To the Editor—I thoroughly enjoyed the review by Vann et al.\(^1\) of anesthesia for ophthalmology. However, I was surprised by their quotation from Pecka and Dexter.\(^2\): "These authors commented that there is 'no justification to decreasing the amount of time that anesthesiologist or nurse anesthetists spend caring for patients undergoing cataract extraction with a retrobulbar block'" (italics added).

The full paragraph is as follows:

In conclusion, [in 1995] at our tertiary medical center, anesthesia providers [did] interventions after placement of the retrobulbar block for 33\% of cases (upper bound < 36\%). Therefore, a retrospective study cannot determine whether, to decrease costs, a registered nurse could safely replace the anesthesia provider after uneventful placement of a retrobulbar block. A prospective study assessing patient outcome related to these interventions is required for a more meaningful assessment of present standards for monitored anesthesia care for cataract extractions... There is currently no justification to decreasing the amount of time that anesthesiologists or certified registered nurse anesthetists spend caring for patients undergoing cataract extraction with a retrobulbar block.

The word currently is important.

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Anesthesia for Ophthalmologic Surgery

To the Editor—I would like to make several comments regarding the excellent article by Vann et al.\(^3\) First, I would encourage anesthesiologists to resist the use of topical anesthesia for ophthalmologic surgery except when the most competent surgeons are doing straightforward procedures in healthy patients. I have been caught several times when cataract surgery went awry and a retinal surgeon had to be called in urgently to perform surgery that could not be tolerated using topical anesthesia alone. The alternatives are to stop the procedure and induce emergent general anesthesia or to induce very deep sedation without control of the airway. A sub-Tenon, peribulbar, or retrobulbar block would have prevented the added risks of either of the above alternatives.

Second, I have performed several hundred retrobulbar blocks without using any premedication or sedation. In addition, I have been the anesthesiologist during many other retrobulbar or peribulbar blocks performed by the surgeon without any premedication or sedation. In the vast majority of cases, all that is required is a little hand-holding, encouragement, and empathy. Occasionally, for patients with high anxiety or a low pain threshold, a transcutaneous electrical nerve stimulation unit with the electrodes placed on the temple and forehead virtually eliminates any discomfort. It is the rare patient who must have something like propofol for the block.

With a little preparation by the surgeon and anesthesiologist, it is seldom that any medication at all is required for ophthalmologic surgery. The less medication is used, the more alert and cooperative the patient will be and the less likely the patient will be to fall asleep, suddenly awaken, and move during surgery. To me, the risk–benefit ratio clearly favors the major block without sedation.

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