

Canadian clinical guidelines for periodic eye examinations in children aged 0-5. Impact on patients

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As an optometry student, the very first patient I encountered in the dispensing clinic was a 3-year-old boy with high hyperopia who was receiving his first spectacles (+8.50). As *'patient A'* gazed wide-eyed at the previously-unseen wonders of the clinic reception area, he started to dance and exclaim "I'm happy! I'm happy!". His mother's eyes welled up as she explained to me that she was very concerned; her son had developed motor and language delays over the past year. He had completed developmental and hearing assessments before anyone suggested testing his vision. Based on his behaviour upon receiving his new spectacles, if visual impairment was not the sole cause of these delays, it certainly was a contributor.

More recently, I refracted *'patient B'*, an 8-year-old boy with a similar uncorrected refractive error. He too showed no outward indication of visual dysfunction. He had a history of poor reading, inattention and disruptive behaviour at school. He had developed mild bilateral refractive amblyopia, but could eke out passing levels of visual acuity with monocular testing. Patient B was of lower socioeconomic status and his parents were not proactive; he may well have had additional reasons for his educational difficulties, but clearly the system had failed to provide optimal vision care. What if the new guidelines of the Joint Clinical Practice Guideline Expert Committee of the Canadian Association of Optometrists and the Canadian Ophthalmological Society, had been implemented when I had seen these patients? Patient A would have had the same, non-optimal outcome: a modest delay in identification of his vision problem and likely the ability to catch up, if there were no other developmental issues. Patient B would likely have benefited from improved childhood development (from age 3 onward) and from optimal vision during his early primary school years.

Both children would have received greater benefit if they had undergone refraction before 1 year of age, as recommended in the AOA guidelines currently used throughout North America. Although this is anecdotal evidence, it illustrates the benefit of following guidelines that provide a higher standard of care than those adopted by the Canadian Committee.

Encouragingly, I've observed a groundswell of progress in awareness, and in the prompt and appropriate referral of young children for visual assessment, particularly those in higher-risk categories. I have also observed some progress in parental awareness. Perhaps there will be fewer cases of strabismus 'waiting' until the child can read letters before an eye examination is attempted. Will these new guidelines roll back this current progress? I encourage Canadian optometrists to download and read the AOA Optometric Clinical Practice Guideline: Pediatric Eye and Vision Examination,¹ for comprehensive guidance regarding not only the frequency of testing but also testing strategies and advice for parents.

REFERENCES

1. American Optometric Association. Optometric Clinical Practice Guideline: Pediatric Eye and Vision Examination. <https://www.aoa.org/documents/optometrists/CPG-2.pdf>