

Letters

Anesthetic Injection or Infusion?

After reading “Anesthesia Trends: Rethinking Topical vs. Blocks” (Clinical Update, April), I agree with your premise that topical anesthesia—although the safest method of anesthesia for cataract surgery—is not suitable for all surgeons, all patients and all procedures. I disagree, however, with your recommendation to consider needle injection of the orbit (either retrobulbar or peribulbar) as an alternative.

Insertion of either a dull or sharp needle into the orbit is one of the greatest risks to both the patient’s eye and general health. I also have concerns about nonophthalmic personnel (e.g., anesthetists or anesthesiologists) administering these injections, as prior studies in the literature show that this scenario may be a major risk factor for ocular penetration or perforation.

The article also states that information such as the presence of staphyloma should be communicated to the anesthesia provider. This advice, however, fails to take into account that staphyloma often cannot be appreciated preoperatively. Better information to provide would include the axial length and any information

about prior ocular or orbital surgery or disease.

I propose that when local anesthesia is desired, a posterior sub-Tenon’s infusion should be used. The blunt cannula employed is much safer than a sharp needle and markedly reduces (although does not completely obviate) the chance of complications such as orbital hemorrhage, ocular perforation, damage to the optic nerve, etc.

The article indicates that the sub-Tenon’s infusion does not give “the degree of akinesia you would get with a retrobulbar block.” That is true if the infusion is given in the operating room just prior to the beginning of surgery.

On the other hand, if the sub-Tenon’s infusion is given in the holding area an hour before surgery, the infusion will provide not only anesthesia but also excellent ocular akinesia and a satisfactory orbicularis block.

Posterior sub-Tenon’s infusion, in my experience, is also safe in patients on any type of anticoagulation therapy.

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An Additional Step in Error Prevention

We encountered the same wrong-site error mentioned in “Wrong-Eye Surgery:

Will It Be Your Turn Next?” (Opinion, March) on three occasions in three different operating rooms.

In each case, we followed the Joint Commission on Accreditation of Healthcare Organization’s Universal Protocol for the Prevention of Wrong Site, Wrong Procedure and Wrong Person Surgery—appropriately marking the patient and ensuring time-out verification with all operating room staff. While the surgeons were scrubbing, however, the operating room nurse placed the drape over the wrong eye.

After reviewing these cases, we realized the main problem was that the tape used to secure the patient’s head was covering the marked site. In each of the three cases, we realized something was incorrect prior to the first incision. Fortunately, in no case was an incision made.

As a result of these events, we have adopted an additional step to the usual recommended time-out procedure. Just before the block is given, a metal shield is applied over the nonsurgical eye. This application is verified with the patient. The retrobulbar injection is



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then given and the patient is prepped. When the nurse comes to drape the patient, it is absolutely clear which eye is to be operated on. At the same time, the contralateral eye is protected from accidental trauma during the procedure.

We have adopted this step as part of resident and fellow training in the vitreoretinal service at the University of Iowa. We strongly believe that this step keeps the responsibility squarely in the hands of the surgeon, and that it will reduce this type of wrong-site surgical error.

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