ERDEY EYE GROUP
Vision For Life

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The Best VisioNewsletter

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"20/30…Why can't I see 20/20?"

Inevitably, we have all examined the otherwise young healthy patient who does not achieve 20/20 and the patient exclaims… "Why only 20/30, doctor?" It's one of those cases in which you are expecting to finish the long day with your pleasant, healthy 35 year old and everything prove normal. Then, you get thrown that curveball and if you are not on your toes it can be much more challenging. We hope to provide some insight so these patients won't strike you out in the ninth!

Don't be fooled by the simple things. Examine the tear film quality and quantity and use your manual keratometer to assess consistency. Give them a mild artificial tear drop and see if the acuity improves. Check your phoropter lens and the patients' vertex distance. Watch for a steamed up lens – it happens. Are they an extended contact lens wearer with mild corneal hypoxia and edema? These patients may see fine in their cls but the spectacle refraction may be 20/30+. Put a rigid contact lens on them temporarily and if they come down to 20/20 – they likely have irregular astigmatism from contact lens overwear. Corneal topography can confirm warpage or form fruste keratoconus. Check their stereo at near and make sure they are not suppressing an eye. Pull out the red-green specs and check your Worth Dot at distance. Are they anisometropic and possibly amblyopic? Just be careful not to assume amblyopia without a good history and ruling out these other issues first. Some people get lenticular changes sooner than you expect but may not jump out at you on the initial slit lamp exam. Take your direct ophthalmoscope and look at their red reflex from arms length. Are the reflexes equal and is there any PSC developing? Any obvious macula/retina abnormalities? New onset mildly decreased vision in one eye of a 40 yo with normal appearing macula could represent central serous maculopathy. A fluorescein will reveal the macula leakage that may not be as apparent in fundus exam. Double check the pupillary response to rule out an afferent pupillary defect (APD). A grade 1 APD can easily be missed if you do not watch closely. Take a few seconds to do a red cap desaturation test as this can also give you a quick idea of optic nerve quality. Screen the patient with color vision plates if you have not done this yet. A visual field may revealing. Hopefully you do not have to run all the above tests to get to your answer but many of them take only several seconds to perform. When all is said and done maybe 20/30 is the best corrected vision in that eye, with mild amblyopia if anisometropic. Bring them back in a month to see if they still measure 20/30. Using a methodical and confident approach will allow you and the patient to sleep better at night!

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We dedicate ourselves to enhancing the quality of life for every individual whose life we touch, by helping each to see his or her best, and by preserving our patients' vision and eye health throughout life.

It Is Our Pleasure To Announce

WILBUR C. BLOUNT, M.D., FACS FICS
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