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REVUE CANADIENNE D'OPTOMÉTRIE

VOL 68 NO 2
MARCH / MARS 2006

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Guest Article • Article Invité

President's Podium • Mot du présidente

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Articles • Articles

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Cover: The Canadian and British Columbia Association of Optometrists succeeded in attaining stellar recognition for their booth at the 2005 Family Medicine Forum in Vancouver. The 'Most Innovative Booth' award was given to CAO / BCAO for piquing family physicians' interest with print outs of their retinal images. The show also signaled the launch of the new CAO brochure '*A guide to your patients' eyes: The role of an optometrist in caring for your patient*'.

Couverture: Les associations de la Colombie-Britannique et canadienne ont reçu une décoration d'excellence pour leur stand au forum 2005 de médecine familiale à Vancouver. Il s'agissait du prix du stand le plus innovateur pour avoir réussi à attirer l'intérêt des médecins de famille avec des impressions de leurs images rétiniennes. L'exposition a également signalé le lancement du dépliant de l'ACO, « *Les yeux de vos patients: Un guide sur le rôle de l'optométriste dans la prestation de soins à vos patients* ».


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EYE HEALTH honored at the Family Medicine Forum

Le Forum en médecine familiale rend hommage à la SANTÉ DE L'ŒIL

Paul Geneau, OD
CAO Councillor, BCAO

The College of Family Physicians of Canada held their annual meeting in Vancouver, December 8-10, 2005, and Optometry was there! As with our educational meetings, there was a large exhibit hall, and the CAO and BCAO shared a double sized booth.

This was the second time that Optometry exhibited at the Family Medicine Forum. Last year CAO shared space with the OAO, in Toronto. It was felt that last year's experience was worthwhile, and this year proved to be an unqualified success.

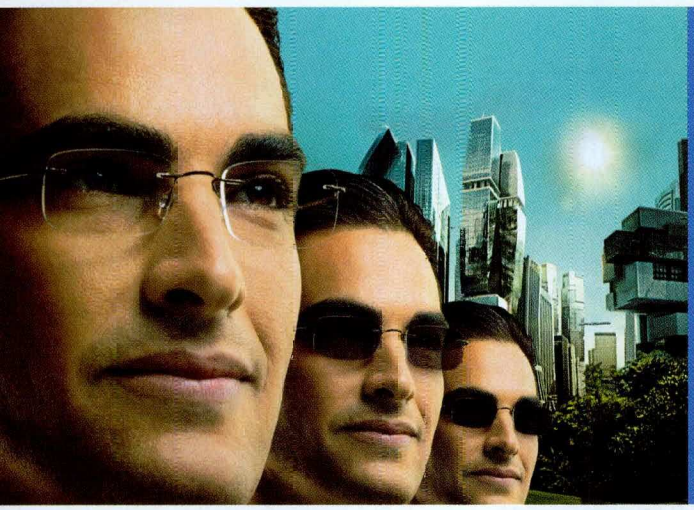
The purpose of having Optometry represented at the Family Medicine Forum is to make contact with family physicians, residents and students, and to make them aware of the training and capability of optometrists, and how we can be a resource to them in the care of our mutual patients. While more and more family physicians collaborate with optometrists, effort is needed to make this more commonplace. Individually, in our practices, we reach out to the family doctors, referring patients back and forth, and reporting to them on the status of their patients' eye health. The Family Medicine Forum provides an opportunity to reinforce those relationships, and to open the eyes (sorry, pun intended) of those family physicians that are unaware of how optometry fits into the health care team.

Immediately prior to the Forum, the National Public Education Committee of CAO worked to have ready a new brochure outlining the educational background and scope of practice of optometrists. This brochure explains how optometrists can be utilized to track the oculo-visual impact of systemic diseases, to assist in better managing those conditions. It explains that optometrists are well qualified to diagnose and manage ocular disease, referring to the appropriate health care provider when indicated. The brochure clearly asserts that Optometry is a valuable member of the health care team.

This brochure proved to be a popular item with the family physicians that visited our booth. As a matter of fact, we had one of the most highly visited booths in the exhibit hall! While we had attractive backdrop displays, and many brochures and fact sheets available for the attendees, the feature that drew so many people to us was the Canon digital retinal camera, generously loaned by Pacific Medical Technologies.

For the three days of the forum, the camera was seldom idle. At times we had a long line of family physicians and students, even other exhibitors, waiting to have their retinal photos taken. Volunteer optometrists took turns doing shifts taking photos, and explaining the features of the images on the computer screen. The subjects were also able to take away prints of their retinal photos. Many visitors to the booth were amazed at the technology, and impressed with the depth of knowledge of the optometrists.

The highlight of the experience was being awarded the Most Innovative Booth Award, a huge beautiful blue ribbon. The associations' staff and volunteer optometrists were very excited and proud



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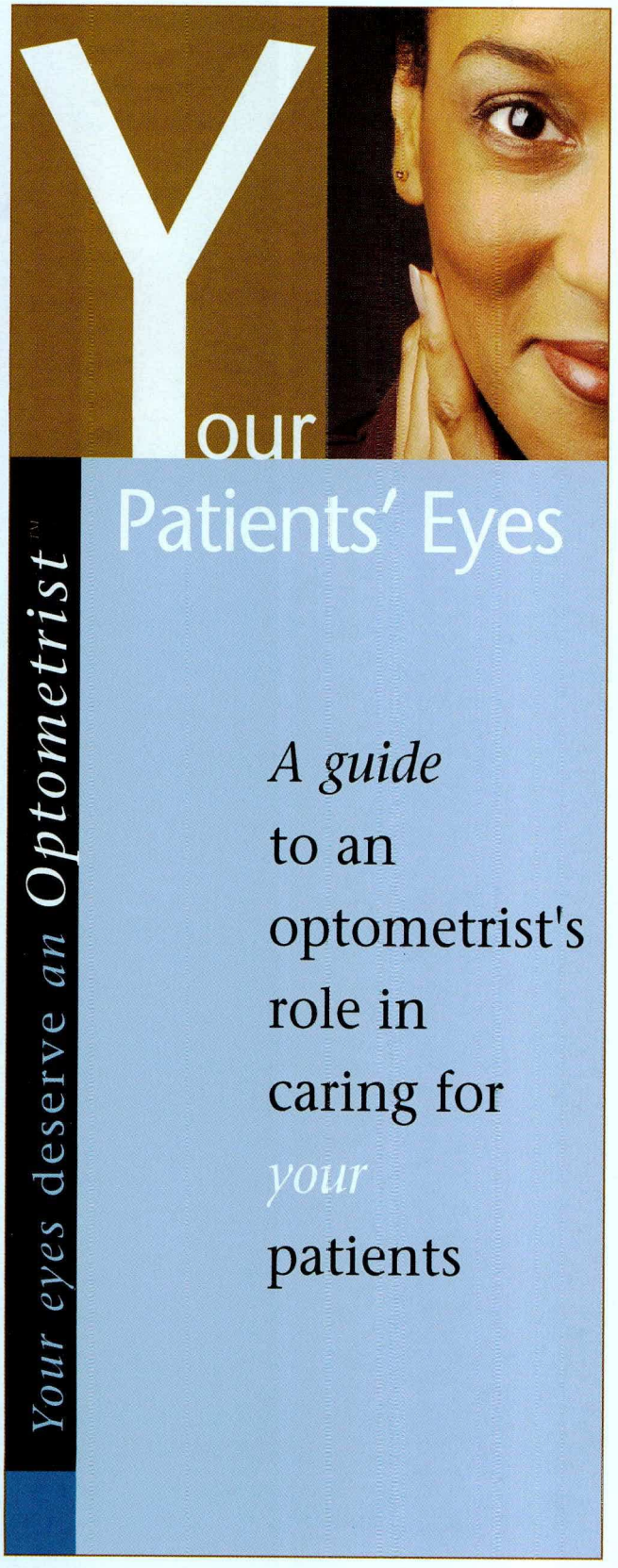
GUEST ARTICLE
ARTICLE INVITÉ



to be recognized in this way. Pacific Medical Technologies representative Doug Davenport was also present, having given up his Saturday to volunteer. We sincerely thank Doug and Pacific Medical, since it was their camera that made our exhibit so successful.

Over the past two years, the Family Medicine Forum has proven to be an effective venue to promote Optometry. In Vancouver, there were 1,468 family physicians, researchers, residents and students in attendance, from all across Canada. There were also 460 individuals displaying in the exhibit hall, including drug and medical device manufacturers and distributors, recruiters from universities, communities and the military, and various medical and health related societies and associations.

We have already been invited to exhibit at the Family Medicine Forum 2006, November 2-4, in Quebec City. It will be another excellent opportunity to build relationships between Optometry and Medicine for the benefit of the Canadian public.

Le Collège des médecins de famille du Canada a tenu son assemblée annuelle à Vancouver, et l'optométrie y était! Tout comme lors de nos conférences éducatives, il y avait une grande salle d'exposition, et l'ACO et l'AOCB ont partagé un stand double.

C'était la deuxième fois que l'optométrie présentait une exposition au Forum en médecine familiale. L'an dernier, l'ACO partageait le stand de l'AOO à Toronto. L'expérience de l'an dernier nous avait semblé valable, mais celle de cette année a eu un succès inégalé.

Par sa présence au Forum en médecine familiale, l'optométrie désire établir des ponts avec les médecins de famille, les résidents et les étudiants, les sensibiliser à la formation et aux compétences des optométristes, et montrer comment l'optométrie peut devenir pour eux une ressource dans les soins qu'ils offrent aux patients que nous avons en commun. Bien que de plus en plus de médecins de famille collaborent avec les optométristes, il faut travailler pour que cela devienne chose courante. Le Forum en médecine familiale offre une occasion de renforcer ces relations et d'« ouvrir les yeux » (désolé, mais c'est voulu!) de ces médecins de famille qui ne connaissent pas la place de l'optométrie dans l'équipe des soins de santé.

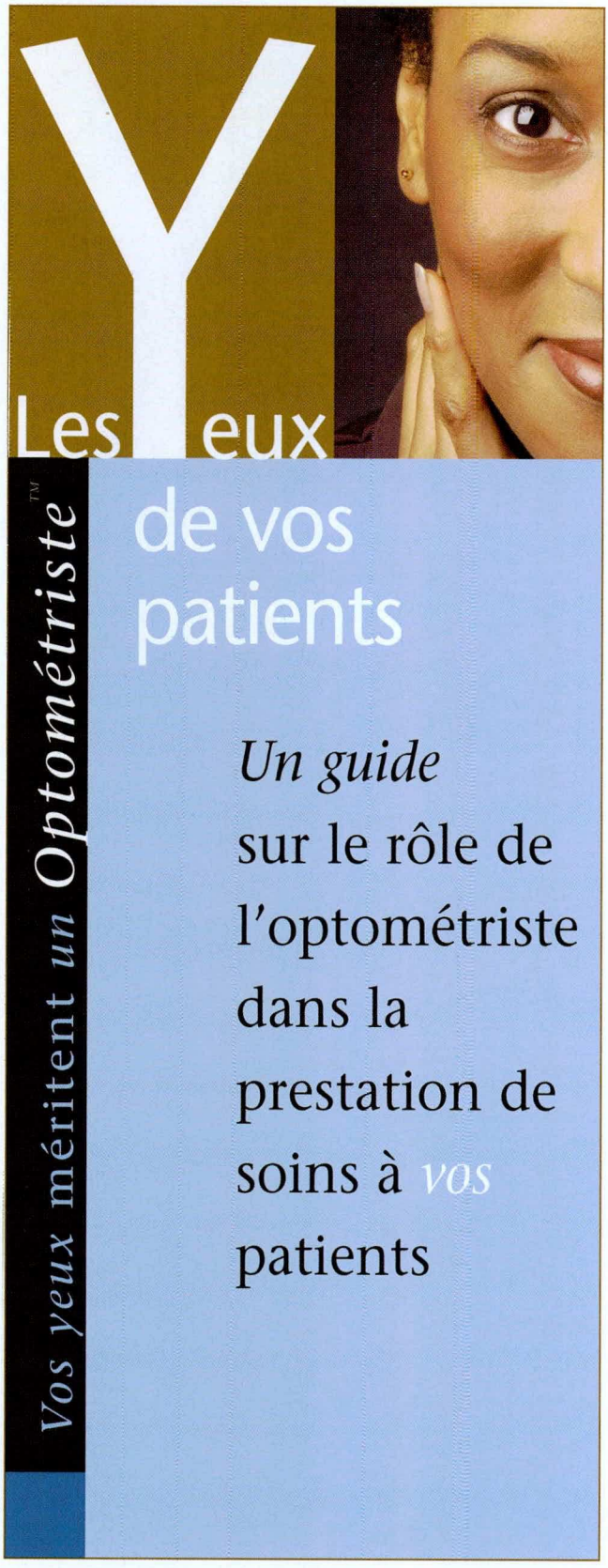
GUEST ARTICLE
ARTICLE INVITÉ

Tout juste avant le Forum, le Comité national d'éducation publique de l'ACO a publié une nouvelle brochure soulignant le contenu et la portée éducative de la pratique des optométristes. Cette brochure explique la collaboration possible des optométristes pour, d'une part, cerner l'incidence des maladies systémiques sur la santé oculo-visuelle et, d'autre part, participer à une meilleure gestion de ces maladies. Elle explique que les optométristes ont la compétence voulue pour diagnostiquer et gérer des maladies oculaires, et pour recourir, au besoin, aux professionnels de la santé appropriés. La brochure affirme que l'optométrie est un membre important de l'équipe de soins de santé.

Cette brochure a été très en demande chez les médecins de famille qui ont visité notre stand. De fait, notre stand a été l'un des plus visités à l'exposition! Même si nous avions des présentoirs attrayants et une foule de brochures et de feuillets d'information à l'intention des participants, la principale attraction a été l'appareil numérique à photos rétiniennes de Canon, généreusement prêté par Pacific Medical Technologies.

Pendant les trois jours du Forum, l'appareil n'a pas chômé! Des optométristes bénévoles se sont remplacés pour prendre les photos et expliquer les caractéristiques des images à l'écran. Les participants ont pu également rapporter des copies imprimées de leurs photos rétiniennes. Pour couronner le tout, nous avons reçu le prix du stand le plus novateur, un immense et magnifique ruban bleu. Le personnel des associations et les optométristes bénévoles étaient fiers d'avoir reçu un tel hommage. Le Forum en médecine familiale des deux dernières années nous a fait réaliser qu'il pouvait promouvoir efficacement l'optométrie. À Vancouver, on a dénombré 1 468 participants de partout au Canada, dont des médecins de famille, des chercheurs, des résidents et des étudiants. Il y avait aussi 460 exposants dans la salle, notamment des fabricants et distributeurs de médicaments et d'appareils médicaux, des recruteurs d'universités, de collectivités et de la défense, et diverses associations et sociétés médicales ou paramédicales.

Nous avons déjà reçu une invitation pour participer à l'exposition du Forum en médecine familiale de 2006, qui se tiendra dans la ville de Québec du 2 au 4 novembre. Ce sera une autre excellente occasion de bâtir des liens entre l'optométrie et la médecine au profit de la population canadienne.



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1 *than original Focus DAILIES. CIBA Vision. Data on file, 2004.

Survival is a Lousy Goal

La survie est un bien mauvais objectif

Dorrie Morrow, OD
President / présidente

CAO Council is about to take a journey in both the figurative and physical sense. During CAO's 2006 Planning Session, your council will be focussing its energy and effort on our profession's future and how we can best position ourselves for that future.

We all know the story of *Chicken Little* as a children's fable; however, it would not be inappropriate to review and consider what we could learn from this simple tale during our meeting: not to over-react, watch who you hang around with, and be wary of short-term solutions.

On this journey we will be well-served by lesson one, not to over-react. A victim of tunnel vision, Chicken Little's perspective becomes his only truth. His fear causes him to panic and leap to the wrong conclusions. For optometry, we learn that it will be critical in the coming months and years that we look at the bigger picture by gathering information and being aware of what is going on beyond our profession's boundaries, and by perhaps extending those boundaries.

Lesson two reminds us to watch who we hang around with. Many times it is easier to only listen to people who agree with us, but the consequences can be dangerous. Often, we are quick to assume a different perspective is wrong, but we need to constantly challenge ourselves to consider and even accept different approaches and viewpoints. Strategic alliances are found everywhere in this new environment and we need to work vigilantly with groups that will help us flourish.

Lesson three cautions us that quick fixes and short-cuts usually result in long-term problems. There are survivalists who think short-term and then there are visionaries who have long-term vision. In this changing healthcare environment, we need visionaries concerned with transformation and to be open to possibilities where changing the status quo is needed.

How do we get that transforming vision? During our time together at the planning session, CAO Council will be asked to address the fear of the unknown. We will "future focus" being reminded and sometimes challenged to believe that the future will be better than the past and that the unknown can be as good, if not better, than the known. All that is required is a transforming vision and belief in our profession and its ability to thrive in new circumstances. To do all this, we are committed to looking at different perspectives, building on effective alliances, and accepting change as a challenge versus a threat.

The 2006 Planning Session will allow CAO Council to embrace different possibilities and prepare our profession for long term solutions, and we look forward to reporting on this journey when we return. We are a group that believes survival is a lousy goal!

PRESIDENT'S PODIUM
MOT DE LA PRÉSIDENTE

Le Conseil de l'ACO s'apprête à partir en voyage aux sens propre et figuré du mot. Lors de la séance de planification de l'ACO, votre Conseil concentrera ses énergies et ses efforts à l'avenir de notre profession et aux moyens que nous pouvons prendre pour mieux nous situer à cette fin.

Nous savons tous ce que fait un alarmiste; toutefois, il serait approprié d'examiner lors de notre réunion les leçons d'une telle attitude, c'est-à-dire ne pas réagir de façon excessive, se méfier de ceux que nous côtoyons et éviter les solutions à court terme.

Durant ce voyage, la première leçon, c'est-à-dire ne pas réagir de façon excessive, nous sera utile. Victime de ses œillères, le point de vue de l'alarmiste devient sa seule vérité. Sa crainte le fait paniquer et sauter aux mauvaises conclusions.

Pour l'optométrie, nous savons qu'il sera essentiel dans les mois et années à venir d'avoir une meilleure perspective en recueillant de l'information et en étant conscient de ce qui se passe au-delà des frontières de notre profession, et peut-être aussi en étendant ces frontières.

La deuxième leçon nous rappelle de nous méfier de ceux qui nous entourent. Il est très souvent plus facile d'écouter seulement ceux qui sont d'accord avec nous mais les conséquences peuvent être dangereuses. Souvent, nous admettrons rapidement qu'un autre point de vue n'est pas valable, mais il importe de constamment nous remettre en question et d'examiner, voire accepter des approches et points de vue différents. Nous pouvons trouver partout des alliances stratégiques dans ce nouvel environnement et nous devons travailler avec vigilance avec les groupes qui nous aideront à progresser.

La troisième leçon nous met en garde contre les solutions miracles et les raccourcis, qui débouchent généralement sur des problèmes à long terme. Les conservateurs pensent à court terme et les visionnaires, à long terme.

Dans cet environnement de soins de santé en évolution continuelle, nous avons besoin de visionnaires axés sur les changements beaucoup plus que sur la simple survie, et ouverts aux occasions d'évolution.

Comment obtenir cette vision de transformation? Lors de notre séance de planification, le Conseil de l'ACO sera confronté à cette peur de l'inconnu. Nous nous concentrerons sur « l'avenir » en nous rappelant et parfois en nous faisant rappeler que l'avenir sera meilleur que le passé et que l'inconnu peut être aussi bon sinon meilleur que le présent.

Tout ce qu'il faut faire, c'est adopter une vision de changement et croire à notre capacité de progresser. Pour réussir tout cela, nous devons examiner différentes perspectives, bâtir des alliances efficaces et accepter le changement comme un défi et non comme une menace.

La séance de planification 2006 permettra au Conseil de l'ACO d'examiner différentes possibilités et de préparer notre profession à des solutions à long terme, et nous sommes impatients de vous faire partager tout cela à notre retour.

Nous croyons que la survie est un bien mauvais objectif!

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CLINICAL DIAGNOSIS

Catherine Chiarelli, OD, FAAO
Vision Institute of Canada

C.W., a 7-year-old male, presented with his parents for another opinion, seeking treatment to improve binocularity. He had been under the care of an ophthalmologist since age 4 years. At that time, glasses were prescribed to correct a right esotropia. Occlusion therapy also was recommended, and was done consistently for several months. Two years ago, bifocal lenses were prescribed to further improve eye alignment. At a recent follow-up, C.W. and his parents were told that visual acuity and the esotropia were adequately corrected with bifocals, and that no further treatment was required. Annual follow-up was advised.

C.W.'s parents remained concerned, however, because they noticed that the right eye still crossed occasionally, even with glasses on. They also observed that C.W. was unable to appreciate three-dimensional pictures in books, and had little interest in them, unlike his siblings. They used the Internet to learn more about visual development and strabismus, and concluded that he must be lacking stereopsis. They were concerned that this might limit his ability to meet future academic or occupational challenges. Therefore they sought a clinic that offered vision therapy treatment.

C.W.'s habitual spectacle prescription was:

OD	+2.50 –1.25 x 001	+3.25D add (ST 28)
OS	+2.50 –1.00 x 178	+3.25D add (ST 28)

Entering aided visual acuities were 20/25+ right eye, 20/20 left eye at distance and 20/20 each eye at near. Cover test, through distance correction, showed 2 pd right esotropia at distance and 20 pd right esotropia at near. The bifocal neutralized the deviation at near, leaving 2 pd residual esophoria. Dynamic retinoscopy showed no lag or lead of accommodation through the add, confirming accurate accommodative function. Extraocular muscle movements were full and smooth for both eyes; the deviation was comitant in all directions of gaze. Diplopia was reported on Worth 4 Dot testing at distance, with flat fusion achieved at near (through the bifocal). There was no appreciation of stereopsis, by Titmus Stereofly or Randot tests. Suppression was demonstrated on attempted testing of convergence and divergence ranges at near.

Cycloplegic refraction revealed:

OD	+3.25 –1.50 x 001
OS	+2.50 –1.00 x 178

Anterior and posterior segment examination, through dilated pupils, was unremarkable.

What is the diagnosis in this case?

Is further treatment necessary?

What treatment options are available, to improve binocularity further?

(see page 85)

C.W., un garçon de sept ans, s'est présenté avec ses parents pour une seconde opinion sur un traitement pour améliorer la vision binoculaire.

DIAGNOSTIC clinique
diagnositic CLINIQUE

Il avait été sous les soins d'un ophtalmologiste depuis l'âge de quatre ans. À ce moment-là, on lui avait prescrit des lunettes pour corriger une isotropie à l'œil droit. On avait aussi recommandé un traitement par occlusion, qui s'est poursuivi de la même manière pendant plusieurs mois. Il y a deux ans, des lentilles bifocales ont été prescrites pour améliorer le réalignement des yeux. Lors d'un récent examen de suivi, on a dit à C.W. et à ses parents que l'acuité visuelle et l'isotropie avaient été corrigées correctement avec les lentilles bifocales et qu'aucun autre traitement ne serait nécessaire. On leur a suggéré un suivi annuel.

Toutefois, les parents de C.W. sont demeurés inquiets parce qu'ils ont remarqué un strabisme occasionnel à l'œil droit, même avec des lunettes. Ils ont aussi remarqué que C.W. était incapable de saisir des images tridimensionnelles dans les livres et y trouvait peu d'intérêt, au contraire de ses frères et sœurs. Grâce à l'Internet, ils se sont renseignés sur le développement visuel et le strabisme et sont venus à la conclusion que l'enfant devait avoir un défaut de la vision stéréoscopique. Ils se sont demandé si cela ne serait pas un handicap futur dans sa vie scolaire ou professionnelle. Ils ont alors cherché une clinique qui offrait un service de thérapie visuelle.

La prescription des lunettes ordinaires de C.W. était :

OD	+2,50 – 1,25 x 001	+3,25D Ajout (ST 28)
OS	+2,50 – 1,00 x 178	+3,25D Ajout (ST 28)

L'acuité visuelle aidée, avant correction, était de 20/25+ OD et de 20/20 OS de loin et 20/20 de près pour chaque œil. Le test à l'écran, après correction de la vision éloignée, indiquait une ésotropie à l'œil droit de 2 dp de loin et une ésotropie à l'œil droit de 20 dp de près. Les lunettes bifocales ont neutralisé la déviation de près, avec une ésophorie résiduelle de 2 dp. La réthinoscopie dynamique ne montre aucun retard ni progrès de l'accommodation grâce à la correction, ce qui confirme une fonction accommodative correcte. Les mouvements des muscles de l'orbite étaient entiers et souples pour chaque œil; la déviation était concomitante, quelle que soit la direction du regard. On signale une diplopie à distance au test de Worth 4 Dot, avec fusion à plat réalisée en vision de près (grâce aux lentilles bifocales). Il n'y a eu aucune évaluation de la stéréopsie par les stéréotests Titmus ou Randot. On a démontré la suppression en réalisant des tests de convergence et de divergence de près.

La réfraction cycloplégique a révélé :

OD	+3,25 – 1,50 x 001
OS	+2,50 – 1,00 x 178

L'examen des segments antérieur et postérieur, avec pupilles dilatées, n'a rien révélé de spécial.

Quel est le diagnostic dans ce cas-ci?

Faut-il poursuivre le traitement?

Quels sont les traitements disponibles pour améliorer la vision binoculaire?

(voir la page 87)

VISUAL EXCELLENCE BY DESIGN

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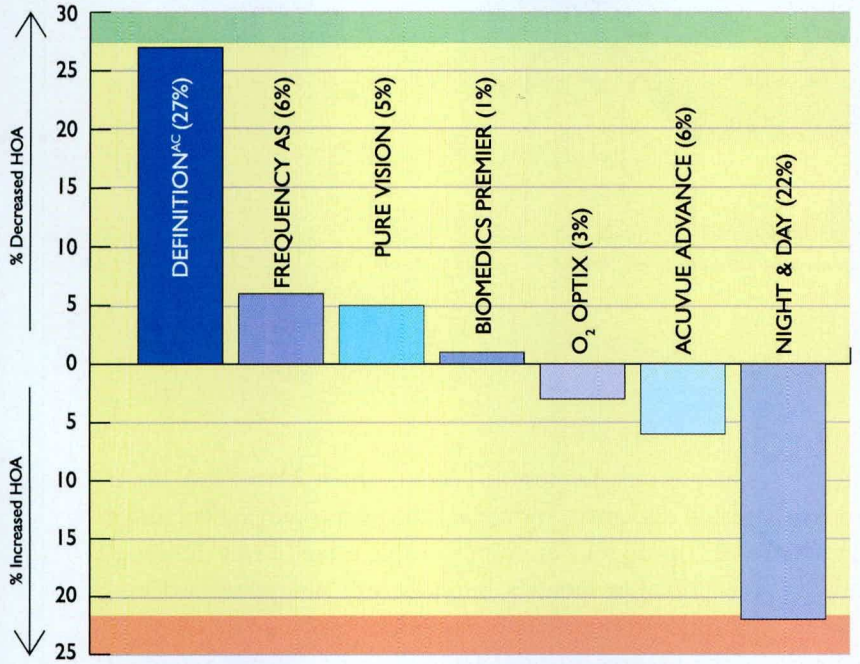

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**Study data on file at Optical Connection, Inc. and has been submitted for publication.*

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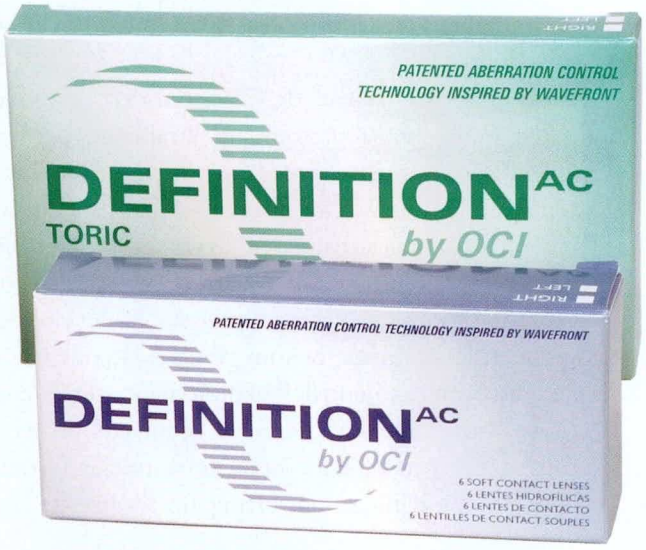

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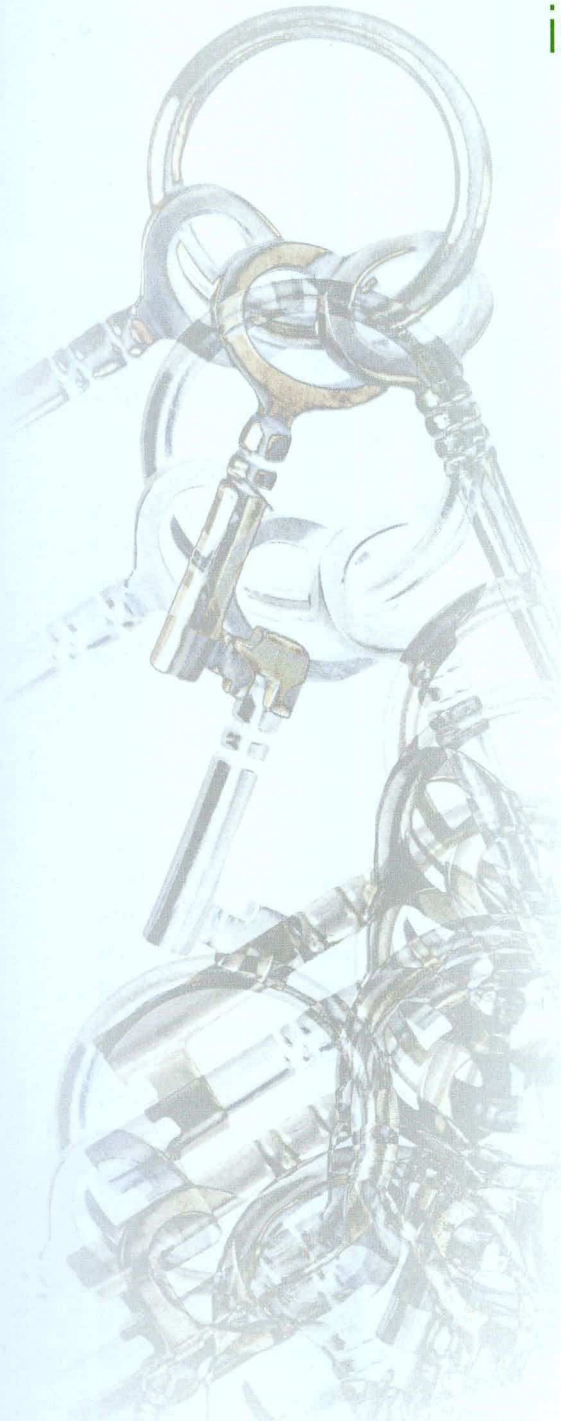


Alphonse Carew
OF, FAAO

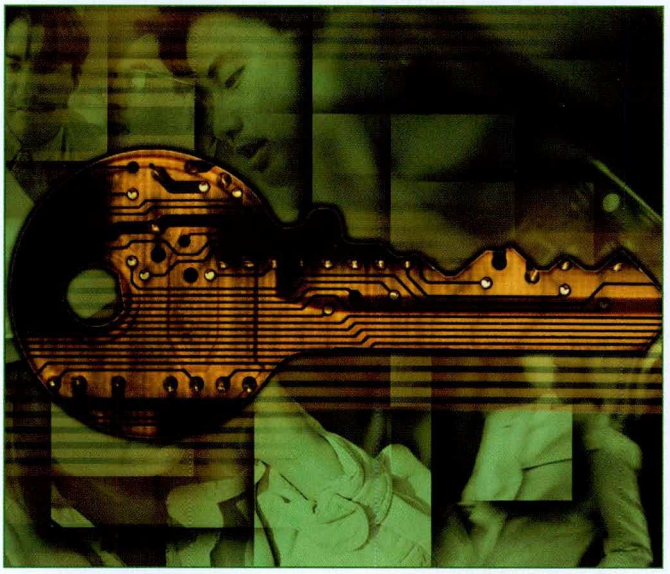
Like so many journeys in life you learn just as much from the mistakes you make, as you do from the successes. When I started my practice, I admit I made plenty of mistakes. One of my largest blunders was keeping my goals and plans for the practice to myself. I believe it stemmed from either a lack of confidence or a concern about the potential loss of any competitive advantage, but it doesn't matter what the reasons were, the end result was a negative effect on my practice.

Holding things "close to my chest", and keeping my staff, my team, in the dark did nothing to help move my practice forward. Keeping them on a "need to know" basis only made it more difficult for the practice to do well. How were they suppose to know where we were going if I didn't communicate this clearly to them?

Then it dawned on me that I could never reach my practice goals without the help of others. I couldn't grow from a single doctor to multiple doctors, from 2 staff to over 30 team members, from a few hundred thousand in gross income to a few million in gross without the help of others. However, just hiring employees doesn't get you where you want to be nearly as fast as having them buy in and really participe in building your vision of the best optometric practice.

It all starts with your vision for the practice. Then you have to be willing to share that vision as well as allow others to shape the plan so they can buy-in to the goals. It starts with a shared mission, or purpose for the practice and then a statement of practice values that your team

will work under to realize your mission and goals. A significant part of communication is listening, so it's important that you listen to the input that your team provides to you.



The most important step in making this happen is effective communication with your team. You have to be able to describe what you feel the perfect practice should be. Start with the end in mind and work backward from there.

You need to communicate why the vision is important, how they can participate (their role) and how they will be rewarded when positive steps towards these goals are made (what's in it for them). It is not enough to do this at a staff meeting once a year you have to constantly bring up these plans, and goals at every opportunity.

Your job then is to communicate often and effectively with your team. You cannot communicate with your team too often. It may seem repetitive to you but your staff does not perceive it that way, they need to know that your practice is living these goals daily. In this case, redundancy and repetition are helpful in communicating effectively.

Make sure your plans and goals are clear and concise. Have your mission and values summarized and use them at every opportunity. It is important to make it as concise as possible. People can only remember a few items at a time so distill your goals down to no more than three and highlight them at every opportunity.

How you communicate is just as important as what you communicate. You have many vehicles at your disposal, the most effective of these are face-to-face meetings. Whether it is with individuals or in teams, meetings can be the best way to reinforce the goals of the practice. The main drawback with meetings is that it is often difficult to schedule them and have all staff be present at one time, this is especially true in larger practices.

Many offices use memos to get the word out but this has limitations because it is only a one-way conversation, and doesn't allow for easy feedback. Sometimes this type of communication can actually hurt you if your staff feel these messages are being sent from "above" as directives, without team participation. Memos have to be used carefully for they can have a negative effect on your efforts.

With a large number of staff, and multiple locations we had to look at imaginative solutions. Around the time we were investigating this, the internet and email were just starting to become popular. We latched onto this technology and we now communicate literally many times daily with individuals, with a select few or all staff, depending on the topic. It also has the advantage of allowing for two-way commination. Although, you do have to be careful because email cannot transmit your tone or passion, you need to use clear and positive language. When added to face-to-face interactions, email can be a valuable tool.

You should make an effort to share all the news about your practice (good and bad) as soon as possible with your team. If you don't communicate quickly, the grapevine will and it is far better for your team to hear accurate information from you than to have damage done by myths or rumours. Your team understands that plans may change and they will appreciate the effort you make in keeping them informed. When you see positive steps towards your goals you need to communicate this quickly to reinforce the plan and start the momentum. If there is bad news, communicate this clearly as well but seek, and offer solutions on how to improve the situation.

Make your messages clear and concise, communicate it often and watch your practice grow.

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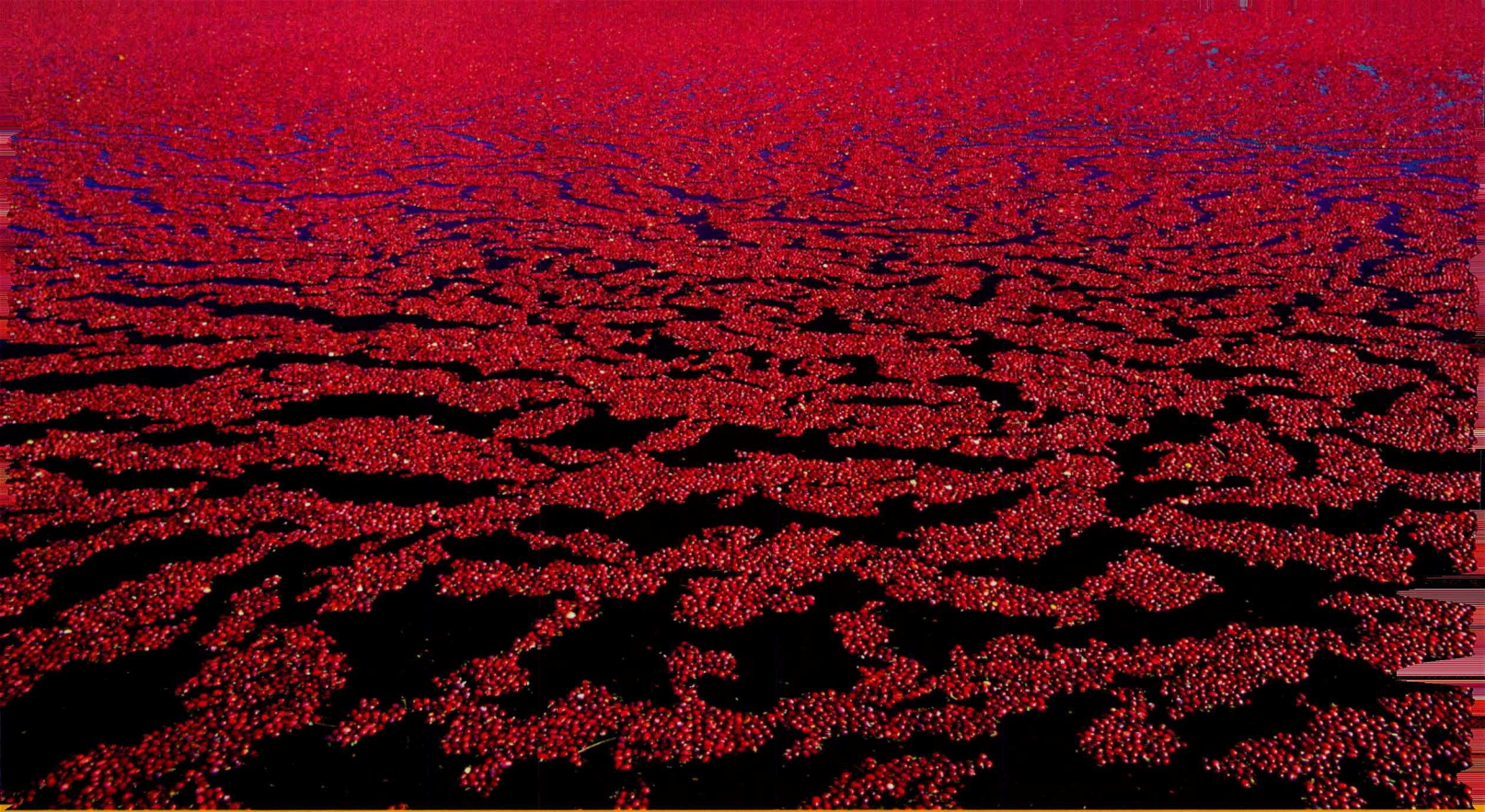

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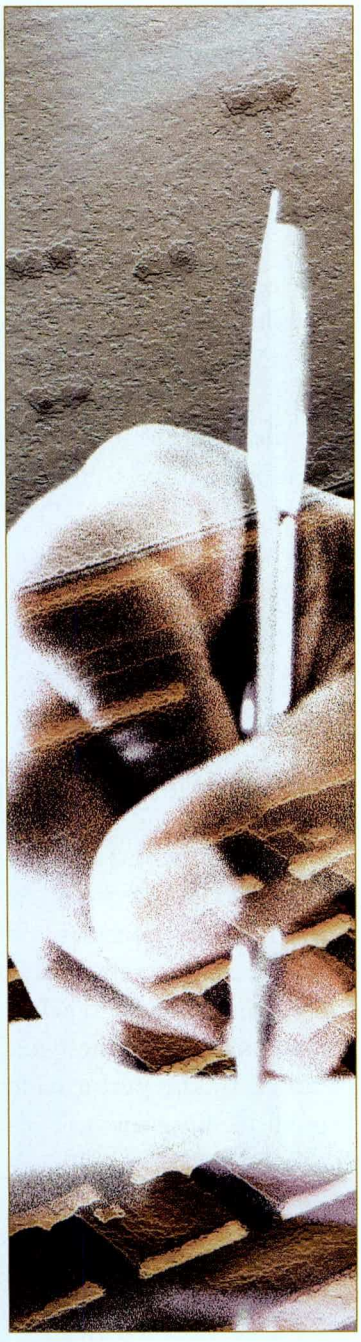
Reference: 1. Environics Research Company, Survey of Optometrists and General Ophthalmologists, April 2004.

LEGAL FOCUS: British Columbia's proposed optician's regulation



The Canadian Association of Optometrists sought legal counsel regarding the proposed opticians regulation in British Columbia. Of interest to members, the following letter by Alan West, dated July 13, 2004, provides a relevant legal perspective to the issue of increasing the permitted scope of practice of opticians.
The document clearly provides an analysis of the proposed regulation from a legal position and touches on critical areas of concern, such as mitigation of risk and liability.
CAO is hopeful that the publication of the letter by Mr West will provide members with, not only a broader view of the serious issues relating to increased scope of practice of opticians, but that it will also be viewed as a useful resource.
In addition, CAO members are encouraged to visit www.opto.ca, "advocacy" section and CAO member website, "inside CAO". Members may also monitor this issue on the BCAO website, www.optometrists.bc.ca.

by Alan West
Gowling Lafleur Henderson LLP,
Barristers & Solicitors

Alan West is a Lawyer and Physician. He can be reached at *Gowling Lafleur Henderson* LLP in Toronto.
www.gowlings.com

Certain amendments have been proposed to the Opticians Regulation to the British Columbia Health Professions Act (the "amended regulation"). The effect of the proposed amendments is to increase the permitted scope of practice of opticians. Opticians will be permitted independently to perform refractive eye examinations (as opposed to merely filling the prescription of an optometrist or ophthalmologist, as is currently required).

One of the factors motivating the proposed amendment is the development of an automated, computerized refraction system, which enables opticians to perform 'refractions' without medical knowledge.

The problem with the proposal, as identified in many representations already made to the British Columbia Ministry of Health Services, is that performing a 'refraction' by way of an automated system does not

screen the patient for potential health problems—in contrast to the system currently in place, and in contrast to the system as it exists in every other jurisdiction in North America. As Dr. T. Peter Seland, Deputy Registrar of the College of Physician and Surgeons of British Columbia wrote in a letter dated April 19, 2004 to Mr. Daryl Beckett, Acting Director, Professional Regulation, Ministry of Health Services:

> *Autorefraction is certainly a safe and accurate procedure to guide the prescribing of eye glasses, as Minister Hansen has noted in his Press Release. The risk of harm arises from the context within which the procedure is done. Specifically, patients will, even with disclaimers to the contrary, often consider that a satisfactory autorefraction (i.e., yielding a prescription which provides good visual acuity) is an adequate testimony to their ocular health. All involved professionals acknowledge that this is manifestly not so.*

The letter then describes the history of two cases of patients who were fitted with glasses with the aid of autorefraction (with prescriptions signed by ophthalmologists who had not actually examined the patients), who subsequently discovered serious ocular health problems which had been missed by reason of the autorefraction procedure. The letter concludes by stating that it would be legally and ethically unacceptable to prescribe based on sight-testing data without a complete ocular examination, even if the patient consents to this procedure by way of a waiver accepting the risk. This position was stated in a College Policy entitled "Provision of Prescriptions for Ocular Refraction by Physicians in British Columbia", referenced in the letter.

In other words, the government of British Columbia intends to enact legislation which it has been reliably informed by the province's own College of Physicians and Surgeons (among many others), will result in an unacceptable level of risk to the public.

This opinion addresses the legal liability issues raised by this unprecedented legislation.

Conclusions

❶ The proposed regulatory amendment will expose large numbers of British Columbia residents to potential harm. The available evidence indicates that tens of thousands of British Columbia residents within the age range affected by the proposed amendment have eye diseases of which they are unaware. As a result of the proposed amendment, they will not be screened adequately, and the provision made in the amendment for their protection is, on its face, inadequate.

❷ Opticians who rely on the proposed amendment to provide autorefraction services are likely to be found liable if injuries result from a failure to detect eye disease. The existence of the amended regulation will not protect opticians from civil liability. In my opinion, the provision of such services, in the absence of a proper medical or optometric examination, breaches the appropriate standard of care in the circumstances.

Discussion

There are two interrelated liability issues raised by the British Columbia government's proposed amended regulation:

- Whether the wording of the regulation adequately mitigates the identified risk to the public; and
- Whether the provision of autorefraction services in accordance with the amended regulation creates any liability issues for participating opticians.

Mitigation of Risk

The wording of the amended regulation is clearly intended to mitigate the anticipated risks to the public that result from the provision of autorefraction without adequate medical or optometric supervision. According to new subsection 6(2), an optician may only perform an assessment based on autorefraction in accordance with Schedule "A" to the regulation. Schedule "A" lists a series of limitations that are designed, in theory, to limit the risk posed by the performance of autorefraction without medical supervision. These limits are (in relevant part) as follows:

① The optician is required to provide written notice to the client, informing the client that the procedure in question is not an ocular examination, defining the

difference between the two, and stating the desirability of periodic medical examinations;

② The client must sign this notice, attesting to the fact that he or she has read and understood the information, is between the ages of 19 and 65, that to the best of his or her knowledge he or she does not have any of the diseases or conditions listed in the Schedule that would render him or her ineligible for autorefraction, and that he or she consents to the procedure;

③ If the autorefraction indicates a change in refractive error exceeding a specified number of diopters, an optician must refuse to dispense eyeglasses based on the assessment and instead recommend that the client seek for medical or optometric examination.

Unfortunately, these safeguards are wholly inadequate to protect the public against the entirely predictable and understood dangers of autorefraction without medical or optometric supervision.

First, the notice and waiver provisions in and of themselves are unlikely to successfully protect the client. This fact is apparently accepted by the legislative draftsmen themselves, who have excluded from the population eligible for autorefraction those clients aged less than 19 years and greater than 65 years. If the notice and waiver provisions were adequate to protect the population from the risks of undiagnosed eye diseases and conditions, there would be no need to restrict the age range of potential clients. Clearly, the government has indicated that for certain populations, the risk of failure to obtain a proper medical examination is too great—even if they are warned that autorefraction is different from a medical examination. In my opinion, in the context of a civil action for damages, this "precaution" in and of itself constitutes evidence of negligence of an optician who "prescribes" lenses without medical or optometric supervision.

The problem with that position is that there is considerable evidence that the population between the ages of 19 and 65 is also at risk. This point is made in an article entitled Prevalence of Asymptomatic Eye Disease, by Dr. Barbara E. Robinson. In that paper, Dr. Robinson describes a cross-sectional Canada-wide clinical study undertaken in order to determine the proportion of persons presenting for an eye examination who are unaware that they have an eye disease. One of her conclusions was as follows:

> *"[a]wareness of eye disease was also related to patient's age and time since last full eye examination. Older patients were more likely to be aware of the presence of an eye disease than younger patients were (Table 4). People whose last full examination prior to the current visit was 1 year or less had the highest probability of knowing about the eye disease." [emphasis added]*

Table 4, for example, indicates that in the 25 to 44 age range 44% of subjects were likely to know of the existence of an eye disease; the 65-85 age range, 58% were likely to know.

The figures also indicate that the risk for those within the category of persons eligible for autorefraction without medical supervision in accordance with Schedule "A" of the amended regulation is not trifling. On table 6, Dr. Robinson lists four major eye diseases and their prevalence by age. To provide some examples, in the 45 to 65 age range 8.57% of subjects had cataract/IOL opacification; 6.87% had glaucoma (or suspected); 1.31 % had diabetic retinopathy; and 2.02% had macular degeneration. Table 6 also lists levels of knowledge of disease by disease: for example, 50% of persons of all ages who have glaucoma are unaware of the fact.

While the data used in this study is prevalence data derived from clinical studies, not population-based data and not specific to British Columbia, the numbers involved are quite similar to population-based studies in similar jurisdictions. The Framingham population study in the United States, for example, revealed that the incidence of glaucoma for the 55 to 64 age range was 7.2%; and other population-based studies in the US, Holland and Australia have found that 50% of cases of glaucoma were undiagnosed.

These figures indicate that the risk is not inconsiderable.

The problem is exacerbated by the design of Schedule "A" to the amended regulation. The regulation is intended to prevent persons with certain conditions from obtaining autorefraction. For example, paragraph

4(b)(i) of Schedule "A" states that clients with glaucoma are ineligible. A client is supposed to sign a waiver stating that "to the best of his or her knowledge", he or she "does not have an ocular disease specified in section 4(b) of this Schedule"—such as glaucoma. However, from the above study, it appears that half of the people who have glaucoma do not know it (with the chance being greater for those who are younger and thus within the accepted age range); and that some 6.87% of those aged 45 to 65 (and thus within the accepted age range) have the disease.

This indicates that at least 3.4% of clients aged 45 to 65 (and probably more) have glaucoma and are unaware of the fact. They could truthfully answer that "to the best of their knowledge" they have no eye disease. Unless the suggestion of the desirability of obtaining a proper medical or optometric examination motivates them (as apparently the government believes will not be the case for those over 65), this condition will go undetected.

According to statistics for the year 2001, the number of people in British Columbia between the ages of 45 to 64 was around one million. This means that some 34,000 persons (and probably more) in British Columbia may have glaucoma and are unaware of the fact, and will be put at risk of not being screened as a result of this amended legislation. That, of course, is just one disease out of many, for the selected age range.

In other words, the stipulation that the client must state that "to the best of his or her knowledge, the client does not have an ocular disease specified..." is completely worthless. Tens of thousands of British Columbians within the 'accepted' age range have eye diseases or conditions which ought to render them ineligible for autorefraction—and are unaware of this fact. Indeed, logically, if they were aware that they had an eye disease, they would likely be under medical care already.

Liability of Opticians

The question is whether the existence of a regulatory procedure can displace an allegation of negligence. Can a person who follows a legislative standard be found negligent?

The answer, unequivocally, is "yes".

The leading case on point is the decision of the Supreme Court of Canada in Ryan v. Victoria (City), [1999] 1 S.C.R. 201 at para. 29:

> *Legislative standards are relevant to the common law standard of care, but the two are not necessarily co-extensive. The fact that a statute prescribes or prohibits certain activities may constitute evidence of reasonable conduct in a given situation, but it does not extinguish the underlying obligation of reasonableness: see R. in right of Canada v. Saskatchewan Wheat Pool, [1983] 1 S.C.R. 205. Thus, a statutory breach does not automatically give rise to civil liability; it is merely some evidence of negligence. See, e.g., Stewart v. Pettie, [1995] 1 S.C.R. 131, at para. 36, and Saskatchewan Wheat Pool, at p. 225. By the same token, mere compliance with a statute does not, in and of itself, preclude a finding of civil liability. See Linden, supra, at p. 219. Statutory standards can, however, be highly relevant to the assessment of reasonable conduct in a particular case, and in fact may render reasonable an act or omission which would otherwise appear to be negligent. This allows courts to consider the legislative framework in which people and companies must operate, while at the same time recognizing that one cannot avoid the underlying obligation of reasonable care simply by discharging statutory duties. [emphasis added]*

Whether or not an optician owes a duty of care to customers is governed by the two-step test in Anns v. Merton London Borough Council, [1978] A.C. 728 (H.L.), at pp. 751-52, which was adopted by the Supreme Court of Canada in Kamloops (City of) v. Nielsen, [1984] 2 S.C.R. 2, and numerous subsequent decisions. The two stages of the test were restated as follows in Kamloops, at pp. 10-11:

> ① *is there a sufficiently close relationship between the parties (the [defendant] and the person who has suffered the damage) so that, in the reasonable contemplation of the [defendant], carelessness on its part might cause damage to that person? If so,*

② *are there any considerations which ought to negative or limit (a) the scope of the duty and (b) the class of persons to whom it is owed or (c) the damages to which a breach of it may give rise?*

The first step of the Anns/Kamloops test presents a relatively low threshold. To establish a prima facie duty of care, it must be shown that a relationship of "proximity" existed between the parties such that it was reasonably foreseeable that a careless act by (for example) the opticians could result in injury to the appellant.

In this case, there is no question that sufficient proximity is created.

The second step of the Anns/Kamloops test requires that it be determined whether any factors exist that would eliminate or limit the duty found under the first branch of the test. This approach recognizes that while the test of "proximity" may be met, liability does not necessarily follow. The existence of a duty of care must be considered in light of all relevant circumstances, including any applicable statutes or regulations. Thus, a legislative exemption from liability can negate a duty of care in circumstances where that duty would otherwise arise.

In this case, the amended regulation does not purport to limit the liability of opticians.

Conduct is negligent if it creates an objectively unreasonable risk of harm. To avoid liability, a person must exercise the standard of care that would be expected of an ordinary, reasonable and prudent person in the same circumstances. The measure of what is reasonable depends on the facts of each case, including the likelihood of a known or foreseeable harm, the gravity of that harm, and the burden or cost which would be incurred to prevent the injury. In addition, one may look to external indicators of reasonable conduct, such as custom, industry practice, and statutory or regulatory standards.

In each case, the risk of foreseeable harm resulting from a lack of screening is established by the evidence:

❶ Likelihood of a known or foreseeable harm. As attested to by numerous letters from self-regulatory bodies all over North America, including the College of Physicians and Surgeons of British Columbia described above, and as further demonstrated by the analysis of the clinical trial data, clearly, the likelihood of foreseeable harm is high;

❷ Gravity of that harm. Untreated eye diseases are clearly a grave matter;

❸ Burden or cost that would be incurred to prevent the injury. The "burden or cost" is minimal—simply to maintain the regulation that now exists;

❹ Custom and industry practice. The current custom and industry practice is to require a medical or optometric examination.

❺ Statutory or regulatory standards. As will be described in further detail, following the procedure as outlined in the proposed amendment is in breach of other established statutory standards.

The "notice" provisions found in Schedule "A" to the proposed amended regulation do not conform to the elements of informed consent to a medical procedure, as described in the Health Care (Consent) and Health Care Facilities (Admission) Act, RSBC 1996, Chapt. 181 as follows:

Elements of consent

❻ An adult consents to health care if

a. the consent relates to the proposed health care,

b. the consent is given voluntarily,

c. the consent is not obtained by fraud or misrepresentation,

d. the adult is capable of making a decision about whether to give or refuse consent to the proposed health care,

e. the health care provider gives the adult the information a reasonable person would require to understand the proposed health care and to make a decision, including information about

i. the condition for which the health care is proposed,
ii. the nature of the proposed health care,
iii. the risks and benefits of the proposed health care that a reasonable person would expect to be told about, and
iv. alternative courses of health care, *and*

f. the adult has an opportunity to ask questions and receive answers about the proposed health care.

In particular, it can hardly be said that the client will be informed of the "... risks and benefits of the proposed health care that a reasonable person would expect to be told about", as required by paragraph 6(e)(iii) of the Act, merely by informing the client of "the distinction between an autorefraction and an ocular examination" and "the desirability of periodic ocular examinations and recommending that an eye health exam be obtained in addition to the sight-test", as required by section 1 of Schedule "A".

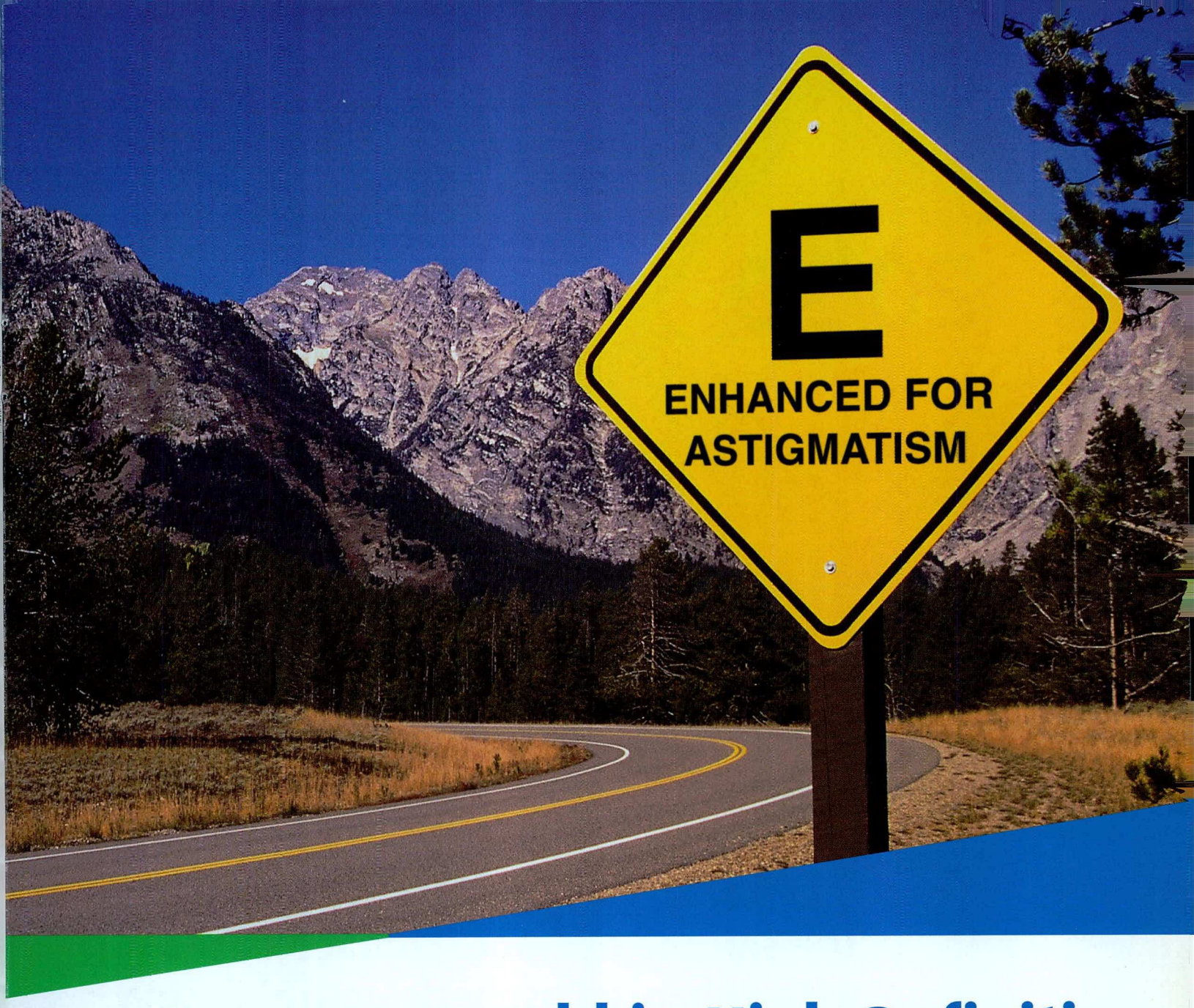
Summary

The chances are very good, given the large numbers of persons involved, that many cases of otherwise avoidable injury will occur as a result of opticians relying on the proposed amended regulation. In my opinion, those injured will have a good case in negligence against the opticians involved. Given the existence of class proceedings in British Columbia, there is a good chance that, ultimately, a class action will be launched.

In my opinion, this may lead to serious insurance issues. Insurers of opticians may refuse to cover this risk, or increase premiums to allow for this risk. If insurers do decide to cover the risk, and adopt a "wait and see" attitude in evaluating the risk, they are likely to find that the risk does not increase incrementally; as noted above, there is a good chance that clients who are injured will organize a class proceeding. This means that the risk is likely to crystallize as a single event.

Even if there is no class action, a drastic increase in lawsuits may result in a discontinuance of insurance coverage. The insurance programs involved are, I understand, "claims made" programs: that is, of the type which only cover liabilities for claims made during the currency of the insurance contract. This means that opticians will not be covered for claims made after insurance is cancelled. There is little chance that any insurance company would be likely to provide alternative policies or "tail coverage" in this case.

The result may be that the injured citizens of British Columbia will be left without recourse. The injuries expected, which may result in blindness, will no doubt prove extremely expensive; the cost will be borne by the people of British Columbia, either directly or by way of payments for social services.



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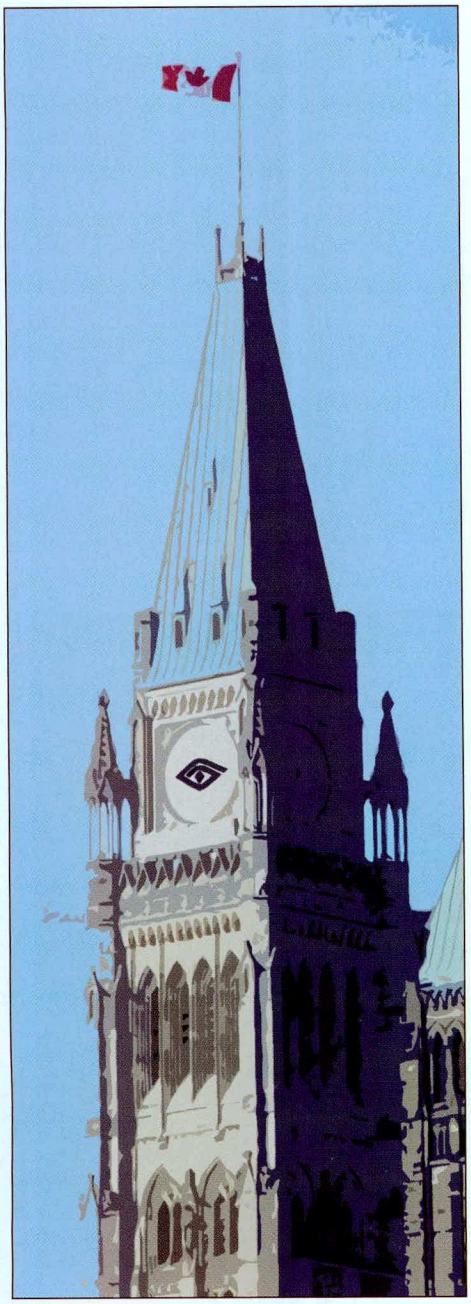
CAO 2006 Report: Optometric Leaders' Forum



CAO held its annual Optometric Leaders' Forum (OLF) in Ottawa, January 27-29. It was a lively and productive session with ample presentations and dialogue surrounding different areas of activity and interest within the optometric community. CAO Committees and Provincial Associations also took this occasion to break out in groups to make presentations and work together to plan for 2006 and beyond.

Following, please find a CAO status report, listing some of the member benefits and resources, as well as brief summaries of some of the reports submitted during the OLF, including updates from Public Visual Welfare, the National Public Education Committee, the Occupational Vision Plan and more.

Should you not find what you are looking for, or if you require further information, please contact the CAO office.

Number of Members (as of Dec. 31, 2005):

CAO is pleased to report a 2.7% increase in its membership from 2004 with a total of 3,442 members. Following is a provincial breakdown:

- *B.C. Association of Optometrists, 416*
- *Alberta Association of Optometrists, 356*
- *Saskatchewan Association of Optometrists, 116*
- *Manitoba Association of Optometrists, 96*
- *Ontario Association of Optometrists, 1064*
- *Quebec Association of Optometrists, 1157*
- *New Brunswick Association of Optometrists, 96*
- *Nova Scotia Association of Optometrists, 86*
- *P.E.I. Association of* Optometrists, *14*

The Canadian Association of Optometrists

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T: (888) 263-4676
F: (613) 235-2025
E: info@opto.ca

www.opto.ca

- *N & L Association of Optometrists, 34*
- *Yukon, 4.*

2006 CAO Assessment

- *$320 per member*
- *AOQ net fee after rebate projected to be $117 per member*
- *$600-800 EHCC assessment (as approved by corporate member).*

Congress Date/ Location:

The 2005 CAO Congress was a great success with record attendance of 507 CAO members and over 1,200 delegates. The 2007 CAO Congress will be held in Saskatoon, Saskatchewan in collaboration with the SAO. Future Congress locations are slated for Charlottetown, PEI (2009), Winnipeg (2011) and Edmonton (2013).

CE Dates/ Location:

The CAO Congress had two streams of CE and hands on workshops. CAO has not considered holding a TPA Certification Course given the results of a survey of corporate members. In the interim, CAO circulates information about US based TPA courses to members. CAO continues to organize a staff education program in conjunction with the OAO CE Program, AGM and Infomart.

Legislation:

The Public Visual Welfare Committee was very active providing support to provinces in the review of opticianry legislation. The proposed legislation in British Columbia continues to be a significant concern and activities accelerated in the latter part of the year. CAO also was active in providing support in the optometry and opticianry referrals to HPRAC in Ontario. This involved the writing of briefs, a teleconference with HPRAC consultants. The Committee has also been involved in the move by Walmart to use Eyelogic systems. PVW has also been asked to assist in forming a Task Force on the use of eye screening equipment in pharmacies.

The regulation of cosmetic contact lenses at a federal level is still not resolved despite several years of work with Health Canada involving optometry, ophthalmology, opticianry and the National Coalition for Vision Health. Several meetings were held and there was correspondence to/from the Department and federal Minister of Health. In the interim, the good news is that cosmetic lenses are not widely sold, other than by internet. We were also buoyed by the passing of US statute that classifies cosmetic lenses as medical devices. CAO also continues to receive member and public inquiries about internet sales of contact lenses and the efficacy of ortho K. As well, Health Canada sought our feedback on guidelines for manufacturers of ortho K lenses.

The view is that the federal role in regulating contact lenses, including cosmetic, will continue to be uncertain given the current narrow scope in federal legislation. This issue may ultimately be tied to the renewal of the Health Protection Act, which is a longer term process. Provincial associations and regulatory bodies may also consider measures with provincial legislation in amending wording to reflect new products, internet sales and contact lens therapies.

In addition, CAO regularly receives inquiries from members and the public about federal policy and legislation. From time to time, we have success in obtaining favorable interpretation and clarification concerning optometric services as it relates to federal policy and programs.

Left to right: Dr Dorrie Morrow, CAO President, and Julie Mahoney, American Optometric Association PR Specialist & InfantSEE Staff.

ARTICLE

Medicare / Third Party Coverage and Negotiations

a. Health Care Reform

CAO's Government Relations Committee and our government relations firm work to monitor to the implementation of the federal/provincial Health Care Accord. This includes CAO involvement in the Health Action Lobby Group and the Health Council of Canada. The federal role in health care is evolving but has diminished in many respects. Nevertheless, priorities of the federal government tend to be focus on wait lists, aboriginal health, diabetes and HHR planning. Medicine and nursing are often the beneficiaries of federal initiatives.

From left: Dr Len Koltun, CAO President-elect, Dr Dorrie Morrow, CAO President, Ms. Nikki Huggins, CAOS representative, Ms. Cheryl Bayer, CAOS President-elect, and Glenn Campbell, CAO Executive Director.

b. Federal Government Departments

There has been interaction between CAO and the Federal Healthcare Partnership (formerly Health Care Coordination Initiative) and individual Departments including Health Canada (policy development and the use of optometric consultants), Veterans Affairs Canada (new benefit grid/ low vision), RCMP (approval of laser surgery for patients unable to wear contact lenses) and the Canadian Revenue Agency (liaison / GST guidelines). CAO also periodically provides assistance to provincial associations in responding to member/ public inquiries.

c. Occupational Vision Plan (OVP)

CAO continues to manage the Occupational Vision Plan in Ontario. CAO began in-house administration of OVP claims in 2004 with the purchase of software from Alberta. This has provided CAO with increased non dues income and the expectation of recovering the initial OVP losses. A business plan for 2006-2009 has been developed.

d. EDI

CAO continues to pursue the implementation of an electronic claims processing system for optometrists through both private insurance companies and government agencies. A public electronic standard was finalized in 2004 by a Special Interest Group (SIG) made up of all stakeholders in the vision sector. The secretariat for the SIG is the Canadian Institute for Health Information. Dr. Pasq Marcantonio, Chair, EDI and Mr. Doug Dean, Director, Third Party Plans will continue to represent CAO in this process.

In 2005, CAO wrote to insurers about our interest in the implementation of EDI either through a pilot project or a more ambitious launch. In the Fall, 2005, CAO received a proposal from a major insurance claims administrator to collaborate on implementation. This process is underway.

Member Services / Programs (group discount, insurance, etc.)

CAO offers several member programs including a professional liability/ practice insurance program (excluding Quebec and Ontario), home/auto insurance, group health benefits, banking services, merchant credit card discount program, car rental, on-hold telephone messaging, member website, Optometric Assistant Course and OA Certification.

CAO, through the National Public Education Committee, has expanded the selection of printed material and electronic resources to complement CAO publications, Canadian Journal of Optometry, Optometric Desk Reference, and In Touch. The pamphlets and fact sheets are available to members at a reasonable cost and have proven to be a popular member benefit. The Eye Health Council of Canada (EHCC) public awareness program continues to be a very important CAO member program that promotes public awareness through paid media.

Inter-intra professional relations

CAO continues to maintain good internal relations with corporate members and other optometric organizations through ongoing communication, attendance at provincial AGMs, the annual Optometric Leaders' Forum and liaisons with CCPP, CAOE, CAOS, Schools of Optometry, CORA, CEO, WCO, AOA and VOSH. CAO attempts to be responsive to the needs of these groups and always welcomes suggestions and other feedback.

CAO's relationships with outside organizations is varied and includes groups such as the Canadian Ophthalmological Society, Opticians Association of Canada, Vision Council of Canada, National Coalition for Vision Health, CNIB, Canadian Diabetes Association, Canadian Public Health Association (literacy), Health Action Lobby (HEAL), Foundation Fighting Blindness and the AMD Alliance. In 2005, activity was particularly significant with CNIB, NCVH, Vision 2020 Partners (World Sight Day) and the COS.

National 30 and 10 second TV ads will begin airing March 2006. Visit the CAO member site for the programming schedule.

This year, CAO endorsed the *Optometry Giving Sight* fundraising program as its 'international charity of choice'. This has resulted in several joint initiatives and CAO secretariat services during the initial stages. CAO also endorses and supports the *Canadian Optometric Education Fund* and established a special task force to map a future for COETF. Optometric leaders will learn more about COETF plans in the near future.

Committees

CAO has a long list of standing committee not noted above, but involved in important work on behalf of the profession. A high priority for CAO has been the Children's Vision Initiative, Chaired by CAO President, Dr. Dorrie Morrow. The CVI has an ambitious plan to ensure that Canadian children receive a comprehensive eye examination prior to entering School.

Another important area is the Optometric Assistant Course Committee, Chaired by Dr. Jacquelyn John which met in December, 2005. The Committee considered whether the course is meeting the demands of members. It will also enhance the services offered to certified optometric assistants, including a newsletter. CAO Council also formed a new Low Vision Committee this past year. It has prepared draft terms of reference and objectives for 2006.

Also, the National Public Education Committee has finalized the paid media for 2006, and the first airings of the :30 second TV will begin in March. Stay tuned! The strategy remains the same: target audience, strong message and *branding*! NPEC encourages members to use what is in the national archive as this is critical in building on members' investment, as well as assisting the national effort of maintaining a consistent branding for eye health and optometry.

Other

CAO's governance status is solid with effective internal operations, finances, and staffing. CAO Council and staff are working on projects related to the CAO Strategic Plan for 2004-2006 and a new 3 year plan will be developed during the CAO Council Planning Session in late February. The Governance Committee continues to look for ways to improve further and it recommends an ongoing accountability process.

Other dry eye therapies come up short compared to SYSTANE® Lubricant Eye Drops.[1,2]

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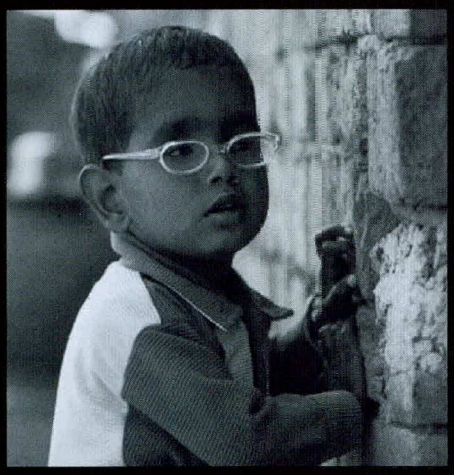
1. Christensen M, *et al.* Clinical Evaluation of an HP-guar gellable lubricant eye drop for the relief of dryness of the eye. *Current Eye Research* 2004, Vol.28, No. 1, 55-62. 2. Hartstein I. An open-label evaluation of HP-Guar gellable lubricant eye drops for the improvement of dry eye signs and symptoms in a moderate dry eye adult population. *Current Medical Research and Opinions.* Vol. 21, No. 2, 2005, 255-260.



SIGHT is the most treasured of our five senses. We see the world and it's myriad colors and shapes through the windows of our eyes. We learn with them. We laugh with them. We communicate with them. We provide for our families with them. We see our loved ones with them.

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250 million people are blind or visually impaired simply because they cannot get the glasses they need. Optometry Giving Sight funds the solution - an eye exam and a pair of glasses. Delivered through sustainable primary eyecare programs, we can give sight to millions in need.

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OPTOMETRYGIVINGSIGHT

ARTICLE

Rapport de l'ACO: Forum des dirigeants optométriques

L'ACO a tenu son Forum des dirigeants optométriques annuel à Ottawa, du 27 au 29 janvier. C'était une session animée et productive avec des présentations et dialogues entourant différents secteurs d'activité et d'intérêt de la communauté optométrique.

Les comités de l'ACO et les associations provinciales ont également profiter de cet occasion pour faire des présentations et pour travailler ensemble pour planifier pour 2006 et au-delà. Veuillez trouver un rapport périodique de l'ACO énumérant certains des avantages et des ressources pour les membres, aussi de brefs sommaires des rapports qui ont été soumis pendant le FDO, y compris des mises à jour du Comité sur le bien-être visuel du public, le Comité national d'éducation publique et autres.

Nombre de membres (au 31 déc. 2005):

L'ACO est heureuse d'annoncer une augmentation de 2.7% par rapport à l'année 2004 avec un total de 3 442 membres :

- Colombie-Britannique, 416
- Alberta, 356
- Saskatchewan, 116
- Manitoba, 96
- Ontario, 1 064
- Québec, 1 157
- Nouveau-Brunswick, 96
- Nouvelle-Écosse, 86
- L'Île-du-Prince-Édouard, 14
- Terre-Neuve-et-Labrador, 34
- Yukon, 4

Cotisation à l'ACO pour 2006

- *320 $ par membre*
- *La cotisation nette pour l'AOQ après remise devrait s'élever à 117 $ par membre*
- *Cotisation au CCSO (approuvée par société membre) : entre 600 $ et 800 $.*

Date/lieu du congrès

Le Congrès de l'ACO de 2005 a remporté un énorme succès avec une participation record de 507 membres de l'ACO et plus de 1 200 délégués. Le Congrès de l'ACO de 2007 se tiendra à Saskatoon (Saskatchewan) en collaboration avec l'AOS. Les prochains congrès auront lieu à Charlottetown (Î.-P.-É.) (2009), à Winnipeg (2011) et à Edmonton (2013).

Dates/lieu de la FC

Le Congrès de l'ACO offrait deux séries de FC et d'ateliers pratiques. Comme suite aux résultats d'un sondage auprès des sociétés membres, l'ACO n'envisage pas de tenir des cours de certification sur les APT. Entre-temps, l'ACO avise les membres que des cours sur les APT sont offerts aux États-Unis. L'ACO continue d'organiser un programme d'éducation du personnel, de concert avec le programme de FC de l'AOO, lors de leur AGA et Infomart.

Législation

Le Comité sur le bien-être visuel du public a appuyé très activement les provinces dans le processus d'examen de la législation sur les opticiens. Le projet de loi en Colombie-Britannique est toujours une cause d'inquiétude et les travaux se sont accélérés dans la dernière partie de l'année. L'ACO a offert son aide dans les cas de renvoi au CCRPS de l'Ontario par les optométristes et les opticiens, notamment par la rédaction de mémoires et une téléconférence avec des conseillers du CCRPS. Le comité s'est impliqué dans la décision de Wal-Mart d'utiliser les systèmes Eyelogic. On a également demandé au comité de collaborer à la formation d'un groupe de travail sur l'utilisation d'un matériel de dépistage des problèmes visuels dans les pharmacies.

La réglementation sur les lentilles de contact cosmétiques à l'échelon fédéral fait toujours problème malgré plusieurs années de travail avec Santé Canada, l'optométrie, l'ophtalmologie, les opticiens et la Coalition nationale en santé oculaire. Il y a eu plusieurs réunions et un échange de correspondance avec le ministre fédéral de la Santé et les fonctionnaires. Entre-temps, il est bon de savoir que les ventes des lentilles cosmétiques sont restreintes à l'Internet. L'adoption d'une loi américaine classant les lentilles cosmétiques comme des appareils

médicaux nous rend aussi très heureux. L'ACO reçoit toujours les questions du public et des membres sur les ventes de lentilles de contact par Internet et sur l'efficacité des lentilles ortho-K. Santé Canada nous a également demandé notre avis sur des lignes directrices pour les fabricants de lentilles ortho-K.

Le rôle du fédéral dans la réglementation des lentilles de contact, même cosmétiques, continuera d'être incertain étant donné les limites de la législation fédérale. Cette question se résoudra peut-être en bout de ligne par la nouvelle *Loi sur la protection de la santé*, mais ce processus est beaucoup plus long. Les associations provinciales et les organismes de réglementation peuvent aussi envisager des mesures au niveau de la législation provinciale pour qu'elle s'applique aux nouveaux produits, aux ventes par Internet et aux lentilles de contact thérapeutiques.

De plus, l'ACO reçoit régulièrement des questions des membres et du public sur la législation et les politiques fédérales. De temps à autre, nous réussissons à obtenir une interprétation et une clarification favorables sur les services optométriques liés aux programmes et politiques du fédéral.

Régime d'assurance-maladie/négociations et couverture par des tiers

a. Réforme des soins de santé

Le Comité des relations avec le gouvernement de l'ACO et notre cabinet de relations avec les gouvernements surveillent la mise en œuvre de l'Accord fédéral-provincial sur les soins de santé, notamment la participation de l'ACO au Groupe d'intervention action santé et au Conseil canadien de la santé. Le rôle du fédéral dans les soins de santé évolue mais il a aussi diminué sur plusieurs points. Toutefois, les priorités du gouvernement fédéral convergent davantage vers les listes d'attente, la santé des Autochtones, le diabète et la planification des RHS. La médecine et les soins infirmiers sont souvent les bénéficiaires des initiatives fédérales.

b. Ministères fédéraux

Il y a eu des échanges entre l'ACO et le Partenariat fédéral pour les soins de santé (autrefois l'Initiative de coordination des soins de santé) et des ministères et organismes comme Santé Canada (élaboration des politiques et utilisation des conseillers optométriques), Anciens Combattants Canada (nouveau tableau des avantages / basse vision), la GRC (approbation de la chirurgie au laser pour les patients incapables de porter des lentilles de contact) et l'Agence du revenu du Canada (liaison/lignes directrices sur la TPS). L'ACO aide périodiquement les associations provinciales à répondre aux demandes des membres/public.

OLF Presenters: *(from left)* Dr Julia Galatis, CAO Councillor, NSAO; Dr Joan Hansen, CAO Past-president; & Dr Susan Cooper, Director of International Optometric Bridging Program (UW).

c. RPV

L'ACO gère le régime professionnel de soins de la vue en Ontario et a commencé l'administration interne des demandes de règlement du RPV en 2004 par l'achat d'un logiciel de l'Alberta. Cela augmente les revenus hors cotisation de l'ACO et lui permet d'espérer le recouvrement des pertes initiales du RPV. Un plan d'affaires pour 2006-2009 a été élaboré.

d. EDE

L'ACO poursuit la mise en œuvre d'un système de traitement des demandes de règlement électroniques avec les sociétés d'assurances privées et les organismes gouvernementaux. Un groupe d'intérêt spécial (GIS) composé de tous les intervenants du secteur de la vision a mis au point une norme électronique publique en 2004. Le Secrétariat pour le GIS est l'Institut canadien d'information sur la santé. Le Dr Pasq Marcantonio, président, EDE, et M. Doug Dean, directeur des régimes de tiers, représenteront encore l'ACO dans ce processus.

En 2005, l'ACO informait les assureurs de notre intérêt pour la mise en œuvre de l'EDE soit par un projet pilote, soit par un lancement plus important. À l'automne 2005, l'administrateur des demandes de remboursement d'une importante société d'assurances invitait l'ACO à collaborer à cette mise en œuvre. Ce processus est en cours.

Services / programmes pour les membres
(rabais de groupe, assurance, etc.)

L'ACO offre plusieurs programmes pour les membres, dont une assurance responsabilité/pratique professionnelle (sauf au Québec et en Ontario), une assurance habitation/automobile, un programme collectif d'assurance-maladie, des services bancaires, des rabais sur cartes de crédit de commerçants, la location de véhicules, des services téléphoniques, un site Web pour les membres, un cours pour les assistants optométriques et l'accréditation des AO.

L'ACO, grâce au Comité national d'éducation publique, offre un plus grand choix d'imprimés et de ressources électroniques pour compléter les publications de l'ACO, le RCO, le LRO et Contact. Les dépliants et les cartes d'information sont disponibles pour les membres à un coût raisonnable et sont très en vogue. Le programme de sensibilisation du public du Conseil canadien de la santé (CCSO) demeure un programme très important des membres de l'ACO.

Relations inter et intraprofessionnelles

L'ACO entretient de bonnes relations internes avec les sociétés membres et d'autres organismes optométriques grâce à une communication continuelle, une participation aux AGA provinciales et au Forum des dirigeants optométriques annuel et grâce à ses liens avec le CCPP, la CAOE, l'ACEO, les écoles d'optométrie, les CORA, le CEO, le CMO, l'AOA et VOSH. L'ACO est attentive aux besoins de ces groupes et sollicite leurs suggestions et commentaires.

Les relations de l'ACO avec des organismes externes sont variées et visent des groupes comme la Société canadienne d'ophtalmologie, l'Association des opticiens du Canada, le Conseil de vision du Canada, la Coalition nationale en santé oculaire, l'INCA, l'Association canadienne du diabète, l'Association canadienne de santé publique (littératie), le Groupe d'intervention action santé (HEAL), la Fondation Lutte contre la cécité et l'Alliance sur la DMA. En 2005, il y a eu d'importantes activités avec l'INCA, la CNSO, les partenaires de Vision 2020 (Journée mondiale de la vue) et la SCO.

Cette année, l'ACO a avalisé la campagne de financement *Optometry Giving Sight* et son organisme de bienfaisance international de choix, en participant à différentes initiatives conjointes et en offrant les services de secrétariat de l'ACO durant les étapes initiales. L'ACO appuie également *le Fonds des optométristes canadiens pour l'éducation* et a mis sur pied un groupe de travail spécial pour étudier l'avenir du FFOCE. Les dirigeants optométriques en apprendront davantage sur les plans relatifs au FFOCE très prochainement.

Comités

L'ACO a une longue liste de comités permanents non mentionnés ci-avant mais engagés dans un important travail. Une des priorités de l'ACO a été l'Initiative pour la vision des enfants, dirigée par la présidente de l'ACO, la D^re^ Dorrie Morrow. L'IVE a un ambitieux plan pour que les enfants canadiens reçoivent un examen de la vue complet avant l'entrée à l'école. Un autre comité important est le Comité du cours pour les assistants optométriques, présidé par la D^re^ Jacquelyn John, qui s'est réuni en décembre 2005. Le comité a cherché à savoir si le cours répond aux demandes des membres. Il améliorera aussi les services offerts aux adjoints optométriques agréés et ajoutera un bulletin d'information. Le Conseil de l'ACO a également formé un nouveau comité sur la basse vision l'an dernier, pour lequel il a élaboré un mandat et des objectifs provisoires pour 2006. En outre, le Comité de l'éducation publique nationale a finalisé les médias payés pour 2006, et les premières parutions à la TV des annonces de 10 et 30 secondes commenceront en mars. La stratégie reste la même: cibler l'audience, message fort et *continuité dans le style*! CNEP encourage les membres à employer ce qui est dans les archives nationales, car c'est essentiel pour accroître leur investissement aussi bien que d'aider l'effort national à maintenir le style uniforme pour l'optométrie et la santé de l'oeil.

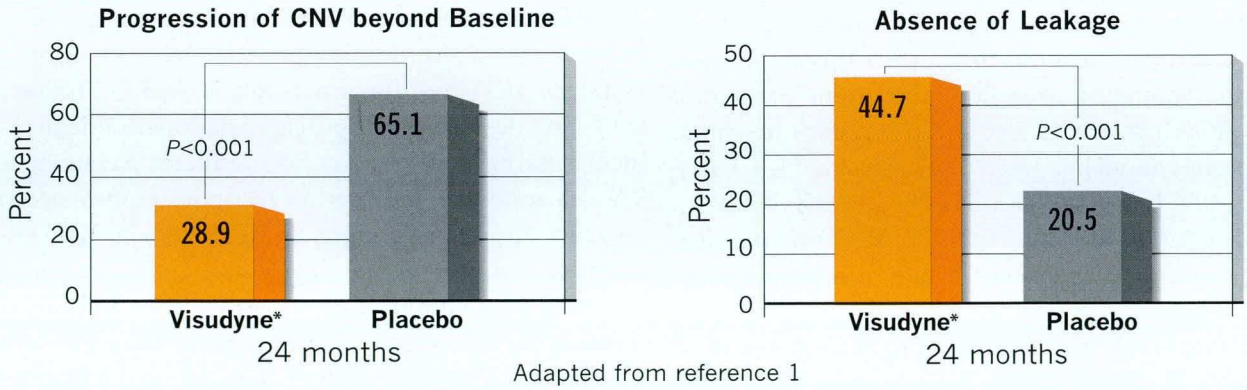
Autre

La structure administrative de l'ACO est solide grâce à un personnel, des finances et une gestion interne efficaces. Le personnel et le Conseil de l'ACO travaillent à des projets reliés au plan stratégique de l'ACO pour 2004-2006, et un nouveau plan triennal sera élaboré durant la session de planification du Conseil de l'ACO à la fin de février. Le Comité d'examen de la structure administrative poursuit sa recherche de moyens d'amélioration et recommande un processus d'imputabilité continu.

THE WORLD IS BEAUTIFUL > TO LOOK AT

PrVisudyne* helps restrict lesion growth[1†]

- Impact of Visudyne* (verteporfin for injection) on Predominantly Classic CNV:



Adapted from reference 1

- At 24 months, significantly fewer Visudyne* patients with predominantly classic CNV had progression of classic CNV compared to placebo[1]

Visudyne* Therapy is indicated for the treatment of age-related macular degeneration, pathologic myopia and presumed ocular histoplasmosis in patients with predominantly classic subfoveal choroidal neovascularization.

VISUDYNE* is a drug to be used in Visudyne* Therapy. Visudyne* Therapy is a two-stage process requiring administration of both verteporfin for injection and non-thermal red light.

CAUTION: Visudyne* Therapy should only be used by physicians trained in the treatment of age-related macular degeneration and pathologic myopia using photodynamic therapy with verteporfin for injection and specified lasers. Following VISUDYNE* injection, residual photosensitivity for 48 hours or more may result in erythema and blistering of the skin when exposed to sunlight or brightly focused indoor light.

VISUDYNE* is contraindicated for patients with porphyria or a known hypersensitivity to any component of this preparation, and in patients with severe hepatic impairment.

Severe vision decrease, equivalent of 4 lines or more, within 7 days has been reported in 1 – 4% of patients. At least partial recovery, defined as more than one line improvement of vision following the event, occurred in most patients (approximately 75% of patients). Safety and efficacy beyond 2 years have not been established.

† Treatment of AMD with PDT. n=609. Combined results from two multicentre, randomized, parallel group, Phase III studies of subfoveal choroidal neovascularization secondary to age-related macular degeneration using photodynamic therapy with verteporfin compared to placebo. Avg. number of treatments: Year 1=3.4, Year 2=2.1 Safety and efficacy beyond 2 years have not been established.

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See prescribing information for references.

Visudyne verteporfin for injection

VIS-051114E

Esotropia

from page 60

The diagnosis is accommodative esotropia secondary to hyperopia and high AC/A ratio.

The esotropia was adequately neutralized with the current bifocal spectacle correction. Esophoria with second-degree fusion (flat fusion) was achieved at near, through the add. A small angle esotropia remained at distance. Cosmesis was good. Many clinicians would agree that this level of correction is sufficient, and that further improvement in binocularity is not likely to occur at this age.

It is possible, however, to improve binocularity through vision therapy, with proper instruction and motivation. C.W. was judged to be a mature and co-operative 7 year-old, and his parents were extremely eager to pursue any therapy that might promote the development of stereopsis.

A home-based vision therapy program was designed:

❶ *Optical Correction*

The cycloplegic refraction indicated increased hyperopia in the right eye. This was considered significant, and a change in spectacle prescription was recommended, to encourage more accurate ocular alignment. No modification of the nearpoint add was recommended, since this would restrict the working distance at near. Relieving prism (2 pd base out OD) was not recommended since it did not improve fusion when demonstrated. The final spectacle correction, for continued full time wear, was:

OD	+3.25 –1.50 x 001	+3.25 add (ST 28)
OS	+2.50 –1.00 x 178	+3.25 add (ST 28)

❷ *Anti-Suppression Therapy*

Anti-suppression therapy was initiated at near, to teach conscious awareness of binocular fixation. C.W. was instructed in the use of the Polaroid Bar Reader, and was able to read without suppression, with some effort. Other, more active therapy procedures to eliminate suppression also were demonstrated. C.W. was unable to understand the concept of physiological diplopia inherent in the Beads on String exercise. He also was unable to perceive anaglyphic targets (red and green pictures, Lego, crayons) through red-green glasses. Anti-suppression therapy therefore was limited to the Polaroid Bar Reader, practiced 20-30 minutes per day for the first month of therapy.

❸ *Monocular Visual Function Therapy*

In cases of strabismus and amblyopia, the non-dominant eye may continue to demonstrate deficiencies in accommodation and motility (saccades, pursuits), even after ocular alignment and visual acuity have been improved. Vision therapy procedures such as Hart Chart, lens flippers, visual tracings and eye tracking are effective in improving monocular visual function. These were not prescribed to C.W. since accommodation and monocular pursuits were within normal limits at the initial visit.

After one month of wearing the new spectacle prescription, and practicing anti-suppression therapy daily, C.W. presented for re-evaluation. Aided visual acuities were 20/20 each eye at distance and at near. Cover test showed intermittent right esotropia (less

Pr Visudyne*
verteporfin for injection

PRESCRIBING INFORMATION (September 2004)

PrVisudyne* Verteporfin for Injection for Intravenous Use

PHOTOSENSITIZING AGENT FOR AGE-RELATED MACULAR DEGENERATION, PATHOLOGIC MYOPIA AND PRESUMED OCULAR HISTOPLASMOSIS

VISUDYNE* (verteporfin) is a drug to be used in Visudyne* Therapy. Visudyne* Therapy is a two-stage process requiring administration of both verteporfin for injection and nonthermal red light.

CAUTION: Visudyne* Therapy should only be used by physicians trained in the treatment of age-related macular degeneration and pathologic myopia using photodynamic therapy with verteporfin for injection and specified lasers. Following VISUDYNE* injection, residual photosensitivity for 48 hours or more may result in erythema and blistering of the skin when exposed to sunlight or brightly focused indoor light.

INDICATIONS AND CLINICAL USE Visudyne* Therapy is indicated for the treatment of age-related macular degeneration, pathologic myopia and presumed ocular histoplasmosis in patients with predominantly classic subfoveal choroidal neovascularization.

CONTRAINDICATIONS VISUDYNE* (verteporfin) is contraindicated for patients with porphyria or a known hypersensitivity to any component of this preparation, and in patients with severe hepatic impairment.

WARNINGS Following injection with VISUDYNE* (verteporfin), care should be taken to avoid exposure of skin or eyes to direct sunlight or bright indoor light for 2 days. In the event of extravasation during infusion, the extravasation area must be thoroughly protected from direct light until the swelling and discoloration have faded in order to prevent the occurrence of a local burn which could be severe. If emergency surgery is necessary within 48 hours after treatment, as much of the internal tissue as possible should be protected from intense light. Patients who experience severe decrease of vision of 4 lines or more within 1 week after treatment should not be retreated, at least until their vision completely recovers to pretreatment levels and the potential benefits and risks of subsequent treatment are carefully considered by the treating physician.

Caution should be exercised when Visudyne* Treatment under general anesthesia is considered (See PRECAUTIONS).

Use of incompatible lasers that do not provide the required characteristics of light for the photoactivation of VISUDYNE* could result in incomplete treatment due to partial photoactivation of VISUDYNE*, overtreatment due to overactivation of VISUDYNE*, or damage to surrounding normal tissue.

Pregnancy TERATOGENIC EFFECTS There are no adequate and well-controlled studies in pregnant women. VISUDYNE* should be used during pregnancy only if the benefit justifies the potential risk to the fetus. Rat fetuses of dams administered verteporfin for injection intravenously at ≥10 mg/kg/day during organogenesis (approximately 40-fold the human exposure at 6 mg/m^2 based on AUC_{inf} in female rats) exhibit an increase in the incidence of anophthalmia/microphthalmia. Rat fetuses of dams administered 25 mg/kg/day (approximately 125-fold the human exposure at 6 mg/m^2 based on AUC_{inf} in female rats) had an increased incidence of wavy ribs and fetal alterations. In pregnant rabbits, a decrease in body weight gain and food consumption was observed in animals that received verteporfin for injection intravenously at 10 mg/kg/day during organogenesis. The no observed adverse effect level (NOAEL) for maternal toxicity was 3 mg/kg/day (approximately 7-fold the human exposure at 6 g/m^2 based on body surface area). There were no teratogenic effects observed in rabbits at doses up to 10 mg/kg/day.

Nursing Mothers Verteporfin and its diacid metabolite have been found in the breast milk of one woman after a 6 mg/m^2 infusion. The verteporfin breast milk levels were up to 66% of the corresponding plasma levels. Verteporfin was undetectable after 12 hours. The diacid metabolite had lower peak concentrations but persisted up to at least 48 hours. Because the effects of verteporfin and its metabolite on neonates are unknown, either nursing should be interrupted or treatment postponed, taking into account the risks of delayed treatment to the mother. Women should not nurse for 96 hours after Visudyne* Therapy.

Pediatric Use Safety and effectiveness in pediatric patients have not been established.

PRECAUTIONS

General Extravasation of VISUDYNE*, especially if the affected area is exposed to light, can cause severe pain, inflammation, swelling or discoloration at the injection site. The relief of pain may require analgesic treatment.

Standard precautions should be taken during infusion of VISUDYNE* (verteporfin) to avoid extravasation. Examples of standard precautions include, but are not limited to:

- A free-flowing intravenous (IV) line should be established before starting VISUDYNE* infusion and the line should be carefully monitored.
- Due to the possible fragility of vein walls of some elderly patients, it is strongly recommended that the largest arm vein possible, preferably antecubital, be used for injection.
- Small veins in the back of the hand should be avoided.

If extravasation does occur, the infusion should be stopped immediately. The extravasation area must be thoroughly protected from direct light until the swelling and discoloration have faded in order to prevent the occurrence of a local burn which could be severe. Cold compresses should be applied to the injection site (see Warnings).

Visudyne* Therapy should be considered carefully in patients with moderate hepatic impairment or biliary obstruction since there is no clinical experience with verteporfin in such patients.

Chest pain, vaso-vagal reactions and hypersensitivity reactions, which on rare occasion can be severe, have been reported. Both vaso-vagal and hypersensitivity reactions are associated with general symptoms such as syncope, sweating, dizziness, rash, dyspnea, flushing, and changes in blood pressure and heart rate.

There is no clinical data related to the use of VISUDYNE* in anesthetized patients. At a >10-fold higher dose given by bolus injection to sedated or anesthetized pigs, verteporfin caused severe hemodynamic effects, including death, probably as a result of complement activation. These effects were diminished or abolished by pretreatment with antihistamine and they were not seen in conscious non-sedated pigs or in any other species, whether conscious or under general anesthesia. Caution should be exercised when Visudyne* Treatment under general anesthesia is considered (see WARNINGS).

VISUDYNE* at >5 times the expected maximum plasma concentration in treated patients caused a low level of complement activation in human blood in vitro. VISUDYNE* resulted in a concentration-dependent increase in complement activation in human blood in vitro. At 10 µg/ml (approximately 5 times the expected plasma concentration in human patients), there was mild to moderate complement activation. At ≥ 100 µg/mL, there was significant complement activation. Signs (chest pain, syncope, dyspnea, and flushing) consistent with complement activation have been observed in < 1% of patients administered VISUDYNE*. Patients should be supervised during VISUDYNE* infusion.

Photosensitivity Patients who receive VISUDYNE will become temporarily photosensitive for 2 days after the infusion. During that period, patients should avoid exposure of unprotected skin, eyes or other body organs to direct sunlight or bright indoor light. This includes, but is not limited to, tanning salons, bright halogen lighting and high power lighting used in surgical operating rooms or dental offices (see Warnings). Prolonged exposure to light from light emitting medical devices such as pulse oximeters should also be avoided for 48 hours following VISUDYNE* administration. If treated patients must go outdoors in daylight during the first 2 days after treatment, they should protect all parts of their skin and their eyes by wearing protective clothing and dark sunglasses. UV sunscreens are not effective in protecting against photosensitivity reactions because photoactivation of the residual drug in the skin can be caused by visible light. Patients should not stay in the dark and should be encouraged to expose their skin to ambient indoor light, as it will help inactivate the drug in the skin through a process called photobleaching.

Drug Interactions Drug interaction studies in humans have not been conducted with VISUDYNE*. Verteporfin is rapidly eliminated by the liver, mainly as unchanged drug. Metabolism is limited and occurs by liver and plasma esterases. Microsomal cytochrome P450 does not appear to play a role in verteporfin metabolism. Based on the mechanism of action of verteporfin, many drugs used concomitantly could influence the effect of Visudyne Therapy. Possible examples include the following. Calcium channel blockers, polymyxin B or radiation therapy could enhance the rate of VISUDYNE* uptake by the vascular endothelium. Other photosensitizing agents (e.g., tetracyclines, sulfonamides, phenothiazines, sulfonylurea hypoglycemic agents, thiazide diuretics and griseofulvin) could increase the potential for skin photosensitivity reactions. Compounds that quench active oxygen species or scavenge radicals, such as dimethyl sulfoxide, b-carotene, ethanol, formate and mannitol, would be expected to decrease VISUDYNE* activity. Drugs that decrease clotting, vasoconstriction or platelet aggregation, e.g., thromboxane A_2 inhibitors, could also decrease the efficacy of Visudyne Therapy.

Carcinogenesis, Mutagenesis, Impairment of Fertility No studies have been conducted to evaluate the carcinogenic potential of verteporfin. Verteporfin was not mutagenic, in the absence or presence of light, when studied in microbial mutagenicity, unscheduled DNA synthesis, mammalian point mutation, chromosome aberration, and mouse micronucleus assays.

Photodynamic therapy (PDT) as a class has been reported to result in DNA damage including DNA strand breaks, alkali-labile sites, DNA degradation, and DNA-protein cross links which may result in chromosomal aberrations, sister chromatid exchanges (SCE), and mutations. In addition, other photodynamic therapeutic agents have been shown to increase the incidence of SCE in Chinese hamster ovary (CHO) cells irradiated with visible light and in Chinese hamster lung fibroblasts irradiated with near UV light, increase mutations and DNA-protein cross-linking in mouse L5178 cells, and increase DNA-strand breaks in malignant human cervical carcinoma cells, but not in normal cells. Verteporfin was not evaluated in these latter systems. It is not known how the potential for DNA damage with PDT agents translates into human risk.

No effect on male or female reproduction has been observed in rats following intravenous administration of verteporfin for injection up to 10 mg/kg/day (approximately 60- and 40-fold human exposure at 6 mg/m^2 based on AUC_{inf} in male and female rats, respectively). Males were dosed 28 days prior to and during mating until necropsy (approximately 60 days). Females were dosed for 14 days prior to and during mating until Gestation Day 7.

Geriatric Use Approximately 90% of the patients treated with VISUDYNE* in the clinical efficacy trials were over the age of 65. A reduced treatment effect was seen with increasing age.

Fluorescein Angiography Standard precautions for fluorescein angiography should be observed. Certain medical conditions (such as pregnancy or allergy to fluorescein) may make the injection of fluorescein dye for a particular patient inadvisable in the opinion of the ophthalmologist. Approximately 1/225,000 patients may experience a severe reaction resulting in a heart attack, stroke, or death. Most reactions are mild, such as temporary nausea or vomiting in a few patients and a rash, hives, or wheezing in about 1%.

Effects on ability to drive and use machines Following Visudyne* Therapy, patients may develop transient visual disturbances such as abnormal vision, vision decrease, or visual field defects that may interfere with their ability to drive or use machines. Patients should be advised to not drive or use machines as long as these symptoms persist.

ADVERSE REACTIONS In randomized clinical trials in choroidal neovascularization, mainly in patients with age-related macular degeneration (AMD), the most frequently reported adverse events to VISUDYNE* (verteporfin) are injection site reactions (including pain, edema, inflammation, extravasation, rashes, and less commonly, hemorrhage and discoloration) and visual disturbances (including blurred vision, flashes of light, decreased visual acuity and visual field defects such as grey or dark haloes, scotoma and black spots). These events occurred in approximately 10-30% of patients. The following events, listed by Body System, occurred in 1-10% of patients:

Ocular Treatment Site: Blepharitis, cataracts, conjunctivitis/conjunctival injection, dry eyes, ocular itching, severe vision decrease with or without subretinal or vitreous hemorrhage

Body as a Whole:	Asthenia, infusion related pain primarily presenting as back pain, fever, flu syndrome, photosensitivity reactions.
Cardiovascular:	Atrial fibrillation, hypertension, peripheral vascular disorder, varicose veins
Dermatologic:	Eczema
Digestive:	Constipation, nausea
Hemic and Lymphatic:	Anemia, white blood cell count decreased, white blood cell count increased
Hepatic:	Elevated liver function tests
Metabolic/Nutritional:	Albuminuria, creatinine increased
Musculoskeletal:	Arthralgia, arthrosis, myasthenia
Nervous System:	Hypesthesia, sleep disorder, vertigo
Respiratory:	Cough, pharyngitis, pneumonia
Special Senses:	Cataracts, decreased hearing, diplopia, lacrimation disorder
Urogenital:	Prostatic disorder

Severe vision decrease, equivalent of 4 lines or more, within 7 days has been reported in 1-4% of patients. At least partial recovery of vision, defined as more than one line improvement of vision following the event, occurred in most patients (approximately 75% of patients).

Photosensitivity reactions usually occurred in the form of skin sunburn following exposure to sunlight during the first 2 days after treatment usually within 24 hours of VISUDYNE* infusion. The higher incidence of back pain in the VISUDYNE* group occurred primarily during infusion and was not associated with any evidence of hemolysis or allergic reaction and usually resolved by the end of the infusion.

The following adverse events have occurred either at low incidence (<1%) during clinical trials or have been reported during the use of VISUDYNE* in clinical practice where these events were reported voluntarily from a population of unknown size and hence the frequency of occurrence cannot be determined precisely. They have been chosen for inclusion based on factors such as seriousness, frequency of reporting, possible causal connection to VISUDYNE*, or a combination of these factors:

Ocular Treatment Site: Retinal detachment (nonrhegmatogenous), retinal or choroidal vessel nonperfusion, severe vision decrease with retinal hemorrhage.

Nonocular Events: Chest and back pain (which may radiate to other areas including but not limited to pelvis, shoulder, girdle or rib cage) and other musculoskeletal pain during infusion.

Vaso-vagal and hypersensitivity reactions can occur, which on rare occasions can be severe. General symptoms can include headache, malaise, syncope, sweating, dizziness, rash, urticaria, pruritus, dyspnea, flushing and changes in blood pressure or heart rate.

Adverse reactions reported in treated eyes in patients with pathologic myopia or presumed ocular histoplasmosis were similar to those reported in AMD patients.

SYMPTOMS AND TREATMENT OF OVERDOSAGE Overdose of drug and/or light in the treated eye may result in nonperfusion of normal retinal vessels with the possibility of severe decrease in vision that could be permanent. An overdose of drug will also result in the prolongation of the period during which the patient remains photosensitive to bright light. In such cases, it is recommended to extend the photosensitivity precautions for a time proportional to the overdose.

DOSAGE AND ADMINISTRATION A course of Visudyne* Therapy is a two-step process requiring administration of both drug and light. The first step is the intravenous infusion of VISUDYNE* (verteporfin). The second step is the activation of VISUDYNE* with light from a nonthermal diode laser. The physician should re-evaluate the patient every 3 months and if choroidal neovascular leakage is detected on fluorescein angiography, therapy should be repeated.

Lesion Size Determination The greatest linear dimension (GLD) of the lesion is estimated by fluorescein angiography and color fundus photography. All classic and occult CNV, blood and/or blocked fluorescence, and any serous detachments of the retinal pigment epithelium should be included for this measurement. Fundus cameras with magnification within the range of 2.4-2.6X are recommended. The GLD of the lesion on the fluorescein angiogram must be corrected for the magnification of the fundus camera to obtain the GLD of the lesion on the retina.

Spot Size Determination The treatment spot size should be 1000 microns larger than the GLD of the lesion on the retina to allow a 500 micron border, ensuring full coverage of the lesion. The maximum spot size used in the clinical trials was 6400 microns. The nasal edge of the treatment spot must be positioned at least 200 microns from the temporal edge of the optic disc, even if this will result in lack of photoactivation of CNV within 200 microns of the optic nerve. For treatment of lesions that are larger than the maximum treatment spot size, apply the light to the greatest possible area of active lesion.

VISUDYNE* Administration VISUDYNE* should be reconstituted according to the directions given under PHARMACEUTICAL INFORMATION, Reconstitution. The volume of reconstituted VISUDYNE* required to achieve the desired dose of 6 mg/m^2 body surface area is withdrawn from the vial and diluted with 5% Dextrose for Injection to a total infusion volume of 30 mL. The full infusion volume is administered intravenously over 10 minutes at a rate of 3 mL/minute, using an appropriate syringe pump and in-line filter. The clinical studies were conducted using a standard infusion line filter of 1.2 microns. Precautions should be taken to prevent extravasation at the injection site. If extravasation occurs, protect the site from light (see Precautions).

Light Administration Initiate 689 nm wavelength laser light delivery to the patient 15 minutes after the start of the 10-minute infusion with VISUDYNE*. Photoactivation of VISUDYNE* is controlled by the total light dose delivered. In the treatment of choroidal neovascularization, the recommended light dose is 50 J/cm^2 of neovascular lesion administered at an intensity of 600 mW/cm^2 . This dose is administered over 83 seconds. Light dose, light intensity, ophthalmic lens magnification factor and zoom lens setting are important parameters for the appropriate delivery of light to the predetermined treatment spot. Follow the laser system manuals for procedure set up and operation. The laser system must be acceptable for the delivery of a stable power output at a wavelength of 689±3 nm. Light is delivered to the retina as a single circular spot via a fiber optic and a slit lamp, using a suitable ophthalmic magnification lens. The following laser systems have been tested for compatibility with VISUDYNE* and are acceptable for the delivery of a stable power output at a wavelength of 689±3 nm:

Lumenis Opal Photoactivator laser console and modified LaserLink adapter, Manufactured by Lumenis, Inc., Santa Clara, CA

Zeiss VISULAS 690s laser and VISULINK PDT adapter, Manufactured by Carl Zeiss, Inc., Thornwood, NY.

Concurrent Bilateral Treatment The controlled trials only allowed treatment of one eye per patient. In patients who present with eligible lesions in both eyes, physicians should evaluate the potential benefits and risks of treating both eyes concurrently. If the patient has already received previous Visudyne* Therapy in one eye with an acceptable safety profile, both eyes can be treated concurrently after a single administration of VISUDYNE*. The more aggressive lesion should be treated first, at 15 minutes after the start of infusion. Immediately at the end of light application to the first eye, the laser settings should be adjusted to introduce the treatment parameters for the second eye, with the same light dose and intensity as for the first eye, starting no later than 20 minutes from the start of infusion. In patients who present for the first time with eligible lesions in both eyes without prior Visudyne* Therapy, it is prudent to treat only one eye (the most aggressive lesion) at the first course. One week after the first course, if no significant safety issues were identified, the second eye can be treated using the same treatment regimen after a second VISUDYNE* infusion. Approximately 3 months later, both eyes can be evaluated and concurrent treatment following a new VISUDYNE* infusion can be started if both lesions still show evidence of leakage.

AVAILABILITY OF DOSAGE FORMS VISUDYNE* (verteporfin) is supplied in a single-use glass vial with a gray bromobutyl stopper and aluminium flip-off cap. It contains a lyophilized cake with 15 mg verteporfin. The product is intended for intravenous injection only.

Product monograph available upon request. September 2004.

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than 2 pd) at distance and esophoria (less than 2 pd) at near. Worth 4 Dot testing showed flat fusion at both distance and near. There was no appreciation of stereopsis, by Titmus Stereofly or Randot tests. Diplopia was reported immediately during vergence testing, indicating severely reduced motor fusion.

❹ *Motor Fusion therapy*

Convergence and divergence ranges must be adequate to ensure stable ocular alignment and normal binocular integration. Vectograms are an ideal tool to train base in and base out ranges, while providing suppression feedback and a stereoscopic target. Unfortunately, C.W. was unable to maintain fusion with this procedure, and found it frustrating. Instead, a motor fusion demand was added to the Polaroid Bar Reader exercise, by adding a 4 pd Base In prism over the right eye. Again, 20-30 minutes of therapy per day was recommended.

Follow-up was in one month. Visual acuity, Worth 4 Dot and cover test results were consistent with the previous visit. However, gross stereopsis (400 seconds of arc) was appreciated for the first time. Vectograms again were demonstrated, and C.W. was able to maintain fusion with effort. Motor fusion training continues using mini-vectograms at this time.

The perception of gross stereopsis is an encouraging development, and indicates a favourable prognosis for continued improvement. C.W. recognizes that his vision is better, and has shown new interest in books with three-dimensional pictures.

❺ *Foveal Sensory Fusion*

The final stage of vision therapy will be to enhance foveal sensory fusion (stereopsis). This may be accomplished through repetitive viewing of three-dimensional images, using the ViewMaster 3D Viewer and non-variable Tranaglyphs.

C.W. and his parents are willing to continue with vision therapy, in view of the progress thus far. It is anticipated that several months of therapy will be required, to achieve near-normal vergence ranges and further enhancement of stereopsis.

(*See References on page 88*)

Ésotropie

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Le diagnostic est une ésotropie accommodative à la suite d'une hypermétropie et un rapport AC/A élevé.

L'ésotropie a été correctement neutralisée grâce aux lunettes correctives bifocales actuelles. L'ésophorie avec fusion au deuxième degré (fusion à plat) a été réalisée de près grâce à la correction. Il reste une ésotropie à petit angle à distance. L'aspect esthétique était bon. Beaucoup de cliniciens s'entendraient pour dire que ce niveau de correction est suffisant et qu'il est fort peu probable que la vision binoculaire s'améliore à cet âge.

Toutefois, il est possible d'améliorer la vision binoculaire grâce à une thérapie visuelle avec motivation et conseils adéquats. On a jugé que C.W. était un garçon de sept ans suffisamment mature pour collaborer et ses parents étaient extrêmement impatients d'entreprendre toute thérapie qui pourrait améliorer la vision stéréoscopique.

Un programme de thérapie visuelle à domicile a été élaboré :

❶ *Correction visuelle*

La réfraction cycloplégique a indiqué une augmentation de l'hypermétropie à l'œil droit. Elle a été jugée importante et on a recommandé une nouvelle prescription des lunettes pour favoriser un alignement oculaire plus précis. Aucune modification de la correction du proximum n'a été recommandée puisque cela aurait gêné la distance de travail de près. On n'a pas recommandé un prisme de réduction (2 dp de convergence OD) puisqu'il n'y a eu aucune amélioration de la fusion lors de l'essai. La correction finale des lunettes à port permanent était de :

OD	+3,25 – 1,50 x 001	+3,25 Ajout (ST 28)
OS	+2,50 – 1,00 x 178	+3,25 Ajout (ST 28)

❷ *Traitement anti-suppression*

Le traitement anti-suppression a débuté de près, afin de montrer à l'enfant à être conscient de la fixation dans la vision binoculaire. On a montré à C.W.

comment utiliser le gril de Javal de Polaroid et il a réussi à lire sans suppression, mais avec un peu d'effort. On lui a également montré d'autres procédures de traitement plus actives pour éliminer la suppression. C.W. était incapable de comprendre le concept de diplopie physiologique inhérente à l'exercice des billes sur fil. Il était également incapable de percevoir des cibles anaglyphiques (images rouges et vertes, Lego, crayons) à travers des vitres rouges-vertes. Le traitement anti-suppression s'est donc limité à la barre de lecture Polaroid pendant 20 à 30 minutes par jour pour le premier mois de traitement.

❸ *Traitement de la fonction visuelle monoculaire*

Dans des cas de strabisme et d'amblyopie, l'œil non dominant peut laisser apparaître des lacunes dans l'accommodation et la motilité (saccades, poursuites), même après une amélioration de l'acuité visuelle et de l'alignement oculaire. Des procédures de traitement de la vision comme le Hart Chart, les lentilles à combinaison multiple, les repérages visuels et la poursuite oculaire sont efficaces pour améliorer la fonction visuelle monoculaire. On ne les a pas prescrites à C.W. puisque l'accommodation et les poursuites monoculaires se situaient dans les limites normales lors de la première visite.

Après avoir porté ses nouvelles lunettes pendant un mois et avoir pratiqué le traitement anti-suppression quotidiennement, C.W. s'est présenté pour une réévaluation. L'acuité visuelle aidée était de 20/20 pour chaque œil à distance et de près. Le test à l'écran montrait une ésotropie à l'œil droit intermittente (moins de 2 dp) à distance et une ésophorie (moins de 2 dp) de près. Le test de Worth 4 Dot a montré une fusion à plat de près et de loin. Il n'y a eu aucune évaluation de la vision stéréoscopique par stéréotests Titmus ou Randot. Le test de vergence a immédiatement révélé la diplopie en indiquant une diminution grave de la fusion motrice.

❹ *Traitement de la fusion motrice*

Les degrés de divergence et de convergence doivent être adéquats pour garantir un alignement oculaire stable et une intégration normale de la vision binoculaire. Les vectogrammes sont un outil idéal pour former les degrés de divergence et de convergence tout en fournissant un retour de suppression et une cible stéréoscopique. Malheureusement, C.W. était incapable de maintenir la fusion avec cette procédure qu'il trouvait frustrante. Au lieu de cela, on a ajouté une demande de fusion motrice à la barre de lecture Polaroid, en plus d'un prisme de divergence de 4 dp sur l'œil droit. On a également suggéré un traitement quotidien de 20 à 30 minutes.

Le suivi a eu lieu après un mois de traitement. Les résultats de l'acuité visuelle, du test de Worth 4 Dot et du test à l'écran se sont révélés conformes à ceux de la visite précédente. Toutefois, on a évalué pour la première fois la vision stéréoscopique grossière (400 secondes d'arc). On a encore utilisé des vectogrammes et C.W. a été capable de maintenir la fusion avec effort. On continue l'entraînement à la fusion motrice en utilisant cette fois-ci des mini-vectogrammes.

La perception de la vision stéréoscopique grossière est un développement prometteur qui indique un pronostic favorable pour une amélioration continue. C.W. reconnaît que sa vue est meilleure et il trouve un nouvel intérêt dans les livres renfermant des images tridimensionnelles.

❺ *Fusion sensorielle fovéale*

La dernière étape de l'entraînement visuel consistera à améliorer la fusion sensorielle fovéale (stéréopsie). On peut accomplir cela grâce au visionnement répétitif d'images tridimensionnelles au moyen de la visionneuse 3D de ViewMaster et de « tranaglyphes » invariables.

Compte tenu des progrès réalisés jusqu'à maintenant, C.W. et ses parents désirent continuer la thérapie visuelle. Plusieurs mois de traitement seront nécessaires pour atteindre des niveaux de vergence à peu près normaux et une nouvelle amélioration de la stéréopsie.

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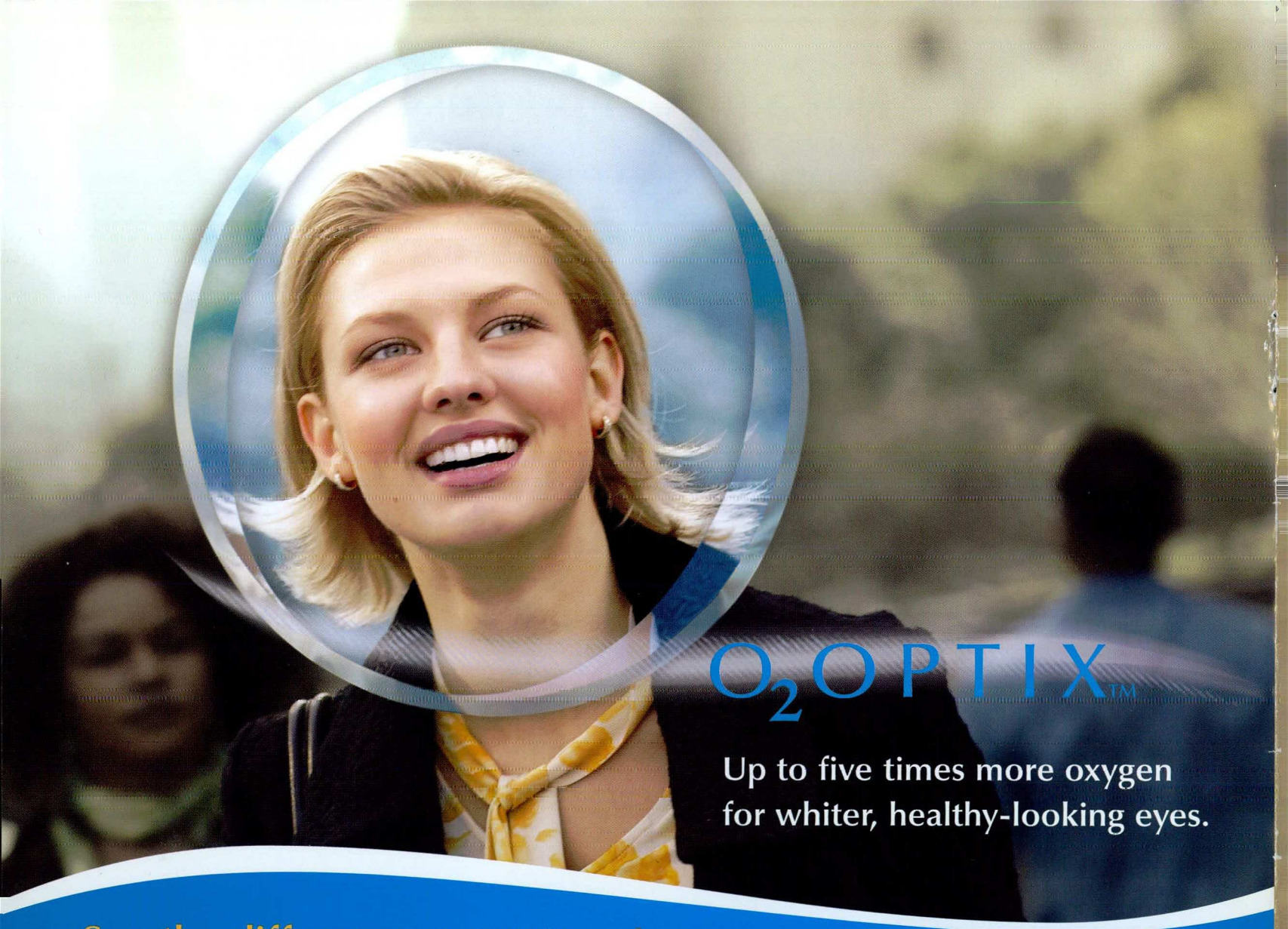

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