

LETTERS TO THE EDITOR

Sir,

We read with interest the editorial by David Boase, the article on ocular perforation by Gillow, Aggarwal and Kirkby and the letter referring to topical anaesthesia by Michael Lindley-Jones in the recent issue of *Eye*.¹⁻³

Despite the number of surgeons using sub-Tenon's anaesthesia, scant regard has been given to this most excellent technique. From 1995 to October 1996, we have performed 1460 cases using this technique: 1290 for cataract surgery and also for squint surgery and other forms of intraocular surgery. With our tech-

Table I. Akinesia

No movement	61
Slight movement	30
Moderate movement	6
All movements remaining	0

Table II. Visual analogue pain score for the operation and administration of anaesthetic (0-10)

<i>Operation</i>	
Score 0 (no pain)	83
Score 1	8
Score 2	1
Unrecorded	4
<i>Anaesthetic</i>	
Score 0 (no pain)	50
Score 1	25
Score 2	16
Score 3	4
Score 4	0
Score 5	1

Table III. Time to onset of anaesthesia

Up to 2 minutes	84
3 minutes	8
4 minutes	1
5 minutes	2
9 minutes	1

Table IV. Effect of hyalase on akinesia and anaesthesia

<i>Akinesia</i>	
Hyalase	1 complete 3 good 1 moderate
No hyalase	2 moderate 1 poor 1 very poor 1 none
<i>Anaesthesia</i>	
Hyalase	5 good
No hyalase	5 good

nique, using 3-3.5 ml drawn from a 20 ml bottle of 2% lignocaine with 1:200 000 adrenaline to which 1 ampoule of hyalase is added and delivered with a re-usable olive-tipped lacrimal canula, the time to onset of anaesthesia is rapid, akinesia complete and, on pain scoring, extremely comfortable.

A study of 96 consecutive cases in which we independently analysed the pain score for the administration of anaesthesia and the procedure showed remarkably low scores. The time to onset was very rapid and akinesia usually complete (Tables I-III).

The addition of hyalase speeds the onset of anaesthesia. A study comparing solutions with and without hyalase was stopped after 10 cases because of the clear difference (Table IV).

We commend this as a very acceptable, cost-effective and safe technique for surgeon and patient alike.

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- Gillow JT, Aggarwal RK, Kirkby GR. Ocular perforation during peribulbar anaesthesia. *Eye* 1996;10:533-6.
- Lindley-Jones M. Letters to the editor. *Eye* 1996;10:650.

Sir,

I read with great interest the case report by Yang and co-authors¹ on a complete third nerve palsy associated with headaches and vomiting in a 6-year-old boy. The case was followed by an excellent discussion on the rules of third nerve palsy in children. I would totally agree with the conclusions of the report; however I believe an important - although not common - cause was missing from the paper discussion. Ophthalmoplegic migraine is an entity encountered in children, and in fact should have

been considered in the differential diagnosis. In a retrospective study Ing *et al.*² found that 3 of the 43 acquired cases (7%) were attributed to migraine, but Keith³ has observed only one case of migrainous origin in the 28 reported palsies of his series. We have also come across two such cases in children within the last year, one of which was a recurrent oculomotor palsy with full recovery without treatment. A similar observation has been reported by Amit and Benezra⁴ in an infant.

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3. Keith CG. Oculomotor nerve palsy in childhood. *Aust NZ J Ophthalmol* 1987;15:181-4.
4. Amit R, Benezra D. Oculomotor ophthalmoplegic migraine in an infant. *Headache* 1987;27:390-1.

Sir,

I thank Dr Karabatsas for his comments. We presented a typical case of a child with painful third nerve palsy to highlight the pitfalls in using the rules of third nerve palsy when assessing for aneurysmal compression in children. The diverse differential diagnosis of third nerve palsy was therefore not discussed in detail in our paper. Dr Karabatsas is right in emphasising the importance of ophthalmoplegic migraine in the diagnostic work-up as it is a diagnosis of exclusion. After excluding the more

common causes of painful nerve palsy such as trauma, infection, inflammation or non-aneurysmal compressive lesions, the remaining differential diagnosis in such cases is often between an aneurysm and ophthalmoplegic migraine. The diagnosis of migraine can be clinched if there is a previous history of a similar episode of migraine associated with ophthalmoplegia, but in a first attack it is still prudent to investigate for an aneurysm unless complete ophthalmoplegia in the presence of total sparing of pupil (third rule) is observed.

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Sir,

We read with interest the recent paper by Potamitis *et al.*¹ on astigmatic decay following suture removal in 34 cataract patients. This paper confirms our study on 50 post-operative cataracts published in *Eye* a year ago.²

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1. Potamitis T, Fouladi M, Eperjese F, McDonnell PJ. Astigmatism decay immediately following suture removal. *Eye* 1997;11:84-6.
2. Churchill AJ, Hillman JS. Post-operative astigmatism control by selective suture removal. *Eye* 1996;10:103-6.