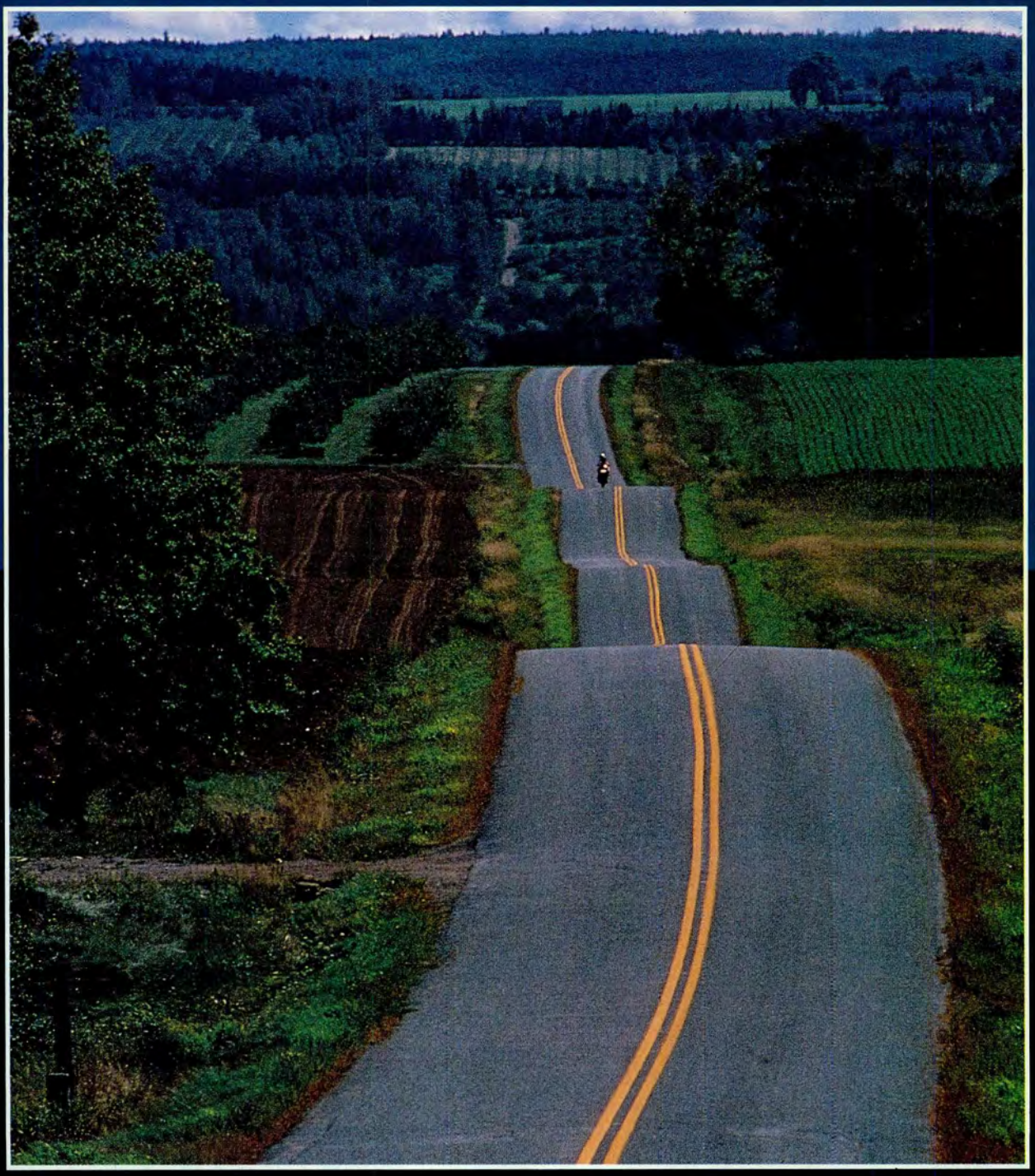
CANADIAN JOURNAL OF OPTOMETRY REVUE CANADIENNE D'OPTOMÉTRIE

CJO RCO

VOL. 53 NO. 1 SPRING/PRINTEMPS 1991



In this issue: The Canadian Association of Optometrists' 1990 Annual Report

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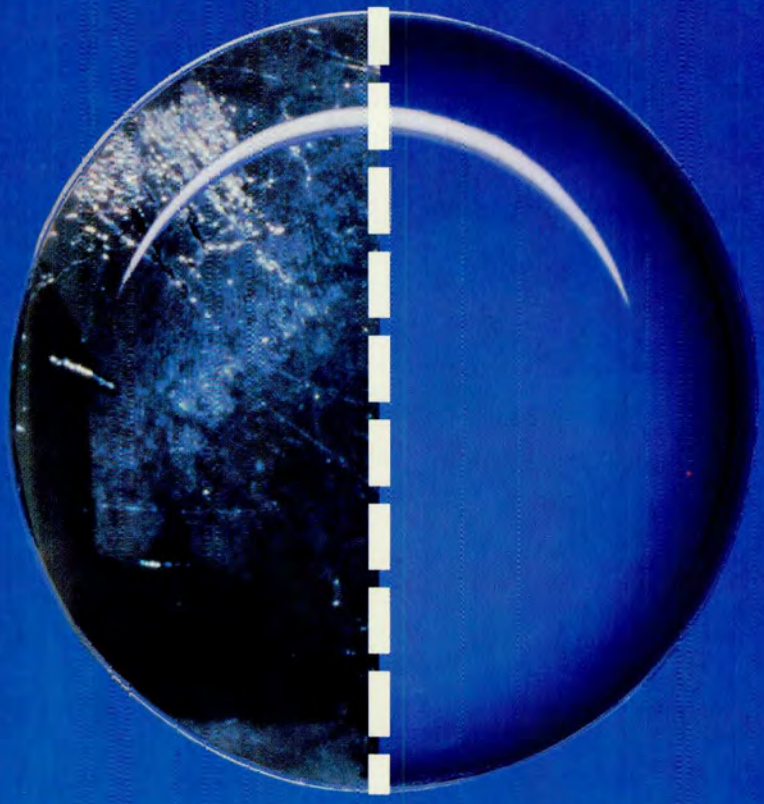

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Canadian Journal of Optometry • la Revue canadienne d'optométrie
Vol. 53, No. 1
Spring / Printemps 1991
ISSN 0045-5075

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Printing / Impression
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Translation / Traduction
Tessier Translations / Les Traductions Tessier

Cover / Couverture
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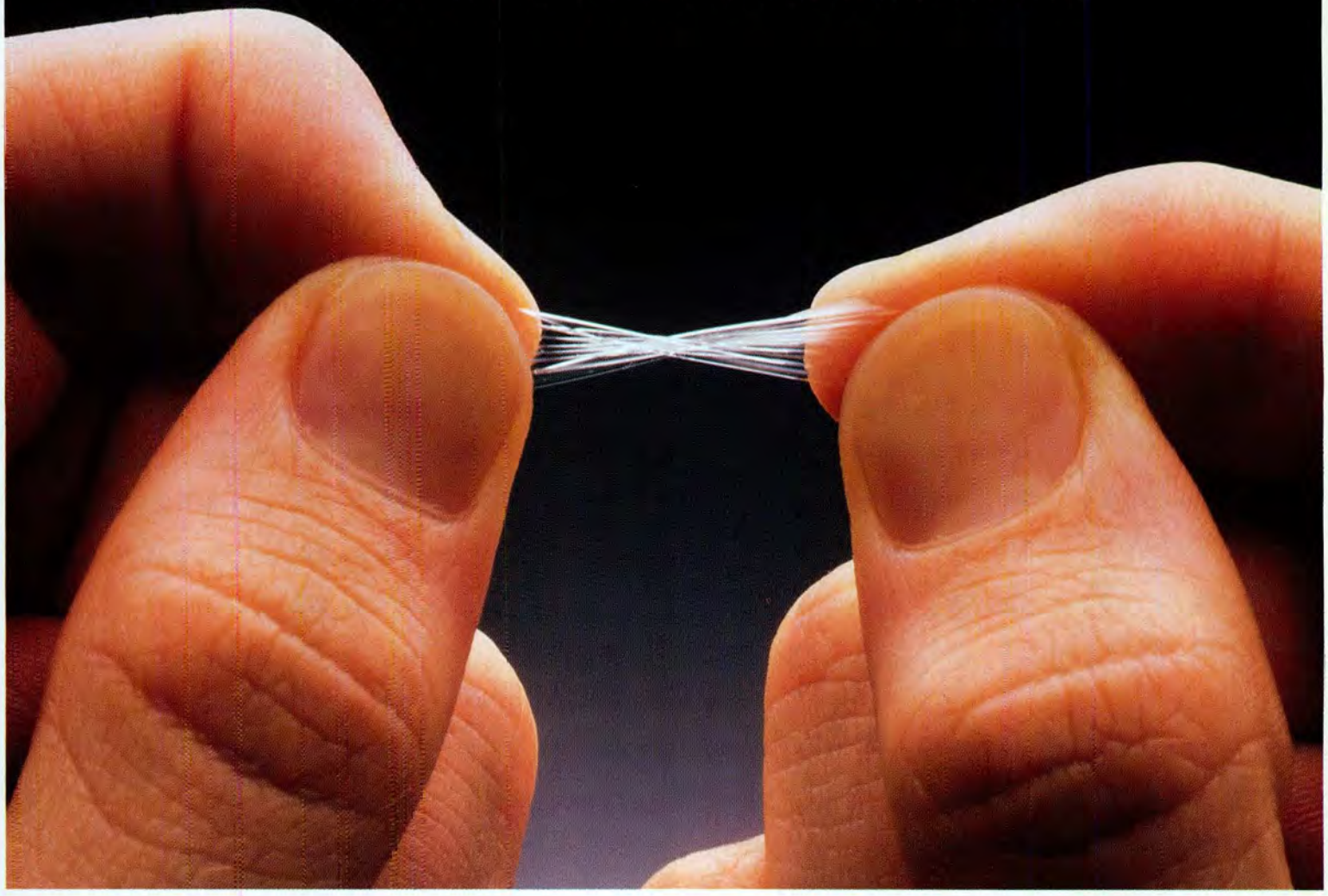

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Editorial

Éditorial

Our Journal

Over the past several issues, the editorial and administrative staff have been making changes to the format and operations of the *CJO*RCO*. The most obvious change this issue is the cover, which we believe not only attracts attention in a visually striking fashion, but also characterizes the nature of our profession as suggested by the visible light spectrum on the masthead, as well as in the "visual" aspects of the cover as a whole.

The second most obvious change, beginning with this issue, is with the format and layout. The clinical papers are presented in a cleaner fashion, with a much "crisper" appearance. This change presents a more professional quality to the journal, and offers, we feel, a more readable, less cluttered format. Additionally, to help differentiate the scientific, clinical papers from general business matters and vision and eye care news items, the latter is now appearing in a three-column format.

In our next issue, we will also be presenting a new set of author guidelines, developed by the American Academy of Optometry, jointly with various optometric publications, and endorsed by this journal. Further to this, our review process for submitted articles, case studies and clinical comments has been enhanced, a process which now ensures adequate and appropriate evaluation that speaks to the scientific and/or clinical merit of each published paper.

On the administrative front, we are pleased to welcome Heather Ebbs to our production team. As Managing Editor, Heather's role will encompass many of the aspects of production co-ordination necessary to publish the journal to a consistent and reliable timetable. Heather has had extensive experience in the editorial arena and has won an award for her editorial abilities. Her arrival will permit us to meet new publication deadlines more effectively and has already allowed us to capitalize on her skills in the areas of format and design.

Change occasionally brings with it a sense of some disruption and a "glitch" or two may materialize that makes the process of change all the more apparent. We apologize accordingly.

Our purpose has been, and continues to be, to enhance the content and practical relevance of the *CJO*RCO*.

To assist us to that end, your comments concerning all aspects of the journal are most welcome. We consider every suggestion, but hold to the Editors' privilege to accept or reject in the continued best interests of our readers.

MJ Samek, OD, MSc, FAAO

Notre revue

Depuis plusieurs numéros, le bureau de rédaction et le personnel administratif apportent des changements à la présentation et au fonctionnement de la *RCO*CJO*. Le changement le plus évident du présent numéro est la couverture qui, nous le croyons, attire non seulement l'attention par son agencement visuel, mais rend également parfaitement la nature de notre profession, telle qu'évoquée par le spectre lumineux visible dans le cartouche, de même que dans les caractéristiques visuelles de la couverture dans son ensemble.

Le deuxième changement le plus évident, qui commence dans le présent numéro, est la disposition et la présentation. Les documents cliniques sont présentés de façon plus nette, avec un aspect plus «tranché». Ce changement donne à la Revue une qualité plus professionnelle et offre à notre avis une information plus lisible, moins touffue. De plus, pour différencier les communications scientifiques et cliniques des questions d'affaires générales et des actualités oculo-visuelles, nous présentons désormais cette dernière rubrique en trois colonnes.

Dans notre prochain numéro, nous présenterons en outre un nouvel ensemble de directives aux auteurs, préparées par divers journaux d'optométrie et l'American Academy of Optometry, directives appuyées par la Revue. En outre, notre mécanisme d'examen des articles présentés, des études de cas et des observations cliniques a été perfectionné et garantit désormais une évaluation appropriée et pertinente qui rend justice à la valeur scientifique ou clinique de chaque article publié.

Sur le plan administratif, nous annonçons avec plaisir la venue de M^me^ Heather Ebbs à notre équipe de production. En tant que directrice de la rédaction, Heather touchera tous les aspects de coordination de la production nécessaires pour publier la Revue selon un échéancier cohérent et fiable. Heather a acquis une vaste expérience dans le domaine de la rédaction et a obtenu un prix pour ses compétences de rédactrice. Son arrivée nous permettra de respecter plus efficacement les échéances nouvelles de publication et nous avons déjà tiré parti de ses compétences sur les plans de la présentation et du concept.

Les changements s'accompagnent occasionnellement de certains chambardements; un «pépin» ou deux peuvent se produire, rendant d'autant plus apparent le mécanisme de changement. Nous nous en excusons.

Notre objet a été et continue d'être l'amélioration du contenu et de la pertinence pratique de la Revue.

Pour nous aider à cette fin, vos observations et suggestions sur tous les aspects de la Revue sont assurément les bienvenues. Nous analysons toutes les suggestions, mais la rédaction se réserve le privilège de les accepter ou de les rejeter, tout cela dans les meilleurs intérêts de nos lecteurs.

MJ Samek, OD, MSc, FAAO

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President's Podium

Mot du président

"The more things change, the more they remain the same"? Not any more.

As many members are already aware from comments I have made in recent issues of the *CAO President's Communiqué*, as well as in spoken addresses at a number of provincial association AGMs, PEP — a Professional (or Practice) Enhancement Program — is a personal priority of mine. And as President, I am continually stressing its importance to the national Association as well.

To many optometrists, the whole concept of practice enhancement begins at their front doors as their patients enter — and ends when they leave. But this is really only half the program. Certainly, PEP is one's professional image. It is, for example, design considerations like the comfort of your waiting room; it is the ease with which patient traffic flows to and from your examination rooms; it is the position and height of seats and mirrors at your frame bar; and it is the way you present yourselves as professional optometrists, your "chairside" manner, if you like, and how well your office support staff performs, etc., etc.

But there is another, more subtle interpretation which can just as accurately be placed in any definition of "PEP": it is also the way Optometry — organized Optometry — presents itself as a profession. And I believe this aspect of PEP is just as important as making sure your examining room equipment is clean, modern and comfortable.

It seems almost everywhere we turn these days, we are seeing the encroachment of the large, commercial chains on independent Optometry.

If we as a profession do not steel ourselves to the inevitability of this growth, and if we fail to learn to compete with it on an equal footing — then we will be swallowed up just as surely, and just as completely, as independent pharmacy was when it disappeared under the drug mart store fronts.

How many North American pharmacists do you think control their own professional destiny today? The other day I heard the President of a major national drug store chain speaking in an interview where he was describing the chain's approach to sales. He called it "CARE", which stands for Customers Are Really Everything. Note that: "customers", not patients.

And I wonder, is that our future, too?

Perhaps you think not. But who among us, and who among the members of the general public, has not heard or read the advertising by Pearle Vision: "Nobody Cares for Your Eyes More Than Pearle"?

To the public ear, that is a very seductive message.

Regardless of one's "professionalism" as an optometrist in Canada today, the most professional practitioner in the country cannot succeed if he or she has to survive alone. Any one member's survival, in fact, is linked to the survival of the profession as a whole. But the link — the bond — that fastens together individuals and their profession is necessarily tied at both ends.

I realize that is simply another way of phrasing the old cliché, "a chain is only as strong as its weakest link", but its age doesn't diminish at all the truth of the message. And without the survival of the profession, even the best and the brightest of the independent practitioners will eventually be lost — except if they practice in a POL, a Protected Optometric Locality.

«Plus ça change plus c'est pareil»? Plus maintenant.

Tel que mentionné dans les récents numéros du *Communiqué du président de l'ACO*, ainsi que dans mes discours prononcés aux assemblées générales annuelles des différentes associations provinciales que j'ai visitées une de mes priorités personnelles est le Programme d'excellence professionnelle (PEP). En tant que président, j'insiste constamment sur son importance.

Pour nombre d'optométristes, ce concept d'excellence professionnelle commence à l'entrée du patient à son bureau, et se termine à son sortie. Pourtant, ce n'est là que la moitié du concept. Il est certain que le «PEP» est une image de marque. Il suppose, par exemple, des aspects de conception comme le confort de la salle d'attente, la facilité avec laquelle les patients circulent dans les salles d'examens, la place et la hauteur des sièges et des miroirs dans les présentoirs à montures, la façon dont vous vous présentez en tant qu'optométriste professionnel, vos manières d'être, l'efficacité avec laquelle le personnel du bureau fait son travail, etc., etc.

Par contre, il existe une autre interprétation, plus subtile, qui peut tout aussi précisément s'insérer dans toute définition du PEP : c'est aussi la façon dont l'optométrie, «l'optométrie officielle», s'entend, se présente en tant que profession. Je crois que cet aspect du PEP est tout aussi important que de veiller à ce que l'équipement de la salle d'examens soit propre, moderne et confortable.

Il semble que presque partout où nous allions, nous voyons la percée des grandes chaînes commerciales au détriment de l'optométrie indépendante.

Si, en tant que profession, nous ne prenons pas les mesures qui s'imposent devant l'inévitabilité de cette croissance et si nous négligeons d'apprendre à les concurrences sur le même pied, nous serons engloutis, aussi sûrement et aussi totalement que les pharmaciens indépendants sont disparus derrière les façades des pharmacies à grande surface.

Combien reste-t-il de pharmaciens en Amérique du Nord qui contrôlent encore leur propre destinée professionnelle aujourd'hui? L'autre jour, j'entendais le président d'une grande chaîne nationale de pharmacies parler au cours d'une entrevue où il décrivait l'approche commerciale de son entreprise résumé par le slogan «CARE», qui signifie «Customers Are Really Everything». Précisons qu'il parlait de clients et non de patients.

Je me demande si c'est là l'avenir qui nous attend nous aussi?

Peut-être croyez-vous que ce ne sera pas le cas, mais qui, parmi nous, et dans la population en général, n'a pas entendu ou lu la publicité de Pearle Vision : «Personne ne se soucie plus de vos yeux que Pearle»?

Pour la population, c'est un message très séduisant.

Malgré son professionnalisme, l'optométriste canadien, de nos jours, ne peut réussir s'il doit survivre seul. En fait, la survie de chaque membre est liée à la survie de la profession dans son ensemble. Le lien qui unit l'optométriste et sa profession est nécessairement fixé à ses deux extrémités.

Je constate que c'est simplement une autre façon de reformuler le vieil adage «La chaîne qui n'a que la force de son maillon le plus faible»; cependant, l'âge ne diminue en rien la vérité de ce message. Et sans la survie de la profession, même le meilleur et le plus habile des praticiens indépendant finira par tomber, sauf s'il exerce dans un ZOC, un «zone optométrique controlée».

Voici ce que je préconise : il nous faut non seulement soutenir la concurrence des «lunettistes commerciaux»,

I would suggest this to you: not only must we compete with the commercials, we must, in fact, do so both with their own tools, and with our own, unique professional differences — and do so better than they do now.

And I hope it is clear what I am asking us to do: to re-assess some of our own professional restrictions.

We have to stop being naive and we have to stop cultivating this self-ascribed angelic image many of us have of this profession to which we have chosen to devote our lives. Time changes all things, and if we fail to adapt to the changes as they take place around us, then we simply fail — period.

Let me give you a simple illustration. Consider our entertainment. In the film theatres now, one can subject oneself to the relentless, raw emotion in *The Silence of the Lambs*. Or even closer to home, in your own living rooms, have you seen what your children are watching these days on the music video stations? Depending from which side of the border your signal comes, you may or may not have seen the images with which contemporary "pop" artists like Mitsou, Madonna, David Lee Roth and the Divinyls choose to accompany their music. Less than ten years ago, many of these images would be found only in movie theatres, and only then under a *Restricted* banner. Yet over the past decade, nobody has actually stood up and spoken in favour of allowing increased permissiveness on television. But limits were just tested, and found wanting in their strength. So new limits are currently in place, and they, too, are only loosely understood; certainly they are undefined and, ultimately, they, too, will yield to the juggernaut that is "artistic licence".

I use the example of rock music videos not to sound moralistic or judgmental, but rather to illustrate that change is a force in itself.

Change is occurring even now in eye care — just as it is with health care in general. And we must make a choice: either be a part of the process, or find ourselves sitting here in ten years' time, bemoaning the loss of the "good old days".

If independent Optometry is not careful; and if official Optometry maintains its holier-than-Thou way of thinking; and finally if we, the practising optometrists, fail to enhance our practices and our profession to keep up with the competition — then Pearle and Lenscrafters and their imitators will be the only eye care services around. And we will be their employees.

Organized (official) Optometry has to change. *We* must become the trendsetters and develop the tools to enable our members not merely to survive, but to compete and to prosper.

The success of independent Optometry is in the combination of two factors: the strength of the individual and the collective unity of the profession.

Dr Jean-M Rodrigue
President

mais nous devons en fait le faire avec leurs propres instruments, en plus de nos propres différences professionnelles. ... Et mieux qu'ils ne le font.

Et j'espère que ce que je préconise est clair : il faut réévaluer certaines de nos propres restrictions professionnelles.

Nous devons cesser d'être naïfs, cesser de cultiver cette image idéale que beaucoup se sont faite de cette profession à laquelle nous avons choisi de consacrer nos vies. Le temps change tout et si nous ne parvenons pas à nous adapter aux changements qui interviennent autour de nous, nous échouerons tout simplement, un point c'est tout.

Permettez-moi une illustration simple. Prenons le domaine du divertissement. Dans nos propres maisons, que croyez-vous que nos enfants regardent, ces jours-ci, aux canaux de vidéo-musique? Selon que les signaux viennent de tel ou tel côté de la frontière, vous aurez ou n'aurez pas le douteux privilège de voir les images que des artistes contemporains «pop» comme Mitsou, Madonna, David Lee Roth et The Divinyls choisissent pour accompagner leur musique. Il y a moins de dix ans, nombre de ces images auraient été réservées au cinéma, sous la cote *Réservé aux adultes*. Pourtant, au cours de la décennie écoulée, personne en fait ne s'est élevé pour se prononcer en faveur d'une plus grande permissivité à la télévision. Mais on tâtait les limites, et on a fini par trouver leurs faiblesses. Ainsi, actuellement, de nouvelles limites sont en place.

Si j'utilise l'exemple des vidéos rock, ce n'est pas pour avoir l'air moraliste ou pour porter un jugement, mais simplement dans le but d'illustrer que le changement est en soi une force et qu'il survient rapidement et insidieusement.

Et des changements se produisent en ce moment même dans les soins visuels, tout comme dans les soins de santé en général. Nous devons faire un choix : soit faire partie du processus, soit nous trouver dans dix ans à nous plaindre de ce que «le bon vieux temps» est passé.

Si l'optométrie indépendante n'y prend garde et si *l'optométrie officielle* maintient sa façon de penser «sainte nitouche» et enfin, si nous, les optométristes ne parvenons pas à améliorer nos méthodes de marketing et celles de notre profession pour soutenir la concurrence, Pearle, Lenscrafters et leurs imitateurs deviendront les seuls distributeurs de services disponibles. ... Et nous serons leurs employés!

L'optométrie organisée (officielle) doit changer. *Nous* devons créer la tendance et non la subir. Nous devons nous doter des outils qui permettront à nos membres, non pas simplement de survivre, mais de soutenir la concurrence et de prospérer.

La réussite de l'optométrie indépendante réside dans la combinaison de deux facteurs : la force des individus et l'unité collective de la profession.

Dr Jean-Marie Rodrigue
Président

Letters

Courrier

The CJO*RCO *welcomes letters to the Editor. Letters must be signed and accompanied by clear identification of the author(s) name(s), address(es) and telephone number(s). Unsigned correspondence will not appear in the* CJO*RCO, *although a writer may request anonymity should the* CJO*RCO *accept the letter for publication. The Editors reserve the right to edit all letters submitted for publication for purposes of grammar, spelling, punctuation and clarity. Submission of a letter does not guarantee publication.*

New vision category

I would like to offer a comment with respect to the article, "Visual Standards in the Aviation Environment", published in the Winter 1990/91 issue (Vol 52, No 4).

The article fails to make reference to a new medical category that has been established by the Ministry of Transport to be known as Category 4. Those in this category will include glider pilots and non-commercial pilots of ultra-light aircraft.

The visual standards for this new category are quite simple: licence holders shall have distant visual acuity of no less than 20/30 (6/9) corrected or uncorrected in the better eye, and must have "normal" fields of vision (although what constitutes a "normal" field is not defined).

I believe this information will be of interest to some of your readers.

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Errata

1. In our last issue (Vol 52, No 4, Winter 1990/91) a figure caption in the article entitled "Industrial Colour Vision Standards" by Drs GK Wallace and JK Hovis was incorrect. The figure caption for Figure 3, which appeared on p.134, should have read:

> Chromaticity coordinates (squares) of a black light and range of the dominant wavelengths of the fluorescein emission spectrum. Representative deutan (dotted lines) and protan (solid line) illustrate that the black light and fluorescein dye are not confused by persons with a red-green colour vision deficiency.

2. In our Autumn 1990 issue (Vol 52, No 3), a section of a review written by Dr AP Cullen of the book *Manual of Fundus Fluorescein Angiography*, by Amresh Chopdar, was inadvertently omitted. The complete text of the review as it should have appeared is included in the book review section of this issue.

The Editors apologize for the errors.

Dr Harry Basman honoured at 1991 Manitoba AGM

Dr Harry Basman, who this year began his 15th year as Executive Director of the Manitoba Optometric Society (MOS), was named Manitoba's Optometrist of the Year at the 1991 Annual General Meeting of the society. The award was presented May 4 by CAO President Dr Jean-Marie Rodrigue.

Dr Harry Basman graduated from l'École d'optométrie, Université de Montréal, in May, 1950, an astonishing achievement since, at the time, he was not bilingual. He succeeded through diligent application to his textbooks, all of which were in English, and considerable classroom assistance from a classmate, Dr Jim Stanners, who was bilingual.

Dr Basman started his practice that same year in Beausejour, Manitoba, and did work for the Department of Indian Affairs for 30 years, covering most of the northern part of the province at one time or another during those three decades. He also served as President of the MOS for three years and as Past President during the three one-year terms of his successor. He has been active on the provincial society's Council for 24 years.

Dr Basman, according to past MOS and CAO President Dr Roy Brown, "has spent a lifetime devoted to the welfare both of his profession and his patients. He is a devoted, dedicated practitioner."

In accepting the award, Dr Basman paid tribute to his wife, Joyce, to whom he said he was particularly indebted for her boundless tolerance of the many long hours he had spent on Optometry. Dr Basman (r) is shown here accepting the plaque from Dr Rodrigue. (photo by Dr Roy Brown)

Bull's-eye maculopathy: Differential diagnosis of Stargardt's disease

Angela C Kothe, John G Flanagan, Michael G Hall, Marlee M Spafford

key words: bull's-eye maculopathy; Stargardt's disease; flash electroretinogram; pattern visual evoked potential; visual fields; colour vision

A bull's-eye macular lesion is a feature of a number of ocular disorders. The case presented herein uses standard clinical tests of visual function and an electrodiagnostic evaluation to detail the differential diagnosis of a patient with moderate vision loss and bull's-eye maculopathy. Fluorescein angiography confirmed a diagnosis of Stargardt's disease.

Une lésion maculaire en forme de cocarde entourée d'un anneau rouge caractérise un certain nombre d'affections oculaires. Le cas présenté ici fait appel à des tests cliniques standard de la fonction visuelle et à une évaluation par diagnostic électrophysiologique pour préciser le diagnostic différentiel de patients qui souffrent d'une légère atteinte visuelle et d'une maculopathie en cocarde entourée d'un anneau rouge. L'angiographie à la fluorescéine a confirmé un diagnostic de la maladie de Stargardt.

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Introduction

A bull's-eye macular lesion is found in a number of retinopathies including cone dystrophies,[1-3] central serous retinopathy,[2] senile predisciform macular degeneration,[4] dominant macular dystrophy,[4] Stargardt's disease and fundus flavimaculatus,[4-6] benign concentric annular macular dystrophy,[7] Batten-Mayou (or Spielmeyer-Vogt) disease[3,8] and drug toxicity, particularly due to chloroquine ingestion.[2,3,9] The bull's-eye lesion, which is generally bilateral and symmetrical in appearance, is characterized by a dark central area at the fovea surrounded by a paler zone, which may be further surrounded by a hyperpigmented ring.[2-4]

The differential diagnosis of a disorder presenting with a bull's-eye lesion is based on the mode of inheritance, presence or absence of accompanying systemic disease, history of drug ingestion, symptomatology and detailed visual examination. Visual function should be carefully evaluated using such measures as visual acuity, colour vision, Amsler grid, perimetry, flash electroretinography, visual evoked potentials, detailed inspection of the fundus and fluorescein angiography.

The following report outlines the differential diagnosis of a bull's-eye macular lesion in a patient who presented with a moderate reduction in visual acuity.

Case report

A 20-year-old Caucasian female was referred to the Electrodiagnostic Clinic at the University of Waterloo School of Optometry for an evaluation due to bilaterally decreased visual acuity of unknown cause. The patient sought an optometric assessment when she was denied a driver's licence because of failure to meet the provincial criterion for visual acuity. The patient believed that her vision always had been poorer than that of her friends and family, although no treatment or diagnosis had been given at previous oculo-visual assessments. The patient denied any difficulties with night vision. The medical history was unremarkable and the patient's only medication was oral contraceptives. Family history was negative for any ocular disorders. The patient had no siblings and was the product of a non consanguineous marriage.

Unaided Snellen acuities were $6/12^{-2}$ ($20/40^{-2}$) OD and OS, and $6/9^{-2}$ ($20/30^{-2}$) OU at 6m, and 1.00M OD, OS, and OU at .4m. A single pinhole provided no subjective improvement in vision. Amplitude of accommodation (push-up technique) was 9D OD and OS. The patient was non-strabismic and orthophoric at 6m, and 4Δ exophoric at .4m. Ocular motility was pain-free and unrestricted in all cardinal positions of gaze. Stereoacuity was 140 sec on the Titmus test.

Cycloplegia yielded a subjective refraction of +0.25 / -0.75 x 004 for the right eye and +0.75 / -1.00 x 006 for the left eye which gave an acuity of 6/18 for either eye. Retinal interferometry (Rodenstock) predicted acuities of 6/15 OD and 6/12 OS, confirming that the decreased vision was not refractive but more likely organic in nature. The reduction in acuities obtained under cycloplegia and predicted by laser interferometry, as compared to those obtained with natural pupils, may be related to the increase in spherical aberration and glare associated with the pupillary dilation.

Monocular colour vision assessment with the saturated panel D-15 test suggested a mild red-green defect for both eyes (Figure 1). Contrast sensitivity testing (Vistech VCTS 6000 system) indicated a depressed contrast sensitivity function across all spatial frequencies for the right and left eyes at the .4m test distance (Figure 2), further confirming that the decreased acuity was likely organic in nature.[10]

On Amsler grid testing the patient reported a ring-shaped scotoma around the point of fixation for either eye. Full

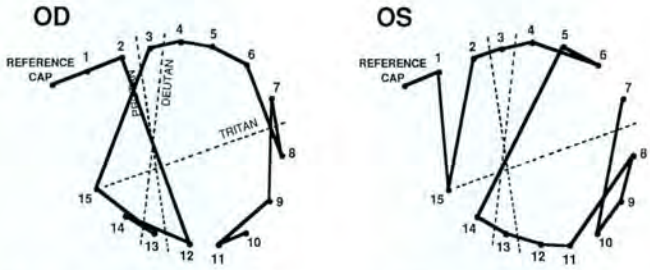

Figure 1. Results of colour vision testing with the standard D-15 for the right and left eyes showing a reversal of caps typical of a red-green defect.

threshold automated perimetry (Humphrey 30-2 program) revealed a dense central scotoma OD and OS (Figure 3).

Intraocular pressures with non-contact tonometry were 15 mmHg OD and 16 mmHg OS at 3:15 p.m.

Visual evoked potentials (VEPs) were recorded for flash and pattern stimulation. Monocular steady state pattern reversal VEPs were assessed for 12° checkerboards composed of high contrast (87%) black/white checks of 7, 14, 28, 56 and 112 min arc. The squares comprising the checkerboard were reversed in counterphase at 7.5 reversals/sec. Thirty 500-msec epochs were differentially amplified and averaged on a Nicolet CA-1000 clinical averager, with bandpass filters set at 1 to 30 Hz, to form a single trial. A bipolar electrode montage was used: the active electrode was placed on the scalp approximately 1 cm above the inion and the reference electrode 5 cm higher along the

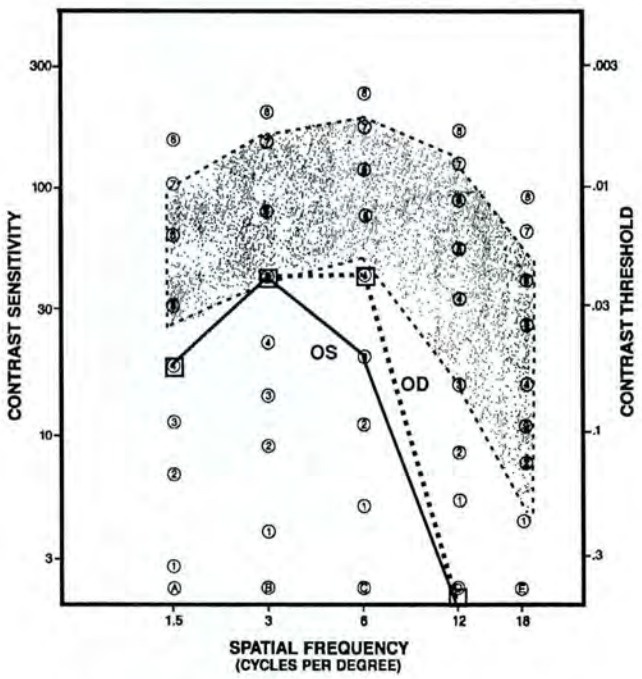

Figure 2. An overall depression of the contrast sensitivity function at 40 cm was recorded for the right (solid line) and left (thick dashed line) eyes using the Vistech system.

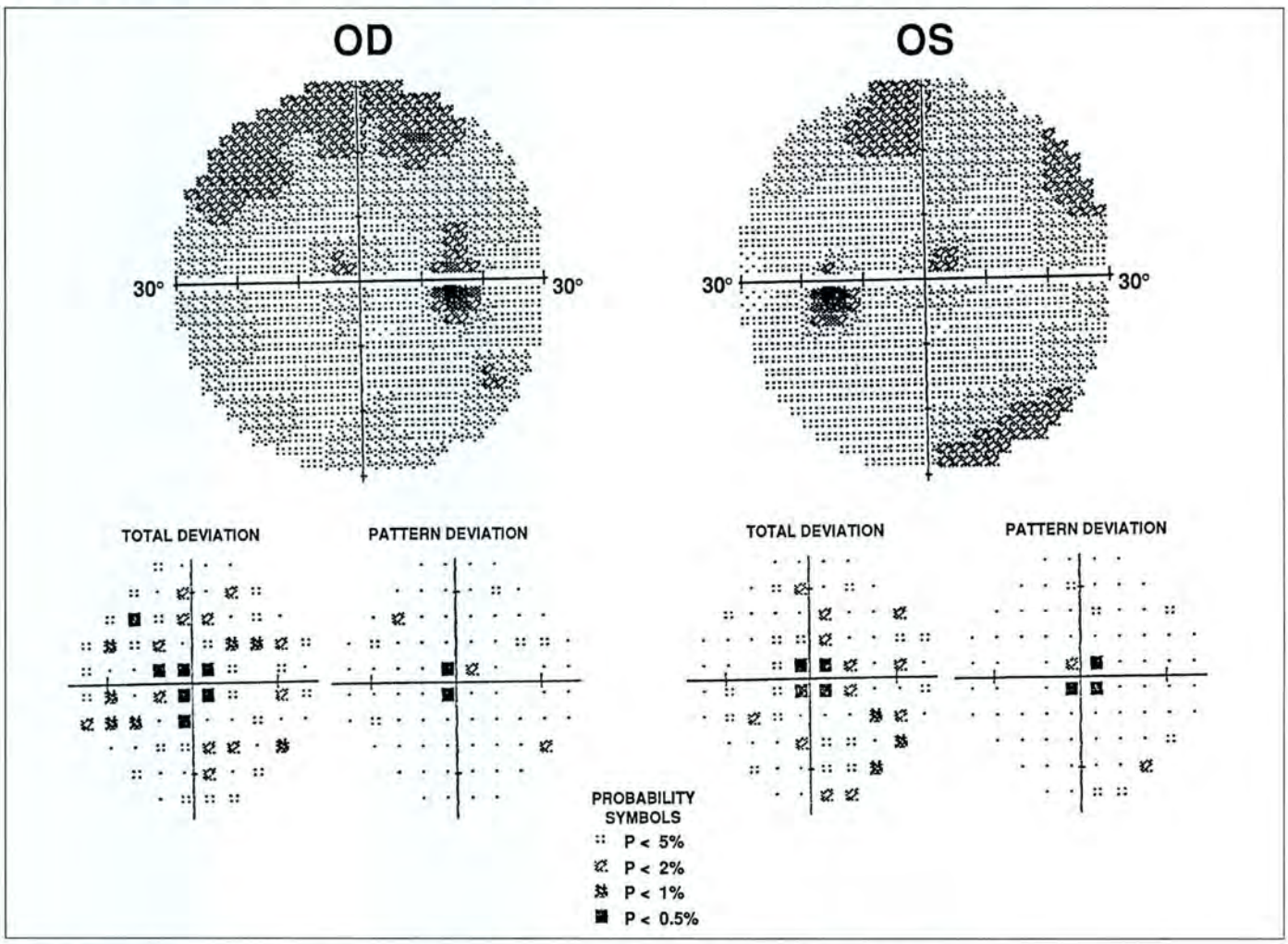

Figure 3. Automated visual field testing (Humphrey 30-2 threshold program) revealed a central scotoma in both eyes.

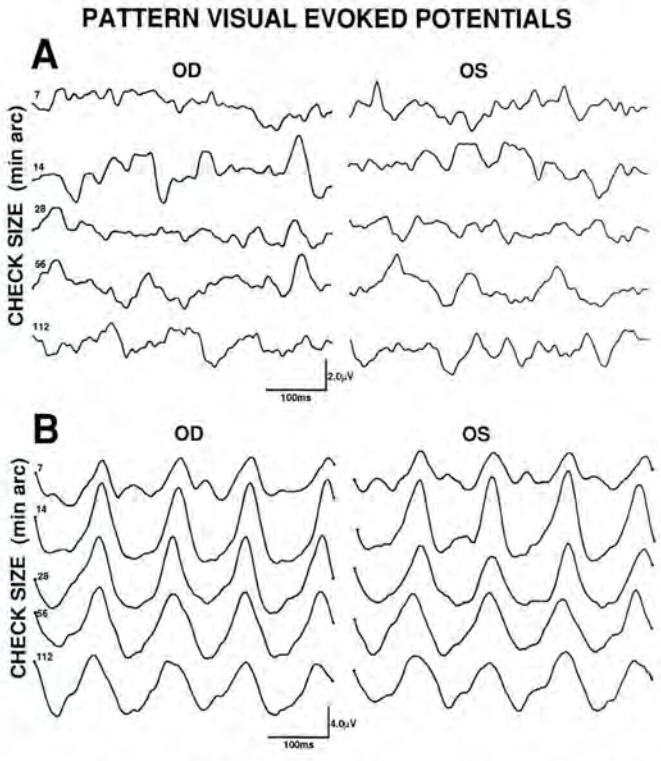

Figure 4. Steady state pattern VEPs for our patient (plate A) were asynchronous and of low amplitude, suggesting of a macular- cortical disorder. Responses for an age- and sex-matched individual with normal visual function and 6/6 visual acuity are shown for comparison in plate B.

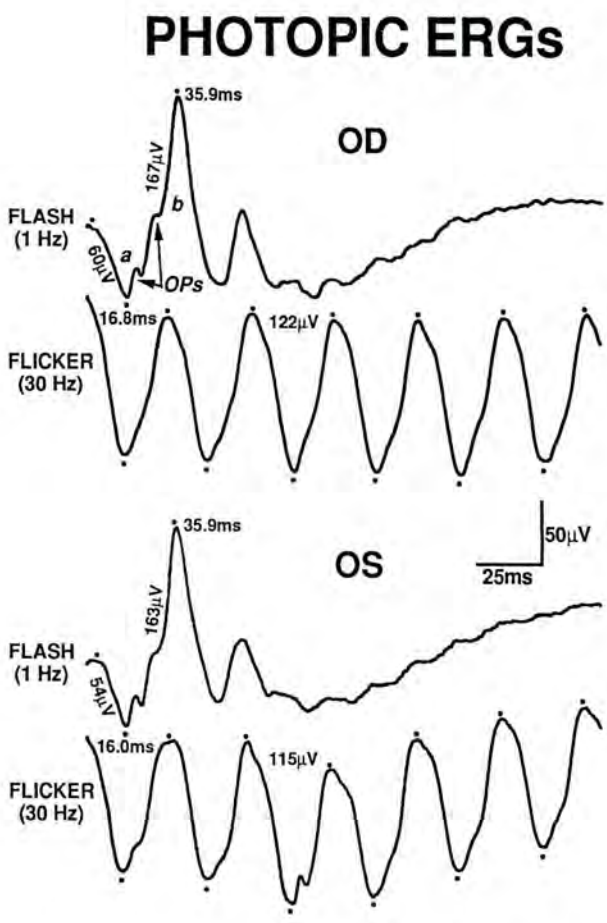

Figure 5. Normal gross cone function for both eyes was indicated by the normal a- and b-wave amplitude and implicit time characteristics of the photopic red flash (1 Hz), and the normal b-wave amplitude of the flicker (30 Hz) ERG. Oscillatory potentials (OPs) could be seen on the rising phase of the flash ERG b-wave.

midsaggital plane. For our patient, low amplitude, asynchronous VEPs were obtained for all check sizes (Figure 4A). VEPs for an age- and sex-matched individual with normal visual function are shown in Figure 4B; these VEPs exhibit regularity of waveform with maximal amplitude responses obtained for checkerboards composed of 14 min arc checks, a finding typical in individuals with normal macular-cortical function.[11]

Transient pattern VEPs for a 56 min arc check size were assessed monocularly and binocularly, with the black/white checks reversed in counterphase at 1.9 reversals/sec. Thirty 200-msec epochs were averaged to form a single trial. These VEP responses were not repeatable for either a 6° or 12° field, and thus optic nerve transmission time could not be assessed. In general, pattern VEPs were indicative of a macular-cortical disorder.

Flash VEPs were tested monocularly in response to high intensity white flashes presented at rates of 10, 20, 30, 40 and 50 Hz within a Ganzfeld bowl. Bandpass filters were set at 1 to 100 Hz, and thirty 200-msec epochs were averaged to form a single trial. A cortical critical frequency of photic driving of at least 50 Hz was derived for the right and left eyes, thus reducing the likelihood that a demyelinating disorder was the cause of the reduction in central visual function.

Photopic flash electroretinography was performed to evaluate retinal cone function. Photopic ERGs to high intensity red flash (1 Hz) and red flicker (30 Hz) stimulation were assessed monocularly within a Ganzfeld using a Burian-Allen contact lens electrode on an anaesthetized cornea with the patient's pupils dilated by the application of 1 drop 1% tropicamide OU. Bandpass filters on the averager were set at 1 to 250 Hz, and eight 200-msec epochs were averaged to form a single trial. For each eye, the amplitudes and implicit times of the a- and b-waves of the red flash ERG were within normal limits for the test conditions as applied in our clinic, as was the amplitude of the b-wave of the flicker ERG (Figure 5). Photopic cone function was further assessed using high intensity (x16) white light of 10, 20, 30, 40, 50, 60, 70 and 80 Hz stimulation to determine the electrophysiologically derived flicker fusion frequency. Normal gross cone function was indicated by the regular periodicity of the ERG b-wave, for both the right and left eyes, up to a stimulation frequency of at least 80 Hz.

Binocular indirect ophthalmoscopy revealed the presence of a bull's-eye macular lesion in the right and left eyes with normal appearance of the optic discs and major retinal vessels (Figure 6).

The appearance of a bull's-eye lesion with decreased central visual acuity, the red-green colour defect and central field loss, in the presence of normal rod and cone function, was suggestive of an early macular dystrophy. The differential diagnosis included Stargardt's disease, early cone dystrophy and benign annular concentric macular dystrophy.

The patient was referred for ophthalmological consultation to a retinal specialist who concurred with the diagnosis of a bull's-eye maculopathy. Fluorescein angiography revealed a bull's-eye pattern in the macula consisting of a central area of hyperfluorescence surrounded by an area of relative hypofluorescence. The normal choroidal flush was not seen. The angiographic pattern of a bull's-eye macular lesion along with a "dark" or "silent" choroid is characteristic of Stargardt's disease.

Figure 6. Fundus photograph of the left eye of the patient demonstrating the bull's-eye appearance of the macula. The macula of the right eye had a similar appearance.

Discussion

Stargardt's disease is usually inherited in an autosomal recessive mode, with symptoms of a bilateral decrease in visual acuity generally beginning in the first or second decade of life. Since there are frequently no ophthalmoscopically visible abnormalities accompanying this initial decrease in acuity, patients may be suspected of malingering. With progression of the disorder, the central retina undergoes characteristic changes beginning with a loss of the foveal reflex and, in some cases, the appearance of a bull's-eye macular lesion, followed by the appearance of yellow flecks and a "beaten metal bronze" macula. The yellowish flecks may extend into the periphery resulting in fundus flavimaculatus.

Loss of visual function is related to the extent of retina that is affected by the disorder. Central and paracentral scotomata are common in Stargardt's patients due to atrophic macular degeneration[5,12] whereas an overall constriction of the visual field may be found in patients with peripheral retinal involvement as occurs in fundus flavimaculatus.[13]

There is no characteristic colour vision defect in Stargardt's disease; colour vision may be normal,[12] there may be a red-green deficiency,[5,12-14] or a non-specific inferior ability to discriminate colours.[12-14] Hart[15] stated that Stargardt's patients typically undergo a progression from an initial blue- yellow to a red-green colour deficiency.

The low amplitude, asynchronous VEPs recorded for our patient were indicative of the macular involvement of the disorder, while gross cone function was normal as indicated by photopic flash and flicker ERGs. Such normal photopic responses are typical in Stargardt's patients,[5,12,16] although, in some cases the photopic ERG may be mildly[5,12,13,16] to moderately[14] abnormal. Since only about 7% of the total retinal cone population resides in the macula (central 10°), cone involvement must be extensive if significant abnormalities are recordable with the photopic ERG.[8,17] The scotopic ERG is almost always normal in patients with Stargardt's disease[5,13] owing to the more peripheral location of rod photoreceptors.

In the present case, the angiographic pattern of foveal hyperfluorescence surrounded by an area of relative hypofluorescence (the bull's-eye pattern) and a dark choroid was typical of Stargardt's disease. Fluorescein angiography plays a vital role in the diagnosis of Stargardt's disease and fundus flavimaculatus, since patients with these disorders demonstrate abolished visibility of the choroidal circulation.[5,18,19] The absence of the choroidal flush is believed to be unique to Stargardt's and fundus flavimaculatus[13] and is seen in some 50 to 88% of these patients[5,20,21] due to extensive accumulation of lipofusin-like material in the retinal pigment epithelium obscuring the underlying choroid.[13,18,21] Gelisken and de Laey[21] noted that in patients with a localized macular lesion, a dark choroid may be suggestive of further progression of the disorder.

The appearance of the retinal vessels and optic nerve head is typically normal in the initial stages of the disorder, however, temporal optic nerve pallor eventually accompanies the macular atrophy.[5,13]

Stargardt's patients tend to benefit from telescopic systems for distance vision, and microscopic systems for reading.[22] An analysis of visual acuity with age[21] has suggested that visual acuity is relatively stable once the initial vision loss has occurred, and generally remains around the 6/60 level.[20,22] Some 10% of cases however, can progress to a generalized retinal degeneration with severe vision loss.[12,21] Our patient was advised that routine visual assessments would be required to determine whether her visual acuity had stabilized, or whether a progressive loss of acuity would occur with time. A low vision assessment and the benefit of optical aids were discussed with the patient. Genetic counselling was also suggested. At the present time, the patient is successfully managed with +2.00DS readers which provide sufficient magnification of printed text for her work as a college student.

We acknowledge the clinical expertise of Dr Richard C Trevino and the assistance of Lisa Prokopich and Lorenda Kornelson in the clinical management of this patient. We also acknowledge the Electrodiagnostic Services of the University of Waterloo School of Optometry, where Dr AC Kothe was a clinical associate at the time of this study.

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Binocular visual field area

T David Williams

key words: vision, binocular; vision screening; age factors

The binocular visual field is defined for this study as the area of overlap of Goldmann perimeter field charts. Two groups of normal individuals were studied: 146 subjects aged 20 to 30 years and 129 subjects aged 15 to 75 years. Monocular fields were measured with the I-2, I-3 and I-4 stimuli, then digitized so the area of the monocular and binocular fields could be computed. Average binocular field isopters were plotted, and show a considerable inferior enlargement of the binocular field for young people with the Goldmann I-4 target, which tends to decrease markedly with age. The rate of decrease of the binocular visual field with age is roughly 25% slower than that for the monocular visual field.

Le champ visuel binoculaire est défini dans cette étude comme la zone de chevauchement des schémas de champ du périmètre de Goldmann. Deux groupes de sujets normaux ont été étudiés : 146 sujets âgés de 20 à 30 ans et 129 sujets âgés de 15 à 75 ans. Les champs monoculaires ont été mesurés au moyen de stimuli I-2, I-3 et I-4, on les a ensuite numérisés pour pouvoir calculer l'étendue des champs monoculaires et binoculaires. Les isoptères moyens des champs binoculaires ont été tracés et indiquent un élargissement considérable à la base du champ binoculaire chez les sujets jeunes avec une cible de Goldmann I-4, cet élargissement ayant tendance à diminuer de façon importance au cours du vieillissement. Le taux de diminution du champ visuel binoculaire en fonction de l'âge est environ 25 % plus lent que celui du champ visuel monoculaire.

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There are few published data on the dimension or shape of the binocular visual field, which is defined for this study as the area of overlap of Goldmann perimeter field charts. Strictly speaking, this method of analysis describes the area of the visual field in which binocular vision is possible, rather than attempting, as Richards has done,[1] to assess the field within which the observer responds to retinal disparity.

Method and materials

Two independent groups of individuals were studied: 146 subjects aged from 20 to 30 years (Group 1), and 129 subjects aged from 15 to 75 years (Group 2). All were free of ocular or systemic disease. The first group was used to provide data for calculation of the binocular visual isopters, while the second group was used to determine the effects of age on the binocular visual field. Although none of the 32 20- to 30-year-old subjects in Group 2 were used in calculating the binocular field norms, their binocular fields closely resembled the norms for their age.

Monocular fields were measured at the Goldmann perimeter using the I-2, I-3 and I-4 stimuli. Field testing was done by three examiners who were following the same testing protocol.[2] All testing was done with pupils and accommodation in their natural state and with appropriate refractive correction for the $^1/_3$ m test distance. All subjects were advised of the nature of threshold testing and were asked to respond as soon as they thought the target was visible, rather than waiting until they were certain it was present. The order of presentation of the stimuli was known to each subject: field test results tend to be more reliable when this information is known.[3]

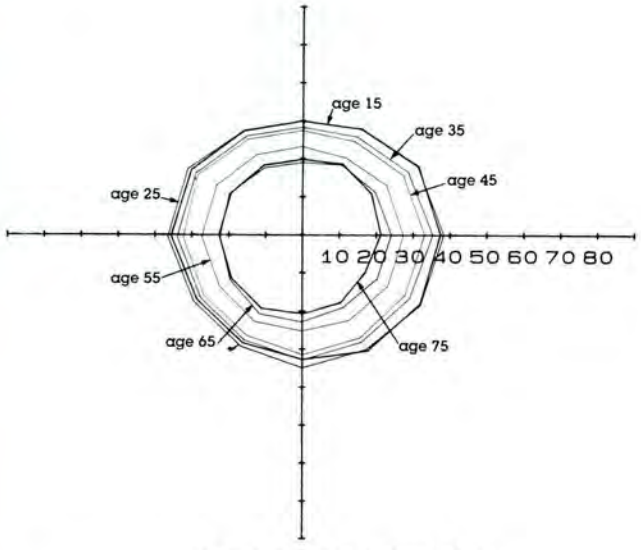
The visual field charts were then placed on a digitizing pad and X and Y coordinates determined for each isopter point.[4] These coordinates were then used to calculate, using analytic geometry, the area (in square millimetres on the visual field chart) of the particular isopter. The resolution of the digitizing pad was 0.1 mm.

Average binocular field isopters were plotted by superimposing the right and left isopters and calculating the area of the field common to both. The visual field area was also divided into 12 30-degree sectors, numbered clockwise starting at the 12:00 position.

Results

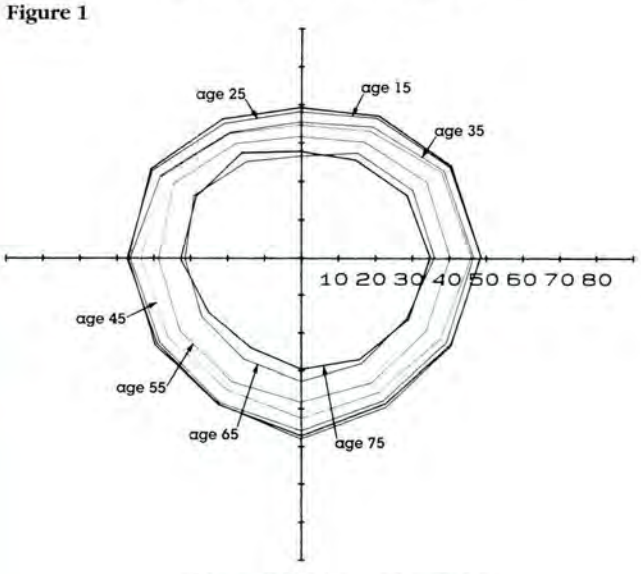
Data on monocular field configuration and area as a function of age and stimulus intensity have been published previously.[4-7] Figures 1, 2 and 3 show the shape and size of the mean binocular visual field for the I-2, I-3 and I-4 Goldmann test targets, respectively, for the six age groups of Group 2. Figure 4 shows, for the 20-to-30-year age group (Group 1), the frequency distributions for the areas of the binocular visual field for the three Goldmann stimuli used.

Figure 5 shows, for each of the six age groups of Group 2, the effect of age on the group mean area of individual sectors of the Goldmann visual field for the right eye, measured with the I-2 stimulus. The field has been divided into 12 sectors, numbered clockwise starting from the 12:00 position. The obvious bulge at the left hand side of the plot is due to the relatively large size of the inferior temporal field (sectors 4, 5 and 6). Figure 6 shows, for each of the six age groups of Group 2, the effect of age on the group mean area of individual sectors of the Goldmann visual field for the right eye, measured with the I-3 stimulus. Figure 7 shows, for each of the six age groups of Group 2, the effect of age on the group mean area of individual sectors of the Goldmann visual field for the right eye, measured with the I-4 stimulus.



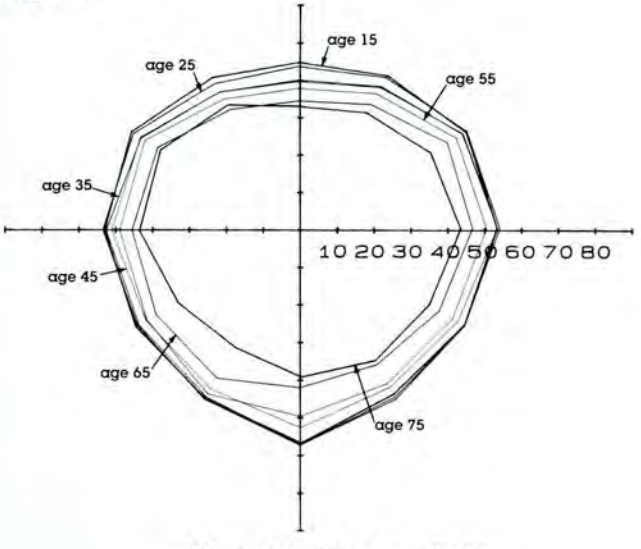
Mean I-2 binocular fields

Figure 1



Mean I-3 binocular fields

Figure 2



Mean I-4 binocular fields

Figure 3

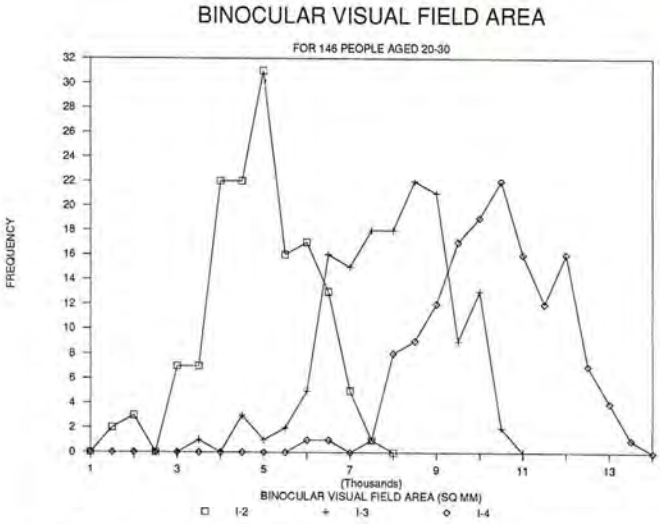


Figure 4. Frequency distribution of binocular visual field area for 146 normal subjects aged 20-30 years (Group 1). Binocular visual field is defined as the area of overlap of the visual fields for the right and left eyes. The area is in square millimeters as measured on the surface of the Goldmann field recording chart by means of a digitizing pad. Data for the Goldmann I-2, I-3 and I-4 test targets are shown. The Goldmann I-3 and I-4 targets are respectively 0.5 and 1 log unit more intense than the I-2 target, but of the same size (5.8 minutes of arc, just slightly larger than the size of a 1 mm target at 1 meter on the tangent screen [3.4 minutes of arc]).

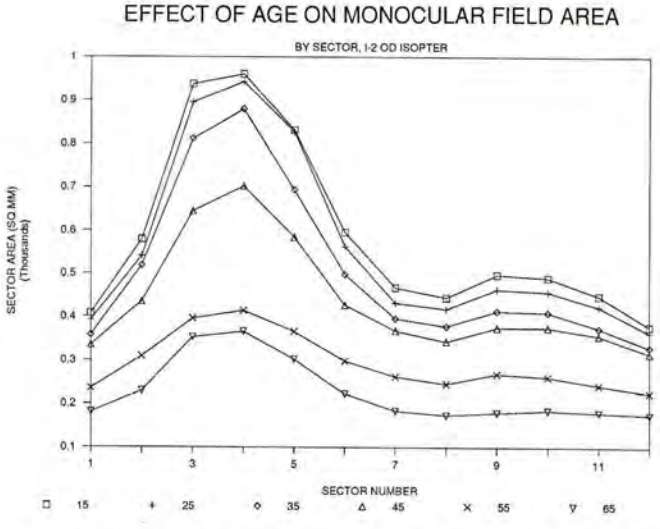


Figure 5. Area of the I-2 visual field of the right eye for the six age groups of Group 2. The isopter area has been divided into 12 sectors, each 30 degrees in extent and numbered clockwise from 1 to 12, starting at the 12:00 position.

Figure 8 shows, for each of the six age groups of Group 2, the effect of age on the group mean area of individual sectors of the binocular visual field, measured with the I-2 stimulus. Figure 9 shows, for each of the six age groups of Group 2, the effect of age on the group mean area of individual sectors of the binocular visual field, measured with the I-3 stimulus. Figure 10 shows, for each of the six age groups of Group 2, the effect of age on the group mean area of individual sectors of the binocular visual field, measured with the I-4 stimulus.

Figure 11 shows, for the 15-year-old and the 65-year-old age groups of Group 2, the variability in the area of each sector of the binocular visual field. In this figure, the area of each sector of the binocular field is expressed as a percentage of the total binocular field area.

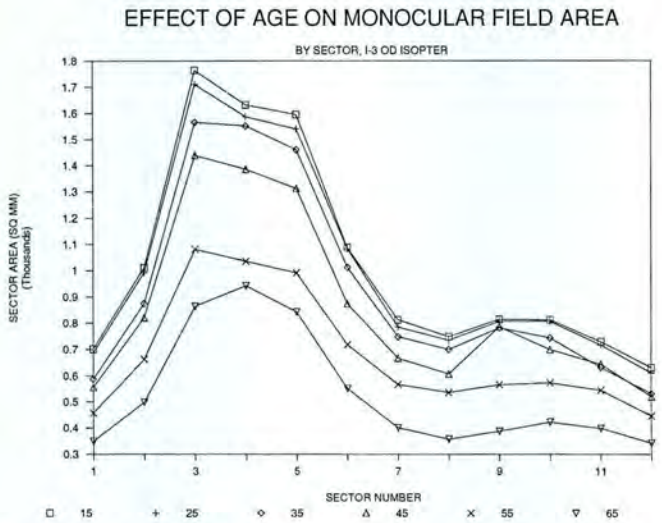


Figure 6. Area of the I-3 visual field of the right eye for the six age groups of Group 2. The isopter area has been divided into 12 sectors, each 30 degrees in extent and numbered clockwise from 1 to 12, starting at the 12:00 position.

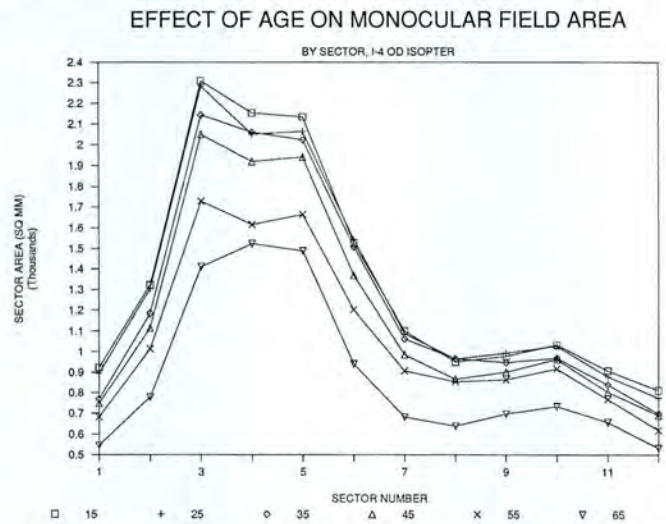


Figure 7. Area of the I-4 visual field of the right eye for the six age groups of Group 2. The isopter area has been divided into 12 sectors, each 30 degrees in extent and numbered clockwise from 1 to 12, starting at the 12:00 position.

Figure 12 is a scatterplot of the area of the monocular I-2 visual field for all members of Group 2. Figure 13 is a scatterplot of the area of the monocular I-3 visual field for all members of Group 2. Figure 14 is a scatterplot of the area of the monocular I-4 visual field for all members of Group 2. Figures 15-17 are corresponding plots for the binocular visual field for Group 2.

Figure 18 shows, for the six age groups of Group 2, the mean increment in monocular visual field area produced by increasing the intensity of the Goldmann stimulus from 2 to 3 (an increase from 100 apostilbs to 315 apostilbs; i.e., of 0.5 log intensity units) and from 3 to 4 (an increase from 315 apostilbs to 1000 apostilbs, also an 0.5 log intensity unit increase). As the symbols show, the upper plot is obtained by subtracting the areas of the I-2 isopters from those of the I-3 isopters; the lower plot is obtained by subtracting the I-3 field areas from the I-4 areas.

Figure 19 shows, for the six age groups of Group 2, the area of the superior monocular visual field as percentage of total field area.

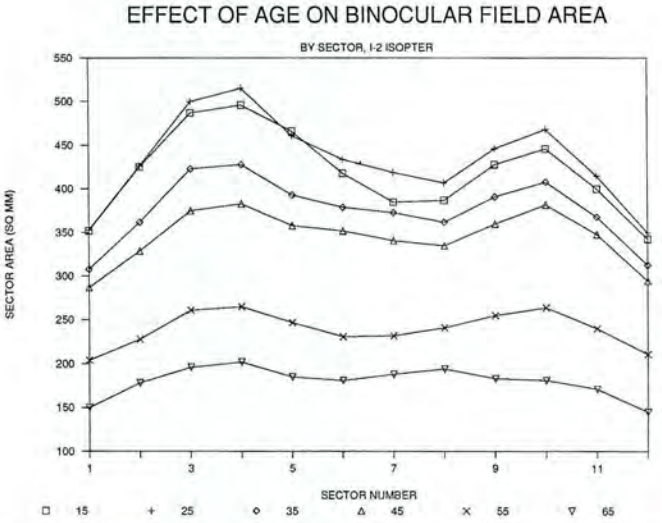


Figure 8. Area of the I-2 binocular visual field for the six age groups of Group 2. The isopter area has been divided into 12 sectors, each 30 degrees in extent and numbered clockwise from 1 to 12, starting at the 12:00 position.

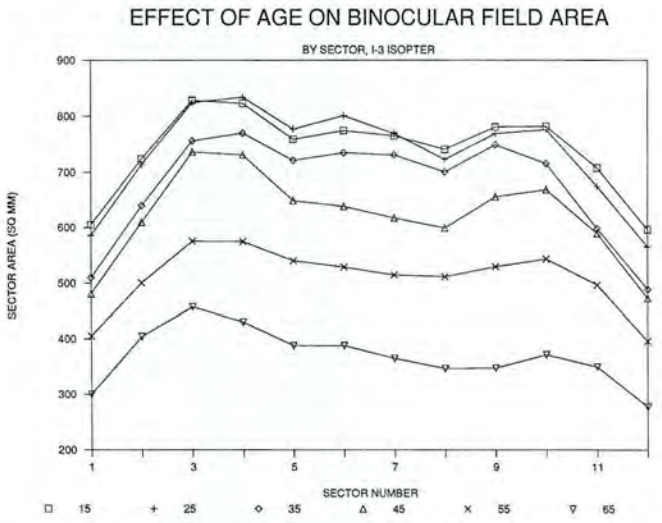


Figure 9. Area of the I-3 binocular visual field for the six age groups of Group 2. The isopter area has been divided into 12 sectors, each 30 degrees in extent and numbered clockwise from 1 to 12, starting at the 12:00 position.

Figure 20 shows, for Group 1, the area of the binocular visual field as a percentage of the sum of the monocular visual field areas. Data for Goldmann I-2, I-3 and I-4 isopters are shown.

Discussion

The shape of the binocular field, as defined in this study and shown in Figures 1 to 3, is symmetrical about the vertical line passing through the fixation point. Some degree of horizontal ovalness is retained for all age groups and stimulus intensities. As shown in Table 1, the monocular inferior field tends to be larger than the monocular superior field; this finding is also true for the binocular field. This difference is found for all age groups and all three stimuli used in this study and is most marked for the I-4 stimulus. The contours of Figures 5, 6 and 7 show that the shape of the monocular visual field does not change greatly with age and that sectors 3, 4 and 5 tend to be consistently larger than the others. These figures show results

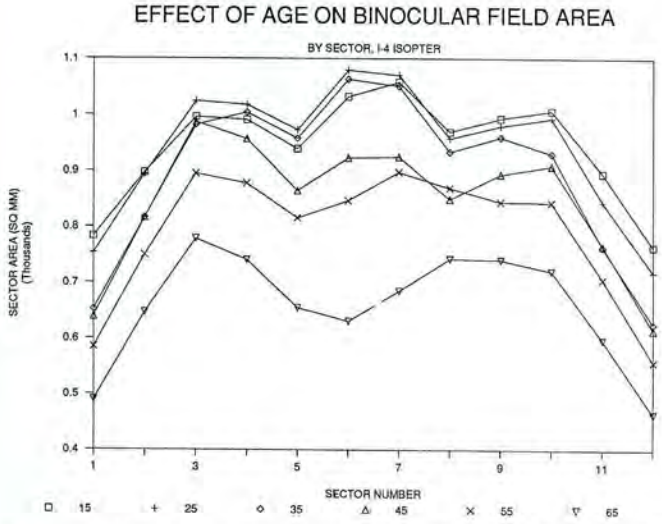


Figure 10. Area of the I-4 binocular visual field for the six age groups of Group 2. The isopter area has been divided into 12 sectors, each 30 degrees in extent and numbered clockwise from 1 to 12, starting at the 12:00 position.

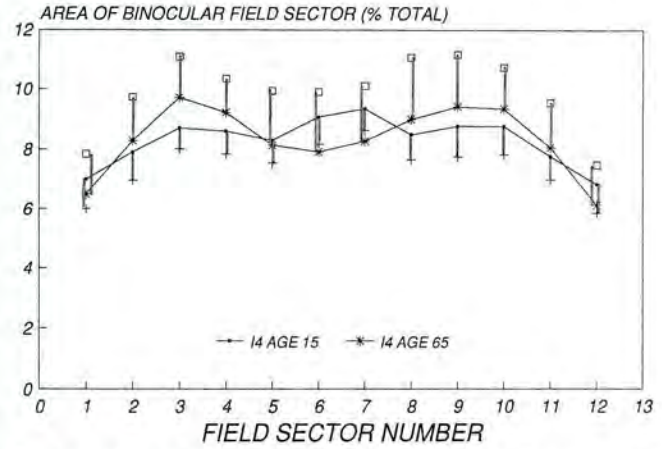


Figure 11. Effect of age on binocular I-4 field area for the 15-year and 65-year age groups of Group 2. To examine the apparent difference between the plots of Figure 10, the area here is represented as percentage of total area and standard deviations are shown. The overlapping of these plots shows that there is no systematic difference between these two age groups.

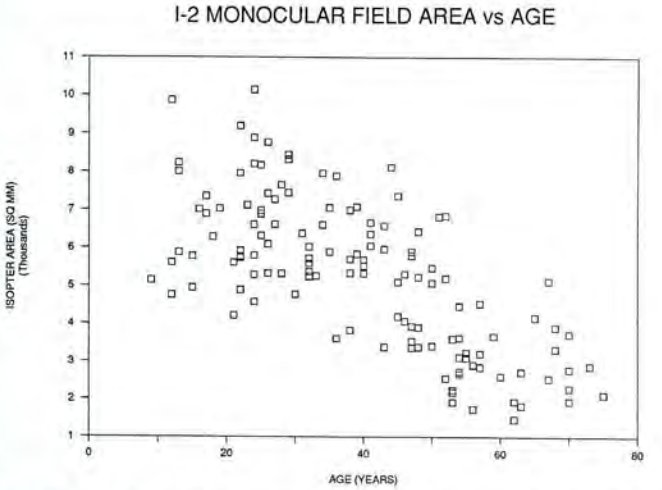


Figure 12. Effect of age on the area of the I-2 monocular visual field (right eye) for Group 2. The area is in square millimeters as measured on the surface of the Goldmann field recording chart by means of a digitizing pad.

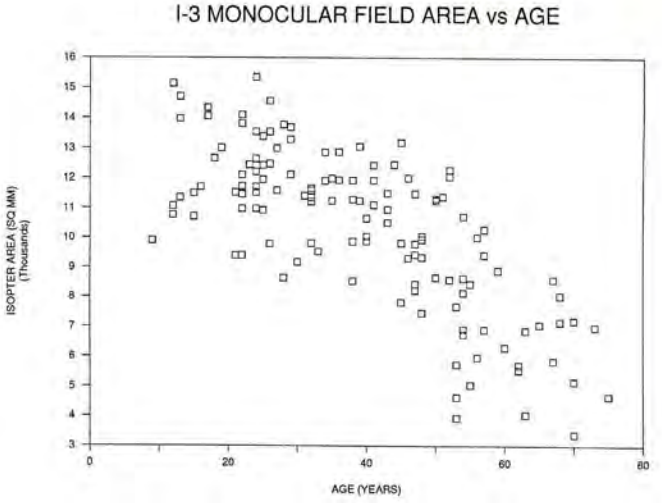


Figure 13. Effect of age on the area of the I-3 monocular visual field (right eye) for Group 2.

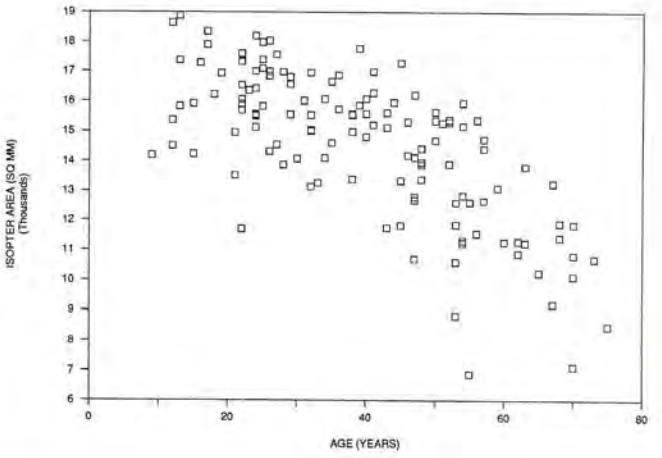


Figure 14. Effect of age on the area of the monocular visual field (right eye) for Group 2.

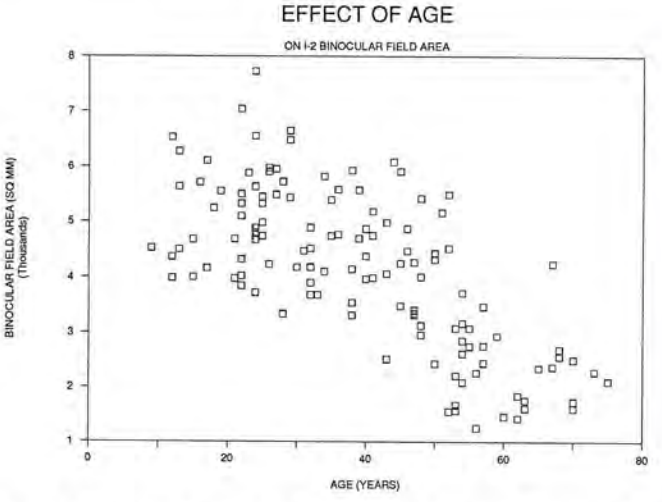


Figure 15. Effect of age on the area of the I-2 binocular visual field for Group 2. Binocular visual field is defined as the area of overlap of the visual fields for the right and left eyes. The area is in square millimeters, as measured on the surface of the Goldmann field recording chart by means of a digitizing pad.

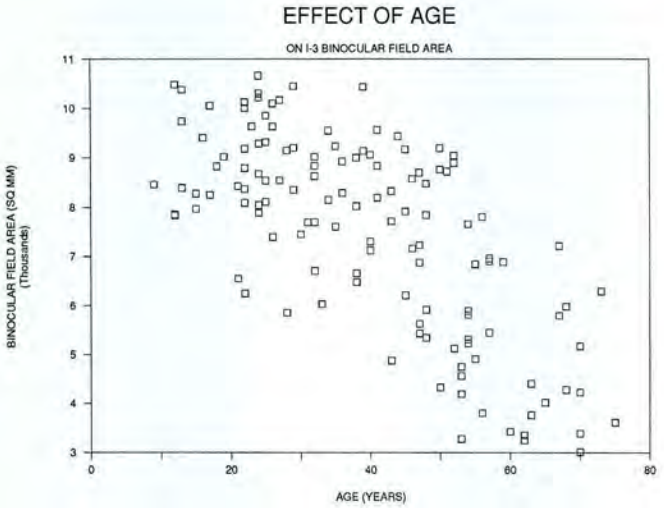


Figure 16. Effect of age on the area of the I-3 binocular visual field for Group 2.

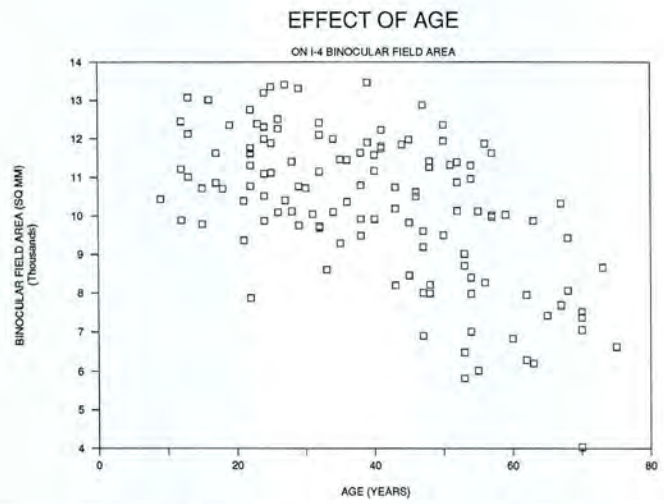


Figure 17. Effect of age on the area of the I-4 bincoular visual field for Group 2.

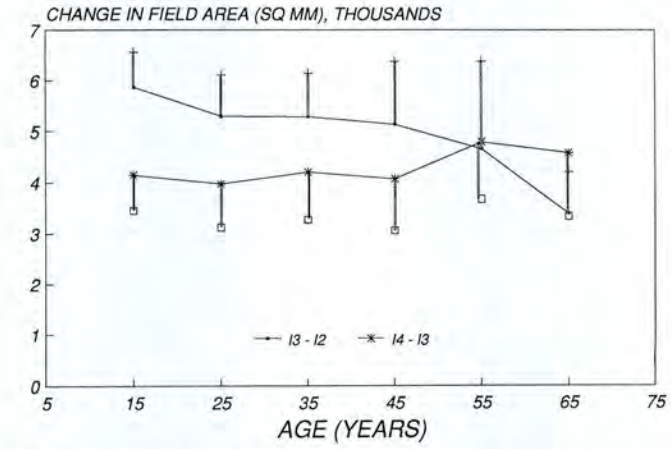


Figure 18. Effect of age on the increment in monocular visual field size produced by a 0.5 log intensity increase. Error symbols represent one standard deviation. Data from Group 2.

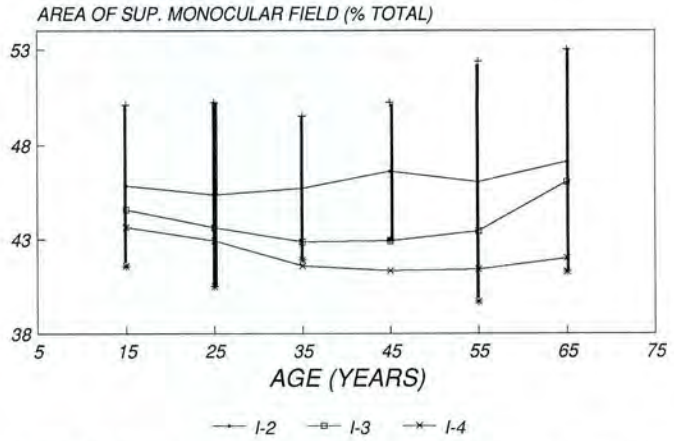


Figure 19. Area of superior monocular visual field (as a percentage of the total field area) for the six age groups of Group 2. Data for Goldmann I-2, I-3 and I-4 isopters are shown. Error symbols indicate +/- one standard deviation for the I-2 data.

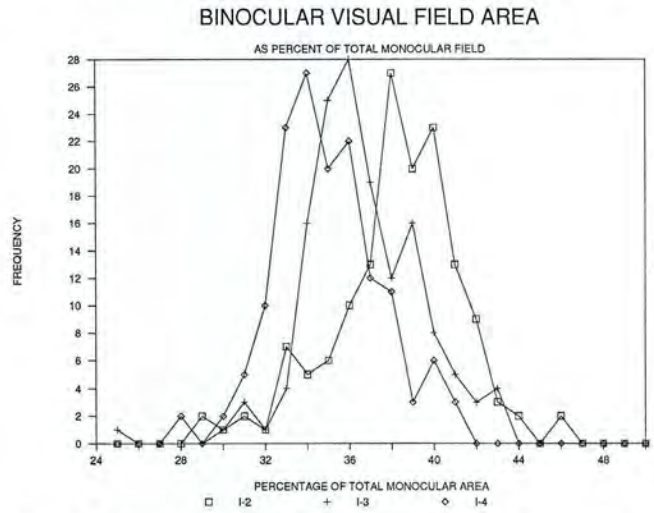


Figure 20. Binocular field area as percentage of sum of monocular field areas. Data from Group 1.

for the right visual fields: thus, sectors 3, 4 and 5 constitute the majority of the temporal field.

When a similar analysis into sector areas is performed for the binocular field data (Figures 8, 9 and 10, also derived from Group 2), one sees for the I-2 and I-3 stimulus that age does not produce a great change in the shape of the plot. For the I-4 stimulus, it appears as though there is a change in the shape of the plot with age: the area of sectors 6 and 7 seems to be markedly reduced in comparison with sectors 3 and 9. However, when one considers sector area as a percent of total area (Figure 11 shows this analysis for the 65- vs 15-year age groups for the Goldmann I-4 stimulus), one sees by inspection that the apparent difference in shape is not systematic. The variability of the field areas for the 65-year age group is considerably greater than that for the 15-year age group.

Linear regression data for the effect of age on the area of the binocular visual field are contrasted with the corresponding monocular data in Table 2. While the I-4 binocular field data, as shown in Figure 17 and Table 2, are not very well described by a straight line, they are not described any better by second- or third-order functions.

Other studies, based on static perimetry, have described the effect of age on the visual field in terms of decrease in

Table 1. Size of superior and inferior field as % of total field area

	Monocular sup/inf	Binocular sup/inf
I-2	46/54	48/51
I-3	45/55	47/53
I-4	44/56	46/54

Table 2. Regression equations for Figures 12 to 17

	Monocular	r	Binocular	r
I-2	y = -83x + 8623	0.71	y = -62x + 6565	0.71
I-3	y = -120x + 15021	0.75	y = -85x + 10851	0.71
I-4	y = -105x + 18686	0.71	y = -68x + 12976	0.59

Table 3. Binocular field area as percentage of monocular areas

	Mean	St. Dev.
I-2	38.2	3.05
I-3	36.6	2.86
I-4	34.9	2.5

sensitivity per decade: Jaffe et al.[8] report a decrease of 0.74 decibels per decade, while Haas et al.[9] found a decrease of 0.58 dB per decade. Direct comparisons between static and kinetic perimetry are difficult because of the different stimuli used (non-moving vs moving) and the threshold strategies used; however, it is possible to calculate a dB per decade value for the kinetic perimetry values I have reported here and elsewhere.[4-6] The effect of increased stimulus intensity on visual field area for Group 2 is shown in Figure 18. By inspection, these plots do not appear to indicate any systematic change in the responsiveness of the visual field to increased stimulus intensity as the older subjects are considered. Looking at the central tendency contained within the uppermost and lowermost error symbols, we could say that a change in stimulus intensity of 0.5 log units (e.g., from the Goldmann I-2 to I-3 target or from the I-3 to I-4 target) produces and average increase in field area of roughly 4500 mm^2. For the Goldmann I-2 isopter, the average decrease in field area per decade is 830 mm^2; this would correspond to an average sensitivity loss of (830/4500) x 0.5 = .092 log units = 0.92 decibels per decade. Corresponding values for the I-3 and I-4 isopters are 1.33 and 1.16 dB/decade.

Katz and Sommer[10] and Haas et al.[9] have reported that the loss of sensitivity of the static visual field is more marked in the superior than in the inferior field, although this finding is not confirmed by Brenton and Phelps.[11] Table 1 shows that the superior monocular kinetic field tends generally to be smaller than the inferior: perhaps this tendency contributes to the observations made by Katz and Sommer and by Brenton and Phelps. Analysis of the monocular field area data for Group 2, shown in Figure 19, indicates only random variation in the size of the superior field; these data thus support the position of Brenton and Phelps.

The rate of decrease of the binocular visual field with age is roughly 25% slower than that for the monocular visual field. This suggests that the temporal field suffers more loss with age than does the nasal field.

From Table 3 and Figure 20, one sees that the binocular field occupies a smaller portion of the combined monocular fields as the stimulus intensity is increased. Since the nasal field does not increase as much as the temporal field when stimulus intensity is increased, this difference is to be expected.

Comment

As is true in the case of the monocular field, it appears that age and intensity have the same effect on the area of the binocular visual field. We know that changes in pupil size and transmission of the ocular media are not at the root of this change, since visual field area shows a poor correlation with both pupil size and lens transmission.[12,13] Some process appears to be decreasing intensity information either en route from the retina to the brain, or at the level of the cortex. The known loss of ganglion cells[14] associated with age is a possible mechanism for this change: it must be a remarkably uniform loss of ganglion cells, since the shape of the visual field remains relatively constant throughout the process. The ability to measure visual field isopters and their areas is one method that permits monitoring of these changes.

This research was supported in part by a grant from the Canadian Optometric Education Trust Fund.

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Dizziness

LG Hart

A frequently encountered complaint for which the optometrist usually is the first practitioner consulted is dizziness. This occurs because it is widely believed that dizziness has an ocular origin. It is not enough to do a complete eye examination to rule out ocular involvement. The optometrist also must be able to make a proper diagnosis of the etiology in order to refer the patient as necessary to the appropriate practitioner.

Steadman's Medical Dictionary defines dizziness as "an imprecise term commonly used by patients in an attempt to describe various peculiar subjective symptoms such as faintness, giddiness, lightheadedness or unsteadiness".[1] Vertigo, a more precise term, is defined as "a sensation of irregular or whirling motion, either of oneself or of external objects".[1] The terms will be used interchangeably throughout this article. However, vertigo or dizziness also can be divided on the basis of subjective and objective signs and symptoms. In subjective vertigo there is a feeling as if one is moving in space, while in objective vertigo, things in space appear to move around one.

The causes of vertigo can be placed in the following categories:[1]

- otogenic: Ménière's syndrome, otitis media, acute vestibular neuronitis, labyrinthitis, obstructed external auditory canal or eustachian tube
- toxic: alcohol, streptomycin, opiates, diuretics
- psychogenic: hysteria plus anxiety attacks
- environmental: motion sickness
- ocular: diplopia
- circulatory: transient vertebrobasilar ischemic attacks
- neurologic: multiple sclerosis, skull fracture, temporal lobe seizures, encephalitis
- neoplastic: tumours of the pons or eighth nerve
- hematogenic: leukemia involving the labyrinth.

Differential diagnosis

Psychogenic vs organic vertigo

Sometimes it is difficult to differentiate anxiety from an organic vertigo. In anxiety, there is a sense of movement within one's head, or one's environment will appear to move. In organic vertigo, any exaggeration of vestibular imbalance — for example, by head movement — will intensify the symptoms (although this will not occur in anxiety).[2] In anxiety, a true imbalance (e.g., a loss of muscular coordination) will not occur. Anxiety is multidimensional and involves motor, cognitive and physiological components.[3]

Panic attacks are manifested by a sudden onset of intense apprehension accompanied by dizziness. Impending doom is felt along with dyspnea, palpitations, chest pain, smothering sensations, feelings of unreality, paresthesia, hot and cold flashes, sweating, faintness, trembling or shaking, fear of dying, going crazy, etc.[3] Attacks will usually last only for a few minutes but have been known to last for hours.

When faced with a patient with a "dizziness" complaint, a careful history is in order. Asking the patient to describe the symptoms in his or her own words, as precisely as possible, is perhaps more important than the assessment that will follow. The history usually enables the practitioner to place the symptom into either an organic or a psychogenic category. Unfortunately, both categories can co-exist and thus complicate the picture.

Usually symptoms related to organic disease will show some organic patterns,[2] such as, "when my surroundings spin around me I will tend to vomit" or "I feel drunk and will fall or stumble."

Symptoms due to psychological causes could include rapid heart beat, a feeling of instability, a feeling of being on the outside looking in at oneself and occasionally a hysterical panic attack. Psychological causes usually produce a variety of confusing symptoms as opposed to more specific, readily identifiable organic causes.[3]

Ménière's syndrome

This is characterized by sudden, episodic attacks of vertigo, tinnitus and progressive deafness. Nausea and vomiting can persist from minutes to hours.[4]

Benign Postural Vertigo (BPV)

While lying flat on one's back and trying to roll over, the room or the head begins to spin. This characterizes BPV. It is usually brief (less than 10 secs.) and postural, and occurs only when the head position is changed and thus the orientation of the vestibular receptors is changed.

Ataxia

This is characterized as unsteady walking or staggering. We achieve balance by the interaction of three senses: visual, vestibular and proprioceptive.

Deprivation of visual sensation, as in darkness, always increases organic ataxia but may not in the anxious person.[2]

Nystagmus

Patients who complain about vertigo must be carefully examined for any nystagmoid movements. Nystagmus can be found in three forms:

- jerk — with slow and quick components in opposite directions
- pendular — movements of equal amplitude and velocity in opposite directions
- rotational — a great majority of nystagmoid movements are of a horizontal nature but also can be vertical. If vertical, the movements are virtually pathognomonic of central nervous system localization.[2]

Horizontal nystagmus occurs in both peripheral vestibular and central nervous system abnormalities. Nystagmus without vertigo is usually congenital, while in the presence of vertigo, primary position nystagmus may be due to either a peripheral or a central lesion.[2]

The most common diagnoses of the cause of dizziness, in descending order of frequency of occurrence, are as follows:[2]

- psychogenic
- undiagnosed/idiopathic
- benign postural vertigo
- Ménière's disease
- vestibular neuropathy
- head injury
- ischemic brain disease.

LG Hart, OD, FAAO — Beaconsfield, Québec

It is interesting to note that an ocular cause is not ranked, but I suspect that this falls into the undiagnosed category. Borish[5] has stated that dizziness, nausea and vertigo may be associated with eyestrain. He postulated that these symptoms usually involve some difficulty with binocularity or spatial perception. People who suffer from chronic spasms of accommodation may complain of feeling dizzy rather than of having blurred vision.

Since dizziness is a common adult complaint and is quite often voiced by the elderly, we must be able to separate the organic cause from the psychogenic. Proper diagnosis and referral can save the patient much time and distress when treatment or appropriate referral is instituted promptly.

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Ophthalmic Abstracts ◈ Abrégés ophtalmiques

Editors reviewing articles from recent issues of ophthalmic publications are identified as follows: (RC) Dr Ralph Chou; (LH) Dr Lorne Hart; (MP) Dr Mark Pogue; (MS) Dr Mitch Samek; (PS) Dr Pierre Simonet. Publication references are included for those wishing to read the complete paper discussed in the abstract.

The BITA telescope: A first impression

Harkins, T; Maino, JH: *Journal of the American Optometric Association*, Vol 62, No 1 (Jan 1991) p 28

In this study, the authors examine the Edwards Optical BITA System and find that subjects obtain the Bi-level effect with no loss in field of view with this system compared to others. The authors mention that patients were warned about the safety hazards to the eye as the BITA System extends behind the lens toward the eye.

Unfortunately, the authors were able to test only one size and power of these telescopes. However, they found that the BITA provided a more functional visual field with less impact on spatial orientation than other similar telescopes. **(MP)**

The Ocutech Vision Enhancing System (VES): Utilization and preference study

Greene, HA; Pekar, J; Brilliant, R et al: *Journal of the American Optometric Association*, Vol 62, No 1 (Jan 1991) p 19

This paper describes a scientific technique to assess user and prescriber preference with the Ocutech VES to two conventional Keplarian spectacle telescopic systems.

Fifty-five visually impaired individuals (aged 18-81) with both telescope and no telescope experience were assessed. The assessment was done using standardized clinical protocol. A statistically significant proportion of both prescribers and users preferred the new device due to its appearance, weight adjustability and fit of frame superiority to other systems.

Although surprised by the results, this reviewer is impressed by the scientific method being used to assess these devices. **(MP)**

Management of scarred cornea with RGP contact lens

Horner, Soni, Heath, Gerstman: *International Contact Lens Clinic*, Vol 18 (Jan-Feb 1991) p 9

A corneal laceration often leaves scarring and distortion of the corneal surface.

In this article, the authors use the corneal molding system (CMS), which makes 7000 measurements of a 31-ring keratoscopic target of nearly the entire 12-mm diameter of the cornea.

The authors use this information, together with the usual techniques of trial contact lens fitting, to fit an eye with fixed irregularly dilated pupil caused by vitrectomy and lensectomy performed to repair ocular penetration. CMS suggested a larger diameter and steeper peripheral curve to provide clearance between the contact lens and the scarred cornea. CMS also revealed features of the scarred cornea not revealed previously by keratometer or photokeratoscope.

CMS was also useful to monitor the cornea after contact lens wear for changes in corneal shape. The cost of the CMS was not mentioned, but this may well be an instrument of the future. **(MP)**

Diabetic retinopathy: "The new imperative"

Cavallerano: *Review of Optometry*, Vol 128, No 1 (Jan 1991) p 9

This excellent article summarizes the findings of the early treatment of diabetic retinopathy study. The risk of severe visual loss can be cut to less than 10% as long as patients receive laser surgery in time. This article goes on to describe the five basic pathological processes involved in diabetic retinopathy. Non-proliferative and proliferative diabetic retinopathy are discussed along with macular edema. The article closes with a summary of post-laser rehabilitation in which, along with early detection and referral, optometrists can play an important role. **(MP)**

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Book Reviews

Lu pour vous

***Visual Impairment: An Overview**, by IL Bailey, A Hall. 1990 by American Foundation for the Blind, 15 West 16th Street, New York, NY, 10011, USA. 49pp, illustrated. $12.95 (US) plus $3 postage and handling (bulk order discounts available)*

I will admit to being a bit of a cynic when it comes to anything that crosses my desk under a letterhead that identifies the sender as "XYZ Society / Foundation / Institute for the Blind". Past experience usually has been to read a document that inevitably carries a heavy medical bias and, when it mentions Optometry at all, is incomplete, woefully out of date or just plain wrong.

Such, however, is most definitely not the case with a new book put out by the American Foundation for the Blind, Inc (AFB) entitled *Visual Impairment: An Overview*.

On p.36, for example, we read: "Optometrists are professionals who specialize in the assessment and treatment of visual problems. They prescribe eyeglasses, low vision optical devices, and contact lenses, provide eye coordination training, evaluate the health status of the eyes, and can prescribe medication for the treatment of ocular disorders. Some optometrists specialize in particular areas, such as contact lenses or low vision or treating children or athletes."

As a definition, this is as generally complete as anything we have used in public statements put out by CAO.

Of course, it helps that the authors of *Visual Impairment* are, respectively, a professor of Optometry and Physiological Optics, and Director of the Low Vision Centre at the School of Optometry, University of California at Berkeley (Bailey) and Low Vision Services Coordinator and Research Specialist at the same institution (Hall). But it is nonetheless a refreshing change of pace for someone used to, at best, the varying degrees of recognition accorded Optometry in documents put out by our own CNIB.

In the introduction, William Gallagher, the AFB's President and Executive Director, presents it as a book "that bridges the gap between material aimed at the clinical specialist and information for the general public". This it is, indeed. *Visual Impairment* begins with an overview of the visual system and common vision problems; proceeds to types of vision loss; causes and treatments of low vision conditions; reactions to vision loss; optical treatments of low vision; coping with vision impairment; and, finally, sources of assistance and a list of available resources (unfortunately, exclusively US based, with no Canadian contacts whatsoever — the book's only failing for Canadian readers) and recommended readings.

It is an informative and potentially reassuring tool for the practitioner faced with explaining a possible low vision condition to a patient. The book, in detailing treatment options and adaptive devices, always begins with the fact: a basic recognition that, yes, you have a visual impairment, possibly a severe one; but it also follows up immediately with a presentation of choices available to the low vision patient. The chapter on impairment and independent living, for example, begins with the necessity of selecting adaptive devices matched to an individual's life situation and goals. Once that is understood, the practitioner is then able to guide the patient through the myriad of low vision aids, training programs and available rehabilitative and/or education resources.

I would recommend *Visual Impairment* as a very good starting point for a practitioner looking for terminology to explain to a patient or family member the nature of the low vision condition; alternatively, it is also written in such a straightforward manner (the "gap bridging" referred to in its introduction) that it could comfortably be loaned to a patient and/or family member to help him or her come to grips with not only the nature of the low vision condition, but also the range of treatment choices available for consideration.

No one can remove the emotional difficulty, stress, indeed the pain, that is undoubtedly felt by both practitioner and patient alike when the former has to tell the latter he or she is facing a serious vision impairment. But this is not the book's goal. It will, however, go a long way toward helping remove the mystery and the unknown from not only what the condition is, but also how it can best be treated and accommodated "to promote independence and a sense of well-being for the individual".

Michael J DiCola
Director of Communications, CAO

***Manual of Fundus Fluorescein Angiography**, by A Chopdar. 1989 by Butterworths & Co, London. 134 pp, illustrated. $72*

Editor's note: In our Autumn 1990 issue (Vol 52, No 3), a section of this review was inadvertently omitted. This is the complete text of the review as it should have appeared.

For some time there has been the need for a book which would provide not only introductory information describing the established diagnostic technique of fluorescein angiography, but also the basics of interpretation of the angiographic findings with respect to the underlying disease processes.

The introduction of a practical fundus camera by Zeiss in the 50s, followed by the extension of the earlier work of Sorsby by Novotny and Alvis, stimulated numerous researchers and clinicians to explore the potential of fluorescein angiography as a practical and helpful ocular diagnostic technique. During the 60s, our efforts concentrated on the technical aspects, such as developing booster packs for the flash to facilitate high speed recording. In addition, we experimented with different exciter and barrier filters, concentrations of fluorescein, the amount and speed of injection to achieve an optimal bolus of dye, types of b/w and colour film, and stereoscopic angiography. Concurrently, the nature of the normal fundus angiogram was defined, and any disorder in which dynamic observation of the ocular circulation might provide valuable or supportive information was evaluated by this procedure. The body of literature from this period is extensive and its importance is emphasized by the references and suggested further readings provided by Chopdar.

The interpretation of fluorescein angiograms requires a knowledge of the dual vascular systems of the posterior eye and the phenomena which may produce abnormal fluorescence. Some ocular tissues (eg cornea, lens, retina) autofluoresce with varying levels of intensity; some abnormal structures may also autofluoresce (eg optic disc drusen). During angiography, hypofluorescence is produced either by filling defects (choroidal infarcts, retinal vascular occlusions) or by blocking of the exciting light by pigment (melanin, blood, xanthophil) or serous fluid. Hyperfluorescence occurs as a result of leaking vessels (neovascularization, telangiectasia, tumour vessels), pooling of dye (central serous retinopathy,

papilloedema) and window defects (atrophy of retinal pigment epithelium, drusen).

Each chapter in this book is introduced by a brief description of the underlying pathology relevant to the conditions to be illustrated by the fluorescein angiograms. Successive chapters discuss retinal vascular disorders, macular disorders, central serous retinopathy, macular dystrophies, choroidal disorders, diseases of the optic nerve head and intraocular tumours. The concluding chapter introduces the vascular changes associated with diabetes mellitus with examples of background and proliferative retinopathy, and diabetic maculopathy in which the angiogram revealed numerous microaneurysms with capillary dilatation and tortuosity, whereas only a few microaneurysms with a suggestion of macular oedema were visible ophthalmoscopically. This latter case serves to remind us that extensive microvascular changes may not be readily detectable by routine clinical methods.

The text is supported by the photography of Kulwant S Sehmi, whose excellent quality angiograms have been well-reproduced by the publishers. One figure, displaying the perimacular capillary network and the foveal capillary-free zone, has been enhanced by a contrast masking technique. This whets the appetite, but those seeking further examples of image analysis and advanced storage and retrieval systems will have to look elsewhere.

Although this book is directed at trainee and practising ophthalmologists, optometrists will find it a valuable aid in interpreting journal articles which include fluorescein angiograms and copies of angiograms which are frequently forwarded by retinal specialists following referrals. It is a useful basic reference and deserves a place on the bookshelf of any eye care practitioner.

AP Cullen, MSc, OD, PhD, FBCO
School of Optometry, University of Waterloo

Calendar

Calendrier

For further information regarding events sponsored by the Canadian Association of Optometrists, call or write to the CAO office in Ottawa unless otherwise indicated below. For events sponsored by a provincial association or society of optometrists, or for international events, contact the hosting organization identified in the item.

1991

May 23-June 27: 1991 Summer Workshop Series, Vision Institute of Canada. Information:
MJ Samek, OD, MSc, FAAO
Vision Institute of Canada
Suite 301 — 815 Danforth Avenue
Toronto, ON, M4J 1L2
Tel (416) 461-6222
Fax (416) 461-3474

May 30-June 22: 1991 Continuing Education Program, School of Optometry, University of Waterloo. Information:
Jeff Hovis, OD, PhD
School of Optometry
University of Waterloo
Waterloo, ON, N2L 3G1
Tel (519) 885-1211
Fax (519) 746-7937

July 12-14: Contact '91, The Congress for Successful Contact Lens Practice co-sponsored by Contact Lens Spectrum and Review of Optometry, Fairmont Hotel, San Francisco, CA. Information:
Jill Stone Squire
PO Box 829
West Redding, CT, 06896, USA
Tel (203) 866-5332
Fax (203) 853-2164

August 5-9: Magique Manitoba Magic, 22nd Biennial Congress of The Canadian Association of Optometrists, Winnipeg, Manitoba. Information:
Dr Scott Mundle, Chairman
310 — 1695 Henderson Highway
Winnipeg, Manitoba, R2G 1P1
Tel (204) 582-2308
Fax (204) 231-1672

October 14-17: National Eye Research Foundation Congress, Mirage Hotel and Casino, Las Vegas, NV. Information:
National Eye Research Foundation
910 Skokie Blvd
Northbrook, IL, 60062, USA
Tel (708) 564-4652

November 1-2: 9th Annual Fundraising Seminar and Draw, Vision Institute of Canada, Sheraton Centre Hotel (Toronto). Information:
MJ Samek, OD, MSc, FAAO
Vision Institute of Canada
Suite 301 — 815 Danforth Avenue
Toronto, ON, M4J 1L2
Tel (416) 461-6222
Fax (416) 461-3474

November 18-21: Bausch & Lomb's European Symposium on Contact Lenses, Geneva, Switzerland. Information:
Mary Dorton, Associate Manager, Professional Services
Bausch & Lomb Canada Inc
85 Leek Crescent
Richmond Hill, ON, L4B 3B3
Tel (416) 886-6860
or 1-800-668-7510

December 12-16: American Academy of Optometry 1991 Annual Meeting, Disneyland Hotel, Anaheim, CA. Information:
The American Academy of Optometry
4330 East-West Highway, Suite 1117
Bethesda, MD, 20814, USA
Tel (301) 718-6500
Fax (301) 656-0989

1992

June 14-19: 6th International Congress of the South African Optometric Association, Sun City, Bophuthatswana. Information:
Congress Secretary
SA Optometric Association
PO Box 3966
Pretoria, 0001, South Africa
Tel (012) 322-1310
Fax (012) 322-1313

Vision Care News Actualité oculo-visuelle

(Unless otherwise noted, all items appearing in Vision Care News are written by ***Michael DiCola****, CAO Director of Communications. Where external information sources were used in compiling an item, these are also identified and an address for readers wishing further information, if provided with the source material, is included.)*

COETF 1991 Awards Program: $63,500

The 1991 Awards Committee of the Canadian Optometric Education Trust Fund met on Friday, 22 March. As a result of its deliberations, the Committee, under Chairman Dr Ralph Rosere of Dartmouth, Nova Scotia, is pleased to announce the following grants and awards:

1. School of Optometry, University of Waterloo

Dr MG Callender: $2,500 for a project entitled "Analysis of Hydrogel Contact Lens Deposits: Morphological and Immuno-Chemical"; **Drs MG Callender, BR Chou, AP Cullen** and **L Sorbara**: $1,000 support towards continued publication of the School's outstanding *Contact Lens Journal*; **Dr BR Chou**: $3,500 for a project entitled "Impact Resistance of Prescription Safety Spectacle Lenses"; **Dr AP Cullen**: $2,500 for a project entitled "Human Conjunctival Response to Ultraviolet Radiation"; **Dr EJ Fisher**: $3,000 in support of the continuation of the Museum of Optometry and Visual Science; **Dr D Fonn**: $3,500 for a project entitled "Correlates of Topographical Corneal Swelling and Contour Change Measurements Using the Topographical Modeling System and Modified Electronic Pachometry"; **I Geer** (under the supervision of **Dr KM Robertson**): $3,000 for a project entitled "The Effects of Velocity and Contrast on Dynamic Visual Acuity"; **Dr WV Hatch** (under the supervision of **Dr J Flanagan**): $2,000 for a project entitled "Psychophysical Investigation of Large Axon Parvo- and Magnocellular Function in the Early Detection of Glaucoma"; **Dr JK Hovis**: $1,500 towards a study entitled "Vision Standards and Colour Vision in the Electronics Industry"; **Dr WM Lyle**: $2,000 for a project which will yield a number of new research papers, many of which will appear in future issues of the *CJO*RCO*: "Inherited Conditions of Importance to Optometrists"; **A Nurani** (under the supervision of **Dr MM Spafford**): $1,000 for a project entitled "Standardization of the Photostress Recovery Time Method for Monitoring Macular Function"; **Dr BE Robinson**: $3,500 towards a study entitled "Analysis of Vision Screening Data: Phase 1 — Compilation and Computer Design"; **Dr MM Spafford**: $3,000 tuition support for a PhD in Education; **Dr GCS Woo**: $1,000 to assist in the production of a Low Contrast Distance Acuity LogMar Chart for clinical use.

2. École d'optométrie, Université de Montréal

RMC Demanins (under the supervision of **Dr A Kothe**): $3,000 for a project entitled "Physical and Physiological Factors Affecting Blood Flow in Man"; **Dr C Giasson**: $3,000 for his "Projet de doctorat en Optique Physiologique (School of Optometry, University of California at Berkeley)" under the supervision of **Dr J Bonanno**; **Dr JV Lovasik**: $2,500 for a project entitled "Digital Imaging Techniques for the Detection and Monitoring of Ocular Disease"; **Dr N-M Quesnel** (under the supervision of **Dr P Simonet**): $1,500 for a project entitled "Effets de la désinfection par micro-ondes sur les paramètres optiques des lentilles cornéennes".

3. Association Sponsored Programs

Nova Scotia Association of Optometrists (under the supervision of **Dr C Davis**): $7,000 towards Vision and Eye Care Exhibits at the Discovery Centre.

4. Vision Institute (in Toronto)

Dr MJ Samek: $8,500 to fund two optometric student summer clerkships at the Institute.

5. Independent Practitioner Research

Dr RA Strath: $2,500 towards a study of the effect of partial pressure of oxygen on visual fields; **Dr MJ Sullivan**: $2,500 towards "A Cross-Sectional Epidemiological Study Involving the Health and Refractive Status of Native North Americans in Northern Manitoba".

Applications this year totalled over $349,000.00. Including the 1991 Awards, the COETF, since its first Award was made in 1980, has now granted over $615,000 in support of vision and eye care research projects in Canada!

New COETF appointments

The Trust Fund is pleased to announce two new appointments: Following the resignation of Trustee Dr Dave McKenna, Dr Mike Duffey of Middleton, Nova Scotia (also the NSAO Councillor to CAO and Secretary-Treasurer of the national Association) was appointed to the Board of Trustees. He joins Chairman Dr Margaret Hansen des Groseilliers of Ottawa and Dr Rix Graham of Smithers, BC.

In addition, the COETF is delighted to welcome Dr Roland des Groseilliers to the position of National Fundraising Chairman. Dr des Groseilliers' appointment was ratified by CAO Council at its Spring 1991 meeting; he succeeds Dr Reid MacDuff, who resigned after several years in the position.

Waterloo update

The 2nd annual Clair Bobier Lecture in Vision, held last October 11 at the School of Optometry, University of Waterloo, featured Ronald Jones, OD, MS, PhD, Professor of Optometry at the College of Optometry, Ohio State University. A 1967 graduate of the College of Optometry in Toronto, Dr Jones received both his MS and PhD from Ohio State. He has been a faculty member there since 1972. Although his research interests include the electroretinogram (ERG) and Visual Evoked Potential (VEP), contrast sensitivity and pseudomyopia, his main interest is the study of the relationship between accommodation and convergence. His lecture topic was "Oculomotor reactions: basic and clinical aspects" and, in it, he reviewed current concepts of the interactions between accommodation, convergence and the pupil, and showed how these may influence the measurement and perhaps the development of refractive error. He also described their implications for optometric case analysis.

Mrs Mildred Bonnett has retired from the School of Optometry on April 1, after 16 years of service in the clinic's Optical Services department. She was chiefly responsible for prescription order processing and management of the clinic's huge frame inventory. During their academic years, many students had

the opportunity for contact with Millie as they dealt with the problems of back-ordered frames and delayed lens orders. She and her husband, Harold, were guests of honour at a farewell dinner held March 5 at the University Club.

The 1991 Meredith Morgan Lecturer at the School of Optometry, University of California at Berkeley is Dr Jacob G Sivak, past Director of the Waterloo School of Optometry. The annual lecture and acompanying symposium are named in honour of one of the giants of American Optometry and long-time Berkeley faculty member Dr Meredith Morgan. The theme of this year's symposium, held May 18-19, was management of cataract. Dr Sivak's lecture was entitled "Optical properties of the cultured lens in cataract research".

Changes in the admissions process, beginning with the class entering this year, have been announced by Dr Marlee Spafford, Admissions Officer. A new Admissions Committee, which is made up of faculty members, a student representative and a local practitioner, has been organized. The interview process has also been revised. It is intended that the changes will result in a more equitable and open selection process, as well as help expedite the administration of the several hundred applications received each year for the School's 60 Year 1 places.

Several new members of the **Centre for Contact Lens Research** staff were welcomed to the School this year. Dr Donna Williams-Lyn, who received her PhD from Aston University, comes to the CCLR after several years' practice in Jamaica. Dr Nicola Pritchard arrived in January from Australia and Dr Kathy Weed in March, from Cardiff, Wales. Dr David Elliott has taken a position as a Research Assistant Professor at the Centre for Sight Enhancement. Dr Elliott comes to Waterloo from the University of Bradford in England. And Dr Susan J Leat brings a special interest in low vision to the School's clinical faculty faculty. Dr Leat is from the University of Wales. (Contributed by Dr BR Chou)

Canadian students in US schools of optometry

The Spring 1991 issue of the *Journal of Optometric Education* offers a revealing survey of foreign student enrollment in US Colleges of Optometry.

Not surprisingly, given our geographical proximity, Canada tops the list of source countries for non-US students, with a total of 65 Canadians enrolled in the four-year OD program, and one in a post-graduate program.

By way of comparison, only three other countries had more than two enrolled students in US Colleges of Optometry: Iran (6); Taiwan (4) and the Bahamas (3).

The survey results also show that Canadian enrollment in US Schools over the past decade has taken a significant jump, but particularly in the past three years. In 1980-81, there were a total of five Canadian students registered in American four-year OD programs. By 1986-87, the number had risen to 23; a year later to 41 and, finally, to the 66 tallied in last year's survey.

Interestingly enough, the author points to Canada's standard of practice, "relatively unfettered by government regulation at this time", and a corresponding "difficulty obtaining entry into optometry schools in Canada" as the reason Canadian students are "turning to United States schools in increasing numbers".

The complete survey and analysis appears as: Katz, Arnold, OD: "A Survey of Foreign Student Enrollment in United States Colleges of Optometry: 1989-1990"; *Journal of Optometric Education*, Volume 16, Number 3 (Spring 1991); pp.91-94.

The *JOE* is the publication of the Association of Schools and Colleges of Optometry (ASCO) with Editorial offices at 6110 Executive Boulevard, Suite 514, Rockville, MD, 20852, USA. Tel (301) 231-5944.

Joining the "Special Few": How to obtain an FAAO

A new brochure issued by the American Academy of Optometry offers a few guidelines for optometrists seeking to qualify for the Fellowship designation (FAAO).

"An optometrist must have practised the profession for a minimum of three years. Each candidate for Fellowship must maintain the highest professional standards and demonstrate a scientific approach to eye care. Each candidate submits written case presentations and is examined by a panel of leading doctors of optometry, who review the presentations and the candidate's professional credentials. Most Fellows of the American Academy of Optometry provide primary eye care. Many have particular interests and limit their practices to such specialties as contact lenses, pediatric vision, binocular vision and low vision care. Some devote their time and efforts to research and teaching. FAAO optometrists are dedicated to providing leadership in scientific and clinical developments. They remain in the forefront of eye care developments by attending continuing education programs, symposia and lectures, particularly those presented at the Annual Meeting of the Academy of Optometry. An FAAO optometrist reads numerous professional journals, including the Academy's monthly journal, which is recognized as the most prestigious optometric publication worldwide."

For more information (NOTE: This is a new address, effective 23 February 1991): The American Academy of Optometry, 4330 East-West Highway, Suite 1117, Bethesda, MD, 20814, USA. Tel (301) 718- 6500. FAX (301) 656-0989.

Academy creates new Primary Care Diplomate

In its January/February 1991 newsletter, the American Academy of Optometry announces the commencement of a Diplomating Process in Primary Care. Chairman of the Primary Care Section, Dr Felix Barker, reports that Executive Council approval was granted after a year and a half of preparation by the Section's Diplomate Committee.

The concept of a Diplomate in Primary Care is that of an experienced practitioner who "assumes responsibility for the total visual, ocular and related care of his/her patients."

Achieving this unique recognition will be a rigourous process. Candidates will be required to combine case reports, written and practical exercises and interviews over a period of two to five years.

Further information and application materials are available at the Academy office (address above).

Info on Behavioral Optometry

The US Optometric Extension Program (OEP) Foundation is a non-profit educational foundation committed to furthering public awareness of vision care through Behavioral Optometry.

Recently, the OEP issued a news release advising that three new pamphlets have just been published for general patient education: "Bound for the Land of Good Vision", a colourful pamphlet designed to educate children about their visual systems; "A Plus for You", which looks at visual stress and lenses which can be used to provide "more comfortable and efficient vision"; and "Strabismus and Amblyopia", which reviews causes, symptoms and treatment options.

Behavioral Optometry emphasizes the holistic approach to vision care. In an explanatory brochure, the OEP advises patients, "You are treated as a whole person and your vision problem as a part of the whole system. Your

behavioral optometrist works *with* you and your children, rather than doing something *to* you." (The process is recommended particularly by the OEP for children just starting school, or for children experiencing reading or learning difficulties.) Behavioral Optometry's therapy begins with "carefully selected stress relieving and preventive lenses and visual training".

For further information: OEP Foundation, 2912 South Daimler, Santa Ana, CA, 92705, USA. Tel (714) 250-8070.

Canadians well represented at first International Conference on Optometric Education

Houston, Texas, played host in December to a conference unique in Optometry's annals — the International Optometric and Optical League (IOOL)'s first ever gathering of optometric educators from around the world.

A total of 51 countries were represented including, for the first time at an IOOL meeting, Poland, the USSR, Bulgaria, Hungary, Jordan and China.

Also at this meeting, the African delegations agreed to form a new optometric body, the Pan-African Optometric Organization, which will hold its inaugural meeting in Namibia this August.

The keynote address was delivered by Dr Irvin Borish. All those papers presented at the Conference will be edited by Dr Henry Hofstetter and the meeting's transactions printed with the generous assistance of a grant from Bausch & Lomb.

Meanwhile, *shown in the photo* are four members of Canada's delegation to the Conference. (L-R): Dr Roland des Groseilliers, CAO's delegate to the International Optometric and Optical League; Dr Margaret Hansen des Groseilliers, President-elect of CAO and Chairman of the Canadian Optometric Education Trust Fund; Dr J Graham Strong and Dr George CS Woo, both of the School of Optometry, University of Waterloo.

Call for papers: 1992 South African Congress

The 6th International Congress of the South African Optometric Association will be held at Sun City, Bophuthatswana, June 14-19, 1992.

The Congress will cover all aspects of Optometry and planned speakers include practitioners, researchers and academics from all around the world. Sun City, with its renowned casinos, glitter and shows, is known around the world as South Africa's Las Vegas. Delgates to the Congress will also be able to take part in a variety of sporting activities and observe wildlife in the Pilanesberg Game Preserve nearby.

The Congress is also inviting papers from interested practitioners and academics. Proposals should be sent to the Congress' Secretary no later than 31 January 1992 and should include the title of the paper, an abstract, the initials and surname(s) of the author(s) along with a full mailing address.

For further information: Congress Secretary, SA Optometric Association, PO Box 3966, Pretoria, 0001, South Africa, Tel (012)-322-1310; FAX (012)-322-1313.

Visual Problems of Aging:

A Report of the 2nd Convention of the Instituto Regionale Studi Ottici e Optometrici (IRSOO) March 10-11, Empoli, Italy

A total of 250 optometrists, ophthalmologists and dispensing opticians gathered for this 2nd conference organized under the auspices of the *L'Oroptero* journal and the Institut Regionale di Studi Ottici e Optometrici (IRSOO). The conference was an important function for Optometry in Italy, a useful combination of Continuing Education and new information. In Italy, optometrists are not yet registered, although there is some provision for opticians. At present, IRSOO provides a one-year full-time course, resulting in an optician's licence. This can be followed by a further two years' study to obtain a Diploma in Optometry. This is an exciting time of possible change for optometrists in Italy as the European Economic Community (EEC) opens up in 1992, providing for the free interchange of skilled and professional personnel within the EEC.

Papers presented over the two days covered topics ranging from Visual Evoked Potentials (VEPs) and endothelial cell density to ultraviolet (UV) protective lenses and practical advice for the accurate prescription of reading additions.

Adriana Fiorentini (University of Pisa) spoke first, on the changes in VEP with age. It is well-documented that the average visual acuity for age decreases after 50 years. So also does contrast sensitivity (the peak shifts downwards and to the left) and temporal contrast sensitivity.

Of particular interest was Lucio Buretta (Secretary of the European Society of Refractive Surgery)'s discussion of the incidence of cataract in Italy and the current trends in cataract surgery. In Italy, the prevalence of legal blindness is 4% of the total population, of which cataract causes some 30-40%. The reasons that surgery has not been undertaken are given as a combination of economic, educational and a fatalistic attitude among the population. However, recently there has been a drastic increase in the amount of cataract surgery being undertaken. The majority of operations are now posterior chamber intraocular lens (IOL) implants. (The percentage of these is similar to that in the US; of IOLs, 90% are posterior chamber. 89% are UV absorbing lenses.) The majority of cataract operations are now treated as day cases.

Fabio Casalboni discussed the changes in endothelial cell density with age and the effects of contact lens wear. This was followed by an afternoon which largely focussed on low vision. Susan Leat reviewed statistics from the Low Vision Clinic at the University of Wales College of Cardiff (UWCC), UK which show that the majority of low vision patients' needs can be met in an optometric practice with a suitable range of simple and inexpensive low vision aids. She also discussed how we may need to modify our understanding of what constitutes a successful outcome from a low vision assessment.

Dr Leat's presentation was followed up by Nicholas Rumney (also from UWCC), who described a rational system for predicting the improvement in print size from hand and stand magnifiers, an area which has been a pitfall for optometrists in the past. Guido Mastellone (IRSOO) delivered a presentation on retinal vascular disease.

In a separate presentation by Alberto Wirth (IRSOO), visual field, ERG amplitudes and dark adaptation were all shown to be affected by age. The visual field isopters decrease in size even after normalizing for the reduction of retinal illumination. He suggested that this might be due to a reduction in the number of Muller cells. He also showed a correlation between ERG amplitudes and thyroid dysfunction. (Contributed by Dr Susan J Leat, Centre for Sight Enhancement, University of Waterloo)

Glaucoma front and centre in two Toronto programs

1. World's first ultrasound device for microscope imaging of the eye unveiled at OCI/PMH

The first ultrasound device in the world capable of producing images of the human eye at microscopic resolution was publicly unveiled at a news conference April 4 at the Ontario Cancer Institute / Princess Margaret Hospital (OCI/PMH).

The basic scientific research has been carried out for the past several years under the direction of Stuart Foster, PhD, a senior scientist now at the Sunnybrook Health Science Centre, and Dr Charles Pavlin, of PMH's Department of Ophthalmology.

According to a news release issued by PMH's Director of Public Relations, the device offers "major" implications for diagnosis and treatment of many different types of eye disease, including determining the causes of, and developing new treatments for, various types of glaucoma.

The device has been called "the most important development in the last seven years in terms of improving our understanding of the underlying mechanisms of glaucoma", by the Chief of the Glaucoma Service at the New York Eye and Ear Infirmary, who had recently brought several of his own patients with him to Toronto, at his own expense, to test the diagnostic procedure.

Further information: Leslie Dutton, Director of Public Relations, OCI/PMH, 500 Sherbourne Street, Toronto, ON, M4X 1K9. Tel (416) 926-4587.

2. Early glaucoma detection study underway in Toronto

Meanwhile, Optometry is very much involved in another new study which is being performed to investigate techniques for the early detection of glaucoma. The project is a joint study being undertaken by the School of Optometry, University of Waterloo and the Department of Ophthalmology at the Toronto Hospital General Division.

The Medical Research Council of Canada is funding the research unit, based at Toronto Hospital and headed up by Dr John Flanagan of the Waterloo School of Optometry and Dr Graham Trope of the hospital's ophthalmology department.

The unit's researchers are currently seeking volunteer ocular hypertensives and patients with primary open angle glaucoma for tests which will be conducted over a five-year period. The tests are non-invasive, subjective, clinical procedures, requiring two visits per year, each of approximately 1½ hours' duration. Testing will include blue on yellow perimetry, peripheral displacement thresholds and flicker fusion frequency.

Anyone wanting more information or wishing to take part should contact the Toronto Glaucoma Research Unit at (416) 340-3743.

VDT safety

In response to concern and a growing pool of data on VDT related injuries and health problems, including "visual distress, musculoskeletal injuries, skin and even genetic abnormalities possibly related to VDT electromagnetic radiation", the City of San Francisco enacted Phase 1 of a tough new video display terminal safety ordinance on January 7.

According to a news release prepared by the Optical Coating Laboratory Inc (OCLI), the ordinance requires San Francisco's "city and private businesses with 15 or more employees ... to provide a safer workplace for people who use desktop computers for four or more hours a day." Quoting from an article in the *San Francisco Examiner*, the OCLI release also advises that "the city ordinance requires ... that the glare on computer screens be reduced, either by adjusting lighting fixtures or by installing a 'glare shield'".

OCLI, not surprisingly, offers the above background to support the announcement of its new Glare/Guard E-shield filter which it claims "eliminates 99.99% of ELF/VLF E-field radiation (using the method of Military Standard 285) emitted from the front of the monitor".

Further information: Optical Coating Laboratory Inc, 2789 Northpoint Parkway, Santa Rosa, CA, 95407-7397, USA. Tel (707) 545-6440.

Junk mail blues

Well, OK, not "junk" mail. But if you feel you're receiving more "national commercial mail" than you want, take heart. A recent advisory issued by the Canadian Direct Marketing Association (CDMA) announces the creation of a new Mail Preference Service (MPS). Obviously, they're proud of it — it's called "Operation Integrity" and is designed to assist consumers who want to decrease the amount of junk mail (sorry, "unwanted national commercial direct mail") received at their homes.

By writing to Operation Integrity — MPS, c/o Canadian Direct Marketing Association, 1 Concorde Gate, Suite 607, Don Mills, ON, M3C 3N6, consumers may register their names, addresses and phone numbers on a special "delete" file which directs their removal from lists of such mailings for a period of three years.

The delete file is distributed to CDMA members and other business subscribers four times a year. The CDMA advises that the delete instruction applies only to mail from CDMA subscribers. Consumers who wish to eliminate mail solicitations from local merchants should write directly to the companies or businesses involved.

TOWN OF ESTERHAZY
PROVINCE OF SASKATCHEWAN

Esterhazy, a town of 3,083 located in east-central Saskatchewan, is seeking the services of an optometrist. The area is generally characterized by mixed farming and potash mining.

Whether you have an existing practice and would like to relocate, or you have recently graduated and would like to set up your first clinic, please consider our thriving community.

Please direct enquiries as follows:

Brian Sych
Esterhazy Economic Development Corp.
Box 490
Esterhazy, Saskatchewan
S0A 0X0
Phone (306) 745-3942

The Canadian Association of Optometrists Annual Report

1990

l'Association canadienne des optométristes Rapport Annuel

CAO and Its Corporate Members

Membership in CAO is automatically extended to those practitioners who are active members in good standing with a provincial Association of Optometrists:

Canadian Association of Optometrists
Suite 301 — 1785 Alta Vista Drive
Ottawa, ON, K1G 3Y6
Tel (613) 738-4412
Fax (613) 738-7161

British Columbia Association of Optometrists
125 — 10451 Shellbridge Way
Richmond, BC, V6X 2W8
Tel (604) 270-9909
Fax (604) 270-4950

Alberta Association of Optometrists
11830 Kingsway Avenue
Edmonton, AL, T5G 0X5
Tel (403) 451-6824
Fax (403) 452-9918

Saskatchewan Association of Optometrists
4 — 117 3rd Avenue South
Saskatoon, SK, S7K 1L7
Tel (306) 652-2069
Fax (306) 244-7743

Manitoba Optometric Society
846 — 167 Lombard Avenue
Winnipeg, MB, R3B 0V3
Tel (204) 943-9811
Fax (204) 943-1208

Ontario Association of Optometrists
290 Lawrence Avenue West
Toronto, ON, M5M 1B3
Tel (416) 256-4411
Fax (416) 256-9881

Association des Optométristes du Québec
133, ouest de la Commune
4e étage — Vieux Montréal
Montréal (Qué) H2Y 2C7
Tél (514) 849-8051
Fax (514) 849-7201

L'ACO est ses membres collectifs

La qualité de membre de l'ACO est automatiquement accordée aux praticiens membres en règle de l'une ou l'autre des associations provinciales d'optométristes :

Association canadienne des optométristes
Pièce 301 — 1785, promenade Alta Vista
Ottawa (Ontario) K1G 3Y6
Téléphone (613) 738-4412
Télécopieur (613) 738-7161

Association des optométristes de la Colombie-Britannique
125 — 10451 chemin Shellbridge
Richmond (C.-B.) V6X 2W8
Téléphone (604) 270-9909
Télécopieur (604) 270-4950

Association des optométristes de l'Alberta
11830, avenue Kingsway
Edmonton (Alberta) T5G 0X5
Téléphone (403) 451-6824
Télécopieur (403) 452-9918

Association des optométristes de la Saskatchewan
4 — 117 sud, 3e Avenue
Saskatoon (Saskatchewan) S7K 1L7
Téléphone (306) 652-2069
Télécopieur (306) 244-7743

Société des optométristes du Manitoba
846 — 167, avenue Lombard
Winnipeg (Manitoba) R3B 0V3
Téléphone (204) 943-9811
Télécopieur (204) 943-1208

Association des optométristes de l'Ontario
290 ouest, avenue Lawrence
Toronto (Ontario) M5M 1B3
Téléphone (416) 256-4411
Télécopieur (416) 256-9881

Association des optométristes du Québec
133 ouest, de la Commune
4e étage, Vieux Montréal
Montréal (Québec) H2Y 2C7
Téléphone (514) 849-8051
Télécopieur (514) 849-7201

New Brunswick Association of Optometrists
Association des optométristes du Nouveau-Brunswick
20 Woodstock Road
Fredericton, NB, E3B 2H3
Tel (506) 458-8759
Fax (506) 458-8759 (Call first)

Nova Scotia Association of Optometrists
833 Sackville Drive
Lower Sackville, NS, B4E 1S2
Tel (902) 835-2020
Fax (N/A)

Prince Edward Island Association of Optometrists
565 North River Road
Charlottetown, PEI, C1E 1J7
Tel (902) 566-1663
Fax (N/A)

Newfoundland Association of Optometrists
PO Box 2284, Station C
St John's, NF, A1C 6E6
Tel (709) 722-9300
Fax (N/A)

Association des optométristes du Nouveau-Brunswick
20, chemin Woodstock
Fredericton (N.-B.) E3B 2H3
Téléphone (506) 458-8759
Télécopieur (506) 458-8759 (téléphoner d'abord)

Association des optométristes de la Nouvelle-Écosse
833, promenade Sackville
Lower Sackville (N.-É.) B4E 1S2
Téléphone (902) 835-2020
Télécopieur (s.o.)

Association des optométristes de l'Île-du-Prince-Édouard
565 nord, chemin River
Charlottetown (Î.-P.-É.) C1E 1J7
Téléphone (902) 566-1663
Télécopieur (s.o.)

Association des optométristes de Terre-Neuve
C.P. 2284, succursale C
Saint-Jean (Terre-Neuve) A1C 6E6
Téléphone (709) 722-9300
Télécopieur (s.o.)

Dr Jean-Marie Rodrigue National President

Effective July 1, Dr Jean-Marie Rodrigue of Laval-sur-le-Lac, Quebec, assumed the office of President of the Canadian Association of Optometrists.

Dr Rodrigue has been a member of l'Ordre des optométristes du Québec (the Quebec optometrists' regulatory body) since 1963 and a member of l'Association des optométristes du Québec (AOQ) since 1970. He was elected President of the AOQ in 1976 and held the position for a total of ten years.

He still serves as President of les Services optométriques, Inc (SOI), a company he helped found in 1983. Since that time, SOI has grown to a membership of over 700 optometrists across Canada.

He is also founding President of the Quebec Foundation for Visual Health and has served as a Board member of this group since its inception in 1984. Dr Rodrigue has been the AOQ's representative to CAO Council since 1981. In 1986, he was elected to the Executive Committee as Secretary-Treasurer and, in 1988, he became President-elect.

Canadian optometrists have already received a detailed outline of Dr Rodrigue's administrative priorities while

Le D[r] Jean-Marie Rodrigue À la Présidence nationale

Le D[r] Jean-Marie Rodrigue, de Laval-sur-le-Lac (Québec), assumait le 1[er] juillet les fonctions de président de l'Association canadienne des optométristes.

Le Dr Rodrigue est membre de l'Ordre des optométristes du Québec (organisme de réglementation des optométristes au Québec) depuis 1983 et, depuis 1970, membre de l'Association des optométristes du Québec (AOQ). Il a été élu président de l'AOQ en 1976, poste qu'il a occupé pendant dix ans.

Il agit toujours comme président des Services optométriques Inc. (SOI), entreprise qu'il a aidé à fonder en 1983. Depuis, les SOI n'ont cessé de croître, pour regrouper plus de 700 optométristes dans l'ensemble du Canada. Il est également président fondateur de la Fondation québécoise pour la santé visuelle et fait partie de son conseil depuis sa création en 1984. Le D[r] Rodrigue est représentant de l'AOQ au Conseil de l'ACO depuis 1981. En 1986, il a été élu au Comité de direction au poste de Secrétaire-trésorier et, en 1988, il est devenu président élu.

Les optométristes canadiens connaissent déjà en détail les priorités administratives du D[r] Rodrigue dans sa charge de président. La gestion d'équipe est probablement le meilleur qualificatif de son style personnel. Son grand objectif est l'image et la survie d'une profession forte et autonome.

Direction et conseil d'administration de l'ACO pour 1990

Président
D[r] Tom Adamack, Fernie (C.-B.)
Président élu
Dr Jean-Marie Rodrigue, Montréal (Qué.)
Secrétaire-trésorier
D[r] Margaret Hansen des Groseilliers, Ottawa (Ont.)
Président sortant
D[r] Scott Brisbin, Edmonton (Alb.)

President. Team Management probably best encapsulates his personal style. The image and survival of a strong and independent profession remains his chief goal.

CAO Executive and Council for 1990

President
Dr Tom Adamack, Fernie, BC
President-elect
Dr Jean-Marie Rodrigue, Montreal, Que
Secretary-Treasurer
Dr Margaret Hansen des Groseilliers, Ottawa, ON
Past President
Dr Scott Brisbin, Edmonton, AL

Effective July 1

President
Dr Jean-Marie Rodrigue
President-elect
Dr Margaret Hansen des Groseilliers
Secretary-Treasurer
Dr Michael Duffey, Middleton, NS
Past President
Dr Tom Adamack

The following Councillors also represented their respective provincial Associations:

British Columbia (as alternate delegate during Dr Adamack's terms as President and Past President)	Dr Rix Graham
Alberta	Dr Grant Campbell
Saskatchewan	Dr Claude Hutton
Manitoba	Dr Steven Mintz
Québec (as alternate delegate during Dr Rodrigue's term as President)	Dr Jean-Claude Émard
New Brunswick	Dr Calvin Smith
	Dr Pasq Marcantonio
Prince Edward Island	Dr David McKenna
Newfoundland	Dr Douglas Côté

CAO National Office Staff

Executive Director	Gérard Lambert
Director of Communications	Michael DiCola
Executive Secretary	Chantal Wall
Secretary of Finance	Joyce Corey
Financial Co-ordinator (effective 1 October)	Pamela Young-Carrière
Secretary/Receptionist	Annette McDonald

Interaction 1990
Directions for the profession

In 1990, CAO set out to address the issue of "changing times" as it relates to the optometric scope of practice. Recognizing that we cannot avoid issues by isolating ourselves in some form of ivory tower, hoping for sufficient legislative protection from the growing commercial forces, Canada's optometric leaders met in the early autumn in Kananaskis Village, Alberta, in an attempt to come to terms with the challenge of change.

Alberta was selected as the site for Interaction 1990 because many of the issues that might soon face optometry across the

À compter du 1er Juillet

Président
Dr Jean-Marie Rodrigue
Présidente élue
Dr Margaret Hansen des Groseilliers
Secrétaire-trésorier
Dr Michael Duffey, Middleton (N.-É.)
Président sortant
Dr Tom Adamack

De plus, les conseillers dont les noms suivent ont été représentants de leurs associations provinciales :

Colombie-Britannique (délégué suppléant pendant le mandat du Dr Adamack comme président et président sortant)	Dr Rix Graham
Alberta	Dr Grant Campbell
Saskatchewan	Dr Claude Hutton
Manitoba	Dr Steven Mintz
Québec (délégué suppléant pendant le mandat du Dr Rodrigue à la présidence)	Dr Jean-Claude Émard
Nouveau-Brunswick	Dr Calvin Smith
	Dr Pasq Marcantonio
Île-du-Prince-Édouard	Dr David McKenna
Terre-Neuve	Dr Douglas Côté

Personnel du bureau national de l'ACO

Directeur général	Gérard Lambert
Directeur des communications	Michael DiCola
Secrétaire de direction	Chantal Wall
Secrétaire aux finances	Joyce Corey
Coordonnatrice des finances (à compter du 1er octobre)	Pamela Young-Carrière
Secrétaire-réceptionniste	Annette McDonald

Interaction 1990
Orientations de la profession

En 1990, l'ACO a tourné son attention vers la question de l'évolution des temps en ce qu'elle touche la portée de la pratique de l'optométrie. Sachant que nous ne pouvons éviter les problèmes en nous isolant dans une sorte de tour d'ivoire et espérant une protection législative suffisante par rapport aux impératifs commerciaux de plus en plus intenses, les meneurs de l'optométrie au Canada se sont réunis à l'automne au village Kananaskis, en Alberta, dans un effort pour relever les défis du changement.

Si l'Alberta était choisie pour recevoir Interaction 1990, c'est parce que nombre des problèmes qui pourraient bientôt se faire sentir en optométrie dans l'ensemble du pays étaient (et sont encore) «sur le feu» en Alberta, y compris une remise en question directe du droit depuis longtemps obtenu par l'optométrie de fixer ses propres règles professionnelles en matière de publicité et d'association.

La réunion 1990 des meneurs de l'optométrie de l'ACO a offert aux délégués de toutes les régions du Canada l'occasion d'interagir avec des membres de l'Association des optométristes de l'Alberta dans le cadre de séminaires planifiés et d'ateliers avec animateurs, non seulement sur la question du défi posé à leur pouvoir de réglementation, mais également dans les aspects les plus généraux de l'exercice de la profession.

Grâce au travail de défrichage accompli à Kananaskis, les meneurs de l'optométrie pouvaient désormais établir les

country were (and still are) "on the boil" in Alberta, including a direct challenge to optometry's long-held right to determine its own rules of professional advertising and association.

The 1990 CAO Optometric Leaders' Meeting offered delegates from all across Canada the opportunity to participate with members of the Alberta Association of Optometrists via their scheduled seminars and moderated workshops in not only the matter of the challenge to their legislation, but also in the more global aspects of professional practice.

With the groundwork laid in Kananaskis, optometric leaders could now proceed to build a foundation for the profession's future structure in Canada. That change will occur is inevitable. The goal expressed at Interaction 1990 is to ensure that a strong and united optometry will rise atop the tide, rather than disappear as it engulfs us.

National Task Force on the Constitution of the Canadian Association of Optometrists

At its meeting of June 20-21 in Penticton, British Columbia, the Council of CAO passed a motion directing the Executive to initiate a study of perceived disparities in the matter of contributions to CAO and benefits received from CAO by its members.

Following that meeting, the Executive of CAO met and prepared a CAO budget for 1991 that reflected a zero dues increase for all provinces except Ontario. (The Ontario Association of Optometrists had already voted earlier in the year to augment its dues to CAO by $25 per member optometrist). Furthermore, the AOQ's delegate to CAO also advised Council at the Kananaskis meeting that AOQ members will be asked to augment their dues to CAO at the next General Meeting of the Quebec Association.

The task force finds a chairman

In the 90 days between our summer and fall Council meetings, CAO Past President Dr Scott Brisbin of Edmonton considered a request to chair the task force and, after further discussion at the fall Council meeting, accepted the appointment with the unanimous approval of the CAO Council.

CAO fully recognizes that the process — essentially nothing less than constitutional reform — will not be instantaneous. Discussion will inevitably go right to the very core of CAO's structure and, as those who watched the agonizing Meech process that summer will agree, constitutional reform is not a simple process. The fact that we are a relatively small national Association of some 2,700 members does not mean it will be any easier for us than it is for a nation of 25 million people.

Dr Brisbin took as his mandate no less a task than re-shaping CAO to the satisfaction of ten corporate members, each of whom undoubtedly has its own agenda and priorities. But he had already demonstrated his abilities when pressed with great responsibility and CAO believes his appointment to chair this task force will be taken on with no less a demonstrated capability.

As 1990 drew to a close, CAO President Dr Rodrigue was asking our corporate members for a commitment: "For the process to work," he said, "we must exercise great caution and give sufficient time to the task force under Dr Brisbin. To prepare and produce sound, lasting proposals for a new CAO constitution will be a task that is neither easy nor fast.

"Time, in this case, must be an ally, not a weapon.

fondements de la structure future de la profession au Canada. Il est inévitable que des changements aient lieu. L'objectif exprimé à Interaction 1990 est de veiller à ce que l'optométrie s'élève forte et unie au-dessus de la vague, plutôt que de se laisser submerger et de disparaître.

Groupe de travail national sur la Charte constitutive de l'Association canadienne des optométristes

À sa réunion des 20 et 21 juin à Penticton (C.-B.), le Conseil de l'ACO a adopté une résolution enjoignant à la Direction de lancer une étude sur les disparités perçues dans la question des contributions à l'ACO et des avantages reçus de l'Association par ses membres.

Après la réunion, la Direction de l'ACO s'est réunie et a préparé pour l'Association un budget 1991 faisant état d'une hausse nulle des cotisations pour toutes les provinces, sauf l'Ontario. (L'Association des optométristes de l'Ontario avait déjà, plus tôt au cours de l'année, décidé par vote de relever ses cotisations à l'ACO de 25 $ par optométriste membre.) De plus, le délégué de l'AOQ à l'ACO avait également informé le Conseil à l'assemblée de Kananaskis que l'AOQ demanderait à ses membres de relever leurs cotisations à l'ACO, à la prochaine assemblée générale de l'association québécoise.

Un Président pour le groupe de travail

Dans les 90 jours entre l'assemblée estivale du Conseil et celle de l'automne, le président sortant de l'ACO, le Dr Scott Brisbin d'Edmonton, a pris le temps de réfléchir à la possibilité d'assumer la présidence du groupe de travail et, après d'autres discussions à l'assemblée d'automne du Conseil, il a accepté la nomination, avec l'approbation unanime du Conseil de l'ACO.

L'ACO sait très bien que le mécanisme, essentiellement rien de moins qu'une réforme constitutionnelle, ne pourra être instantané. Les discussions, inévitablement, toucheront le coeur même de la structure de l'Association et, ceux qui ont suivi le difficile débat du Lac Meech l'été dernier en conviendront, une réforme constitutionnelle n'est pas un processus aussi simple. Que nous soyons une association nationale relativement modeste, de quelque 2 700 membres, cela ne signifie pas que ce sera plus facile pour nous que pour un pays de 25 millions de personnes.

Le Dr Brisbin a interprété son mandat comme rien de moins que de refaçonner l'ACO à la satisfaction des dix membres collectifs, chacun évidemment avec son propre calendrier et ses priorités particulières. Cependant, il a déjà prouvé ses capacités sous le poids de la pression et des responsabilités et l'ACO croit fermement que sa nomination à la présidence de ce groupe de travail sera menée à bien avec la même énergie, la même capacité.

L'année 1990 tirait à sa fin et le président de l'ACO, le Dr Rodrigue, demandait à nos membres collectifs un engagement : «Pour que le mécanisme fonctionne, disait-il, nous devons faire preuve d'une grande prudence et accorder suffisamment de temps au groupe de travail dirigé par le Dr Brisbin. Préparer et produire des propositions fondées et durables portant sur une nouvelle constitution pour l'ACO est une tâche qui ne sera ni facile, ni réalisable rapidement.

«En l'occurrence, le temps doit être un allié, non une arme.

«Pour que l'avenir de l'optométrie au Canada en tant que profession organisée soit assuré, je vous invite à bien analyser la tâche qui vous attend.»

"For the sake of a sound future for organized optometry in Canada, I urge you to consider well the task that lies ahead."

Public and Member Programs

In addition to acting as a national lobbying and legislation-monitoring office on behalf of Canadian optometry, CAO offers a number of public and member information programs.

Vision Awareness Week

Vision Awareness Week 1990 took shameless advantage of the coincident 150th anniversary of photography. With the aid of a blue/black, white and silver poster, the camera's optical ties to the profession of optometry were graphically illustrated, showing the clear parallels between it and the operation of the human eye. Kodak Canada provided detailed instructions on the manufacture of a simple pinhole camera and shutter-bugs across the country rediscovered the roots of putting images on film.

The Canadian Journal of Optometry

The *CJO*RCO* continued to chart new waters under the guiding helm of Senior Editor Dr Mitch Samek. A number of subtle design changes were incorporated into 1990's issues, reflecting a renewed emphasis on using the Journal as both a forum for Association information and a source of new Canadian clinical and academic research.

But editorial content aside, the *CJO*RCO* also felt the brunt of many of the same pressures facing Canadians everywhere. As 1990 progressed, the impact of the current recession compounded itself with both rising costs and depleting advertising revenue. Although funded wholly as a member service through dues payments, the goal of the *CJO*RCO* is to recover fully its production and distribution costs. By year end, it was clear that, to continue to realize this goal, the Journal would have to consider a number of innovative options to reduce its expenses in the face of declining revenues. The Editors agree, however, that quality will not be among the items cut in their efforts to continue to be cost effective.

An affinity for CAO members

No, not an unusual attraction to optometrists, an "Affinity card" program is a credit card option that offers members the opportunity to provide additional revenue to CAO simply by using the Affinity card rather than their regular bank credit cards. In 1990, CAO's Member Services Committee began exploring the possibilities of offering the service to CAO members. The investigation requires a thorough analysis of not just the benefits of the card itself, but also the whole realm of professional liability. As a result, the program was not available by year end 1990, but the Committee was seeking to have a

Programmes pour le public et les membres

En plus d'agir comme bureau national de lobbying et de surveillance de la loi au nom des optométristes canadiens, l'ACO offre un certain nombre de programmes d'information pour la population et ses membres.

Semaine de la vision

La Semaine 1990 de la vision a tiré sans vergogne parti de ce qu'elle coïncidait avec le 150^{e} anniversaire de la photographie. À l'aide d'une affiche dans les tons de bleu/noir, de blanc et d'argent, les liens optiques entre l'appareil-photo et l'optométrie ont trouvé leur illustration dans l'image, qui faisait ressortir les parallèles évidents entre l'appareil et le fonctionnement de l'oeil humain. La firme Kodak Canada a fourni des directives détaillées sur la fabrication d'un appareil-photo à sténopé, de sorte que dans l'ensemble du pays, les maniaques de la photo ont redécouvert les principes de la fixation d'images sur pellicule.

La Revue canadienne d'optométrie

La *RCO*CJO* a continué à tracer de nouvelles voies, sous l'habile gouverne du directeur principal, le D^{r} Mitch Samek. Un certain nombre de subtils changements de conception ont été apportés aux numéros de 1990, rendant compte d'une volonté accrue d'utiliser la revue en tant que tribune pour informer l'Association et source de référence sur les nouvelles recherches cliniques et universitaires au Canada.

Par contre, le contenu éditorial mis à part, la *RCO*CJO* a elle aussi ressenti les effets de nombre de pressions qu'éprouvent les Canadiens partout au pays. À mesure que 1990 s'égrenait, l'effet de la récession actuelle s'est amplifié avec la hausse des coûts et la fuite des recettes de publicité. Même si la *Revue* est entièrement financée à titre de service aux membres par les cotisations, l'objectif de la *RCO* est de recouvrer entièrement ses coûts de production et de distribution. À la fin de l'année, il était devenu évident que pour continuer en ce sens, la Revue devrait envisager un certain nombre de choix nouveaux afin de réduire ses dépenses, compte tenu du déclin des recettes. Les rédacteurs ont convenu par contre que la qualité demeurerait la même, malgré leurs efforts de compressions budgétaires pour que la Revue demeure rentable.

Carte d'affinité pour les membres de l'ACO

Non ce n'est pas une attraction habituelle pour les optométristes! Le programme de la carte d'affinité est un choix de carte de crédit offrant aux membres la possibilité de générer des recettes supplémentaires pour l'ACO par la simple utilisation de la carte, au lieu de leur carte ordinaire de crédit bancaire. En 1990, le Comité des services aux membres a entrepris d'étudier les possibilités d'offrir ce service aux membres de l'ACO. L'enquête exige une analyse approfondie, non simplement des avantages de la carte elle-même, mais également du domaine global de la responsabilité professionnelle. En conséquence, le programme n'a pu être offert avant la fin de l'année 1990, mais le Comité compte pouvoir présenter une recommandation à l'assemblée du Conseil de l'ACO au printemps 1991.

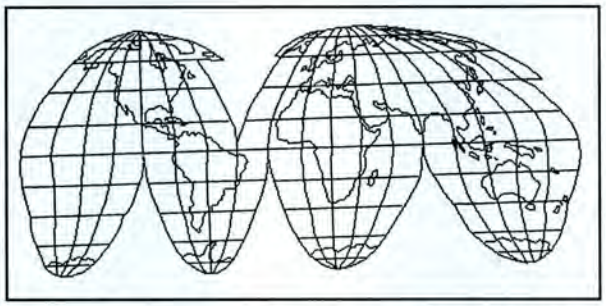
InTrav

InTrav est un service de coordination de voyage qui organise et offre aux membres de l'ACO certains forfaits de voyage assez

recommendation in place by the time of the Spring 1991 CAO Council meeting.

InTrav

InTrav is a travel co-ordination service that arranges and offers some pretty exclusive package travel tours to exotic destinations to members of CAO. Following a detailed review and analysis by CAO Council, InTrav was authorized to distribute a number of promotional travel options to CAO's members in 1990.



Unfortunately, InTrav suffered the same fate as global travel co-ordinators everywhere when the Persian Gulf War erupted with the invasion of Kuwait and, as a corollary, fears of travel-related terrorism arose. Both InTrav and CAO, however, are hopeful that the resolution to the crisis will ease related travel concerns somewhat and that InTrav's foreign destination packages will once more attract the adventurous holiday planners from among our membership.

The Canadian Optometric Education Trust Fund

In 1990, the COETF provided a total of over $63,000 in direct support of vision and eye care research in Canada. Here is a complete list of grants made under the Fund's 1990 Awards Program (the abbreviations in the following summary are as follows: UM — Ecole d'optométrie, Université de Montréal; UW — School of Optometry, University of Waterloo; VI — Vision Institute):

British Columbia Association of Optometrists: $3,000 (Promotional Video for Marketing Optometric Occupational Vision Programs); **Dr BR Chou (UW):** $4,000 (Impact Resistance Correlation with Safety Spectacle Lens Parameters); **Dr AP Cullen (UW):** $2,500 (Ultraviolet Action Spectrum for Human Conjunctiva: Evaluation of the Toxic Effect of UV on Human Conjunctiva in vivo: (a) Action Spectrum; (b) Evaluation of Nature and Time Course in the Response; (c) Evaluation of Mechanisms); **Dr MJ Doughty (UW):** $500 (Drug-Eye Data Base); **Dr EJ Fisher (UW):** $4,000 (Maintenance and Extension of the Museum of Visual Science and Optometry); **Dr C Giasson (UM):** $3,000 (PhD Program at the University of California at Berkeley); **Dr J Gresset (UM):** $3,000 (Bours de soutien pour la troisième année d'études au programmes de PhD en Medecine expérimentale (Épidemiologie) à l'Université Laval); **Dr EL Irving (UW)** (Supervisor: Dr KM Robertson): $3,000 (The Design, Manufacture and Implementation of an Optometric Device which Measures the Variation of Ocular Misalignment during Visual Pursuits); **Dr C Letheran (UW)** (Supervisors: (i) At Waterloo: R Trevino; (ii) At Philadelphia: GE White): $500 (Summer Internship Program at the JFK Memorial Hospital in Philadelphia, PA); **Dr JV Lovasik (UM):** $7,000 (Institutional Grant to l'École d'optométrie, Université de

exclusifs vers des destinations exotiques. Après un examen et une analyse détaillés, le Conseil de l'ACO a autorisé InTrav à distribuer un certain nombre d'options de voyages promotionnels aux membres de l'ACO en 1990.

Malheureusement, InTrav a subi le même sort que les coordonnateurs de voyages mondiaux partout ailleurs, à cause de la Guerre du Golfe, de l'invasion du Koweït et de l'augmentation des craintes relatives au terrorisme dans les transports. Par contre, tant InTrav que l'ACO espèrent que le règlement de la crise dissipera quelque peu les inquiétudes, en matière de voyages, et que les forfaits touristiques étrangers préparés par InTrav attireront encore une fois ceux de nos membres qui ont soif de vacances et d'aventures.

Le Fonds de fiducie des optométristes canadiens pour l'éducation

En 1990, le FFOCE a offert au total plus de 63 000 $ d'aide directe à la recherche sur les soins oculo-visuels au Canada. Voici la liste complète des subventions accordées dans le cadre du programme de bourses 1990 du Fonds (abréviations utilisées dans le résumé qui suit : UM : école d'optométrie de l'Université de Montréal; UW : école d'optométrie de l'Université de Waterloo; VI : Vision Institute) :

Association des optométristes de la C.-B. : 3 000 $ (Publicité vidéo pour la commercialisation des programmes d'optométrie en vision professionnelle); **D^r^ BR Chou (UW)** : 4 000 $ (Corrélation de la résistance aux chocs et des paramètres des lentilles des lunettes de sécurité); **D^r^ AP Cullen (UW)** : 2 500 $ (Spectre d'action de l'ultraviolet sur la conjonctive humaine : évaluation des effets toxiques des UV sur la conjonctive humaine in vivo : a) spectre d'action; b) évaluation de la nature et du déroulement de la réponse; c) évaluation des mécanismes); **D^r^ MJ Doughty (UW)** : 500 $ (Base de données sur les médicaments et les yeux); **D^r^ EJ Fisher (UW)** : 4 000 $ (Entretien et expansion du Musée des sciences visuelles et de l'optométrie); **D^r^ C Giasson (UM)** : 3 000 $ (Programme de doctorat à l'Université de Californie à Berkeley); **D^r^ J Gresset (UM)** : 3 000 $ (Bourse de soutien pour la troisième étude au programme de doctorat en médecine expérimentale (épidémiologie) à l'Université Laval); **D^r^ EL Irving (UW)** : (surveillant : D^r^ KM Robertson) : 3 000 $ (Conception, fabrication et mise en place d'un dispositif d'optométrie mesurant la variation du mauvais alignement oculaire pendant les recherches visuelles); **D^r^ C Letheran (UW)** (surveillants : (i) à Waterloo : R Trevino; (ii) à Philadelphie : GE White) : 500 $ (Programme d'internat d'été à l'hôpital JFK Memorial de Philadelphie, Pennsylvanie); **D^r^ JV Lovasik (UM)** : 7 000 $ (Subvention institutionnelle à l'École d'optométrie de l'Université de Montréal pour la création de capacités d'enseignement clinique et de recherche); **D^r^ B Lu (UW)** (surveillant : D^r^ J Hovis) : 1 500 $ (Identification des fils électriques par les personnes à déficit chromatique à l'aide de divers types d'illuminants); **D^r^ KA MacNeill (UW)** : 1 300 $ (Évaluation de la courbure des lentilles et effet sur la vision pendant le port de LRPG faits de divers matériaux); **D^r^ CE Matyas** (surveillant : D^r^ Eric Roy, Département de kinésiologie, Université de Waterloo) : 500 $ (L'effet de l'accommodation et de la convergence sur la précision des mouvements); **D^r^ Y Michaud (UM)** (surveillant : D^r^ Stephane Molotchnikoff) : 1 500 $ (L'effet d'une inactivation locale et réversible de l'aire striée (V1 ou 17) sur les réponses de neurones de l'aire visuelle secondaire (V2 ou 18) chez le chat); **Association des optométristes du Nouveau-Brunswick** : 4 000 $ (Programme de basse vision du N.-B. pour l'évaluation complète et la

Montréal for Development of Clinical Teaching and Research Capabilities); **Dr B Lu (UW)** (Supervisor: Dr J Hovis): $1,500 (Electrical Wire Identification by Colour Defective Individuals Using Different Types of Illuminants); **Dr KA MacNeill (UW):** $1,300 (Assessment of Lens Flexure and its Effect on Vision While Wearing Various RGP Lens Materials); **Dr CE Matyas** (Supervisor: Dr Eric Roy, Department of Kinesiology, University of Waterloo): $500 (The Effect of Accommodation and Vergence on Aiming Movements); **Dr Y Michaud (UM)** (Supervisor: Dr Stephane Molotchnikoff): $1,500 (L'éffet d'une inactivation locale et reversible de l'aire striée (V1 ou 17) sur les réponses de neurones de l'aire visuelle secondaire (V2 ou 18) chez le chat); **New Brunswick Association of Optometrists:** $4,000 (NB Low Vision Program for Comprehensive Assessment and Dispensing of Low Vision Aids); **Dr SC Perera (UW)** (Supervisor: Dr AP Cullen): $2,500 (Qualification of the Ultraviolet B Induced Response in Human Conjunctiva); **Dr J Peroff:** $7,000 (Glare Recovery Through Tinted Lenses in Alpine Ski Racing and the Effect of Tinted Lenses on Pupil Response and Reaction Time); **Dr MJ Samek (VI):** $4,500 (Optometry Internship); **Dr JG Sivak (UW):** $2,500 (The Effect of Undercorrection on Progressive Myopia); **Drs L Sorbara; M Callender; BR Chou; JG Sivak (UW):** $1,000 (U of W Contact Lens Journal Publication Support); **Dr M Thomas (UW)** (Supervisor: Dr JV Lovasik): $1,500 (Computer Image Analysis of Retinal Vascular Adjustments to Elevated IOP); **Drs V Timpano, RE Miller, K MacNeill:** $2,500 (The Efficacy of Visual Field Screening and Long Term Variability of the Differential Light Threshold); **Dr GC Woo (UW):** $2,750 (Production of a New University of Waterloo Near Vision Chart).

A decade of awards — over $500,000!

Since 1980, the COETF has awarded over $550,000 and, in the process, funded an extensive program of worthy vision and eye care research projects across Canada. From the very first award in 1980 (to Dr JV Lovasik at the School of Optometry, University of Waterloo) through the 1990 Awards Program, the Fund has awarded the following total research grants: to the **School of Optometry, University of Waterloo:** $332,955; to **l'École d'optométrie, Université de Montréal:** $86,350; to the **Vision Institute**, located in Toronto and, since its foundation, under the direction of Dr MJ Samek: $38,368; to projects sponsored by **National or Provincial Associations of Optometrists:** $38,300; and to **Independent practitioners:** $51,182.

A Year of Federal Issues

1. GST

In 1990, the Canadian Association of Optometrists (CAO) expended a great deal of energy — along with almost everyone in Canada — in trying to come to grips with the Mulroney government's new Goods and Services Tax (GST). Optometry's education of Ministry officials began right at the grass roots: What is an optometrist and what does an optometrist do? As the January 1 (1991) implementation date drew closer, our Association office in Ottawa was a focal point for many long hours of meetings, nationwide telephone conferences with members of the Executive Committee and Council and facsimile transmissions from Middleton, Nova Scotia (the home of our Secretary-Treasurer), to Fernie, British Columbia (home of our Past President). A GST Guide for Optometrists would not be a reality until the New Year, in spite of early delivery promises by the overburdened personnel at Revenue Canada. But the

prescription de dispositifs d'aide chez les malvoyants); **Dr SC Perera (UW)** (surveillant : Dr AP Cullen) : 2 500 $ (Qualification de la réaction induite aux ultraviolets B dans la conjonctive humaine); **Dr J Peroff** : 7 000 $ (Temps d'adaptation aux éblouissements grâce aux verres fumés dans les courses de ski alpin et effet des verres fumés sur le temps de réponse et de réaction des écoliers); **Dr MJ Samek (IV)** : 4 500 $ (Internat en optométrie); **Dr JG Sivak (UW)** : 2 500 $ (Effet de la sous-correction sur la myopie progressive); **Drs L Sorbara, M Callender, BR Chou, JG Sivak (UW)** : 1 000 $ (Appui à la publication du journal sur les lentilles de contact Université de Waterloo); **Dr M Thomas (UW)** (surveillant : Dr JV Lovasik) : 1 500 $ (Analyse d'images par ordinateur des adaptations vasculaires rétiniennes à la tension intraoculaire élevée); **Drs V Timpano, RE Miller, K MacNeill** : 2 500 $ (Efficacité du dépistage visuel sur le terrain et variabilité à long terme du seuil lumineux différentiel); **Dr GC Woo (UW)** : 2 750 $ (Production du nouveau tableau de vision rapprochée de l'Université de Waterloo).

Une décennie de bourses — plus de 500 000 $!

Depuis 1980, le FFOCE a accordé plus de 550 000 $ de bourses et a ainsi financé un vaste programme de projets de recherche précieux en soins oculo-visuels dans l'ensemble du Canada. Dès la première bourse, accordée en 1980 (au Dr JV Lovasik de l'école d'optométrie de l'Université de Waterloo), jusqu'au programme de bourses de 1990, le Fonds a accordé aux diverses écoles d'optométrie des montants importants en subventions de recherche : **École d'optométrie de l'Université de Waterloo** : 332 955 $; **École d'optométrie de l'Université de Montréal** : 86 350 $; **Vision Institute** de Toronto qui, depuis sa fondation, est sous la direction du Dr MJ Samek : 38 368 $; projets parrainés par **les associations nationale ou provinciales d'optométristes** : 38 300 $; **praticiens indépendants** : 51 182 $.

Une Année de questions fédérales

1. TPS

En 1990, l'Association canadienne des optométristes (ACO) a consacré beaucoup d'énergie, comme presque tous au Canada, pour intégrer la nouvelle taxe sur les produits et services (TPS) du gouvernement Mulroney. La sensibilisation des représentants du ministère à l'optométrie a commencé par la base : qu'est-ce qu'un optométriste, que fait-il? Et puisque s'approchait à grands pas la date de mise en application de la nouvelle taxe, soit le 1er janvier 1991, le bureau de l'Association à Ottawa est devenu le centre nerveux de longues et nombreuses heures de réunion, de conférences téléphoniques d'un bout à l'autre du pays avec des membres du Comité de direction et du Conseil et de transmissions par télécopieur de Middleton, Nouvelle-Écosse (où demeure notre secrétaire-trésorier) à Fernie, C.-B. (où réside notre président sortant). Le Guide de la TPS à l'intention des optométristes ne devait pas devenir réalité avant la nouvelle année, malgré les promesses antérieures, voire hâtives, du personnel surchargé de Revenu Canada. Par contre, le travail de base s'est effectué pendant une bonne partie des quatre derniers mois de 1990.

À la fin de l'année, l'ACO avait la certitude que le guide de la TPS, lorsqu'il serait enfin publié, rendrait compte véritablement des préoccupations communiquées à notre bureau par nos membres.

groundwork was done throughout much of the last four months of 1990.

By year end, CAO was satisfied that the GST Guide, when finally made available, would reflect and accommodate fully the concerns conveyed to our office by our members.

2. Indian Affairs and non-insured services

It appeared to be a laudable goal: simplifying the process of reimbursing for non-insured vision and eye care services delivered to Canada's first peoples. In 1990, the Federal Ministry of Indian Affairs set out to develop an agreement under which these services would be provided across the country. There proved to be a problem, however, from the very first draft when it was apparent that the Ministry was trying to find an arbitrary point at which vision and eye care services could be deemed "necessary". It has become known as the "half dioptre rule", because Ministry bureaucrats have yet to be convinced that any treatment is required when the change in vision is less than 0.5D. It was just one of several stumbling blocks.

Discussions to year end, however, yielded a new (and positive) benefit to CAO. Our first, official optometric consultant to a federal Ministry was accepted: BCAO Councillor Dr G Rix Graham of Smithers, British Columbia.

3. Bureau of Medical Devices

CAO was also surprised to discover, late in the year, a quiet note contained in the *Canada Gazette* (the official federal government advisory of pending legislation). In it, it was revealed that Health and Welfare Canada's Bureau of Medical Devices was seeking to remove prolonged wear contact lenses from the list of products requiring a Premarket Review before entering the country's marketplace.

Acting on behalf of our membership, CAO immediately forwarded a commentary to the Ministry in which several recent instances of problems with prolonged wear lenses were recounted. We expressed our great concern that they were considering the elimination of a testing process.

It seemed to us that the Ministry was perhaps yielding to commercial pressures for early Canadian market availability of new prolonged wear lenses. To our way of thinking, the recommended cancellation of the Premarket Review process flew in the face of this same body's earlier advisory *against* wearing any prolonged wear lens for more than a week at a time, despite manufacturer claims that month-long wearing times are possible in some cases. In other words, if it is apparent that manufacturers' claims are occasionally at odds with a product's actual performance, why remove one of Canada's crucial verification processes — particularly where a health care device is concerned?

One of CAO's most important roles is that of "watchdog" with respect to existing and pending federal legislation. It is a role which was formulated decades ago by those Directors who chose to move CAO's administration from a Toronto location to one in the national capital. The three foregoing examples, demanding though they might have been (and *continue* to be), are still only a small part of CAO's active federal issues file.

From a bank of windows at our Alta Vista Drive address, a visitor can see the spire of the Peace Tower in the distance. For our part, we remain committed to ensuring that those government actions that will have an impact on our members are equally visible — and accessible — through the Canadian legislative process.

2. Les Affaires indiennes et les services non assurés

L'objectif semblait louable : simplifier le mécanisme de remboursement des services oculo-visuels non assurés prestés aux autochtones du Canada. En 1990, le ministre fédéral des Affaires indiennes a entrepris de préparer une entente en vertu de laquelle ces services seraient fournis partout au pays. Par contre, un problème a surgi dès la première version du projet, lorsqu'on a constaté que le ministère essayait de fixer un point arbitraire auquel les soins oculo-visuels seraient réputés «nécessaires». Cette tentative a été qualifiée de «règle de la demi-dioptre», parce que les bureaucrates du ministère ne sont pas encore convaincus qu'un traitement est nécessaire lorsque le changement dans l'acuité visuelle est inférieur à 0,5 D. Ce n'était là que l'une des nombreuses pierres d'achoppement.

À la fin de l'année, cependant, les discussions avaient abouti à un nouvel avantage (encourageant) pour l'ACO : notre premier conseiller officiel en optométrie auprès d'un ministère fédéral était accepté, savoir le conseiller de l'AOCB, le D[r] G Rix Graham, de Smithers (C.-B.).

3. Bureau des instruments médicaux

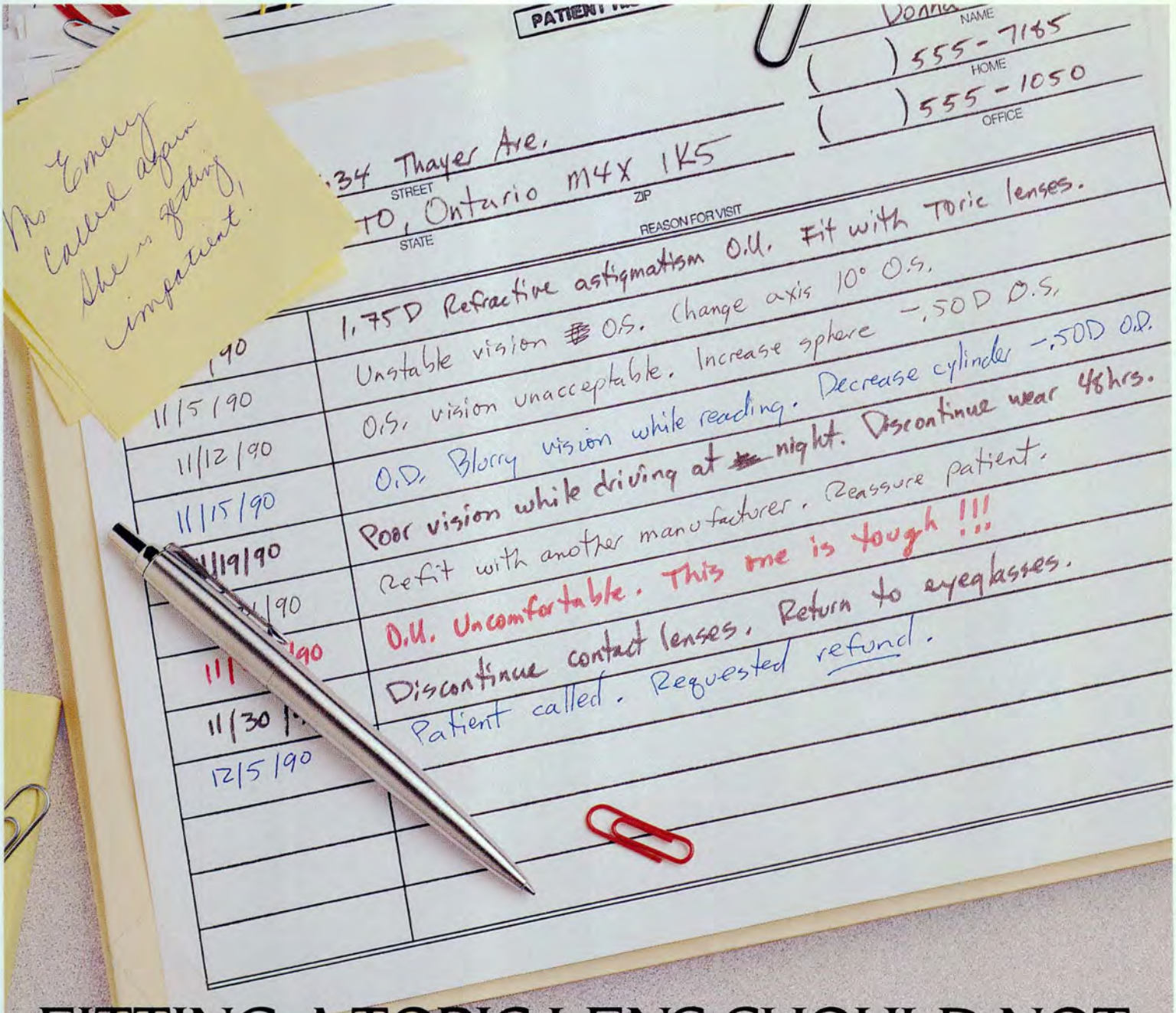
L'ACO a été également étonnée de découvrir, tard au cours de l'année, une note anodine publiée dans la *Gazette du Canada* (où le gouvernement fédéral publie officiellement des renseignements sur les projets de loi). On y lisait que le Bureau des instruments médicaux de Santé et Bien-être social Canada essayait d'enlever le port prolongé des verres de contact de la liste des produits exigeant un examen précommercialisation avant d'être offerts dans le commerce au pays.

Agissant au nom de nos membres, l'ACO a immédiatement transmis au ministère un commentaire où elle traitait de plusieurs cas récents de problèmes touchant le port prolongé de ces lentilles. L'Association a exprimé sa vive inquiétude au sujet du projet d'élimination du mécanisme d'essai.

Il nous semblait que le ministère cédait peut-être à des pressions commerciales visant à mettre en marché rapidement au Canada les nouvelles lentilles à port prolongé. À notre avis, la recommandation d'annuler le mécanisme d'examen précommercialisation était contraire aux recommandations formulées antérieurement par l'organisme *contre* le port de toute lentille à port prolongé pour plus d'une semaine à la fois, malgré les prétentions des fabricants, qui disent que des périodes de port d'un mois sont possibles dans certains cas. En d'autres termes, s'il est apparent que les prétentions des fabricants sont parfois incompatibles avec le rendement réel d'un produit, pourquoi éliminer l'un des mécanismes essentiels de vérification du Canada, particulièrement dans le cas d'un dispositif de soins de santé?

L'un des rôles les plus importants de l'ACO est celui de «chien de garde» à l'égard des lois fédérales actuelles et envisagées. C'est un rôle qui a été formulé il y a des décennies par les directeurs qui ont choisi de déplacer l'administration de l'ACO de ses locaux de Toronto vers la capitale nationale. Les trois exemples qui précèdent, aussi exigeants qu'ils puissent avoir été (et continuent d'être), ne sont qu'une fraction des dossiers en cours à l'ACO, au chapitre des questions fédérales.

Des fenêtres de nos locaux sur la promenade Alta Vista, le visiteur peut voir la flèche de la Tour de la paix, dans le lointain. Pour nous, nous restons décidés à veiller à ce que les interventions gouvernementales qui ont un effet sur nos membres soient aussi visibles, et accessibles, dans le cadre du mécanisme législatif canadien.



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Cylinder Powers	−0.75D to −2.25D
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Axis Increments	5°

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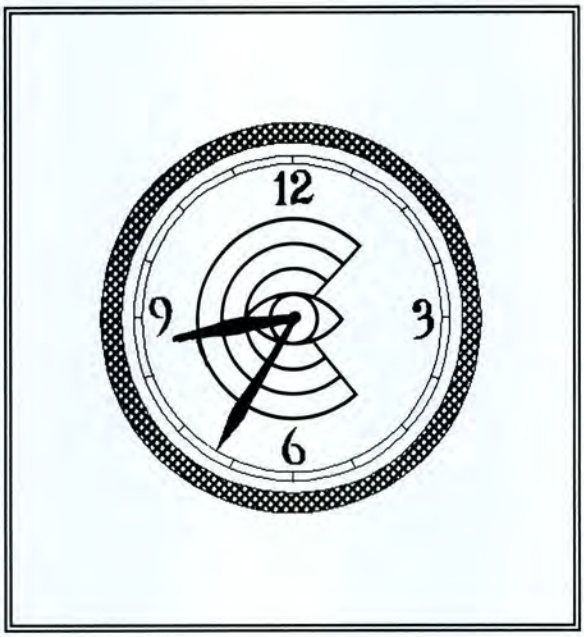

No time like the present

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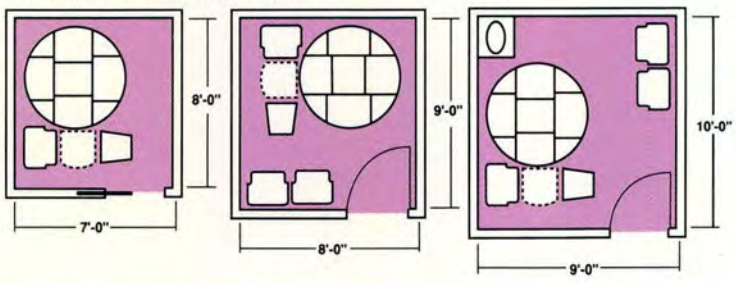

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