Low vision. Psychology applied for ophthalmology
La baja visión. La psicología aplicada a la oftalmología

In the years I have been practising ophthalmology, I have found myself in the terrible situation of explaining the terrifying prognosis for some pathologies and the scant possibilities of successful therapy.

Anti-angiogenic drugs, TNF, photodynamic therapies, lasers, etc, have helped improve that terrible prognosis. The advent of stem cells is the great hope for patients and ophthalmologists alike, but until then … patients continue to leave our offices and clinics sad and depressed.

Low vision aids help patients to «get by» in life and relieves the desperation of the drama of blindness.

Despite current techniques, psychological assistance is what helps them not to see but to «graduate» their expectations.

The visual aids we most often use are:

- **Filters.** These improve spectrum sensitivity to prevent glare.
- **Telescopes.** These increase the size of the image on the retina.
- **Telemicroscopes.** Lens systems adapted to glasses help increase the size of the image.
- **Prismatic spectacles.** Binocular system for near vision with considerable add-ons. These incorporate a prism at the base of the nose (convergence).
- **Clear field magnifying glasses.** Assistance with reading. Great luminosity.

- **Electronic aids.** Large magnification systems based on electronics.
- **Special adjustable lamps.** These improve contrast and reduce strain.

The most common pathologies are: ARMD, diabetic retinopathy, advanced glaucomas, eye trauma, retinal dystrophies, circulation problems, difficulties with the optic route, the cornea and cataracts.

Cases such as those described below make it clear that there are situations in which the way to proceed marks the difference between achieving something positive or not.

Case 1. Male patient of 74 years of age, operated 4 years ago for binocular cataracts with central vision problems. He was diagnosed as having age-related macular degeneration (ARMD) and treated with photodynamic therapy. VA RE: perceives and projects light (PPL) and LE: 0.2.

In the personal interview he indicated a great interest in watching television and going for walks. He is not a reader.

He commented on problems with light and we prescribed CPF 527 cut-off filters for use in the street so as to obtain greater contrast.

To watch TV, we prescribed: 2x Galileo Telescope for the left eye, mounted on spectacles.

Case 2. Patient aged 27 diagnosed as having Stargardt’s syndrome.

VA RE: 0.2 and LE: 0.15.

Interview. We observed a high degree of acceptance for any kind of assistance. Strong photophobia. He is working and studying.

We tried a telescope, with poor results due to binocularity problems. We assembled a 2x telescope.
pe on the right eye and we fitted an approximation lens of +6.25 with good results.

The psychological factor, personalized attention to patients, lots of patience, giving them the feeling they are being listened to, all lead to an increase in the patient’s confidence and a greater predisposition to accept aids.

There are two main barriers in Low Vision patients:

– Age. It is essential that they find an important stimulus to continue fighting to regain their eyesight.

– Assimilation of their problems. A patient with an established pathology is more receptive and more aware of the limitations. They are not looking to see well, but rather to obtain some assistance. Patients who have recently lost their sight have not yet assimilated that they will not be able to see the way they used to. They come with the hope of a solution that will enable them to see well. In Low Vision pathologies, these are practically unattainable goals.

In short, with Low Vision the goal is not to improve visual acuity but to make the most of what little there is. That is the application of psychology to ophthalmology.

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