

Commentary: Part time occlusion for amblyopia: The unsung hero!

We appreciate the authors for their study "Efficacy of part time occlusion in amblyopia in Indian children."^[1]

We all know amblyopia is one of the causes of visual impairment in children. There have been various treatment options for amblyopia and occlusion therapy is one of the most commonly practised choice of treatment for any type of amblyopia. The PEDIG group has done an extensive research in this field and has laid the guidelines for amblyopia therapy which is currently being followed world over.^[2-4] The study on efficacy of part time occlusion in amblyopia in Indian population is therefore pertinent as the studies done by PEDIG recruited only the western population. Though many pediatric ophthalmologists across India are practising part time occlusion therapy, there have been very few studies published. One such study was published by Singh *et al.*^[5] in the year 2008 which had assessed the efficacy of part time occlusion for amblyopia in the Indian population and that too in the older children. Hence, in present-day pediatric ophthalmology practice in India this study is very relevant.

Part time occlusion or full time occlusion has been a long drawn debate. Numerous studies have been done to assess the effectiveness of these regimens of occlusion therapy in different age groups. The PEDIG undertook two concurrent randomized control trials of patching to address this matter and they prescribed 2 h/day versus 6 h/day for moderate amblyopia and 6 h/day versus full time for severe amblyopia in 3–6 year olds and found no obvious benefit in longer hours of patching.^[6] A meta-analysis which compared the two concluded that both are equally effective and a minimum of 6 h of occlusion provides the maximum vision improvement.^[7] The current study also shows that those who were started on full time occlusion therapy following failure of partial occlusion therapy did not show any improvement in vision.^[1]

Despite the innumerable studies proving that part time occlusion is as effective or even better than full time occlusion therapy in mild to moderate amblyopia, many paediatric ophthalmologists continue to advocate full time occlusion therapy. Furthermore, considering the adverse effects of full time occlusion such as development of amblyopia in the patched eye and school going children being victimised by the peers, it's desirable to do part time occlusion depending upon the severity of amblyopia. We have been advising part time occlusion therapy for our patients with reasonably good results.

This study is one such study which emphasises the fact that part time occlusion is a dependable treatment choice for amblyopia as against full time occlusion. It is also one of the few to study the efficacy of occlusion therapy in the Indian population and also dismisses the belief that Indian children are not complaint with occlusion therapy.

To conclude, we can advocate part time occlusion therapy as a primary treatment modality over full time occlusion for mild to moderate amblyopia.

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