

focus

 Ontario Opticians Association

“The Official Voice of Ontario Opticians”

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JANUARY 2009 | Winter Issue

President's Message

By Ali Badreddine, RO



Another year has come and gone and it feels like there is still so much to do. Our directors love their profession and work tirelessly to protect it and improve it but our work is never done.

For years we have been trying to get a meeting with the senior policy advisor to the Minister of Health without any results. The response was always, “The issue is resolved and there is nothing new.” We did not give up. We kept on lobbying MPPS and we kept on attending their fundraisers until finally the Minister of Health at the time George Smitherman instructed his senior policy advisor Abid Malik to meet with us. We had our first meeting June 11th this year and our second meeting September 11th. It seems that the Ministry has recognized the strength of the association and they want to meet with us every 3 months with our next meeting set for Dec. 11th. This is a huge accomplishment; to be able to sit with the senior policy advisor to Minister of Health every 3 months is unprecedented. To have him listen to our issues and take notes is more than we could ask for. But it was not easy. It took directors of this organization years of attending meetings and fundraisers with these MPPs to be able to accomplish this. You can be assured your association will take full advantage of our access to the Ministry of Health.

Another successful Inside Optics was held October 5th 2008, with 450 opticians in attendance and a completely sold out trade show. It was a result we have become accustomed to. Opticians in Ontario are supporting their association like never before and are seeing the value that they receive from that support, be it continuing education, insurance, or just the fact that they need to support their professional association so

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The Under-Corrected Hypermetrope

By G.S. Briede, RO

After what must seem like a never ending series of articles and courses with titles like “An Introduction to Clinical Refraction” and/or “The Basics of Clinical Refraction,” I thought an article dealing with an actual clinical refraction problem would be welcomed by my readers. With that in mind I have decided to describe a situation that is intellectually interesting despite the fact that it is quite commonplace, in a clinical sense.

We have all read in articles and been told during lectures that accommodation is the nemesis of the refractionist. I intend to illustrate in the following example just how much of a problem accommodation can create for the conscientious refractionist. The clinician seeks to find a comfortable spectacle prescription which will provide stable, comfortable vision for an optical system (the human eye) which is capable of manifesting a different power at every moment of the day; it can be a problem.

Let's start with the hypermetropic patient: imagine being presented with the following 31 year old male taxi driver:

Vision without glasses:		20/40
Present glasses:	+1.00 D	20/20
Manifest refraction:	+4.00D	20/20
Cycloplegic refraction:	+5.50D	20/20
Post-cycloplegic refraction:	+4.00D	20/20

Discussion: though this patient has 5.5 D of total hypermetropia, the post-cycloplegic refraction confirms that he will accept/tolerate no more than 4 D of plus correction; this 4 D finding is called the manifest hypermetropia. The remaining 1.5 D of error cannot be corrected without causing a subjective blur, which means that the patient is unable to relax his accommodation by the 1.5 D we know he must be exerting. This 1.5 D – the difference between the manifest hypermetropia and the total hypermetropia uncovered by cycloplegia – is called the latent (hidden) hypermetropia; it can be unmasked only by cycloplegia.

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we can become a stronger voice. Whatever your reason we welcome your support and hope to hear from you on issues that affect you and the profession as a whole.

The OOA has partnered with the OAC and NAIT to offer Ontario opticians the refracting course. This is a distance education course with hands on refraction that has been approved by the College. We are offering this course because we believe that the more opticians that are trained the better our chances are in expanding our scope of practice to include refraction. The response has been phenomenal and much better than we had predicted. This goes to show that Ontario opticians are hungry for knowledge, they always want to improve themselves and they agree with our vision on refraction. If you need more information you can contact Karin at the office or the OAC directly.

Finally, I would like to invite younger opticians to become active and vocal regarding issues that concern them. To enable that interaction we have started a Facebook page so we can attract those who use the Internet as their main communications tool. So if you use Facebook please join the Ontario Opticians Association page and let's start discussing issues that are important to you. You don't have to be a member to join the Facebook page.



Ali Badreddine, RO

Although the patient can wear no more than +4 D if he is to keep his retinal image sharp, he can nevertheless maintain clarity with less plus power than this. He makes up this difference by accommodating – 1 dioptre of accommodation for each dioptre of reduction in plus. In this case, he can continue to see the 20/20 line clearly until the correction is reduced to +1 D. This 1 D is his absolute hypermetropia, since any further reduction blurs his vision. Put in other words, the patient can adequately compensate for corrective lens powers from +1 D to +4 D by accommodating and this 3 D range is termed his facultative (or accommodative) hypermetropia.

In summary then: this patient's total hypermetropia (elicited by cycloplegia) is +5.5 D. It is composed of +1.5 D of latent hypermetropia (uncovered only by cycloplegia) and +4 D of manifest hypermetropia. The manifest hypermetropia, in turn, consists of +1 D of absolute hypermetropia (which cannot be overcome by his accommodation) and +3 D of facultative hypermetropia (which can be compensated for by accommodation).

This situation is far more commonplace than one unfamiliar with the refraction process might think; humans from infants until well into their 20's have no problem exerting accommodation and in some cases seem even to enjoy doing so. So much so that they resent it if you give them glasses that reduce the need for accommodating – and if you insist they wear them and they in turn are successful in relaxing their accommodation enough to see clearly, they will continue to tell their friends and relatives (and anyone else that will listen) that they didn't need glasses this powerful until the day they went to see you. Some will even come to the conclusion that your forcing such a strong prescription upon them is what created the need for such powerful glasses in the first place. Of course, explaining after the fact about cycloplegia and accommodation and the ageing process, and how they would one day undoubtedly and inevitably need glasses this powerful makes no difference at all. This is why most ophthalmic practitioners and clinics observe the corollary to the "Do no harm" rule of conduct, where it concerns spectacle refractions: don't treat asymptomatic patients. In other words, with under-corrected hypermetropes (and over-corrected myopes, for that matter) when the patient is no longer comfortable accommodating so much, they will seek out a refractionist to get more plus (or less minus – it's the same thing) who will then go down in their version of history as a hero: the proverbial knight in shining armour.

It is in the pre-presbyopic years (from about 35 to 40) that patients begin to feel the impact of their waning accommodation. Latent hypermetropia becomes increasingly manifest. The 1.25 D hypermetropes who could always get along easily without wearing their correction will suddenly find they cannot. So, they watch TV with glasses that were prescribed years ago "for reading." The 2.25 D hypermetrope rediscovers a 4-year-old pair of +1 D spheres lying in mint condition in a drawer somewhere. And so on it goes. As their accommodative amplitude continues to decrease and more of the latent hyper-

metropia becomes manifest patients find their old unused plus lenses increasingly necessary. Such patients are easy to live with and help as, more often than not, they are able to satisfy their own needs by spontaneously and gradually increasing the use of their old spectacle corrections.

However do be careful with such patients of one sure way of ruining your day: by neglecting to uncover a substantial quantity of hypermetropia in a pre-presbyopic patient and, as a result, prescribing them bifocals prematurely.

Next newsletter: The Over-Corrected Myope

References: "The Fine Art of Prescribing Glasses Without Making a Spectacle of Yourself" by Benjamin Milder, MD & Melvin L. Rubin, MD.

You can email Geoff at: geoff.briede@gmail.com.

Membership Benefits Update

In our effort to gain more of the optician's interest in their association we are working hard to bring more benefits to the membership. We have recently consolidated a good partnership with Vision Insurance Brokers Ltd. that provides a comprehensive extended health benefit plan.

Whether you are the only employee of the operation or you are part of a large enterprise, the new plan is there for you. By getting in touch with Vision Insurance (see advertisement on last page) you can tailor a plan that covers: life insurance, health benefits (chiropractor, massage therapist, chiropodist, dietician and more), prescription drugs, and dental. By participating, as a member of the association you are treated as part of a larger pool of people, therefore rates are more affordable.

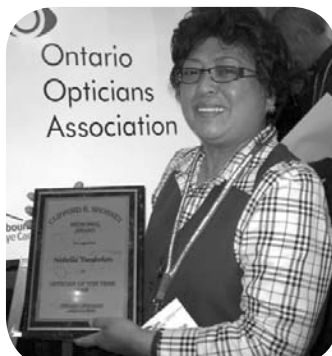
Wishing you a prosperous year,

Dorina Reiz R.O.

OOA, Director of Members' Benefits

Award Announcements

The Ontario Opticians Association is proud to announce the following Awards for 2008

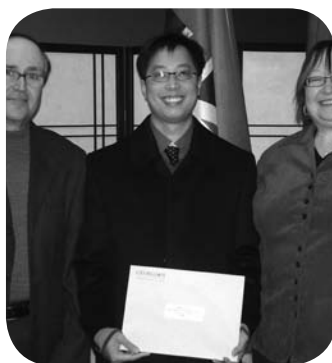


Optician of the Year 2008
Nobella Tumbokon



Ioana Danciu celebrating her award with the OOA president and Linda Wren.

Seneca Student Achievement, Shelly Dewell Memorial Award of Excellence
Ioana Danciu



Billy Wong accepts his award from Terry Finkelman and Jean Warbarks.

Georgian College Graduate Student Achievement Award
Billy Wong

Issues Issues and more Issues

By Rick Hayward, RO
OOA Director

As a volunteer of the OOA for the past thirty something years, and as a volunteer elected Director this past year, (All Directors of the Association are volunteers), I constantly hear about issues that affect our profession. The issues have changed over the years, and members and non-members of the Ontario Opticians Association are much more vocal than ever before with their complaints. We get complaints in writing, e-mail, verbally face to face and telephone. It does not matter how this Association handles all of the issues that it is presented with, we never seem to satisfy everyone.

This Association receives complaints about nearly everything, from how we run our seminars, the food provided, how hot or cold the hall was, the chairs are too hard or soft, not enough seating, not enough credited lectures, and the list goes on and on. Do we attend these seminars for the gourmet menu or are we there to get some educational credits? I realize that everything is not perfect, but when most of the complaints come from non-members of the Association, it makes you wonder if the effort of the Association to provide these educational opportunities is appreciated.

Other complaints we often hear about include, "The store down the street practices with no optician on site, what are you going to do about it?", "My customers are switching to mail order contacts and glasses, what are you going to do about it?", "How come you don't raise our issues with the College of Opticians of Ontario and the Government? What are you going to do about it?", etc., etc., etc.

Why is the OOA hearing more complaints from the opticians of this province? Why? Because the issues and complaints of today are starting to have repercussions on us all. They are starting to affect us all personally and financially. When issues start to affect someone personally, then, they usually become more motivated to actually do something to rectify the situation. The members and non-members alike are telling us their complaints are not being heard, or they are falling on deaf ears, and they repeat again, "what are you going to do about it?"

"WHAT ARE WE GOING TO DO ABOUT IT?",

Well, I can honestly say that each and every complaint or inquiry received by the OOA is taken seriously and dealt with in the most timely and effective manner possible. However, the Association faces many hurdles when it comes to political issues and concerns.

In the early years of the OADO, the noise we made often fell on deaf ears, and we as a profession struggled with the Government to address our concerns. More members of the profession joined the Association and our whisper started to get louder and louder until the Government started to hear what our Members were saying. This was accomplished by the many past and present volunteers who gave and give generously of their time to ensure that we continue to

be a strong and respected profession, and "you", the current Members of the Association who give us our strength. But, we need to be as strong as we can be, and strength comes in numbers.

Just imagine the strength and potential impact of twenty-five hundred licensed Ontario Opticians joining together as members of the Association to raise their voices about current issues and concerns affecting their profession. That level of noise would definitely be addressed in a hurry.

Don't sit back, criticize, and silently voice your concerns. Stand up, be counted. Protect and support your profession. Get involved and do something to bolster your chosen career. Join your colleagues within the Association and become a Member. Then when someone comes to you with a complaint and says, "What are you going to do about it?", you can proudly say, "I am doing something about it, I support my Association."

The Ivey AMD Video

By Dr. Tom Sheidow MD FRCS (C)
*Retina Specialist and Vitreo-Retinal surgeon
at the Ivey Eye Institute, London Ontario*

Age Related Macular Degeneration or AMD is the most common cause of permanent visual impairment in the people over the age of 50. 15% of Canadians over the age of 55 are affected by AMD and this number rises quickly to over 30% by the age of 75. The key to successful outcomes in AMD lie in early detection and treatment. This video will provide you with background knowledge and information on risk factors and the available treatment options for this condition.

The eye functions like a camera with the front portion of the eye – the lens - focusing the light onto the retina at the back of the eye. The retina acts like the film in a camera, recording images and sending the information to the brain. As its name implies, age-related macular degeneration affects the macula, which is a very small area in the centre of the retina – it's like the bull's-eye of the retina. The macula is responsible for fine detailed central vision and color vision. For example, while the entire retina lets you see that you're holding a book, the macula is needed to read it. It is the central vision provided by the macula that is affected by AMD. Although it is normal with aging to see some changes in the retina, it is not a normal to suffer vision loss as you get older.

Age related macular degeneration has 2 forms – dry and wet. The dry form affects the vast majority of patients and results in slow and gradual loss of vision. This form is characterized by the presence of small yellow-ish deposits under the retina known as drusen as well as changes in the pigment within the macula itself. Dry AMD results in only 10% of the vision loss due to AMD within our society.

Wet AMD affects a much smaller proportion of patients, in the range of 10 - 15% of those diagnosed with AMD. Wet AMD results from the growth of new and abnormal blood vessels under the retina called

choroidal neovascularization, or CNV. It's called wet AMD because these new and abnormal blood vessels leak their contents of blood and other fluids into the retina, disrupting its normal function. This can lead to a rapid decline in vision, typically over weeks or months. With the passage of time, a permanent scar can develop in the macula with a corresponding and permanent loss of vision. Currently wet AMD accounts for 80-90% of all vision loss due to AMD.

The impact of AMD on society is staggering. AMD affects over 30% of patients over 75 years of age and as such, results in approximately 180 000 new cases of AMD each year of which approximately 17 000 are new cases of wet AMD. The Canadian National Institute for the Blind, or CNIB, reports that more than 50% of new patients seeking assistance for vision loss are patients affected by AMD. It is important for patients and family members to be aware that despite our efforts and new treatments options, the number of people losing their sight to AMD is increasing, if only because our population is aging. It is critically important that patients be made aware of this condition and the steps they can take to monitor vision changes and reduce their risk for developing AMD.

Risk factors for the development of AMD fall into 2 categories: those which we can alter and those which we cannot. Of those that we cannot control, age is clearly the number one risk factor for AMD. Heredity is also a significant risk factor over which we have no control. Current evidence suggests that multiple genes may contribute to the development of AMD. Patients with one or more family members with AMD have a significantly increased risk of developing AMD themselves. Presently, there is no genetic testing or bloodwork available to determine your risk for AMD.

As for risk factors that are within our control, smoking tops the list. It is the #1 avoidable risk factor proven to increase the risk of developing AMD. Smoking also increases the risk of disease progression once you have it. Studies have shown that smokers are 3-4 times more likely to develop AMD over non-smokers, and if combined with genetic risk factors, patients who smoke may increase their risk by as much as 34 times. As for the relationship between cataract surgery and macular degeneration, there is much conflicting evidence making it difficult to know whether the combination represents a significant risk factor or not.

Dry AMD represents the first stage of the disease, and the appearance of drusen within the retina is the first visible sign that can be detected in a routine eye exam by your eye care professional. The retina has many layers between the outer light-sensitive photoreceptor layer and the bottom blood layer known as the choroid. One such layer is a barrier layer called the retinal pigment epithelium or RPE. This layer is important for sustaining the health of the retina. In patients with macular degeneration, the RPE layer begins to weaken, resulting in the formation drusen, which are actually deposits of waste material. These yellow deposits vary in size and extent in people with AMD. An abnormal build-up of drusen can affect the transfer of waste materials and nutrients between the various retinal layers and can also act as a pathway for the growth of new blood vessels in wet AMD.

In early AMD, most patients are not aware that these deposits are forming and are not aware of any visual changes as the better seeing eye can compensate for the other. What changes do occur, occur slowly and appear as a mild distortion or blurring of central vision. For 85-90% of patients, they will remain at the dry stage of AMD throughout their lives. The symptoms of macular degeneration that are shown in these slides demonstrate the central blurring of vision while patients maintain clear peripheral vision.

The vision loss from AMD is permanent at the present time. Although vision can be assisted with the use of magnifiers and other low vision aids, it is important to realize that it cannot be completely corrected. The peripheral vision is, however, always maintained and only 5% of patients will see progression to the level of legal blindness. Usually this progression, if it occurs, takes over 10 years to develop.

Dry AMD is typically diagnosed by an optometrist or ophthalmologist during a routine dilated eye examination and does not require any special testing. The key to monitoring your vision is by the use of the Amsler grid. This simple test, done one eye at a time, can help you monitor and evaluate your central vision in an effort to pick up new distortion or changes at an early stage and seek further attention.

Optical aids and services offered through the CNIB and Low Vision Clinics can be of great assistance to patients experiencing varying degrees of visual loss. Local contacts and service providers in your region are available from your eye care professional.

While there is no cure for dry AMD, the Age Related Eye Disease Study or AREDS was performed to evaluate the roll of vitamin and mineral supplementation in patients with AMD. This study showed an approximate 25% reduction in the risk of vision loss progression in the patients taking a specific combination of antioxidants and Zinc. These combinations are available as over the counter medications in your pharmacy. An important note is that no significant reduction and risk was present when any one component was taken and that Beta Carotene in patients who smoke can increase the risk of lung cancer. Over the years, other smaller studies have suggested the benefits of Lutein in protecting the macula and a new study is now underway to evaluate this. Although results will take several years, many of the current eye products contain Lutein. Lutein absorbs harmful blue light and acts as an antioxidant to prevent cell damage. With these facts in mind, and support from an article within the Journal of American Medical Association, a new product called Vitalux Healthy Eyes has been developed to support patients with very early AMD and those with a strong family history.

As opposed to dry AMD, wet macular degeneration can strike with alarming speed causing severe and sometimes irreversible damage to central vision. Often, patients first notice distortion and blurring described as a central spot or fog. These changes result from the growth of CNV, the abnormal blood vessels that can spontaneously begin to grow under the retina similar to the sprouting of weeds through the crack in a sidewalk. As these weak and abnormal blood vessels grow, fluid and blood leak out of them into the retinal layers

resulting in swelling. These changes prevent the retina from sending visual signals to the brain and eventually result in the formation of a scar and permanent visual loss. All these changes occur without causing any physical pain to the patient. The majority of patients with untreated Wet Macular Degeneration will eventually develop vision below 20/200, termed legal blindness within Canada. In the vast majority of these patients, peripheral vision is not affected. Unfortunately, for patients with wet AMD in one eye, 50% will go on to have wet AMD in the other eye.

Fortunately however, there are tests which can quickly detect wet AMD. These include an intravenous fluorescein angiogram or IVFA. During this procedure, a dye is injected into a hand vein and photographs are taken of the retina and blood circulation. Side effects from the dye used are uncommon and typically mild if they occur. Severe reactions rarely occur but if you should develop an unusual rash or breathing difficulties following this test, make sure to let your physician know.

A Fluorescein angiogram helps to confirm the presence of wet macular degeneration, the location of the blood vessels and in determining the treatment plan. As seen in these photographs, the abnormal lacy blood work in the center of the image on the left become quite fuzzy, indicating dye is leaking from these abnormal vessels on the right. It is this leakage shown on the angiogram that therapies attempt to control.

In recent years the Optical Coherence Tomography or OCT test, has taken a leading role in the monitoring and management of patients with AMD. OCT does not only confirm the presence or absence of fluid, but can be useful to your physician in monitoring the response to treatment and determining the early recurrence of active wet disease. OCT images are able to show the fluid within the retina as black circular areas or spaces separating the layers of the retina.

To review this information and find out more about treatment options please go to www.healthmediachannel.com

You will find a link for the Ivey AMD Video and a questionnaire. This is an accredited activity. 1EG/CL

Providing Better Lens Solutions



Today our role as Eye care professionals is to provide the best options which allow optimal vision. With all the technology changes, there are many options available, which we need to ensure not only we understand, but more importantly,

can help our clients learn how the lens design, treatment and specialized lens, can impact how they see the world. We need to understand the technology, because just like tube televisions are becoming a thing of the past, we owe our clients who are wearing

lens which are designed many years ago, the option to buy better lens. Education is what it is all about. People will pay more, when they understand what they are getting, and the value this will give them. High Definition TV is becoming a standard, and let's ensure our clients are seeing through lens that provide high definition vision for them.

More than 80% of information transmitted to the brain is received through our eyesight.

That is why, when we talk about High Resolution Vision, we are referring to the sharpest, clearest vision possible. This can only be achieved by taking contrast sensitivity into account, which is not measured during the standard eye exam.

Visual Acuity vs Contrast Sensitivity

Visual acuity is the accepted standard for quantifying vision. It is determined by using the Snellen chart, which presents a black target on an illuminated white background. It also assumes life is black and white – and we all know that is not the case.

Contrast sensitivity improves visual performance by allowing wearers to see more details – the shades of snow, the veins in leaves, the ripples on a pond's surface. It is impacted by:

- Dim light and near-dark conditions, where the human eye is less able to perceive contrast
- As the eye ages, the aberration of its optical structures tends to increase due to breakdown and disease (i.e. cataract).
- Aberrations can also be added to the optical structure of the eye through surgery, as well as with ophthalmic devices, spectacle lenses or contact lenses, all have aberrations which contribute to the overall aberration of the ocular system

The factors impacting contrast sensitivity can be eliminated by providing optimal optics, adding protective coatings and reducing exposure to harmful light.

Contrast sensitivity is a vital component of perceived visual quality. Although clients may have acceptable resolution with 20/20 vision, decreased contrast sensitivity will negatively impact their vision. By recommending lens to our clients that are the newest in lens design and have the latest in anti reflection and/or treatments, we will provide them with better contrast sensitivity. But we need to make sure we understand the benefits of the newest in technology, so we can educate our clients. This is our role as an Eye care profession and the final result is a better visual experience and more satisfaction for our clients.

Contact your Essilor representative to learn more about these lens and treatments.

Inside Optics Recap Sunday October 5, 2008

By Karen Tarshis, RO
OOA Director

Wow...fantastic...Inside optics was in a new location with a new venue and it was great.

The hall was larger, spacious and warmer. Over 350 opticians attended and 34 vendors showcased the latest.

Thank you to Essilor who invested a great deal of time and money energizing our tradeshow. Essilor had innovative attractions, the WI challenge with Jean-Luc Brassward and a special focus group.

New for the Inside Optics was a fashion show which showed the latest in eyewear from vendors, Georges et Phina, Allison, Looky Corporation and COS.

Hands on workshops were a hit and industry platforms were offered to any vendor that wanted to have the stage for 10 minutes at a time.

Optician of the year 2008 was awarded to Nobella, congratulations and well deserved.

Ali Badreddine, president of the OOA gave an outstanding speech just before lunch. For anyone that did not attend or did not hear his speech, it is available by emailing the association.

Board Members, we would like to welcome Bill Snelgrove as a new member of the OOA and for Ali Badreddine for renewing again for the next 3 year term.

Sherry Courville has finished her 3 year term we thank you for your time and contribution.

A special thank you to all of the directors and board members. Inside Optics could not have been successful without your help.

Thank you to all of the opticians that attended, we hope to see you on April 5, 2008 for our next Inside Optics.

Calling all Motorcyclists

OOA is hoping to run a team for the "Ride for Sight", Foundation for Fighting Blindness.

If you love riding and enjoy charity work please contact the OOA office. For details on 2009 event go to:

www.rideforsight.com

OOA office: 905-709-4141/877-709-4141



NECF Volunteer Katrina enjoys meeting some of the Biker attendees



NECF is well received at the "Right for Sight"



It an impressive scene to see 6000 Bikers roll into the "Right for Sight" Park

Take This Survey! Win an iPod!

The Opticians Council of Canada, which includes your provincial regulatory body and association, is working to create a brand that will raise awareness of the Opticianry profession. This is your brand, and it needs to accurately reflect your profession, resonate with you and support your efforts.

To achieve that, we need your input. We invite you to take the online survey and let us know your opinions.

It takes just 10 minutes to complete.

The survey closes Dec 31 at 17:00 PST.

After the survey closes, a random participant will be drawn and that person will win a iPod!

Just don't forget to enter your name & email (you have the opportunity to do so during the survey).

Take the survey at www.cobc.ca

Thank you



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