




2023

It's How You Ask the Question.....

Paul Freeman OD
pafreema@uiwtx.edu

Follow this and additional works at: https://athenaeum.uiw.edu/optometric_clinical_practice

 Part of the [Adult and Continuing Education and Teaching Commons](#), [Health and Physical Education Commons](#), [Optometry Commons](#), [Other Education Commons](#), [Other Medicine and Health Sciences Commons](#), and the [Other Teacher Education and Professional Development Commons](#)

The Athenaeum provides a publication platform for fully open access journals, which means that all articles are available on the Internet to all users immediately upon publication. However, the opinions and sentiments expressed by the authors of articles published in our journal does not necessarily indicate the endorsement or reflect the views of the University of the Incarnate Word and its employees. The authors are solely responsible for the content of their work. Please address questions to athenaeum@uiwtx.edu.

Recommended Citation

Freeman P. It's How You Ask the Question..... *Optometric Clinical Practice*. 2023; 5(2):1. doi:doi.org/10.37685/uiwlibraries.2575-7717.5.2.1008. <https://doi.org/doi.org/10.37685/uiwlibraries.2575-7717.5.2.1008>

This Editor's Column is brought to you for free and open access by The Athenaeum. It has been accepted for inclusion in *Optometric Clinical Practice* by an authorized editor of The Athenaeum. For more information, please contact athenaeum@uiwtx.edu.

It's How You Ask the Question.....

Abstract

Letter from the Editor

Creative Commons License



This work is licensed under a [Creative Commons Attribution 4.0 International License](https://creativecommons.org/licenses/by/4.0/).

It's how you ask the question....

At some point in an eye care practitioner's experience, a patient with a visual impairment will present for an eye examination for new glasses in hopes of an improvement in vision. After determining that a change in conventional lens treatments will not improve the vision, a discussion about low vision rehabilitation will hopefully be included in the potential remaining alternatives for that patient, especially with respect to ways to improve quality of life. A brief discussion about those visual activities of daily living (such as reading, watching television, being able to identify medication, and driving) which will enhance that quality of life often follows, and how low vision management will go a long way in helping to achieving those ends. However, a question that is not typically asked of these patients is whether any part of that quality of life is impacted by visual hallucinations. Because asking a question like that could be uncomfortable from the doctor's perspective and potentially off-putting to a patient or family members, rather than a question, a comment might be shared about the potential of visual hallucinations for patients who suffer vision loss: the Charles Bonnet Syndrome. (This assumes that cognitive deficiencies, neurological diseases, or psychiatric disorders have been either ruled out or identified prior.) This type of comment could allow that patient to share instances of visual hallucinations which could have been heretofore left unmentioned for fear of being labeled mentally ill. An often-immediate response by both the patient (for sure) and family members will be the relief in knowing that these symptoms have an explainable etiology.

The Charles Bonnet Syndrome has been described primarily in the older population and mostly with respect to central visual loss, most often due to macular degeneration. However, this syndrome can be due to a disruption anywhere along the visual pathway. For example, there is some research which suggests that this syndrome can also be affected by visual field loss in patients with glaucoma.¹ Additionally, it has been reported that children (who had been diagnosed with rod-cone dystrophy) can be affected by this visual hallucinatory syndrome as well.² So what might a patient see?

It has been my experience, having worked with visually impaired patients for almost a half century, that Charles Bonnet visual hallucinations manifest in diverse ways, but importantly, for the most part, the patient knows that these visual hallucinations are not real. In some scenarios, my patients have described stationary objects, like "purple flowers" and "white picket fences," or other neutral shapes. In another, my patients have reported seeing movement. In one instance, while I was examining a patient, she reported seeing ants crawling all over my white coat, but fortunately neither of us perceived (or felt) that to be real. In another instance, a patient reported while watching television in the evening, she was joined by a "mother and small child;" again she realized that these images were not real. Most often these hallucinations are not frightening and, to a large extent, seem to be innocuous. However, patients report they can also be annoying and can impact quality of life as they can interfere with other activities. Once this syndrome is identified, what options are there to address it?

First, of course, is a frank discussion with the patient and family, reassuring them that this is *likely* related to a visual impairment. Additionally, in my practice, I have had some patients whose remaining vision is enhanced through the use of optical and non-optical devices, report a diminution (not total resolution) of these hallucinations. I suspect that this change in the Charles Bonnet Syndrome hallucinations is due to stimulating the occipital cortex in some fashion, but I have not seen that explanation reported in the literature, and it surely is fertile ground for research.

With the increase in the aging population and the associated increase in age-related conditions causing visual impairment, this type of visual hallucination will continue to exist. Being able to alleviate some fears related to the manifestations of this syndrome, as well as offering strategies which can minimize the negative impact of a visual impairment on activities of daily living, remains the responsibility of all health care providers involved with the care of this population.

Postscript. I still want to give a nod to those front-line workers who continue to attend to those of us who get infected or “insist” on reinfecting ourselves with COVID. Cleverly, I apparently subscribe to the rule “do as I say not as I do,” as I did not follow my own admonition from one of my editorials suggesting the need to be vigilant with respect to COVID,³ and not only did I get COVID from attending a large gathering (sans mask), but I then gave it to my wife as well. And, as I write this, new variants are starting to make their way into our lives, so although not all of them might be as potent as the previous virus, and we do not appear to be in pandemic mode, we are still in the throes of this nasty little bug; ‘nuff said.

1. Peters D, Molander S, Lomo T, Singh A. Charles Bonnet Syndrome in patients with open-angle glaucoma. *Ophthalmol Glaucoma*. 2022; 5(3):337-344. doi: [10.1016/j.ogla.2021.10.010](https://doi.org/10.1016/j.ogla.2021.10.010)
2. Schwartz TL, Vahgei L. Charles Bonnet Syndrome in children. *J AAPOS*. 1998;2(5):310-313. doi: [10.1016/s1091-8531\(98\)90091-x](https://doi.org/10.1016/s1091-8531(98)90091-x)
3. Freeman PB. Just when you thought it was safe to go back in the water. *Optometric Clinical Practice*. 2022;4(2):1-4. doi: [10.37685/uiwlibraries.2575-7717.4.2.1108](https://doi.org/10.37685/uiwlibraries.2575-7717.4.2.1108)