confounding factors, we cannot determine if lead exposure may explain part of the generational decline in AMD.

The matched case-control study proposed would not answer this key question, and because of the limitations of case-control designs, it could add only weak evidence for an association with lead. While bone levels represent cumulative exposure, measuring current exposure with blood levels may be more important in prospective studies of health outcomes. A stronger study design would use historical prospective cohort studies of incident AMD with stored whole-blood samples to test the association between lead and AMD incidence. Multicenter studies with geographic variation in both lead exposure and AMD risk could be conducted to further explore the contribution of lead exposure to risk for AMD. Regulatory changes that led to the decrease in lead exposure affected everyone, so there might be a period effect, rather than a birth cohort effect. This would increase the challenges of disentangling generational patterns, because people of different ages had (perhaps) different susceptibilities during this period. It also is possible that lead is only 1 of many neurotoxins that affect AMD risk, so a broader spectrum of exposures should be considered.

It is likely that we may never know the exact reasons for the dramatic decline in incidence of AMD experienced by birth cohorts throughout the 20th century. Researchers have not fully explained the decline in risk for cardiovascular disease first recognized decades ago. Nonetheless, it is important to study novel exposures, such as the neurotoxins suggested by Fuller-Thomson, that may play important roles in the development of AMD to improve the ocular health of future generations.

Karen J. Cruickshanks, PhD

Author Affiliations: Department of Ophthalmology and Visual Sciences, School of Medicine, University of Wisconsin, Madison; Department of Population Health Sciences, School of Public Health, University of Wisconsin, Madison.

Published Online: June 14, 2018. doi:10.1001/jamaophthalmol.2018.2175

Corresponding Author: Karen J. Cruickshanks, PhD, Department of Ophthalmology and Visual Sciences, School of Medicine, University of Wisconsin-Madison, 610 Walnut St, 1038 WARRF, Madison, WI 53726-2397 (kjcruick@wisc.edu).

Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Cruickshanks reports receiving support from the National Institute on Aging and the National Eye Institute (grant ROI AG021917), the National Eye Institute (grant U10EY06594), and Research to Prevent Blindness (an unrestricted grant). No other disclosures were reported.

Disclaimer: The content is solely the responsibility of the author and does not necessarily represent the official views of the National Institute on Aging, National Eye Institute or the National Institutes of Health.


CORRECTION

Content Omitted From Abstract: In the Original Investigation titled “Economic Evaluation of Low-Vision Rehabilitation for Veterans With Macular Disease in the US Department of Veterans Affairs,” the Conclusions and Relevance section of the abstract was inadvertently omitted. This article was corrected online.


Error in Key Points: In the Original Investigation titled “Trends in US Emergency Department Visits for Pediatric Acute Ocular Injury,” published online June 7, 2018, there was an error in the Key Points. The second sentence of the Findings paragraph should read: “During the study period, there was a 26.1% decline in ocular injuries observed across all demographic characteristics, mechanisms of injury, and injury patterns.” This article was corrected online.