References

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Sir,

David Boase's excellent editorial is most welcome.[1] One question posed is whether it is better for a peribulbar block (with bupivacaine) using a 'short' 25 mm needle possibly performed by an anaesthetist, or for topical anaesthesia with an anaesthetist in attendance for intravenous sedation. Having had the experience of a junior doctor perforate an eyeball with this so-called 'short' needle, may I offer a compromise that will give both patient and surgeon considerable satisfaction as well as improved safety.

We now recommend 2% prilocaine, 3.0 ml of which is given inferotemporally and 3.0 ml superonasally through a 16 mm (orange) needle to ensure peribulbar location followed by standard oculocompression. The effect lasts 2½ hours. Advantages over bupivacaine (with or without lignocaine) are that it is less toxic, is much more comfortable, has better diffusion properties so obviating the need for hyaluronidase, is more readily metabolised so safer, provides faster return of vision, does not require a post-operative pad and is cheaper. Advantages over topical anaesthesia are akinesia, that it is more reassuring for the patient 'to have the eye frozen', that it is more relaxing for the surgeon should complications occur or the operation be unexpectedly prolonged, and there are no problems should bridle sutures, iris or scleral surgery be necessary. Above all, there is no need for an attendant anaesthetist!

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Sir,

I read with interest Mr David Boase's editorial entitled 'Local anaesthesia revisited' (Eye 1996;10:531–2). May I make the following remarks:

1. The surgeon is responsible for his or her surgery, which means that the surgeon should be involved in the anaesthetic administered in the case. One should never allow a college doctor, ophthalmologist or anaesthetist to administer the anaesthetic – it is the surgeon's direct responsibility!

2. No mention was made of intraocular anaesthesia, which is an excellent method for cataract surgery, either by itself or whenever the patient feels the intraocular manoeuvre during surgery. I have performed 428 cases already this way.

3. Subconjunctival mercaine 0.5% 0.2–0.3 ml at the upper limbal area between 10 and 14 o'clock is sufficient to start and end cataract surgery.

4. Local anaesthesia is a misnomer. It should be called regional anaesthesia, as it is anaesthetising a major nerve to a whole organ! Peribulbar anaesthesia is local anaesthetic. One should always remember that switching from retrobulbar anaesthesia to peribulbar, topical, intraocular or subconjunctival anaesthesia involves a whole different approach to the surgical manoeuvres as the eye moves freely and a sudden move is critical in different operations.

All the above remarks are related to manual small-incision, sutureless, sclero-corneal pocket tunnel surgery. If it is good for manual extracapsular cataract extraction (ECCE), it should be enough for phaco ECCE too.

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Sir,

We read with interest the article by J. T. Gillow *et al.* entitled 'Ocular perforation during peribulbar anaesthesia'.[1] In the vitreo-retinal unit in this hospital we have recently had similar experience which supports their findings.

Seven patients have been seen in this hospital over a 20 month period following ocular perforation during peribulbar anaesthesia prior to cataract surgery. Axial lengths ranged between 22.06 mm and 23.58 mm. All the local anaesthetic procedures were performed by anaesthetists of the following