## E.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)?

| Bibliographic reference | Cheong A M; Lovie-Kitchin J E; Bowers A R; Brown. Short-term in-office practice improves reading performance with stand magnifiers for people with AMD. Optometry and vision science 82(2). 2005 |
|---|---|
| Country/ies where the study was carried out | Australia |
| Study type | Comparison study |
| Aim of the study | To investigate the effect of home-based large print reading practice on reading performance when stand magnifiers (STMs) are first prescribed. |
| Study dates | Published in 2005 |
| Source of funding | Supported by a Queensland University of Technology Postgraduate Research Scholarship. |
| Sample size | 32 selected, and 25 included in the study |
| Length follow-up | Up to 20 weeks |
| Inclusion criteria | People with low vision because of AMD<br>People whose monocular near visual acuity in the better eyes was equal to or better than 1.4logMAR (15 EDTRS letter, 6/150) |
| Exclusion criteria | Not reported |
| Patient characteristics | Age, mean (SD) years: 80.3 (4.4)<br><br>Gender, M, %: not reported<br><br>Distance visual acuity (logMAR):<br>Control group: 0.18,<br>Large print practice group (p1): .026,<br>Large print with reduced field of view practice (p2): 0.30<br>Participants were generally in good health with no cognitive problem that might affect their compliance with home-training instructions. |

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<table>
<tr><th>Bibliographic reference</th><th>Cheong A M; Lovie-Kitchin J E; Bowers A R; Brown. Short-term in-office practice improves reading performance with stand magnifiers for people with AMD. Optometry and vision science 82(2). 2005</th></tr>
<tr><td>Details</td><td>A full optometric examination was conducted for each participant before the experiment to ensure that his/her distance spectacle prescription provided best vision.<br>Participants in practice groups were instructed to read large print book at home at least 10min.day for 2 weeks. Participants recorded on the large print book the number of pages read each day in an attempt to verify compliance with the reading practice.</td></tr>
<tr><td>Intervention</td><td>Participants were assigned to one of 3 experimental groups according to age and near visual acuity to ensure that the distribution of these variables were not significant different among groups.<br>Participants in the control group received no reading practice at home but repeated reading measure with and without STM’s were taken in the laboratory at week 0,1, and 2 before the STM’s were supplied for home use.<br>Participants in the practice groups (P1 and P2) were instructed to do 10min/day of large print reading practice at home. P2 participants were additionally requested to read the large print through a restricted field of view. Repeated reading measure with and without STM’s were taken in the laboratory at week 0,1, and 2 before the STM’s were supplied for home use. The STM’s were supplied at week 2 to all the participants for reading small print, at that point, large print reading practice ceased. Further reading measures with STM’s were made at week 4,8 and 20.</td></tr>
<tr><td>Results</td><td>
<table>
<tr><td></td><td>P1 (home training large print reading)</td><td>P2 (home training large print reading with additional request to read with a restrict field of view)</td><td>Control (no reading practice)</td><td colspan="2">Effect (95%CI)</td></tr>
<tr><td>Number of participants</td><td>10</td><td>9</td><td>6</td><td>P1 vs control</td><td>P2 vs control</td></tr>
<tr><td>Relative log reading rate (wpm), 2 weeks</td><td>0.08 (0.05, 0.12)</td><td>0.065 (0.03, 0.1)</td><td>0.025 (-0.02, 0.07)</td><td>0.06 (-0.06, 0.17)</td><td>0.04 (-0.07, 0.15)</td></tr>
<tr><td>Relative log reading rate (wpm), 8 weeks</td><td>0.12 (0.08, 0.16)</td><td>0.1 (0.06, 0.14)</td><td>0.08 (0.03, 0.13)</td><td>0.04 (-0.09, 0.17)</td><td>0.02 (-0.10, 0.14)</td></tr>
</table>
</td></tr>
</table>

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| Bibliographic reference | Cheong A M; Lovie-Kitchin J E; Bowers A R; Brown. Short-term in-office practice improves reading performance with stand magnifiers for people with AMD. Optometry and vision science 82(2). 2005 |
|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Relative log reading rate (wpm), 20 weeks | 0.135 (0.08, 0.19) | 0.05 (-0.01, 0.11) | 0.06 (-0.01,0.13) | 0.08 (-0.09, 0.25) | -0.01 (-0.19, 0.17) |

Exponentials relative log reading rate, effect between treatment and control

| | Effect (95%CI) MD | |
|---|---|---|
| | P1 vs control | P2 vs control |
| Relative log reading rate (wpm), 2 weeks | 1.06 (0.94, 1.19) | 1.04 (0.93, 1.16) |
| Relative log reading rate (wpm), 8 weeks | 1.04 (0.40, 1.18) | 1.02 (0.90, 1.15) |
| Relative log reading rate (wpm), 20 weeks | 1.08 (0.91, 1.28) | 0.99 (0.83, 1.18) |

| | |
|---|---|
| Missing data handling/loss to follow up | Not reported |
| Was allocation adequately concealed? | Unclear |
| Was knowledge of the allocated intervention adequately prevented during the study? | Unclear |

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| Bibliographic reference | Cheong A M; Lovie-Kitchin J E; Bowers A R; Brown. Short-term in-office practice improves reading performance with stand magnifiers for people with AMD. Optometry and vision science 82(2). 2005 |
|---|---|
| Was the allocation sequence adequately generated? | Unclear |
| Was the study apparently free of other problems that could put it at a high risk of bias? | Unclear |
| Were incomplete outcome data adequately addressed? | Unclear |
| Are reports of the study free of suggestion of selective outcome reporting? | Unclear |

| Bibliographic reference | Eklund K ; Sonn U ; Dahlin-Ivanoff S. Long-term evaluation of a health education programme for elderly persons with visual impairment. A randomized study. Disability & Rehabilitation 26 (7), 2004. |
|---|---|
| Country/ies where the study was carried out | Sweden |
| Study type | RCT |
| Aim of the study | To investigate the impact of the health education programme on perceived security in the performance of daily activities. |
| Study dates | Published in 2004 |
| Source of funding | Not reported |
| Sample size | 229 participants, and 98 person dropout |
| Length follow-up | 28 months |
| Inclusion criteria | People aged 65 years or older<br>Living at home |

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| Bibliographic reference | **Eklund K ; Sonn U ; Dahlin-Ivanoff S. Long-term evaluation of a health education programme for elderly persons with visual impairment. A randomized study. Disability & Rehabilitation 26 (7), 2004.** |
|---|---|
| | Diagnosed with AMD<br>A distance VA of better eye with BCVA no lower than 0.1 (VA was tested with a letter chart graded 0.1 to 1.0 at distance of 5 m with the person's own glasses and with best refraction). |
| Exclusion criteria | Not reported |
| Patient characteristics | Age, mean (SD) years: 78<br><br>Gender, M, %: 26%<br><br>Visual acuity: 0.3 (range 1.0-0.1)<br><br>Participants living alone, %: 60%<br>Participants receiving public transportation service: 37%<br>Participants receiving social service: 18%<br>Participants reported perceived good health: 86% |
| Details | The participants were randomly assigned, according a random number table, either to the health education programme, or to an individual intervention programme that was standard at the low vision clinic.<br>The occupational therapists that collected the data were not blinded to the composition of the groups but were not involved in the programme.<br>Assessment at baseline at the 28 months follow-up were made when participants attended the low vision clinic.<br>The study procedure did not differ between the programs. Independent registered occupational therapists interviewed the participants according to a structured protocol that consisted of questions about marital status, living arrangements, social service, and health problems. An assessment of perceived security in performing daily occupations also was completed; details about this assessment follow in the next section. An optometrist made the optical evaluation during the visit. Visual acuity was tested with a letter chart (Monoyer-Granström, Kifa), graded .1 to 1.0 at a distance of 5 m, with the person's own eyeglasses and with best refraction.<br>The instrument for measuring the primary outcome—perceived security in performing daily occupations was developed for the purpose of evaluating the health education program. The instrument is a questionnaire that consists 29 items divided into 7 performance areas:<br>Meals, self-care and care of clothing, communication, cleaning, mobility, shopping, and financial management. |

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<table>
<tr><th>Bibliographic reference</th><th>Eklund K ; Sonn U ; Dahlin-Ivanoff S. Long-term evaluation of a health education programme for elderly persons with visual impairment. A randomized study. Disability & Rehabilitation 26 (7), 2004.</th></tr>
<tr><td></td><td>Perceived confidence in performing each task is rated on a 4-point ordinal scale (very insecure, insecure, quite secure, secure). The participants completed the questionnaire after instructions from the occupational therapists.</td></tr>
<tr><td>Intervention</td><td>Intervention with the health education program.<br>Groups of 4 to 6 participated in the health education program for a total of 20 formed consecutively during the study period.<br>The intervention period for each group was 8 weeks, and the groups met once a week for 2 hr.<br>The groups were led by occupational therapists, and each group always had the same leader. The therapists were experienced in leading groups and trained in the methodology and theoretical foundations of the program before the start of the study. The occupational therapist provided information and skills training based on the occupational categories and guided and encouraged the participants in the learning process. Other health professionals, such as an ophthalmologist, an optometrist, a low vision therapist, and a light expert, were invited to give information.<br>The information and the skills training were derived from strategies elderly persons with age-related macular degeneration use to continue to perform daily occupations. The strategies were presented within the program as a problem-solving model, and the participants were taught to use the model as a way of thinking when performing daily occupations. A booklet containing the information given by health professionals as well as information about occupational categories was used in the health education program. The participants were asked to prepare themselves before participating in the sessions by reading relevant chapters and formulating questions.<br>Individual intervention programme<br>The individual intervention program was the standard intervention for the target group at the low vision clinics. The participants were provided with optical aids with the aim to improve reading and near and distance viewing. Hand and stand magnifiers as well as eyeglasses for reading were prescribed. The participants were given information about the disease if they requested it. The individual intervention measures were carried out by an occupational therapist with special training in low vision. The individual intervention typically included one to two 1-hr sessions at the clinic, with follow-up phone calls over a 4-week period.</td></tr>
<tr><td>Results</td><td>
<table>
<tr><td></td><td colspan="2">Relative position (95%CI)</td><td colspan="2">Relative variance</td></tr>
<tr><td></td><td>Health education programme</td><td>Individual education programme</td><td>Health education programme</td><td>Individual education programme</td></tr>
<tr><td>Median</td><td>0.25 (-0.09, 0.47)</td><td>-0.14 (-0.32, 0.15)</td><td>0.16 (0.04, 0.32)</td><td>0.1 (0.05, 0.46)</td></tr>
</table>
</td></tr>
</table>

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| Bibliographic reference | Eklund K ; Sonn U ; Dahlin-Ivanoff S. Long-term evaluation of a health education programme for elderly persons with visual impairment. A randomized study. Disability & Rehabilitation 26 (7), 2004. |
|---|---|

| | | |
|---|---|---|
| | Significant difference in perceived security in performance daily activities between groups | Non-significant difference in perceived security in performance daily activities between groups |
| **Meal** | pouring coffee/tea for yourself | Finding food on the plate |
| | finding utensils and supplies in cabinets | Finding things on the table while eating |
| | measuring ingredients for making coffee | Slicing bread |
| | determining if vegetables are clear | |
| | managing the knobs on the stove | |
| | determining if the dishes are clear | |
| **Self-care and care of clothing** | cutting/filing your nails | Treading a needle and sewing on a button |
| | discovering if your clothes are stained | |
| **Communication** | writing a memo to yourself | Reading an article in your newspaper |
| | | Following the news on your TV |

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| Bibliographic reference | Eklund K ; Sonn U ; Dahlin-Ivanoff S. Long-term evaluation of a health education programme for elderly persons with visual impairment. A randomized study. Disability & Rehabilitation 26 (7), 2004. | | |
|---|---|---|---|
| | | | Dialling on your phone |
| | **Clean** | dusting your apartment | Vacuuming your apartment |
| | **Mobility** | going to your local shop | |
| | | using a pedestrian traffic light crossing | |
| | | distinguishing irregularity in the street | |
| | **Financial management** | Knowing your turn in the queue | Reading a bank statement |
| | | Filing in a withdrawal form | |
| | **Shopping** | | Finding your way in your local shop |
| | | | Picking the right product |
| | | | Knowing the price on the products |
| | | | Managing money and paying |
| | | Relative position (RP), intervention group=0.27 (0.10, 0.43) | |

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| Bibliographic reference | Eklund K ; Sonn U ; Dahlin-Ivanoff S. Long-term evaluation of a health education programme for elderly persons with visual impairment. A randomized study. Disability & Rehabilitation 26 (7), 2004. |
|---|---|
| | <table><tr><td></td><td>Individual group=-0.15 (-0.31, 0)</td><td></td></tr></table> |
| Missing data handling/loss to follow up | 98 drop out from the participations |
| Was allocation adequately concealed? | Unclear |
| Was knowledge of the allocated intervention adequately prevented during the study? | Masking technique was not applied |
| Was the allocation sequence adequately generated? | Yes |
| Was the study apparently free of other problems that could put it at a high risk of bias? | No |
| Were incomplete outcome data adequately addressed? | Drop outs did not differ from the participants at baseline |
| Are reports of the study free of suggestion of selective outcome reporting? | Yes |
| Other | There was an early publication on this trial reporting 4 month follow up (Dahlin Ivanoff 2002). |

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| Bibliographic reference | Eklund K ; Sjostrand J ; Dahlin-Ivanoff S. A randomized controlled trial of a health-promotion programme and its effect on ADL dependence and self-reported health problems for the elderly visually impaired. Scandinavian Journal of Occupational Therapy 15 (2): 68-74. 2008. |
|---|---|
| Country/ies where the study was carried out | Sweden |
| Study type | RCT |
| Aim of the study | To compare the differences between an activity-based health promotion programme and an individual programme concerning their effect on activities of daily living (ADL) dependence and self-reported health. |
| Study dates | Published in 2008 |
| Source of funding | Not reported |
| Sample size | 229 participated, 81 lost to follow-up, and 131 included in the analysis |
| Length follow-up | 28 months |
| Inclusion criteria | People with AMD as the primary diagnosis<br>People with a distance visual acuity of the better than with best correction ≥0.1<br>65 years or older<br>Living at home<br>Being capable of participation in group discussion |
| Exclusion criteria | Not reported |
| Patient characteristics | Age, mean (SD) years: 78<br><br>Gender, M, %: 26%<br><br>Visual acuity: 0.3 (range 1.0-0.1)<br><br>Participants living alone, %: 60%<br>Participants receiving public transportation service: 37%<br>Participants receiving social service: 18%<br>Participants reported perceived good health: 86% |

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| Bibliographic reference | **Eklund K ; Sjostrand J ; Dahlin-Ivanoff S. A randomized controlled trial of a health-promotion programme and its effect on ADL dependence and self-reported health problems for the elderly visually impaired. Scandinavian Journal of Occupational Therapy 15 (2): 68-74. 2008.** |
|---|---|
| Details | The participants were randomly assigned, according a random number table, either to the health promotion programme, or to an individual intervention programme that was standard at the low vision clinic.<br>The occupational therapists that collected the data were not blinded to the composition of the groups but were not involved in the programme. |
| Intervention | The health-promotion programme<br>This programme was carried out with groups of 4 to 6 persons. A total of 20 formed consecutively during the study period.<br>The intervention period for each group was 8 weeks, and the groups met once a week for 2 hr.<br>The content of the programme included 8 occupation themes:<br>Self-care; meals; communications, orientation and mobility; food preparation; shopping; financial management, and cleaning.<br><br>Health professional such as ophthalmologist, optician, low vision therapies and a lightening expert provided information. The optician also prescribed glasses. Occupational therapists led the groups, and each group had the same leader.<br><br>Individual intervention programme<br>The individual intervention program was the standard intervention for the target group at the low vision clinics. Magnifiers and reading glasses were prescribed and introduced at the clinic and were taken home directly for practice application. Information about lighting, mainly for reading was provided. If requested, the participants also received information about the disease. The individual programme measures were carried out by occupational therapies with special training in low vision. The individual intervention typically included one to two 1-hr sessions at the clinic, with follow-up phone calls over a 2-4-week period. An optician therapists prescribed glasses and the occupational therapists prescribed low-vision aids. |
| Results | |

| | Baseline | | 28 months | | Effect (95%CI), at 28 months |
|---|---|---|---|---|---|
| | Health promotion programme (n=62) | Individual programme (n=69) | Health promotion programme (n=62) | Individual programme (n=69) | |

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| Bibliographic reference | Eklund K ; Sjostrand J ; Dahlin-Ivanoff S. A randomized controlled trial of a health-promotion programme and its effect on ADL dependence and self-reported health problems for the elderly visually impaired. Scandinavian Journal of Occupational Therapy 15 (2): 68-74. 2008. | | | | | |
|---|---|---|---|---|---|---|
| | ADL step, n(%) | | | | | |
| | 0 | 26 (42) | 33 (48) | 24 (39) | 15 (22) | 1.78 (1.03, 3.08) |
| | 1 | 19 (31) | 18 (26) | 14 (23) | 15 (22) | 1.04 (0.55, 1.97) |
| | 2 | 8 (13) | 5 (7) | 8 (13) | 16 (23) | 0.56 (0.26, 1.21) |
| | 3 | 7(11) | 10 (15) | 9 (15) | 13 (19) | 0.77 (0.35, 1.68) |
| | 4 | 2 (3) | 3 (4) | 4 (7) | 5 (7) | 0.89 (0.25, 3.17) |
| | 5 | | | 2 (3) | 2 (3) | 1.11 (0.16, 7.67) |
| | 6 | | | 1 (2) | 1 (1) | 1.11 (0.07, 17.42) |
| | 7 | | | | 0 (0) | |
| | 8 | | | | 1 (1) | |
| | 9 | | | | 1 (1) | |
| | General health (SF-36) | | | | | |

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| Bibliographic reference | Eklund K ; Sjostrand J ; Dahlin-Ivanoff S. A randomized controlled trial of a health-promotion programme and its effect on ADL dependence and self-reported health problems for the elderly visually impaired. Scandinavian Journal of Occupational Therapy 15 (2): 68-74. 2008. | | | | | |
|---|---|---|---|---|---|---|
| | Excellent | 13 (21) | 10 (15) | 6 (10) | 1 (1) | 6.68 (0.83, 53.93) |
| | Poor/fairly poor | 41 (66) | 48 (70) | 42 (68) | 40 (58) | 1.17 (0.90, 1.52) |
| | Bad | 5 (8) | 10 (15) | 13 (21) | 26 (38) | 0.56 (0.31, 0.98) |
| | Health problems | | | | | |
| | 0 | 8 (13) | 5 (7) | 7 (11) | 1 (1) | 7.79 (0.99, 61.55) |
| | 1-2 | 32 (52) | 38 (55) | 42 (68) | 40 (58) | 1.17 (0.90, 1.52) |
| | 3-4 | 15 (25) | 20 (29) | 12 (19) | 21 (30) | 0.64 (0.34, 1.18) |
| | 5 or more | 7(11) | 6 (9) | 1 (2) | 7 (10) | 0.16 (0.02, 1.26) |
| | Visual acuity | | | | | |
| | 1.0-0.8 | 2 (3) | 0 | 2 (3) | 2 (3) | 1.11 (0.16, 7.67) |
| | 0.7-0.5 | 9 (15) | 18 (26) | 4 (6) | 8 (12) | 0.56 (0.18, 1.76) |
| | 0.4-0.2 | 40 (65) | 41 (59) | 23 (37) | 28 (41) | 0.91 (0.59, 1.41) |

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| Bibliographic reference | Eklund K ; Sjostrand J ; Dahlin-Ivanoff S. A randomized controlled trial of a health-promotion programme and its effect on ADL dependence and self-reported health problems for the elderly visually impaired. Scandinavian Journal of Occupational Therapy 15 (2): 68-74. 2008. |
|---|---|
| | 0.1 \| 10 (16) \| 10 (15) \| 14 ((23) \| 16 (23) \| 0.97 (0.52, 1.83)<br>Finger counting \| \| \| 19 (31) \| 14 (20) \| 1.51 (0.83, 2.75) |
| Missing data handling/loss to follow up | 81 lost to follow-up |
| Was allocation adequately concealed? | Unclear |
| Was knowledge of the allocated intervention adequately prevented during the study? | Masking technique was not applied |
| Was the allocation sequence adequately generated? | Yes |
| Was the study apparently free of other problems that could put it at a high risk of bias? | No |
| Were incomplete outcome data adequately addressed? | Drop outs did not differ from the participants at baseline |
| Are reports of the study free of suggestion of selective outcome reporting? | Yes |

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| Bibliographic reference | Parodi M B; Toto L ; Mastropasqua L ; Depollo M ; Ravalico G. Prismatic correction in patients affected by age-related macular degeneration. Clinical Rehabilitation 18 (7): 828-32. 2004 |
|---|---|
| Country/ies where the study was carried out | Italy |
| Study type | RCT |
| Aim of the study | To evaluate the effectiveness and the tolerance of prismatic correction in improving visual function in patients affected by advanced AMD |
| Study dates | Published in 2004 |
| Source of funding | Not reported |
| Sample size | 28 |
| Length follow-up | Up to 360 days |
| Inclusion criteria | People with advanced AMD, presented with bilateral exudative AMD at an advanced stage<br>Visual acuity better than 6/19<br>Stable visual acuity for at least one year<br>Being able to consent their participation |
| Exclusion criteria | Presence of any other ocular disease able to impair visual function;<br>Presence of disorder causing choroidal neovascularisation other than AMD;<br>Previous laser photocoagulation |
| Patient characteristics | Age, mean (SD) years: treatment group: 72 years; control group: 71 years<br><br>Gender, M, %: not reported<br><br>Visual acuity (logMAR): treatment group: 1.06 logMAR; control group:1.06 logMAR |
| Details | The variation of visual acuity during the study period was evaluated using the analysis of variance for repeated measurement. |
| Intervention | Patients were randomly assigned to the treatment or control group, following a computer generated list using a block randomisation.<br>The treatment group received spectacles providing prismatic correction. A prism of low power (4-7 prismatic dioptres) placed in front of the better eyes was rotated to the position of clearest vision. |

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<table>
<tr><th>Bibliographic reference</th><td colspan="4">Parodi M B; Toto L ; Mastropasqua L ; Depollo M ; Ravalico G. Prismatic correction in patients affected by age-related macular degeneration. Clinical Rehabilitation 18 (7): 828-32. 2004</td></tr>
<tr><td></td><td colspan="4">Visual acuity in control group was assessed in the same way, using the best optical correction (without prismatic correction) that had been prescribed at baseline.</td></tr>
<tr><td>Results</td><td colspan="4"><table>
<tr><td>VA (logMAR)</td><td>Prismatic correction (n=14)</td><td>Control (without prismatic correction) (n=14)</td><td>Effect (95%CI)</td></tr>
<tr><td>Baseline</td><td>1.062857 (1.01, 1.10)</td><td>1.084285714 (1.02, 1.13)</td><td>-0.02 (-0.16, 0.12)</td></tr>
<tr><td>1 day</td><td>0.89 (0.81,0.91)</td><td>1.08 (1.01, 1.13)</td><td>-0.19 (-0.34, -0.04)</td></tr>
<tr><td>90 days</td><td>0.80 (0.77,0.85)</td><td>1.12 (1.09,1.14)</td><td>-0.32 (-0.41, -0.23)</td></tr>
<tr><td>180 days</td><td>0.71 (0.68, 0.79)</td><td>1.10 (1.08, 1.13)</td><td>-0.39 (-0.51, -0.27)</td></tr>
<tr><td>360 days</td><td>0.69 (0.65, 0.73)</td><td>1.09 (1.02,1.10)</td><td>-0.40 (-0.52, -0.28)</td></tr>
</table></td></tr>
<tr><td>Missing data handling/loss to follow up</td><td colspan="4">2 participants in treatment groups lost to follow-up</td></tr>
<tr><td>Was allocation adequately concealed?</td><td colspan="4">Unclear</td></tr>
<tr><td>Was knowledge of the allocated intervention adequately prevented during the study?</td><td colspan="4">Unclear</td></tr>
<tr><td>Was the allocation sequence adequately generated?</td><td colspan="4">Yes</td></tr>
</table>

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| Bibliographic reference | Parodi M B; Toto L ; Mastropasqua L ; Depollo M ; Ravalico G. Prismatic correction in patients affected by age-related macular degeneration. Clinical Rehabilitation 18 (7): 828-32. 2004 |
|---|---|
| Was the study apparently free of other problems that could put it at a high risk of bias? | Unclear |
| Were incomplete outcome data adequately addressed? | Yes |
| Are reports of the study free of suggestion of selective outcome reporting? | Yes |

| Bibliographic reference | Reeves B C; Harper R A; Russell W B. Enhanced low vision rehabilitation for people with age related macular degeneration: a randomised controlled trial. British Journal of Ophthalmology 88 (11): 1443-9. 2004 |
|---|---|
| Country/ies where the study was carried out | UK |
| Study type | RCT |
| Aim of the study | To compare the effectiveness of three models of low vision rehabilitation for people with age related macular degeneration (AMD) referred for low vision rehabilitation (LVR): (a) an enhanced low vision rehabilitation model (ELVR) including supplementary home based low vision rehabilitation; (b) conventional low vision rehabilitation (CLVR) based in a hospital clinic; (c) CLVR with home visits that did not include rehabilitation (CELVR), intended to act as a control for the additional contact time with ELVR. |
| Study dates | Published in 2004 |
| Source of funding | The trial was funded by North West Regional Health Authority (research grant RDO/18/39); Manchester Royal Eye Hospital General Research endowment fund. |
| Sample size | 226 randomised, and 194 completed trial |
| Length follow-up | 12 months |
| Inclusion criteria | People were eligible for the trial if they were newly referred to the low vision clinic at Manchester Royal Eye Hospital with a primary diagnosis of AMD. |

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| Bibliographic reference | Reeves B C; Harper R A; Russell W B. Enhanced low vision rehabilitation for people with age related macular degeneration: a randomised controlled trial. British Journal of Ophthalmology 88 (11): 1443-9. 2004 |
|---|---|
| | Participants had to have Snellen visual acuity worse than 6/18 (.0.5 logMAR) in both eyes and equal to or better than 1/60 ((1.8 logMAR) in the ‘‘better’’ eye. |
| Exclusion criteria | People were ineligible if they were living in a residential or nursing home, were suffering from mental illness or dementia, or were not proficient in English. |
| Patient characteristics | Age, median (IQR) years:<br>CLVR group: 81 (77-84) years; ELVR group: 80 (76-85) years; CELVR group: 83 (78-86) years<br><br>Gender, M, %<br>CLVR group: 37%; ELVR group: 36%; CELVR group: 28%<br><br>Living alone, %<br>CLVR group: 42%; ELVR group: 52%; CELVR group: 60%<br><br>Median distance visual acuity (logMAR):<br>CLVR group: 0.81 (0.48-1.00); ELVR group: 0.90 (0.56-1.08); CELVR group: 0.62 (0.44-1.00) |
| Details | Participants allocated to CLVR received a clinical low vision assessment at the hospital provided by a team of qualified optometrists, a dispensing optician, and a limited number of preregistration optometrists working under supervision.<br>As a pragmatic trial, assessments were carried out as part of standard hospital care for people referred to the low vision clinic. While general guidelines were suggested, practitioners did not have to adhere to a strict assessment protocol, although they were asked to complete data sheets requesting information on diagnosis, co-morbidity, visual requirements, unaided vision, performance with existing LVAs (if any), refraction, corrected acuities, contrast sensitivity, and performance with new LVAs.<br>Participants allocated to ELVR received all components of CLVR but, in addition, received additional low vision training at home. A rehabilitation officer, with specific training in the rehabilitation of people with visual impairment and 5 years’ experience in this role, provided the home visits.<br>Participants allocated to CELVR also received all components of CLVR but, in addition, were visited at home by one of four community care workers from Age Concern. Community care workers do not have training about visual impairment or any formal training in low vision. Hence, they did not provide any specific LVR. The community care workers did not have any formal link with the hospital through a reporting system and did not visit the low vision clinic. |
| Intervention | Conventional low vision rehabilitation (CLVR) |

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| Bibliographic reference | Reeves B C; Harper R A; Russell W B. Enhanced low vision rehabilitation for people with age related macular degeneration: a randomised controlled trial. British Journal of Ophthalmology 88 (11): 1443-9. 2004 |
|---|---|
| | Check a patient's understanding of the diagnosis and prognosis<br>Discuss needs/visual requirements and set initial goals<br>Assess vision (including sight test and near acuities)<br>Re-appraise goals<br>Demonstrate specific LVAs<br>Explain use and handling of prescribed LVAs<br>Advise about lighting and other methods of enhancing vision<br>Provide large print literature about diagnosis, vision enhancement, use of LVAs and other services<br>Refer to other services where necessary (e.g., to a hospital support worker)<br>Arrange for follow ups, usually at 3 months with additional appointments being offered if necessary<br><br>Enhanced low vision rehabilitation (ELVR)<br>As for conventional LVR, plus up to three home visits (at approximately 2 weeks, 4–8 weeks, and at 4–6 months after the first low vision assessment) by a trained rehabilitation officer to:<br>advise on use of LVA(s): assess patterns of LVA use (e.g., tasks attempted, frequency and duration of use) and difficulties experienced in using LVAs;<br>demonstrate and supply alternative or additional LVAs, if appropriate;<br>provide wider patient support—e.g., direct patients to relevant support and welfare services<br><br>Controlled for additional contact time in enhanced low vision rehabilitation (CELVR)<br>As for conventional LVR, plus up to three home visits (at approximately 2 weeks, 4–8 weeks, and at 4–6 months after the first low vision assessment) by a community care worker to:<br>discuss ability to cope with daily activities<br>discuss ability to take part in leisure activities<br>discuss other problems or topics raised by participant |

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| Bibliographic reference | Reeves B C; Harper R A; Russell W B. Enhanced low vision rehabilitation for people with age related macular degeneration: a randomised controlled trial. British Journal of Ophthalmology 88 (11): 1443-9. 2004 | | | | | |
|---|---|---|---|---|---|---|
| Results | | | | | | |
| | | Enhanced low vision rehabilitation (ELVR) | Controlled for additional contact time in enhanced low vision rehabilitation (CELVR) | Conventional low vision rehabilitation (CLVR) | Effect (95%CI) ELVR vs CLVR | Effect (95%CI) CELVR vs CLVR |
| | At 12 month | | | | | |
| | No. | 64 | 70 | 60 | | |
| | Vision specific QoL (VCM), median (IQR) | 2.2 (1.7, 3.0) | 2.3 (1.5, 2.9) | 2.4 (1.8,3.1) | 0.06 (-0.17, 0.30) | -0.05 (-0.29, 0.18) |
| | SF-36 (physical health), median (IQR) | 26 (14,40) | 28 (17,41) | 38 (24,44) | -6.05 (-10.2, -1.91) | -2.27 (-6.29, 1.76) |
| | SF-36 (mental health), median (IQR) | 53 (41,57) | 53 (45,57) | 52 (43,59) | -4.04 (-7.44, -0.65) | -1.48 (-4.69, 1.73) |
| | Nottingham adjustment scale (NAC) | | | | | |
| | Locus of control | 18 (14,20) | 18 (16,20) | 18 (14,20) | -0.42 (-1.68, 0.83) | 0.02 (-1.21, 1.25) |

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| Bibliographic reference | Reeves B C; Harper R A; Russell W B. Enhanced low vision rehabilitation for people with age related macular degeneration: a randomised controlled trial. British Journal of Ophthalmology 88 (11): 1443-9. 2004 | | | | | |
|---|---|---|---|---|---|---|
| | Acceptance | 36 (29,42) | 38 (29,42) | 38 (27,41) | -0.36 (-3.04,2.32) | 0.36 (-2.24, 2.97) |
| | Attitude | 20 (17,24) | 19 (17,25) | 20 (15,23) | 0.22 (-1.34, 1.77) | 0.25 (-1.27, 1.77) |
| | Self-efficacy | 28 (23,34) | 29 (24,34) | 28(24,33) | -0.44 (-2.88, 2.00) | 0.44 (-1.91, 2.79) |
| | Manchester low vision questionnaire (MLVQ) | | | | | |
| | Self rated restriction score | 0.6 (0.4, 0.7) | 0.4 (0.3,0.6) | 0.6 (0.4, 0.70) | 0.04 (-0.02, 0.11) | -0 (-0.06, 0.06) |
| | Using at least one low vision aid, n(%) | 58 (90.6%) | 67 (95.7%) | 57 (95.5%) | 0.95 (0.87, 1.05) | 1.01 (0.93, 1.09) |
| | Using low vision aid daily, n(%) | 47 (73.4%) | 51 (72.9%) | 42 (70.0%) | 1.05 (0.84, 1.31) | 1.04 (0.84, 1.30) |
| | Using low vision aid for≥5 minutes, n(%) | 22 (34.4%) | 16 (22.9%) | 18 (30.0%) | 1.15 (0.69, 1.92) | 0.76 (0.43, 1.36) |
| | Measured task performance, no. (%) | | | | | |
| | Read one or both use by dates | 39 (61.9%) | 54 (77.1%) | 39 (66.1%) | 0.94 (0.72, 1.23) | 1.19 (0.95, 1.49) |
| | Read drug name | 30 (46.9%) | 43 (61.4%) | 32 (55.2%) | 0.88 (0.62, 1.25) | 1.15 (0.85, 1.56) |

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| Bibliographic reference | Reeves B C; Harper R A; Russell W B. Enhanced low vision rehabilitation for people with age related macular degeneration: a randomised controlled trial. British Journal of Ophthalmology 88 (11): 1443-9. 2004 |
|---|---|
| Missing data handling/loss to follow up | 32 lost to follow-up of 3 groups |
| Was allocation adequately concealed? | Allocation codes were generated by computer before the start of the study by BCR (who took no part in recruitment, data collection, or the care of patients) and were concealed in sealed opaque envelopes. |
| Was knowledge of the allocated intervention adequately prevented during the study? | Allocation codes were generated by computer before the start of the study by BCR (who took no part in recruitment, data collection, or the care of patients) and were concealed in sealed opaque envelopes.<br>Eligible people were told about the study and were invited to participate by a large print letter. Those who agreed to participate gave written informed consent. At recruitment, an appointment was made for the initial home visit. RAH then randomised the participant by opening the next sealed envelope, keeping the allocation secret from the researcher who measured outcomes (WBR). |
| Was the allocation sequence adequately generated? | Allocation was randomised and blocked using blocks of unequal length |
| Was the study apparently free of other problems that could put it at a high risk of bias? | No |
| Were incomplete outcome data adequately addressed? | Yes |
| Are reports of the study free of suggestion of selective outcome reporting? | Yes |

| Bibliographic reference | Smith H J; Dickinson C M; Cacho I ; Reeves B C; Harper R A. A randomized controlled trial to determine the effectiveness of prism spectacles for patients with age-related macular degeneration. Archives of Ophthalmology 123 (8): 1042-50. 2005. |
|---|---|
| Country/ies where the study was carried out | UK |
| Study type | RCT |

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| Bibliographic reference | **Smith H J; Dickinson C M; Cacho I ; Reeves B C; Harper R A. A randomized controlled trial to determine the effectiveness of prism spectacles for patients with age-related macular degeneration. Archives of Ophthalmology 123 (8): 1042-50. 2005.** |
|---|---|
| Aim of the study | To determine the effectiveness of prism spectacle in people with AMD by relocating the retinal image. |
| Study dates | Published in 2005 |
| Source of funding | Supported by the Health Foundation, London |
| Sample size | 225 people |
| Inclusion criteria | People with bilateral AMD<br>People with visual acuity of at least 1/60 but no better than 6/18 in the better seeing eye<br>Free of mental illness, dementia, and severe physical limitations<br>Proficient in English and literate<br>Not a resident in a hospital or a nursing home |
| Exclusion criteria | Not reported |
| Patient characteristics | Age, median (IQR) year:<br>Custom group: 81 (77-85) years; Standard group: 81 (77-85) years; Placebo: 81 (76-86) years<br><br>Gender, M, %:<br>Custom group: 36%; Standard group: 32%; Placebo: 38%<br><br>Median visual acuity better eye, logMAR (IQR):<br>Custom group: 0.82 (0.62-1.12); Standard group: 0.92 (0.63-1.19); Placebo group: 1.00 (0.66-1.00)<br><br>Living alone, %<br>Custom group: 56%; Standard group: 51%; Placebo: 53% |
| Details | Participants were allocated to groups using computer generated randomisation codes prepared in advance by one of researchers. Randomisation and the ordering of spectacles were performed by a principal investigator who had no contact with participants during the study. Participants were recruited by the trial optometrist and another investigator collected all outcome data at baseline and follow-up. |
| Intervention | Participants received 1 of the following 3 types of test spectacles: |

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| Bibliographic reference | **Smith H J; Dickinson C M; Cacho I ; Reeves B C; Harper R A. A randomized controlled trial to determine the effectiveness of prism spectacles for patients with age-related macular degeneration. Archives of Ophthalmology 123 (8): 1042-50. 2005.** |
|---|---|
| | Custom, incorporating bilateral prisms to match participants' preferred power and base direction.<br>Standard, incorporating standard bilateral prisms (6 prism dioptres base up for logMAR VA of 0.48-1.00 and 10 prism dioptres base up for logMAR VA of 1.02-1.68.<br>Placebo, consisting of spectacles matched in weight and thickness to prism spectacles but without prism. |
| Results | |

| | Custom prisms group | Standard prisms group | Placebo | Effect1 (95%CI) Custom vs placebo | Effect (95%CI) Standard vs placebo |
|---|---|---|---|---|---|
| No. of participants, 3 months follow-up | 70 | 75 | 80 | | |
| logMAR, ETDRS (SD) | 0.88 (0.32) | 0.89 (0.32) | 0.95 (0.32) | -0.02 (-0.07, 0.02) | -0.02 (-0.06, 0.03) |
| logMAR, critical print size | 1.45 (0.26) | 1.45 (0.26) | 1.50 (0.24) | -0.04 (-0.10, 0.03) | -0.05 (-0.11, 0.01) |
| Words per minutes | 73 (54) | 74 (53) | 67 (52) | -2.70 (-10.35, 4.96) | 1.39 (-6.09, 8.87) |
| NEI-VFQ 25, self-assessed visual function | 53 (16) | 54 (17) | 53 (15) | 1.25 (-1.98, 4.47) | 0.29 (-2.90, 3.49) |
| Manchester low vision questionnaire, part 1observed task performance | 36 (12) | 36 (14) | 36 (12) | -0.72 (-2.30, 0.87) | 0.45 (-1.11, 2.01) |
| Manchester low vision questionnaire, part 2, activities of daily living | 28 (4) | 28 (5) | 29 (4) | -0.14 (-0.67, 0.39) | -0.07 (-0.59, 0.45) |
| Observed performance dependent on vision (OPTV) | 48 (19) | 50 (22) | 49 (17) | -1.44 (-4.47, 1.59) | 1.84 (-1.14, 4.81) |

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| Bibliographic reference | Smith H J; Dickinson C M; Cacho I ; Reeves B C; Harper R A. A randomized controlled trial to determine the effectiveness of prism spectacles for patients with age-related macular degeneration. Archives of Ophthalmology 123 (8): 1042-50. 2005. |
|---|---|
| | Activities of daily living (ADL) \| 46 (20) \| 49 (20) \| 48 (17) \| -0.56 (-3.08, 1.97) \| -0.10 (-2.59, 2.39)<br>Adjusted mean differences (using ANCOVA) |
| Missing data handling/loss to follow up | 18 lost to follow-up |
| Was allocation adequately concealed? | Yes |
| Was knowledge of the allocated intervention adequately prevented during the study? | Yes |
| Was the allocation sequence adequately generated? | Yes |
| Was the study apparently free of other problems that could put it at a high risk of bias? | Yes |
| Were incomplete outcome data adequately addressed? | Yes |
| Are reports of the study free of suggestion of selective outcome reporting? | Yes |

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| Bibliographic reference | Vukicevic Meri and Fitzmaurice Kerry. Eccentric viewing training in the home environment: can it improve the performance of activities of daily living? Journal of visual impairment & blindness 103 (5): 277-289. 2009. |
|---|---|
| Country/ies where the study was carried out | Australia |
| Study type | RCT |
| Aim of the study | To investigate the impact of eccentric viewing on near acuity and self-care activities of daily living from the point of view of a clinician working in the field of low vision. |
| Study dates | Published in 2009 |
| Source of funding | Not reported |
| Sample size | 48 |
| Length follow-up | 8 weeks |
| Inclusion criteria | People in good general health, aged 60 years and older<br>People with a visual acuity of 20/200 (1.0 logMAR unit) (equivalent to 6/60)<br>People with a diagnosis of AMD |
| Exclusion criteria | People were excluded if they had secondary ocular pathologies that affected their vision.<br>People with a diagnosis of dementia<br>People had received previous training in eccentric viewing |
| Patient characteristics | Age, mean (SD) years:<br>Treatment group: 82.4 (4.9); Control group: 81.4 (7.9)<br><br>Gender, M, %:<br>Treatment group: 16.7%; Control group: 41.7%)<br><br>Distance visual acuity (logMAR):<br>Treatment group: 1.15 (0.17); Control group: 1.17 (0.22)<br><br>Mean schooling completed (in years)<br>Treatment group: 9.92 (2.02); Control group: 9.38 (1.2) |

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<table>
<tr><th>Bibliographic reference</th><th>Vukicevic Meri and Fitzmaurice Kerry. Eccentric viewing training in the home environment: can it improve the performance of activities of daily living? Journal of visual impairment & blindness 103 (5): 277-289. 2009.</th></tr>
<tr><td>Details</td><td>All the data collection, assessment and rehabilitation training were conducted in the participants' homes. Training in eccentric viewing is commonly conducted as part of a home visit by clinicians of low vision agencies in Australia, and an additional purpose of providing in-home training was to decrease the amount of traveling required by the participants.<br>Training in eccentric viewing was conducted using the EccVue computer programme presented on a laptop personal computer.</td></tr>
<tr><td>Intervention</td><td>Participants were sequentially allocated to either an eccentric viewing group or a non-intervention group. The participants were told that they would be allocated to a study group but were not told to which group they were assigned.<br>The eccentric viewing group received 8 training sessions in eccentric viewing. The number of training sessions was chosen based on the basis of data from a pilot study.<br>The non-intervention group was a control group that received a weekly telephone call of 15 or fewer minutes for the duration of study in which they received support but no rehabilitation advice.</td></tr>
<tr><td>Results</td><td>
<table>
<tr><td></td><td>Eccentric viewing group (n=24)</td><td>Control group (n=24)</td><td>Effect (95%CI)</td></tr>
<tr><td>Mean near visual acuity logMAR (SD)</td><td>1.0 (0.18)</td><td>1.40 (0.17)</td><td>-0.38 (-0.47, -0.29)</td></tr>
<tr><td>Activities of daily living (MLVAI)</td><td>31.58 (3.88 )</td><td>25.33 (4.98)</td><td>6.25 (3.72, 8.78)</td></tr>
</table>
</td></tr>
<tr><td>Missing data handling/loss to follow up</td><td>All completed study</td></tr>
<tr><td>Was allocation adequately concealed?</td><td>Unclear</td></tr>
<tr><td>Was knowledge of the allocated intervention adequately prevented during the study?</td><td>Unclear</td></tr>
<tr><td>Was the allocation sequence adequately generated?</td><td>Unclear</td></tr>
</table>

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| Bibliographic reference | Vukicevic Meri and Fitzmaurice Kerry. Eccentric viewing training in the home environment: can it improve the performance of activities of daily living? Journal of visual impairment & blindness 103 (5): 277-289. 2009. |
|---|---|
| Was the study apparently free of other problems that could put it at a high risk of bias? | Unclear |
| Were incomplete outcome data adequately addressed? | N/A |
| Are reports of the study free of suggestion of selective outcome reporting? | Unclear |

| Bibliographic reference | Vukicevic Meri and Fitzmaurice Kerry. Rehabilitation strategies used to ameliorate the impact of centre field loss. Visual impairment research 7: 79-84. 2005. |
|---|---|
| Country/ies where the study was carried out | Australia |
| Study type | RCT |
| Aim of the study | To compare the impact of 3 interventions (eccentric viewing, magnification, and combined intervention) upon near print size and the performance of daily living task. |
| Study dates | Published in 2005 |
| Source of funding | Not reported |
| Sample size | 58 |
| Length follow-up | 8 weeks |
| Inclusion criteria | People aged 50 years or older<br>People were legally blind according to Australian Social Security classifications, which equates to a level of visual acuity of 6/60 (20/200) or worse due to AMD. |
| Exclusion criteria | People were secondary ocular pathology or diagnosed with dementia. |
| Patient characteristics | Age, mean (SD) years: 82 years |

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<table>
<tr><th>Bibliographic reference</th><td colspan="5">Vukicevic Meri and Fitzmaurice Kerry. Rehabilitation strategies used to ameliorate the impact of centre field loss. Visual impairment research 7: 79-84. 2005.</td></tr>
<tr><td></td><td colspan="5">Gender, M, %: 33.7% (n=19)</td></tr>
<tr><td>Details</td><td colspan="5">N/A</td></tr>
<tr><td>Intervention</td><td colspan="5">Participants were randomly allocated into one of 4 age-matched groups:<br>Group 1: eccentric viewing received 8 training session in eccentric viewing using the “EccVue” computer programme;<br>Group 2: combination group received 8 training sessions in eccentric viewing using “EccVue” and assessment and instruction in the use of magnification;<br>Group 3: Magnification group received assessment and up to 3 instruction sessions in the use of magnification which telephone contact from the researcher to the equivalent to the 8 eccentric viewing session;<br>Group 4: a non-intervention group that received a weekly phone call for the 8 weeks of the study, each lasting no more than 15 minutes.</td></tr>
<tr><td>Results</td><td colspan="5">
<table>
<tr><td></td><td>Eccentric viewing</td><td>Magnification</td><td>Combination (eccentric viewing + magnification)</td><td>Non-intervention</td></tr>
<tr><td>Number of participants</td><td>22</td><td>12</td><td>12</td><td>12</td></tr>
<tr><td>Near visual acuity</td><td></td><td></td><td></td><td></td></tr>
<tr><td>ADL score, part A</td><td>35.2</td><td>45.3</td><td>45.1</td><td>30</td></tr>
<tr><td>ADL score, part A change from baseline</td><td>5.2</td><td>12.8</td><td>16.6</td><td>0</td></tr>
<tr><td>ADL score, part B</td><td>30</td><td>24</td><td>31</td><td>26</td></tr>
<tr><td>ADL score, part B change from baseline</td><td>6</td><td>1</td><td>5</td><td>-1</td></tr>
</table>
Percentage of people had their goals achieved.</td></tr>
</table>

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| Bibliographic reference | Vukicevic Meri and Fitzmaurice Kerry. Rehabilitation strategies used to ameliorate the impact of centre field loss. Visual impairment research 7: 79-84. 2005. |
|---|---|
| | <table><tr><td></td><td>Eccentric viewing</td><td>Magnification</td><td>Combination (eccentric viewing + magnification)</td><td>Non-intervention</td></tr><tr><td>Number of participants</td><td>22</td><td>12</td><td>12</td><td>12</td></tr><tr><td>% of people reported goals achieved</td><td>74%</td><td>55%</td><td>71%</td><td>0</td></tr></table> |
| Missing data handling/loss to follow up | N/A |
| Was allocation adequately concealed? | Unclear |
| Was knowledge of the allocated intervention adequately prevented during the study? | Unclear |
| Was the allocation sequence adequately generated? | Unclear |
| Was the study apparently free of other problems that could put it at a high risk of bias? | Unclear |
| Were incomplete outcome data adequately addressed? | Unclear |
| Are reports of the study free of suggestion of selective outcome reporting? | Unclear |

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