

A Viewpoint of Pediatric Care

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There are numerous lessons that I learned when I decided very early in my career to limit my practice to taking care of the visually impaired. I needed to go through the certification process to become a low vision specialist and I needed to surround myself with an interdisciplinary team. This was in 1986.

Pediatrics is, and will always be, a very challenging endeavor when evaluating and providing individual rehabilitation plans for the visually impaired child. The first question is: What is the impairment and how does it affect this child, parents and family? The next question is: What am I going to do about it? What do I need to do now vs. in the future?

I had the good fortune of beginning my practice as the first OD employed full-time by a 1200 bed hospital in suburban Detroit. The second good fortune was to hire a young extremely dedicated orientation & mobility specialist who worked with me to expeditiously evaluate a child or infant and provide the best of care. Additionally, the Youth Low Vision Program in Michigan was very well funded, providing timely evaluations, funding for assistive devices that were necessary and, most importantly, a group of visually impaired teacher consultants (TVI's) who worked seven days a week for their children exuding concern for their well-being.

The stimulating test of abilities with pediatric patients is to think, observe, evaluate and make decisions based on multiple visits if necessary and appropriate. There are two types of patients that are almost never resolved in one visit: the visually impaired child and the neurologically impaired patient. The difficulty is based on common systemic entities, frequent decreased communication capability and therefore a one-sided evaluation due to lack of straightforward, fluid communication wherewithal. From a logical point of view, a team assessment is critical and I have never practiced otherwise.

A case in point: In the mid 1990's I was asked by a renowned retina ophthalmologist, who is a specialist in retinopathy of prematurity, to perform an ocular ultrasound on an 11-week-old baby in NICU. The ultrasound indicated that the infant had eyes that were two times shorter than normal. This seriously high prescription indicated the need for correction as soon as possible to prevent near-total visual impairment throughout life. The young infant was seen at two months (once stabilized from complications at birth and weaned off oxygen) for an exam in the operating room under anesthesia for evaluation of the retina. Once again, I performed an ultrasound, this time indicating eye length of just less than 11 mm (normal 22-24mm). An objective eye evaluation was done by me using a retinoscope along with a trial set of lenses to determine the prescription (as I would do in a village in a third world country) arriving at a power 14 times greater than what is considered a high refractive error. The infant was ultimately

fit soon after, based on that evaluation, with rigid gas permeable lenses of +54.00 and +47.00 diopters of correction. The prescription was so extreme that multiple lens companies in the United States were contacted. Only one company would even attempt to make the lenses. The baby was followed on short intervals until age four.

When last seen at age six, Daniel had vision of 20/100, with normal contrast sensitivity and was able to read standard print in a magazine without visual devices. Ultimately, early low vision intervention would allow this child to grow up to be able to obtain a driver's license in most states, perform and complete academic exercises throughout his educational career and to realize all goals desired occupationally and otherwise.

Contact lenses are absolutely paramount in visually impaired persons with high refractive error (prescriptions), aniridia, nystagmus, many retinal dystrophies and other visual disorders (see published papers).

It has been my career-long experience that too many persons were not fit with contact lenses in early infancy or at an early age (even though it was indicated) resulting in lost opportunities and misdirection in every aspect of life for these individuals.

Reflection – there is nothing that gives feedback more than loyal patients. For a variety of reasons, some have followed me from all the locations I have practiced. They come from Canada, Michigan, Maryland, and West Virginia, making their way to Kansas. Two decades later, I see that as a result of the rehabilitation they have received, they are now successful accountants, attorneys, computer analysts, faculty at universities and on and on.

What Parents Should Know and Do:

1. Do not second-guess yourself, if you feel your child has a visual impairment, see a doctor. During the age of birth through seven years, time is critical.
2. Ask other parents, visually impaired teachers and friends who you should see to evaluate your child.
3. Look for a doctor that gives you face to face time, appears interested, communicates to your satisfaction and has you feeling resolved with the evaluation, communication, care and long term plan. If they don't, change doctors, immediately. They are not your higher being.
4. Align yourself with your children's teachers, other parents with visually impaired children and all individuals that teach your child that all things are possible.

5. Remember that the first years of life are critical for good vision and an all-out effort for intervention is extremely important to your child's "rest of their life."
6. Just as you would expect in the emergency room, collectively, a team is likely to provide better care than a single person - even a doctor.