

Case report: A timely referral in maintaining quality of life

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A 62-year-old woman was seen for low vision rehabilitation as a result of visual impairment due to proliferative diabetic retinopathy. Chief goals were to read labels, directions, draw up her own insulin, balance her checkbook, see her computer and if at all possible, drive and return to work.

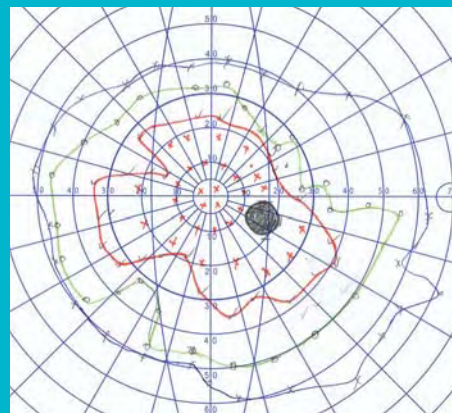
Referred by her retinal specialist, there was a myriad of systemic difficulties that affected her life and included: coronary artery bypass (3 procedures), peripheral neuropathy resulting in a history of falls (with a subsequent right foot fracture stepping off a curb she didn't see), decreased endurance, decreased range of motion of all limbs and balance difficulty.

Visual acuity was variable due to her long standing diabetes mellitus (25 years) and her overall health. Multiple visits would be necessary to establish reliability in the prescription for best visual acuity to be achieved.

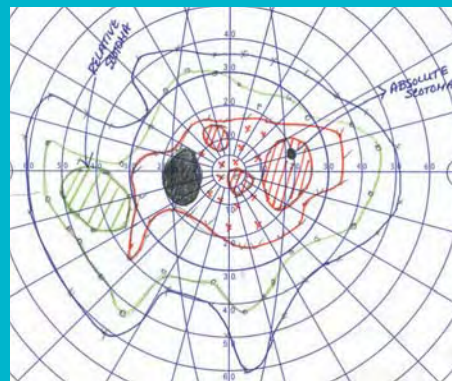
Contrast sensitivity was severely impaired, to the level in which this patient needed more than 4x contrast to recognize low contrast objects. As a result, this loss of contrast posed serious implications for future falls and traveling safely down stairways. Simplistic tasks such as facial recognition were either impossible or problematic.

After four visits, best corrected visual acuity (BCVA) was established as 20/70 (primarily due to poor diabetic management).

The patient was subsequently referred to occupational therapy for education on insulin management, filters for enhancement of



OD



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contrast and reduction of glare, assistive devices (high plus readers, video magnification, hands-free magnifiers) for reading, participation in avocations and diabetes management. Activities of daily living and safety were addressed at an in-home assessment.

An on-site work assessment established patient's vocational responsibilities and resultant recommendations. The patient was

made aware over the course of 11 visits by the low vision practitioner and occupational therapist of her visual performance capability in performing her occupational role as a radiology technician using assistive devices vs. early disability retirement. Of paramount concern was her psychological status short-term and long-term following any job-related decision.

The patient was further counseled on her visual field loss caused by the effect of the treatment and management of her retinal disease, and the implications posed by this on safe travel, orientation and mobility, driving and overall personal safety.

Ultimately, DK was resolved and happy with her choice of retirement and with the beginning of a new phase of her life; enjoying her retirement on her terms, without compromise of her avocations, lifestyle or general well being, as a result of her benefiting from low vision rehabilitation.

For most visually-impaired individuals, low vision rehabilitation is seldom solely about magnifiers and assistive devices, but rather resolving all their issues. This case greatly illustrates, more significantly, the importance of an interdisciplinary team approach in achieving patient goals.