



*an eu curriculum for
visual disabilityEs
RehabilitatOrs*



Clinical cases analysis based on a biopsychosocial approach

Pr. BAILLIF S., Dr. DAVID R., DI MEO M.

VERSIONING DETAILS

Version of the document	Version 2
Date of delivery	June 29 th 2023



Co-funded by the
Erasmus+ Programme
of the European Union

The European Commission's support for the production of this publication does not constitute an endorsement of the contents, which reflect the views only of the authors, and the Commission cannot be held responsible for any use which may be made of the information contained therein

Table of Contents

1	Introduction.....	3
2	Clinical case #1	4
3	Clinical case #2	6
4	References	8

1 Introduction

2 Clinical case #1

Ms. N, 24 y.o, is attending an ophthalmology consultation due to experiencing a partial loss of vision in both eyes accompanied by a mild pain sensation at the back of her eyes.

During the examination (visual acuity, slit lamp, fundus oculi), the physician suspected partial bilateral scotoma and confirmed it with a visual field.

When asking for additional clinical aspects, the following are noticed:

- Sensitive deficit in the legs along with pain
- Walking abnormalities
- Headache

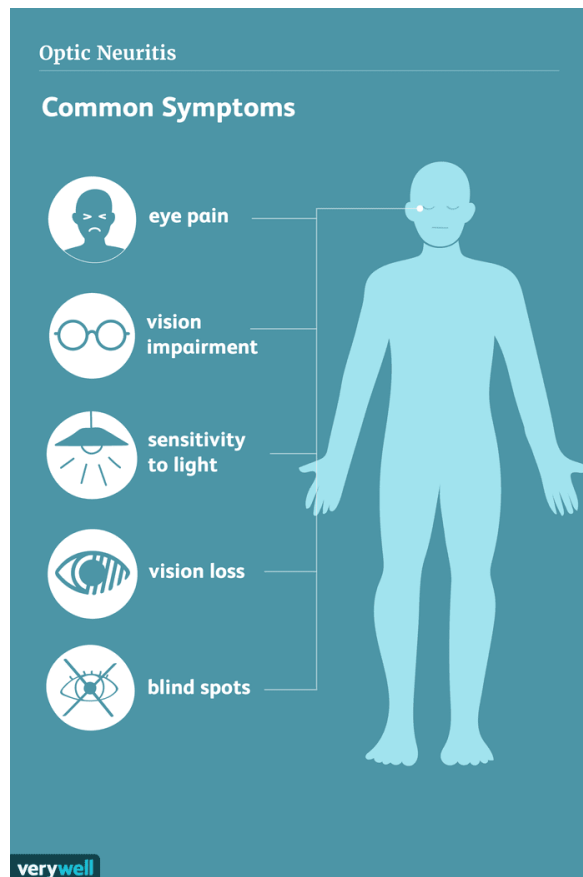


Figure 2.1 <Figure title>

Considering the patient's young age and clinical symptoms, the physician has requested additional tests, including brain and spine MRI.

The MRI reveals the presence of multiple T2 hyperintensities.

Based on the findings there is a suspected diagnosis of multiple sclerosis with associated Bilateral Retrobulbar optic Neuritis.

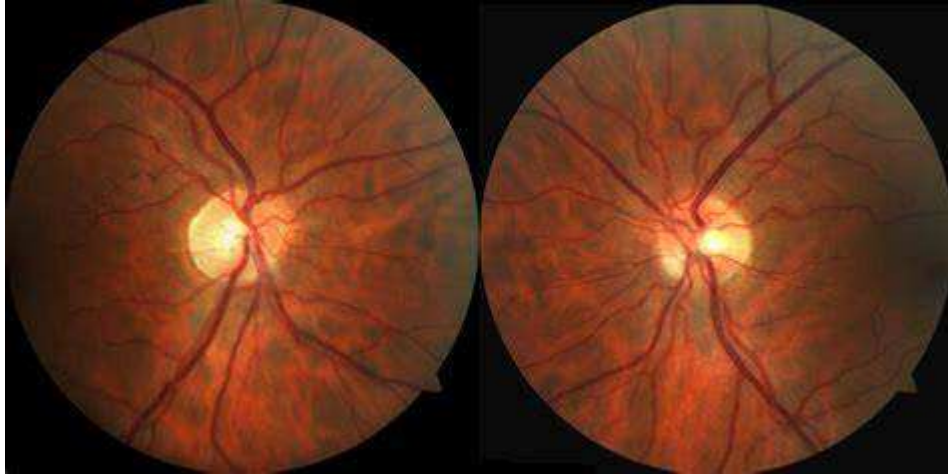


Figure 2.2 <Figure title>

Ms. N is terribly frightened by the diagnosis and her mood is starting to change rapidly with:

- Sleep disturbances
- Episodes of anxiety
- Sadness

The ophthalmologist is referring her to a psychiatrist.

During the consultation with the psychiatrist, several psychological symptoms are present.

Q#1: Which psychiatric diagnosis are you suspecting?

Q#2: How could you better assess the observed psychiatric symptoms?

Q#3: Which psychiatric risks do you need to evaluate as a priority?

Q#4: As a VDR, how would you communicate on the global management of the RON from a biopsychosocial point of view?

3 Clinical case #2

Mr. C. aged 80 y.o

With history of glaucoma with partial 1/10 and 1/20 vision loss.

He has been referred to the family ophthalmologist by his children due to his description of unusual hallucinations, such as perceiving multiple coloured children and dragons in his garden. These hallucinations occur numerous times per month, despite his full awareness that it is impossible for children to be present in his garden.

The patient's low vision and glaucoma-related signs were still evident. No new abnormalities were observed, and as a result, no specific recommendations or prescriptions were proposed.

Mr. C is going back home but the aforementioned symptoms continue.

Mr. C, although initially amused by the hallucinations, is now experiencing increasing distress due to this situation. Consequently, he is seeking assistance to alleviate or eliminate these hallucinations.

Together with his children, he visited the GP who ultimately recommended seeing a psychiatrist.

During the psychiatrist consultation, the diagnosis of Charles Bonnet Syndrome is confirmed and information on this syndrome are given.

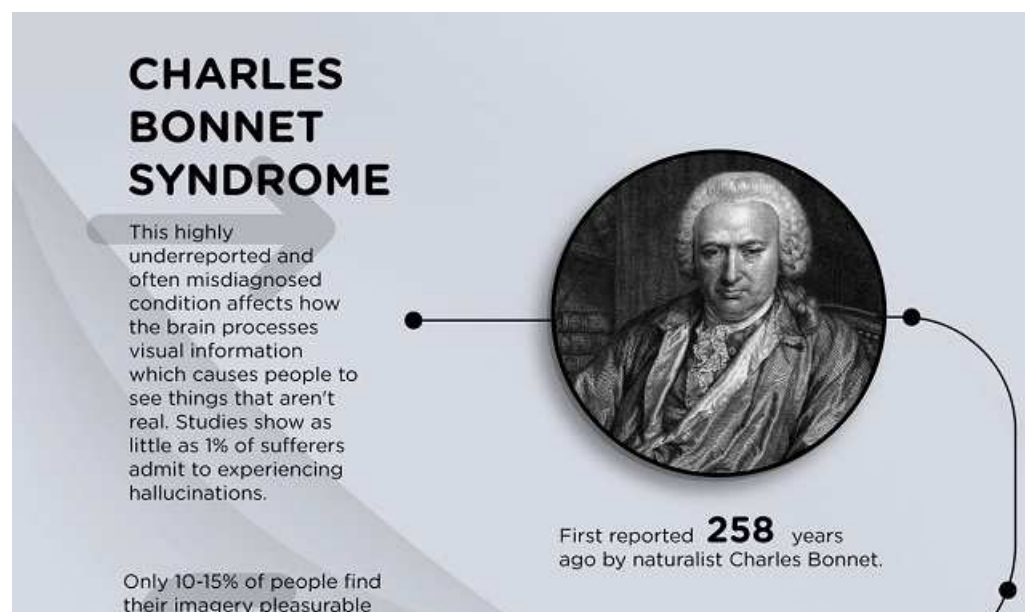


Figure 3.1 <Figure title>

Q#1: how could you confirm that the described hallucinations are not related to a psychiatric disorder like schizophrenia?

Q#2: As a VDR, how would you communicate about the comprehensive management of Charles Bonnet syndrome from a biopsychosocial perspective?

Q#3: What psychiatric progression should you be vigilant about?

4 References

Reference 1

Reference 2

Reference 3