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Blacks at Greater Risk for Blindness

To the Editor.—Preventable blindness is and should be a major concern for all opthalmologists. The recent report of the Baltimore (Md) Eye Survey by Tielsch et al[1] in the February 1990 issue of the ARCHIVES should be required reading not only for all ophthalmologists, but for all family-practice physicians and other providers of primary health care because of the compelling public health implications of their findings. The authors report the finding of a prevalence rate of blindness among blacks that is double the rate among whites. In 1979, I reported identical findings based on analysis of model reporting area (MRA) data.[2] In addition, I found that blacks were eight times more likely to be blinded due to glaucoma than whites (Figure and Table).

Comparatively, the MRA data in Table 4[1] show a lower prevalence of blindness among blacks (ie, 1.20% in the age group 65 to 74 years) than the Baltimore Eye Survey (ie, 2.24% in the age group 65 to 74 years). Tielsch et al[1] incorrectly credit the authors of the MRA study with surmising that their findings represented an underestimate. Kahn and Moorehead[3] concluded the opposite and boldly stated, "In our society it can be considered axiomatic that poor blind persons are more likely to be registered with the state agency for the blind than are persons who are rich or perhaps even middle class. Because the nonwhites include a larger proportion of poor than the whites, it follows that, in general, registration of blind nonwhites is more complete than registration of whites." However, in my 1979 report, I correctly predicted that the true prevalence rates were higher than those reported in the MRA with the following statement: "It must be recognized that register reporting is incomplete and probably that true incidence and true prevalence are underestimated."

Tielsch et al[1] report finding a large number of patients (54%) who could improve their vision with eyeglasses but did not have the eyeglasses. They state "the reasons why such a large volume of undercorrected refractive error remains in the population despite the ready availability of optometric and ophthalmic services are not clear and will be explored in subsequent publications." In my opinion the reasons are very clear, albeit painful, and relate to medical poverty, ie, the lack of affordable tertiary eye care services in the ghetto. The marriage of medical poverty to economic poverty and educational poverty has historically been rampant in urban areas such as those cited.

Reality teaches that there is no ready accessibility of optometric and ophthalmology care in our urban ghettos. However, the unanimous finding of the double prevalence rate of blindness among blacks compared with whites by the MRA report, the Bath report, and the Baltimore Eye Survey represents an impressive acknowledgment of fact by diverse sources over the span of three decades. Consequently, the next step lies in the analysis of the causes of blindness along with a careful study of demographics combined with sensitive needs assessment and action. I believe that greater emphasis on vision screening, health education, and community planning will be critical. Although ophthalmology in America exists as a tertiary health-care luxury, to address the excessive rates of blindness it will be necessary for primary eye care to trickle down the nefarious infrastructure of our urban island ghettos submerged amidst our oceans of plenty.

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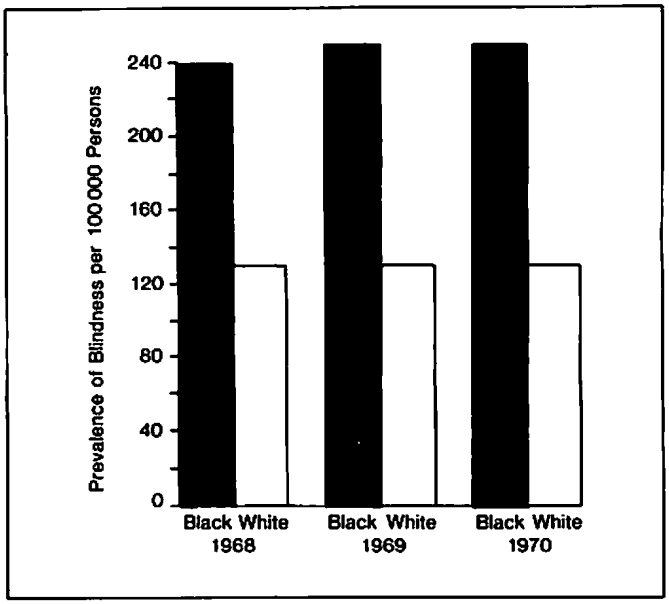
1. Tielsch JM, Sommer A, Witt K, Katz J, Royall RM, the Baltimore Eye Survey Research Group. Blindness and visual impairment in an American urban population: the Baltimore Eye Survey. *Arch Ophthalmol.* 1990; 108:286-290.
2. Bath PE. Rationale for a program in community ophthalmology. *J Natl Med Assoc.* 1979;71:145-148.
3. Kahn HA, Moorehead HB. *Statistics on Blindness in the Model Reporting Area, 1969-1970.* Rockville, MD: National Institutes of Health; 1971. US Department of Health, Education, and Welfare publication NIH 73-427.



Prevalence of blindness according to race, 1968-1970.

Age-Standardized Incidence of Blindness by Cause and Race*

	Rates per 100 000	
	Black	White
Glaucoma	6.5	0.8
Cataract	4.1	1.8
Retinal disease	5.3	4.1
Retrolental fibroplasia	0.1	0.1
Myopia	0.6	0.1
Cornea or sclera	1.2	0.2
Uveitis	1.0	0.3
Optic nerve disease	2.0	0.8
Multiple affections	2.8	1.2
Other	2.2	1.0
Unknown	2.9	1.6

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In Reply.—We appreciate Dr Bath's impassioned plea for action regarding the unmet eye care needs of those members of our population living in poor, inner-city neighborhoods. She cites the lack of affordable tertiary eye care services as the obvious reason a large volume of undercorrected refractive error remains in the east Baltimore population. There is a clear difference between the availability and the accessibility of tertiary ophthalmologic services and more basic services such as those required for prescribing and fitting spectacles. The reasons these services are underutilized in particular segments of the population are not clear and may be different for these two types of eye care services. We feel it is important to attempt to identify the specific barriers to appropriate utilization, be they financial, social, educational, or motivational, in order to develop intervention strategies that will have the greatest potential to address these critical problems.

Dr Bath's comments, however, serve as an excellent reminder that the public health and medical professions must be proactive in supporting stronger programs that encourage appropriate utilization of both preventive and curative health services.

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