CJO·RCO
Canadian Journal of Optometry
Revue Canadienne d'Optométrie
Vol 68 No 3
May / mai 2006

Canadian Optometric Education Trust Fund REPORT

RAPPORT DU Fonds de fiducie des optométristes canadiens pour l'éducation

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Guest Article • Article Invité

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Clinical Diagnosis • Diagnostic Clinique

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COETF Report • Rapport du FFOCE

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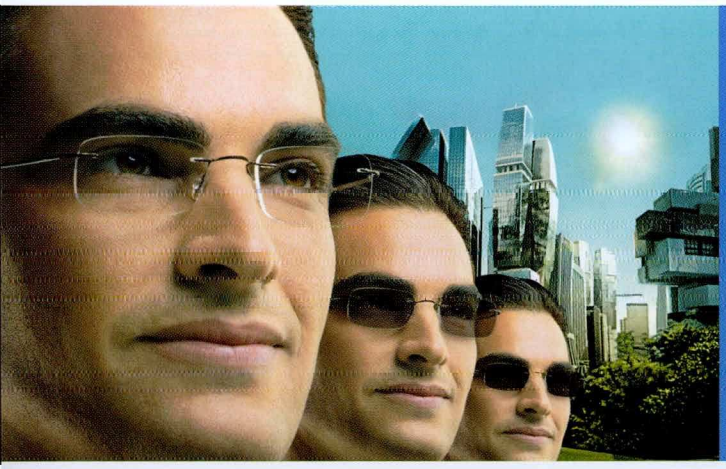
Cover: With Spring in the air, the front cover shows a frangipiani flower in a swimming pool. Flowers are also often a symbol of giving, and in this spirit this issue provides an in-depth look of the CAO's national charity of choice, the Canadian Optometric Education Trust Fund.

Couverture: Avec le printemps dans l'air, la couverture montre la fleur d'un frangipanier dans une piscine. Les fleurs sont aussi souvent un symbole de don, et c'est dans cet esprit que ce numéro fournit un regard détaillé du choix national d'organisme caritatif de l'ACO, soit les Fonds de fiducie des optométristes canadiens pour l'éducation.



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COETF Report: December, 2005

FFOCE: Rapport du groupe de travail, décembre 2005

Scott Mundle, OD
Chair, COETF Task Force / Président, Groupe de travail du FFOCE

Key words:
The Canadian Optometric Education Trust Fund

Mots clefs:
Le Fonds de fiducie des optométristes canadiens pour l'éducation

Purpose & History of COETF

The Canadian Optometric Education Trust Fund (COETF) was formally established in 1976 as a vehicle through which the profession of Optometry could contribute directly to its own development. In its initial stages, the COETF fundraising was targeted to members of the Canadian Association of Optometrists (CAO) to support several key goals:

1. *the development of optometric manpower; through projects/ research instituted by faculty members at both Canadian Schools of Optometry; through the enrollment of students in specialized graduates programs in Canada and elsewhere and through the encouragement of specific research by undergraduate students.*
2. *The development and publication of research projects undertaken by optometrists in private practice.*
3. *The development of a capital aid resource whose purpose would be the establishment of a third School of Optometry in Canada. COETF funds would also provide assistance for existing Schools in undertaking alterations, renovations, acquiring specialized instructional equipment and strengthening library holdings.*
4. *The establishment of a Chair of Physiological Optics and Continuing Education.*

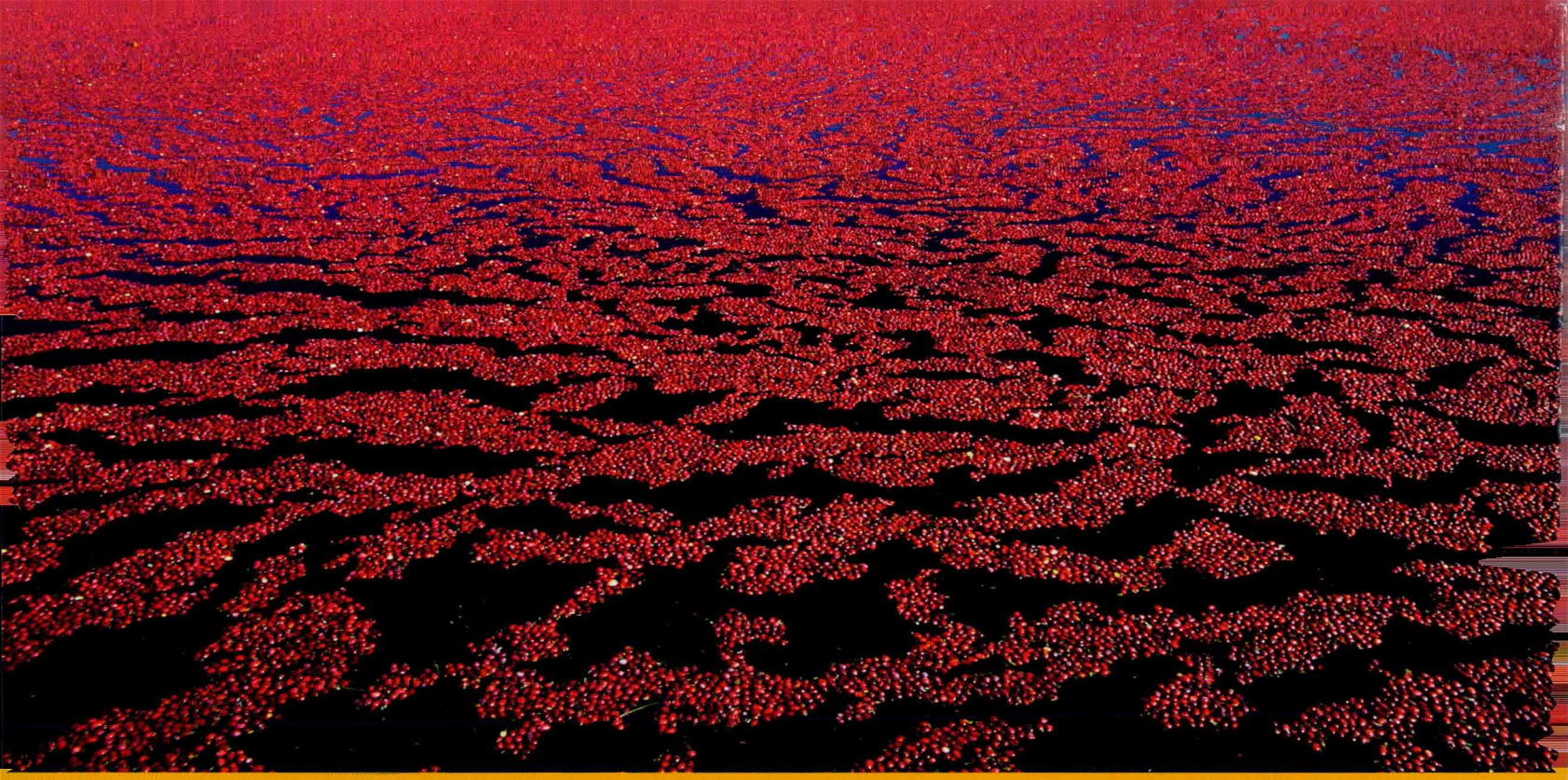
Since the inception of the fund, COETF has awarded over $1 million in grants to optometric researchers, organizations and Schools of Optometry.

History of COETF Fundraising

A large and energetic structure was set up shortly after the Fund's establishment, whose purpose was the co-ordination of the first phase of the COETF's fundraising activities; the appeal to the ordinary members of CAO. Fundraising goals and programs were established in collaboration between Trustees of COETF and a National Fundraising Chairperson. Under this structure, in each province, the fundraising activities were designated the responsibility of a Chairperson who, in turn, further sub-divided the responsibilities among zone, or regional Chairpersons. By late 1984, the structure resulted in the generation of the first $1,000,000 in pledges from among the association's (then) 2,300 ordinary members. Since that time, the fund's capital has remained just under $1,000,000.

The 1990's saw the development in Canada of techniques to improve the visual welfare of optometric patients such as the use of therapeutic pharmaceutical agents and improved diagnostic technology. During this time, the COETF Trustees approved, in 1995, the establishment of a New Technologies Fellowship. The seed money for this Fellowship received in the form of a one-time grant of $7,500 from CAO along with a matching grant from the COETF.

Falling interest rates along with increasing



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difficulties in obtaining donations from ordinary members had, by the mid 1990s, resulted in a stagnation of the Fund at the $1,000,000 level with annual pledges and interest income barely offsetting the costs of operation and grant awards. Dr James Kerr, Chair, National Fundraising Committee and the COETF Trustees undertook efforts to increase substantially the amount of capital in the fund to address the increasing demand for funding. A special fundraising program, the Millennium Campaign, sought pledges for $2001 from CAO members from 1998 - 2001. It ultimately raised $220,000 with support most evident in Western Canada and Atlantic Canada. Those who contributed the full $2001 were recognized on a "Wall of Fame" located at the CAO national office.

In 2004, the COETF Trustees considered a request from the School of Optometry, University of Waterloo to provide financial support for the UW Capital Campaign and to assist in the expansion of the School of Optometry. Following a meeting with University officials and considerable review (including communication with several prominent donors), the Trustees awarded a significant contribution of $250,000, to be paid in 3 installments in 2005-2007.

In recent years, it was apparent that fundraising was relatively stagnant other than small provincial projects and the collection of any remaining Millennium campaign pledges. COETF Trustees developed a discussion paper and allocated funding for fundraising. A meeting between Trustees and the National Fundraising Committee was held at the CAO Biennial Congress in July, 2005. The National Fundraising Chair prepared a report for review by CAO Council at its Fall Council meeting on October 29, 2005. Council provided feedback and formed a special Task Force to prepare a report outlining recommendations for COETF, with emphasis on its fundraising strategies.

Terms of Reference of COETF

COETF Trustees

Responsible for overall management of COETF, management and investment of funds, approval of fundraising strategies and liaison with the National Fundraising Chair. The Trustees are appointed annually by CAO Council. The CAO Secretary Treasurer serves as a Trustee during his/ her term.

Awards Committee

Responsible for the annual review of applications for COETF grants. The Committee is chaired by the immediate Past Chair, COETF Trustees. The Trustees serve as the Committee. The Awards committee has a manual of operations that guides the application and award process. The Committee meets in the Spring to review and award grants. The Trustees meet at the same time.

National Fundraising Committee / Chair

Responsible for liaison with COETF Trustees in establishing fundraising goals and strategies and liaison with provincial fundraising Chairs. The Chair also works with staff at the CAO national office in the promotion of the COETF fundraising program and in the administration of pledges and reports for the Fundraising Committee. When there is a vacancy, the National Fundraising Chair is responsible for recruiting new provincial fundraising Chairs through communication with the provincial optometric association and/or provincial CAO Councillor.

Provincial Fundraising Chair

Responsible for implementing the COETF fundraising program on a provincial basis. In this capacity, the provincial Chair may appoint additional committee members. The provincial Chair is responsible for reporting on behalf of the COETF fundraising program at provincial Annual General Meetings. The provincial Chair also provides a report to the National Fundraising Chair on at least an annual basis.

CAO National Office Staff

Responsible for providing ongoing support to the COETF Trustees and Fundraising Committee.

Current Challenges

Increasing competition for charitable dollars

The number of good charitable causes continues to increase including charities specific to eye care and optometry. These charities have become more sophisticated and aggressive in raising funds. The Optometry profession is seen as a source of fundraising from optometrists themselves, optometric organizations, ophthalmic suppliers and optometric patients. In addition,

the World Council of Optometry expanded its role in international eye care and raising funds for worthy projects and organizations through a new program, Optometry Giving Sight. In 2005, CAO endorsed OGS as its "international charity of choice". A limited amount of secretariat support is provided to OGS by CAO.

Relevance of COETF

CAO members are largely unaware of COETF activities and its purpose. Some suggest that COETF provide funding for 'issue related' projects that directly impact the profession. For those involved in research, COETF plays a smaller role as a funding source given the smaller pool of award money available for annual grants. Furthermore, research projects funded by COETF are rarely published in the Canadian Journal of Optometry.

COETF Staff Resources

There are limited staff resources available to COETF at the CAO National office. This is reflected in a reduced administration fee charged by CAO to COETF. This situation is not likely to improve in the foreseeable future.

COETF Trustees/ Committees

There has been little opportunity for strategic planning for COETF Trustees and Committees. A significant commitment is required to address current challenges and take COETF to the next level.

Task Force Recommendations

The Task Force considered all factors above and makes several recommendations for consideration by CAO Council and COETF Trustees including:

- *The hiring of a part time staff person to assist the National Fundraising Committee, COETF;*
- *Undertake a review of COETF terms of reference, operations and governance by seeking feedback from CAO members, grant recipients, donors and optometric leaders. Following this review, Trustees should promote and ensure broad support for revised terms of reference and objectives for COETF;*
- *CAO Council would articulate its support of COETF as its "national charity of choice".*

The Task Force recommendations were ratified by CAO Council at the Winter, 2006 meeting and referred to the COETF Trustees meeting on April 1, 2006. The Trustees established several ambitious goals to be implemented this year.

CAO members can expect to hear and learn more about the good work of COETF. One example is the publishing in each issue of the *CJO* a report highlighting a research project funded by COETF. These reports will not only be relevant and beneficial for CAO members, they will profile why the COETF is so important to the profession. After all, COETF is Canadian Optometry's Charity.

But et historique du FFOCE

Le Fonds de fiducie des optométristes canadiens pour l'éducation (FFOCE) a été officiellement créé en 1976 comme un moyen pour la profession de l'optométrie de travailler directement à sa propre expansion. À leurs débuts, les campagnes de financement du FFOCE s'adressaient aux membres de l'Association canadienne des optométristes (ACO) et appuyaient plusieurs objectifs clés :

1. *Le perfectionnement de la main-d'œuvre optométrique; grâce à des projets/ recherches créés par le corps professoral des deux écoles d'optométrie canadiennes; grâce à l'inscription d'étudiants dans des programmes de troisième cycle spécialisés au Canada et ailleurs et à des recherches spécifiques par des étudiants de premier cycle.*
2. *L'élaboration et la publication de projets de recherche entrepris par des optométristes en cabinet privé.*
3. *Une aide financière dont l'objectif serait la création d'une troisième école d'optométrie au Canada. Les fonds du FFOCE serviraient également à aider les écoles existantes à entreprendre des modifications et rénovations, à acquérir de l'équipement pédagogique spécialisé et à renforcer leurs fonds documentaires.*
4. *La création d'une chaire en « Physiological Optics and Continuing Education ».*

Depuis sa création, le FFOCE a remis plus de un million de dollars en bourses à des chercheurs optométriques, à des organismes et à des écoles d'optométrie.

Historique du financement du FFOCE

Une vaste structure dynamique a été mise sur pied peu de temps après la création du fonds, dont le but était de coordonner la première phase des activités de financement du FFOCE; elle s'adressait aux

membres réguliers de l'ACO. Les objectifs et les programmes de financement ont été établis en collaboration avec les conseillers du FFOCE et le président national de la campagne. Chapeautées par cette structure, dans chaque province, les activités de financement ont été confiées à un président qui, à son tour, a délégué ses responsabilités à des présidents des zones ou régions. À la fin de 1984, la structure avait permis de recueillir le premier million de dollars en promesses de dons auprès des 2 300 membres réguliers que comptait l'association à ce moment-là. Depuis ce temps, le capital du fonds s'est maintenu à près de un million de dollars.

Au cours des années 1990 sont apparues au Canada des techniques destinées à améliorer le bien-être visuel des patients optométriques, comme l'utilisation d'agents pharmaceutiques thérapeutiques et une technologie de diagnostic améliorée. Pendant ce temps, les conseillers du FFOCE ont approuvé, en 1995, la création d'une bourse de recherche pour les nouvelles technologies à laquelle l'ACO a fourni un montant unique de 7 500 $ et le FFOCE, une subvention équivalente.

À cause des taux d'intérêt à la baisse et des difficultés accrues à obtenir des dons des membres réguliers, le fonds stagnait, vers le milieu des années 90, à un niveau de 1 000 000 $, les promesses de dons annuelles et les revenus d'intérêt couvrant à peine les coûts de fonctionnement et les subventions. Les conseillers du FFOCE ont alors cherché à augmenter substantiellement le capital du fonds afin de répondre à la demande croissante de financement. Un programme de financement spécial, la campagne du millénaire, demandait aux membres réguliers de l'ACO de faire une promesse de don de 2 001 $ pour la période de 1998 à 2001. Une somme de 220 000 $ a été récoltée surtout de l'Ouest canadien et du Canada atlantique. Les donateurs de 2 001 $ figurent sur un tableau d'honneur au bureau national de l'ACO.

En 2004, les conseillers du FFOCE ont étudié une demande d'aide financière de l'École d'optométrie de l'Université de Waterloo pour la campagne de financement de l'UW et pour l'agrandissement de l'École d'optométrie. Après une réunion avec les responsables de l'université et une étude approfondie (dont des contacts avec plusieurs donateurs éminents), les conseillers ont promis une somme importante de 250 000 $, à être payée en trois versements en 2005-2007.

Dans les années récentes, il était évident que le financement stagnait, sauf pour quelques petits projets provinciaux et la collecte des dernières promesses de dons provenant de la campagne du millénaire. Les conseillers du FFOCE ont préparé un document de travail et alloué des fonds à des activités de financement. Une réunion a eu lieu entre les conseillers et le comité de financement national au Congrès biennal de l'ACO en juillet 2005. Le président national de la campagne a préparé un rapport que devait étudier le Conseil de l'ACO à sa réunion d'automne du 29 octobre 2005. Après avoir fait ses observations, le Conseil a mis sur pied un groupe de travail spécial pour préparer un rapport présentant des recommandations au FFOCE, qui mettait l'accent sur ses stratégies de financement.

Mandat du FFOCE

Conseillers du FFOCE

Ils sont responsables de l'administration générale du FFOCE, de la gestion et du placement des fonds, de l'approbation des stratégies de financement et des relations avec le président national de la campagne de financement. Les conseillers sont nommés annuellement par le Conseil de l'ACO. Le secrétaire-trésorier de l'ACO siège comme conseiller pendant son mandat.

Comité d'attribution

Il est responsable de l'examen annuel des demandes de bourse au FFOCE. Le comité est présidé par le président sortant des conseillers du FFOCE. Les conseillers sont les membres du comité. Le comité d'attribution recourt à un manuel pour mener à bien le processus de demandes et d'attribution. Il se réunit au printemps pour étudier les demandes et attribuer les bourses. Les conseillers se réunissent au même moment.

Comité/président national de la campagne de financement

Ils sont responsables des relations avec les conseillers du FFOCE pour établir les objectifs et les stratégies de financement, et des relations avec les présidents provinciaux des campagnes de financement. Le président travaille également avec le personnel du bureau national de l'ACO pour promouvoir le programme de financement du

FFOCE et pour administrer les promesses de dons et les rapports au comité de financement. Lorsqu'il y a vacance au comité, le président national de la campagne de financement doit recruter de nouveaux présidents provinciaux en contactant l'association optométrique provinciale et/ou le conseiller provincial de l'ACO.

Président provincial de la campagne de financement

Il est responsable du programme de financement du FFOCE au niveau provincial. À ce titre, le président provincial peut nommer des membres supplémentaires au comité. Le président provincial a pour tâche de faire rapport du programme de financement du FFOCE à l'assemblée générale annuelle provinciale. Il présente aussi un rapport au président national de la campagne de financement au moins une fois par année.

Personnel du bureau national de l'ACO

Il fournit une aide permanente aux conseillers du FFOCE et au Comité de financement.

Défis actuels

Sollicitation accrue auprès des donateurs

Le nombre d'œuvres de bienfaisance ne cesse d'augmenter, y compris les œuvres de bienfaisance liées aux soins de l'œil et à l'optométrie. Ces œuvres sont devenues de plus en plus spécialisées et dynamiques dans leur campagne de financement. La profession de l'optométrie est perçue comme une source de financement par les optométristes eux-mêmes, les organismes optométriques, les fournisseurs ophtalmiques et les patients optométriques. De plus, le Conseil mondial de l'optométrie a élargi son rôle dans le domaine des soins oculo-visuels au plan international et, grâce à un nouveau programme, *Optometry Giving Sight*, il collecte des fonds pour des projets et des organismes méritoires. En 2005, l'ACO a fait de l'OGS son organisme de bienfaisance international officiel. L'ACO assure un secrétariat limité à l'OGS.

Pertinence du FFOCE

Les membres de l'ACO connaissent généralement très peu les activités et les buts du FFOCE. Quelques-uns pensent que le FFOCE étudie des projets de financement qui ont une incidence directe sur la profession. Pour les chercheurs, le FFOCE joue un rôle restreint comme source de financement étant donné la somme infime allouée aux subventions annuelles. De plus, les projets de recherche financés par le FFOCE sont rarement publiés dans la *Revue canadienne d'optométrie.*

Ressources humaines

Les ressources humaines du Bureau de l'ACO disponibles pour le FFOCE sont limitées, comme en font foi les frais d'administration réduits facturés par l'ACO au FFOCE. Il ne semble pas que cette situation s'améliore dans un avenir immédiat.

Conseillers/comités du FFOCE

Les conseillers et les comités du FFOCE ont eu peu d'occasion d'établir une planification stratégique. Pour répondre aux défis actuels et pour que le FFOCE continue sa croissance, un engagement important s'impose.

Recommandations du groupe de travail

Le groupe de travail a étudié tous les facteurs ci-avant et fait plusieurs recommandations, dont les suivantes, que le Conseil de l'ACO et le FFOCE ont étudiées :

- *engager une personne à temps partiel pour aider le Comité national de financement du FFOCE;*
- *revoir le mandat, les activités et la gouvernance du FFOCE en sollicitant les commentaires des membres de l'ACO, des chercheurs subventionnés, des donateurs et des chefs de file optométriques. À la suite de cet examen, les conseillers devront promouvoir le mandat et les objectifs révisés du FFOCE et faire en sorte qu'on les appuie;*
- *le Conseil de l'ACO doit appuyer le FFOCE comme son organisme de bienfaisance national de choix.*

Les recommandations du groupe de travail ont été adoptées par le Conseil de l'ACO à sa réunion de l'hiver 2006 et envoyées à la réunion des conseillers du FFOCE du 1er avril 2006. Les conseillers ont établi plusieurs objectifs ambitieux à mettre en œuvre cette année.

Les membres de l'ACO entendront parler davantage du bon travail du FFOCE. Par exemple, chaque numéro de la *Revue canadienne d'optométrie* publiera un article sur un projet de recherche financé par le FFOCE.

Outre leur pertinence et leur utilité pour les membres de l'ACO, ces articles révéleront pourquoi le FFOCE est si important pour la profession. Après tout, le FFOCE est l'œuvre de bienfaisance de l'optométrie.

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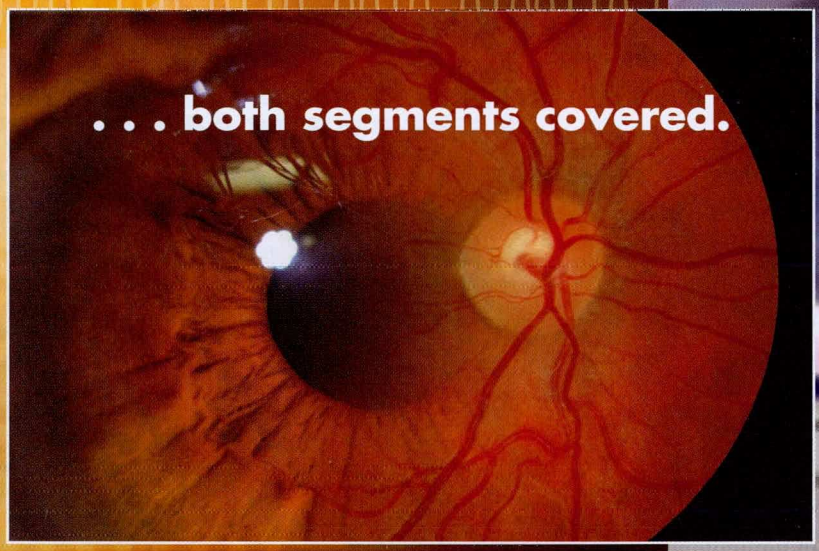

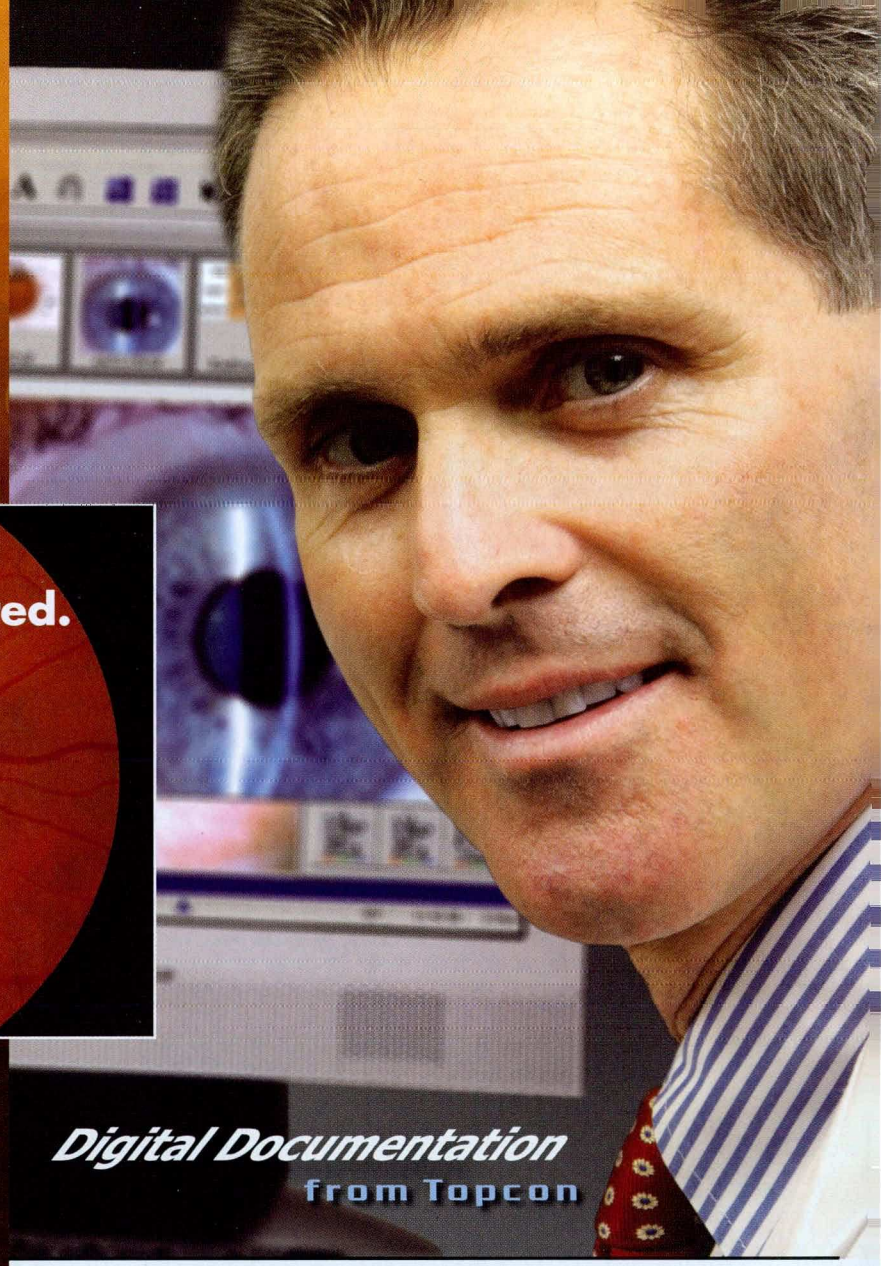

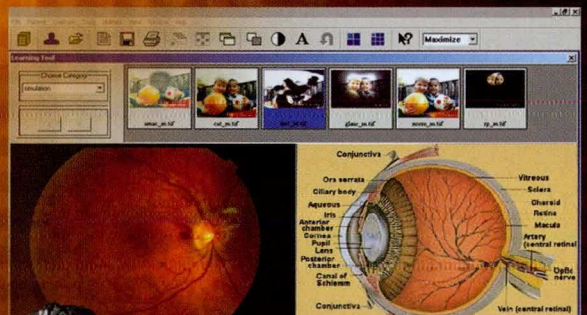

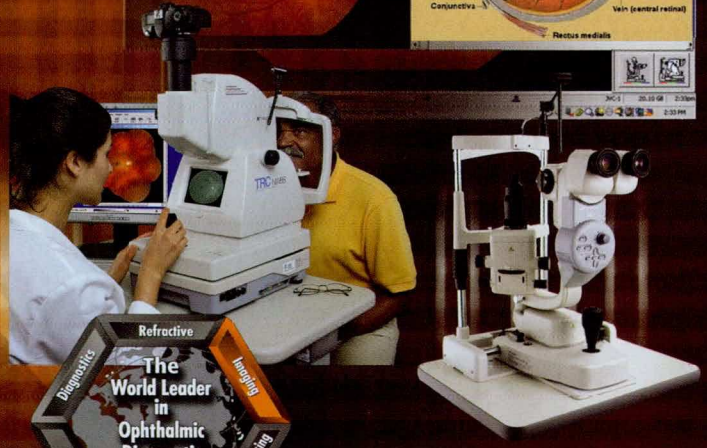

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When recognition does not count!

Quand on ne court pas après les hommages!

As many of you may know, I am proud to be the mother of three very talented children who have, among other things, excelled in athletics. While each one of them has a preference and area of specialty, they all share a natural enthusiasm for team sports and activities that require a group effort to achieve success.

Many great coaches have been marked in history for their profound statements such as, "There is no I in TEAM!" and, "It is amazing what can be accomplished when no one is worried about who will get the credit!"

It is the ability to work within a team structure rather than personal skill or notoriety that I am most proud of. It is the "team ethic" that shines through in my children's eyes, but also within the eyes of my optometric colleagues, that continually motivates and inspires me.

Many of our members have amazing stories about their work for the profession, within their communities or in international work. In some cases, it may be a personal pursuit that is remarkable.

We could fill pages with names of people who have given much to our profession and their communities but I fear it would only be a list of names, with inadequate tributes that may be worse than no recognition or tribute at all. It is however my intent to put in place a way to recognize our "unsung heroes" that will do them justice. Hopefully, it could be a regular feature in CJO.

Acquiring these member profiles is a difficult task. That is why I put it to each an every one of you to send me stories of optometrists who have influenced you or your community. I believe there are countless individuals who have made significant contributions to the "team of optometry" and beyond and whose stories need to be told.

I look forward to hearing from you!

Member profiles may be sent directly to Dr Morrow at damorrow@telusplanet.ca or to dircomm@opto.ca. The length should be in the range of 300-400 words. CJO editors may suggest edits and reserves the right on profiles to publish.

Comme beaucoup d'entre vous le savent, je suis fière d'être la mère de trois enfants très talentueux qui ont, entre autres choses, excellé dans les

PRESIDENT'S PODIUM
MOT DE LA PRÉSIDENTE

sports. Même si chacun a ses goûts et sa spécialité, ils partagent un enthousiasme naturel pour les sports d'équipe et les activités qui demandent un effort de groupe pour réussir.

Nombre d'entraîneurs importants ont laissé une marque dans l'histoire par leurs paroles pleines de sagesse comme le mot ÉQUIPE exclut le JE! et c'est extraordinaire tout ce qu'on peut accomplir quand personne ne s'inquiète de savoir qui sera la vedette!

L'aptitude à travailler à l'intérieur d'une structure d'équipe, et non la compétence ou la renommée personnelles, voilà ce dont je suis le plus fière. « L'éthique d'équipe » qui transparaît dans les yeux de mes enfants, mais aussi dans les yeux de mes collègues optométriques, me motive et m'inspire continuellement.

Beaucoup de nos membres ont des histoires fascinantes à raconter au sujet de leur contribution à la profession, tant dans leur collectivité qu'au plan international. Dans certains cas, il peut s'agir d'une démarche personnelle remarquable.

Le nom des personnes qui ont beaucoup donné à notre profession et à leur collectivité pourrait remplir des pages et des pages, mais ce faible hommage serait sans doute pire qu'une absence totale de reconnaissance.

Toutefois, j'ai l'intention de rendre hommage à nos « héros cachés » d'une façon qui leur fera justice. Cela pourrait même devenir une rubrique régulière de la RCO.

Obtenir le profil de ces membres est une tâche difficile. C'est pourquoi je vous invite tout un chacun à me parler des optométristes qui vous ont influencé, vous ou votre collectivité. Il y a selon moi d'innombrables individus qui ont apporté une contribution significative à « l'équipe de l'optométrie » et au-delà et dont l'histoire mérite d'être racontée.

J'ai très hâte d'avoir de vos nouvelles!

Les profils des membres peuvent être envoyés à la Dre Morrow à damorrow@telusplanet.ca ou à dircomm@opto.ca. Un profil peut compter de 300 à 400 mots. Les rédacteurs de la RCO peuvent modifier les profils et se réservent les droits sur les profils à publier.

CJO wants to hear from you!

Send your comments to
Letters to the Editor

Vous avez des réactions sur un article paru dans la RCO!

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WANTED
Clinical Articles

The editors of CJO*RCO encourage submissions of clinical articles, including original research and case studies. Contact info@opto.ca for more information.

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Les rédacteurs du CJO*RCO vous encouragent à leur soumettre vos articles cliniques. Contactez info@opto.ca pour plus de renseignements.

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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 J. 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.

CLINICAL DIAGNOSIS

Catherine Chiarelli, OD, FAAO
Vision Institute of Canada

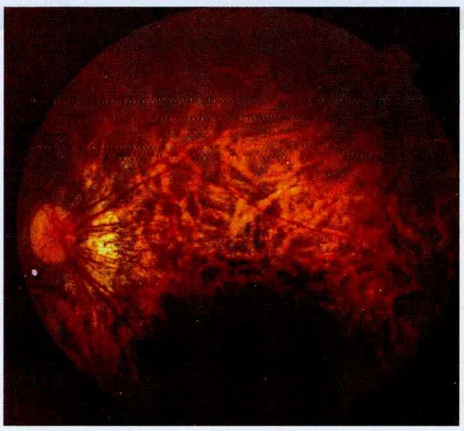

photo 1

A 12-year-old male presents for vision examination, along with teachers and classmates from the local school for deaf children. An initiative to ensure that the students receive regular vision care was undertaken by the school, in response to concerns about undetected and untreated vision problems in this at-risk population. The child's teachers have observed that his left eye turns out, and that he displays difficulty with glare. He himself reports that vision in the left eye is poor, and that people must stand on his right side in order for him to communicate with them by sign language. His kindergarten teacher remembers that he was supposed to wear a contact lens in one eye, however this was seldom done. The child reports that he has glasses at home, but that he never wears them. No further information regarding the cause of deafness, health status, visual status or ongoing vision care was available, in part due to language barriers between the school and the family.

Unaided visual acuity in the right eye is 10/10- at distance and at near. Acuity in the left eye cannot be determined at distance but is quantified as 20/400-20/500 at near. A large angle constant left exotropia is evident. No stereoacuity is appreciated. Cycloplegic refraction reveals: Right eye –0.75-0.50x180, Left eye +7.50-2.50x180. Anterior segment examination reveals aphakia in the left eye. Applanation tonometry cannot be completed due to patient apprehension, however intraocular pressures are equal by palpation. Dilated fundus examination is unremarkable in the right eye. Posterior pole of the left eye is shown in Photo 1. Non-specific pigmentary degeneration is observed peripherally in the left eye.

What condition is evident in the left eye?
What ocular history is assumed?
What treatment is advised?
What is the long-term prognosis?

(see page 119)

DIAGNOSTIC clinique
diagnositic CLINIQUE

Un garçon de 12 ans se présente pour un examen visuel, accompagné d'enseignants et d'élèves de l'école locale pour enfants sourds. L'école, préoccupée par les problèmes de la vue non détectés et non traités chez cette population à risque, a mis sur pied cette initiative pour que les élèves reçoivent des soins de la vue réguliers. Les enseignants de l'enfant ont observé un strabisme à l'œil gauche et un problème d'éblouissement. L'enfant lui-même affirme que sa vision de l'œil gauche est pauvre et que les gens doivent se placer à sa droite afin qu'il puisse communiquer avec eux par signes. Son enseignante de maternelle se rappelle qu'il devait porter une lentille de contact sur un œil, ce qu'il faisait rarement. L'enfant dit avoir des lunettes à la maison mais ne jamais les porter. Aucun renseignement supplémentaire au sujet de la cause de la surdité, de l'état de santé, de l'état visuel ou des soins de la vue en cours, en partie à cause des obstacles de langue entre l'école et la famille.

L'acuité visuelle sans aide est 10/10- de loin et de près pour l'œil droit. On ne peut préciser l'acuité visuelle de loin pour l'œil gauche mais elle s'établit à 20/400-20/500 de près. Une exotropie continuelle à grand angle à l'œil gauche est évidente. On ne dénote aucune acuité stéréoscopique. La réfraction cycloplégique révèle : œil droit –0,75-0,50x180, œil gauche +7,50-2,50x180. L'examen du segment antérieur révèle une aphakie à l'œil gauche. On ne peut effectuer la tonométrie par aplanation en raison des craintes du patient, toutefois les pressions intra-oculaires par palpation sont égales. L'examen du fond de l'œil dilaté ne révèle rien de spécial à l'œil droit. La photo 1 indique le pôle postérieur de l'œil gauche. On observe une dégénérescence pigmentaire non spécifique à la périphérie de l'œil gauche.

Quel état est évident à l'œil gauche?
Quels seraient les antécédents oculaires?
Quel est le traitement approprié?
Quel est le pronostic à long terme?

(voir la page 121)

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The Momentum of Change

Alphonse Carew
OF, FAAO

Many of the inquiries that I get from optometrists across Canada start with the very typical phrase "I have a problem in my practice…". Then, they go on to explain that revenue is down or flat, or the office morale is terrible, or one of the many other typical problems we all face in our practices. At the core of each problem, and its subsequent solution, is a call for change; however, nothing seems to be feared by so many as the prospect of having to *change*.

Even though most people understand that change is inevitable, many are compelled to resist. The path of least resistance is to continue doing things the way they have always been done, even when in the long run it could be detrimental. As the saying goes "if the going is easy, then you maybe going downhill".

Fundamentally, to affect change in your practice you need to change behaviours, both your own and that of your staff. This is not an easy feat. It is immensely difficult because people have to make short-term sacrifices and endure short-term pain in order to realize long-term goals. A great little book that can help you understand the many different subtle aspects of change is *Who Moved My Cheese*, by Spencer Johnson. We gave a copy of this book to each of our staff members and it proved quite valuable in helping us understand the various personalities and problems that transforming the practice would have to undergo.

The first step in any change process is to make your case for change as clear and frank as possible. Your team needs to know why it is important to you, and your practice that

this takes place. You should also highlight the likely detrimental outcome if this change does not take place.

From there, communicate clearly and often about your progress. Celebrate even the smallest of wins and don't let any setbacks derail your efforts. Reward those that help champion your plans and re-energize those that resist. At the outset, schedule time to review and refine your plan with your staff and stick to this timetable.

Everyone wants to know how long it will take to see the transformation. This is a difficult question to answer but often it is several times longer than you think it should. I made changes to our management style in our practice and it took more than two years to see concrete evidence that it was working. These clear 'eureka moments' will come but you need to focus more on small daily improvements that will amplify over time.

These clear 'eureka moments' will come but you need to focus more on small daily improvements that will amplify over time.

These 'miracle moments' have been compared to the proverbial egg. At the moment the chick breaks out of its shell, it is obvious that change has taken place; however, what is often overlooked are the many small daily changes that take place inside the shell over the preceding weeks.

The good news is that with small sustained changes over a long period of time you will build to a place where change will sustain itself. This is best described as the 'Flywheel Effect' by Jim Collins in his book, "*Good to Great*", wherein he describes the flywheel:

> *Now picture a huge, heavy flywheel. It's a massive, metal disk mounted horizontally on an axle. It's about 100 feet in diameter, 10 feet thick, and it weighs about 25 tons. That flywheel is your company. Your job is to get that flywheel to move as fast as possible, because momentum – mass times velocity – is what will generate superior economic results over time.*
>
> *Right now, the flywheel is at a standstill. To get it moving, you make a tremendous effort. You push with all of your might, and finally, you get the flywheel to inch forward. After two or three days of sustained effort, you get the flywheel to complete one entire turn. You keep pushing, and the flywheel begins to move a bit faster. It takes a lot of work, but at last the flywheel makes a second rotation. You keep pushing steadily. It makes three turns, four turns, five, six. With each turn, it moves faster, and then – at some point, you can't say exactly when – you break through. The momentum of the heavy wheel kicks in your favour. It spins faster and faster, with its own weight propelling it. You aren't pushing any harder, but the flywheel is accelerating, its momentum building, its speed increasing.*

Getting your practice to this point will take effort and time but the end result is well worth it. Many practices plateau or stagnate and can't seem to push to the next level. The fear of change can be paralyzing. If you don't learn to embrace change and like it, then you are certainly not going to like it when your practice doesn't reach its true potential.

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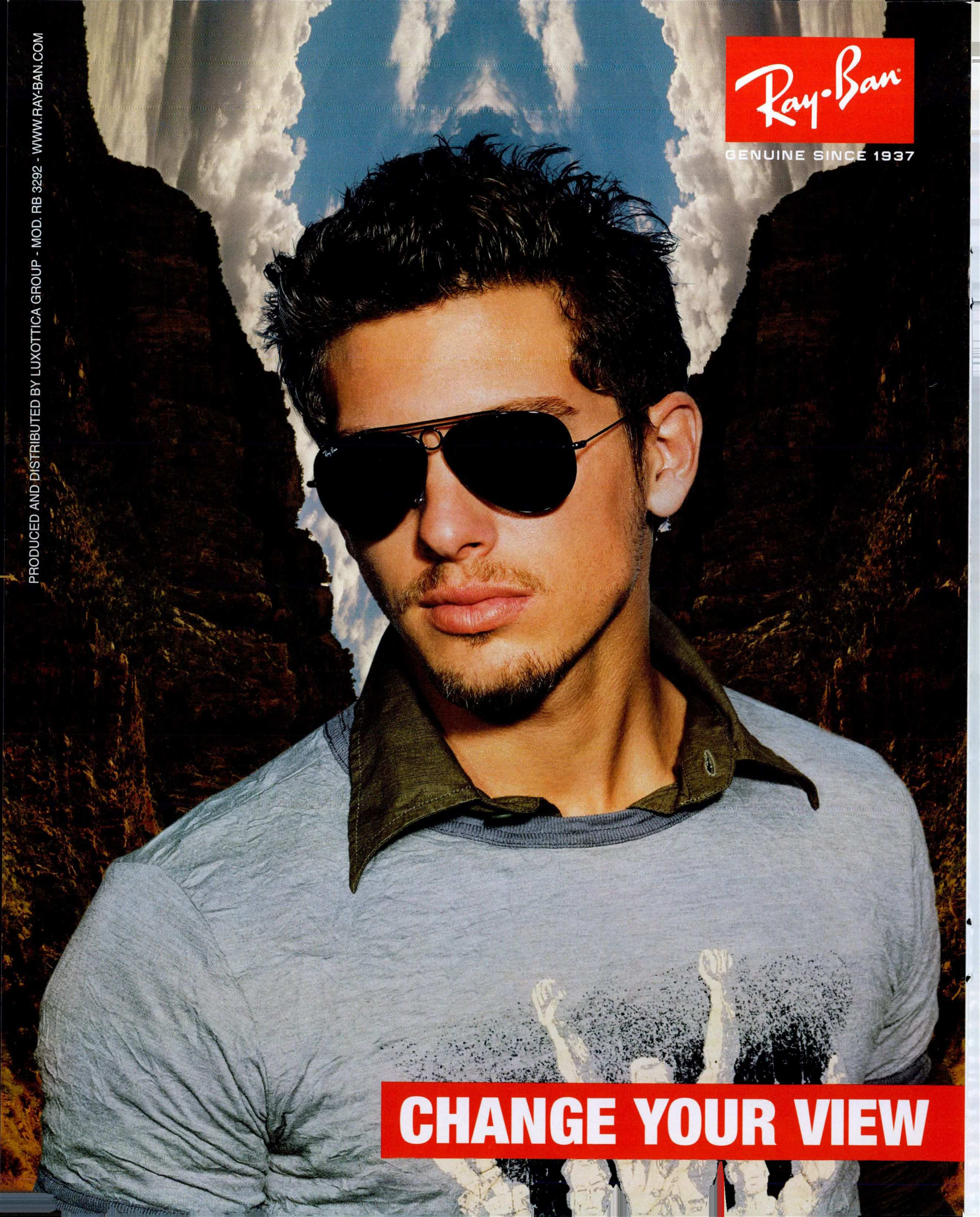
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COETF REPORT
RAPPORT DU FFOCÉ

In an effort to highlight some of the projects and research by COETF award recipients, the COETF Trustees and Awards Committee have selected project reports to be published in the Canadian Journal of Optometry · Revue canadienne des optométristes. Recognizing that many recipients intend to publish their work in cited journals, the reports are not considered to be clinical articles. COETF funded research, when completed and peer reviewed, may be published in CJO·RCO and other journals. The COETF reports are intended to provide relevant information for the benefit of our readers and to showcase the high caliber of optometric research funded by COETF … Canadian Optometry's Charity.

The effects of contact lens care solutions on the corneal epithelium - a comparative investigation using confocal microscopy

Project Investigator: Krystynne Harvey

Certain combinations of silicone hydrogel contact lenses and care regimens have previously been found to produce significant asymptomatic annular corneal staining in contact lens wearers (*Jones et al 2002*). This project focused on investigating the etiology behind this staining. From the data obtained, contact lens companies will be assisted in the design of lens care products to prevent/reduce such corneal staining if indeed it is deemed clinically necessary to do so.

High resolution confocal microscopy was employed to observe the response (and its permanence) of corneal epithelial cells and sub-basal corneal nerve fibers to two popularly marketed contact lens care solutions. The project investigated the effect of OptiFree® Express® MPDS no rub cleaning solution and Bausch & Lomb ReNu MultiPlus® no rub cleaning solution on the cornea of PureVisionTM contact lens wearers. The corneal epithelium and sub-basal nerve fibers were observed at 500 times magnification (with a theoretical lateral resolution of 1 μm) using the ConfoScan3 confocal microscope (Nidek Technologies, Italy).

Twenty asymptomatic silicone hydrogel contact lens wearers were recruited. These contact lens wearers were on average 26 years old and had been wearing soft contact lenses for approximately 8 years. Previous silicone hydrogel lens use had occurred over the past 20 months on average. Ten non contact lens-wearing control subjects were also recruited. These non contact lens wearing controls averaged 25 years in age. Data from the 10 control subjects, as well as data from the 20 contact lens wearers were analyzed using Statistica7.

The basal epithelial cell density of non contact lens wearers was significantly greater than that of contact lens wearers ($p<0.05$). Neural width of non contact lens wearers was significantly larger than that of contact lens wearers ($p<0.05$). Contact lens wearers tended to show greater pre confocal staining compared to non contact lens wearers, when examined on the slit lamp biomicroscope.

Superficial epithelial cells were easier to resolve on confocal microscopy when either of the two care solutions was used (Figures 1 and 2). Individual sloughed off cells were visible on confocal microscopy when staining was observed on slit lamp biomicroscopy (Figures 3 and 4). Staining and sloughing off was greater for ReNu MultiPlus® compared to OptiFree® Express® MPDS, ($p<0.05$). Fluorescence extending to the basal epithelium was at times observed for ReNu MultiPlus® but not OptiFree® Express® MPDS (Figure 5).

Basal epithelial cell density declined significantly ($p<0.05$) for ReNu MultiPlus®, perhaps indicative

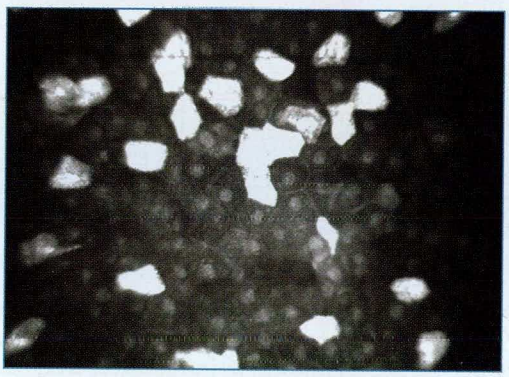
of oedema. There was no significant change in basal epithelial density with OptiFree® Express® MPDS ($p>0.05$). ReNu MultiPlus® showed a decline in neural density compared to the OptiFree® Express® MPDS care regimen. However, this decline was not significant ($p>0.05$). Subbasal nerve fibre width declined significantly on the ReNu MultiPlus® care regimen ($p<0.05$). There was no decline in neural width on the OptiFree® Express® MPDS care regimen.

In conclusion, it was seen that contact lens care solutions affected the corneal epithelium of silicone hydrogel contact lens wearers. The observed corneal staining was caused by contact lens and care solution interactions.

Reference

1. Jones L, MacDougall N, Sorbara LG. Asymptomatic corneal staining associated with the use of balafilcon silicone-hydrogel contact lenses disinfected with a polyaminopropyl biguanide-preserved care regimen. Optom Vis Sci 2002; 79(12) 753-761.

Figures 1 & 2- Superficial epithelium. Figure 1 was taken at baseline for participant 31 and figure 2 was taken for the same participant after one week of contact lens and OptiFree® Express® MPDS solution use.



Figures 3 & 4 - Superficial epithelium. Figure 3 was taken at baseline for participant 27 and figure 4 was taken for the same participant after two weeks of contact lens and ReNu MultiPlus® solution use. Participant 27 showed significant annular staining on slit lamp examination.

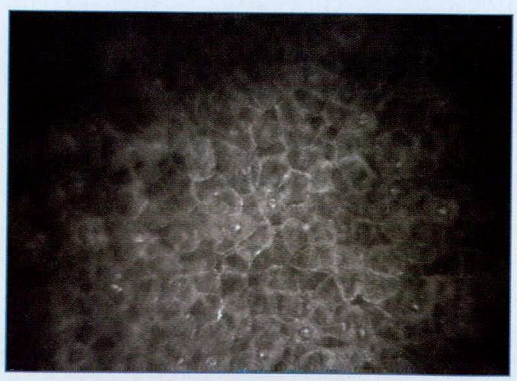


Figure 5 - Basal epithelium. Figure 5 was taken on participant 19 after 4 weeks of contact lens and ReNu MultiPlus® solution use. Participant 19 showed minimal annular staining on slit lamp examination.

The COETF Annual Awards Program for 2006

The COETF received a total of 31 applications for awards in 2006. Of those 31 applications, 18 were granted at least partial funding for projects or research. In most cases, applicants are not given full funding as the total amount of funding requested greatly exceeds the money available for granting. Awards funding is based on the Trust Fund's interest earned over the previous year.

All award recipients are required to submit an interim report on their project and a final report upon completion. In an effort to recognize some of the projects and research being done by COETF award recipients, the Awards Committee intends to publish project reports in the *Canadian Journal of Optometry* (CJO) so that our members across the country can learn more about where COETF funding goes as well as highlighting exciting optometric research.

APPLICATIONS SUMMARY

Total WATERLOO School of Optometry APPLICATIONS	20	$103,788.00
Total WATERLOO School of Optometry AWARDS	12	$21,550.00
Total MONTREAL Ecole d'Optometrie APPLICATIONS	7	$52,511.40
Total MONTREAL Ecole d'Optometrie AWARDS	3	$6,500.00
Total VISION INSTITUTE Practitioner APPLICATIONS	2	$5,725.00
Total VISION INSTITUTE Practitioner AWARDS	2	$5,725.00
Total INDEPENDENT Practitioner APPLICATIONS	2	$1,500.00
Total INDEPENDENT Practitioner AWARDS	1	$1,000.00
Total APPLICATIONS for 2006	31	$163,524.40
Total AWARDS for 2006	18	$34,775.00
Total APPLICATIONS (since inception)		**$5,250,844.78**
Total AWARDS		**$1,277,288.00**

Quick Facts:
The Canadian Optometric Education Trust Fund (COETF) was created in 1976 by the members of the Canadian Association of Optometrists to assist programs in research, education and human resources development in the vision and eye care field in Canada.

Through its annual program of Awards, the COETF has supported (i) faculty development, (ii) research and/or specialized education programs carried out by graduate students, and (iii) investigative projects conducted by undergraduate students enrolled or on staff at Canada's Schools of Optometry.

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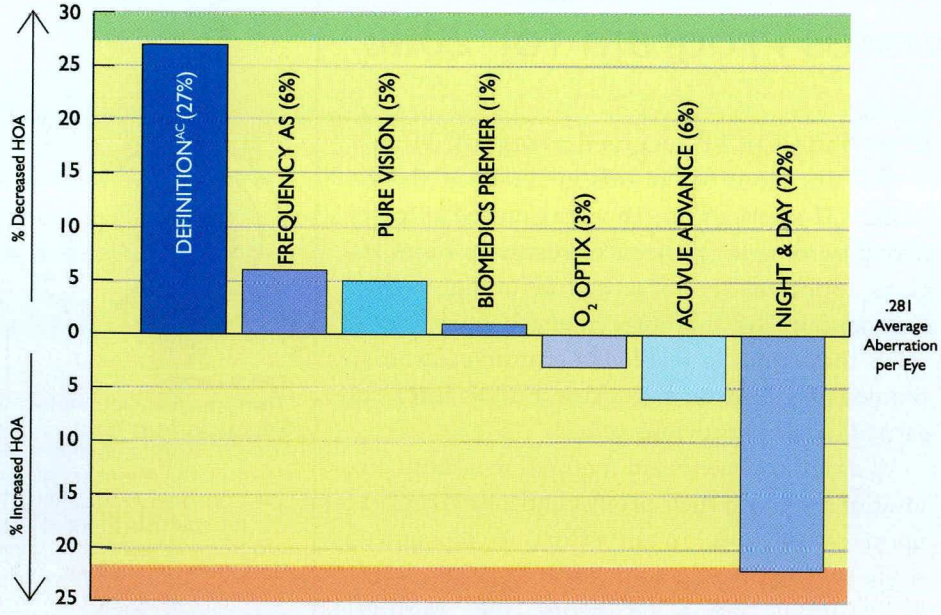

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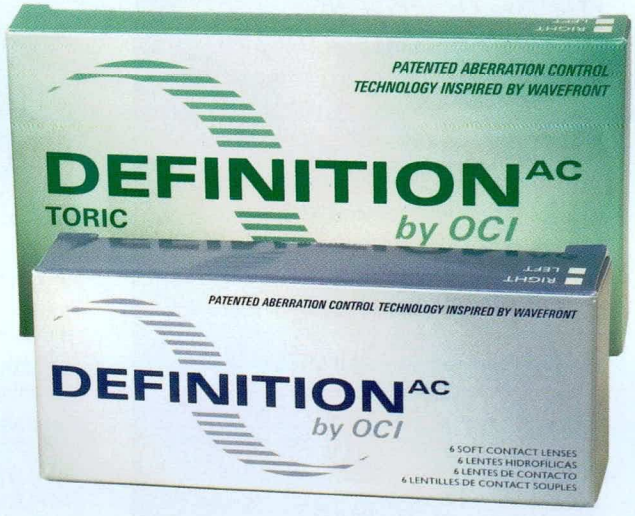

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THE COETF ANNUAL AWARDS PROGRAM FOR 2006

SCHOOL OF OPTOMETRY, UNIVERSITY OF WATERLOO (UW)

CANADIAN ASSOCIATION OF OPTOMETRY STUDENTS (CAOS) (Project Supervisor: Dr. B. Robinson)
"The Canadian Handbook of Optometry"

CAFFERY, B.: "A Cross Sectional study of Sjogren's Syndrome Patients" (PhD PROGRAM)

DUENCH, S.: "Bulbar Conjunctival Blood Flow and Oximetry" (PhD PROGRAM)

KEIR, NJ.: "Customised LASIK: A procedure to optomise visual performance following refractive surgery (Based on current ORE study #12000)" (PhD PROGRAM)

ROBINSON, B.E.: "Awareness of Age-related Macular Degeneration"

ROGERS, R.: "Wettability Over Time of Ex Vivo pHEMA Contact Lenses" (MASTER'S DEGREE PROGRAM)

SITU, P.: "Clinical Assessments of Corneal Neural Function and Morphology in Contact Lens Wearers" (PhD PROGRAM)

SRINIVASAN, S.: "Diurnal variation of the tear meniscus height determined by Optical Coherence Tomography in patients with and without dry eye symptoms" (PhD PROGRAM)

STEPHENSON, C.: "Continuance of 'Library Information Resources & Services for Canadian Optometrists' program"

SUBBARAMAN, L.N.: "An in vitro comparison of the Kinetics of Lysozyme Denaturation on Silicone Hydrogel and Conventional Hydrogel Contact Lenses" (PhD PROGRAM)

WALKER-COULTICE, L.: "Historical Archive Project"

ZHANG, F.: "Kinetics of Lysozyme Penetration on Contact Lens Materials by Confocal Microscopy" (MASTER'S DEGREE PROGRAM)

ECOLE D'OPTOMETRIE, UNIVERSITE DE MONTREAL

CARCENAC, G., KERGOAT, H.: "Assessment of vision problems experienced by elderly long-term care patients in a university geriatric hospital, with a view to improving the quality of vision care provided" (PhD PROGRAM)

CHARLES, N., WODDELL, A.: "Assessment of the number of bubbles in the pupil area with the piggyback system"(PhD PROGRAM)

RENAUD, J.: "Quality of life and social participation in the visually impaired elderly"
(PhD PROGRAM / Supervisor Dr M.J. Durand - Université de Sherbrooke)

VISION INSTITUTE

CHIARELLI, C.: "Stereoacuity Tests"

CHRIS, A.P.: "Vision Services for Family Shelter Residents"

INDEPENDENT PRACTITIONER

KUMAR, S.: "Cultural changes in blindness prevention for remote, rural & indigenous populations through innovative medical, information and communication technology"

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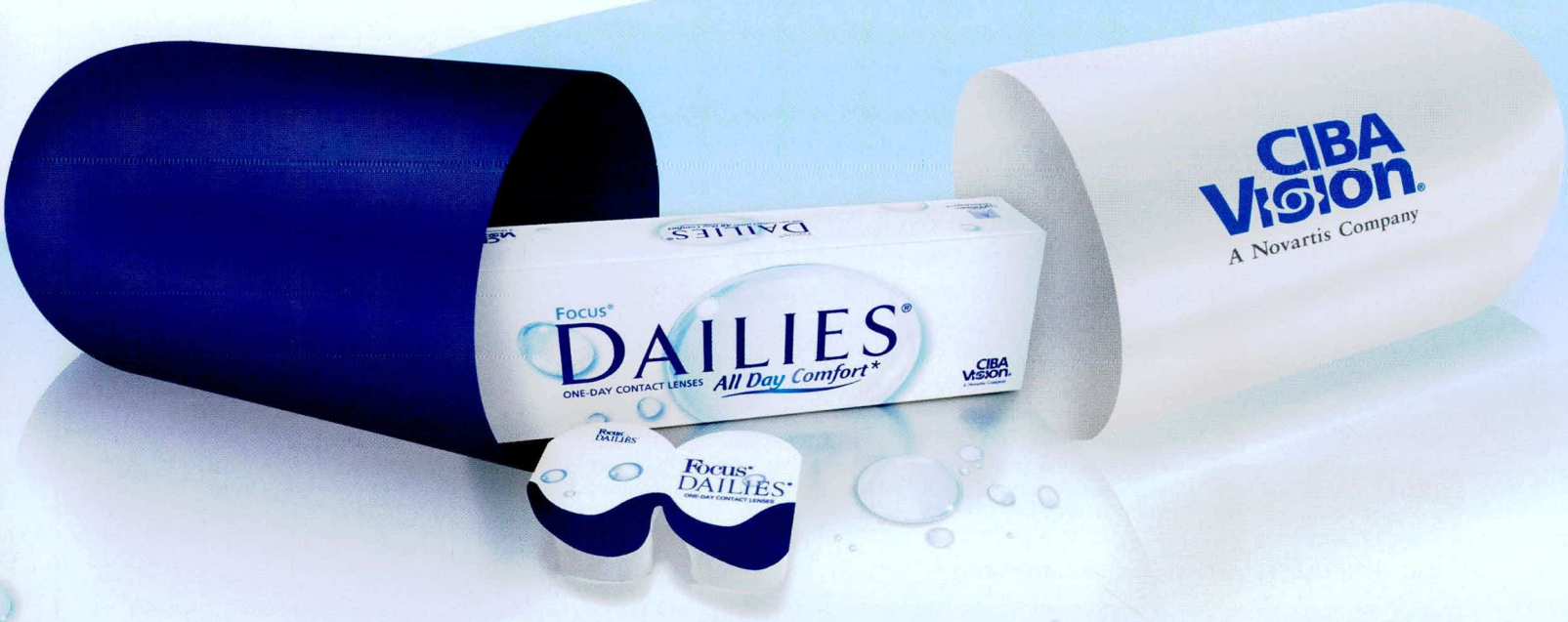

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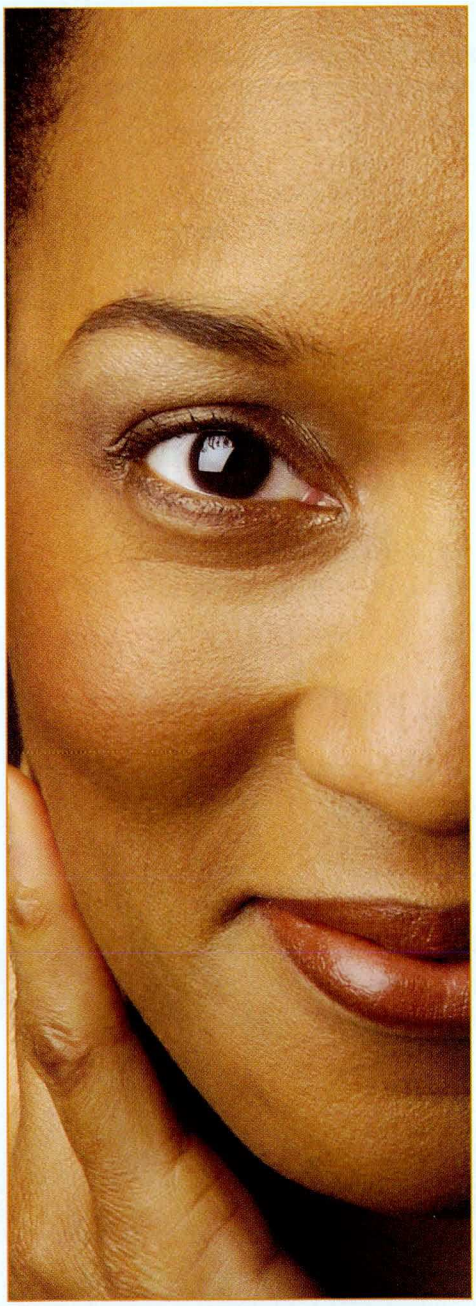
Media Gratis



Doris Mirella
CAO, Director of Communications

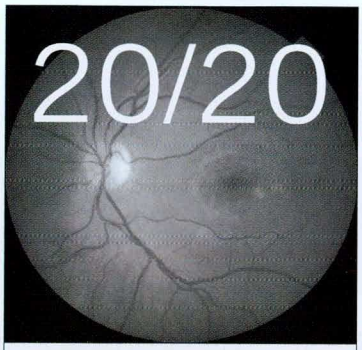
Quick Facts:
The National Public Education Committee (NPEC) is responsible for the operation of the Eye Health Council of Canada (EHCC), which is the public relations division for CAO. NPEC delivers a national public awareness campaign through the purchase of advertising and the co-ordination of member activities including the Eye Health Canada Month. NPEC is also responsible for maintaining contact with the ophthalmic supplier community, to establish industry partnerships in the EHCC and to coordinate partner activities.

Media doesn't come free, … or does it? To some extent, there are possibilities that are available for not-for-profit organisations, such as the Canadian Association of Optometrists (CAO). With ready media tools in one hand and a creative approach in the other, the National Public Education Committee (NPEC) has devised a number of different strategies to carry the momentum of the national paid media.

There is not a simple instruction manual that can address all the different opportunities and possibilities for getting an extended and 'free' eye health message in the public realm. It involves a number of different strategies, including negotiating 'value-added' to the national paid media, providing ready Public Service Announcements (PSAs) to TV stations, preparing print PSAs that target the public as well as health care professionals, and leveraging potentials with the Eye Health Council of Canada (EHCC) to coordinate a concerted effort regarding eye health awareness.

Before listing the '*gratis*' opportunities and potentials, it is equally important to know what sustains this effort. As you may know, this year the paid media is being exclusively invested in television using a combination of 30-second and 10-second TV ads. The video format for the eye health message is a powerful unit that speaks directly to the unique challenge of changing public attitude regarding eye health.

One gentleman from Quebec saw the ad last year and was encouraged to make an appointment for him and his son. The eye examination revealed that Mr Holtzman's son,



DOESN'T EQUAL PERFECT VISION

This person is seeing 20/20 but her retina is showing early signs of Macular Degeneration (AMD) - she is one of over 72,000 Canadians who will lose their sight to AMD this year alone. In a recent study, 15% of asymptomatic patients who went for an eye health exam in Canada had eye disease. To find out more, request a copy of "*A guide to an optometrist's role in caring for your patient*", at info@opto.ca.

Please, for patients of all ages, ASK: "When was the last time you had your eyes checked?" - The question is simple. The outcome is profound.

YOUR EYES *deserve* AN OPTOMETRIST

www.opto.ca

The Canadian Association of Optometrists

FAMILY PHYSICIANS *(left)*: Bilingual Public Service Announcements were developed and provided to the Canadian Family Physician's for its national publication, "Family Medicine Journal". The PSA appeared in the May issue of the journal and is expected to be picked up for future issues. A special thank you goes to Melissa Secord, Assistant Executive Director of the Ontario Association of Optometrists, for making this possible.

CO-OP ADVERTISING: CAO / CIBA ad has a total of 15 placements in *Chatelaine*, *Homemakers* and *Today's Parent* in a Spring and Fall flight schedule. The ads prominently advocate the CAO brand, "*Your eyes deserve an optometrist*".

Eric, had a swollen optic nerve head. After MRIs and other tests, it was discovered the boy had a mass in his sinus cavity that needed to be removed immediately:

"I am writing to you to say thank you for getting the message across to Canadians on how important it is to have your eyes checked. … I kept on seeing the commercial which you run on CTV regarding regular health care of your eyes and visiting an Optometrist. My son could have lost his eyesight and possibly something worse could have developed. … I wish you all the very best and thank you again for a brilliant marketing campaign which helped my family!"

The national campaign has also received encouraging feedback from its members, including Dr Neepun Sharma from Sherwood Park Alberta:

'This is the most feedback I've gotten on an NPEC ad. Patients that have not had their eyes examined in over 10 years are coming in. In the last two weeks, I've had 10 new patients that saw the ad and thought they should come in."

While the national paid media is the necessary starting point for promoting guaranteed exposure and comprehensive awareness, NPEC continues with its efforts to further extend the message in non-paid media venues. An excellent example of this is shown through its use of video format PSAs. These are no-charge airings of commercials that satisfy specific Canadian Radio-television and Telecommunications Commission (CRTC) criteria. To meet the criteria you will notice that the 30 second PSA uses the COETF logo (versus the CAO logo). This is because the COETF is a registered charity, a key requirement to qualify as an official PSA.

The national PSA was submitted to various stations. Qualifying ads are run in unsold inventory but are not guaranteed to air; however, the CAO PSA has been approved for free national airplay on the CBC English Network, CBC Newsworld and Country Canada for a one-year period. The CAO PSA has also been scheduled for airing from January 23, 2006 to January 21, 2007 on Report on Business Television. OMNI Television has responded and will likely air the spot. A PSA tracking is in place to monitor the reach and a post analysis on PSA airings will be available at the end of the year.

While NPEC has worked hard in negotiating free air time at a national level, it has also thought to provide members with the tools to approach local TV stations encouraging them to air the PSAs at a community level. Members can access the 30- and 10-second PSAs from the CAO order form, or they can be uploaded at no charge to a dedicated FTP site. As well, a letter that asks TV stations to air the PSA can be downloaded from the CAO member website.

CAO and NPEC encourage members to use these materials and to explore the possibilities in getting this important message out at a community level.

While video is a powerful medium, PSAs in print format have exceptional potential, especially as it is an intelligent echo to the video format of the national message. While the national paid media buy is exclusively invested in TV, NPEC has ensured that the eye health message gets exposure in print.

At the end of 2005, immediately after the EHCC November partner meetings, CIBA approached CAO/

NPEC regarding co-op print advertising opportunities. With an agreement to pursue this effort, NPEC and CIBA collaborated on ad formats and a programming schedule. The co-op ad, shown on page 116, will appear in women's magazines that target the NPEC audience, and, of distinct importance, the ads prominently advocate, "*Your eyes deserve an optometrist*". As with the TV programming, the co-op ads have a total of 15 placements in *Chatelaine*, *Homemakers* and *Today's Parent,* in a Spring and Fall flight schedule.

Thanks in large part to CIBA's leadership and example, EHCC partners signaled great interest at the 2006 Roundtable in learning more regarding co-op advertising opportunities with CAO. Getting industry dollars to promote preventive eye health examinations to Canadians is a noteworthy achievement for optometry. Dr Lillian Linton, chair of the NPEC, is to be thanked in for realizing this project and the potentials it carries for the profession.

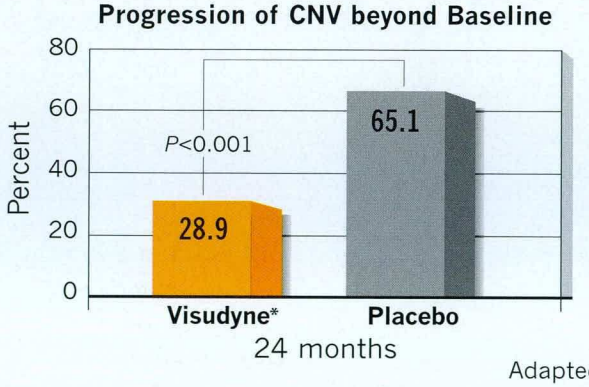
With great effort directed towards the target audience, NPEC also used its resources to connect to family physicians. In tune with the new CAO brochure for health care professionals "*A guide to an optometrist's role in caring for your patient*", bilingual PSAs were developed and provided to the Canadian Family Physician's for its national publication, "*Family Medicine Journal*" (see page 116). The PSA appeared in the May issue of the journal and is expected to be picked up for future issues. A special thank you goes to Melissa Secord, Assistant Executive Director of the Ontario Association of Optometrists, who made this possible.

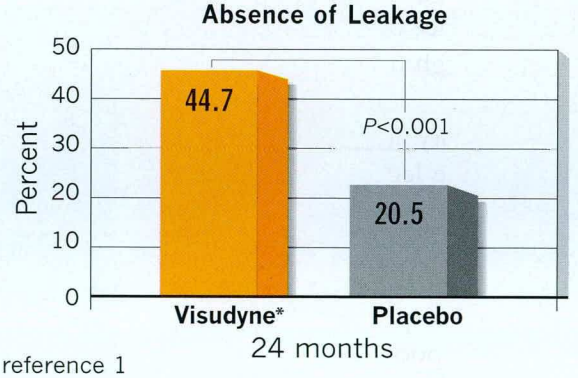
While paid media and non-paid media continues to be a priority for NPEC, the greatest resource it has available is the membership base. NPEC continues to encourage members to tie into the national communications program and resources, which reinforce the tone and message of the national media buy and core message regarding preventive eye health.

THE WORLD IS BEAUTIFUL > TO LOOK AT

Pr Visudyne* 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.

NOVARTIS OPHTHALMICS

Novartis Ophthalmics
Novartis Pharmaceuticals Canada Inc.
Mississauga, ON L5N 2X7
T: 1-866-393-6337 F: 1-866-467-4842

* Visudyne is a registered trademark

PAAB

See prescribing information for references.

Visudyne verteporfin for injection

VIS-051114E

Pathological Myopia

from page 102

Moderate myopic retinal degeneration is evident in the left eye. This is consistent with the level of refractive error predicted by the residual aphakic refraction. Myopia greater than 6D is considered to be pathological. It is caused by elongation of the globe, with characteristic fundus changes. Within the posterior pole, a temporal peripapillary atrophic crescent is seen and the retinal pigment epithelium is stretched and atrophic, causing increased visualization of choroidal vessels. Posterior staphyloma often forms, causing ectasia and outpouching of the retina, with associated pigmentary changes and variable loss of retinal function. Peripherally, there is a higher incidence of lattice degeneration, pavingstone degeneration, vitreo-retinal degeneration and retinal holes in pathological myopia. In this case, non-specific peripheral retinal degeneration is observed. There also is a higher occurrence of nuclear and posterior subcapsular cataracts in high myopia, and an increased risk of glaucoma.

The ocular history in this case is unconfirmed. It is assumed that the lens of the left eye was removed surgically, perhaps to remove a congenital cataract and/or to reduce the degree of anisometropia. Such treatment might permit refractive correction with spectacles and thereby improve the potential for visual development in the left eye after poor tolerance and compliance with contact lens correction. Unfortunately, any spectacle treatment plan was not followed through, and deep amblyopia has resulted. At this time, the prognosis for amblyopia therapy is quite poor, considering the constant exotropia, anisometropia, severely reduced visual acuity and the child's age.

A strategy to maximize remaining visual function is crucial to this hearing-impaired child. Full prescription polycarbonate spectacles were prescribed for constant wear, for eye protection. The importance of eye safety was explained to the child, with emphasis on the implications of being deaf *and* blind, should any injury damage the right eye. The responsibility for wearing protective glasses was assigned to the child, as he is old enough to comprehend the situation.

Compensatory strategies for home and school also were discussed:

1. *visual materials for learning and communication are to be placed on the right side*
2. *seat assignment in the classroom is to be on the left side of the room*
3. *interaction with people for lip-reading and sign language is to be on the right side*
4. *classroom work is to be modified for reduced copying and scanning from blackboard to desk*
5. *extreme caution and safety goggles are to be used for sports activities; contact sports are to be avoided*
6. *orientation and mobility training are to be considered, to teach compensatory safety skills in view of reduced depth perception and functional peripheral vision, so that greater independence may be permitted*
7. *an education and counselling session with the child, his parents and his teachers is to be held so that all parties understand the importance of these strategies*

The prognosis to maintain good vision in the right eye over time is favourable, provided that protection of this eye is maintained. The left eye, however, remains at risk for myopia- and aphakia-related complications, including subretinal hemorrhage, laquer cracks through the RPE, choroidal neovascularization, peripheral retinal breaks, retinal detachment and glaucoma. Regular examination, every 6-12 months, is recommended.

This hearing-impaired child's overall visual function is compromised, due to the visual impairment in the left eye. This will have significant implications in the development of communication, cognitive and learning skills throughout his life. Intervention to address these issues should have been initiated in infancy, or immediately upon diagnosis of the hearing impairment.

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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* Visudyne is a registered trademark

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1. Treatment of Age-Related Macular Degeneration With Photodynamic Therapy (TAP) Study Group. Photodynamic Therapy of Subfoveal Choroidal Neovascularization in Age-Related Macular Degeneration with Verteporfin. TAP Report 2. Arch Ophthalmol 2001;119:198-207

PAAB

VIS-051114

The need for deaf children to undergo early vision examination is widely recognized. The incidence of vision problems in deaf children is at least 2-3 times greater than in hearing children. The literature reports that up to 43% have significant ocular and/or vision problems, including refractive error, strabismus, amblyopia or retinopathy associated with systemic conditions. Unfortunately, there is no established standard of care to provide routine vision care to all deaf children, either through medical facilities or schools. As a result, vision problems may go undetected and untreated for many years.

In Toronto, a partnership has been established between the Vision Institute of Canada, the Toronto District School Board and a local school for the deaf. The '*Eyes to the Future*' committee ensures that all children undergo a comprehensive vision examination, with treatment and follow-up as needed. To date, 25% of children have been newly diagnosed with vision problems through the program. Diagnoses include refractive errors, strabismus, psychogenic visual impairment, accommodative esotropia, retinopathy and one case of Usher's Syndrome. Overall, approximately 43% of children have a significant vision problem requiring treatment.

Optometrists in all communities are encouraged to promote their services to schools and caregivers for deaf and hard-of-hearing students. The service is greatly needed in many cases, and it is a uniquely rewarding experience.

Myopie pathologique

from page 103

La dégénérescence rétinienne myopique modérée évidente à l'œil gauche est conforme au niveau d'erreur de réfraction prévu par la réfraction aphake résiduelle. Une myopie au-delà de 6D est considérée comme pathologique. Elle est causée par l'allongement du globe oculaire et elle présente des modifications caractéristiques du fond de l'œil. Au pôle postérieur, on voit un croissant atrophié péri-papillaire temporal, et l'épithélium pigmentaire rétinien est étiré et atrophié, causant une visualisation accrue des vaisseaux choroïdiens. Il se forme souvent un staphylome postérieur, causant une ectasie et une enflure de la rétine, avec modifications pigmentaires associées et perte variable de la fonction rétinienne. En périphérie, la myopie pathologique comporte une plus grande incidence de dégénérescence palissadique, de dégénérescence maculaire, de dégénérescence vitréo-rétinienne et de trous rétiniens. Dans ce cas-ci, on observe une dégénérescence rétinienne périphérique non spécifique. Il y a également beaucoup plus de cataractes sous-capsulaires postérieures et nucléaires dans les cas de myopie avancée, et un risque accru de glaucome.

Les antécédents oculaires dans ce cas-ci ne sont pas confirmés. On présume que le cristallin de l'oeil gauche a été retiré chirugicalement, peut-être pour enlever une cataracte congénitale et/ou réduire le degré d'anisométropie. Un tel traitement pourrait permettre une correction de la réfraction au moyen de lunettes et, par conséquent, améliorer le développement visuel de l'œil gauche à la suite de la faible tolérance et de la négligence entourant la correction par lentilles de contact. Malheureusement, il n'y a eu aucun traitement avec des lunettes et une grave amblyopie a suivi. À ce moment-ci, le pronostic d'un traitement de l'amblyopie est très peu reluisant, si l'on tient compte de l'exotropie continuelle, de l'anisométropie, de l'acuité visuelle gravement réduite et de l'âge de l'enfant.

Il est de la plus haute importance d'optimiser la fonction visuelle restante chez cet enfant malentendant. On a prescrit des lunettes en polycarbonate à port permanent pour protéger l'œil. On a expliqué à l'enfant l'importance de protéger l'œil et les conséquences d'une cécité *et* d'une surdité à la suite d'une blessure à l'œil droit. On a attribué à l'enfant la responsabilité de porter ses lunettes de protection, car il est suffisamment âgé pour comprendre la situation.

On a aussi discuté de stratégies compensatoires pour l'école et la maison :

1. *placer le matériel visuel d'apprentissage et de communication à la droite de l'enfant*
2. *asseoir l'enfant du côté gauche de la classe*
3. *les intervenants pour la lecture labiale et le langage gestuel devraient être placés à la droite de l'enfant*

4. *diminuer en classe le travail de copie et de visualisation au tableau*
5. *extrême prudence et lunettes de sécurité pour les activités sportives; éviter les sports de contact*
6. *rééducation de l'orientation et de la mobilité pour donner à l'enfant des capacités compensatoires sécuritaires en raison de sa perception de la profondeur et de sa vision périphérique fonctionnelle réduites, ce qui lui permettrait une plus grande autonomie*
7. *tenir une rencontre d'aide et de formation avec l'enfant, les parents et les enseignants afin que toutes les parties comprennent l'importance de ces stratégies*

Le pronostic de maintenir une bonne vision de l'œil droit au fil du temps est favorable, à condition de protéger cet œil. Toutefois, l'œil gauche demeure à risque d'être affecté par des problèmes liés à la myopie et à l'aphakie, comme une hémorragie sous-rétinienne, des bris en laque de l'EPR, l'apparition d'une néovascularisation choroïdienne, des altérations rétiniennes périphériques, un décollement de rétine et un glaucome. On recommande un examen régulier tous les 6 à 12 mois.

Comme la fonction visuelle globale de cet enfant malentendant est compromise en raison du handicap visuel de l'œil gauche, elle aura des incidences significatives sur le développement des habiletés de communication, cognitives et d'apprentissage tout au long de sa vie. On aurait dû intervenir dès l'enfance pour répondre à ces problèmes ou immédiatement après le diagnostic du handicap auditif.

On reconnaît généralement la nécessité pour les enfants malentendants de subir un examen visuel précoce. L'incidence de problèmes visuels chez les enfants malentendants est au moins deux à trois fois plus élevée que chez les enfants sans problème d'audition. Selon la documentation, jusqu'à 43 % d'entre eux ont des problèmes oculaires et/ou visuels majeurs, comme l'erreur de réfraction, le strabisme, l'amblyopie ou la rétinopathie associées à des états systémiques. Malheureusement, on ne trouve aucune norme de soins prévoyant des soins de la vue réguliers à tous les enfants malentendants par l'entremise d'institutions médicales ou scolaires. Voilà pourquoi de nombreux problèmes visuels peuvent demeurer non détectés et non traités pendant une longue période.

À Toronto, on a établi un partenariat entre le Vision Institute of Canada, le Toronto District School Board et une école locale pour sourds. Le Comité « *Eyes to the Future* » fait en sorte que tous les enfants reçoivent un examen de la vue complet avec traitement et suivi au besoin. Grâce au programme, on a récemment diagnostiqué des problèmes de la vue chez 25 % des enfants. Les diagnostics incluent : erreur de réfraction, strabisme, handicap visuel psychogène, ésotropie accomodative, rétinopathie et un cas de syndrome de Usher. Globalement, environ 43 % des enfants ont un problème de vision important nécessitant un traitement.

On invite les optométristes de toutes les collectivités à offrir leurs services aux écoles et aux aidants travaillant auprès d'élèves sourds et malentendants. Ce service est urgent dans beaucoup de cas et représente une expérience très enrichissante.

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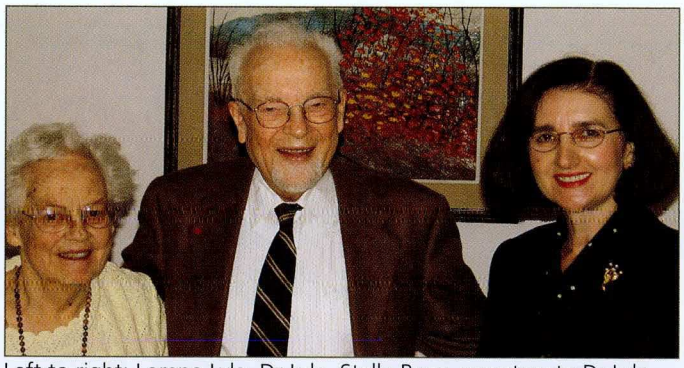

Left to right: Lorena Lyle, Dr Lyle, Stella Ruza, secretary to Dr Lyle

William Montgomery LYLE

(1913~2006)

by T.D. Williams

Dr Lyle was born 4 October 1913 in Summerside, PEI, and died on 17 March 2006 in Kitchener, Ontario. He studied at the College of Optometry of Ontario in Toronto, graduating in 1938. Dr Lyle practised Optometry in Manitoba from 1938 to 1942. In 1941, Dr Lyle joined the Royal Winnipeg Rifles as a second-lieutenant. After military training in Canada and England, Dr Lyle landed in France with reinforcements in late June of 1944 (*D-day was on 6 June 1944*). He was at that time second in command of an anti-tank platoon, and continued with this unit until the end of hostilities in Europe in May 1945. Dr Lyle saw action in Caen and Calais, France, in Belgium, and participated in the liberation of Holland. He was discharged with the rank of Captain.

In 1946, Dr Lyle resumed his optometric practice in Manitoba. He received his Doctor of Optometry degree in 1958. From 1955 to 1957, Dr Lyle served as President of the Canadian Association of Optometrists.

Dr Lyle undertook postgraduate studies at the University of Manitoba from 1958 to 1960, after which he began work on his MSc degree at Indiana University. He completed the MSc in 1963, and went on to his doctoral work, receiving his PhD in 1965. Dr Lyle was the first Canadian to receive the Doctor of Philosophy degree in Physiological Optics (*Visual Science*). He served as a lecturer at Indiana University from 1962 to 1965, at which time he returned to the College of Optometry of Ontario.

Dr Lyle joined the University of Waterloo when the Optometry program was integrated into the Faculty of Science there in 1967. Dr Lyle was instrumental in developing the School's pharmacology curriculum, and also served as an expert adviser to provincial bodies regulating the use of pharmaceuticals by Optometrists. He continued on the faculty as a professor and as Director of Clinics (the latter from 1974-1977) until his retirement in 1982. Since that time, he has continued to contribute to the academic life of the School of Optometry in various part-time and adjunct positions.

From 1979 to 1995, Dr Lyle served as Editor of the journal of the American Academy of Optometry, the first non-US citizen to do so. He was the longest-serving editor of the Academy journal.

Throughout his career, Dr Lyle participated in continuing education programs for Optometrists and other health care practitioners. He lectured throughout Canada and the US, as well as in the United Kingdom.

Dr Lyle's research interests were broad, ranging from work on the inheritance of corneal astigmatism sponsored by the US Department of Health, Education and Welfare (*his first publication on this topic appeared in 1951*) to his last project on the genetic bases of eye disease. The latter project generated a large document which was published on the University of Waterloo School of Optometry webpage.

Through his long career, Dr. Lyle received numerous awards and honors: In 1979, Dr. Lyle received the Canadian Association of Optometrists President's award; In 1989, the University of Waterloo awarded Dr. Lyle the title *Distinguished Professor Emeritus*; Also in 1989, Dr. Lyle received the award of *Life Fellowship* in the American Academy of Optometry; In 1999, Dr. Lyle received the H. James Cobean Award from the Ontario Association of Optometrists; In 2000, Dr. Lyle was the recipient of the John H. Carter Memorial Pharmacology Award and Prize, sponsored by Merck & Co.

Dr. Lyle was a member of the following organizations: Canadian and Ontario Association of Optometrists; The Genetics Society of Canada; Association of Schools of Optometry of Canada; Sigma Xi; American Optometric Association; American Academy of Optometry; American Society of Human Genetics; American Association for the Advancement of Science

Dr. Lyle is survived by his wife of almost 50 years, Lorena; his children, Lesley, Joan, and Barb; his grandchildren, Bruce and Amy, Lesley-Ann and Derek, Laura, Lauren and Kaitlyn and his great-grandchildren, Kiera and Rogan. Dr. Lyle was predeceased by his first wife, Helen; brother, Ralph and his wife Thelma.

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1. *Data on file, Bausch & Lomb Incorporated.*
2. *Aston University Technical Report, Birmingham, England; 1997.*

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A contact lens, whether to correct your vision or simply to change eye colour, is a medical device. As such, there are many potential complications that can be prevented with proper lens care. For example, corneal abrasions can occur if a contact lens is not fitted/inserted properly, moves excessively, or if the lens is damaged. As well, a lack of adequate oxygen to the corneal cells can occur if the lenses are not compatible, cleaned properly or are over-worn. An optometrist can vary the contact lens parameters, power, solutions and wearing schedule in order to match visual needs and maintain eye health. For safe and successful contact lens wear, consult with your optometrist.

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