lines may need to be modified if other departments report similar experiences to our own. This would not only reduce the number of unnecessary screenings but also lessen the psychological burden on parents who will already be under enormous strain in having to cope with their premature child.

Vernon Geh, FRCOphth

Department of Ophthalmology
St James's University Hospital
Beckett Street
Leeds LS9 7TF
UK

References

1. Fleck BW, Wright E, Dhillon G, Millar T, Laing IA. An audit of the 1995 Royal College of Ophthalmologists guidelines for screening for retinopathy of prematurity applied retrospectively in one regional neonatal intensive care unit. Eye 1995;9(Suppl):31–5.
2. Royal College of Ophthalmologists and British Association of Perinatal Medicine. Retinopathy of prematurity: guidelines for screening and treatment. The report of a joint working party, 1995.
3. Acheson JF, Schulenburg WE. Surveillance for retinopathy of prematurity in practice: experience from one neonatal intensive care unit. Eye 1991;5:80–5.
4. Palmer EA. Optimal timing of examination for acute retrolental fibroplasia. Ophthalmology 1981;88:662-6.
5. Flynn JT, Bancalari E, Bachynski BN, Buckley EB, Bawol R, Goldberg R, *et al*. Retinopathy of prematurity: diagnosis, severity and natural history. Ophthalmology 1987;94:620–9.
6. Flynn JT. Discussion of the paper 'Optimal timing of examination for acute retrolental fibroplasia' by Palmer EA. Ophthalmology 1981;88:667–8.

Sir,

I read Mr Manners and Mr Burton's excellent paper 'A randomised trial of topical versus sub-Tenon's local anaesthesia for small-incision cataract surgery' (Eye 1996;10:367–70) with great interest, having used topical anaesthesia as my only local anaesthetic technique for in excess of 3 years.

I was, however, quite concerned that the title of this paper was misleading in as much as the 'topical group' were in fact all recipients of a subconjunctival injection of local anaesthesia. This is a sharp needle technique and has theoretical risks of globe perforation, subconjunctival haemorrhage, etc. I believe that this otherwise excellent paper should have been entitled 'A randomised trial of subconjunctival injectional versus sub-Tenon's local anaesthesia for small incision cataract surgery' and I wonder whether the authors would agree with this.

Charles Claoué, MA, MD, FRCS, FRCOphth

North East London Eye Partnership

Sir,

In their paper 'Randomised trial of topical versus sub-Tenon's local anaesthesia for small-incision cataract surgery' (Eye 1996;10:367–70) Manners and Burton compare sub-Tenon's anaesthesia of 4-5 ml with 'topical' anaesthesia. With the latter mode of anaesthesia they additionally administer subconjunctival lignocaine behind the superior limbus to facilitate painless cautery. Strictly speaking this is a study comparing subconjunctival anaesthesia, rather than topical anaesthesia, with sub-Tenon's anaesthesia.

We studied 193 patients undergoing ocular surgery under local anaesthesia. We used peribulbar anaesthesia or subconjunctival anaesthesia (0.3 ml of 2% lignocaine with 1 : 200 000 of adrenaline). For high-volume phaco surgeons 78% of patients had subconjunctival anaesthesia. Not all patients are suitable for this technique and our guidelines are that the patients should be cooperative with uncomplicated ocular anatomy. Surgical experience is essential with this technique; special care is needed during capsulorrhexis as well as during insertion of the intraocular lens. Cooperation of the theatre staff is required during these manoeuvres to avoid distracting patient or surgeon. The advantage of subconjunctival anaesthesia is that the patient can look down to facilitate exposure of the globe and post-operative visual rehabilitation is rapid. This is of real benefit in an only eye.

We found mean pain levels of induction of subconjunctival anaesthesia of 0.5 (median 0, range 0–5) on a visual analogue scale from 0 to 10. Intraoperative mean pain levels were 0.36 (median 0, range 0–4). These are very similar to Manners and Burton's results.

Some patients with subconjunctival anaesthesia are very sensitive to raised intraocular pressure and the eye should not be overfilled with viscoelastic or balanced salt solution during capsulorrhexis or hydrodissection. Conversion to extracapsular cataract extraction or anterior vitrectomy is possible without additional anaesthesia.

We disagree with Manners and Burton over the role of sedation. Sedation can be a welcome anxiolytic for patients many of whom are nervous about surgery. Currently 9.1% of our patients have minimal sedation to allay anxiety – a decision made at the preoperative assessment. Monitoring is required, as it is for all patients, and the anaesthetist should be available should resuscitation be necessary.

We are pleased that Manners and Burton also find that topical combined with subconjunctival anaesthesia provides excellent surgical conditions for patient and surgeon. We would recommend its