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എഡിറ്റോറിയൽ

കാലചക്രം തിരിഞ്ഞ് ഋതുക്കൾ മാറി വന്ന് ഒരാണ്ട് കൂടി പിന്നിടുന്നു. നമ്മുടെ ആരോഗ്യമേഖലയിലെ ശക്തമായ സാന്നിദ്ധ്യമായ കേരളാ ഗവൺമെന്റ് ഒപ്റ്റോമെട്രിസ്റ്റ് അസ്സോസിയേഷൻ 18 വയസ്സ് പിന്നിടുന്നു. ആരോഗ്യമേഖലയിലെ ജനവിരുദ്ധമായ നയങ്ങൾക്കും പ്രവർത്തനങ്ങൾക്കുമെതിരെ എന്നും ജനപക്ഷത്തുനിന്ന് പോരാടിയ നമ്മുടെ പ്രസ്ഥാനത്തിന്റെ സംസ്ഥാന സമ്മേളനം കൊല്ലത്ത് വച്ച് സംഘടിപ്പിക്കുന്നു.

മെഡിക്കൽ കോളേജുകളെ പൂർണ്ണമായും റഫറൽ ആശുപത്രികളാക്കുമ്പോൾ ജനങ്ങൾക്ക് ബുദ്ധിമുട്ട് ഉണ്ടാകുന്നുവെങ്കിൽ അത് പുനഃപരിശോധിക്കുവാൻ തയ്യാറാകണം. സാധാരണക്കാരന് അപ്രാപ്യമായ സ്വകാര്യമേഖലയിലേക്ക് ജനങ്ങളെ തള്ളിവിടാതെ മെഡിക്കൽ കോളേജുകളെ ജനകീയ ആതുരാലയങ്ങളാക്കുവാൻ നടപടി സ്വീകരിക്കണം. കരാറടിസ്ഥാനത്തിൽ മാത്രം ജീവനക്കാരെ നിയമിക്കുമ്പോൾ ആരോടും യാതൊരു ബാധ്യതയും ഇല്ലാത്ത ഈ വിഭാഗം ജീവനക്കാർ ജനങ്ങൾക്കും സർക്കാരിനും ബാധ്യതയാകുന്ന വിവരം സർക്കാർ അറിയുന്നില്ലേ?

Bifurcation നടപടികൾ പൂർത്തീകരിക്കുവാൻ സമയ ബന്ധിതമായി നടപടി സ്വീകരിക്കണം. സ്ഥലം മാറ്റങ്ങൾ ഇഷ്ടപ്രകാരം നടത്തുന്നത് മാത്രമല്ല ഒരു വകുപ്പിന്റെ കർത്തവ്യം. മാനദണ്ഡങ്ങളും അർഹതകളും കാറ്റിൽ പറത്തി നടത്തുന്ന സ്ഥലം മാറ്റങ്ങൾക്ക് നൽകുന്നതിന്റെ പകുതി ശ്രദ്ധ വകുപ്പിന്റെ പ്രവർത്തനങ്ങൾക്ക് നൽകിയാൽ ആരോഗ്യവകുപ്പിനെ രക്ഷിക്കാൻ കഴിയും.

ആരോഗ്യ വകുപ്പിന്റെ പ്രവർത്തനങ്ങൾ മെച്ചപ്പെടുത്തുന്നതിനുള്ള ബദൽരേഖ സംസ്ഥാന സമ്മേളനത്തിൽ രൂപപ്പെടുത്തി സർക്കാരിന് സമർപ്പിക്കുവാനുള്ള ശ്രമത്തിലാണ്. സമ്മേളന വേദിയിൽ നേരിൽ കാണമെന്നുള്ള പ്രതീക്ഷയോടെ

അരുൺ ആർ ജെ
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PRESIDENT'S VOICE

സുഹൃത്തുക്കളെ,

അപ്രതീക്ഷിതമായ സാഹചര്യത്തിൽ കേരളാ ഗവൺമന്റ് ഒപ്റ്റോമെട്രിസ്റ്റ് അസ്സോസിയേഷന്റെ പ്രസിഡന്റ് സ്ഥാനം ഏറ്റെടുത്തിട്ട് മൂന്ന് മാസം പിന്നിടുകയാണ്.

സംഘടനയുടെ നേതൃത്വത്തിന് നിങ്ങൾ നൽക്കുന്ന ആത്മാർഥമായ പിന്തുണയ്ക്ക് തീരാത്ത നന്ദിയുണ്ട്. ജോലി സമയം പുനഃക്രമീകരിക്കുന്നത് സംബന്ധിച്ച ചർയ്ച്ചക്ക് ബഹു. ആരോഗ്യവകുപ്പ് സെക്രട്ടറി വിളിച്ച് ചേർത്ത യോഗത്തിൽ അസ്സോസിയേഷൻ ജനറൽ സെക്രട്ടറിയെ പങ്കെടുപ്പിക്കാനും അംഗങ്ങളുടെ പൊതു അഭിപ്രായങ്ങൾ വളരെ ശക്തമായിതന്നെ അവതരിപ്പിക്കാനും കഴിഞ്ഞു.

Bifurcation സംബന്ധിച്ച വിഷയങ്ങളിൽ തീരുമാനമെടുക്കാൻ കോടതി സർക്കരിനോട് നിർദ്ദേശിച്ചിരിക്കുന്ന സാഹചര്യത്തിൽ, സർക്കാർ തീരുമാനം വരുന്നതുവരെ അനീതി ഉണ്ടാകിലെന്ന ശുഭാപ്തി വിശ്വാസത്തോടെ കാത്തിരിക്കാം.

സംഘടനയുടെ ഐക്യത്തെ വെല്ല് വിളിക്കുന്ന ചിലരുടെ ഗൂഢലക്ഷ്യങ്ങളിൽ കുരുങ്ങിപ്പോയ, നമ്മുടെ തസ്തിക പുനർ നാമകരണം എന്ന ചിരകാല സ്വപ്നത്തെ യാഥാർത്ഥ്യമാക്കാൻ സംഘടന വീണ്ടും ശക്തമായ സ്വാധീനം ചെലുത്തുകയാണ്. നിങ്ങളുടെ അകമഴിഞ്ഞ പിന്തുണ ഉണ്ടെങ്കിൽ നാം ലക്ഷ്യം നേടുക തന്നെ ചെയ്യും.

കേരളാ ഗവൺമന്റ് ഒപ്റ്റോമെട്രിസ്റ്റ് അസ്സോസിയേഷന്റെ 18ാം സംസ്ഥാന സമ്മേളനത്തിന് അതിന്റെ എല്ലാ മനോഹാരിതയും നൽകാനുള്ള തീവ്ര ശ്രമത്തിലാണ് സംസ്ഥാന കമ്മിറ്റി. ഇത്രയും പ്രതിച്ഛായയുള്ള ഒരു സർവ്വീസ് സംഘടനയുടെ ശക്തമായ സംസ്ഥാന കമ്മിറ്റിയെ നയിക്കാൻ അവസരം ലഭിച്ചതിൽ അഭിമാനം കൊള്ളുന്നു. സംസ്ഥാന സമ്മേളനത്തിനും മറ്റെല്ലാ സംഘടനാ പ്രവർത്തനങ്ങൾക്കും നിങ്ങളുടെ തുടർന്നുള്ള എല്ലാ പിന്തുണയും അഭ്യർത്ഥിക്കുന്നു.

അഭിവാദനങ്ങളോടെ

സുധീഷ് ബി ആർ
പ്രസിഡന്റ്

FROM SECRETARY'S DESK

സുഹൃത്തുക്കളെ,

സംഘടനാ ചരിത്രത്തിലേക്ക് ഒരു വർഷം കൂടി കടന്ന് പോവുകവാണ്. കഴിഞ്ഞ വർഷം നിങ്ങളെന്നെ ഏൽപ്പിച്ച ദൗത്യം, എന്റെ മനസ്സാക്ഷിക്ക് നിരക്കുന്ന നിലയ്ക്ക് സത്യസന്ധമായി നിർവ്വഹിക്കാൻ സാധിച്ചു എന്ന് വിശ്വസിക്കുന്നു.

നേട്ടങ്ങളുടെ നീണ്ടനിരയൊന്നും നിരത്താനില്ലെങ്കിലും പല നയപരമായ കാര്യങ്ങളിലും സർക്കാരിൽ യഥാസമയം സമ്മർദ്ദം ചെലുത്താനും വസ്തുനിഷ്ഠമായി കാര്യങ്ങൾ മേലുദ്യോഗസ്ഥരെ ധരിപ്പിക്കാനും സാധിച്ചു എന്നതിൽ ചാരിതാർഥ്യമുണ്ട്.

Bifurcation വിഷയത്തെക്കുറിച്ച് നടക്കുന്ന കുപ്രചരണങ്ങൾക്ക് ആരും ചെവി കൊടുക്കരുതെന്ന് അഭ്യർഥിക്കുന്നു. 2:2:1 അനുപാതത്തിൽ പട്ടിക തയ്യാറക്കുന്നതിന്റെ അവസാന ഘട്ടത്തിലാണ്. ചില സാങ്കേതിക തടസ്സങ്ങൾ കൊണ്ടാണ് ഉത്തരവ് വൈകുന്നത്. തസ്തിക പുനർനാമകരണം ഒരു കീറാമുട്ടിയായി നമ്മുടെ മുന്നിൽ ഇപ്പോഴും ഉണ്ട് എന്നുള്ളത് ഒരു നഗ്ന സത്യമാണ്. അതിന്റെ തടസ്സങ്ങൾ നീക്കാനുള്ള നടപടികൾ നടന്നുകൊണ്ടിരിക്കുകയാണ്. എത്ര വൈകിയാലും ആ സ്വപ്നം പൂവണിയുക തന്നെ ചെയ്യും.

ഒരു സുപ്രദാന കാര്യം ഇതിനോടൊപ്പം സൂചിപ്പിക്കാൻ ഞാൻ നിർബന്ധിതനാകുന്നു. നമ്മുടെ അംഗങ്ങൾ സംഘടനയ്ക്ക് നൽകുന്ന പിന്തുണ വളരെ പ്രോത്സാഹനജനകമാണ്. പക്ഷെ ചില ജില്ലകളിലെങ്കിലും പലരും ഉണർന്ന് പ്രവർത്തിക്കുവാൻ തയ്യാറാകുന്നില്ല. ഇത് തികച്ചും ആശങ്കാജനകമാണ്. നമ്മുടേത് ഒരു രാഷ്ട്രീയേതര സംഘടനയാണെന്ന് ഏവർക്കും അറിയാവുന്നതാണ്. എന്നിട്ടും ഈ വൈമനസ്യം എന്തുകൊണ്ടാണെന്ന് മനസ്സിലാക്കാൻ സാധിക്കുന്നില്ല. ഒരു സംഗതി ഓർമ്മിപ്പിക്കട്ടെ – 'ഒത്ത് പിടിച്ചാൽ മലയും പോരും'. ആയതിനാൽ വരും നാളുകളിലെങ്കിലും നിങ്ങളുടെ നിസ്തുലമായ അഭിപ്രായങ്ങളും പ്രവർത്തനങ്ങളുമെല്ലാം ഈ സംഘടനയ്ക്ക് ശക്തി പകരട്ടെ എന്ന് ആത്മാർത്ഥമായി ആഗ്രഹിക്കുന്നു.

ഒപ്റ്റോമെട്രിസ്റ്റുകൾ ഇപ്പോൾ ജോലി ചെയ്യുന്ന സ്ഥലങ്ങളിൽ മെച്ചപ്പെട്ട ഭൗതിക സാഹചര്യങ്ങൾ ഉണ്ടായിക്കൊണ്ടിരിക്കുന്നതിനാൽ നമ്മുടെ പ്രവർത്തനങ്ങൾ കുറച്ചുകൂടി പ്രൊഫഷണൽ ആക്കാൻ സാധിക്കും. അതിലേക്കായി ശാസ്ത്രീയവും വ്യക്തിത്വവികസനത്തിനുമുള്ള സാഹചര്യം സംഘടന ഒരുക്കുന്ന അവസരങ്ങളിൽ അവ പരമാവധി പ്രയോജനപ്പെടുത്തണമെന്ന് അഭ്യർഥിക്കുന്നു. ക്രിസ്തുമസ്സിന്റെ പ്രതീക്ഷയാർന്ന സന്ദേശവും പുതുവർഷത്തിന്റെ പ്രത്യാശയും നമ്മെ നയിക്കട്ടെ എന്ന് ആശംസിച്ചു കൊണ്ട്

"Merry Chritmas & Happy New Year 2010"

ആശംസകളോടെ

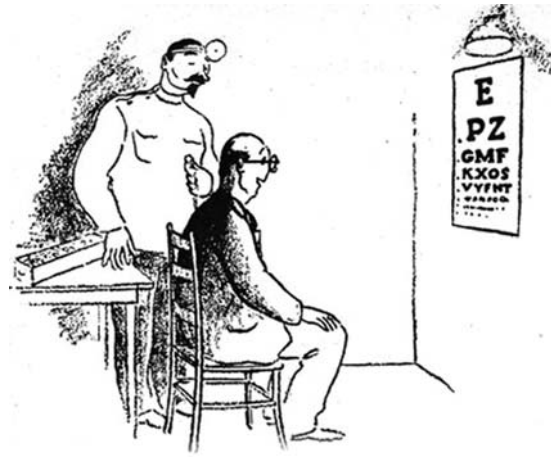
ബിജു കെ ആർ
സെക്രട്ടറി

The Ideal Optometrist

Dr. Ashley Thomas Jacob
MS, DNB, MRCOphth (London), FICO (Cambridge)
Medical Director
Mulamoottil Eye Hospital & Research Center
Kozhencherry

Attributes of a good optometrist:

1. Professional demeanour
2. Pleasant
3. Good communicator
4. Well Groomed
5. Excellent Personal Hygiene



Optometrist as an ideal eye care partner

The ideal optometrist would prove to be an indispensable partner to the ophthalmic surgeon in the discharge of cutting edge patient care.

These are the following capacities in which an optometrist can make themselves vital to the delivery of an outstanding eye care experience for the patient.

1.History taking

An optometrist would be expected to take history regarding the patients' primary reason for opting for an eye check up, additional symptoms, medical history, ophthalmic treatment history, allergies, etc.

A history of previous treatment taken for the same disease from other centres would be of immense help. Also a poor optical history with progressive, etc would prevent repeat mistakes.

A diabetic patient would be more myopic if his sugar level is very high. Such a glass prescription should not be issued.

2.Refraction

Any optometrist would be able to do a reasonably good refraction. Most would still do the refraction based on the results of the automated refraction (computerised eye test) even though it is well known that the AR is only a guide to the actual refractive power and it is not the correct power.

The ideal optometrist would look for and exclude pseudo-myopia commonly seen in children and avoid prescription of unnecessary glasses to children. Prescriptions of 0.25 cyl and 0.25 sph are best avoided.

A 40 year old, who accepts a near correction of +1.5 needs to be asked if she is wearing her husband's glasses for reading.

3.Retinoscopy

A sound knowledge of streak Retinoscopy in the dynamic and static state is vital to a good refraction. So is the PMT.

An observant optometrist would look for scissoring shadows, media opacities, discoloration of the red reflex, compare the red reflex between the two eyes, etc.

4.Best Glass Prescription

Glass prescription is indeed the most important function of an optometrist and of the eye hospital.

A good prescription would need the following:

- **Duochrome test**: To obtain the ideal spherical correction
- **Jackson Cross cylinder**: To verify the cylinder power and identify the correct axis of placement
- **The MEH walk-test**: We encourage our optometrists to ask the patient to attempt to walk with the prescribed cylindrical power in the trial frame and see for any sloping effect (which is the bane of a cylindrical over correction).
- **Diplopia test**: Ask if the patient has any Diplopia with the prescription.
- **Binocular visual acuity**: Always record the final refraction binocularly if either eye has below 6/9.
- **The MEH Specs trial**: Encourage patients who are having a refraction of hyperopic correction upto +1.0 under fogging to opt for a trial of the spectacles for around 20mins prior to finalising the prescription.
- **IPD**: Inter-pupillary distance with separate values for each eye would be ideal for progressive glass prescription.

5.Diagnosis

Many an optometrist can diagnose the following:

- **Cataract**: From the altered red glow
- **Glaucoma**: From history of frequent glass changes, or accepting near correction above the normal level for that age
- **AMD**: Missing of snellen lines on one line

6.Review visits

How wonderful it would be if a patient on a review visit could be asked "how are you? I hope you are better." If an optometrist could do just this much, all patients who walk into the hospital would be happy and mighty pleased with the level of patient care.

7.Surgical Counselling

Optometrists could be invaluable to the organisation in the proper explanation of cataract diagnosis, treatment and surgical counselling.

Specialised ophthalmic techniques that a capable optometrist could perform

1) Visual Field Analysis
2) Pachymetry
3) Contact lens dispensing
4) Topography
5) A-Scan
6) OCT
7) Angiography (FFA)
8) Hess Charting
9) Paediatric Vision Assessment
10) Slit Lamp exam + Tonometry (once he/she has gained the confidence of the ophthalmic surgeon)

Conclusion

As we can see, an extremely talented optometrist can be an invaluable partner to an ophthalmic surgeon in the delivery of high quality eye care. Any ophthalmic surgeon would be willing to teach an enterprising optometrist all the techniques described above as it would be a huge relief to them.

All it takes is the desire to be the best and the willingness to put extra effort and time to learn the skills necessary.

H1N1 ഇൻഫ്ലുവൻസ

H1N1 എന്ന് നാമകരണം ചെയ്യപ്പെട്ടിട്ടുള്ള ടൈപ്പ് 'എ' ഇൻഫ്ലുവൻസ വിഭാഗത്തിൽ പെടുന്ന ഒരു പുതിയ വൈറസാണ് ഈ രോഗമുണ്ടാക്കുന്നത്. 1930കളിൽ പന്നികളിലാണ് ഈ രോഗം ആദ്യമായി കണ്ടെത്തിയത്. ഇത്തരം ഇൻഫ്ലൂൻസ രോഗത്തിന് നാല് ഉപവിഭാഗങ്ങളുണ്ട്- H1N1, H1N2, H3N1, H3N2. ഇപ്പോൾ ലോകം മുഴുവൻ പടർന്ന് പിടിച്ചുകൊണ്ടിരിക്കുന്നത് H1N1 വിഭാഗത്തിൽ പെടുന്ന ഇൻഫ്ലുവൻസയാണ്. ഇത് മനുഷ്യരിൽ രണ്ട് തരത്തിൽ കാണപ്പെടുന്നു.

1. ജ്വരദോഷം പോലുള്ള അസുഖങ്ങൾ(Influenza Like Illness)

ലക്ഷണങ്ങൾ:-

- **പെട്ടെന്നുണ്ടാകുന്ന പനി (38°C കൂടുതലുള്ളത്)**
- **ചുമ**
- **തൊണ്ടവേദന**
- **മുകളിൽ പറഞ്ഞ ലക്ഷണങ്ങൾക്ക് മറ്റ് കാരണങ്ങളൊന്നും ഇല്ലാതിരിക്കൽ**

2. SARI – Severe Acute Respiratory Illness

ലക്ഷണങ്ങൾ:-

- **38°C കൂടുതലുള്ള പനി**
- **ചുമ, തൊണ്ടവേദന**
- **ശ്വാസതടസ്സം, ക്ഷീണം, രക്തസമ്മർദ്ദം കുറയൽ**
- **രക്തം കലർന്ന കഫം**

മേൽ പറഞ്ഞ ലക്ഷണങ്ങളുള്ള രോഗികളെ ആശുപത്രിയിൽ പ്രവേശിപ്പിച്ച് ചികിത്സിക്കണം

സ്ഥിരീകരിച്ച രോഗികൾ (Confirmed Cases)

ലബോറട്ടറി പരിശോധനയിൽ പോസിറ്റീവ് ആയ രോഗികൾ

പരിശോധനാ മാർഗ്ഗങ്ങൾ

- **Realtime PCR**
- **Virul Culture**
- **Fourfold rise in H1N1**
- **Neutralising Antibodies**

സംശയിക്കപ്പെടുന്ന രോഗികൾ (Suspected Cases)

ജ്വരദോഷം പോലെയുള്ള അസുഖങ്ങൾ ഉള്ള ഒരു വ്യക്തി

- **7 ദിവസത്തിനുള്ളിൽ അണുബാധയുള്ള ഒരാളുമായി അടുത്ത് പെരുമാറിയിട്ടുണ്ടെങ്കിൽ**
- **7 ദിവസത്തിനുള്ളിൽ ഒന്നോ അതിലധികമോ സ്ഥിരീകരിച്ച രോഗികളുള്ള സ്ഥലം സന്ദർശിച്ചിട്ടുണ്ടെങ്കിൽ**
- **സ്ഥിരീകരിച്ച രോഗികളുള്ള സ്ഥലത്ത് താമസിക്കുന്നയാൾ**

സംശയിക്കപെടുന്ന രോഗികളെ ചികിത്സാ ആവശ്യങ്ങൾക്കായി മൂന്നായി തരം തിരിച്ചിരിക്കുന്നു

Category A

ചെറിയ പനി, ചുമ, തൊണ്ടവേദന - ഈ ലക്ഷണങ്ങൾ പ്രകടിപ്പിക്കുന്നവർ
ഇവർക്ക് ചികിത്സയുടെ ആവശ്യമില്ല. വീട്ടിൽ തന്നെ വിശ്രമിച്ചാൽ മതി. ലബോറട്ടറി പരിശോധനയുടേയും ആവശ്യമില്ല.

Category B

1.മുകളിൽ പറഞ്ഞ ലക്ഷണങ്ങൾ കൂടാതെ കൂടിയ അളവിലുള്ള പനി, തൊണ്ടവേദന മുതലായവ ഉള്ള രോഗികൾ

ഇവർക്ക് വീട്ടിൽ വിശ്രമവും Oseltamivir (ടാമിഫ്ലൂ) ഗുളികയും ആവശ്യമാണ്.
2.മുകളിൽ പറഞ്ഞ ലക്ഷണങ്ങൾ കൂടാതെ താഴെ പറയുന്ന വിഭാഗങ്ങളിൽ പെടുന്നവർ

- 5 വയസ്സിൽ താഴെ പ്രായമുള്ളവർ
- ഗർഭിണികൾ
- 65 വയസ്സിൽ കൂടുതൽ പ്രായമുള്ളവർ
- ശ്വാസതടസ്സം, ഹൃദയം, കരൾ, കിഡ്നി, രക്തസംബന്ധമായ അസുഖങ്ങൾ, പ്രമേഹം, ഞരമ്പ് സംബന്ധമായ അസുഖങ്ങൾ, ക്യാൻസർ, എയിഡ്സ് എന്നീ അസുഖങ്ങൾ ഉള്ളവർ
- ദീർഘകാലമായി കോർട്ടിസോൺ മരുന്ന് കഴിക്കുന്നവർ.

ഈ രോഗികൾക്ക് Oseltamivir ഗുളിക കൊടുക്കേണ്ടതാണ്.

Category B1,2ലും പെട്ടയാളുകൾ വീട്ടിൽ തന്നെ കഴിഞ്ഞുകൂടണം. മറ്റ് ആളുകളുമായി ഒരാഴ്ച്ച യാതൊരു ബന്ധവും പാടില്ല.

Category C

മുകളിൽ പറഞ്ഞ ലക്ഷണങ്ങൾ കൂടാതെ ശ്വാസതടസ്സം, നെഞ്ചുവേദന, ക്ഷീണം, രക്തസമ്മർദ്ദം കുറയൽ, രക്തം കലർന്ന കഫം, നഖത്തിൽ നീല നിറം കാണുക.
ഈ വിഭാഗത്തിൽ പെടുന്ന രോഗികളെ ഉടനടി ആശുപത്രിയിൽ പ്രവേശിപ്പിക്കേണ്ടതും ലബോറട്ടറി പരിശോധനകൾ നടത്തേണ്ടതുമാണ്.

രോഗം ഉണ്ടെന്ന് സംശയിക്കുന്നവരും, അല്ലാതെ തന്നെ സാധാരണ പനിയും ജലദോഷവും ഉള്ള ആളുകളും

- വീട്ടിൽ തന്നെ ഇരിക്കാനും, ഒരാഴ്ച്ച വിശ്രമിക്കാനും, പൊതു ചടങ്ങുകളിൽ പങ്കെടുക്കാതിരിക്കാനും ശ്രദ്ധിക്കുക.
- ശ്രവങ്ങൾ കൈകളിൽ പറ്റി രോഗം പകരാതിരിക്കാൻ ഇടയ്ക്കിടെ കൈകൾ സോപ്പും വെള്ളവും ഉപയോഗിച്ച് കഴുകി വൃത്തിയാക്കുക
- ചുമയ്ക്കുമ്പോഴും തുമ്മുമ്പോഴും മാസ്ക്ക് ഉപയോഗിച്ചോ ടൗവ്വൽ ഉപയോഗിച്ചോ വായ അടച്ചുപിടിക്കുന്നത് രോഗം പകരുന്നത് തടയാൻ സഹായകമാകും

Elimination of river blindness feasible

The first evidence that onchocerciasis elimination is feasible with ivermectin treatment was published in the open-access journal PLoS Neglected Tropical Diseases. Onchocerciasis is also called river blindness because the blackfly which transmits the disease breeds in rivers; it often blinds people, as well as causing debilitating skin disease. Over 37 million people are infected, often living in poor, rural African communities.

"This evidence is an historic milestone — it has far-reaching implications for the fight against this disease. Prior to this study we did not know if we would ever be able to stop treatment," says Uche Amazigo, the Director of the African Programme for Onchocerciasis Control (APOC). APOC is the organization charged with implementing control of the disease across Africa.

The multi-country study showed that treatment with ivermectin stopped further infections and transmission in 3 specific areas in Africa where the disease has existed continuously (an endemic area).

Annual treatments to prevent resurgence

Ivermectin kills the larvae but not the adult worms of Onchocerca volvulus, the parasite that causes the disease, so annual or biannual treatments are required to prevent resurgence. Merck & Co., the company that discovered and manufactures the drug, agreed in 1987 to donate the drug free of charge to countries where onchocerciasis is endemic. This has resulted in annual treatments to all eligible community members – over 60 million people were treated in 26 African countries in 2008. But although this large-scale treatment has enabled the control of onchocerciasis in Africa, it has not been clear whether it could also be used to eliminate infection and transmission to the extent that treatment with ivermectin could be safely stopped. Many scientists have doubted whether onchocerciasis elimination with ivermectin is feasible in Africa, where more than 99% of cases are found. This new study in three areas in Mali and Senegal where onchocerciasis was endemic has now provided the first evidence of the feasibility of onchocerciasis elimination with ivermectin in some endemic areas in Africa. Previously, it was thought that elimination of onchocerciasis was only possible in the limited, isolated areas in the Americas where the disease is endemic.

However, the studies showed that after 15 to 17 years of six-monthly or annual treatments, only a few infections remained in the human population. Transmission levels were below predicted thresholds for elimination, so treatment was subsequently stopped in test areas and follow-up evaluations after 1.5 to 2 years showed that no further infections or transmission occurred.

Further studies needed

Although further studies are needed to determine to what extent these findings can be extrapolated to other areas in Africa, the principle of onchocerciasis elimination with ivermectin treatment has been established. Dr Robert Ridley, Director of TDR, the Special Programme for Research and Training in Tropical Diseases (that coordinated the study), said, "This is an excellent example of how research like this can not only provide important answers to major health questions, but with this type of partnership, can also help develop research capacity in low-income countries."

As a result of the study, the board of APOC has already adopted a new objective for the programme to determine where and when treatment can be safely stopped in the 16 African countries where APOC is supporting mass ivermectin treatment programmes.

The studies were undertaken by research teams from the ministries of health of Mali and Senegal, in collaboration with the WHO Multi-Disease Surveillance Centre in Burkina Faso. Main funding for the study was provided by the Bill & Melinda Gates Foundation. The study was coordinated by TDR, a co-sponsored programme of UNICEF, UNDP, the World Bank and WHO.

WHO News Letter 21 July 2009

PATIENTS' HEADACHE IS YOUR 'HEADACHE'

K.J.MANOJ
PHC KOPPAM

Headache is a very common clinical problem. Although the majority of headache are benign, it may sometimes be associated wtih some serious medical disorders as their initial or main symptom. Patients with headache may be reffered to optometrist to rule out refractive errors or any other eye disorders. If a patient with headache comes to an optometrist, first of all he has to check whether the patient has any optical or ocular defect. If the patient's ocular state is normal or if the headache persists ever after correcting the ocular/optical defect, the patient has to be referred for specialist medical opinion. So knowledge of the common headache syndrome is very important to asses which patients require further investigations and medical referral.

Broadly speaking headache refers to any head pain. A systemic clinical approach is essential to ruleout a serious underlying disease and to make accurate diagnosis and treatment.

Headache is classified into primary headache syndrome where no obvious underlying cause of headache can be found and secondary headache syndrome where headache is a symptom of an underlying medical problem.

The systemic clinical approach to headache begins with a thorough history and examination. It should include onset of headache with duration,. (ie, was it sudden or instantaneous over a few seconds or minutes or lasts for hours) severity of headache, its location (ie. focal unilateral or generalised), the nature of the pain (dull, sharp, continuous or sharp shooting). The associated symptom accopaning headache should also be noted (such as vomiting, nausea, photophobia, phonophobia, osmophobia, mechanophobia etc.)

The common causes of ocular pain may include

- ✔ Acute angle closure glaucoma
- ✔ Refractive errors - excessive accommodation
- ✔ Strabismus/amblyopia/diplopia - excessive ocular muscle activity
- ✔ Uveitis
- ✔ Posterior scleritis
- ✔ Sinusitis

In addition to these headache may occur in connection with the following neurological problems.

CLUSTER HEADACHE

It is very much less common. Here headache is very severe, unilateral and nocturnal. Pain is usually localised to face and orbit and is associated with ipsilateral tearing, conjunctival congestion and neural congestion. The pain is so severe and it is often relieved by walking around. History is often typical in the diagnosis

MIGRAINE

Migraine is a periodic paroxysmal headache. Stress, food stuffs, menstruation and bright lights may precipitate migraine headaches and maby be associated with nausea, vomiting, photophobia, phonophobia, osmophobia and mechanosensitivity. During the attack the sufferers tend to lie down in a dark, quiet room. The acute attack may lasts for 4 - 72 hrs. Some patients sees auras, that is a wave of moving lights which usually take the form of sigzag lines that are followed by a scotoma.

CAROTID ARTERY DISSECTION

Often presents e ocular pain localised to the temporal, frontal orbital area associated with neckpain

ORBITAL APEX AND CAVERNOUS SINUS DISEASES

Numerous disease that involve the orbital apex and cavernous sinus present with retro orbital headache. The pain may very in character but is often exagerated by eye movements. Associated signs include visual loss, proptosis and restriction of ocular movements etc.

OPTHALMIC NEURALGIA

It usually develops as a complication of herpeszoster that involves the opthalmic division of the trigeminal nerve. It may also occur after trauma and other pathologies that result in nerve injury. The pain may be precipitated by sensory stimuli

OPTIC NEURITIS

Optic neuritis is an inflammatory demyelinating disease of the optic nerve which is associated with multiple sclerosis. The condition is usually uniletril and causes a central or paracentral scotoma. Retro orbital pain which is exacerbated by eye movements occur in majority of cases.

RAISED INTRACRANIAL PRESSURE

Raised intra cramial pressure causes generalised headache more severe in occipital region. It is typically made worse by lying down, straining, coughing etc which increases crarial pressure. Other symptoms include nausea, vomiting and bluring of vision. Papilloedema with enlarged blind spot is a late manifestation.

Headache may occur as a symptom of a lot of ocular, systemic or neurological disorders. Timely referral is very important as far as Optometrist is concerned.

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Spectacle Intolerance

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In any refraction clinic at least 6% of the patients come back unhappy with their spectacles. The reasons may be several ranging from Cosmetic to Functional.

The common complaints are the following

- Vision not clear for working distance
- Reading distance is too short
- Ill-fitting frames
- Eye strain due to decentration and subsequent induced phoria
- Distorted or tilted image
- Pin cushion distortion
- Awkward head position
- Diplopia

This may be the result of the patient's selection of spectacles or due to the prescriber or dispenser.

The intolerance of spectacles may be broadly divided into

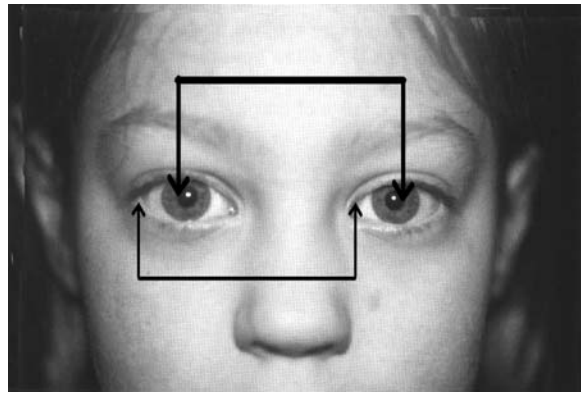
- Cosmetic – This is outside the purview of this article. Readers can get good guide on the selection of frames from the following website

  www.allaboutvision.com/.../eyeglasses_shape_color_analysis.htm

- Functional

Functional Intolerance is due to

- Improper frame selection
- Improper lens fitting
- Wrong prescriptions
- Anisometropia & Aniseikonoa
- High refractive errors
- Organic diseases
- Heterophoria

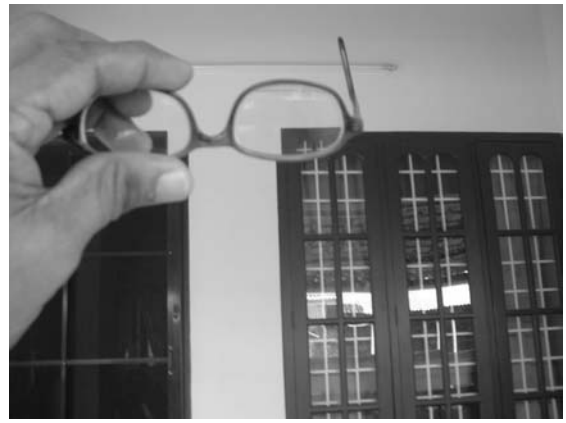


Frame selection

They must be rigid, strong, light and must be comfortable. The frame must touch only three points on the head – the nasal bridge and top of both ears- called the "fitting triangle". The refractionist can only give a broad information on the frames since it is the patient's choice that ultimately matters.

The hairline to hairline measurement and Interpupillary distance (IPD) measurement are very important in frame selection, lens adaptation and final adjustment of the lens and frame. The IPD is the

distance between inner canthus of one to outer canthus of other eye or the distance between nasal border of one pupil to temporal border of other pupil



Assessment of Intolerance

* Check power and axis
* Check centration
* Check alignment on the face
* Check bifocal segment

How to check the centration

Optical center of the lens may be different from its geometric center. The optical center ican be determined by the following methods

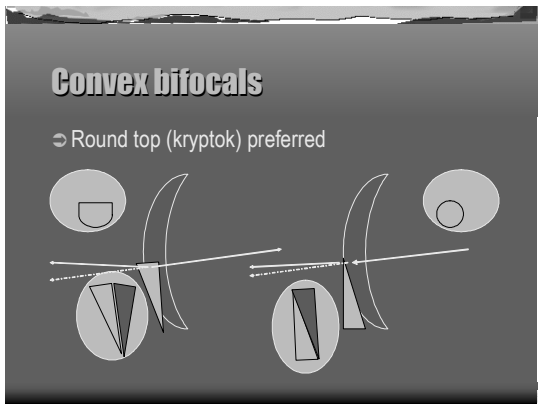
* Holding lens against a rectangular edge to form an unbroken edge inside and outside the lens
* Aligning the reflected images of a source of light from the convex surface of the lens
* Lensometer

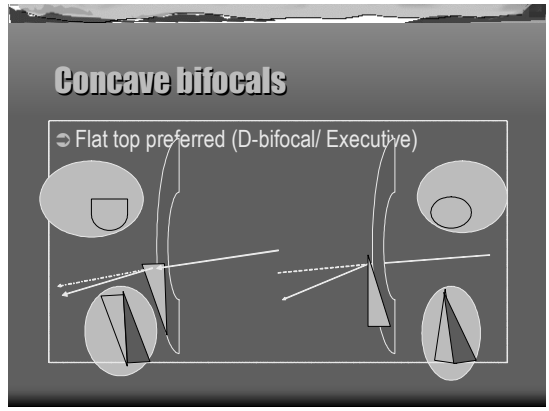
Alignment on the face

The frames must be comfortable and the lens should be perpendicular to visual axis. Bridge size is usually between 18-26 mm. The frames should have 10-15^0 downward tilt. An upward tilt is not advisable. The lens must be fitted ideally at the ant: focal point to give an image that has the same size as that of ametropia. Metal frames with nose pad may tilt and may produce eye strain in high astigmatism. The frame should not rest on the apple of the cheek as it will move when the patient talks or laughs. Frames covering the eyebrow will fog the lenses due to sweating. Round frames are not advisable in astigmatism as the lens may rotate in it. Be careful when the patient changes the frame size from the present glasses, especially presbyopes. Chances of decentration and improper bifocal segment height is more common in such cases

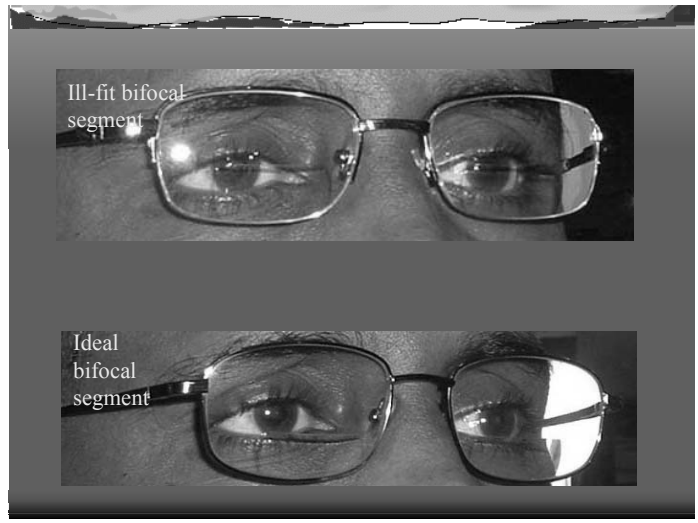
Bifocal segment

The important feature of a bifocal segment is the image jump created by the sudden introduction of prismatic power at the top of the bifocal segment. It is less if optical center of bifocal segment is close to the top. The prismatic power exerted by the bifocal segment is dependant on the type of bifocal.





The top of the bifical segment should ideally be at the level of lower lid margin in straight gaze. The segments should be decentered inwards to account for the convergence in near vision.



In any case one has to rule out Cataract, Glaucoma and Diabetes if the patient has to frequently change the glasses.

The following points are worth considering during prescribing and dispensing spectacles

- Do not change if not symptomatic
- Give same base curve as before
- Steeper Base curve for lash clearance is to be avoided as it will cause image magnification
- Advice antiglare coating to certain professionals who use computers more.
- High minus – specify high index glass, avoid large frames
- Proper counselling of the patient
  - Who is wearing spectacles for the first time
  - Shifting to bifocals
  - Changing frame size

Do You Know?

Dr.Gowri R Warrier
Dist. Mobile Unit II
Malappuram

- √ **The human eyeball weighs only 28gms.**
- √ **Human eye can distinguish 500 shades of grey.**
- √ **The only living tissue in the human body without any blood vessels is the cornea.**
- √ **Males can read fine print better than females.**
- √ **The eyes are the second most powerful body part - only next to brain.**
- √ **The eyes contribute 85% of all the knowledge you aquire.**
- √ **People generally read 25% slower from a computer screen compared to paper.**
- √ **Normal person blinks about 10,000 times a day.**
- √ **The images sent to your brain are actually upside down and backwards.**
- √ **Blind persons also can see dreams except for those who are born blind.**
- √ **Sailors once thought that wearing a gold ear ring would improve their eye sight.**

- √ **The horse has the largest eyes of any land animal, even though elephant is much larger. Elephants eyes only the second biggest.**
- √ **It is a mis-conception that bats are blind. Almost all bats can see, but they dont use their eyes for vision (they use sound waves for echo-location).**
- √ **An eagle can see a rabit about 1 mile (1760 yards) away. An average person need to be at about 550 yards to see the same rabit.**
- √ **The shark cornea has been used in eye surgeory as it is similar to human cornea.**
- √ **Cat's eye are equiped with tapitum lucidum (meanig bright carpet) - a thick reflective membrane beneath retina. It collects and re-emits light back to retina a second time giving rods a second chance to aborb image information, thus maximising the little light available to them.**

Corneal Topographic System

From IRIS 2008

About Cornea

Cornea is the most powerful refractive element of the eye contributing about 43D {70% of refractive power to the eye out of the total 60D.Since the shape of the corneal surface determine its refractive power, even a minor modification on its surface can lead to a significant alternative of the images formed on the retina.

What is Keratoconus?

It is a condition in which the cornea assumes conical shape. The hall mark of Keratoconus is central of or Para central stromal thinning

Classification

By Keratometry Keratoconus is classified as mild [48 D] moderate [<48 – 54 D] and severe [>540D]

Morphological types

1. Nipple cones.

They are charactised by their small size (5mm) and steep curvature. The apical centre is either central or para central and displaced inferionasally

2. Oval cones.

They are larger and ellipsoid and displaced inferiotemporally.

3. Globus cones

They are the largest and may involve the whole cornea.

About Corneal Topographic System (CTS)

Corneal topography system (CTS) implies computerized, video- assisted techniques which provide detailed information about the shape of the corneal surface. It provides a colour coded map of the corneal surface. The dioptric powers of the steepest and flattest merdia and their axes are also calculated and displayed. It helps in determining the refractive status of the eyes. These have an excellent accuracy and reproducibility.

Indications

1. To diagnose early Keratoconus. While advanced Keratoconus is easy to diagnose, early or sun clinical cases pose a diagnostic challenge.

2. To quantify irregular astigmatism and corneal war page associated with contact lens wear.

3. To evaluate post operative changes in corneal shape after refractive surgery corneal grafting or contract extraction.

4. Helps in giving a comfortable fit in routine contact lens practice, particularly in rigid contact lens (RGP) fitting thus providing maximum possible visual correction.

Interpretation

Interpretation can be acquired only by practice.

Scales

1. Absolute scales have fixed end - points and each individual colour represents a specific dioptric power interval. Most normal corneas remain within the yellow - green spectrum of the scale. This scale is useful in routine practice, pre operative screening.

Colour codes

1. Hot colour ie red and its various hues represent the steep portions of cornea.
2. Cool colour i.e. blue and its various hues represent the flat portions of cornea.

So the colour red – orange- yellow – green – purple- blue denotes progressively lessening refractive power.

Relative scales are not fixed and vary according to the dioptric range of the individual cornea. It is very important to look carefully at the

scale before attempting to interpret the map. In this scale more minute topographic details within an individual cornea are appreciated.

Quantitative indices

Kf	Keratometry flat
Ks	Keratometry steep
SimK	Simulated keratometry reading
Min K	Minimum Keratometry reading
SRI	Surface regularity index
SA I	Surface asymmetric index
PVA	Predicted Visual acuity based on corneal shape

Common Medical Terminologies

ALEXIA -	Inability to read
ALGESIA-	Sensitiveness to pain
AGEUSIA-	Lack of the sense of Taste
ANOREXIA-	Lose of Appetite for Food
ALOGIA-	Inability to Speak due to a Central Lesion
AMBLYAPHIA-	Dullness of the Sense of Touch
AKINESIA-	Absence of movements
ASPHYXIA-	Actual cessation of Breathing/ Death by Suffocation
DYSPEPSIA-	Impairment of Digestion
EUPEPSIA-	Normal Digestion
DYSPNEA-	Difficult Breathing
EUPNEA-	Normal Breathing
TACHYPNEA-	Rapid Breathing
DYSPLASIA-	Abnormality of Development
DYSPHASIA-	Impairment of Speech
TACHYCARDIA-	Abnormally Rapid Heart Beat
TRITANOPIA-	Blue Blindness
DEUTERANOPIA-	Green Blindness
PROTANOPIA-	Red Blindness
ANISOCORIA-	Inequality in the size of the Pupils of the Eye

Sujatha P.V
PHC Pizhala

From Community Ophthalmology Journal

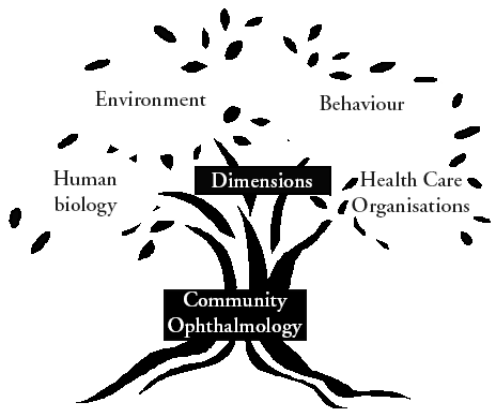
Community Ophthalmology-Dimensions

Mr. Keerti Bhusan Pradhan, Lions Aravind Institute of Community Ophthalmology, Madurai & Mr. Partho Banerjee

Abstract:

This article gives an overview about the concept of community ophthalmology and its application to the changing scenario in eye care services. It focuses on the shift from individualised care to community based eye care services. The article also highlights the broad spectrum of conditions and circumstances
that come in the purview of community ophthalmology and their importance in the current scenario. Community ophthalmology is much more than simply ophthalmic practice in the hospital. It's rather a conceptual shift to improve the eye health status through preventive, promotive, curative and rehabilitative approaches thereby giving a holistic view of eye health. It can be envisaged as a health management approach of preventive eye diseases, to reduce the rates of eye morbidity and promote eye health by active community participation at the grassroots.

Dimensions of Community Ophthalmology



We often forget that eye disease do not exist in isolation. Ocular health is the end product of the interactions of the multi-factorial determinants of disease

It attempts to unravel the role of diverse factors including biological factors like genetic influences and aging, environmental factors like sanitation and clean water supply, behavioural patterns like attitudes, life styles, religious beliefs and dogmas and the health care organisations on ocular health. It is felt that the occurrence and severity of ocular disease is a result of an interrelationship of these diverse factors. In reality community ophthalmology encompasses a broad spectrum of components which can supplement the eye care services as follows:

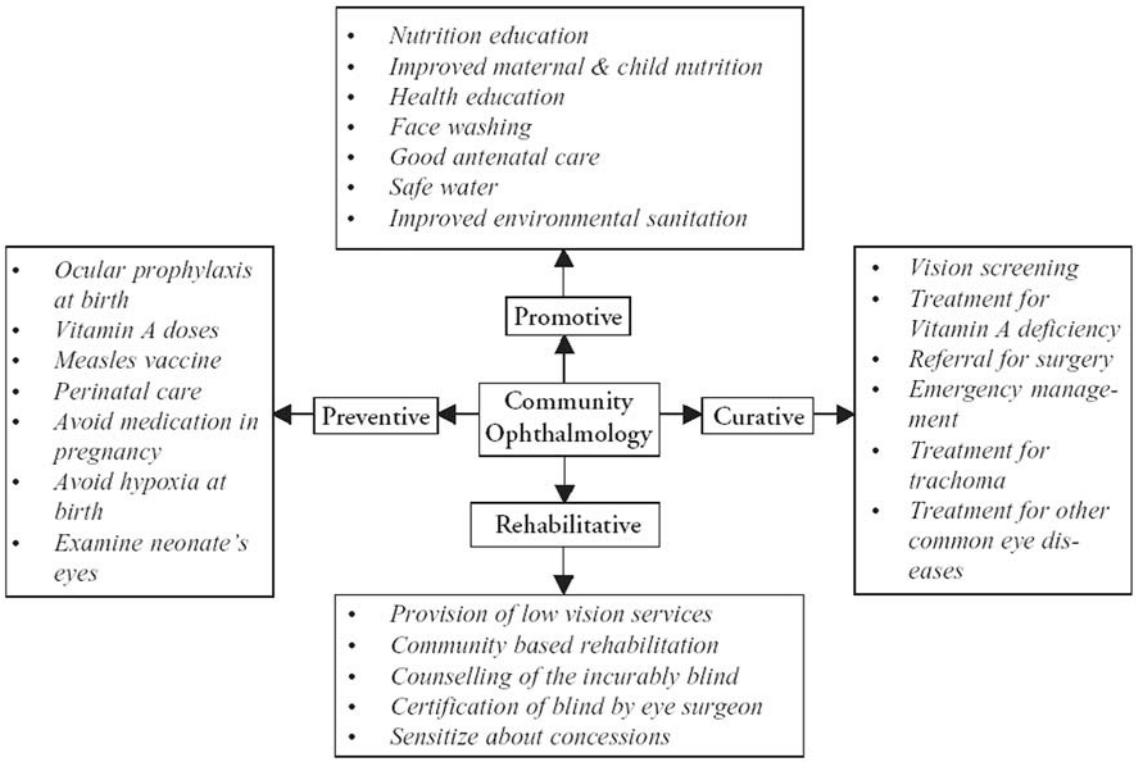
- Creating community awareness on eye health through various strategies
- Conducting epidemiological research and community based surveys
- Planning and management of sustainable eye care services
- Dissemination of information to eye care service providers and service users
- Social marketing of eye care services
- Improving the utilisation of eye care services
- Provision of comprehensive eye care services
- Integration of key components like Vitamin A, school screening, community based rehabilitation, primary eye care etc
- Training of primary eye care workers

Distinction between clinical ophthalmology and community ophthalmology

Distinguishing factors	Clinical ophthalmology	Community ophthalmology
Goal	Treatment & Cure	• Treatment & Cure • Community participation • Preventive approach • Health education & Promotion • Community based rehabilitation • Epidemiological research
Target	Single patient	• Population or community as a whole
Diagnosis	Physical examination, Laboratory investigations, Tests	• Health survey of population • Screening camps
Therapy	Surgery/Medicine	• Surgery/Medicine • Health education • Counselling
Base	Clinic based	• Clinic • Community based
Relationship	Doctor & Patient	• Doctor • Patient • Community volunteers • Social workers
Patient Mobilisation	Low	• High
Accessibility & Affordability	Not flexible	• Patient friendly
Research interest	Mostly clinical	• Clinical • Population based surveys • Community surveys
Drive	Provider driven	• Consumer driven/Community driven

As rightly said by Hans Limburg,
"Ophthalmology over the last decade has been largely characterised by its extensive use of high technology. More eye disorders can be diagnosed earlier and treated better than before. Nevertheless, one of the main problems in cataract blindness is that patients only report at a late stage, when they have lost their jobs already and become a burden on their family. Many patients do not come for surgery, because they have nobody to accompany them, because they are afraid, because they do not feel the need, because they do not feel where to go. High tech will not solve this, but health education can, creating more awareness can. Glaucoma cases, too often, report at a late stage. Earlier reporting through awareness campaigns can prevent people getting blind due to glaucoma."

Flow of various components



Relationship between community Ophthalmology and eye health status

Community Ophthalmology	Impact on Eye Health Status
Provision of safe water	• Reduced trachoma • Vitamin A deficiency
Environmental sanitation	• Reduced trachoma • Vitamin A deficiency
Eye health education	• Reduces prevalence of all diseases
Nutrition and food production	• Influences Vitamin A deficiency • Cataract • Diabetic Retinopathy
MCH and Family spacing	• Positive impact on Vitamin A deficiency
Immunisation	• Measles vaccine prevents Vitamin A blind
Control of communicable diseases	• Affects leprosy • Trachoma • Vitamin A deficiency • Congenitally acquired blindness
Control of locally endemic diseases like IDD	• Affects congenital blindness
Provision of essential drugs	• Affects leprosy • Vitamin A deficiency • Trachoma • Ocular injuries

In community medicine, we talk about five stages of prevention and control of a disease, which also holds good for community eye health. The five levels of prevention are:

1. Positive health promotion

In eye care it can be done through health education, environmental hygiene and healthy nutritional dietary practices.

2. Specific prevention of diseases

In eye care it can be through immunisation and Vitamin A supplementation in the childhood and to mothers while pregnancy and also through awareness for preventing the unhealthy practices during delivery.

3. Early diagnosis and treatment

In eye care it can be achieved through a screening system where cases like cataract can be diagnosed early and treated to prevent blindness at a later stage.

4. Disability control

In eye care it can be through monitoring of cases and treating them as in cases like glaucoma and diabetic treatment where, though a complete cure may not be given but the magnitude of disability can be controlled to a considerable extent. This also can be achieved by creating awareness through health education and ensuring maximum utilisation of the existing services. This can also be achieved through the low vision services.

5. Rehabilitation

In eye care it is for the absolute and irreversible blind cases who need social and economical support. The rehabilitation programme can support the wellbeing of a blind person by their *capacity building* in various facets of life so that they can live independently. Community ophthalmology can also be instrumental in contributing to policy advocacy, wherein it will:

- Assess ocular needs of the population
- Prioritise the needs
- Inform the decision-makers for resource allocation
- Formulate preventive, promotive, curative programmes

In the global community as well, considerable amount of attention is not laid on community ophthalmology. This is evident by the fact that there exists only one journal of *Community Eye Health* in the international arena. A survey done by the journal showed an alarming finding that 60% of the respondents do not have access to any other source of up-to-date information on eye health. As for the other eye care journals, the community dimension of eye health is not much apparent as it should be. There is a desperate need to meet the requirements of health workers for relevant and accessible resource materials to support participatory community based teaching and learning. Community ophthalmology or public eye health to be more precise, is emerging as one of the most challenging areas in eye care. Traditionally curative eye care focusing on cataract removal, has been the main focus in eye health sidelining the more essential factors that influence the epidemic of eye problems.

The profoundly changing scenario in terms of *increased life span, changes in life style, environmental degradation*, has a tremendous impact on eye health and exceeds much beyond the curative aspect.

In the recent times the eye care delivery systems have taken a new twist, which tries to look at the problem in a broader perspective. There are 15 million blind in India, majority of whom reside in rural and remote areas. Around 80- 90% of the blindness is completely avoidable in an effective manner. To establish a community based eye care delivery system there needs to be a concentrated deliberation for *easy accessibility, effortless affordability and absolute availability* of services in the community by the providers.

In a country like India, that is housing a burgeoning second largest population of the world, does not have much adequate infrastructure in terms of trained workforce in community ophthalmology. As of today three centers namely *R P Center-AIIMS, Delhi, L V Prasad, Hyderabad,* and *LAICO-Aravind Eye Hospital, Madurai,* are considered as professional agencies that renders community ophthalmology services in some form or the other and are in the process of developing a separate wing for it. It is significant here to note that, this is highly insufficient for a country with such a magnitude of eye related problems. Even in the 150 odd medical colleges spread all over India little importance is given to community ophthalmology and the entire training is based on

clinical treatment.The community also needs to be actively involved in the design, implementation and assessment of eye health services leading to their continuing improvement.

The community also needs to be actively involved in deciding the staffing and training for the primary health care systems and mobilisation of local resources that can strengthen and make the most of primary health care provisions. *Community participation* in ophthalmology envisages the involvement of Health functionaries, Non-governmental organisations (NGO), Teachers, Social workers, Voluntary/Charitable Organisations, Opinion leaders and Local practitioners of different systems of medicine.

References:

1. Prof. V.K. Dada, Dr. G.V.S. Murthy, Dr. Sanjeev K. Gupta, Dr. K. B. Singh, Community Ophthalmology Practice at Primary Care Level.
2. Larry Schwab, Eye Care in Developing Nations, 1999.
3. Hans Limburg, Monitoring and evaluation of intervention programmes for cataract and for refractive errors in India, 1999.
4. Dr. P. K. Khosla, Community Ophthalmology: An Indian Prespective, Proceedings of the First National Workshop on Community Ophthalmology, New Delhi, November 11-16, 1991.

VISION ASSESSMENT AND PRESCRIPTION OF LOW VISION DEVICES

Deepa
PHC Edathala

Assessment of low vision and prescription of low vision devices are a part of a comprehensive low vision service. Others components of the service include training the person affected by low vision in use of vision and other senses, mobility, activities for daily living, and support for education, employment and leisure activities.

At a tertiary low vision clinic, a team of low vision specialists assess infants, children and adults who need complex assessments and high power low vision devices. At a secondary low vision clinic , low and medium power magnification devices and rehabilitation services can be given.

VISION ASSESSMENT

The low vision assessment is usually conducted by ophthalmologist or optometrist. The aim of the first appointment is to understand how low vision has impacted on the person‘s daily activities and what he or she wants to do. At the end of the appointment there should be an understanding of what low vision devices and other low vision services the person needs. The essential question is, how has the impaired vision affected the person‘s quality of life?

VISUAL ACUITY

To assess both distance and near vision, it is essential to use LogMAR tests rather than traditional Snellens tests. In a logMAR (Logarithm of the minimum angle of resolution) test, the steps between each size are the same throughout the test. This is necessary to determine the need for magnification. Typically, the distance visual acuity tests based on designs by Bailey and Lovie have 5 letters in each line so that there are sufficient symbols to reliably test both good and poor vision.

Vision should not be described as ‘count fingers’or hand movements. The test distance should be reduced to obtain a measure of distance visual acuity so that the required magnification can be

calculated.

Distance visual acuity should be measured with a pinhole to assess possible refractive error. A multiple pinhole is preferably used for people with low vision.

Ideally, ***near vision*** should be tested using passages of print (in the LogMAR) but if not possible, letters, numbers or symbols can be used. The smallest print read and the distance should be recorded. Magnification is prescribed to improve the reading distance, print size able to be read, or both.

Contrast sensitivity is the ability to detect objects at low contrast. Contrast sensitivity is usually tested with letters, numbers, or symbols at standard or intermediate distances. This measure has been shown to relate visual functioning and activities of daily living more closely than visual acuity measured with high contrast tests. As contrast is usually affected in people with low vision, it is an important test to help in the prescription of low vision devices, so that lighting and other non optical devices can be considered.

Similarly people with eye disease causing low vision are also affected severely by ***glare***. Vision should be tested under various levels of lighting to determine if filters are to be used to reduce glare.

Refraction is an essential part of a low vision assessment to ensure that any minor refractive error should also be corrected. Most low vision devices are used in connection with refractive connection.

*A **routine eye examination*** should be included to determine the ocular health, testing of visual field and colour vision. A thorough assessment not only lead to the proper low vision devices, but also give sufficient information for the person with low vision, their family, health workers, and the rehabilitation workers.

Prescription of low vision devices

Low vision devices(LVD) help low vision patients to maximize their remaining vision and live independently. Basically LVDs are either optical or non optical. Optical devices have one or more lenses to modify the image size and they have to be prescribed by an Ophthalmologist or an Optometrist. Non optical devices do not have a lens system, but can make it easier to see objects.

Optical devices consist of one or more lens placed between the eye and the object to be viewed,which increase the size of the image on the retina. Optical low vision devices work on the principles of optical magnification and provide an enlarged image of the object. Magnifiers , telescopes and glare control devices are the mainly prescribed optical devices.

Non optical devices alter the environmental perception through enhancing illumination, contrast, and spatial relationships. Electronic devices include close circuit television which use a zoom camera to magnify materials onto a television screen.

LVDs should be considered for all ages from young children to the oldest adults.Before prescribing LVDs , we should consider the types of tasks at home, work, or school. The size of the letters to be read should also be seriously considered. Most LVDs are difficult to use because of the limited field of view through the lens. Training in the use of prescribed LVD is very important for the successful use of the limited vision with the device. ●

PROCEEDINGS OF THE ADDL. DIRECTOR OF HEALTH SERVICES (MEDICAL) DIRECTORATE OF HEALTH SERVICES THIRUVANANTHAPURAM

Sub:- Transfer and posting of Ophthalmic Assts. - orders issued
Ref:- Representation from Smt.Jasim U, Senior grade Ophthalmic Asst., PHC, Pallarimangalam. Dtd 31.08.09

Order no.EF4-26644/09/DHS Dt 14.09.09

Smt.Jasim.U, ophthalmic Assistant, PH Centre, Pallarimangalam, Ernakulam has requested transfer to C.H Centre, Vellarada, Thiruvananthapuram on compassionate grounds.

Smt.Jasim.U, ophthalmic Assistant, PH Centre, Pallarimangalam, Ernakulam district is transferred to C.H Centre, Vellarada, Thiruvananthapuram in the excisting vaccancy.

The date of relief and joining should be reported prommptly.

Sd/-
Dr.M.K.Jeevan
Addl. Director of Health Services (Medical)

LET US REMEMBER.....

It is futile to waste time repenting on what we lost
Effective use of what we have is more rewarding.

PROCEEDINGS OF THE ADDL. DIRECTOR OF HEALTH SERVICES (MEDICAL) DIRECTORATE OF HEALTH SERVICES THIRUVANANTHAPURAM

Sub:- Estt - Health Services Department - Transfer and posting of Ophthalmic Assistants - Orders issued

Read:- 1) Order No.EF4-26644/09/DHS dtd. 1-8-2009
2) WP(C) No.22241/09(A) filed by Smt.S.K.Bhuvaneswari.

ORDER NO.EF4-26644/09/DHS DATED:31/8/2009

Sri.A Sureshkumar, Ophthalmic Assistant, Community Health Centre, Puthenchira, Thrissur who is under orders of transfer to Primary Health Centre, Vechoochira is relieved of his duties of the institution. Since Smt.R.Geethakumari is retained at PHC Vechoochira as she cannot join PHC, Pulluvila due to the interim stay on the transfer of Smt.S.K.Bhuvaneswari in the Writ Petition read as 2nd above. Smt.Hazeeja.B.L, CHC Bedaduka who is under orders of transfer to GH Ernakulam in the order read as 1st above has requested to cancel her transfer.

In these circumstances, the following Ophthalmic Assistants are reposted to the stations mentioned below.

Sl No	Name & Present Station	Station to which transferred/reported
1	A Sureshkumar CHC Puthenchira Thrissur	General Hospital Ernakulam (Vice Jeeja P Sadasivan transfereed)
2	Mary Poulose PHC Tholur, Thrissur	CHC Adimali, Idukki (in the excisting vaccancy)

The transfer order read as 1st above is modified to this extent. Sri.A Sureshkumar is deemed to have joined duty on 22-8-2009.

Dates of relief and joining duty should be reported promptly.

Sd/-
Dr.M.K.Jeevan
Addl. Director of Health Services (Medical)

GOVERNMENT OF KERALA

FINANCE (STREAMLINING) DEPARTMENT

CIRCULAR

No.92/09/Fin. ***Dated, Thiruvananthapuram 2nd November 2009***

Sub:-Authorisation of Anual Increment to Gazetted Officers through seperate Pay Slip - discontinuance - Reg

Ref:- Letter No. Co-ordn VI/17-46/Vol.59/115/82 dated 13-10-09 from the Accountant General (A&E), Kerala

In the letter cited, the Accountant General (A&E), Kerala, has informed that as per rules pay slips are being issued to the Gazetted Officers of the State Government indicating the rates of pay, allowances etc. to be paid from specified dates, on the authority of which Gazetted Officers of the State can draw annual increments. Accountant General (A&E), Kerala has informed that it has been decided to stop the issue of separate authorisation for annual increments and instead of this the next pay slips issued will include details such as the scale of pay of the postof the Officer, the due date of increments with instructions to allow the drawal of increments in the absence of any instructions in the contarary. The Accountant General (A&E), Kerala has requested Government to issue necessary instruction to all departments in this regard.

Governement after having considered the matter, issue the following instructions that separate authorisation for annual increments will not be issued by the Accountant General (A&E), Kerala from November 2009 onwards, but the next pay slips issued will include details of scale of pay (in full expansion) and the due date of increments, for the time being which shall be incorporated either in writing or by affixing separate stamp seal on the next page of both the copies of pay slip duly authenticated by Branch Officer of the Accountant General (A&E), Keral as shown below:

"The *Scale of Pay is ..... increment accrues on ..... every year and, in the absence of instuctions to the contarary, this may be drawn till the stage ..... (maximum of the scale) is reached

Signature
Designation

*The cmplete expansion of pay scale will also be shown in the pay slip.

The above instructions are brought to the notice of all concerned.

Dr.P PRABHAKARAN
Additional Cheif Secretary (Finance)