

A HOLISTIC APPROACH TO GLAUCOMA CARE



Understanding the psychosocial determinants of health is a key part of understanding patients with glaucoma.

BY ALEXANDRA "OLA" PIETRASZKIEWICZ, MD

Tell me what's been going on these past few months" is how I often start conversations with patients who have glaucoma. They may tell me about their recent hip replacement, the death of their spouse, or a family reunion. Listening to my patients' stories provides me with important insight into their disease as I seek to understand why their IOP has increased or why a visual field test was unreliable. A holistic approach to care is important in medicine, particularly when treating diseases requires significant collaboration with patients. If I had to choose the medical school rotation that prepared me most for ophthalmology residency, it would be psychiatry. In my experience, understanding the psychosocial determinants of health for each patient improves not only the patient-physician relationship but also health outcomes.

VISION LOSS AND DEPRESSION

Blindness is consistently rated as one of the top three or four most-feared medical conditions, and adults who lose visual function are 90% more likely to experience depression than people whose visual function is not compromised.¹ Studies have shown that vision loss is one of the most common chronic conditions associated with depression in the geriatric population. Both glaucoma and depression are treatable, but they are frequent causes of a reduced

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quality of life, partly because of inadequate screening. A cross-sectional study based on the National Health and Nutrition Examination Survey (NHANES) estimated the prevalence of depression among 10,480 adults who were at least 20 years old and either reported visual function loss or had visual acuity impairment.¹ The 25-item National Eye Institute Visual Functioning Questionnaire, a visual acuity examination, and the nine-item Patient Health Questionnaire depression scale (PHQ-9), were used to assess the main outcome measures of vision loss and depression, with visual acuity impairment defined as a visual acuity worse than 20/40 in the better-seeing eye and depression qualified as a PHQ-9 score of 10 or higher.

The survey results were striking. The prevalence of depression was 11.3% among adults with self-reported visual function loss versus 4.8% among adults who reported no loss of visual function. Interestingly, the prevalence of depression was 10.7% among adults with decreased visual acuity versus 6.8% in adults with normal vision. After correcting for 15 variables, only a self-reported

loss of visual function was significantly associated with depression, with an odds ratio of 1.9. The important distinction between self-reported visual function and measured visual acuity is that visual function takes into account patients' perceptions of their limitations and permits them to quantify their disability. Individuals who perceive a reduction in their ability to perform instrumental activities of daily living have been shown to be at increased risk of depression. People who are depressed may not seek care for eye problems, and if they do, they may be less likely to adhere to treatment. For these reasons, depression may hasten the pace of vision loss.

PUTTING HOLISTIC CARE INTO PRACTICE

One suggestion stemming from the findings of the NHANES is that eye care professionals consider screening for, diagnosing, and potentially treating depression to reduce the burden of depression-related disability. Given the state of health care today, ophthalmologists are unlikely to find the time to diagnose and treat depression; however, it may be reasonable to administer the PHQ-9 to screen patients and provide an appropri-

ate referral. Another option is to refer patients who exhibit signs of depression for case management. Eye care providers in hospital-based health systems can request the aid of a social worker with issues surrounding insurance, financial assistance, transportation, access to medications, and patient education.

Perhaps the most direct way for ophthalmologists to provide holistic care to patients with glaucoma is to routinely refer them to low vision services. The AAO Preferred Practice Pattern (PPP) on Vision Rehabilitation recommends referring patients whose visual acuity is less than 20/40 in the better-seeing eye and those who have contrast sensitivity loss, scotoma, or peripheral field loss.² Many patients with glaucoma fall into one or more of these categories. Kaleem et al surveyed members of the American Glaucoma Society to identify barriers to low vision referral. Barriers included patients' not reporting functional issues related to vision, a

lack of time to provide counseling, and patients' perceived financial barriers.³

A similar study identified characteristics of ophthalmologists who refer patients for low vision services. These included a familiarity with the AAO PPP on Vision Rehabilitation, a practice with a patient population who has used low vision services, and the provider's satisfaction with their current referral practices.⁴ Of note, only 22% of respondents reported following the PPP guidelines.

CONCLUSION

Although our time with patients may be limited, we can still strive to provide them with a safe space and respond to them with empathy. This approach can strengthen the patient-physician relationship and can help us to better understand the factors affecting our patients' health. Given the current state of the health care system, referring patients for additional services and care when

appropriate may be the most efficient method of providing holistic care. ■

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ALBERT S. KHOURI, MD | SECTION EDITOR

- Associate Professor of Ophthalmology and Director of Glaucoma Division and Ophthalmology Residency, Rutgers New Jersey Medical School, Newark, New Jersey
- Member, GT Editorial Advisory Board
- khourias@njms.rutgers.edu
- Financial disclosure: None

ALEXANDRA "OLA" PIETRASZKIEWICZ, MD

- Second-year ophthalmology resident, The Krieger Eye Institute, Sinai Hospital of Baltimore
- apietraszkiewicz@lifebridgehealth.org
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