Letter to the Editor

Simulation in opthalmology

Simulación en oftalmología

Dear Editor,

The term simulation in ophthalmology has been substituted (erroneously for some) by functional visual loss (FVL). Alternative proposals included retinal anesthesia, retinal paralysis and other similar terms which are generally rooted in archaic terminology related to the meaning of amblyopia or blindness, respectively.1,2

Said entity is not infrequent in children. It can be found in percentages of 1–15% of children who visit an ophthalmological general practice.

In adults, simulated visual acuity loss occurs when an individual deliberately refers loss of vision with the clear aim of obtaining some personal benefit.

However, in children simulation is not always deliberate. Therefore, in the case of ophthalmopediastric simulation FVL could be valid. In contrast with an adult who deliberately and fraudulently simulates an ocular disease or exaggerates its symptoms, a child usually is undergoing a subconscious process which frequently requires psychotherapy.1,2

However, both adults and children can be simulators and have an ophthalmological disorder associated. Even so, it is clear that adults incur in more fraudulent simulation than children who, due to their age, have no legal responsibility although some children lie and simulate blatantly and deliberately. Similarly, there are adults who simulate due to psychological problems which can be resolved only by psychiatrists instead of ophthalmologists.3

Apparently, children begin to distinguish what is true from what is false at the age of 6 or 7, and when they reach 18 their judgments start to become intentional.

A number of studies emphasize the fact that a significant percentage of young people affected by FVL exhibited school or family adaptation problems as well as sexual abuse.3

Even so, it must be pointed out that, as occurs in adults, ophthalmological disorders in children can be important and bilateral and frequently require significant concentration efforts. For this reason these patients simply refer blurred vision with eventual campimetric involvement (either permanent or intermittent) and/or headaches, mono- or binocular diplopia and micropsia.4

A study carried out with 14,000 schoolchildren between 7 and 18 years of age found a higher prevalence in children between 9 and 11 and in the period from September to October, with August and December having the lowest prevalence.

The need to establish an early diagnostic in these cases is multiple and diverse:

- It avoids excessive workload for specialists due to numerous visits from anxious parents due to a process that in most cases is not significant.
- It avoids multiple costly and in some cases painful diagnostic tests.
- These patients can be referred at an early stage to a psychologist, a psychiatrist or to other institutions for effective treatment.1,3

In the diagnostic, we should always consider the possibility of concomitant organic and functional disease. Basic exploration of a child with FVL involves visual acuity test (Figgassou, Landolt rings, Snellen, Pfuger hooks, among others); pupil reflex and extrinsic motility studies, refraction under cycloplegia, fundoscopy gaze verification with visuscopy, study of phorias, trophys, convergence amplitude, posterior pole assessment, tonometry and calculation of the iridocorneal angle and campimetry if necessary.

For the above reasons, it is very important to carry out an exhaustive study in this type of patients.

REFERENCES


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