

COLLABORATIVE CARE IN MYOPIA MANAGEMENT: OPHTHALMOLOGY AND OPTOMETRY PERSPECTIVES

Global Specialty Lens Symposium, Friday 20th January 2023, 13:30 to 14:20 PST

Lecture, 1 hour

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Abstract:

This session examines the opportunities and challenges of collaborative care in myopia management, including the current roles of different categories of eye care practitioners and how the extra workload arising from active myopia management should optimally be managed in the future. Most cases for myopia management are ideally managed within an optometric setting, but a few children will have more complex syndromic forms of myopia which require a multidisciplinary approach. We will look at a number of cases and explore how optometric, ophthalmological and shared care options provide best-practice patient care and public health outcomes.

Learning Outcomes: at the conclusion of this course, delegates should be able to:

- Outline the opportunities for better patient and public health outcomes through collaborative care in myopia management
- Describe specific patient presentations which require a collaborative care approach to provide safe clinical care
- Explain further clinical examples of how collaborative care leads to best-practice patient outcomes.

Part 1: Professional roles and cooperation

1. What are the opportunities and challenges of collaboration and co-management?
 - a. Opportunities: including improved patient care; greater access to care; more efficient use of resources and enhanced patient education.
 - b. Challenges: differences in training and scope of practice; limited time and resources and legal and regulatory barriers.
 - c. Importance of collaboration: for safe patient care in 'red flag' cases; overcoming limitations of scope or setting of practice to provide best-practice patient care
2. Should Optometrists or Ophthalmologists be taking the lead role in myopia control?
 - a. Access to care indicates that optometry needs to take a lead role on the basis of the large number of young myopes who could benefit from myopia control and the greater number of optometrists as compared to pediatric ophthalmologists
 - b. Biometry devices (in particular optical axial length devices) are far more prevalent in ophthalmological setting. Until axial length measurement devices become standard in optometric practices, co-management may have a role
 - c. International variations in optometric recognition and scope of practice will have a major impact on the relative contributions of optometry and ophthalmology.
3. Are there any types of myopes that are best managed in secondary or tertiary care settings?
 - a. Myopia of prematurity
 - b. Syndromic myopia
 - c. Myopia combined with neuro-developmental disorders
4. Are ophthalmologists more likely to prescribe pharmacological treatments as a first line treatment and will optometrists prescribe optical treatments as a first line?
 - a. Is that a rational approach to management?
 - b. What communication is needed if either practitioner adds an additional intervention
5. Are current optical prescriptions issued by ophthalmologists fit for purpose?
 - a. Do we need a new type of prescription for myopia control?
 - b. How specific should a myopia control optical prescription be?
6. Do any other eye conditions provide a good framework for a shared care model in myopia control?
 - a. Glaucoma
 - b. Strabismus
 - c. Amblyopia

Part 2: Case studies

1. The very young myope.

- a. Case AB, age 3, family history of high myopia in one parent
- b. Presents to optometrist:
 - i. dry retinoscopy OD(R) -4.00/-1.00x180 and OS(L) -5.25/-1.50x180
- c. Acuity difficult to measure, no strabismus
- d. Clinical care considerations: vision correction, myopia management, ocular health, general health
- e. Optometrist and ophthalmologist role in management of this case

2. The astigmatic myope.

- a. Case CD, age 13, no family history of myopia
- b. Presents to optometrist:
 - i. refraction 12 months ago was OD(R) -1.00/-1.50x30 and OS(L) -0.75/-1.25x25
 - ii. refraction today OD(R) -2.00/-2.50x35 and OS(L) -2.00/-2.75x28
- c. Clinical care considerations: progressive myopia and astigmatism, vision correction, myopia management, ocular health diagnostics and management
- d. Optometrist and ophthalmologist role in management

3. The familial myope.

- a. Case EF, age 9, both parents are high myopes
- b. Presents to ophthalmologist:
 - i. Vision reported as normal until recently, refraction now OD(R) -1.25 and OS(L) -1.00/-0.50x170
 - ii. Accuity normal with correction, no strabismus
 - iii. Axial length measured as OD(R) 24.4mm OD(L) 24.2mm
- c. Clinical care considerations: vision correction, myopia management, ocular health monitoring, ongoing diagnostic measurement, patient and parent education
- d. Optometrist and ophthalmologist role in management.

4. The young adult myope.

- a. Case GH, age 22, studying law full time
- b. Presents to ophthalmologist:
 - i. Myopia reported as stable, glasses 3 years old OD(R) -4.50 OS(L) -3.75
 - ii. Acuity with current correction is OD(R) 20/30+ or 6/9+ and OS(L) 20/25+ or 6/7.5+
 - iii. Fundus examination reveals lattice degeneration in R inferior retina
 - iv. Axial length measured as OD(R) 25.2mm and OS(L) 25.0mm
- c. Clinical care considerations: vision correction, myopia management, ocular health monitoring
- d. Optometrist and ophthalmologist role in management.

