COLLEGE OF SYNTONIC OPTOMETRY

Journal

FEBRUARY, 1988

PRESIDENT'S LETTER

Dear Colleagues;

The 1987 Conference on Light and Vision was truly a great success. Sixty registered doctors made it the largest Syntonic Conference to date. Fifty percent of those registered were first time attendees. Surely this makes the statement "Our time has come".

The educational portion of the conference offered many new ideas and added many new pieces to the "puzzle". Our scientific base keeps growing, thereby explaining many of the miracles all of us have experienced.

The Awards Banquet was as beautiful as it was heartwarming. Special acknowledgements for continued dedicated service to the College of Syntonic Optometry were presented to Dr. Charles Butts, Dr. Lowell Becraft, Dr. J. O. Jenkins, Dr. Ray Gottlieb, Dr. Larry Wallace, Dr. John Downing, Dr. David Luke, Dr. George Haffner and Dr. Sanford Cohen.

At the completion of the meeting I travelled directly to New York to present lectures at the Eastern States Congress. My presentation on Syntonics was enthusiastically received by all 186 registrants, and stimulated at least one Syntonics course to be presented later this year at Dr. Glen Swartwout's office. Amsterdam, Holland awaits me in June and from there I will travel directly to Munich, Germany. Soon Syntonics will be internationally recognized.

Our hearts go out to Dr. Lowell Becraft who recently lost his son. Lowell, please accept our deepest sympathy. Collectively we feel your great loss and we send you our energy and love to help you through this period.

The 1988 Annual Conference is already being arranged. Colorado, here we come!

I am grateful for all your support.

Jack Liberman O.D., Ph.D.

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IN THIS ISSUE

The guest lecture at the 1987 Washington C.S.O. Conference featured the subject of

"Anti-Depressant Effects of Visual Lights"

delivered by Norman Rosenthal, M.D.

Dr. Rosenthal is a psychiatrist with the National Institute of Mental Health, and director of its "seasonality program". With his pioneering studies which have since been replicated by others throughout the world, he has guided S.A.D. (Seasonal Affective Disorder) and its treatment (Phototherapy) "from the lunatic fringe to the mainstream".

Dr. Rosenthal in his opening statements endeared himself to his audience when he said that pioneers in the health field are motivated by an "intuitive feeling that they are doing 'something' that makes a 'difference'". The challenge lies in engineering a transition from the anecdotal to the scientific level, and Dr. Rosenthal proceeded to share, in summary, the years of research which culminated in acceptance of and excitement about light's still-mysterious influence on the human condition. He had come, he said, to encourage the C.S.O. in research and to offer advice on procedure, drawn from his experience.

Many disparate clues, which ran the gamut from the behaviour of hamsters in summer to the diary of a patient recording feelings over the years, contributed to the "discovery" of S.A.D. (Seasonal Affective Disorder).

A newspaper advertisement sponsored by the N.I.M.H. asking for volunteers suffering major seasonal depression recruited a population, and the project was launched. If a volunteer qualified by identifying recurrence over at least two years, the symptoms and related information was recorded, and syndromes were subsequently defined and documented.

Using the illustration of the discovery that the depression most often peaks in January when days are short, Dr. Rosenthal warned against considering a correlation to be causal. "One must postulate the cause and design an experiment to intervene".

Such an experiment must be in the form of a controlled study in which the patients are not aware of whether they are part of the experimental or the control group. The control treatment must be plausible but ineffective.

The parameters drawn up for S.A.D. experiments included intensity (of light), timing, duration (of exposure), spectrum, and presentation (to the skin or the eyes). Seven different controlled studies were done which replicated results, bringing the phenomenon "into the realm of reality". In addition, opponents of the hypothesis also replicated (thus validated) the results.

A number of theories about the beneficial effect of light were suggested, and some questions still remain unanswered. However, after two years the experimenters were able to conclude that it is not a placebo effect. The experiments also proved that the visual pathway provides the photochemical activity rather than the skin. An unexpected conclusion which resulted was that the light treatment normalized immune functions, a fact that had never before been documented. Photon emissions were matched for red, blue, and white light, and results showed white light to generate the maximum effect.

Dr. Rosenthal concluded his presentation with the triumphant announcement that the condition (S.A.D.) and "Phototherapy" will appear in the next edition of medicine's Manual of Conditions.

* * * *

Editor's note:
A 1986 report in the Los Angeles Times related the experience of Dr. Daniel Kripke of the Veteran's Administration Medical Center in La Jolla, "a light therapy pioneer" who suggests that any white light (rather than full spectrum) is effective. His treatment affected several patients adversely when mania was induced, and two patients had to be restrained. Members will recall the syntonic study by Dr. Kaplan in which young control patients were exposed to the unfiltered 'white' light source of the syntonic instrument. The patients became restless and irritable, some experienced nightmares, and a number were withdrawn from the study by their parents because of ill effects.

C.O.S. '88 CONVENTION
— COLORADO —

Chairman Rebecca Hutchins has announced that the site for the convention is Aspen Lodge. This rustic ranch high in the mountains (10,000') is near Estes Park and the Continental Divide. Dr. Hutchins is sure we will be entranced by the beauty of the Lodge and its alpine setting.

Dr. Liberman has announced that the Guest Speaker will be Russel J. Reiter, Ph.D., who is considered a leading authority on the Pineal Gland. Professor Reiter teaches in the Department of Cellular and Structural Biology at the Health and Science Center of the University of Texas in San Antonio. Dr. Reiter will present two lectures: "Light Reception and Transduction" and "Light as a Drug".

Mark your calendar for the May 20 week-end, 1988. Aspen Lodge: Colorado 6120; 303.440.3371 (Hwy. 7 near Estes Park Colo.).

THE HIPPUS TEST

by Raymond Gottlieb O.D. Ph.D.

Syntonic theory teaches that autonomic imbalance causes vision and other health problems and that these can be remedied by light therapy. Scientific studies support H. Riley Spitler's view that blue stimulates parasympathetic and red stimulates sympathetic function. We evaluate autonomic function in order to determine the syntonic prescription.

The Syntonic Principle describes several ways to judge sympathetic/parasympathetic balance. These include body morphology, basal metabolism, symptom syndromes (such as chronic dryness of the mouth and constipation characteristics), and visual measures such as eso/exophoria. Dr. Spitler even built an elaborate galvanic skin resistance device which syntonists once used to investigate sympathetic/parasympathetic balance.

The pupil can also help us determine autonomic function because the iris is governed by both sympathetic and parasympathetic input. Alpha-omega pupils, for example, are regarded as a sign of parasympathetic weakness. However, alpha-omega pupil testing provides qualitative but not quantitative information. We cannot easily compare small changes nor can we adequately communicate the finding to other practitioners. These limitations have deterred acceptance of this phenomenon by more orthodox colleagues.

A new pupil test provides an objective probe of parasympathetic function. The "hippus test" records pupil oscillation speed. Perhaps the hippus test will become standard Syntonic procedure in diagnostic and post treatment evaluation.

Hippus is an exaggerated fluctuation of the pupil which occurs when a narrow beam of light is focused at the inner edge of the iris. The pupil opens slightly, due to natural fluctuation, allowing the beam to enter the eye. The light causes the pupil to constrict. Now the iris blocks the light and the retina becomes dark. When the pupil opens in reaction, the light passes through again, and the pupil closes. Dark follows bright follows dark ... In a cycle of cause and effect, the pupil oscillates until the light is extinguished.

As I reported at the 1987 Syntonic course in Washington, D.C., a recent experiment found hippus speed to correlate with parasympathetic function.*

The study compared hippus in diabetic patients whose parasympathetic weakness was evaluated on five different cardiovascular reflex tests. Hippus speed decreased as the number of failed cardiovascular reflex tests increased. Some diabetics cycled five to ten times more slowly than normals; others had no hippus response at all. Interestingly, all the diabetics had normal reflexes when measured by standard direct and consensual pupil tests, even the patients who demonstrated no hippus.

Hippus for 50 normal adults ranged from .750 to 1.3 seconds per cycle. The mean was .94 seconds. In normals, parasympathetic blockers slowed hippus but sympathetic drugs did not alter the rhythm.

The hippus test is very reliable. Cycle time did not correlate with age, width of the slit, time of day, or duration of dark adaptation, and the cycle time did not change with prolonged measurement. In addition, oscillation speed was independent of the brightness of the stimulating light over a wide range of intensities. When the test was repeated on the same subjects after several weeks, there was a very high level of repeatability.

To do the test, the patient is asked to look at the light source of a slit-lamp. A narrow, half-millimeter wide, horizontally-oriented slit is focused on the iris just below the pupil. The beam is slowly elevated until it impinges on the lower edge of the pupil. The time for 30 cycles (one cycle lasts from one constriction to the next) is measured with a stopwatch. The pupillary cycle time is then calculated by dividing the time (in seconds) by 30. Each eye is measured.

I propose the following:

1. *Send a postcard indicating your participation in this study to* ***Ray Gottlieb, Box 42211, Los Angeles, CA 90042.***
2. *Record the pupil cycle time (PCT), age, gender, alpha-omega pupil,** Rx, and phoria*** (far and near) for 25 or more* ***non-syntonic*** *patients.*
   Do this in the following form:

   Age: ____ yrs. Gender: M F
   PCT: R____ sec. L ____ sec. A/0 Pupil: Y N
   Rx: R _____ D. L _____ D.
   Phoria: F _____ eso exo N _____ eso exo

3. *Record these same findings for 10 or more* ***Syntonic*** *patients, along with visual field size,**** Syntonic prescription and results of these same tests after completion of therapy.*
   Do this in the following form:
   Initial findings:

   Age: ____ yrs. Gender: M F
   PCT: R ____ sec. L ____ sec. A/O Pupil: Y N
   Rx: R _____ D. L _____ D.
   Phoria: F _____ eso exo N _____ eso exo.
   Field: R _____ mm, L _____ mm
   Syntonic Rx: _____
   Symptoms:

   Post Treatment findings:
   PCT: R _____ sec. L _____ sec.
   A/O pupil: Y N
   Phoria: F _____ eso exo, N _____ eso exo.
   Field: R _____ mm, L _____ mm
   Symptoms:

4. *Send the data to me, Ray Gottlieb, Box 42211, Los Angeles, CA 90042. The results will appear in a subsequent* ***CSO Journal.***
   If only ten of you send data we will have 100 syntonic and 250 optometric patients!

Working together we can find diagnostic ranges, evaluate prescriptive meaning, and measure therapeutic outcomes.

* *Pupil Cycle Time: A Simple Way of Measuring an Autonomic Reflex, Martyn CN & Ewing JD:* ***Journal of Neurology, Neurosurgery and Psychiatry,*** *1986;49:771-774.*

** *For this study, 'alpha omega pupil' means a pupil which, in the presence of high illumination, fails to hold its constriction for more than 10 seconds.*

*** *For this study, 'phoria' means the phoria measured by prism dissociation at near (16 inches) and far.*

**** *For this study, 'visual field size' means total horizontal diameter (nasal to temporal limits) using a 1 mm white target approaching the point of fixation. (Campimetry).*

CRITICAL FLICKER FUSION and VISUAL FIELDS

by Larry Wallace, O.D.

With the recent invention of the Photron Neurovisual Stimulator, critical flicker fusion(C.F.F.) can now be routinely measured. Two examples are presented which demonstrate possible correlations between C.F.F. and visual fields, and the possible diagnostic value of C.F.F. measurements.

Example I:

Judy, age 30, reported a long history of visual complaints including diplopia and blur at near and far. She experienced fatigue and depression. Bifocals worn for four years had given little relief. Visual Analysis showed severely reduced accommodation and vergence ranges. Pupil response showed a strong 'alpha-omega' effect.

C.F.F. was measured three times (and averaged) for each eye on the A (aperture) setting using Red-Orange and the measuring procedure was then repeated, using Indigo. See Table 1

Visual Fields were measured with half degree targets in a stereo campimeter. Horizontal field measurements are noted in Table 1.

The low C.F.F. measurements for Red-Orange relative to Indigo were used as a possible indication of a deficiency in red-orange assimilation by the visual system.

Seven treatments of Red (alpha delta) and Yellow-Green (mu delta) were given. (Treatment time was twenty minutes, ten minutes for each colour.) Post treatment C.F.F. and field measurements are noted in Table 2.

Example II:

Mary, age 54, reported a chief complaint of pain in the left eye which was exacerbated by daily (close) work at a video display terminal. Case History was unremarkable. Visual Analysis revealed a hyperdeviation of the left eye, exoposture, poor convergence skills and a mild 'alpha-omega' pupil.

C.C.F. and field s were measured as in Example I, and are represented in Table 3.

A reduced C.F.F. measurement for Indigo was used as a possible indication of need for more efficient assimilation in that frequency range.

Seven treatments of Indigo (mu upsilon) (twenty minutes each) were given. Post treatment C.F.F. and field measurements are noted in Table 4.

TABLE 1

	CFF R/O	CFF I	HORIZ. FORM° FIELD	GR/BL FIELD°	RED FIELD°	BLIND SPOT
OD	20.2	26.8	20°	5°	10°	NOT MEASURABLE
OS	24.15	31.4	20°	5°	10°	NOT MEASURABLE

TABLE 2

POST 7 TREATMENTS

OD	24.0	32.0	50°	12°-15°	20°	ENLARGED 20%
OS	29.5	35.0	40°	12°-15°	20°	ENLARGED 25%

TABLE 3

	CFF R/O	CFF I	HORIZ. FORM° FIELD	GR/BL FIELD°	RED FIELD°	BLIND SPOT
OD	35.9	19.9	70°	12°	17°	ENLARGED 20%
OS	29.9	20.4	70°	18°	20°	ENLARGED 20%

TABLE 4

POST 7 TREATMENTS

OD	31.7	24.2	70°	20°	30°	WITHIN NORMAL LIMITS
OS	32.7	24.8	70°	20°	35°	WITHIN NORMAL LIMITS

As the C.F.F. values rose there were significant increases of form and colour fields noted in both cases. In addition, both patients reported significant lessening of symptoms and the analytical findings were more within normal limits. The changes (in percentages) in each case are noted in Table 5 and Table 6.

In both examples the C.F.F. increased more for the colour which was originally found to have lower C.F.F. value. That is, for Judy the treatment exposure to the colours in the red range appeared to increase the C.F.F. for Red-Orange more than for Indigo. For Mary, the percentage increase in C.F.F. for Indigo was greater than that for Red-Orange.

It can be noted in both cases (Tables 5 and 6) that the C.F.F. for the Red-Orange and Indigo remain different i.e., Red-Orange C.F.F. remains lower for Judy, Indigo C.F.F. remains lower for Mary. This might be an indication that further therapy is needed. In both cases the writer drew this conclusion and continued treatment.

TABLE 5

	CFF R/O	CFF I	HORIZ. FORM° FIELD	GR/BL FIELD	RED FIELD
OD	18% ↑	19% ↑	150% ↑	160% ↑	100% ↑
OS	22% ↑	11% ↑	100% ↑	160% ↑	100% ↑

TABLE 6

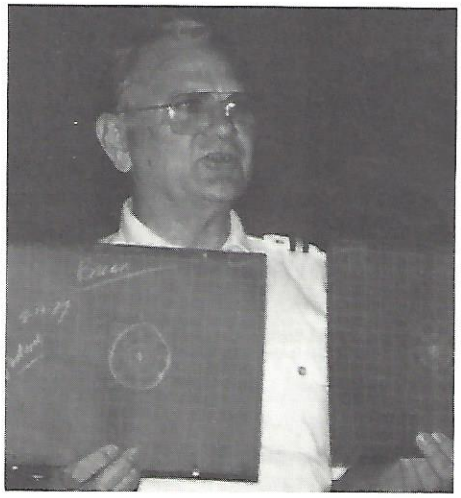
	CFF R/O	CFF I	HORIZ. FORM° FIELD	GR/BL FIELD	RED FIELD
OD	12% ↓	22% ↑	NO CHANGE	66% ↑	75% ↑
OD	9% ↑	22% ↑	NO CHANGE	88% ↑	75% ↑

Summary:
In both examples it appeared that reduced C.F.F. might be related to reduced visual fields. The lowered value of C.F.F. for Red-Orange may be a representation of the reduced neural efficiency in absorbing light at that end of the colour spectrum. A similar statement would apply to low C.F.F. values for Indigo with relation to the blue end of the spectrum. If so, it may be an indication for therapy to begin with those colours which have lower C.F.F. values. Modification of deficiency in C.F.F. by syntonic treatment is demonstrated here by the increased C.F.F. values and the corresponding increases in visual fields. An imbalance in C.F.F readings may be an indication for continued therapy. C.F.F. measurement shows potential for significant diagnostic value in prescribing syntonic therapy, and deserves further study and statistical evaluation.

Editor's Note:
Dr. John Downing has initiated a study of C.F.F. relative to Syntonic treatment by requesting specific information from optometrists who are using the Photron Neurovisual Stimulator.

Dr. **Larry Wallace** and his pupils watching pupils.

Banquet Night (L to R) Dr. **Joseph & Bonnie Shapiro**, Dr. **John & Sheila Searfoss.**



Dr. **Charles Butts** conducting his popular "CASES" session.

CONVENTION CANDIDS

Photos courtesy Dr. ***John Searfoss.***

IN THE MINUTES

The Annual General Meeting of the CSO was held on Saturday, May 16, in Washington, D.C.

Three actions taken by the members at the A.G.M. are of particular interest and worthy of your attention.

1) Effective with the 1988 dues there will be an increase to $100.00 (U.S.) of the annual membership fee.
2) An ad hoc Planning Committee was appointed. Dr. Solomon K. Slobins agreed to chair the Planning Committee.
3) The same Officers and Committees (see the Journal, March/87) will continue to serve the C.S.O. during the current year.

An additional trustee, Dr. Solomon Slobins of Fall River, Mass. was appointed.

CASE REPORT:

by Dr. Solomon K. Slobins

This case report was selected from those presented by Dr. Solomon Slobins in qualifying for Fellowship in the C.S.O., May, 1987.

V.H., a female student aged 17½ years, was referred by a colleague.

Feb. 02/87 History: now in grade 9, this girl had been labelled "dyslexic" in grammar school, and had been in special education classes throughout her school life. Bifocals had been prescribed in grade 4 but were not worn.
Complaints included difficulty when reading or copying (losing her place, rereading, line skipping, reversals, inability to remember what was read).

Symptoms: included frontal headaches after reading; difficulty seeing at far or near (words seem "squished"); diplopia when reading and at the chalkboard; sensitivity to light indoors or outdoors, (light also caused headaches).

Health History: age 18 months — concussion;
age 18 months to 4 years, convulsions associated with high fevers; recurring throat and ear infections; on phenobarbital for three years.
1986 whiplash suffered in a car accident; currently, health good, no medications.

Ocular Health: internal and external examination unremarkable.
pupil size 5 mm, with response to light; constriction to 2 mm and releasing quickly to 4 mm with hippus.

Pursuits: (Binocular) extensive but erratic in all directions. Patient reported pulling, hurting, and was observed to frown during this test.
(Monocular) extensive but jerky and erratic in all directions — patient reported pain and that a headache was beginning over the right eye.

Saccades: with repetition, eyes become uncoordinated, with the left lagging (near to far to near etc.).

Stereopsis: (near) Randot: no response
Titmus Stereo Fly only
(could not achieve circles)

Visual Acuity: (no Rx) FAR: OD 20/60, OS 20/60, OU 20/50
NEAR: OD 20/80, OS 20/80, OU 20/80

Static Retinoscopy: OD -.75 -.50 x 180: $20/60^{-2}$
OS -.75 -1.00 x 180: $20/70^{-2}$

Subjective: OD plano: 20/60
no lens improves V/A
OS plano: 20/60
no lens improves V/A

Visual Fields: reduced in each eye (see charts).

Treatment: Syntonic Therapy (Photron N.V.S.)
Patient could not tolerate flicker, steady light was used.

Feb. 17/87 6 sessions I_{10} (upsilon omega) BG_{10} (mu upsilon)
4 sessions I_{20} (patient could not tolerate B.G. colour)

Fields:
Mar. 3/87 Reassessment indicated minor expansion of motion, form and contour fields; no change in blind spots or acuities.

Treatment: 10 sessions RU_{20} (alpha omega):
(patient could not tolerate brightness of mu delta)
from Mar. 3 to Mar. 31, 1987.

Progress Evaluation: May 2, 1987

History: patient reported seeing better at all distances, cessation of headaches, copying and reading improved, no diplopia at near, occasional diplopia at far, improved marks which have put her first in her special education class.

Pursuits: (Binocular) extensive, some jerkiness in all directions.
(Monocular) extensive, short jerky movements in all directions.
Patient reported no feeling of strain or discomfort during these tests.

Saccades: Blinks to change fixation, co-ordination improved, efficiency increased with repetition.

Stereopsis: Randot — 30 seconds of arc. (#7)

Visual Acuity: (no Rx) FAR: OD $20/30^{-3}$,
OS $20/25^{+1}$, OU $20/20^{-3}$
NEAR: OD 20/25,
OS 20/25, OU 20/25.

Static Retinoscopy: OD -1.00 $20/25^{+3}$
OS -1.00 20/20

Subjective: OD -.50 20/20
OS -.75 -.25 x 180 20/20

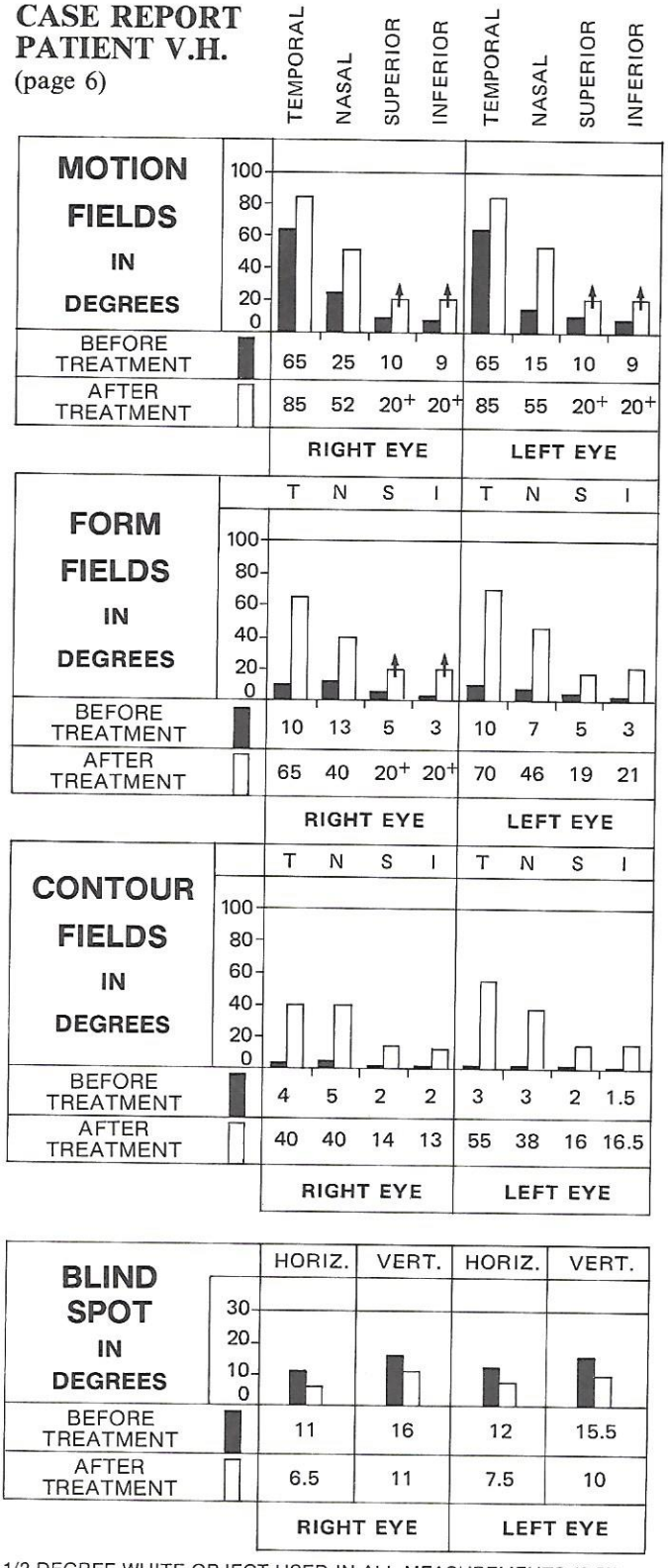
Fields: expansions in all fields:
reduction in blind spots (see charts).

Future Considerations: a) further syntonic treatment possibly with Y.G. (mu delta)
b) Vision Training for enhancement of visual performance skills.
c) Yoked prisms base down for support with near work.

Editor's note:
This report is summarized with Dr. Slobins' permission.

COMPARATIVE FIELDS

CASE REPORT
PATIENT V.H.
(page 6)



1/2 DEGREE WHITE OBJECT USED IN ALL MEASUREMENTS (0.5°).

Editor's Note:

Dr. Slobins uses *Brombach's* field descriptions:

Motion: Object is first noticed during movement but disappears when motion stops.

Form: Object first remains visible when stationary.

Contour: Object shape is first discernible.

In Memoriam:

NORMAN F. FOY

1895-1987

"Thou wert my guide, philosopher and friend" — Pope

With deepest respect, we in Ontario, Canada, mark the passing of Dr. Norman Foy. In the "thirties" he was one of a number of Canadians who attended Riley Spitler's courses. Dr. Foy espoused and used syntonics until he ceased practice a decade ago at age 82. His steadfast dedication to the Syntonic Principle was the inspiration which kindled and encouraged its survival in Ontario. We think of him fondly, often, and with immeasurable gratitude.

SUPPLIES AND INSTRUMENTS

New Billing Procedures

Dr. J.O. Jenkins has announced changes in billing procedures for syntonizers, field instruments and supplies ordered from his North Platte headquarters.

1. All orders must be accompanied by a cheque or money order in the amount of the instrument or supplies requested. (U.S. funds)
2. All orders not prepaid will be sent C.O.D.
3. Interest will be charged on past due accounts at the rate of 1½% per month.
4. Any accounts necessitating collection by an agency will be augmented by the agency's charges.
5. Instruments may be bought on contract one half 'down' and balance one hundred dollars a month with interest at 1½% per month until paid.

PRICE LIST

Photosensitizer	$800.00
6 Bulbs	7.50
Stereo Attachment	100.00
Accommodation Target	10.00
Field Charter	500.00
100 Field Charts	25.00

PRESIDENT'S SURVEY:

O.D.'s using Syntonics

1. Name the frequency you use most often; then list others in descending order.
2. Name specific frequencies you use for specific problems. (name both).

Send immediately to ***Dr. J. Liberman, 3870 Leafy Way, Coconut Grove, Florida 33133***

? ? QUESTIONS ? ?

1. "I've seen a patient exhibit eso in the cover test and exo in the phoropter. Which is a better indicator of what to use as a filter Rx?"
2. "Do we need the lenses in our field plotters?"
3. "How do the theories of caeconometry (toxic plotting of the nerve head) relate to syntonics in nerve sensitivity?"

These questions were submitted by Dr. John Searfoss. Answers are solicited from you, the readers, and will be published in the next Journal.

A 'DEFECT-IVE' THEORY
AN ADVANCED HYPOTHESIS

(PRESENTED TO THE 55TH ANNUAL CONVENTION, WASH., D.C.)

by Dr. Joseph Shapiro

A functional field loss is traditionally thought of as contributing to reading dysfunction, visual spatial navigational difficulty and a host of other problems. We measure a field loss, and immediately tie the patient's symptoms up into a neat cause-effect relationship package. We reason that if we can expand the patient's visual fields, then the negative symptoms which the constrictions have created will be eradicated.

If the above is true, what then can be said about case trends which I have selected from my practice for presentation to you? They do not follow the cause-effect rule. Does it mean that these cases are just those magical exceptions to the rule — to every rule, or does it point to another underlying unknown mechanism for the symptomatology that our patients report? Do visual field desensitizations and our patients' symptoms represent two separate sets of circumstances that coincide closely in time, or do the constrictions and the symptoms represent by-products of more subtle high level "psycho-neurological-energetic" breakdowns, for lack of a better term? These questions that I have raised fit in well with Psychiatrist Dr. Rosenthal's talk in which he cautioned us that correlations are not to be linked with causation.

Two years ago, at the New York Conference, I gave an in-depth presentation about the relationship between Homeopathy and Syntonics. Dr. Spitler, the developer of Syntonics, also compared Homeopathy to Syntonics.

Homeopathy is a system of healing which does not believe in cause-effect relationships. Homeopathy proposes that once there is a breakdown in a person's 'vital force' or energy balance, that individual develops a specific symptom picture, a sort of simultaneous presentation of a wide variety of symptoms unique for that individual. Traditional medicine (and Syntonists for that matter) would try to assign a causal relationship for those symptoms. Homeopathic philosophy reasons that when the vital force is restored to equilibrium, then the symptom picture of that individual improves in a very specific manner and direction. The symptoms that were proposed to have had specific causes are cured without ever dealing with those causes.

The following are 6 specific exceptions to the rule — all examples of trends that cast doubt in my mind as to whether we actually have a causal relationship between visual fields and patients' symptoms. Please keep in mind that these case trends represent a small percentage of my case load.

CASE TRENDS

(1) — I find a visual field defect
— Patient has symptoms
— I treat the patient
— Symptoms vanish
— No changes in field

(2) — I find a visual field defect — (constriction down to 10°)
— Patient has symptoms
— I treat the patient
— Symptoms totally vanish — patient functioning at extremely high levels of efficiency
— Fields open to only 20°

(3) — I find a visual field defect
— Patient has symptoms
— I treat the patient
— Fields normalize
— Symptoms remain

(4) — I find no field defect
— Patient has symptoms
— I treat the patient
— Symptoms vanish

(5) — I find a normal analytical picture
— I find a visual field defect
— Patient has symptoms
— I treat patient
— Symptoms vanish
— Fields normalize
— Analytical findings stay the same

(6) — I find a normal analytical picture
— I find a field defect
— The patient has no symptoms

What do the above case trends mean in terms of the every-day practise of Syntonics?

The fact that the mechanism of breakdown and cure is still unknown should not necessarily change the way we prescribe or approach our syntonic patients. However, the direct conclusion that we must draw from case trend #4 is that we should consider treating patients who are symptomatic yet have normal visual fields.

Your current **JOURNAL** has been published in Oakville, Ontario, Canada. This publication is intended to serve as a link in those bonds of Optometry and Syntony which unite us despite the distances separating us.

The direction this publication takes depends as much on you as it does on me. Contributions are not only welcome, but essential, (unless you favour a northern exposure).

June Robertson, Editor **1515 Rebecca St., Ste. 208 Oakville, Ontario, Canada L6L 5G8** **Tel. (416) 827-4701 (Res.) (416) 827-4711 (Off.)**