EDITORIAL

The Silent Warrior

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Editor-in-Chief

I wrote a blog recently[1] about a middle-aged man with a long-standing intermittent esotropia of the divergence insufficiency type who was decompensating both visually and psychologically, though it's not always easy to separate the two. Nor should we think that it would be, given that the eyes, brain, and body are intertwined. The patient gave the following description: "I feel like my whole body contracts when my eyes start to turn inward. It's like my body is holding the stress, but it's centered in my eyes. The process is so fatiguing to keep from seeing double, that I often look first and then process the information afterward." And while describing the contortion that he experiences from head to toe, the patient choreographed his feeling as illustrated (he gave permission to share this).

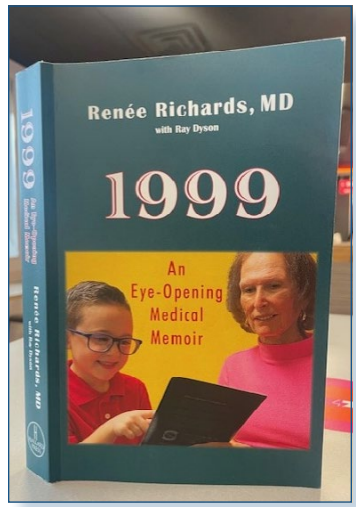
I prescribed a low amount (one diopter) of yoked prism bases down in addition to +0.50 sphere OU to be used in conjunction with his contact lenses that provided the patient with a great deal of calm. It was more than a placebo effect, as the patient has had an ample number of interventions in the past, ophthalmic and otherwise, that provided little if any relief. Plus I had done an A/B single subject crossover design by interposing bases down versus bases up prism chairside, and the patient could easily discriminate a difference in sensation.



The patient called and asked if I could increase the amount of prism. It's a natural tendency for patients (and some doctors) to think that if a little bit of something is good, a greater amount will be better. Rather than an arbitrary increase, I asked the patient to return so that we could probe what higher amounts would do. I used the same A/B crossover design except this time it involved magnitude rather than direction. The patient preferred 2.0^ to 1.0^, and then 3.0^ to 2.0^. Each time I interposed the prism, the patient would close his eyes, take a deep breath, exhale, and then open his eyes.

I noticed something on his second visit that I had overlooked on the first. The patient had a subtle "V" pattern intermittent esotropia, with slightly higher eso on downgaze as compared to upgaze. So I re-wrote the Rx as 3^ yoked bases down, and the patient will follow-up with a colleague nearby who has the perfect holistic approach to optometric vision therapy needed in this case. At the end of our visit the patient remarked: "It's such a pleasure to explain how I feel to you. You're the first doctor who took the time to really listen, and who speaks my language. You're a silent warrior, doc."

The silent warrior theme brought to mind a book authored by Dr. Renée Richards, published in 2021. It is titled 1999: An Eye-Opening Medical Memoir, and that it is[2] For those who don't recall or are not aware, Dr. Richards specialized in pediatric ophthalmology and strabismus as Dr. Richard Raskind, prior to undergoing a gender-transforming operation in the mid-1970s. An accomplished tennis player, she took five years off to pursue her dream and returned to the practice of ophthalmology in Manhattan in 1982.



Dr. Richards notes that colleagues considered her to have a boutique practice, and she recognized that as a solo practitioner she was a dinosaur. When asked in 1999 much longer she intended to practice (she was 65 years old then) she replied: "As long as I can still contribute and as long as I enjoy it, I'll keep going."

No apologies are made, in her book, about strabismus surgery being as much an art as a science. She writes: "That's where the skill and the judgment of doing eye muscle surgery come in. The numbers are not etched in stone for how much you move the muscle for how many degrees of turn of the eye you've measured. Many things come into account: whether it's a large myopic eye or a very small child's eye; whether there has been previous surgery; what the condition of the muscle is when we expose it and look at it — many, many possibilities for variation in the result from the predicted amount of surgery."

The year that Dr. Richards returned to Manhattan Eye and Ear Hospital (1982) was the year that I came to Manhattan to serve as Chief of the Vision Therapy Service at SUNY Optometry. Our in-house strabismus consultant was Dr. Norman Medow, a close colleague of Dr. Richards, who collaborated with my optometric colleague Dr. Jeffrey Cooper on a landmark paper about intermittent exotropia.[3] Dr. Medow and Dr. Cooper were silent warriors in their own right.

What is lacking in Dr. Richards' revealing medical diary for the year 1999 is any mention of collaboration with optometrists. While there are a number of cases she shares that needed prism to neutralize diplopia, there is scant mention of the role of orthoptists who at one time rendered therapeutic services within ophthalmologic practices. They too, Dr. Richards notes, have become dinosaurs with regard to their original function, with most transitioning to medical assisting in a technician role.

Part of the problem in underutilization of optometric therapeutic services (OVT) by fellow professionals stems from the misconception that viable OVT is limited to orthoptics. If that is the case, then there would be no need to refer a patient to an optometrist. The ophthalmologist/orthoptist collaboration suffices. That misconception persists to this day, as evidenced by a recent article by Huhtanen et al.[4] To improve the utilization of a pediatric ophthalmologist's time, four groups were identified by the Ophthalmology Department at Royal Children's Hospital (RCH) in Melbourne, Australia who could be well managed in Primary Care Optometry. The authors state that patients with amblyopia and strabismus were not included, "due to being in a separate, similar collaborative care program between RCH and the Discipline of Orthoptics at La Trobe University."

As a COVD working group thirty years ago, Jim Bosse, Dave Cook, Lou Hoffman and I co-authored an article on how ophthalmologists and optometrists should have the same synergistic relationship when it comes to managing strabismus as exists for cataract co-management.[5] The model of cataract co-management has continued to evolve in the ensuing years since that article was published. Dr. Arthur Benjamin, a California cataract surgeon, summarizes that synergy beautifully on his website when he writes: "Co-management in eye care represents a seamless, patient-focused approach that leverages the specialized skills of both ophthalmologists and optometrists. It's a partnership that ensures patients receive high-quality, comprehensive care."[6] He adds that the symbiosis combines the strengths of both professions, and that he upholds that relationship with pride and commitment. In that regard, Dr. Benjamin is a silent warrior.

Which brings me to the OVDRA online CE session on September 29 given by the optometrist Samantha Del Campo and the strabismus surgeon Thomas Lenart regarding Collaborative Management of Strabismus.

The original silent warrior in the relationship with Dr. Lenart was our colleague, Dr. Nancy Torgerson. They lectured about the synergy in their collaboration at the COVD meeting in 2014 in San Diego, and at the SECO meeting in Atlanta the same year. Dr. Curt Baxstrom, a fellow Washington state colleague of Dr. Torgerson, has also collaborated closely with Dr. Lenart. It is wonderful that working models of the symbiotic relationship exist, but they are too few and far between. Although the symbiosis between our two professions is now commonplace regarding cataract care, it remains scant in regard to optometric vision therapy.

To remedy that, Dr. Del Campo and Dr. Lenart co-authored a chapter last year on their symbiosis in the only periodical that represents a joint venture

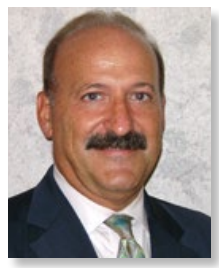


between Optometry and Ophthalmology.[7] That is an important step in the right direction of leveraging the specialized skills of both ophthalmologists and optometrists, as Dr. Benjamin phrased it. Its clear when it comes to vision development and rehabilitation that OVDRA optometrists and therapists have a skill set not possessed by most ophthalmologists and orthoptists.

At some point, hopefully in our lifetime, presentations such as the joint CE on Collaborative Management of Strabismus will be welcomed in primary care optometric settings and in a variety of medical forums including pediatrics, pediatric ophthalmology, and rehabilitation medicine. While being a silent warrior is a badge of honor in some respects, it is one that we would rather not have to wear.

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