# EDITORIAL

# The Non-Strabismic Anomalies of Binocular Vision—They Can Also be Serious

When I received the May, 1995 issue of the Journal of the American Optometric Association, the article entitled "Binocular Vision Anomalies: an Emerging Cause of Malpractice Claims"[1] caught my attention. I hoped that here was the long-needed article documenting the legal implications of practitioners who fail to diagnose and appropriately manage all types of binocular vision anomalies, i.e., both strabismic and non-strabismic. However, the title fooled me; a reading of the article showed that the authors had focused on strabismus and amblyopia.

While I was disappointed to the degree to which my expectation was not fully met, I still feel the article is a valuable addition to the optometric literature. It is particularly noteworthy because both authors are well respected optometric clinical educators; additionally, Classé is an attorney, while Rutstein is well known in the area of binocular vision. The important message they wished to convey is:

> Strabismus and amblyopia in children, if not promptly diagnosed and properly treated, can be the basis for a malpractice claim. Binocular vision disorders may also result from brain or intraocular tumors affecting children, and failure to timely detect the presence of these underlying diseases can also become the basis for a malpractice claim.[1](p.305)

They amplify these points with case abstracts illustrating undiagnosed tumors and inadequately treated amblyopia and esotropia.

Now, esotropia and amblyopia are serious conditions whether they occur in children or adults and I believe are in reality rarely undiagnosed and left untreated by optometrists and ophthalmologists. The blatancy of these entities does not allow for practitioner neglect. Parents seek care for their children because of the turned eye or school report of reduced visual acuity. Consequently, virtually all eye doctors take these conditions quite seriously. Still, this is not to detract from Classé and Rutstein's important admonitions; rather, it is to give their very legitimate concerns a sense of balance.

But what about the conditions that comprise the non-strabismic anomalies of binocular vision (NSABVs), the accommodative, vergence and eye movement disorders? Overall, are they taken as seriously?

My clinical experience and communication with many of the readers of this Journal have led me to conclude that they are not. Indeed, I, like many of you, was able to build practices, both private and institutional, with extraordinarily appreciative and loyal patients who had NSABVs that I diagnosed and treated. But, most importantly, the overwhelming majority of these patients had previously had their "eyes examined." Our successes were very much the product of becoming "the court of last resort" for patients and other professionals who referred to us (educators, psychologists, occupational therapists, etc.) because many other eye care practitioners apparently did not take these NSABVs seriously.

In this issue some of the consequences of under-diagnosis and/or under-treatment of NSABVs are addressed in two places. Press,[2] in his Guest Editorial, tells of a prominent politician who, as a child, had strabismus surgery. It then took two years for his "mind to catch up with my new sensations." Press implies that the politician might have had a residual NSABV and that vision therapy might well have been useful had it been proposed.

Werner[3] raises the issue of under-diagnosis and under-treatment as an ethical one. He points out that when vision therapy is a viable option that is not presented to the patient, the doctor is not acting with competence. Additionally, the patient's rights to make his or her own decision (autonomy) and to be treated justly are violated. These have never been trite considerations, but have become particularly important in the present climate of patients' rights.

So the question remains as to why these NSABVs are not taken as seriously as overt strabismus and amblyopia. One obvious answer is that in cases of childhood strabismus and amblyopia, there is the distinct possibility of an underlying life-threatening cause and that failure to detect and refer can lead to litigation. That is certainly the main message Classé and Rutstein[1] so well conveyed. However, the possibility of tumors or other neurological conditions being the cause of NSABVs is far

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

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less. Careful clinical testing of pupils, eye movements and visual fields, along with internal eye evaluations, rule out a neurological cause in the vast majority of cases.

And perhaps here lies the difference. This accounts for the tongue-in-cheek banter of some clinicians that "I'm being paged for an emergency convergence insufficiency" or that "my patient is in the last stages of accommodative instability." Essentially, because these conditions are rarely life-threatening or neurologically based, the specter of litigation is not very strong.

But this attitude, prevalent in both optometry and ophthalmology, misses an important point. The negative effects these conditions can have on the patient's ability to work, play, read and live are not seriously considered. This, in spite of the recent popularity of the quality of life issues in health care promulgated by the government[4] and the moral-ethical obligation we all have to do the best for our patients.[3]

Optometrists who are engaged in the total management of these NSABVs often become passionate about the frequency of under-diagnosis and lack of treatment of these entities. Anger is often expressed because the patient has been seen by other practitioners who either did not diagnose the problem or informed the patient of its existence but advised that "you'll have to learn to live with it because nothing can be done."

The unfortunate thing is that as optometry, because of economic necessity, moves more and more into areas of care that were exclusively the domain of ophthalmology, these conditions will be taken less seriously.

## References


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2. Press LJ. On being visually deprived. J Behav Optom, Guest Editorial, 1995; 6(5):127.
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4. Hoffman LG, Rouse MW, Brin BN. Quality of life: a review. J Am Optom Assn, 1995; 66(5): 281-89.