



B.O.A.S.

Ophthalmic Anaesthesia News

The Official Newsletter of the British Ophthalmic Anaesthesia Society
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Ophthalmic Anaesthesia News

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BOAS 2003 – Chester meeting report

Dr Monica Hardwick, Council Member, Worcester

The fifth Annual Scientific meeting of the Society was held at the Grosvenor Hotel, Chester on Thursday the 26th and Friday the 27th June 2003. The attractive venue and excellent scientific programme attracted over 120 delegates from all over the UK, while the speakers originated from as far afield as Canada, the USA and France. The trade exhibition was well represented, and there were no less than ten excellent poster presentations. Congratulations must go to the organisers: Sean Tighe, Guri Thind, Jeremy Butcher, Les Gordon and their secretarial support.

The events started at 11.00 on Thursday with a series of rotating workshops on the subjects of orbital anatomy, sub-Tenons and needle techniques, GA, sedation and ALS. After Lunch, Prof Chris Dodds, BOAS President opened the main meeting and welcomed the delegates and speakers.

Session 1 was entitled Ophthalmic Regional Anaesthesia Update, and consisted of three very different but equally intriguing subjects. Andrew Smith from Lancaster gave a very informative and well-researched lecture on IOP and blood flow during regional ophthalmic anaesthesia. He described the use of an ocular blood flow pneumotonometer, which has shown that there is a reduction in ocular blood flow during regional anaesthesia, which could have clinical implications. The second speaker was Prof Jacques Ripart from Nimes who gave a beautifully illustrated lecture on the use of imaging techniques to study the anatomy and spread of local anaesthetic solutions during different regional anaesthetic blocks. He also described his own technique of "episcleral" sub-Tenons injection using a short bevelled needle inserted into the medial episcleral space. This somewhat controversial method of performing a sub-tenons block has been used successfully and without complication by the author. Chandra Kumar presented a fascinating lecture on visual sensations during ophthalmic regional anaesthesia. Patients have reported a wide variety of different visual sensations during all types of anaesthetic blocks and some have found the experience frightening. It is suggested that patients should be counselled and reassured regarding possible visual experiences prior to their surgery.

As a new departure for the society a ceremony was held to confer the title of lifetime achievement awards in Ophthalmic Anaesthesia to Dr Tony Rubin from London and Dr Roy Hamilton from Calgary.

The second session of the afternoon was a Pro-Con discussion on who should perform Sub-tenons blocks i.e. The Surgeon, the Anaesthetist or the Nurse? A pre-lecture show of hands was definitely in favour of the Anaesthetist performing the block – not surprising, as the majority of delegates were anaesthetists. Mike Bearn, an Ophthalmologist from Carlisle gave a very

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shock; and use in paracervical block in obstetrics. The 7.5 mg/ml solution is contra-indicated for obstetric use due to an enhanced risk for cardiotoxic events based on experience with bupivacaine. There is no experience of levobupivacaine 7.5 mg/ml in obstetric surgery. **Precautions:** Epidural anaesthesia with any local anaesthetic may cause hypotension and bradycardia. All patients must have intravenous access established. The availability of appropriate fluids, vasopressors, anaesthetics with anticonvulsant properties, myorelaxants, atropine, resuscitation equipment and expertise must be ensured. Levobupivacaine should be used with caution for regional anaesthesia in patients with impaired cardiovascular function e.g. serious cardiac arrhythmias and in patients with liver disease or with reduced liver blood flow e.g. alcoholics or cirrhotics. **Interactions:** Metabolism of levobupivacaine may be affected by CYP3A4 inhibitors eg: ketoconazole and CYP1A2 inhibitors eg: methylxanthines. Levobupivacaine should be used with caution in patients receiving anti-arrhythmic agents with local anaesthetic activity, e.g. mexiletine, or Class III anti-arrhythmic agents since their toxic effects may be additive. No clinical studies have been completed to assess levobupivacaine in combination with adrenaline. **Side-Effects:** Adverse reactions with local anaesthetics of the amide type are rare, but they may occur as a result of overdosage or unintentional intravascular injection and may be serious. Accidental intrathecal injection of local anaesthetics can lead to very high spinal anaesthesia possibly with apnoea, severe hypotension and loss of consciousness. The most frequent adverse events reported in clinical trials irrespective of causality include hypotension (22%), nausea (13%), anaemia (11%), post-operative pain (8%), vomiting (8%), back pain (7%), fever (6%), dizziness (6%), foetal distress (6%) and headache (5%). Other side effects include: CNS effects: numbness of the tongue, light headedness, dizziness, blurred vision and muscle twitch followed by drowsiness, convulsions, unconsciousness and possible respiratory arrest. CVS effects: decreased cardiac output, hypotension and ECG changes indicative of either heart block, bradycardia or ventricular

tachyarrhythmias that may lead to cardiac arrest. Neurological damage is a rare but well recognised consequence of regional and particularly epidural and spinal anaesthesia. This may result in localised areas of paraesthesia or anaesthesia, motor weakness, loss of sphincter control and paraplegia. Rarely, these may be permanent. **Use in Pregnancy and Lactation:** Levobupivacaine should not be used during early pregnancy unless clearly necessary. The clinical experience of local anaesthetics of the amide type including bupivacaine for obstetrical surgery is extensive. The safety profile of such use is considered adequately known. There are no data available on excretion of levobupivacaine into human breast milk. However, levobupivacaine is likely to be transmitted in the mother's milk, but the risk of affecting the child at therapeutic doses is minimal. **Overdose:** Accidental intravascular injection of local anaesthetics may cause immediate toxic reactions. In the event of overdose, peak plasma concentrations may not be reached until 2 hours after administration depending upon the injection site and, therefore, signs of toxicity may be delayed. Systemic adverse reactions following overdose or accidental intravascular injection reported with long acting local anaesthetic agents involve both serious CNS and CVS effects. **Special Storage Conditions:** No special storage precautions for the closed ampoule. Once opened, use immediately. **Legal Category:** POM. **Marketing Authorisation Number:** PL 0037/0300-0302. **Basic NHS Price:** 2.5 mg/ml pack: £16.60, 5.0 mg/ml pack: £19.00, 7.5 mg/ml pack: £28.50. Further information is available on request from Abbott Laboratories Ltd, Abbott House, Norder Road, Maidenhead, Berkshire SL6 4XE. PI/93/1/001. **Date of Preparation:** March 2003. **Reference:** 1. Burke D & Bannister J. Current Anaesthesia and Critical Care 1999; 10: 262-269.  **ABBOTT ANAESTHETICS**
operating with care

convincing argument in favour of the surgeon doing the block since they were more familiar with the anatomy, had all the necessary tools at their disposal, and were confident of the safe track record of Sub-tenons. Guri Thind from Aintree proposed that on the grounds of safety, standards of care and throughput, the anaesthetist should perform the block, and he had also sought patient's views on who they would prefer. Sheila Mayer, the cataract service co-ordinator from Manchester Royal Eye Hospital had been trained in the technique in 1998 and since then performed thousands of blocks with great success and few complications. After three very convincing presentations a second show of hand was still in favour of the anaesthetist but there was a definite increase in favour of nurses performing the block. A feast was in store for those who attended the Annual Dinner of the society in the Belgrave suite at the Grosvenor Hotel on Thursday evening. The elegant surroundings were enhanced by a delightful string quartet and plentiful quantities of excellent food and wine.

Friday morning started with a session entitled Choroid and Retinal Surgery and Anaesthesia. Prof Bertil Damato from Liverpool, amazed us with his beautifully illustrated lecture on local resection of intra-ocular melanomas, while Andrew Jones his brave anaesthetic colleague described the use of profound hypotensive anaesthesia often required for this type of surgery. Also from Liverpool Mr David Wong described the somewhat controversial and extremely complicated technique of surgery for macular degeneration, while his anaesthetist Dr Fred Mostafa, explained how to anaesthetise patients for this often very lengthy operation. After coffee there were seven free paper presentations, which were all of very high standard. Interestingly two were on the subject of globe deviation during general anaesthesia and its interference with ocular surgery. The authors suggested various techniques to minimise this effect including muscle paralysis. Dr R Ling eventually won the prize with his excellent presentation on Subchoroidal haemorrhage complicating cataract surgery in the UK. No meeting would be complete without its Controversies session, which commenced after lunch. Prof Chris Dodds entertained us in his inimitable style with his presentation on GA versus RA in Ophthalmic Surgery. He made several important points regarding the risk to

training with the decline in the use of general anaesthesia.

Ellen O'Sullivan from Dublin had been involved in the development of joint association and college guidelines on patient information and described the long and somewhat controversial process involved in their production. As an extra item on the programme Steve Mather from Bristol presented the results of a survey on the management of hypertension prior to ophthalmic surgery, which had received some very varied responses.

There then followed a fascinating session entitled Ophthalmic Surgery and Anaesthesia in Developing countries in which two surgeons and two anaesthetists described their experiences in Africa, India and on board the flying eye hospital with operation Orbis. Particularly interesting and somewhat controversial was the presentation by Dr Suresh Panday who described the technique of "No-Anaesthesia Cataract Surgery" and the possible ways in which this can be achieved with apparently no discomfort for the patient.

The scientific meeting ended with the Abbott Lecture, where Abbott had generously sponsored the lecturer, Dr Roy Hamilton from Calgary, who presented his Musings on Two Decades of Ophthalmic Regional Anaesthesia. Dr Hamilton is a world renowned Ophthalmic Anaesthetist who probably has more experience in the art of ophthalmic regional anaesthesia than any other person. He has trained and educated many of the UK's leading experts and has supported BOAS enthusiastically since its birth. No wonder he was honoured with the lifetime achievement award by the society. This was a fitting end to a very successful fifth Annual BOAS meeting.

June 2003

Mortality and non-ocular morbidity following cataract surgery under local anaesthesia compared to general anaesthesia

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Introduction

Previously¹ we have raised concerns over the safety of local anaesthesia in ocular surgery – based on the results of the National Survey^{2,3}. Local anaesthesia has been shown to be the largest single risk factor in producing a poor outcome – principally from ocular complications such as retrobulbar haemorrhage and globe perforation. Accepting this, then local anaesthesia ought only to be used in preference to general anaesthesia if a clear benefit to the patient can be shown in terms of lower mortality or morbidity. There are, to our knowledge, no studies that address this issue⁴.

Methods

We have therefore retrospectively reviewed systemic outcomes [death within 30 days of surgery or re-admission to hospital for non-ophthalmic/non-elective reasons within 30 days of surgery] for patients undergoing cataract surgery comparing the results for patients receiving a local anaesthetic (without reference to technique) compared to patients in whom surgery was performed under general anaesthetic (again without reference to technique).

Data was obtained from Wirral NHS Trust central computerised records (PCIS and ORSOS).

Between 1/1/93 and 31/12/2000, 8783 patients underwent cataract surgery local anaesthetic was used in 81.4% (7154 patients) under local anaesthetic and 18.6% under general anaesthetic (1629 patients).

Results

In the 30 days following surgery 11 patients died following surgery. Following local anaesthetic 10 patients died, 1 died following general anaesthetic.

Data was analysed using the Chi-squared test and no statistically significant difference ($p = 0.4192$) was shown between the two groups.

[95% confidence interval was $-0.002116 - 0.002107$ (standard error 0.000971).

In the 30 days following surgery 63 patients were re-admitted to hospital for non-ophthalmic/non-

elective reasons. This was following local anaesthetic in 53 patients and following general anaesthetic in 10 patients.

Data was analysed using the Chi-squared test and no statistically significant difference ($p = 0.5834$) was shown between the two groups.

[95% confidence interval was $-0.00493 - 0.004105$ (standard error 0.0002317)].

Discussion

Clearly these results need to be interpreted with great caution. This is because of the very obvious limitations of the study, which was retrospective and based on computerised hospital records. Analysis was unsatisfactory in a number of key areas.

It was not possible to determine the technique of anaesthetic used in either group. Having said that the most predominant technique of local anaesthetic used in the department during this time was injectional, either retrobulbar or peribulbar. It was not possible to determine the reasons for either re-admission – although all were for non-elective reasons. It was not possible to determine whether the cause of death or the reason for re-admission could be related in any way to the patient having had a local or general anaesthetic in the preceding 30 days. It was not possible to what if there were any specific indications for the type or the technique of anaesthetic used in either group – however local anaesthetic was certainly preferred by the ophthalmologist, anaesthetists and managers working in the trust at that time.

However this study is to our knowledge the first to attempt to determine whether local anaesthesia confers any benefit to the patient over general anaesthesia. It comprises a large group of patients and fails to show that there is any benefit in terms of reduced mortality or lower systemic morbidity in the 30 days following cataract surgery.

Unfortunately it was beyond the scope of this project to investigate whether visual outcome was better or ocular complications less in either group or whether there was any economic benefit linked to the choice of anaesthetic.

Conclusion

We do not believe that the results ought, of themselves to lead to any change in current anaesthetic practice in relation to cataract surgery. However we do feel that given the ocular complications associated with local anaesthetic, further study is required to determine which type or technique of anaesthetic produces the best

outcome for patients. We feel such a study is long overdue.

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A glaucoma surgeon's view of anaesthesia techniques

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Glaucoma is a term used to describe a group of chronic, sight-threatening conditions characterised by progressive damage to the optic nerve with associated progressive visual field defects. Glaucoma affects around 2% of adults, and prevalence increases with age. Damage seems to occur at the optic nerve head, with damage caused by elevated intra-ocular pressure (IOP), ischaemia of the optic nerve head, or a combination of factors. Established treatments aim to reduce IOP by means of eye-drops, laser or surgery.

Many patients with glaucoma will require surgery, usually either for cataract or to reduce IOP by means of trabeculectomy.

Trabeculectomy involves making a small hole in through the sclera and into the anterior chamber drainage angle, to allow aqueous humour to flow directly to the sub-conjunctival area, forming a drainage 'bleb'. Trabeculectomy is more likely to fail if there is too much post-operative scarring, and this is more likely to occur if there has been some previous pro-inflammatory insult to the conjunctiva such as trauma, surgery, or prolonged use of eye-drops.

Because of these considerations, care should be taken when choosing an anaesthesia technique for glaucoma patients who need eye surgery. The particular concerns related to anaesthesia technique are (i) induced ischaemia of the optic nerve head, and (ii) induced conjunctival scarring that might jeopardise the success of any future trabeculectomy.

It is desirable to avoid exacerbating any pre-existing ischaemia of the optic nerve head, as this could potentially cause acute loss of vision at the time of surgery. While there is no direct evidence that local anaesthesia can be blamed for visual field 'wipe-out', there is indirect evidence that this can occur. For example, retrobulbar or peribulbar injections may induce a rise in intra-orbital pressure, either directly due to a volume effect, or indirectly due to an induced orbital haemorrhage, and this could compromise blood flow to the optic nerve head. Hyaluronidase may reduce this risk, by allowing better diffusion

through the anatomical 'compartments' of the orbit. If there is adrenaline in the mixture, then vasoconstriction might induce transient ischaemia at the optic nerve head. For patients who have already lost a lot of vision to glaucoma, a small amount of ischaemic damage could potentially cause noticeable loss of vision.

Many patients who need trabeculectomy have previously undergone cataract surgery. Therefore, cataract surgery in glaucoma patients should be performed in a way that does not increase the risk of failure for any subsequent trabeculectomy. Conjunctival manipulation should be kept to a minimum, by using a clear-corneal approach and not using toothed conjunctival forceps to steady the eye during surgery. Anaesthesia techniques that induce conjunctival scarring should also be avoided. Sub-Tenon anaesthesia is likely to induce an inflammatory response in the conjunctiva and Tenon's capsule, due to the surgical manipulation of tissues and also the consequences of chemosis, which can also occur with other injection techniques.

It is clear from the above discussion that neither peribulbar, retrobulbar nor sub-Tenon's anaesthesia are ideal for glaucoma patients. General anaesthesia is an option, provided that care is taken regarding haemodynamic stability of the patient. My personal preference for cataract surgery is to use topical-intracameral anaesthesia, employing a clear-corneal approach, non-toothed forceps, and intracameral antibiotic in place of the subconjunctival injection at the end of surgery. For trabeculectomy, topical anaesthesia alone is inadequate because scleral diathermy is required. For the past year, I have used subconjunctival-intracameral anaesthesia for trabeculectomy, with good results and a high degree of patient acceptance.

My preferred technique for subconjunctival-intracameral anaesthesia is as follows. After instilling proxymetacaine, amethocaine and povidone-iodine drops, I position the patient under the operating microscope and choose the site for surgery. Sedation is not used. Using a 2ml syringe and 26 gauge (brown) needle, I give about 0.5-1ml of non-preserved 0.5% lignocaine as a sub-conjunctival injection, raising a bleb which covers the area of the proposed drainage bleb. I then scrub for surgery, allowing a few minutes for the anaesthetic to take effect before commencing the procedure. A corneal stay

suture is used to keep the eye still, and surgery proceeds as normal. After making the paracentesis incision and prior to making the peripheral iridectomy, further 0.5% lignocaine is instilled into the anterior chamber, using a Rycroft canula. To date, I have had no complications attributable to anaesthetic technique, no choroidal haemorrhages, and no need for top-up anaesthesia by a different technique. While this technique is not new, it has not been formally evaluated in terms of surgical outcome (pressure control and bleb morphology) and patient acceptance. Although these aspects do not appear to be a problem, I shall be auditing them in the coming months. Fuller assessment is required before recommending widespread use of this technique.

Ophthalmic Anesthesia Society
17th scientific meeting
Chicago
3rd – 5th Oct 2003
Dr Monica Hardwick, Council Member
Worcester

The American equivalent of BOAS is OAS, which has been in existence for seventeen years and traditionally holds its annual meetings in Chicago in October. The hotel venue changes from year to year but the favourite seems to be the Westin Hotel where this year's meeting was held. Not surprising, as it is right in the centre of "downtown" Chicago, with its fantastic shops, restaurants and architecture, while being only a few hundred yards from the banks of Lake Michigan. Ken Barber and I were lucky enough to attend the OAS meeting this year for the second time, having been once before in 1999. We were also fortunate enough to stay with one of our American Colleagues and visit their Ophthalmic "Surgicentre" but that, as they say, is another story.

Rather than give a "blow by blow" account of the whole meeting I would like to mention a few of the many excellent lectures which particularly caught my attention.

The meeting opened on Friday lunchtime with a lecture on Post Operative Visual Loss (POVL) after Non-Ophthalmic Surgery given by Steven Roth, Professor of Anaesthesia and Neurobiology in Chicago. There appears to be an incidence of up to 1.3% of POVL after cardiac surgery and 0.2% after spinal surgery. The causes include central or branch retinal artery occlusion and anterior or posterior optic neuropathy. The speaker gave a very detailed discussion of factors predisposing to these, for example peri-operative hypotension, blood loss and increased orbital venous pressure. Treatment of POVL is usually unsuccessful and prevention should be directed towards maintaining ocular perfusion. Finally there was consideration of whether to include POVL when discussing post-operative complications with the patient prior to cardiac or spinal surgery.

Louise Weizer, who is a registered Nurse Anaesthetist from Cleveland, talked about "Safety and Comfort under the Drapes". Most of her lecture was familiar to us in terms of provision of oxygen and prevention of build up of carbon dioxide. But how many of us have

considered the dangers of a HIGH concentration of oxygen under the drapes when combined with a surgical technique requiring diathermy! I was pleased to note that the speaker recommended the venturi system of oxygen enriched air under the drapes, which is the system in use in my own unit.

The debate on anticoagulation during ophthalmic surgery still continues in the USA, but an excellent and very sensible lecture was given on the subject by Prof. Brent G Petty from Johns Hopkins in Baltimore. He stressed the importance of continuing warfarin therapy during cataract surgery and also discussed the potential complications from taking Aspirin. He quoted a study of 20,000 cataract procedures in the USA and Canada where the reported incidence of haemorrhage, even using retrobulbar blocks, was 0.59 per thousand cases in patients taking aspirin, compared to 0.56 per thousand in patients not taking aspirin. He suggested that the risk/benefit ratio be carefully considered before stopping anticoagulant or anti-platelet therapy prior to surgery.

One feature of the American Society meeting is the session on the "Politics and Economics of Ophthalmic Anaesthesia", an area that is normally does not feature at UK meetings. There were several lectures on different aspects of the problems in the USA, particularly with respect to the insurers – Noridian Medicare, and their definition of "Monitored Anaesthesia Care" or MAC. The question is whether an anaesthesiologist who is providing IV cannulation, monitoring and attendance if medication be required (MAC), should be remunerated differently from one providing IV sedation, regional or general anaesthesia. These discussions are very different from problems such as capacity, waiting lists and manpower that beset us in the UK.

An ophthalmologist and a nurse manager from an Ambulatory Surgery Centre in Arkansas presented the results of their 7-year study on 13,000 intraocular cases in which strict protocols had prevented any occurrence of endophthalmitis. Although their results were very impressive the lengths to which they went to achieve these were somewhat extreme. These included the patients washing their faces repeatedly with antibacterial soap prior to surgery, and being cancelled if they showed any evidence of systemic infection or had a high blood sugar suspicious of diabetes. The

nurse manager enforced strict aseptic protocols in the operating theatre and any member of the nursing staff who breached these even once was immediately dismissed on the spot! I am not sure how well these practices would be accepted in the UK.

Obesity has reached epidemic proportions in the USA, and the problems that this poses to the anaesthetist were eloquently put forward by Stephanie Mouton, an anaesthesiologist from Nashville. The reasons suggested for the increase in obesity are the fondness for Americans to eat out, their fear of going out to exercise in case of mugging, and the increasing use of technology. Restaurants have been criticised for serving oversized portions (and believe me they are HUGE!) and for serving food with hidden or “Trans Fats”. It may soon become law for restaurants to itemise all the ingredients in their menus. Dr Mouton pointed out that obesity leads to diabetes which leads to eye disease, so if ophthalmic anaesthetists wish to avoid having to deal with greater numbers of obese patients we have a duty to warn our patients of the dangers of overeating.

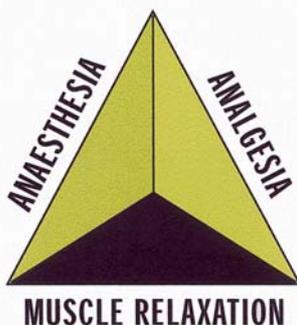
The Americans are very concerned with patient satisfaction, quite rightly so, and I think we have a lot to learn from them about how to treat patients well. However I could not help but be amused by Mark Feldman’s lecture on the subject, where he conducted an audit and found that 60% of patients felt that they had been treated with “dignity and respect”. However after a system of scripted dialogue had been adopted

(i.e. the Anaesthetist introduced himself to the patient and said he was there to treat them with “dignity and respect”) the percentage of satisfied patients rose to 80%.

The workshops held during the OAS meeting are completely different to those usually held during British meetings. They take the form of small group case discussion panels, medical, anaesthetic or ophthalmic. There was also a case management summary presented by Gary Fanning from Sycamore, on a very interesting patient with Shy-Drager Syndrome and severe autonomic failure. There are no free paper presentations and the only posters were from the UK, also the trade exhibition was notable by its absence, so there are several organisational differences from the traditional UK meetings.

Delegates are also free to organise their own eating arrangements and evening entertainment, which is a great opportunity to explore some of the fantastic restaurants in Chicago. While we were there the city was buzzing with the success of the baseball team, the Chicago Cubs, who were doing so well in the World Series. Preparations were also in place for the Chicago Marathon the following weekend, and the track along the shores of Lake Michigan was full of would-be competitors in the last stages of their training. Chicago is a great city to visit, and the OAS organise a very worthwhile conference every October, so get your study leave requests in early for next year!

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Is he as strong as she thinks?



51% of patients over 60, undergoing general anaesthesia in the UK, have cardiac problems¹

Sevoflurane does not significantly alter the heart rate²

Sevoflurane Prescribing Information: Presentation:

Amber glass bottle containing 250ml sevoflurane. **Indications:** For induction and maintenance of general anaesthesia in adult and paediatric patients for inpatient and outpatient surgery. **Dose:** MAC values decrease with age and the addition of nitrous oxide (see Summary of Product Characteristics). **Induction:** In adults up to 5% sevoflurane usually produces surgical anaesthesia in less than 2 minutes; in children up to 7% sevoflurane usually produces surgical anaesthesia in less than 2 minutes. Up to 8% sevoflurane can be used for induction in unpremedicated patients. Maintenance concentrations range from 0.5-3%. Elderly: lesser concentrations normally required. **Administration:** Deliver via a vapouriser specifically calibrated for use with sevoflurane. Induction can be achieved and maintenance sustained in oxygen or oxygen-nitrous oxide mixtures. **Contraindications:** Sensitivity to sevoflurane. Known or suspected genetic susceptibility to malignant hyperthermia. **Precautions:** For use only

by trained anaesthetists. Hypotension and respiratory depression increase as anaesthesia is deepened. Malignant hyperthermia. Experience with repeat exposure is very limited. Until further data are obtained, sevoflurane should be used with caution in patients with renal insufficiency. Levels of Compound A (produced by direct contact with CO₂ absorbents) increase with:- increase in canister temperature; increase in anaesthetic concentration; decrease in gas flow rate and increase more with the use of Baralyme rather than soda lime. **Interactions:** Potentiation of non-depolarising muscle relaxants. Similar to isoflurane in the sensitisation of the myocardium to the arrhythmogenic effect of adrenaline. Lesser concentrations may be required following use of an IV anaesthetic. Sevoflurane metabolism may be induced by CYP2E1 inducers, but not by barbiturates. **Side-Effects:** Dose-dependent cardio-respiratory depression. The type, severity and frequency of adverse events are comparable to those seen with other inhalation anaesthetics. Most adverse

events are mild to moderate and transient: nausea, vomiting, increased cough, hypotension, agitation and bradycardia. Hepatitis has been reported rarely. Convulsions may occur extremely rarely, particularly in children. There have been very rare reports of pulmonary oedema. As with other anaesthetics, twitching and jerking movements, with spontaneous resolution have been reported in children during induction. Patients should not be allowed to drive for a suitable period after sevoflurane anaesthesia. **Use in Pregnancy and Lactation:** Use during pregnancy only if clearly needed. It is not known whether sevoflurane is excreted in human milk - caution in nursing women. **Overdose:** Stop sevoflurane administration, establish a clear airway and initiate assisted or controlled ventilation with pure oxygen and maintain adequate cardiovascular function. **Special Storage Conditions:** Do not store above 25°C. Do not refrigerate. Keep cap tightly closed. **Legal Category:** POM. **Marketing Authorisation Number:** PL 0037/0258. **Basic NHS Price:** 250ml Bottle £123.00.

Further information is available on request from Abbott Laboratories Ltd., Abbott House, Norden Road, Maidenhead, Berkshire SL6 4XE. **Ref.** PI/12/1/008. **References:** 1. 2000 Medicare Anaesthesia Diary Study. 2. Ebert T J et al. *Anaesthesiology* 1994; A138. **Date of Preparation:** February 2001. HXSEV2001011.



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LONDON

World Congress on Ophthalmic Anaesthesia

Hosted by

British Ophthalmic Anaesthesia Society

APRIL 15-16th 2004

To be held at

The Royal College of Physicians

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10th Jan 2004**

Further details and application form:

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A visit to an American Surgicentre Ken Barber, Worcester

Within the next twelve months we will witness the opening of a series of Diagnostic and Treatment Centres (DTC's) throughout the UK. Before they are opened, their name has already changed to 'Treatment Centres', and I am not sure what has happened to the diagnostic element. With the number planned it is likely that one will be opening near to you. This combined with the introduction of the Patient Choice Agenda will have an effect on the local provision of ophthalmology services. Some clinicians will wish to be involved and practice in the DTC's. Others will be prohibited from participating by discrimination against UK consultants in favour of foreign clinicians. The DTC's have been modelled on the American Surgicentre concept. Whether you will or will not be practicing in a DTC it is likely that they will have an effect on your NHS work and also your private practice. With this in mind I took up the kind offer of Gary Fanning to visit the Hauser-Ross Eye Institute Sycamore, Illinois. This is a surgicentre near to Chicago, which predominantly provides day care eye surgery, but also other surgery for example carpal tunnel procedures. Gary is an anaesthesiologist. He is also the Medical Director of the Institute.

We not only visited the Institute but we had the opportunity of staying as guests in the home of Gary and his wife Arline. This was a wonderful opportunity to get a real feel for the lifestyle of an anaesthetist in America. The house is large by UK standards and has a modern open plan design. There was a real feeling of space both inside and around the estate of houses.



The doctor's house.

The Hauser-Ross Eye Institute was founded by two ophthalmologists Neil Ross and Lynne Hauser. They have since retired and the Institute is now owned by the local hospital. Visiting another centre is a rewarding experience, especially when that centre is in another country. There are two features that stay in my mind after the visit. Firstly this centre scores highly on patient handling. They treat their patients well. Each patient is given space, time with staff, and attention. It is in an environment that is also relaxed and professional. Secondly the institute has a real feel for efficiency, both in the surgical area and also in the outpatients. It is not surprising however that these two features are so apparent. The centre is in direct competition with other providers and it is a buyers market. The reputation of the centre needs to be maintained to keep the customer base. The efficiency needs to be high to keep the cost per case low, and hence the financial stability and success of the centre. This contrasts with the UK NHS where demand outstrips supply, and clinical priority such as malignancy, competes with political priority like routine waiting times.

On the day of the visit 13 cataract operations were scheduled for the morning session. Two theatres, two anaesthetic rooms and a day care area were available. They start early about 8.00am and the list finished at 11.45am. One surgeon and one anaesthetist carried out their work in an unhurried organised fashion. With the twin theatres each with their own staff they have been known to go up to 22 cases in one session. So 13 cases was not stretching them. The surgery was standard phacoemulsification surgery and some patients were having astigmatic corrections and some were having toric lenses inserted. All decisions regarding the surgery seemed to have taken place prior to the day of surgery, so that the list could continue smoothly. Everyone in the team seemed to know their job well, and there was good communication between patients and different members of staff. Their procedures for various situations are well mapped out. An example of this is when the patient wishes to cough during cataract surgery. The nurse with the patient informs the surgeon clearly that the patient wishes to cough. Instruments are immediately removed from the eye and the patient is invited to cough.

The two operating rooms were well equipped, and were linked to in-house CCSD, which reduced the need for large banks of sterilised instruments. The CCSD team quickly removed instruments from one theatre to recycle ready for use later on the list. This activity took place like clockwork in an unhurried fashion. The whole team worked well together, and I suppose it is the only way that they can deal with the workloads that they are involved in. One surprising element was the amount of paperwork in the anaesthetic room that required a signature from the anaesthetist. If a signature were missed on a chart, the document would crop up at a later stage in the office of the anaesthetist for a post-dated signature. The other unusual feature of the theatre was the relative's gallery. This was an area behind a glass screen, where friends or relatives of the patient would sit with a member of staff who would give a commentary on the stages of the operation. This was viewed on a monitor, and gave a live recording of the surgical view.



The Viewing Gallery

This concept is quite unusual by European standards, and I am sure would need quite a lot of adaptation on behalf of the surgeon and other theatre staff.

The atmosphere of the Institute was very positive and the feeling was that these people who work there enjoyed, and took pride in their work. Having said that, I also believe that most do indeed work hard. The days start early, volumes of surgery are high, and there seems to be less annual leave taken compared to UK standards.



Surgeon and Anaesthetist.

Of course as we know in ophthalmology, for every surgical patient there are many more outpatient visits. High volume surgery required an organisation that can cope with high volumes of outpatient visits. We next visited the outpatient clinic; here too we can see a high level of organisational sophistication. Each consultant may see about 30 clinic patients. How is that possible? The answer is firstly to create many more consulting rooms than clinicians. Fourteen fully equipped consulting rooms were in the clinic zone where up to a maximum of three clinicians may be working. The principle is that the patient goes into a consulting room and stays there. The ophthalmologist will move between a number of rooms. Usually for ophthalmology patients the doctor will definitely move quicker than the patient, so the patient stays put. Working alongside the ophthalmologist is a team of staff, who prepares the patient, take some history, and partly examine a patient. When this is done a light on a board will indicate that the patient is ready to see the doctor.



Out-patient signal system

The clinician also has the help of a writer who will record in a legible fashion the clinical record. If a patient is going ahead with surgery, they will then see another member of staff to sign a consent form, and to arrange a date for surgery. They therefore are able to see much larger numbers of patients, with the help of a team of support staff. Visiting another centre can be very rewarding. There are so many new ideas to be gleaned, and

some of these ideas are well worth importing into our own practice in the UK. The culture, and the environment are however different, and there are some concepts that do not relate to the non-profit, high demand situations of the NHS in the UK. We are indebted to Gary Fanning, and Arline Fanning for a memorable visit to Chicago, the Hauser Ross Eye Institute, and an American family home.

News and information

World Congress of Ophthalmic Anaesthesia

World Congress of Ophthalmic Anaesthesia will be hosted by BOAS on 15-16th April 2004 in the premises of the Royal College of Physicians, London. Details are available on BOAS Website www.boas.org
Please register early.

No subscription for retired members

Retired members do not need to pay the annual subscription fee.

Income Tax Rebate to Society Members

BOAS is registered with Her Majesty's Inland Revenue for the purposes of Corporation Tax. Members can claim income tax allowance against the BOAS subscription.

Contribution for the 10th issue

The next Newsletter will be published in May 2004. Please send your articles or any contributions for inclusion in the Newsletter by 30th April 2004, to Dr Chandra Kumar, Secretary BOAS, The James Cook University Hospital, Middlesbrough TS4 3BW, UK or email cmkumar@boas.org

Subscription to Journal of Cataract and Refractive Surgery

Anaesthetist members of BOAS can receive the journal at a discounted rate of £65 by writing to Andre Welsh, UKISCRS, PO Box 598, Stockton on Tees TS20 1WY. Tel 01642651208, Fax 01642651208, Email: ukiscrs@onyxnet.co.uk, Website: www.ukiscrs.org.uk

Acknowledgement

BOAS office is grateful to Mr Stephen Moore, Information Officer, The James Cook University Hospital, Middlesbrough for his valuable help in the production of the Newsletter.

Mrs Pat McSorley

Mrs Pat McSorley has been running the society administration since 1998. She has now retired. BOAS wishes her a happy retirement. She will continue to administer the society business from her home.

Reasons for joining BOAS

BOAS was formed in 1998 to provide a forum for anaesthetists, ophthalmologists and other professionals with an interest in ophthalmic anaesthesia to facilitate co-operation on all matters concerned with the safety, efficacy and efficiency of anaesthesia for ophthalmic surgery. It is concerned with education, achievement of high standards, audit and research. BOAS will organise annual scientific meetings, produce a newsletter and maintain a web page.

Membership

Membership of BOAS includes anaesthetists, ophthalmologists and other professionals with an interest in ophthalmic anaesthesia.

Membership subscription

Membership runs from January each year. The current subscription is £25.00 payable by banker's standing order.

Liaison and specialist professional advice

With the Association of Anaesthetists of Great Britain and Ireland and the Ophthalmic Anesthesia Society of the USA.

Benefits of Membership

- Opportunity to participate in BOAS annual scientific meetings
- Reduced registration fee for BOAS annual scientific meetings
- Reduced registration fee for other ophthalmic anaesthesia meetings and courses in UK
- Free advice from experts on matters related to ophthalmic anaesthesia
- BOAS newsletter and Directory of Members
- Opportunity to contribute towards development and improvement of ophthalmic anaesthesia
- Access to BOAS web page and scientific literature database
- Eligibility for election to Council of BOAS

Administrative Office and Membership information from

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 Tel 01642 854601
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 Email cmkumar@boas.org
 Web address <http://www.boas.org>

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Members are advised to inform the secretary if there is a change of email or postal address.

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British Ophthalmic Anaesthesia Society Member Registration Form

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If you would like to become a member of the British Ophthalmic Anaesthesia Society, please complete the bank standing order and your personal details.

Completed form should be sent to:-

Dr. Chandra M Kumar
 Secretary, BOAS
 Dept. of Anaesthesia
 The James Cook University Hospital
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Local Anaesthesia for Ophthalmic Surgery

Friday, 6th February 2004, Middlesbrough

12th Video-conference Meeting

A CME approved meeting for anaesthetists and ophthalmologists on Local Anaesthesia for Ophthalmic Surgery will be held in Education Centre, The James Cook University Hospital, Middlesbrough on Friday, 6th February 2004. The meeting will include **lectures and live demonstration of orbital blocks**. Attendance is limited to 50 participants. Application form and information from Elaine Tucker (Course Administrator 01642-854601 email: elaine.tucker@stees.nhs.uk). Registration fee is £225 (BOAS Members £200) (inclusive of catering). Cheque payable to Ophthalmic Anaesthesia Education Trust Fund.

PROGRAMME

09.00-9.25	Registration & Coffee
9.25	Welcome: Prof Chris Dodds, Middlesbrough
Chairman:	Dr Robert Johnson, Bristol
9.30-10.15	Anatomical considerations for ophthalmic block Prof Chris Dodds, Middlesbrough
10.15-11.00	Pharmacological considerations for ophthalmic block Dr Hamish McLure, Leeds
11.00 - 11.30	Coffee Break
Chairman	Dr A P Rubin, London
11.30- 12.00	Review of eye blocks Dr Chandra Kumar, Middlesbrough
12.00 - 12.30	Eye blocks in perforating eye injuries Dr Steven Gayer, USA
12.30-13.45	Lunch
13.45 -17.00	Live Demonstration of Orbital Blocks
Demonstration Co-ordinators: Drs Anthony Rubin, Robert Johnson, Chandra Kumar, Mr Tim Dowd, Mr Mamdouh El-Naggar, Mr David Smerdon & Prof Chris Dodds	
<u>Retro and/ or peribulbar</u>	Dr Chandra Kumar, Middlesbrough Dr Anthony Rubin, London Dr Sean Tighe, Chester Dr Narinder Dhariwal, Sunderland Dr K L Kong, Birmingham Dr Steven Gayer, USA
Medial peribulbar Recorded video	
<u>Sub-Tenon's</u>	Dr Guri Thind, Liverpool
Stevens' Cannula	Prof Chris Dodds, Middlesbrough
Kumar-Dodds Cannula	Dr Raju Chabria, Middlesbrough
Greenbaum's Cannula	Dr Chandra Kumar, Middlesbrough
Ultrashort Metal Cannula	Mr Bartley McNeela, Jersey
17.00 Closing remarks	Prof Chris Dodds, Middlesbrough

Programme director and meeting organiser: Dr Chandra Kumar, Consultant Anaesthetist, University Department of Anaesthesia, The James Cook University Hospital, Middlesbrough TS4 3BW. Tel: 01642-854601, email: cmkumar@boas.org