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Sir,

I read with keen interest the editorial titled 'why are we so bad at treating amblyopia?'.[1] The author has nicely covered in brief the various difficulties encountered by strabismologists in treating amblyopia. We have been treating amblyopic patients and had encountered the various difficulties at one stage or the other. Poor compliance remains the most important cause for treatment failure in amblyopia. Various authors in literature have quoted 47–82% compliance rate.[2,3] We have been achieving more than 95% compliance rate because of the emphasis on regular follow-ups and importance of occlusion mentioned from baseline to the last follow-up to parents. Parental understanding and cooperation is crucial in the treatment plan, which requires behavioural modification on the part of both patients and parents alike. We have also enlisted the help of teachers in this project, who supervised the child occlusion during school hour, and ensured that child sat near the blackboard so as to avail his /her lesions in spite of patching.

Most authors credit the low visual acuity of the nonoccluded eye to be a factor in default to occlusion. We realise from our data that strong motivation of parents and patients alike ensure 100% compliance even in patients with vision as low as finger counting close to the face. We also found a change in compliance with respect to age, which could be attributed to the fact that we are emphasizing on screening of amblyopes and treatment at the earliest opportunity. I am of the opinion that augmentation of occlusion with levo dopa speeds up recovery of visual functions, improves the compliance and decreases the duration and cost of treatment.

Thus, based on the fact that benefits of treatment are outweighed by adverse effects of treatment, the screening programmes should be made mandatory at the time of admission in school.

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