

CORRESPONDENCE

A survey of understanding and application of UK blind registration criteria

Dear Editor,

The study of changes in blind and low vision registration in Taipei City by Tsai et al (1) used the voluntary blind and low vision registration mechanism to give an indication of shifts in the relative prevalence of causes of visual impairment in their population (1). Their report also included a comprehensive discussion about the problems that exist in interpreting registration data.

We have recently conducted an analysis of our own West Yorkshire (UK) blind registration data and found some additional problems with interpreting our findings, which may be pertinent to many other registration systems.

Tsai et al found that less than 5% (142/3151) of patients registered did not actually meet the criteria for low vision registration. This compared extremely favorably with other studies, such as the UK report cited in their discussion in which 40% of patients were inappropriately registered (2). As part of our own registration data analysis we conducted a survey and written assessment of local ophthalmologists to determine their knowledge of the UK registration criteria for sight impaired (SI) and severely sight impaired (SSI). The assessment included 10 case reports of patients to be classified as either non-registrable SI or SSI.

The UK system defines three groups of patients as eligible for SSI registration based on visual acuity and field defects. Of the 26 ophthalmologists surveyed, 18 were unable to correctly identify any of the three groups and none could give the definition of all three groups. Results for the "sight impaired" definitions were even worse, and the scores for senior ophthalmologists were no better than for their less experienced colleagues.

The ophthalmologists correctly classified the case studies in a mean of 6/10 cases. Although better than the 3/10 expected by random chance, it did not inspire confidence in the quality of the data in the blind register we are analyzing. The ophthalmologists all had a lower threshold for registration, with only one example from the 260 cases marked of a patient being assigned to "non-registrable" when they did in fact meet the criteria for SI registration.

The explanation for the difference between the UK and Taiwan in the capacity of ophthalmologists to correctly apply national registration criteria perhaps lies in their choice of definitions of low vision/SI and blindness/SSI. In Taiwan, the relatively straightforward and widely used WHO defini-

tions are employed, with visual acuity criteria for low vision being $<6/18$ and blindness $<3/60$ in the better eye with best correction (3). By contrast, the UK system, as is the case in other European countries (4, 5), departs from the WHO definitions, adopting instead more detailed but lengthy explanations of exactly which patients are to be classified as SI and SSI

(www.rcophth.ac.uk/standards/cvi).

The reason for national blind registers using non-WHO definitions may be historic or attributable to the link between registration and receipt of financial support or other benefits. Although the motivation for employing such complicated definitions may be a legitimate desire to make the registration criteria reflect the level of visual disability suffered, the price we pay in the UK for our complex definitions for blind registration is the inaccuracy in classification of patients, and the possibility of deterring ophthalmologists from initiating the registration process if they feel uncertain of what category of registration is appropriate.

As Tsai et al state, less than half of those eligible in the population may actually be registered, even after a consultation with an ophthalmologist (1). We have tried to increase coverage locally by empowering the nurses who routinely perform vision testing to put patients forward for registration, but with very limited success. While low coverage remains a major constraint on the usefulness of registration data, before attempts are made to increase this proportion, consideration should perhaps be given to adopting definitions that can be understood and applied accurately by ophthalmologists. The WHO definitions, as used in Taiwan, might be a sensible choice to allow creation of a national registration system that is fit for purpose, allowing estimation of visual impairment and disease prevalences, and monitoring these prevalences within our populations, while also permitting national and international comparisons.

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Author reply

We appreciate and agree with the comments by Buchan and Cassels-Brown. Adoption of the WHO criteria for blindness and low vision across countries would likely make it easier for physicians to recommend registration in governmental registries. An additional benefit would be comparable criteria for comparison of blindness and low vision rates among various countries.

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