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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References

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2. Gillow JT, Aggarwal RK, Kirkby GR. Ocular perforation during peribulbar anaesthesia. *Eye* 1996;10:533-6.
3. 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