do this, the student, or more likely the resident who works with me, asks why I modified the "refractive error" finding, and exactly how I determined the final Rx.. In other words, what are the variables that led me to consider the modification in the first place, and what are the variables that determine what I write on the prescription pad. These are superb questions, and in truth, I don't have superb answers. Nevertheless, I give some answers that seem to satisfy most students and residents, but do not totally satisfy me.

I believe it is worthwhile to bring your issue to the attention of the profession and I agree that it needs to get into the literature. An initial article should review all proposed methods for determining the distant refraction; this would include graphical analysis, OEP's 21-point refraction, the method you were taught at Pacific University, College of Optometry, where, I believe you start at near and then go to distance, and others, such as the regimen that Dr. Joe Miele has proposed from the lecture platform and in print. Hopefully, this will "light the fire," cause discussion and Letters to the Editor. But, until that article is written, let's start with asking people to specify the variables that I referred to above. And what role does the concept of emmetropization play in determining the best distance prescription for the younger patient?

My best,
Irwin

Editor's note: The above represents two edited E-mail messages between Dr. Greg Kitchener, a member of the Optometric Extension Program Foundation's Board of Directors, and me. Dr. Kitchener responded to my questions, but in the hope that readers will give their ideas on the variables involved in determining the distance prescription, it is not included here. Both he and I welcome and anticipate your thoughts on this topic. We are of one mind that it is the basis for virtually all of what we do; yet, with the expansion of our scope of practice, it is increasingly thought to be a purely technical task.