Vertoporfin should be stored at room temperature, and when reconstituted, should be protected from light by aluminum foil wrapped around the bag and tubing. The procedure involves dilating the affected eye with mydriatic eye drops. Vertoporfin is infused by pump for 10 minutes. Any infiltration should be stopped immediately and cold compresses applied.

Five minutes after the infusion is completed, anesthetic drops are given, and an 83-second diode laser treatment is administered by the physician (Rich, et al., 2001). Occasionally, back pain is a side effect of the medication, and can be alleviated with nonnarcotic analgesics. Appropriate safety glasses should be worn by support personnel during the laser treatment.

After the treatment, the client is discharged home with a family member or friend. The client will be photosensitive for 5 days and should wear an identification bracelet during this time (Rich et al., 2001). Written discharge instructions should include information about light sensitivity and how to avoid harmful light, such as wearing sunglasses, avoiding bright light. The client should not stay in the dark, however, because indoor light helps to inactivate the drug in the skin (Porter & Nesbitt, 2001). Sunscreen is not protective (Rich, et al., 2001), therefore, clients should wear long-sleeve shirts. The client’s vision should be checked every 3 months, and fluorescein angiogram and PDT should be repeated (Porter & Nesbitt, 2001).

**Conclusion**

ARMD significantly affects a person’s health, function, and quality of life. Research has shown that clinicians tend to under estimate the impact of ARMD on their clients (Stein, et al., 2003). Understanding ARMD within the health promotion framework enables rehabilitation nurses to provide more comprehensive, holistic care. Knowledge and understanding about the

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**Commentary**

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Age-related macular degeneration (ARMD) is an important concern for rehabilitation nurses. With the development of newer treatment measures that are alleviating other causes of vision degeneration, ARMD is now a leading cause of vision loss. ARMD also is complicated by the many other causes of vision loss in the elderly, such as diabetic retinopathy and glaucoma. Thus, ARMD increasingly will be seen not as a primary reason for admission to rehabilitation, but as a comorbidity.

Integrating the gains from therapy into daily living to reduce the burden of disability is an important role for rehabilitation nurses. ARMD significantly increases this burden. For example, the stroke survivor’s ability to negotiate a new and bewildering environment is influenced greatly by ARMD. The risk of injury for those with physical limitations necessitating rehabilitation also is increased appreciably when the client suffers from ARMD.

The authors provide specific, helpful guidance for nurses caring for patients with ARMD. Incorporating vision screening in the initial rehabilitation assessment is not always routine, yet vision greatly affects the patient’s ability to participate in his or her own recovery. The authors mention several assessment tools: the Amsler Grid, Isihara color plates, Snellen eye chart, and the Visual Function Index (VF-14). These tools are helpful in identifying vision loss, but are only a first step for nurses because they describe little about the meaning of the loss to a person’s health and functioning. The use of a nursing health history model, such as Gordon’s Functional Health Patterns, is much more likely to uncover the impact of the vision loss on daily activities. Assisting individuals to mitigate this loss is a unique role for nurses.

Another role for rehabilitation nurses is in educating the public on disability risk reduction. The development of ARMD begins long before patients arrive for rehabilitation, and there is enough evidence to support preventive practices for this cause of vision loss. The lay community increasingly is addressing this problem. The authors note several organizations offering support. Additionally, there are several Web sites dedicated to ARMD with clearly written information for families and patients. Rehabilitation nurses can educate patients and families about the Americans with Disabilities Act (ADA), which may offer some legal protections.

Underscoring a national priority for ARMD, many clinical trials in other disciplines addressing various aspects of treatment currently are underway. The authors note the paucity of literature on ARMD in nursing, which includes nursing research. This is a vital area for rehabilitation nurses. Over the years, many studies have demonstrated that clinicians’ perceptions of pain, and end-of-life choices, for example, do not mirror the patients’—indeed, the perceptions often are quite at odds! It is not surprising, then, that McGrory and Remington note that clinicians “underestimate the impact [of ARMD] on their clients.”

Improving the quality of life for those with disabilities is a fundamental role of rehabilitation, but we must first explore the meaning of those disabilities to patients. Understanding the impact of ARMD, particularly when compounded by other conditions necessitating rehabilitation, is an important area for future nursing research. Another area to explore is whether interventions that utilize adaptive measures are more effective in reducing the burden of disability when taught early in the course of ARMD. The authors have introduced an important topic for nurses in all areas of practice. Rehabilitation nurses can provide leadership in developing nursing interventions to ease the devastation that can result from vision loss resulting from ARMD.