

Quotation from Article about Anesthesia Providers' Activities during Ophthalmology Cases

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 extrac-

tions . . . 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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References

1. Vann MA, Ogunnaik BO, Joshi GP: Sedation and anesthesia care for ophthalmologic surgery during local/regional anesthesia. *ANESTHESIOLOGY* 2007; 107:502-8
2. Pecka SL, Dexter F: Anesthesia providers' interventions during cataract extraction under monitored anesthesia care. *AANA J* 1997; 65:357-60

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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.*¹ 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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Reference

1. Vann MA, Babatunde OO, Joshi GP: Sedation and anesthesia care for ophthalmologic surgery during local/regional anesthesia. *ANESTHESIOLOGY* 2007; 107:502-8

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In Reply:—We thank Drs. Dexter and Bourke for their comments on our article.¹ First, in response to Dr. Dexter, we believe that we maintained the meaning of the quotation from his article² that anesthesia care is justified during eye surgery performed under *retrobulbar block* (italics added). The administration of a retrobulbar block has not changed in the years since his article was written; therefore, the word *currently* does not change our sentiment.

Second, in reply to Dr. Bourke, we appreciate his concerns about topical anesthesia and emphasize in our article that the best technique for local/regional anesthesia considers the surgeon's skill and anesthesiologist's comfort as well as patient needs. Regarding the conversion of a phaco procedure during topical anesthesia to vitreoretinal surgery, we note that these procedures can be conducted under a sub-Tenon

block that the surgeon can administer to the topicalized eye on the surgical field. As far as his concerns about sedation, we covered sedation techniques and outcomes in the article, also noting that patient expectations as well as demographic and regional differences often account for choice of sedation during a block. We appreciate his use of alternative techniques such as transcutaneous electrical stimulation. However, use of transcutaneous electrical stimulation as an alternative to sedation techniques needs to be formally evaluated before it can be recommended for routine use.

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