Eye Care for the Elderly

There should, of course, be a suitable balance between quality and quantity. An excessive emphasis on quality will reduce the number of procedures carried out. Spending more time, resources and effort on fewer people may mean that there is less overall benefit to the population. In fact, quality and quantity can improve together as long as efficiency and accuracy are maintained. Pushing too hard for quantity will inevitably degrade quality and vice versa.

Compliance

Successful treatment of chronic blinding eye conditions such as glaucoma or diabetic retinopathy depends on the compliance of the patient. In both cases treatment is required before there is an obvious problem for the patient. This means that the doctor must carefully explain the purpose of the treatment in terms which the patient can understand. It is all too easy for the doctor to blame the patient for failure to comply but it is the doctor’s responsibility to ensure that the chosen treatment is acceptable and its purpose fully understood. Elderly patients from rural communities may have considerable difficulty in accepting the word of a strange doctor that, unless something is done, worse will follow. Many of the patients attending the glaucoma clinic in Queen Elizabeth’s Hospital, Bridgetown, Barbados preferred to ‘put their trust in the Lord’ than to do as the white doctor ordered and use pilocarpine four times a day.

Thus medical treatment of glaucoma is so often unsuccessful. Patients may be happy to comply with a ‘course’ of treatment for a definite time, but long term treatment is not an attractive proposition, especially when the patient is unaware of benefit. Given that facilities for follow up are often so poor, one time surgical intervention is often the only real option. But every effort must be made to ensure that the patient fully understands the purpose of the operation before surgery, and that there is no expectation of seeing better after surgery.

Although treatment at present is very rarely effective in preventing sight loss from age-related macular degeneration, much can be done to rehabilitate the affected person. Again, for this to work, the patient must be willing and motivated to benefit from the support offered. An elderly person who has lost sight is often, not surprisingly, depressed. This must be overcome if the rehabilitation is to be effective. In dealing with this type of problem, the doctor must understand the impact of loss of sight. Much of this is similar to the stages of bereavement in the loss of a loved one: denial, anger, profound sorrow and self pity, despair and hopelessness. This was well described in a recent article by Fitzgerald and Parkes.

The Elderly Person’s Perspective

If we wish to be successful in improving the quality of life of our ageing populations, we must be careful to view things from their perspective. Elderly people are usually cautious and conservative; they tend to distrust new and unfamiliar things. They are aware of their vulnerability and are conscious of time and effort to gain acceptance for something we implicitly believe in.

Reference


The analysis applied to relatively narrow definitions of POAG. If ‘probable’ cases and also ‘ocular hypertensives requiring treatment’ (of relevance for glaucoma screening) were included, the prevalence would be almost twice as high. Also, a larger proportion of potential cases for a screen would be less than 55 years old, partly because the average age of incident (i.e., newly developed) cases is less than that of prevalent (i.e., all existing) cases.

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* Ferndale, Wales (1966); Framingham, USA (1977); Baltimore, USA (1991); Beaver Dam, USA (1992); Roscommon, Eire (1993); Rotterdam, Netherlands (1994); Casteldaccia, Sicily (1995); Blue Mountains, Australia (1996).

Abstract

The age distribution of primary open angle glaucoma

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Prevalence data for primary open angle glaucoma (POAG), taken from eight population surveys,* was smoothed by curve-fitting to derive composite estimates with respect to quinquennial age groups from 40-44 to 85-89 years. These were applied to national population figures to provide a distribution of cases with respect to age.

Estimated prevalence for age 40-89 years in mainly white Caucasian people was 1.2%, rising from 0.2% for those in their 40s to 4.3% for those in their 80s. Of the total cases, 7% were less than 55 years old, 44% were aged 55-74 years, and 49% were older. ‘Implied incidence’ was estimated from the prevalence results, being 0.11% per year in people aged 55 to 74 years.

The analysis applied to relatively narrow definitions of POAG. If ‘probable’ cases and also ‘ocular hypertensives requiring treatment’ (of relevance for glaucoma screening) were included, the prevalence would be almost twice as high. Also, a larger proportion of potential cases for a screen would be less than 55 years old, partly because the average age of incident (i.e., newly developed) cases is less than that of prevalent (i.e., all existing) cases.

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