FUNCTIONAL VISION LOSS

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COURSE DESCRIPTION: This course discusses the sometimes perplexing condition of functional vision loss (FVL). We need to consider the diagnosis of FVL when exam results are inconsistent, while also being sure not to miss any underlying pathology. A case based approach is used to show various presentations and triggers of FVL, useful testing techniques, and management options.

COURSE OBJECTIVES:

1. To gain a better understanding of functional vision loss and why it manifests.
2. To understand that functional vision loss is often associated with psychologic conditions.
3. To expand your testing strategies to accurately diagnose functional vision loss.
4. To appreciate that functional vision loss can be very real to patients and they often need a “way out” or “treatment” for this condition

COURSE OUTLINE:

I. FUNCTIONAL VISION LOSS (FVL)

   a. Definition
      i. Non-organic vision loss
      ii. Vision loss without a pathologic cause

   b. Triggers
      i. Mild injury
      ii. Psychosocial event
      iii. Existing health condition

   c. Manifestations
      i. Visual field loss
         1. Generalized constriction
         2. Homonymous hemianopia
      ii. Reduced visual acuity (range)
         1. Blur
         2. To blindness

   d. Laterality
      i. Unilateral
      ii. Bilateral
   i. Deliberate Malingeringer
      1. Faking of visual problem
         a. For monetary gain (lawsuit)
         b. For attention
   ii. Worrying imposter
      1. Knowingly exaggerating visual symptoms
      2. Worried has a serious problem
      3. Doesn’t want problem to be overlooked / miss out on future benefits if needed
   iii. Impressionable exaggerator
      1. Thinks something wrong with eyes
      2. Wants to help the doctor and make the symptoms easy to recognize
   iv. Suggestible Innocent
      1. Convinced self of a vision problem
      2. Very complacent – not very worried about problem

f. Associated diagnoses
   i. Anxiety
   ii. Depression
   iii. Panic attacks
   iv. Fibromyalgia
   v. Psychiatric disorders in up to 50%
   vi. Conversion disorder

g. Cause for suspicion of FVL
   i. Fluctuations in best-corrected visual acuity / visual fields
   ii. Lack of RAPD with unilateral or asymmetric vision loss
   iii. Better visual function when not being tested or doing something they enjoy
   iv. Visual field loss does not match optic disc appearance
   v. Suspicious visual field findings
      1. Humphrey visual fields
         a. Cloverleaf pattern
      2. Goldmann visual field
         a. Spiral fields
         b. Crossing isopters
         c. Tunnel fields (same size field regardless of isopter used)

h. In-office testing for FVL
   1. History
a. Try to find out the “back story”
b. Is the patient involved in any litigation
c. Recent injuries?
d. What is the patient worried / concerned about?
e. How are things at home?
f. How are things at work / school?
g. Stressors?
h. History of psychiatric issues / anxiety / depression, etc?

2. Visual acuity
   a. Hide letter size indicators if possible
   b. Test from bottom up – start with 20/10 line
   c. Fog on eye in phoropter so pt thinks testing with both eyes
   d. Watch pt in waiting room – looking at watch, phone, textng, etc
   e. Optokinetic nystagmus testing

3. Confrontation Fields
   a. Test outside of the “eye exam”
      i. Neurologic exam “mimicking” holding target in peripheral field
      ii. Watch patient navigating into the exam room, around stools, etc

4. Automated visual Fields
   a. See if VF improves with “special lenses”
      ii. “Treatment” / Giving the patient an “out”
         1. “special strong lenses”
            a. +20 / -20 D combo
         2. “special eye drops”
         3. Other in-office techniques
            a. Eye spray
            b. Eye foam “cleaner
            c. Heated eye mask
            d. Others

iii. Other management options
    1. If cannot prove that vision is really normal, work-up may be warranted to rule out pathologic causes
    2. Ensure the patient that vision will improve
    3. Placebo glasses, drops, etc
    4. Consider psychiatric evaluation
    5. Change what is bothering the patient work/school, etc
    6. Support groups, etc to help deal with stressors