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Opinion

# Myopia Control at Low resource setting

**Henry Ngogo***

*Optometrist, CCBRT Disability Hospital, Tanzania*

***Corresponding Author:** Henry Ngogo, Optometrist, CCBRT Disability Hospital, Tanzania.

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Due to the rise of Myopia in the world, Myopia control treatments become famous among eye care practitioners as days go. Myopia is expected to affect half of the world population by 2050 if actions won't be taken, among the environmental factors which contribute to the growth of the Myopia epidemic is urbanization of cities of which developing countries are not behind, but when it comes to the issue of myopia control most of countries which research and practice the myopia control treatments are developed nations and this has to do with the fact that in developing nations there are poor resources in eye care practitioner's offices to treat and monitor myopia so the mainstay treatment has remained to be single vision glasses even for kids with progressive myopia although research has documented again and again on how ineffective they're when it comes to reducing the rate of myopia progression.

Here's my opinion on how we can do more with little that we have in low resource clinical settings:

I'll start by discussing about the instruments that we use in the clinic, for every patient that you want to start on any myopia treatment method you should have baseline findings which includes their wet refraction, K-reading, A-scan measurements and fundus recordings, these measurements will help us in the future whenever there's an increase in myopia to know how much change has happened and whether it's due to axial elongation or corneal curvature changes, when you are at a setting that do not have A scan machine, a baseline refraction together with K reading and fundoscopy can still give better cues on changes happening in the eye of a progressing myope.

On myopia control methods, there are several methods each with different efficacy these includes atropine treatment, multifocal contact lenses, Orthokeratology and aspheric lenses which have shown greater treatment outcomes then there's bifocal glasses and progressive addition lenses which has shown less efficacy in clinical trials but still they're way better than single vision lenses alone. When in low resource setting it can be very hard to use multifocal contact lenses and ortho-k lenses because they need sophisticated and expensive instruments like corneal topographer which are not available to all eye care practitioners especially in the developing world so fitting these contact lenses successfully in a low resource setting might be a nightmare to an eye care practitioner. Instead of these ways we can always use atropine 0.01% as a way to control myopia with almost the same efficacy as multifocal contact lenses and ortho-k lenses although the challenge here might be the associated costs of buying drops now and then by the patient.

Bifocal and progressive addition lenses can be used and whenever possible coupled with atropine eye drops to enhance the myopia control effect, although when used alone their efficacy is low but whatever method that we have at hand is better than single vision lenses alone.

Apart from these ways we should always remind our patients of environmental modifications like increasing outdoors time and decreasing near work time which may also help with the decrease in the rate of myopia progression.

When it comes to myopia control whether you are in a high or low resource setting whatever tools and myopia control methods that are available to you, use them to the maximum in order to decrease the rate of progression and impact high myopia might cause to that particular kid. Also whenever you think the patient might benefit by referring to a colleague or a nearby high resource center then do that as the patient will build trust in you by referring them

to the right place and they'll always remain your patients when they're in a dilemma about the options they're having [1].

## Bibliography

1. https://journals.sagepub.com/doi/10.1177/1120672121998960

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