

CORRESPONDENCE



Comment on: 'Sub-Tenon's anaesthesia for modern eye surgery—clinicians' perspective, 30 years after re-introduction'

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TO THE EDITOR:

To pulverise a cataract with ultrasound is a marvel that has enhanced surgical efficiency. More cases can be shoehorned into a treatment list. Belting along, the production line, however, meets a hindrance—the obstacle of anaesthesia. Each time the eye must be etherised before the blade can cut.

For eons the surgical eye has been numbed with drops or a subtenon block. A recent paper distilled the information on subtenon anaesthesia [1]. Before the rise of subtenon in the 1990s the peribulbar route was the mainstay. These methods comprise the passage of a needle or a cannula into the orbit.

Piercing of orbital flesh with a long needle carries the worry of ocular perforation. By contrast, a subtenon delivery seems innocuous, but it entails a digging in retrobulbar depths. Mostly done with ease, the subtenon can be undoable in a tight orbit.

Ocular anaesthesia is enlarged by being attuned to a newly-hatched method. Wu and Tang have trialled 'advanced subconjunctival anaesthesia' (ASA) [2]. It involves a retraction of the upper lid to uncover the superotemporal eyeball. The patient looks feet-ward. Lignocaine is injected posteriorly, seeping into the subconjunctival and subtenon planes. Infiltration is with 5–10 ml of lignocaine 2% admixed with hyaluronidase. On the counts of akinesia and anaesthesia the method fares well beside the posterior subtenon block. Though expected, chemosis, that bugbear, was of minor extent insofar as being curtailable. And in 60 patients, their case series, the safety profile fell within tolerable bounds.

Wu and Tang have mentioned the usability of ASA in austere conditions. In bygonees, as surgeon in charitable camps, I have wielded the peribulbar block [3]. Orbit-piercing in nature, it was splendidly safe in the right hands. Minus speculum, forceps, and scissors, the peribulbar had only a bare outlay—a long needle on a syringe abrim with lignocaine.

The appeal of ASA is its start on the eye surface: a short needle is visible as it worms along under the conjunctiva and tenon layer. Anterior injection then diffuses backward across the subtenon space. But there is no needle nosing into the orbit. Aside from safety, ASA, like peribulbar, does not rely on instruments. Ecological harm is thus reduced. Juxtapose with the posterior subtenon and its reliance on dissectional kit. Today a fondness

of convenience has led to throwaway metal instruments. Such bloodied weapons are moreover not recycled. Bashed widely, the environment receives further injury with every disposal.

Eco-friendliness is a most valuable trait of ASA. Crucially, ASA lowers cost in the rivers of cataract surgery. In its leanest form, the upper lid is tethered back with a finger, which acts as speculum. Other digits of the same hand raise a fold of conjunctiva with a cotton bud. As the fellow hand injects, the cotton bud falls away. More fingers are now summonable to complete the procedure.

Needle anaesthesia has receded in Britain, as evinced by the unfamiliarity of a peribulbar block. But the needle can be reintroduced: ASA is a workable and eco-kind method that broadens the array of ocular anaesthesia.

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COMPETING INTERESTS

The authors declare no competing interests.

ADDITIONAL INFORMATION

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