

Editorial

The Blur of Myopia

Roberto Kaplan*

Clinical Department, Eye See Life Institut, Germany

EDITORIAL

Myopia has reached epidemic proportions. By 2050, half of the world population will be Myopic, unless a truly effective prevention and remedial approach is implemented.

Extended axial length or a too powerful cornea is offered as the reason for Myopia. Out of focus light reaches the macula of the eye. Standard medical treatments include eyeglasses, contact lenses, refractive surgery and medications. The evidence suggests that in spite of the best intentions of Doctors, these approaches have not fully addressed the deeper reason for Myopia. The cause of Myopia has been limited to environmental and genetic factors.

A clinical case illustrates how using lowered diopter eyeglasses, a prescribed blur/clarity ratio, offers a deeper treatment and management approach to Myopia. The challenge is how to motivate the patient to become involved in dealing with the background suggested causes. Some new clinical strategies are offered.

JS., A male age 32, was refracted at -8.00 in both eyes, with no astigmatism. He had worn minus lenses since age 8 and his father had -6.00 lenses for eyeglasses. JS wished to avoid further increases in Myopia as a way to prevent eye diseases. His father had retinal detachment problems as well as macular degeneration [1-5]. In a functional holistic approach to vision problems, I first investigated his lifestyle, his eating patterns, work and personal life, driving, reading habits and sports needs.

Since JS had a part-time legal assistant job in the city, he needed to drive 22 miles twice a week. The rest of the time he lived in the country, grew his own organic vegetables, was vegetarian, walked his dog on the plantation, played guitar and led a relative healthy lifestyle [6-8]. I offered JS the opportunity to integrate a new attitude about his eyes and vision into his way of living. I first taught him an integrated form of breathing, fast in-breath, slow out-breath and then a pause. The breathing was a way for JS to enter more into his whole body than just his thoughts. Secondly, I lowered his spherical diopters equally to -6.75, before both eyes, until he saw 20/40. (50% in metric) with the -6.75 diopters in place, I had him notice that 60% of the letters were clear on the eye-chart, and the rest unclear. I guided JS to have a new perception about the unclear letters, the blur [9-12]. With awareness, his blur became a friend offering him feeling feedback. Why and how? He experienced that when he engaged the integrated breathing he noticed one row of the unclear letters becoming clearer. He then had to feel his inner state of being in order to maintain the clearness. Soon JS learnt that his vision was

*Corresponding author

Roberto Kaplan, Clinical Department, Eye See Life Institut, Eichhaldenstr. 46, Oberstenfeld, 71720, Germany, Tel 49-160-218-6160; Email: pr@eye-see-life.de

Submitted: 31 January 2018

Accepted: 31 January 2018

Published: 31 January 2018

ISSN: 2333-6447

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not a static function. His participation in looking through his eyes revealed how his inner world of perceptions affected the level of clearness on the outside. JS took a training eye-chart home with him.

Very excited, he left my office ordering two new pairs of glasses. -8.00 for his driving needs and -6.75 for everyday use at home and the office. After two months, JS returned with a smiling face [13]. He reported that his progress had been remarkable. He explained that his eyesight level now through the -6.75 was consistently 20/20 (100% metric). He could only wear the -8.00 eyeglasses for night driving; otherwise it was uncomfortably too strong.

In addition, he had visited India. Because eyeglasses are quite inexpensive, he bought himself 5 new glasses with diopters of -6.00, -5.00, -4.00, -3.00 and -2.00. Now he could wake up in the morning and decide which glasses to wear based on the need and demand of the day. He chose a -3.00 when he walked the dog. While playing his keyboard a -2.00 felt very good. At the computer the -5.00 was comfortable. For day time driving he took responsibility to check his eyesight and chose the -6.00, -6.75 or -8.00 depending on varying feeling factors.

Did he feel rested from his sleep? Did anything he eat affect his vision? How did emotional difficulties in his relationship affect his seeing? JS became involved and aware of how his lifestyle affected his eyesight and relationship with different powered eyeglasses. A prevention process was in place. The measured diopters were now weaker. The probability of less retinal tension was higher. With advanced steps, JS learnt further about the role of binocular vision and his eyesight. He could monitor how certain destructive emotional patterns lowered his visual acuity. He mastered how to restructure new perceptions to build healthy emotions, thus sharpening his vision.

From a simple curiosity of wondering if eye prevention was possible led JS on a journey of self discovery. He became responsible for his visual wellbeing. I as the vision practitioner served an important role. I provided information. I coached about possibilities. I trained JS in the correct steps. The office management structure was arranged in two ways. The fees for the two new pairs of glasses were one part. The second was an agreed upon service fee for my participation in the coaching.

For the primary care practitioner, it is possible to have a trained assistant provide the coaching steps. The practitioner maintains the connection to the measurements and engaging the patient to participate in the eye² prevention. In this way, eye prevention becomes a viable office process where usually more than one pair of eyeglasses are prescribed, and an extras service fee is gained. It is the author's 45 year clinical experience, that eye prevention is a viable adjunct to primary vision care. The outcomes provide a higher rate of enthusiastic referrals, and the satisfaction of watching patients get weaker lens prescription of over time. In no way does eye prevention lower the probability of patients needing eyeglasses. The blur in Myopia becomes the impetus to guide the patient into a new form of preventive vision care.

Let's get ready for the year 2020.

CONFLICT OF INTEREST

The author is one of the principle owners of the Eye See Life Institute.

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Cite this article

Kaplan R (2018) The Blur of Myopia. JSM Ophthalmol 6(1): 1066.