Letters

In Defense of Block Anesthesia

After being in practice for some 20 years—and doing some 500 cataract surgeries each year—I can no longer sit by and listen to the "experts" drone on about what a terrible thing block anesthesia is. With this in mind, I felt vindicated to see the article "Anesthesia Trends: Rethinking Topical vs. Blocks" (Clinical Update, April).

I have seen at least 30 patients in the last two years who were terrified to even consider having their second eye done because of the pain experienced during their first surgery (which was done topically). Each of these patients reported to their surgeons at the time of surgery that they were in pain. They were told to "remain still" and that what they were feeling was "just pressure."

Here is just one example of a recent complication during topical anesthesia. A young surgeon brought his patient to his ASC for topical surgery. The patient had a dense 2+ nuclear sclerotic cataract. As the surgery started, the patient was immediately uncomfortable. As the patient began to move, he was told to be still. More sedation was ordered, the posterior capsule broke and the lens began to sink into the posterior chamber. The surgeon opened the wound without further anesthesia to the globe in an attempt to catch the falling lens fragments. The patient, now in agony was once again told to remain still. Hypertension became a factor, and the patient's blood pressure reached 220/145 mmHg. An expulsive hemorrhage began to push out the intraocular contents. The office retina specialist is called into the OR and performed several sclerotomies in an attempt to save the eye. At the end of the day, the eye was lost.

Here is a description of my anesthetic technique. First, I give all injections myself. In our block, I use 3 cc of 2 percent Xylocaine (lidocaine) without epinephrine, 2 cc of 0.5 percent Marcaine (bupivacaine) and a 1/2 cc of Amphadase (hyaluronidase) in a 5-cc syringe with a 1.5-inch 25-gauge needle. We run two rooms in our center. I give the retrobulbar injection after 40 to 60 cc of propofol, which is given by our anesthesia personnel, go scrub and come back into the room to drape my patient, confirm the correct site of surgery, sit down and do the case. Using two rooms, I do three cases an hour. In more than 10,000 cases, I have never had a globe perforation or postoperative strabismus induced by the block. I have also had fewer than five hemorrhages, none of which was significant enough to cancel the case.

James D. Sutton, MD
Ocean Springs, Miss.

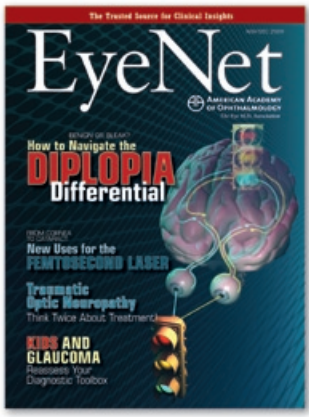
Bounced Back

After reading "Seven Risk Factors for Injury, and Seven Solutions: Ergonomics, Part Two" (Practice Perfect, September), I felt compelled to relay my own experience. During my career as a corneal ophthalmologist, I underwent two neck-fusion surgeries with bone grafts taken from my hip and supplemental wiring. After that, I revamped my office by changing the level of the sink spouts in the exam rooms and buying new Haag-Streit slit lamps so I could get angled eyepieces. I also stopped assisting or teaching at surgery. Changing the eyepieces' angle made a huge difference. Unfortunately, I don't have a long trunk (5' 7" height) so I wound up reaching out more with my arms in an unsupported way—which added a new flavor to the neck problem.

I also developed rheumatoid arthritis and could only continue to function medically and surgically by taking large-dose steroids. That led to central serous retinopathy. In spite of macular laser treatment and subsequent cataract surgeries, I never regained distortion-free central vision in that eye or binocular vision. So I had to sell my practice in 2003. It took a long while, but I bounced back nicely. I became a certified Chopra Center instructor and teach meditation to those in recovery from illness or unfortunate life circumstances.

Thank you and Dr. Fung for an important conversation.

Michael K. Farley, MD
Laguna Beach, Calif.



Last month's issue is online at www.eyenetmagazine.org/archives.

WRITE TO US Send your letters of 150 words or fewer to us at *EyeNet Magazine*, AAO, 655 Beach Street, San Francisco, CA 94109; e-mail eyenet@aao.org; or fax 415-561-8575. (*EyeNet Magazine* reserves the right to edit letters.)