

Letters

Maybe Somewhere In-between?

I read Dr. Richard Mills' column entitled "Selfie-Refraction—Really?" with great interest (Opinion, January).

I agree with Dr. Mills—given present levels of technology, self-guided refractions are likely to be suboptimal, particularly when compared with a refined refraction performed by an eye doctor. But everything is relative.

What if refractions were entirely automated, or if the starting point of a self-guided refraction were a reasonably good autofraction? In our industrialized nation, offering an incompletely refined refraction is substandard care. But in some parts of the world, as Dr. Mills points out, there must be a balance between good care and no care at all. If we were discussing a surgical or medical intervention where there were risks to health, I would certainly lean toward maintaining the highest standards. Glasses, however, are arguably among the most benign of prosthetic devices. I believe that glasses that improve vision even incompletely might be better than nothing at all for many people.

I have been privileged to work with a team of eye care specialists that studied the feasibility of using portable

technology not only for refracting¹ but even measuring pupillary distance² in the hope of one day automating spectacle dispensing. This dream was driven by our experiences offering eye care during medical missions. Our research supports Dr. Mills' opinion that we are not ready to employ a minimally trained person to sit in a kiosk in an urban shopping mall with an autorefractor prescribing spectacles. But our results also suggest that training a local villager in an underserved area with those same tools could provide prescriptions that are at least adequate if not very good. And if we provide that person lenses, frames, and lens-grinding equipment, that person could dispense spectacles. If that underserved area did not have the means to support a freestanding optical shop, we could still provide the portable devices needed to measure and transmit patient refractive and biometric data wirelessly; this data could be used to rapidly and inexpensively cut lenses and ship them (or air-drop them by unmanned drone) to wherever they might be needed.

The future is coming upon us quickly. Even the portable devices we have now pale in comparison to the handheld, battery-powered multicapable "selfie" tool such as the i2i under

development by Dr. Alexander Walsh.³

Refractive error is the largest single cause of visual acuity reduction in the world. Certainly we want to treat it equally well for everyone. But as Dr. Mills points out, there are millions of schoolchildren worldwide who are waiting. The technology is available now, even for high myopes and high astigmats, and that technology is sure to provide better vision for most of these people compared with what they have right now.

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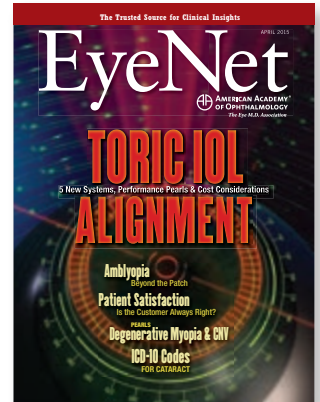
1 Peng MY et al. *J AAPOS*. 2014; 18(4):327-331.

2 Singman E et al. *Strabismus*. 2014;22(1):21-25.

3 Walsh AC. *OSLI Retina*. 2011; 42(4):S95-S105.

Drug Costs of the Future

I read with interest the sidebar titled "A Sampling of Costly and Missing Drugs" in "The State of Generic Drugs" (Feature, January). I learned that brimonidine 0.15 percent is more expensive than 0.2 percent. I also know that 100 mg Neurontin tablets



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are more expensive than 300 mg.

This is an example of business ethics. It has been said that the American consumers' expectations are two years ahead of medical inventions. Even though Americans know how to make healthy choices, they don't want to: They're looking for a magic pill or drop (generic or brand-name), despite the cost.

In an era in which the medical profession and hospitals are adopting a more business-oriented model, I hope the medical profession will not follow this pharmaceutical blueprint.

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