Visual System Assessment in Infants, Children, and Young Adults by Pediatricians

COMMITTEE ON PRACTICE AND AMBULATORY MEDICINE, SECTION ON OPHTHALMOLOGY, AMERICAN ASSOCIATION OF CERTIFIED ORTHOPTISTS, AMERICAN ASSOCIATION FOR PEDIATRIC OPHTHALMOLOGY AND STRABISMUS, AMERICAN ACADEMY OF OPHTHALMOLOGY

Appropriate visual assessments help identify children who may benefit from early interventions to correct or improve vision. Examination of the eyes and visual system should begin in the nursery and continue throughout both childhood and adolescence during routine well-child visits in the medical home. Newborn infants should be examined using inspection and red reflex testing to detect structural ocular abnormalities, such as cataract, corneal opacity, and ptosis. Instrument-based screening, if available, should be first attempted between 12 months and 3 years of age and at annual well-child visits until acuity can be tested directly. Direct testing of visual acuity can often begin by 4 years of age, using age-appropriate symbols (optotypes). Children found to have an ocular abnormality or who fail a vision assessment should be referred to a pediatric ophthalmologist or an eye care specialist appropriately trained to treat pediatric patients.

INTRODUCTION


Eye examinations and vision assessments are critical for the detection of conditions that often result in visual impairment, signify serious systemic disease, lead to problems with school performance, and, in some cases, threaten the child’s life. Through careful evaluation of the visual system, retinal abnormalities, cataracts, glaucoma, retinoblastoma, strabismus, and
neurologic disorders, including amblyopia, can be identified. Ocular problems can also be the first indicator of general health concerns. Timely treatment of these conditions is critical, as is the education of parents with respect to the importance of timely follow-up and documentation in the medical record that the education occurred. Regular vision screening assessments in early childhood reduce the risk of persistent amblyopia at 7 years of age by more than 50%. However, vision screening cannot be expected to detect all causes of amblyopia.

**TIMING OF EXAMINATIONS AND SCREENING**

Preterm infants should initially be evaluated under the guidance of the American Academy of Pediatrics policy statement “Retinopathy of Prematurity Screening” and referred for a specialized eye examination by an ophthalmologist experienced in evaluating and treating infants, if required. Similar referral to a specialist should be made for newborn infants with family histories of congenital cataracts, retinoblastoma, or metabolic disease or in whom systemic disease associated with serious ocular abnormalities is suspected. Because family history is an important risk factor for amblyopia and strabismus, pediatric clinicians should consider referring children who have first-degree relatives with these conditions; referral should take place promptly if symptoms or signs are present and, if not, once a child is of sufficient age to cooperate for examinations. Otherwise healthy children should be screened in the primary care setting at the intervals provided in Table 1. Because ocular problems can be the initial manifestation of neurologic or systemic disease, pediatricians should be aware of subtle but important findings that can be detected through screening or careful examination of

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Newborn to 6 mo</th>
<th>6–12 mo</th>
<th>1–3 y</th>
<th>4–5 y</th>
<th>6 y and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ocular history</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>External inspection of lids and eyes</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Red reflex testing</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Pupil examination</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Ocular motility assessment</td>
<td>—</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Instrument-based screening</td>
<td>—</td>
<td>b</td>
<td>x</td>
<td>x</td>
<td>c</td>
</tr>
<tr>
<td>Visual acuity fixate and follow response</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Visual acuity age-appropriate optotype assessment</td>
<td>—</td>
<td>—</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>


The American Academy of Ophthalmology (AAO) has recommended instrument-based screening at age 6 mo. However, the rate of false-positive results is high for this age group, and the likelihood of ophthalmic intervention is low. A future AAO policy statement will likely reconcile what appears to be a discrepancy.

Instrument-based screening at any age is suggested if unable to test visual acuity monocularly with age-appropriate optotypes.


Visual acuity screening may be attempted in cooperative 5-y-old children.

Development of fixating and following a target should occur by 6 months of age; children who do not meet this milestone should be referred.

**PROCEDURES FOR EYE EVALUATION**

Detailed explanations for obtaining the visual system history and examining the afferent and efferent visual system in infants and children are provided in the accompanying...
clinical report on visual assessment in the infant and children.  

**SUMMARY**

Evaluation of the visual system should begin in infancy and continue at regular intervals throughout childhood and adolescence. Serial visual system screenings in the medical home, using validated techniques, provide an effective mechanism for the detection and subsequent referral of potentially treatable visual system disorders.

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**REFERENCES**


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