

H.5.2 The effectiveness of support strategies for people with impairment and age-related macular degeneration (AMD)

RQ9: What is the effectiveness of support strategies for people with visual impairment and AMD (for example reablement services and strategies for optimising existing visual performance)?

Activities of daily living

Number of RCTs	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Sample size	Effect	Quality
ADL step scale 0-9, rate "0" as least dependence , 28 months follow-up (health education programme vs individual programme)								
1 (Eklund 2008)	RCT	Very serious ^{1,6}	N/A	Not serious	Serious ²	131	RR 1.78 (1.03, 3.08)	VERY LOW
Self rated restriction in everyday activities because of vision impairment, Manchester Low Vision Questionnaire, 12 months follow-up (enhanced low vision rehabilitation vs conventional low vision rehabilitation)								
Self rated restriction score (enhanced low vision rehabilitation by a rehabilitation officer vs conventional low vision rehabilitation)								
1 (Reeves 2004)	RCT	Not serious	N/A	Not serious	Not serious ⁴	124	MD 0.04 (-0.02, 0.11)	HIGH
Self rated restriction score, enhanced low vision rehabilitation by community care worker vs conventional low vision rehabilitation								
1 (Reeves 2004)	RCT	Not serious	N/A	Not serious	Serious ³	130	MD -0.00 (-0.06, 0.06)	MODERATE
Melbourne low vision activities of daily living index, at 3 months follow-up (prism spectacle vs placebo)								
Melbourne low vision activities of daily living, part 1 (performance of ADL dependent on vision), custom prisms vs placebo (higher values better)								
1 (Smith 2005)	RCT	Not serious	N/A	Not serious	Serious ³	150	MD -0.72 (-2.30, 0.87)	MODERATE
Melbourne low vision activities of daily living, part 1 (performance of ADL dependent on vision), standard prisms vs placebo (higher values better)								
1 (Smith 2005)	RCT	Not serious	N/A	Not serious	Serious ³	155	MD 0.45 (-1.11, 2.01)	MODERATE
Melbourne low vision activities of daily living, part 2 (self assessment of ADL performance), custom prisms vs placebo (higher values better)								

Number of RCTs	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Sample size	Effect	Quality
1 (Smith 2005)	RCT	Not serious	N/A	Not serious	Serious ³	150	MD -0.14 (-0.67, 0.39)	MODERATE
Melbourne low vision activities of daily living, part 2 (self assessment of ADL performance), standard prisms vs placebo (higher values better)								
1 (Smith 2005)	RCT	Not serious	N/A	Not serious	Serious ³	155	MD -0.07 (-0.59, 0.45)	MODERATE
Melbourne low vision activities of daily living index (part 2), 8 weeks (eccentric viewing vs control) (higher values better)								
1 (Vukicevic 2009)	RCT	Serious ⁵	N/A	Not serious	Not serious	48	MD 6.25 (3.72, 8.78)	MODERATE
<ol style="list-style-type: none"> 1. Downgraded one level for masking of study participants not reported. 2. Downgraded one level for confidence interval cross 1 line of a defined minimal important difference. 3. Downgraded one level for non-significant effect. 4. Non-significant result but confidence interval sufficiently narrow as to be confident there is no clinically meaningful effect. 5. Downgrade one level for risk of bias due to allocation and randomisation were unclear in the study. 6. Downgraded one level for high dropout rate (75%). 								

Perceived security in the performance of daily activities

Number of RCTs	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Sample size	Effect	Quality
Perceived security in the performance of daily activities, 28 months follow-up (health education programme vs individual programme)								
1 (Eklund 2004)	RCTs	Very serious ^{1,3}	N/A	Not serious	Not serious	131	MD ² 0.42 (0.19, 0.65)	LOW
<ol style="list-style-type: none"> 1. Downgraded one level for non-significant effect 2. Difference in relative positions between two groups (based on 15 activities that two groups had significant differences in perceived security) 3. Downgraded one level for high dropout rate (75%) 								

Visual acuity

Number of RCTs	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Sample size	Effect	Quality
Visual acuity, percentage of people with VA 0.1 (20/200), measure the distance visual acuity at a test distance of 5m, 28 months follow-up (health promotion vs individual programme)								
1 (Eklund 2008)	RCT	Very serious ^{1,3}	N/A	Not serious	Very serious ²	131	RR 0.97 (0.52, 1.83)	VERY LOW
Visual acuity logMAR at 1 year (prisms correction vs control) (lower values indicate better vision)								
1 (Parodi 2004)	RCT	Serious ¹	N/A	Not serious	Not serious	28	MD -0.40 (-0.52, -0.28)	MODERATE
Visual acuity at 3 month (prism spectacle vs placebo)								
Visual acuity logMAR at 3 month (custom prism spectacle vs placebo) (lower values indicate better vision)								
1 (Smith 2005)	RCT	Not serious	N/A	Not serious	Not serious	150	MD -0.02 (-0.07, 0.02)	HIGH
Visual acuity logMAR at 3 month (standard prism spectacle vs placebo) (lower values indicate better vision)								
1 (Smith 2005)	RCT	Not serious	N/A	Not serious	Not serious	155	MD -0.02 (-0.06, 0.03)	HIGH
Visual acuity logMAR at 8-week follow up (eccentric viewing vs control) (lower values indicate better vision)								
1 (Vukicevic 2009)	RCT	Serious ⁴	N/A	Not serious	Not serious	48	MD -0.38 (-0.47, -0.29)	MODERATE
<ol style="list-style-type: none"> 1. Downgraded one level for masking of study participants not reported; 2. Downgraded two levels for confidence interval crossing 2 lines of a defined minimal important difference; 3. Downgraded one level for high dropout rate (75%) 4. Downgrade one level for allocation and randomisation were unclear in the study 								

Quality of life

Number of RCTs	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Sample size	Effect	Quality
Vision-specific QoL, 12 months follow-up (enhanced low vision rehabilitation by rehabilitation officer or community worker vs conventional low vision rehabilitation)								
Vision specific quality of life score (enhanced low vision rehabilitation vs conventional low vision rehabilitation) (higher scores indicate poorer QoL)								
1 (Reeves 2004)	RCT	Not serious	N/A	Not serious	Serious ¹	124	MD 0.06 (-0.17, 0.30)	MODERATE
Vision specific quality of life score, enhanced low vision rehabilitation by community worker vs conventional low vision rehabilitation (higher scores indicate poorer QoL)								
1 (Reeves 2004)	RCT	Not serious	N/A	Not serious	Serious ¹	130	MD -0.05 (-0.29, 0.18)	MODERATE
NEI-VFQ-25 at 3 months								
NEI-VFQ-25, custom prisms vs placebo (higher scores indicate better QoL)								
1 (Smith 2005)	RCT	Not serious	N/A	Not serious	Serious ²	150	MD 1.25 (-1.98, 4.47)	MODERATE
NEI-VFQ-25, standard prisms vs placebo (higher scores indicate better QoL)								
1 (Smith 2005)	RCT	Not serious	N/A	Not serious	Serious ²	155	MD 0.29 (-2.90, 3.49)	MODERATE
1. Downgraded one level for non-significant effect 2. Downgraded one level of confidence interval crossing 1 line of a defined minimal important difference								

General health

Number of RCTs	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Sample size	Effect	Quality
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Number of RCTs	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Sample size	Effect	Quality
SF-36, percentage of people reporting “excellent” health 28 month follow-up (health promotion programme vs individual programme)								
1 (Eklund 2008)	RCT	Serious ¹	N/A	Not serious	Serious ²	131	RR 6.68 (0.83, 53.93)	LOW
SF-36, percentage of people reporting “bad” health 28 month follow-up (health education programme vs individual programme)								
1 (Eklund 2008)	RCT	Vert serious ^{1,4}	N/A	Not serious	Serious ²	131	RR 0.56 (0.31, 0.98)	VERY LOW
SF-36 (enhanced low vision rehabilitation by rehabilitation officer or community worker vs conventional low vision rehabilitation), 12 months follow-up								
SF-36, physical health (enhanced low vision rehabilitation by rehabilitation officer vs conventional low vision rehabilitation) (higher values indicate better HRQoL)								
1 (Reeves 2004)	RCT	Not serious	N/A	Not serious	Serious ²	124	MD -6.05 (-10.2, -1.91)	MODERATE
SF-36, physical (enhanced low vision rehabilitation by community worker vs conventional low vision rehabilitation) (higher values indicate better HRQoL)								
1 (Reeves 2004)	RCT	Not serious	N/A	Not serious	Serious ³	130	MD -2.27 (-6.29, 1.76)	MODERATE
SF-36, mental health (enhanced low vision rehabilitation by rehabilitation officer vs conventional low vision rehabilitation) (higher values indicate better HRQoL)								
1 (Reeves 2004)	RCT	Not serious	N/A	Not serious	Serious ²	124	MD -4.04 (-7.44, -0.65)	MODERATE
SF-36, physical (enhanced low vision rehabilitation by community worker vs conventional low vision rehabilitation) (higher values indicate better HRQoL)								
1 (Reeves 2004)	RCT	Not serious	N/A	Not serious	Serious ³	130	MD -1.48 (-4.69, 1.73)	MODERATE

1. Downgraded one level for masking of study populations not reported in the study

Macular Degeneration
Appendix H: Grade tables and meta-analysis results

Number of RCTs	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Sample size	Effect	Quality
2. Downgraded one level for confidence interval crossing 1 line of a defined minimal important difference 3. Downgraded one level for non-significant effect 4. Downgraded one level for high dropout rate (75%)								

Reading performance

Number of RCTs	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Sample size	Effect	Quality
Reading rate, at 3-months (prism spectacle vs control) (higher scores indicate better reading)								
1 (Smith 2005)	RCTs	Not serious	N/A	Not serious	Serious ¹	250	MD 6.50 (-7.84, 20.84)	MODERATE
1. Downgraded one level for non-significant effect								