Role of the anaesthetist during cataract surgery under local anaesthesia

Editor—We read with interest the article by Chandradeva and colleagues. The inference drawn by the authors is that in future, with greater use of topical anaesthesia, the ‘perceived requirement’ for anaesthetists will diminish. Phacoemulsification techniques have undoubtedly minimized the surgical complexity of cataract extraction. Additionally, topical solutions or gels have established themselves as viable anaesthesia alternatives. Despite these simplifications in surgical and anaesthesia technique, patient factors are a third key variable essential to successful outcomes.

Coughing, bucking, and an unanticipated inability to remain quiescent can contribute to abrupt motion and poor visual outcome. A closed claims study of injury and liability associated with monitored anaesthesia care found that more than 20% of claims in that database occurred with elective eye surgery cases; of these, 83% were associated with inadequate analgesia, gross patient movement, or both. Another earlier article based upon the ASA Closed Claims Project found 21 cases of blindness purportedly due to movement during surgery. The five injuries in patients not under general anaesthesia were attributed to intraoperative restlessness or coughing.

Underlying anxiety, tactile perception, and even light detection may also result in paroxysmal patient movement. In a recent clinical study, nearly 20% of patients having cataract surgery with topical anaesthesia found their visual experience frightening. Topical ophthalmic anaesthesia fails to provide akinesia or complete sensory block which means that an unpredictable subset of patients will be uncomfortable and require rescue interventions. ‘Vocal local’, the occasional reality of talking a distressed patient through an ophthalmic operation conducted without the presence of an anaesthetist, is a scenario unsatisfactory to one and all. Patient discomfort during cataract surgery under topical anaesthesia may create greater demand for intraoperative anxiolysis.

Although application of topical anaesthesia is simple, it is not a fail-proof mechanism. Many situations mandate the immediate availability of personnel adept in sedation, anaesthesia, and airway management.

Conflict of interest

None declared.

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Editor—We thank Dr Palte and colleagues for their interest in our paper. However, our survey was designed purely to investigate the current practice in the UK and perceived future developments in the need for anaesthetists, as viewed by ophthalmologists. We would entirely agree with Dr Palte and colleagues’ remarks concerning patient factors in modern cataract surgery, and it is not our intention to promote or recommend any particular technique for this.

We wish to reiterate, as discussed in the paper, that there should be appropriate guidelines on the selection of patients for phacoemulsification under local anaesthesia with or without anaesthetists. Outcome of these procedures needs to be monitored carefully to ensure the safety of patients.