Disability-Based Nomenclature for Vision and Function

Zhang et al1 recently reported that visual function loss but not visual acuity was associated with depression. In an accompanying editorial, Morse2 further described how the loss of functional vision (ie, actual task-related visual performance) leads to depression. The article and editorial raise important questions about the terminology of vision and function.

To explore understanding of these terms, we informally discussed the abstract with 20 ophthalmologist colleagues. Based solely on the abstract, 6 participants (30%) believed that the study focused on conversion symptoms (ie, a somatoform disorder). According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), “The common feature of somatoform disorders is the presence of physical symptoms that suggest a general medical condition... and are not fully explained by a general medical condition, by the direct effects of a substance, or by another mental disorder.”3 Psychiatrists have replaced the term functional with the more specific DSM-IV-TR classification. Ophthalmologists appear to lack a clear sense of the term functional when describing vision and function.

How should loss of visual function (ie, physical decline in the ocular system), self-reported loss of function due to poor vision, and functional vision loss (ie, perceived vision loss in the absence of organic pathology) be described? The disablement literature provides a unique framework for separating organic and somatoform loss of vision, and their functional sequelae. Verbrugge and Jette posited in 1994 the “disablement process,” a sociomedical model of disability that describes “how chronic and acute conditions affect functioning”4 and how “personal and environmental factors speed or slow disablement.”5 In this model, pathology leads to impairment (ie, actual task-related visual performance) leads to disability (difficulties performing activities of daily life).

Ophthalmologists might best adhere to this model when describing eye disease and its consequences, invoking vision loss, visual impairment, loss of visual function, and visual disability. This schema will improve communication between clinicians and in the medical literature and provide a clearer conception of the impact of vision loss on function. As to our patients who report high levels of disability due to vision loss, perhaps beyond what we might expect based on what we see in their eyes, we should abandon any depreciatory terms, recognize their distress, and direct treatment to the whole person.6

Varicella-Zoster Virus Detection in Varicella-Associated Stromal Keratitis

Stromal keratitis is a well-known development in herpes zoster ophthalmicus but is uncommonly noted following varicella, the primary infection with varicella-zoster virus.7 Keratitis typically occurs several weeks to months following varicella and is often described as disciform in nature. We describe a case of varicella-associated stromal keratitis in which the cornea was positive for varicella-zoster virus by polymerase chain reaction (PCR) testing. We believe that this is the first case of varicella-associated stromal keratitis documented by identification of varicella-zoster virus in the cornea.

Report of a Case | A healthy 9-year-old girl presented with a 3-month history of redness and blurring of the right eye. A history of varicella 3 months prior to the onset of symptoms was elicited. Best-corrected visual acuity was 20/60. There was a central 5-mm circular area of full-thickness nonsuppurative stromal inflammation. The epithelium was intact.

Serologic testing revealed elevated IgM and IgG levels for varicella-zoster virus. Antibodies to herpes simplex virus were negative. Epstein-Barr viral antibodies were consistent with