Editorial: Why retrobulbar anaesthesia?

Having been asked if she would consent to a local anaesthetic for her cataract extraction a patient replied that she did not have complete confidence in the local doctors but would prefer a London man, preferably from Harley Street. However, when the matter was further explained, and the superior safety of local anaesthesia enlarged upon, she duly gave her consent.

Fortunately the optimistic prediction of the harmlessness of this type of anaesthetic proved to be accurate. But was she really informed? What if she had had a retrobulbar haemorrhage, an accidental perforation of the globe,[1] transitory blindness,[2] central retinal artery occlusion,[3] central retinal vein occlusion,[4] or a contralateral second and third cranial nerve dysfunction, as reported by Rodgers and Orellana in this issue? This particular patient's ophthalmologist (myself) would have had some explaining to do which, in view of the response to the initial questioning, could have been awkward.

The usual reason for choosing local anaesthesia in our hospital is because the patient is judged to be unfit for a general anaesthetic, but one is well aware that the choice of local or general anaesthesia varies from hospital to hospital and from country to country. However, when local anaesthesia is used for reasons of safety, it ought to be as safe as possible. Although Rodgers and Orellana rightly point out that retrobulbar anaesthesia is seldom associated with serious sequelae, nevertheless their case and others in the literature indicate that serious problems can and do occasionally occur. It is perhaps worth pointing out that it is almost as easy to carry out cataract extraction without a retrobulbar anaesthetic (or even a seventh nerve block), though most surgeons using a microscope believe (mistakenly) that there will be so much movement as to render the operation unduly hazardous. Let me assure readers that a few drops of amethocaine followed by 1 ml of subconjunctival 2% lignocaine injected under direct vision in the region of the superior rectus insertion are all that is required. This might be thought preferable to the alternative suggestion of a retrobulbar injection with a blunt needle as advocated by some authors.

If it does nothing else it at least removes the inconvenience and embarrassment of the inevitable occasional retrobulbar haemorrhage.

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References

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