Letter to the Editor

Visual rehabilitation in low vision

Rehabilitación visual en baja visión

Dear Sir,

A Low Vision and Visual Rehabilitation Unit comprises a group of professionals with a range of degrees and specialized training in charge of providing comprehensive attention for patients with severe visual deficiencies in order to improve their daily lives with the application of specific technical equipment.1,2

Low vision patients are referred to the said units in order to begin a visual rehabilitation program to maximize their eyesight and other potential abilities so as to lead a life as normal as possible, recover their autonomy and achieve full integration.3

In Spain there are about 800,000 people with poor vision and in the world there are about 124,000,000. However, it is estimated that by 2020 there will be 200,000,000 individuals with poor vision, an equivalent of 1–2% of Europeans distributed in 1% of individuals <75 years, 5% in the age group of 75–85 and nearly 15% in individuals over 85.

The most frequent causes of low vision are macular degeneration, diabetic retinopathy, myopia Magnus, glaucoma, pigment retinosis and retinal dystrophy.

A visual rehabilitation program comprises the following sections1–3:

- Visual function diagnostic, consisting in developing an accurate diagnostic of the patients’ visual condition.
- Prescription of visual aids, in order to improve the image of an object in the retina, either by increasing its size with optical instruments or enhancing the quality of vision by means of filters. The size of objects can be increased by using larger objects, increasing them by means of photocopies or computer applications, reducing the distance between the patient and the object or applying magnifying glasses, microscopes or telescopes. To improve quality, contrast-increasing filters can be used to diminish photophobia and blinding as well as to provide a protective effect on the retina.
- Prescription of non-visual aids, typically used to increase size and contrast (such as thick fiber pens, patterns for signing and writing addresses, kitchen gloves, cutting boards, etc.).
- Development of potentialities: when central vision is impaired, the creation of a new preferential fixation area is attempted but when peripheral vision affecting spatial perception is lost patients must be trained in spatial movements. If peripheral vision is entirely lost, the patient must be readapted to optimize the use of other senses.

Children under 3 years of age are a special case because they are able to offset their visual deficit and as they do not communicate their difficulty it goes unnoticed and detection is delayed, involving delays in special education during the most important period of their development.

- Training and readaptation of the patient to his/her daily environment.
- Personal reorientation: training with optical or other aids in the Low Vision Units is useless if it is not applied to the activities carried out by patients in their usual environment. This adaptation involves the development of new reading and writing habits, eating habits, use of transport and many other routine activities.

Low Vision Units are in operation in Spain and other countries. However they are not linked to the National Health System, which means that a large number of patients are not properly cared for and many must turn to private healthcare.1,2 This situation calls for a profound analysis to assess changes that must be implemented in order to provide better care for a significant group of patients.
REFERENCES


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