How to Counsel Patients With Far-Advanced Glaucoma

Several questions come to my mind when dealing with someone who has severe glaucoma.

BY GEORGE L. SPAETH, MD

This edition of *Glaucoma Today* features three articles on far-advanced glaucoma—one dealing with staging and counseling, one with rehabilitation, and one with regeneration. I would love to take credit for suggesting those highly appropriate subdivisions of this important topic. (I can't, but I am glad to have been asked to participate.)

For a variety of reasons, some individuals with glaucoma end up with severely excavated optic nerves and visual loss. The latter is frightening for and limiting to patients, and when it occurs, the damaged person suffers. The impact of the loss of sight, however, is highly influenced by how the person handles that loss. Here, the physician can play a positive and favorable role.

John Milton, who is thought to have had glaucoma, commented, "To be blind is not miserable; not to be able to bear blindness, that is miserable."

After a person has lost a great deal of sight, it is easy for both the doctor and the patient to slip into the "custodial care" mentality. This is never (I repeat, never) appropriate. The patient's mindset should always be, "What can be done to allow me to live as fully as possible?" The doctor's approach should be, "What can I do to make this person's life better?"

IS THIS FAR-ADVANCED GLAUCOMA?

Whenever the vision of a patient considered to have glaucoma continues to decline, especially despite low pressures, the clinician's first thought should be, "Is this really glaucoma?" That question needs a definitive answer, and the cause of the visual loss must be understood. The absence of another apparent reason for visual loss is not adequate justification for concluding that the patient has glaucoma.

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The physician's second thought should be, "Is this glaucoma *and* something else as well?" Patients with glaucoma also develop retinal detachments, cataracts, pituitary tumors, and other causes for visual loss.

Usually, just raising these questions initiates the activities that will promptly lead to the correct answers.

WHAT STAGE IS THE GLAUCOMA?

The amount of damage in the patient's better-seeing eye determines how severely he or she will be incapacitated. Someone with an extinguished field (35 dB of mean defect) in the worse eye and a normal field in the better eye can function wonderfully. A person with the same 35 dB of loss divided equally between his or her two eyes, however, would have severe visual difficulties. I prefer using the Disc Damage Likelihood Scale (DDLS) as the most objective and easiest way to assess the stage of glaucoma.[1,2] From DDLS stage 1 to 5, there will be no disability, even if both eyes are involved. When the DDLS is worse than 6 in both eyes, the person will definitely have a problem with visual function.

HOW CAN FURTHER VISUAL LOSS BE PREVENTED?

Even an increment of further deterioration in a person who already has advanced damage in his or her better-seeing eye will decrease that individual's ability to function and worsen his or her symptoms. I am not a fan of "the lower the pressure, the better" approach to glaucoma, except in most patients with far-advanced damage. One needs to be cautious about lowering pressure markedly in young patients, especially myopes. In elderly patients with almost totally excavated discs, however, lowering pressure maximally is usually the goal. Even when the IOP falls to around 5 mm Hg, most elderly individuals with far-advanced glaucoma will not experience visual symptoms due to the low pressure. Laser trabeculoplasty is usually appropriate in patients older than 40 years who have primary open-angle glaucoma or open-angle glaucoma in association with exfoliation syndrome. The option of pilocarpine is worth remembering, because it is often highly effective in pseudophakes or aphakes.

Patients thought to have glaucoma lose vision for three reasons. First, the cause for the visual loss is something other than the glaucoma for which the person has been treated. Second, whatever the IOP, it is higher than the eye can tolerate. Third, the neurons are mortally wounded and will die no matter what is done. Even with competent care and appropriate attention to the first two of these causes, sometimes, patients will continue to lose vision from glaucoma.

HOW CAN THIS PERSON BE HELPED?

Although it is not always possible to prevent *vision* from worsening, it is always possible to help the *person* not to become worse. Clinicians can almost always help the person actually become better. Losing vision can increase an individual's awareness of the preciousness of life, the wonders of existence, and the magnificence of relationships. Physicians who help their patients to improve their own lives bless their patients and themselves. To be effective in this regard requires truly knowing patients and oneself, connecting physically and emotionally (not just intellectually) with patients, and being proactively but realistically positive. ❑

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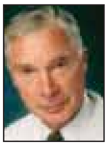

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2. Emerick GT. Highlights of the AGS Annual Meeting. *Glaucoma Today*. April 2009;7(3):14-16. http://bmctoday.net/glaucomatoday/2009/04/article.asp?f=GT0409_02.php. Accessed November 16, 2009.