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FURTHER ROLES OF THE ORTHOPTIST IN THE REHABILITATION OF THE PARTIALLY SIGHTED.

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Abstract
The role of the orthoptist at the Royal Blind Society is described, with emphasis given to the vision training programme for those who have lost macular vision.

Key Words
Vision training, visual aids

For the greater part of this year an orthoptist has been working for the Royal Blind Society in three main areas; The Child Development Unit, The Sensory Development Programme and The Low Vision Clinic. The orthoptist's role in the first two of these areas has been previously well described by Pardey and Guy [1] and Wulff [2], so this paper will describe the additional aspect of the orthoptist's role in the Low Vision Clinic.

LOW VISION CLINIC: (L.V.C.)

This is the main area of involvement for the orthoptist at present.

As described by Wulff[2] the L.V.C. provides a vision training programme which is aimed at patients who have lost their central vision, but still have useful peripheral vision.

The paramacular point providing the best visual acuity is established subjectively. The patient is asked to describe the position where he sees a card the clearest as it is moved into different positions (up, down, right and left). As he is doing this he fixates a point straight ahead. The card is the size of a large playing card and is held approximately 33 cms from the eye. The same procedure is then repeated at 3 metres and 6 metres. As the distance increases the patient must turn his eyes off centre, further away from the object but maintaining the same visual angle.

Once this point has been established it must be frequently reinforced to become firmly established. This reinforcing is done at first by the patient at home where he is instructed to use this point for everyday tasks, for example t.v. and meals.

In the clinic, various tasks are performed by the patient such as identifying dominoes of different sizes, playing cards and common street signs, as well as practice with visual aids to ensure that the correct retinal point is being used.

Once paramacular fixation becomes automatic, use of visual aids and the visual functioning of the patient usually improve greatly.

The average number of visits to the clinic is five, with the patient attending weekly or fortnightly.

It should be understood that the aim of vision training is to enable the patient to make better use of his remaining vision. Although most patients show an improvement in visual acuity and improved motility, some patients' measured visual acuity only improves minimally; however the mobility of these patients is markedly improved. The improvement of visual acuity is not always indicative of the patient's improvement in performing everyday tasks.

Recently the orthoptist has also become involved in providing a training session in the use of the visual aids for patients with newly acquired visual aids, as well as providing a home follow-up service.

These two services were provided as it was becoming more obvious that patients were being prescribed aids and, after brief instruction as to the use of the aid, were going home where they were tried once and then put away, and never

tried again. Consequently there were a number of unhappy patients returning to the clinic for further visits and some that did not return at all.

As a result of this, the orthoptist is instructed in the method of use of each visual aid and now after a patient has received his new aid he spends some time before going home learning what that aid can be used for, how to use it, how to arrange correct lighting and generally practising with the aid so he is confident handling it.

Some time later the orthoptist visits the patient's home to ensure that the aid is being used correctly and is satisfactory. As many of the patients are elderly we find that their homes do not have adequate lighting and often that they have forgotten how to use the aid or do not know whether to us it for near or distance tasks, in the house or outside, or both. In these cases a home follow-up is very beneficial.

After this visit a report is made to the other staff members of the L.V.C. and any further needs of the patients are discussed. A further appointment with the L.V.C. is arranged if necessary.

The following examples illustrate some of the benefits gained:–

Mrs. D.S. – Age 77
Macular degeneration and aphakia
Left convergent squint

Initial V.A.	– 5/24 (both eyes open)
	– 3/9 (both eyes open)
	– N4.5 with magnifier
	– N8 without magnifier

Mrs. D.S. is now reading and writing well, watching television, playing cards and seeing the prices at the supermarket.

Mrs. R.L. – Age 72
Macular degeneration

Initial V.A.	– 2/15 (both eyes open)
Final V.A.	– 2/4 (both eyes open)
	– N4.5 with magnifier

Mrs. R.L. now reads, does crosswords and plays scrabble.

Mr. T.C. – Age 65
Chorio – retinal dystrophy with macular degeneration

Initial V.A.	– 3/45 (both eyes open)
Final V.A.	– 3/24 (both eyes open)
	– N12 with magnifier

Mr. T.C. owns his own business and can now manage his own books.

References

1. Pardey, J. and Guy, M – "The Orthoptist's role in a team approach to Visually Handicapped Children". Aust. Orthop. J. 1978 Vol. 16, 33.

2. Wulff, J. – "The Orthoptists Role in Rehabilitation of the Partially Sighted". Aust. Orthop. J. 1979 Vol. 17, 59.