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Just when you thought it was safe to go back in the water

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Abstract

Letter from the Editor

Keywords

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Letter from the Editor



Paul B. Freeman, OD
Editor-in-Chief

“Just when you thought it was safe to go back in the water”

We are not yet out of the COVID pandemic, so I find myself beginning this editorial with the pledge from my April 2021 editorial: “Until we have conquered this pathogen, I will continue to recognize and thank, in each issue of our journal, the frontline professionals and those workers who keep our lives moving forward while putting themselves in harm’s way. My hope is that each time I begin with this, it will be the last time.”¹ Unfortunately, there really doesn’t seem to be an end in sight to the challenges we are going to face with respect to pandemic-related eye and health issues, which are exacerbated by COVID fatigue (masking, social distancing, psychological challenges, and all of the other limits on our lives), SARS variants, seasonal COVID changes (like the flu), and now a new, potentially emerging crisis: monkeypox virus. By the time this editorial is being read, I am concerned that we could be in the midst of far more healthcare confusion than we currently are in, regardless, I might add, of political persuasion. And, in addition to the ophthalmic conditions caused by SARS-CoV2, we now must contend with the ocular conditions that this newly circulating virus, “a member of the Orthopoxvirus genus in the family Poxviridae,”² will cause. So how do we prepare for *this* new potential pandemic?

Fortunately(?), we have been well schooled in hygiene and protection from respiratory droplets by using personal protective equipment (PPE) and plastic shields, which we have become accustomed to since the onset of COVID-19. Because one of the ways that monkeypox can be transmitted from person to person is by respiratory droplets transmitted with prolonged face-to-face contact (think slit lamp examination), or close contact with lesions, we may not be quite ready to let

down our protective shields or casually dismiss the use of gloves. Perhaps like our dental colleagues, eyecare providers should use masks for assessments or procedures that require close or prolonged face- to- face time. Like all viruses, this virus can lead to complaints of red, itching, or burning eyes, discharge, light sensitivity, pain or discomfort, and/or blurred vision, which can result from conjunctivitis, blepharitis, eye lid swelling, keratitis, corneal ulceration, and scarring. Importantly, patients need to know that because they have these signs or symptoms, that does not necessarily mean that they have monkeypox. With online and social media information prevalent but not always accurate or complete, our patients will rely on us for the best scientific information. Someone with monkeypox will get a rash (the biggest “red flag”), but will also show symptoms of fever, chills, swollen lymph nodes, exhaustion, muscle aches and backache, headache, and respiratory symptoms such as sore throat, nasal congestion, or coughing.³ And while we are still suffering from what I am calling posttraumatic virus disorder (PTVD), optometrists need to know that unlike the SARS-CoV2, the monkeypox virus is self-limiting and tends to last 2 to 4 weeks, during which time, because no specific treatment has been recommended, ophthalmic conditions should be treated as one would treat any virus, with instructions to the patient regarding hand washing and to avoid sharing anything that could transmit the virus to another.

It seems that the bulk of the global population is at a low risk for monkeypox infection but, as we have also heard on more than one occasion, “it ain’t rare if it’s in your chair.” I suspect that some who are reading this editorial have already had an opportunity to interact with someone with this virus or who was concerned that their symptoms suggested they have the virus. I had this experience with a patient who was concerned about a rash she had developed but had none of the other symptoms. Both her husband and I talked her through the possible ways one could get monkeypox, and we collectively decided that her rash was undoubtedly not due to monkeypox. However, after seeing me, she also saw her primary care doctor who assured her that she did not have this condition, a relief quite frankly, for me as well. Finally, despite the fact that mortality is low with this disease, monkeypox can be itchy or painful due to the rash.³

We are all familiar with treatments for both COVID-19, and now monkeypox. For COVID-19, early on there were no definitive treatments, but we were all aware of the importance for some needing respiratory care and hospitalization. Fortunately, now there are 4 treatments for COVID-19 (specifically IV monoclonal antibody bebtelovimab, and antivirals remdesivir, Paxlovid™, and molnupiravir⁴) and there are vaccines which are designed to minimize the impact of COVID-19, just as flu vaccines are designed to minimize the severe effects of influenza. For monkeypox,

there is one specific vaccine (JYNNEOS®), and a vaccine developed for smallpox (ACAM2000™) being used to prevent monkeypox infections.⁵ However, we continue to have challenges with patients who have had multiple bouts of COVID and we are now seeing patients who are suffering from long COVID.

In my low vision practice, the two biggest long-term effects of COVID that I have seen are fatigue and brain fog, both of which can impact low vision patients, possibly more so than someone with “normal” visual acuity. My concern for these patients, especially given the advanced age of most, is whether the latter effect can exacerbate the impact of decreased vision on cognition. A recent systematic review and meta-analysis reported on the relationship between vision and cognition and found “evidence for a direct link between visual impairment and cognitive impairment, with visual impairment being associated with an approximately two-fold increased odds of prevalent or incident cognitive impairment.”⁶ This is undoubtedly due to visual impairments often limiting social and mentally stimulating activities, and that was before considering the issue of brain fog from COVID; now, add brain fog, which can be described as “difficulty thinking or concentrating.”⁷ Please note that I’m not suggesting low vision rehabilitation is the answer to brain fog, but actively stimulating cognition by using low vision rehabilitative management techniques may mitigate the impact of brain fog when combined with the impact of vision loss on cognition. Helping these patients engage with mentally stimulating activities (especially as one gets older) like reading books, playing games, computer use, and getting involved in social activities can minimize mild cognitive impairment, a potential precursor to more severe cognitive difficulties,⁸ and can be accomplished with low vision rehabilitation management.

So where do we go from here? I am reminded of the recent increase in shark attacks in the United States, some only a few hours apart, as was the case in South Carolina this August. Swimmers were reminded not to swim at dawn or dusk, not to swim where there are schools of small fish, or where people are fishing. Despite that, one of the shark attacks happened when the victim was only waist deep in water, and not in any of the situations that were warned against.⁹ Warnings and consequences sound familiar? So, as swimmers are reminded when it’s safe to go back into the water, they must still be vigilant and aware of the consequences of their actions even under ideal conditions. As the COVID restrictions placed on us are loosened and we feel it is safe to go back into the “viral” water, we must also be aware of consequences, even under ideal conditions. As optometrists, we are part of the public health care team, and we each should decide how much precaution we are going to take individually, in our practices, and when counseling our patients, because just when we think it is safe to go back into the water...

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