Kraskin Invitational Skeffington Symposium on Vision 2018

Two Sisters

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Mom interviewed 35 docs before calling me after seeing my website. She was worried about eight year-old Anahita's nearsightedness. The doctor (MD) who saw the then 7-year-old said, "She will never be able to use her eyes together and she will need to come back every 6 months to have her lenses increased." Or something to that effect. Mom did not find that pronouncement satisfactory.

I evaluated Anahita in 2011 and found that she did indeed require compensating lenses for distance. I also found that she had alternating, intermittent exotropia with alternating, intermittent suppression of binocular vision, as well as pursuit and saccadic eye movement deficiencies. I recommended vision therapy and a more thoughtful, less ominous approach to lenses.

Anahita's parents appreciated the thorough evaluation and immediately asked me to evaluate their older daughter, which I did two days later. There were no concerns with Nikita, but her parents figured, "What the heck?" Nikita, then 12 years old, was revealed to be unilaterally (left eye) nearsighted with apparent accommodative spasm in that eye. Nikita also demonstrated reduced eye movement efficiency and alternating, intermittent suppression of binocular vision. Again, I recommended vision therapy and near lenses.

Particularly given the fact that there were no concerns and no complaints – and unsteady acuity – I decided not to provide a compensating lens for Nikita's left eye. I felt it would be better to see how things played out with her near lenses and vision therapy before jumping to any conclusion on that score.

Both girls were avid readers, spent no time outdoors or moving very much. Their school – for reasons that no one was able to discern – had them reading in the dark. Neither girl had any complaints whatsoever, since all they ever did was read, and did so very successfully as far as everyone was concerned.

We were not able to begin either therapy or any lens prescriptions until the following year for reasons that will be revealed a little later.

The following year, lenses were prescribed for both girls. Anahita got -3.00 contact lenses and +0.50 in glasses form to be worn over the distance Rx for near. Nikita was prescribed +0.50 near only glasses. After six months of vision therapy, both girls demonstrated significant across-the-board improvement. Nikita was extremely compliant with her near lenses, but Anahita was not. The two girls had very different personalities and exhibited very different levels of engagement in the training room.

Nikita was generally upbeat and engaged; Anahita more aloof and seemingly disinterested. Nonetheless, they both seemed to benefit from the work.

It might be of interest to know that the first six months of therapy was done over a period of three years. Anahita and Nikita, it turns out, came from 800 miles away and for some reason, were unwilling to adhere to my typical once-a-week in-office vision therapy program. In fact, after our initial encounter, I told their parents that I would rather not even prescribe lenses for the girls because they had so many other visual issues. I advised that they find a practitioner close to home, begin vision therapy immediately and follow the advice of that practitioner as far as lenses and long-term vision care.

I recommended a colleague with whom I had some degree of familiarity and confidence. Both girls were evaluated back home and Mom requested that I have a conversation with the local doctor and report my thoughts to her. I have to admit that what I heard in the way of approach to treatment – particularly as regarded lenses – made me a bit uneasy. However, I know that each of us has our own assumptions, idiosyncrasies and preferences. I am as aware as anyone of the *art* aspect of the art and science of behavioral optometry – and hopefully all healthcare practice. Despite my significant reservations about the approach I heard from my colleague, I told the mother that he was a skilled practitioner with many years of successfully treating people with the types of visual issues her daughters had. I insisted that this was the best option and wished them all well.

When I called to follow up a few months later, I was told that, "The girls did not like the other doctor and we never went back.* I want them to come and see you again. We would like to come in for a week or two and do therapy with you." I suggested that this was a very bad idea because vision therapy doesn't work that way. I firmly believed that the only way to do VT was to have consistent weekly visits. No more, no less. After 20 years in practice, I was pretty sure I knew what I was talking about, since that was the way I had been taught, and that was the way I always structured my VT programs.

I was quite certain that this would not work for the girls and tried to dissuade their mother from even attempting such folly. She insisted. I relented. And we scheduled eight therapy sessions over a 10-day stretch during the following summer. And this is the real reason for sharing this experience.

We squeezed many sessions into a small time-span each year – 2017 was the sixth consecutive year. When the girls returned in 2012 I first re-evaluated them. Then we did a bunch of therapy over the course of a week, and then I re-evaluated them. The improvement in findings for both girls was surprising to me. I did not expect findings to change over that short a period of time. Each year they returned (this family has been more loyal and compliant than the vast majority of my local patients) they at least

maintained the improvements from the previous year. And each year, they demonstrated further improvement after the accelerated – I would say, excessive – VT.

Anahita has not had one change in her distance Rx – despite being consistently non-compliant with her near lenses. Nikita has been very compliant with her near lenses, has never worn distance lenses, and her left eye, which started out with an unsteady 20/70, is now an unsteady 20/25.

When I first started in practice and had out-of-town patients come to see me, I was very impressed with myself. I would bet that many of you have had out-of-towners in your offices over the years and have equally good stories to tell. As I became less impressed with myself, I began to question the wisdom of having people come from great distances, especially when there were qualified colleagues available. In most of these cases, it was unlikely that there would be an opportunity for therapy. It was usually just an evaluation, prescribing lenses, and long-distance communication with minimal in-person follow-up. I have had the privilege of working with a number of out-of-towners over the years, and in almost every case, the results have been rewarding for all concerned.

Each of us has our unique personalities, talents and philosophies. We fit well with some patients and may not mesh with others. Sometimes it is our personality that doesn't fit, sometimes our approach. I always enjoy being able to refer patients to colleagues, but sometimes I get the sense that spending a little quality time with me can be helpful.

The main point, and this is a consistent theme for me, is to always endeavor to keep your assumptions pliable. Be open to breaking your rules because each patient is unique and it is all but impossible for us to do damage. They say that necessity is the mother of invention, I think the father is accident.

Know your strengths, but don't be afraid to step outside your comfort zone…unless your out-of-town patient is from the Philadelphia area – send those to me.

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*I'm sure I have had the same effect on people.