



Complete Summary

GUIDELINE TITLE

Care of the patient with myopia.

BIBLIOGRAPHIC SOURCE(S)

American Optometric Association. Care of the patient with myopia. St. Louis (MO): American Optometric Association; 1997. 75 p. (Optometric clinical practice guideline; no. 15). [231 references]

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Myopia:

- Simple myopia
- Nocturnal myopia
- Pseudomyopia
- Degenerative myopia
- Induced myopia

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management

CLINICAL SPECIALTY

Optometry

INTENDED USERS

Health Plans
Optometrists

GUIDELINE OBJECTIVE(S)

- To accurately diagnose the different types of myopia
- To improve the quality of care rendered to patients with myopia
- To inform and educate parents, patients, and other health care practitioners about the options of correction, control, or reduction of myopia
- To decrease visual morbidity related to high degrees of myopia

TARGET POPULATION

Patients of all ages with myopia

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis of Myopia

1. Patient History
 - Simple Myopia
 - Nocturnal Myopia
 - Pseudomyopia
 - Degenerative Myopia
 - Induced Myopia
2. Ocular Examination
 - Visual Acuity
 - Refraction
 - Ocular Motility, Binocular Vision, and Accommodation
 - Ocular Health Assessment and Systemic Health Screening
3. Supplemental Testing

Treatment

1. Optical Correction
2. Medical (Pharmaceutical)
3. Vision Therapy
4. Orthokeratology
5. Refractive Surgery

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline developer performed literature searches using the National Library of Medicine's Medline database and the VisionNet database.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The Reference Guide for Clinicians was reviewed by the American Optometric Association (AOA) Clinical Guidelines Coordinating Committee and approved by the AOA Board of Trustees.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The major symptom of myopia (blurred distance vision) and the major sign (reduced unaided distance visual acuity) can generally be improved with appropriate minus power lenses.

The examination of patients who have any of the forms of myopia should include a comprehensive patient history, measurement of refraction, investigation of accommodation and vergence function, and evaluation of ocular health. The patient should be advised about available treatment options and counseled regarding the need for follow-up care.

The frequency and composition of evaluation and management visits for myopia are summarized in the table, below.

Frequency and Composition of Evaluation and Management Visits for Myopia

Type of Patient	Number of Evaluation Visits	Treatment Options	Frequency of Follow-Up Visits	Composition of Follow-Up Evaluations			
				VA	REF	A/V	OH
Simple myopia	1	Myopia correction: optical correction vision therapy	Children: annually Adults: every 2 yr or p.r.n.	Each visit	Each visit	Each visit	Each vis
		Possible myopia control: optical correction, vision therapy	Every 6 mos	Each visit	Each visit	Each visit	Contact lenses: anterior segmen each vis posterior segmen annually Bifocals: annually

		Myopia reduction: orthokeratology, refractive surgery	Variable, depending on method of myopia reduction	Each visit	Each visit	Annually	Anterior segment each visit Posterior segment annually
Nocturnal myopia	1 to 2	Optical correction	3 to 4 wk after dispensing of prescription, then annually	Each visit	Annually or p.r.n.	Annually	Annually
Pseudo-myopia	1 to 2	Optical correction, pharmaceutical, vision therapy	Every 1 to 4 wk until accommodative excess is eliminated, then annually	Each visit	Each visit	Annually or p.r.n.	Annually
Degenerative Myopia	1 to 2	Optical correction	Annually or more frequently, depending on retinal and ocular changes	Each visit	Annually or p.r.n.	Annually or p.r.n.	Each visit
Induced myopia	1 to 2	Variable, depending on inducing agent or condition	Variable, depending on inducing agent or condition	Each visit	Each visit	Variable, depending on inducing agent or condition	Variable, depending on inducing agent or condition

VA = visual acuity testing
REF = refraction
A/V = accommodative vergence testing
OH = ocular health assessment
p.r.n. = as necessary

CLINICAL ALGORITHM(S)

An algorithm is provided for Optometric Management of the Patient with Myopia.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Accurate optometric diagnosis and improved visual acuity for myopic patients

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

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Clinicians should not rely on this Clinical Guideline alone for patient care and management. Please refer to the references and other sources listed in the original guideline for a more detailed analysis and discussion of research and patient care information.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1997 (reviewed 2001)

GUIDELINE DEVELOPER(S)

American Optometric Association - Professional Association

SOURCE(S) OF FUNDING

Funding was provided by the Vision Service Plan (Rancho Cordova, California) and its subsidiary Altair Eyewear (Rancho Cordova, California)

GUIDELINE COMMITTEE

American Optometric Association Consensus Panel on Care of the Patient with Myopia

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Members: David A. Goss, O.D., Ph.D. (Principal Author); Theodore P. Grosvenor, O.D., Ph.D.; Jeffrey T. Keller, O.D., M.P.H.; Wendy Marsh-Tootle, O.D., M.S.; Thomas T. Norton, Ph.D.; Karla Zadnik, O.D., Ph.D.

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

According to the guideline developer, this guideline has been reviewed on a biannual basis and is considered to be current. This review process involves updated literature searches of electronic databases and expert panel review of new evidence that has emerged since the original publication date.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [American Optometric Association Web site](#).

Print copies: Available from the American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

The following is available:

- Answers to your questions about nearsightedness. St. Louis, MO: American Optometric Association. (Patient information pamphlet).

Print copies: Available from the American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881; Web site, www.aoanet.org.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material

and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was completed by ECRI on December 1, 1999. The information was verified by the guideline developer on January 31, 2000.

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