Meeting the needs of older patients in optics

BY FIONA ANDERSON

Fiona Anderson discusses the important role of community-based eyecare practitioners in meeting the visual needs of ageing patients.

It has been well documented that today we live for longer. Statistics show in 1997, around one in every six people (15.9%) were aged 65 years and over, increasing to one in every five people (18.2%) in 2017 and is projected to reach around one in every four people (24%) by 2037 [1]. The visual demands of our older patients have also changed; people work for longer and lead more active lives. Coupled with the inevitable ocular changes associated with age, dispensing spectacles to older patients can present challenges which make community practice both interesting and rewarding.

As an optician in community practice I am responsible for delivering eyecare services to patients daily. Colleagues in optometry and ophthalmology cater for the clinical needs of the patient and in my role as a dispensing optician (DO) it is my remit to supply the spectacles and / or optical appliance to make the most of their vision. Registered with the General Optical Council, my role is very patient-centred.

The ageing eye

With advancing years, pathologies such as cataract, glaucoma and age-related macular degeneration (AMD) give rise to prescription changes, declining visual acuity (VA) and the need for a change in spectacles and / or optical appliance which is often difficult to dispense. Additionally, older patients often also have a hearing impairment which makes the dispensing of spectacles that fit appropriately a little more difficult if hearing aids are worn.

A large proportion of patients seen in community practice are referred to ophthalmology for cataract surgery. Recent changes in referral protocols [2] have increased the numbers significantly and these patients require their spectacles to be updated after postoperative care. It sounds simple enough, but, often it is not. Take the case of a long-time spectacle wearer with a moderate prescription. After surgery their new prescription may be grossly anisometroptic and they can no longer wear their usual progressive or bifocal lenses comfortably. Ideally they suppress the eye with the weaker VA, which is actually helpful to the DO, as if the patient does not have good binocular VAs the issues associated with anisometropia all but disappear!

There are many ways of dealing with this issue in practice as most patients are listed for the second eye within a relatively short space of time. However, the effects of anisometropia can be debilitating to the patient and it is not uncommon for them to experience double vision, loss of stereopsis and difficulty with balance which increases the risk of trips and falls. Temporary measures such as removing the spectacle lens from the eye which has been operated on in existing spectacles, or making up a 'budget' pair of spectacles in the interim are often adequate short-term solutions.

If the patient decides, for whatever reason, not to have surgery on the second eye then a more permanent solution must be sought. New spectacles incorporating the updated prescription must be ordered for the patient to maximise their VA.

Various lenses and techniques are at the disposal of the DO to alleviate the symptoms of anisometropia such as 'slab on / slab off' prism (Figure 1), prism controlled bifocals, different size round segment bifocals, 'Presto' lens (Figure 2), progressive lenses with no cosmetic thinning in one eye, or using different corridor lengths in each eye in a progressive lens to alleviate diplopia.

Very occasionally nowadays do we see an aphakic patient in community practice. Having spent 35 years in the sector, I have dispensed my fair share of lenticular and post-cataract spectacles. The management of high prescriptions still remains a core competence for DOs and optometrists alike. Although less common, it is not inconceivable that such a patient may consult us so we must be able to meet their needs.

A pair of spectacles for any patient must fit correctly for the wearer to obtain optimal VA and comfort. Any prescription lens has associated weight and it is of the utmost importance that any eyewear is as light and comfortable as possible. In fact, the best spectacles are the ones you forget you are wearing.

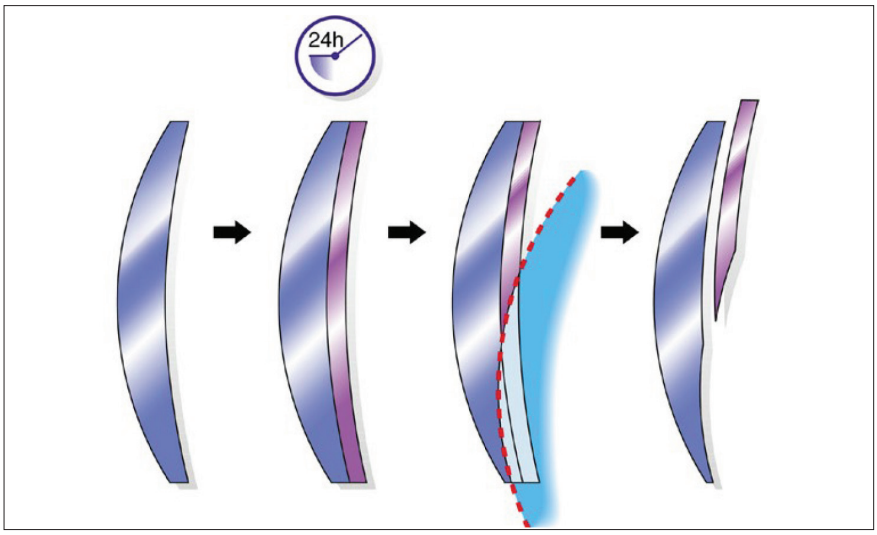

Figure 1: A 'slab-off' to alleviate differential prism in a bifocal lens (photo courtesy of Zeiss Vision Care).

Figure 2: A 'Presto' lens which is bonded to the front surface. It enables different addition, prism or cylinder correction in the near portion (photo courtesy of Norville Optical).

Figure 3: A well-fitting plastics frame with a 'keyhole' bridge (photo courtesy of Specsavers Australia).

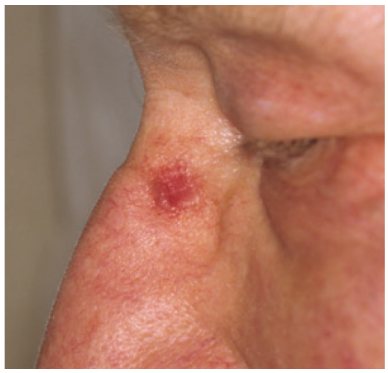

Figure 4: A spectacle frame acanthoma (photo courtesy of Crutchfield Dermatology).

A good spectacle fit

A well-fitting spectacle frame is extremely important for older patients as associated issues of thinning skin and 'lumps and bumps', which inevitably appear as we age, must be assessed and taken into account when dispensing. The DO needs to remain vigilant and anything which looks suspicious is managed or referred appropriately. The loss of elasticity in skin as we age often causes the skin to loosen and become more fragile. A frame that fits well around the bridge and distributes weight evenly is more comfortable for the wearer; plastics fixed pad bridge frames do this very well (Figure 3). If a metal frame is selected, then the nose pads must be adjusted to sit in contact with the nose over a reasonable area to distribute the weight so as not to 'dig in' or leave marks when the spectacles are removed.

It is equally important that spectacles fit well over the ears and do not press too tightly on the temples. If a frame front is too small for a patient, increased tension on the temples will not only be uncomfortable, but it can cause the spectacles to be pushed down the nose. With the spectacles not sitting in the correct position, the vision can be blurred as the patient is looking through the wrong part of the lens.

When dispensed, the patient will be required to be measured so that the prescription lenses can be accurately set up within the frame to achieve optimum VA and the fit must be maintained with regular adjustments to maintain optimum VA and comfort. Many patients are reluctant to return to have their spectacles tightened or checked, feeling they are being a nuisance. I would actively encourage it as part of ongoing aftercare and service to my patients. The better the relationship between practitioner and patient, the more likely we are to achieve satisfaction.

Ill-fitting spectacles are not only uncomfortable for the wearer but they may actually damage the delicate skin and give rise to spectacle acanthoma due to poorly fitting spectacles and / or hearing aids. In my many years in practice, I have witnessed basal cell carcinomas in patients which have initially been hidden by and later aggravated by spectacle wear (Figure 4), especially around the bridge of the nose [3]. All registrant opticians, whether DO or optometrist, have a duty of care to their patients. If they suspect any such skin irritations / conditions they should refer the patient to an appropriate medical practitioner in order that their concerns may be investigated.

Dispensing for low vision

Another aspect we often are required to deal with in community practice is when we are faced with patients who cannot have their VA improved by the dispensing of a pair of spectacles. Typically these patients have pathology such as AMD which gives rise to low vision. All DOs and optometrists must achieve core competence in low vision before being admitted to the register, and some go on to specialise in this area after further study. Patients in the community deserve to be given advice, optical appliances and instruction in how to use them. Patients are often very reluctant to use magnifiers and other aids around the home as they see it as an admission of defeat.

In my experience most patients do not use the magnifiers they have been given purely because no-one has taken the time to teach them how to use them effectively. Sometimes it is simply just the batteries that need changing in an illuminated appliance that is the issue. DOs are ideally placed to deliver low vision services in a community setting as they often have more time than optometry colleagues who have a more rigid appointment schedule. The instruction in how to use a low vision aid or magnifier may need to be repeated due to hearing or cognitive impairment, or a family member or carer might be involved in the consultation.

In conclusion, community eyecare services have a vital role to play in the ocular health of our nation. Patients have a right to access local, high quality eyecare in a timely manner from qualified professionals with a varied skill set. DOs are well placed and qualified to support the visual requirements of our older patients.

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AUTHOR

Fiona Anderson BSc(Hons) FBDO R SMC(Tech) FEAOO,

President, International Opticians Association (IOA); Immediate past president, Association of British Dispensing Opticians (ABDO), Aberdeen, UK.

SECTION EDITOR

Dr Janet E Pooley,

Optometric Advisor, Scottish Government.

E: janetpooley@nhs.net