The First World Congress Of Ophthalmic Anaesthesia
London - April 2004

The very first world Congress of Ophthalmic Anaesthesia was hosted by BOAS at the Royal College of Physicians in London on the 15th and 16th of April. The Congress was the “brainchild” of the secretary of BOAS, Professor Chandra Kumar, to coincide with the World Congress of Anaesthesia being held in Paris the following week. It was an adventurous undertaking for a relatively new Society, but with Chandra’s experience and enthusiasm, an attendance of nearly 200 delegates and faculty from over 40 countries, we were confident that it would be successful.

The venue proved to be ideal, with excellent conference facilities and had the added advantage of a stroll in the adjacent Regent’s park during the Lunch breaks! With the delightful spring sunshine I think our overseas delegates gained a very favourable impression of London!

The congress opened on Thursday morning, with Professor Chris Dodds, the president of BOAS, chairing a session mainly devoted to training in Ophthalmic Anaesthesia, with the views of both the colleges of Anaesthesia and Ophthalmology being represented. Professor Roy Hamilton from Calgary also gave a global view of Ophthalmic Anaesthesia, and Tom Eke presented the preliminary results of a one-year survey of adverse events associated with cataract surgery. This showed a marked increase in the use of the sub-Tenons technique for local Anaesthesia since the last audit in 1996. Although the data for adverse events were incomplete it appears that “no needle” i.e. topical or sub-Tenons anaesthesia is associated with a lower incidence of sight or life threatening complications.

There were a number of parallel workshops running during the remainder of the Thursday morning including such topics as; Needle Block techniques, Sub-Tenon’s technique, Anatomy for eye blocks and Education and Ophthalmic Anaesthesia. With careful planning it was possible for delegates to attend all of the workshops during the congress.

After Lunch, came a session on Ophthalmic injury and Anaesthesia, which started with Chris Dodds showing some rather graphic photographs of Traumatic Eye injuries. Roy Hamilton described iatrogenic injuries mainly produced by sharp needle local anaesthetic techniques, but also reminded us that damage can be caused by over enthusiastic digital compression.
Why take extra risk?

Equal efficacy & lower toxicity than bupivacaine

Ophthalmic Anaesthesia News, Issue 10, July 2004
Email: info@boas.org  Website http://www.boas.org
Steve Gayer from Miami described the Anaesthetic management of patients presenting with Ophthalmic Trauma, which can include regional techniques as long as they avoid rises in intra-ocular pressure when the globe has been perforated. Dr Emile Callenda from Rouen, France presented the management of pain after ophthalmic injury including superficial injury such as abrasion and more serious injury such as ocular burns. He stressed that topical anaesthesia should be reserved for examination or minor surgery, and should not be used for treatment of painful ocular conditions, because of adverse effects on lacrimation and tear film stability.

Professor Chandra Kumar, Organiser, World Congress of Ophthalmic Anaesthesia

Mr Nick Astbury, President, The Royal College of Ophthalmologists, London

Professor Chris Dodds, Chairman Scientific Committee and BOAS President

Dr Doug Justins, Senior Vice President, The Royal College of Anaesthetists, London

Professor Roy Hamilton, President, International Ophthalmic Anaesthesia Society
The last session of the afternoon was entitled Perioperative Management of Ophthalmic Patients and had a truly international flavour, with speakers including Marc Feldman from Ohio, Bob Johnson from Bristol and Helena Kallio from Finland, who all gave excellent presentations. However, the presentation which produced the greatest response from the audience, was given by Daniel Espada Lahoz from Sao Paulo on the subject of sedation. This was twenty minutes of hilarious animated visual cartoons with sound effects, which reduced the whole audience to tears of laughter – it was the funniest presentation at a scientific meeting that I have ever witnessed, and Dr Lahoz was given a huge round of applause and several shouts of “encore”!
The Conference Dinner was held at the prestigious Berkley Hotel in Knightsbridge in truly palatial surroundings and was attended by about ninety delegates, faculty and their partners. The food was of exceptional quality, the service was excellent, and many agreed that it was one of the best conference dinners they had attended.

Friday morning dawned fine and sunny, and the first session sponsored by Abbott Laboratories Ltd was on the subject of Pharmacology and Eye Anaesthesia. The five excellent speakers came from as far afield as India, The Netherlands and South Africa. Hamish McLure from Leeds, persuaded us that the addition of adrenaline and hyalase to our local anaesthetic mixture was probably unnecessary, and Dr Uday Gorakhsa from Mumbai suggested intravenous lidocaine 2% up to 2mg/kg as a useful technique for lowering intraocular pressure.

The four parallel workshops were repeated again after the coffee break on the same topics, but with different faculty, and then followed the Annual General Meeting of the Society. Several important announcements were made including the decision by Chandra Kumar to hand over the post of Secretary to Sean Tighe from Chester. The President thanked Chandra on behalf of council for all his hard work and enthusiasm in creating and maintaining the Society. Other announcements were that Ken Barber from Worcester would take over as President of the Society from April 2005, and the next Annual Scientific meeting would take place in Jersey on June 9th and 10th 2005. A proposal was made for a four yearly World Congress of Ophthalmic Anaesthesia and this was strongly supported by the membership, with offers of hosts from Egypt and South Africa. A new logo is being sought for the Society’s letterheads, and the membership were asked to submit their artistic ideas.

Following the AGM there was a presentation of two Lifetime Achievement awards in Ophthalmic Anaesthesia, one to Dr Bob Johnson, the first President of BOAS and the other to Dr Gary Fanning the past president of the OAS. Both recipients were complimented on their numerous contributions to Ophthalmic Anaesthesia and BOAS over the years.

After lunch, the free papers were presented in two parallel sessions of four papers each, so it was impossible to attend them all. Half of them were on the subject of sub-Tenon’s, three on intravenous sedation and one on a local anaesthetic technique for trabeculectomy. According to my colleagues, all the papers were of high standard, but one particularly impressed me. This was a paper on orbital exenteration under local anaesthesia with intravenous sedation, presented by Anne Cook, an Oculoplastics Fellow from Manchester. The paper was so beautifully presented and the subject so interesting that I almost forgot my duty as timekeeper! In addition to the free papers there was also an excellent video being shown during the lunch and coffee breaks, on peribulbar technique, by Dr John Prosser from Worcester. Several pharmaceutical and equipment companies, who financially supported the congress, provided other entertainment during the breaks.

The final session of the Congress, on Innovations in Ophthalmic Anaesthesia was again an international affair with speakers from Nimes, Cairo and Auckland who all gave excellent lectures. However, it was when The chairman Dr Roy Hamilton introduced Chandra Kumar and congratulated him on his creation and success of the society, his unstinting work as secretary, and the success of the World Congress, that an unusual event occurred – The audience gave Chandra a standing ovation! I have rarely seen such a demonstration of appreciation shown at a scientific meeting and it was certainly well deserved.

So congratulations go to Professor Chandra Kumar and his excellent support team, for an enormously successful World Congress of Ophthalmic Anaesthesia. We all look forward to the next!

Dr Monica Hardwick, BOAS Council Member, Worcester, UK
Orbital exenteration under local anaesthesia with intravenous sedation

A Cook, R M Slater, B Leatherbarrow,
Manchester Royal Eye Hospital
Manchester, UK

Introduction
Orbital exenteration was first described by Gaisford in 1963 (1). It is a disfiguring operation, involving the removal of the entire contents of the orbit, with or without the eyelids. It is most commonly performed for the management of malignancies such as choroidal/lid/conjunctival melanoma (2,3), basal cell carcinoma (4), sebaceous or squamous cell carcinomata (5,6), lacrimal gland tumours (7), and sino-nasal tumours with orbital spread (8). It is also used to manage benign conditions such as end-stage socket contracture (9), and infections, such as mucormycosis (10).

It is widely felt that such extensive surgery can only be performed under general anaesthesia. Most patients requiring an exenteration are elderly, with significant co-morbidities, in whom general anaesthesia poses significant risks. Sedation in the form of intravenous midazolam has previously been successfully used for the management of intra-operative anxiolysis during routine oculoplastic procedures performed on a day-case basis (11). We therefore wished to enhance this technique for the more extensive procedure of orbital exenteration. We report our experience with a group of patients who underwent orbital exenteration under local anaesthesia with intravenous sedation.

Patients and Methods
Over a two-year period, five patients underwent total orbital exenteration under local anaesthesia with intravenous sedation:

Patient Number 1
91 year old male.
The patient was referred from a peripheral unit with a sudden increase in size of a pigmented right caruncular lesion. This had been watched over the last 10 years, during which time it had remained static.
Upon examination, the lesion appeared to have extended along the inferior conjunctiva and had spread on to the lower lid (photograph A). Possibly it had become necrotic and haemorrhaged.

The gentleman had previous ischaemic heart disease and a degree of renal failure, hence the decision to utilise local anaesthesia with sedation for the exenteration.

The patient underwent a ‘tailored’ exenteration; sparing the upper lid skin, but removing the entire lower lid. Intra-operatively, the blood pressure averaged 120/60, and the pulse 65 and regular.

Post-operatively, the patient recovered well and was discharged the following day. The socket healed well, with no infection.

Patient Number 2
64 year old male.
The patient was referred from a distant plastic surgery unit with orbital invasion of a lower lid basal cell carcinoma. He had undergone a local resection (non-Mohs’) and reconstruction ten years before. When he re-presented with lower lid tethering, a CT scan revealed the extent of the invasion.

He had considerable medical co-morbidity, including Hodgkin’s lymphoma, four myocardial infarction, hypertension, and chronic obstructive airways disease.

He underwent complete exenteration. Intra-operative blood pressure readings were stable, averaging 130/80, with a regular pulse rate of 68.
Post-operatively he was moderately nauseated, but this settled with treatment and was discharged home the following day. His socket healed well and he was able to be fitted with a prosthesis.

Patient Number 3
70 year old female.
The patient had undergone enucleation for ocular trauma many years previously. Despite several procedures to aid fitting of her artificial eye, she had ended up with end-stage contracture of the socket and was referred for exenteration.
She was wheelchair bound, with a past medical history including 3 cerebrovascular accident, thyroid dysfunction, and hypertension.
She underwent a lid-sparing exenteration, and intra-operatively the blood pressure averaged 160/90, and the pulse 78.

Post-operatively she recovered quickly and returned home the following day.

Patient Number 4
68 year old male.
The patient had a long history since his first herpetic corneal ulcer eventually resulted in him undergoing a penetrating keratoplasty. This failed, as did a second, and the eye was enucleated ten years later. He had a Roper-Hall orbital implant inserted, but this extruded five years later. The socket then became grossly contracted and he was unable to wear an artificial eye.

He had severe Rheumatoid arthritis, with plates in his cervical vertebrae, as well as Raynaud’s disease.

He underwent a lid-sparing exenteration, with stable blood pressure and pulse intra-operatively, averaging 120/60 and 80 respectively.

He had no post-operative complications, and was discharged the following day.
The socket has healed well, and a prosthesis has been fitted.

Patient Number 5
88 year old female.
This lady had undergone the first excision of her right lower lid basal cell carcinoma 12 years age under the care of a local plastic surgery unit. The lid had been reconstructed utilising a local myocutaneous flap but unfortunately the lesion recurred. Over the following ten years she underwent four procedures to attempt clearance and reconstruction, as well as one course of radiotherapy. Eventually, she was referred with the lower lid contracted and tethered to the inferior orbital rim, such that it was impossible to see the globe.

The patient was frail with a degree of congestive cardiac failure, hypertension, and ischaemic heart disease.

A complete exenteration was carried out with stable blood pressure and pulse throughout. The patient was discharged to a nursing home the following day.

Technique
All patients had venous cannulation and received midazolam 1-2mg as a bolus followed by a target-controlled infusion (TCI) of propofol in the range 0.2-2 microgram/ml. Patients were monitored with pulse oximetry, ECG, non-invasive blood pressure and respiration before sedation, and throughout surgery they received supplemental oxygen.

Local anaesthesia was provided with a 10ml peribulbar injection of bupivicaine 0.5% with adrenaline 1:200,000 with 5000 units of hyaluronidase, (figure 1).

Thereafter, a further 10ml injection of bupivicaine 0.5% with adrenaline 1: 200,000 was infiltrated locally around the orbital rims to directly block the supra-trochlear, supra-orbital, infra-trochlear, infra-orbital, anterior ethmoidal, zygomatico-facial and zygomatico-temporal nerves, (figure 2).

Patients were monitored at all times during surgery by the anaesthetist (RMS) who altered the TCI of propofol according to the surgical stimulus. The patient was specifically monitored for signs of an oculo-cardiac reflex.

A standard exenteration was then performed, with or without the lids, according to the pathology involved.

Results
All patients tolerated the procedure well, with no episodes of hypoxaemia or bradycardia. A respiratory rate of > 8/minute was maintained at all times. No patients experienced pain intraoperatively. No patient required any additional postoperative analgesia, other than routine non-steroidal agents. All patients were discharged home on the first post-operative day.
We have demonstrated that such extensive orbital surgery can be carried out safely and satisfactorily in a population of frail elderly patients, without the potential risks of general anaesthesia.

References
Life Time Achievements Awards

Dr Gary Fanning, Sycamore, USA

Citation read by Professor R. C. Hamilton, Calgary, Canada

It is a great pleasure and honour to present to you Dr. Gary Fanning, for inauguration as a Lifetime Member of the British Ophthalmic Anaesthesia Society.

Dr. Fanning obtained his MD from the University of Syracuse in 1966. His residency in anaesthesia was at the University of Rochester, New York, following which he completed his military service.

There followed a staff anaesthesiologist appointment at the renowned McFarland Clinic in Ames, Iowa where he served for nineteen years and was responsible for anaesthesia for a wide range of surgical specialties.

In 1991 Gary took up the position as senior anesthesiologist at the Hauser-Ross Eye Institute, a private outpatient facility in Sycamore, a satellite community of Chicago, Illinois. He remains in that position to the present time. I am pleased to acknowledge that Lynne Hauser and Neil Ross are here in our audience today, joining the rest of us in honouring their loyal colleague.

Starting 20 years ago was the first of the ophthalmic anaesthesia societies, known simply as the Ophthalmic Anaesthesia Society, under the leadership of Dr. Robert F. Hustead, Bob Hustead for short. Bob had a dream of promoting the subspecialty of anaesthesia for all manner of eye surgery; he was indeed the founding father of the OAS. Like many of us, Gary benefitted from regular attendance at the annual scientific meetings of OAS and soon was to become its program director, a position he held for seven years. Currently Gary is editor of a lively OAS newsletter aptly named OASIS. The memberships of OAS now numbering more than 150 eagerly await each issue of this beautifully produced publication. And as if this were not enough, Dr. Fanning has jointly edited a recently published textbook on ophthalmic anaesthesia, in addition to which he has published many peer-reviewed articles.

Behind every successful man there is a powerhouse of support; this can most certainly be said of Gary’s helpmate, Arline. There must be a gene for jurisprudence in their family; two sons and a daughter are all lawyers!

Ladies and gentlemen, it is with great pleasure that I ask Dr. Gary Fanning to come forward to accept this certificate signifying lifetime membership of the British Ophthalmic Anaesthesia Society.

Dear BOAS members:
I wish to thank you all for the honour you bestowed on me by giving me the Lifetime Achievement Award at your annual meeting in London in April. As I mentioned in my remarks at the time, never has an award been less deserved nor more gratefully received.

My association with the British Ophthalmic Anaesthesia Society has been one of the most
happy and productive of my career. I have been welcomed by you; blessed with your warmth and hospitality; impressed and enlightened by your knowledge and experience; and awed by your abilities to organise and communicate. I know that I have received more than I have imparted.

I also wish to thank all of you who worked so hard to achieve the tremendous success of the first World Congress of Ophthalmic Anaesthesia. It was a marvellous meeting, and your Society deserves the highest degree of congratulations for having organised and carried out such an event. It was truly an honour to have been a delegate at this inaugural conference.

I send my warmest regards to you all along with my deepest gratitude for all the kindness you have given me.

Sincerely,

Gary L. Fanning, MD
Sycamore, Illinois, USA

Dr Robert Johnson, Bristol, UK

Citation read by Dr Anthony Rubin, London, UK

It is a particular pleasure to say a few words about Bob Johnson, who has so many different attributes.

Although we are here primarily to mark his contributions to ophthalmic anaesthesia, it should not be forgotten that he was a renowned obstetric anaesthetist who filled the post of honorary secretary of the Obstetric Anaesthetists Association. He is also very well known in the field of chronic pain, being one of the leading lights in the management of herpes zoster and especially post-herpetic neuralgia. He is regularly invited to lecture and to take part in working groups on this very difficult subject.

As an ophthalmic anaesthetist he has been a regular attendee at the British Ophthalmic Anaesthesia Society and was its first President. His devotion to that task set the Society on the right road and under his leadership it grew to its present healthy and established position. He has published with Frances Forrest an excellent textbook on ophthalmic anaesthesia.

He is a renowned lecturer, and always in demand for meetings large and small. His excellent command of the English language, coupled with an almost faultless, and never excessive, use of audiovisual aids, make him the perfect model for others to follow.

Recently he was away at an international conference, and he knew that on his return he would need a human skull to aid him in imminent workshops on ophthalmic regional anaesthesia. To be sure not to forget it, he left it on his entrance hall table, and set his burglar alarm to safeguard his lovely house. Unfortunately during his temporary absence the alarm went off and, as it was linked to the police station, the police duly arrived with the nominated key holder. They were more than surprised to be greeted by the human skull. We do not know yet whether they are digging up his garden to find the rest of the body!

Behind all eminent men, there is an exceptional woman, and Bob has been ably supported and
encouraged by his wife Ursula, and we are all so pleased to see her among us today.

President, it is a great pleasure for me to be able to present to you Robert Johnson to receive the Lifetime Achievement Award of the British Ophthalmic Anaesthesia Society.
Observer variability in assessment of ophthalmic regional anaesthesia
A Patel A, M Saldana M and H A McLure
St James's University Hospital, Beckett Street, Leeds, LS9 7TF

Introduction
The assessment of ocular movement after an injection of local anaesthetic is an important task for the ophthalmic anaesthetist. Akinesia is commonly used as a surrogate marker of sensory block, with the assumption that a given level of akinesia should ensure adequate analgesia for the surgical procedure. When local anaesthetic solutions or techniques are compared the assessment of akinesia is formalized so that differences in the level of block can be tested statistically. The assessment usually involves grading eye movement in the secondary directions of gaze (elevation, depression, abduction and adduction), sometimes including eyelid opening and closing. The degree of movement is scored according to a predetermined scale which may vary from simply recording that akinesia was adequate for surgery, to more detailed scoring of each direction of gaze on a 2 to 5 point scale (1-4). Scoring systems differ not only in the number of points, but also in the direction of the scale. Most investigators use a ‘movement score’ where zero equates to no movement (i.e. full block) and full movement earns a maximal score, whereas others use a ‘block score’ where zero equates to no block (i.e. full movement) and no movement earns a maximal score. This scoring may vary between observers and this is likely to influence the conclusions of the study. We were unable to find any studies that acknowledged the potential differences between observers, or reported attempts to ensure that all observers were ‘calibrated’. Consequently, we performed a study to examine the variability between observers when assessing ocular movement.

Method
Ethical committee approval was given for the study. After obtaining informed consent 15 patents were recruited to act as subjects for akinesia assessments. All patients underwent standard techniques of administration of local anaesthesia. Digital video (Sony 120 1.5 megapixel digital camera) was used to record a full view of both eyes as the patient looked in the four secondary directions of gaze. The investigators selected 15 video sequences with varying degrees of ocular akinesia. Investigators scored ocular movements using the scale shown in Table 1.

<table>
<thead>
<tr>
<th>Ocular Movement</th>
<th>Scale 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Movement</td>
<td>3</td>
</tr>
<tr>
<td>Partial Movement</td>
<td>2</td>
</tr>
<tr>
<td>Flicker</td>
<td>1</td>
</tr>
<tr>
<td>No Movement</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 1 – Ocular movement grading scales
Ten anaesthetists and eleven ophthalmologists were recruited to act as volunteer assessors to score akinesia in the 15 video sequences, which were shown on a laptop computer (Compaq Presario, Microsoft Windows XP, Studio DV software). The first five cases were to familiarise the volunteers with the scoring scales, and the remaining ten were test cases. For the practice cases, the volunteers were shown the investigators scores to help calibrate their own scoring. They were allowed to watch practice cases as many times as they wished until they felt competent with that scale. The test cases could be seen a maximum of two times. For each assessment ocular mobility in each direction of gaze was scored. Eyelid movement was not assessed. Assessor scores were then compared with those of the investigators to calculate agreement rates. Where there was widespread disagreement with the conclusion of the investigators, the video clip was reviewed, and in a single assessment this resulted in a re-marking of the volunteers’ assessments.

Results
Each of the 21 volunteers assessed four eye movements in 10 video sequences resulting in a total of 840 scores (Table 2). Of the 40 eye movements in the 10 video sequences, the investigators scored 11 (27.5%) as no movement, 16 (40%) as a flicker of movement, 10 (25%) as partial movement and 3 (7.5%) as full movement. Observations by volunteer assessors that differed from those of the investigators were defined as ‘disagreements’. Disagreement was by a single
point in 98.5% of observer differences. For each volunteer assessor the proportion of assessments that agreed with the investigators was calculated. There was a wide variation in agreement ranging from 44 – 77% (mean 63%).

<table>
<thead>
<tr>
<th></th>
<th>Agreements (%)</th>
<th>Under-estimate</th>
<th>Over-estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>No movement (n = 231)</td>
<td>186 (81)</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Flicker (n = 336)</td>
<td>183 (54)</td>
<td>54</td>
<td>99</td>
</tr>
<tr>
<td>Partial movement (n = 210)</td>
<td>125 (60)</td>
<td>31</td>
<td>54</td>
</tr>
<tr>
<td>Full movement (n = 63)</td>
<td>35 (56)</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>529 (63)</td>
<td>130</td>
<td>181</td>
</tr>
</tbody>
</table>

Table 2 – Number and direction of disagreements. Significantly greater overall proportion of under-estimates of block compared to over-estimates (p 0.002).

Discussion
Measurement by direct observation of patients has inherent weaknesses due to the subjectivity of observation. Visual assessment of ocular movement may appear to be a simple task. Grading eye movement as present or absent is easy, but of little use where differences between treatment groups may be small. For statistical analysis a more discriminative quantitative approach is required. However, although complex scoring systems yield more data they may be too clumsy to use in practice. We used a four point scoring system similar to that described by Bramha which is the most frequently quoted scale found in the literature (1).

Our study revealed a wide variation in agreement rate between assessors. This could have been a result of technical difficulties (poor image quality due to lighting, camera or laptop inadequacies), poor skills of the assessors, limited time to complete assessments, incorrect scoring by the investigators, difficult ocular movements to score, or the natural variability in observer assessments. We attempted to reduce technical obstacles by optimizing lighting and positioning, and satisfying ourselves that the image quality using the laptop was adequate. However, the image quality could never be as clear as direct observation of a real subject. The ideal would have been to use real subjects, perhaps those with pre-existing cranial nerve palsies, although in practice this would be extremely difficult to organise. Some observer variability may have been introduced by using relatively untrained assessors. We attempted to minimise this by using volunteers who were ophthalmologists, or performed ophthalmic anaesthesia, and so were familiar with informal assessment of ocular movements. In addition, they were allowed to delay the test cases until they felt comfortable with each scale. We limited the number of times the test video sequences were seen in an attempt to replicate studies where assessments were performed every minute, so there would be an element of pressure to assign a score within a limited time period. In addition, some regional blocks progress rapidly and if multiple attempts are made the block score may differ from the first to the last assessment.

Variability between observers resulted in agreement scores varying from 44% to 77%. This observer variability may have a major impact on study conclusions if investigators with varying skills are involved in the assessment of a large proportion of just one treatment group. To reduce bias it would be sensible to ensure that all observers have been correctly ‘calibrated’, and that individual observers are involved in equal numbers of patients from each treatment group. Future studies with multiple assessors should detail efforts to calibrate assessors, and document the number of assessments each assessor performs in different treatment groups.

References
2. McLure HA, Rubin AP. Comparison of 0.75% levobupivacaine with 0.75% bupivacaine for peribulbar anaesthesia. Anaesthesia 1998;53:1160-4.
Anaesthesia for botulinum toxin injections in ophthalmic surgery
Muhammad Al-Khalid
Consultant Anaesthetist
North Cheshire Hospitals NHS Trust
Warrington General Hospital
E-mail: alkhalid@tiscali.co.uk

Introduction
Botulinum toxin (BT) inhibits the release of acetyl choline (ACh) from nerve terminals. Muscles paralysed with BT recover their function as axons resprout and new extra junctional ACh receptors form. BT type A is available commercially as Dysport (Speywood Pharmaceuticals) and Botox (Allergan).

The main indications for BT injections include 1,2
1. Therapeutic and diagnostic in Strabismus.
2. Treatment of essential blepharospasm and hemifacial spasm.
3. Treatment of oscillopsia associated with acquired nystagmus.
4. To induce protective ptosis.
5. Treatment of dystonias (syndrome of sustained extra-ocular muscle spasm).

Use of BT in patients with strabismus and nystagmus
The first clinical use of BT was in the field of strabismus. Alan Scott explored its possible role as an alternative to strabismus surgery 3. Since its introduction BT has been used in most forms of strabismus in both adults and children.

Anaesthesia for BT injections in children
In our series, 50 children had BT injections for the correction of strabismus. BT injections in children present a real challenge for the Ophthalmic Anaesthetist.

Children as young as 6 months undergo this procedure. The fact that the use of inhalational anaesthetic agents is relatively contra-indicated adds even more challenge to the anaesthetist. Therefore, establishing venous access in these children is of prime importance. A 25-G venflon with a 3 cm extension is usually used for the very young children. Premedication is achieved with a local anaesthetic cream.

Conduct of anaesthesia
Ketamine is the anaesthetic agent of choice in these procedures. It does not suppress muscle tone and the child will maintain an adequate airway without any use of airway adjuncts. Monitoring usually involves pulse oximetry, non-invasive blood pressure and ECG.

The dose of ketamine ranges from 1-2 mg per kg body weight i.v. (usually 1.5 mg per kg body wt). Midazolam injection i.v. is used to prevent emergence phenomena from ketamine anaesthesia. The dose of midazolam ranges from 0.08-0.1 mg per kg body weight i.v. (maximum dose 3 mg i.v.). The effects of midazolam in the paediatric age group –unlike adults- is quite unpredictable. Nevertheless, children do recover quite quickly from the residual effects of midazolam because of the high volume of distribution in their bodies.

Diazepam is another useful agent to minimise the side effects of ketamine, especially at night time. Having said that, all these procedures are done as day-cases, and a rapid recovery from the effects of anaesthesia is essential before discharging the child home. We found in our series that the routine use of antisialagogue agents is not necessary.

Post-operative Recovery
After the end of the procedure, the child is recovered in a head-up position to prevent the complication of post-operative ptosis. The child is recovered in a warm room (temperature 26 degrees Celsius) and quiet environment. The lights are dimmed and easy listening music in the background (usually nursery rhymes) helps a great deal in reducing the incidence of emergence phenomena and possibly other side effects of ketamine. After a recovery period of approximately 15-20 minutes, the child will
return to the ward. A final decision to discharge home is not made until the child has eaten, drunk and passed urine. Parents are warned about sleepless nights and/or nightmares, especially during the first 12-24 hours post-operatively. In our current series, there were four cases of reported nightmares in the first night, but no incidence of emergence phenomena.

Discussion
Therapeutic BT injections are useful and safe procedures under ketamine and midazolam anaesthesia. The technique is not hugely popular amongst surgeons because of the possible risk of ptosis post-operatively. We found in our series that avoiding inhalational anaesthetic agents and careful positioning after the injections mitigate this risk.

References
Publication of this newsletter has been possible by a generous donation from

Mr Ed Scott
Abbott Laboratories Ltd
Queenborough
Kent, ME11 5EL
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

Further information is available on request from Abbott Laboratories Ltd, Abbott House, Wardan Road, Macclesfield, Cheshire SK11 8EY. Ref: P/03025558.


Ophthalmic Anaesthesia News, Issue 10, July 2004
Email: info@boas.org    Website http://www.boas.org
News and information

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 November 2004. Please send your articles or any contributions for inclusion in the Newsletter by 30th October 2004, to Professor Chandra Kumar, Editor Ophthalmic Anaesthesia News, The James Cook University Hospital, Middlesbrough TS4 3BW, UK or email chandra.kumar@stees.nhs.uk

Subscription to Journal of Cataract and Refractive Surgery
Anaesthetic 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

Annual Ophthalmic Anesthesia Scientific Meeting
18th Annual Scientific Meeting of OAS will be held on 1-3rd October 2004 in the Westin Hotel, Michigan Avenue, Chicago IL. BOAS members will receive similar discounts as OAS members. Programme and registration form is printed in this Newsletter (pages 25-27). Should you need further details please visit www.eyeanesthesia.org or email info@eyeanesthesia.org

Acknowledgement
Mrs Pat McSorley has maintained the BOAS membership database since 1998 but has now retired. She continues to maintain the membership database 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

Web address
http://www.boas.org

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

Dr. Sean Tighe
Secretary, BOAS
Dept. of Anaesthesia
Countess of Chester Hospital
Liverpool Road
Chester CH2 1UL
Email: sean.tighe@coch.nhs.uk
BOAS Executive Committee

President
Professor Chris Dodds

President Elect
Mr. Ken Barber

Secretary
Dr. Sean Tighe

Treasurer
Mr Tim C Dowd

Council Members
Mr. Louis Clearkin
Mr Tom Eke
Dr. David Greaves
Dr. Monica Hardwick
Dr K L Kong
Professor Chandra Kumar
Dr Stephen Mather
Dr. Anthony P Rubin
Mr. David Smerdon
Dr Guri Singh Thind
Dr. Sean Tighe
British Ophthalmic Anaesthesia Society Member Registration Form

The Branch Manager

Postal Address of your bank: ________________________________ ________________________________ ________________________________

Please Pay: Bank: __________________ Branch Title (not address) __________________ Sorting Code Number: _______ _______ _______ _______

Beneficiary’s Name: __________________ Account Number: _______ _______ _______ _______

for the credit of: __________________ __________________ __________________ __________________

Amount: __________________ Amount in words: __________________

the sum of: __________________ __________________

Date of first payment: __________________ Date of last payment: __________________

Due date and frequency: __________________ __________________

and debit my/our account accordingly.

PLEASE CANCEL ALL PREVIOUS STANDING ORDER/ DIRECT DEBIT MANDATES IN FAVOUR OF __________________

UNDER REFERENCE NUMBER: __________________

Account to be debited: __________________

Account Number: __________________

Signature(s) ……………………………………………………………………………………………………………………... Date …………………

Banks may decline to accept instructions to charge Standing Orders to certain types of account other than Current Accounts

NOTE: The Bank will not undertake to
a) make any reference to Value Added Tax or pay a stated sum plus V.A.T., or other indeterminate element.
b) advise remitter’s address to beneficiary.
c) advise beneficiary of inability to pay
d) request beneficiary’s banker to advise beneficiary of receipt.
e) accept instructions to pay as soon after the specified date as there are funds to meet the payment, if funds not available on the specified date.

Payments may take 3 working days or more to reach the beneficiary’s account. Your branch can give further details.

Personal details

Last name (Dr, Mr, Mrs, Miss, Ms) …………………………………………………………………… First name: __________________

Department: __________________ Institution: __________________

Address: …………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………..

……………………………………………………………………………………………………………………………..

City/County/ ……………………………………… Post code: __________________

Phone: ………………… Fax: ………………… Email: …………………

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. Sean Tighe
Secretary, BOAS
Dept. of Anaesthesia
Countess of Chester Hospital
Liverpool Road
Chester CH2 1UL

Ophthalmic Anaesthesia News, Issue 10, July 2004
Email: info@boas.org Website http://www.boas.org
OPHTHALMIC ANESTHESIA SOCIETY
18TH ANNUAL SCIENTIFIC MEETING
October 1-3, 2004 • Westin Michigan Avenue • Chicago

PROGRAM CO-CHAIRS: Steve Charles MD, Steven Gayer MD MBA
ACTIVITY DIRECTOR: Marc Allan Feldman MD MHS

FRIDAY, OCTOBER 1
1:20 Welcome Remarks
Steve Charles MD, President
Steven Gayer MD MBA, Vice President

1:30 What is Really Medically Necessary when Preparing Patients for Anesthesia and Ophthalmologic Surgery?
Bobbie Jean Switzer MD
Participant Objective: Describe and differentiate preoperative testing and preparation for the various types of ophthalmic surgical procedures

2:15 Teamwork Components of Defusing Organizational Accidents
Stephen Small MD
Participant Objective: Describe methods for the perioperative team to ensure patient safety

3:00 Fire in the Operating Room
Jan Ehrenworth MD
Participant Objective: Describe methods for avoiding fire accidents in the OR and methods for eliminating fires when they occur

3:45 Questions and Answers

4:00 Break

4:15 Visual Experiences/Sensations During Ophthalmic Blocks
Prof. Chandra Kumar MD
Participant Objective: Describe visual experiences and sensations of patients while anesthetized for eye surgery

5:00 Questions and Answers

5:15 Ophthalmic Anesthesia Jeopardy!!!
Steven Gayer MD MBA, Game Host
Participant Objective: Learning via an enjoyable, fun game-show format

6:00 Adjourn

6:00 Reception

SATURDAY, OCTOBER 2

Session A

7:50 Welcome Remarks
Steven Gayer MD MBA

8:00 Regional Anesthesia for Dacryocystorhinostomy
Gary L. Fanning MD
Participant Objective: Review the anatomy of the lacrimal system and describe a technique of regional anesthesia for DCR surgery

8:45 Economic Evaluation of Cataract Surgery and Anesthesia
Marc Allan Feldman MD MHS
Participant Objective: Understanding the current microfinance economics of cataract surgery

9:30 Questions and Answers

9:45 Break

10:15 Implanted Defibrillators and Pacemakers for the Ophthalmic Surgery Patient
Joseph Bayes MD
Participant Objective: Determine the various indications for preoperative evaluation and intraoperative management of the patient with an implanted defibrillator and pacemaker

11:00 Anesthesia Informatics and the Rapid-Turnover Ambulatory Surgery Center
Carlos M. Nunez MD
Participant Objective: Evaluate the use of automated anesthesia informatics systems for operating rooms performing high volume, rapid turnover ophthalmic surgery

11:45 Questions and Answers

12:00 Lunch Break

1:30 Another Myth 'Busted': An Historical Approach to the Teaching Concerning Succinylcholine and Open Eye Injury
Douglas R. Bacon MD
Participant Objective: Describe indications/contraindications of succinylcholine use for patients with open globe injuries

Ophthalmic Anaesthesia News, Issue 10, July 2004
Email: info@boas.org  Website http://www.boas.org
2:15 Choices of Local Anesthetics for Ophthalmic Surgery
Gary Cass MD
Participant Objective: Describe and evaluate the use of newer ophthalmic local anesthetics

2:45 Complications of Needle and Cannula-Based Ophthalmic Regional Anesthesia: An Evidence-Based Approach
Robert Johnson FRCA
Participant Objective: Describe evidence-based literature regarding complications of ophthalmic anesthesia

3:15 Workshops
(Participants may attend two of three workshops in rotation)
Participant Objective: Describe various techniques and potential complications related to ophthalmic anesthesia procedures
A. Needle-Based Ophthalmic Regional Anesthesia
Gary L. Fanning MD, Marc Allan Feldman MD MHS, Robert Johnson FRCA
B. Cannula-Based Ophthalmic Regional Anesthesia
Steven Gaynor MD MBA, Scott Greenbaum MD, Chandra Kumar MD
C. Parallel Approach to Orbital Blocks
Randy Harvey BS CRNA

4:00 Break

4:15 Workshops Repeat

5:00 Adjourn

Session B

7:50 Welcoming Remarks
Karen Rouse RN BSN, Donna Acord RN Kelly Gummerson RN

8:00 Keynote Speaker: When Opportunity Knocks
Laurie Guest COT
Participant Objective: Identify 5 ways to improve workplace relationship; describe communication tools to achieve desired results; describe staff development concepts to improve patient communication

8:45 Wrong Side, Wrong Procedure, and Wrong Patient Errors: Are They Preventable?
Paul Barach MD
Participant Objective: Describe systems for the perioperative team to avoid errors

9:30 Questions and Answers

9:45 Break

10:00 A Proven System for the Prevention of Endophthalmitis
Donna Acord RN
Participant Objective: Describe perioperative methods for preventing infection

11:00 Comparison of Billing Systems: The Difference Between Hospital and ASC
JoAnn Stengerwald RHT
Participant Objective: Describe billing systems addressing the needs of ambulatory surgery centers

11:45 Questions and Answers

12:00 Lunch Break

1:30 Best Kept Secrets of Successful Practices
Laurie Guest COT
Participant Objective: List strategies for balancing the practice triad (doctor, staff and patient); create an action plan for business growth or needed change; describe options for handling stress in a changing environment

2:30 Knocking Down the Generational Gap
Karen Rouse RN BSN
Participant Objective: Describe the effect of generational differences in the ASC workforce

3:30 Is It Reality or Am I Dreaming? Everyday Challenges in Running an Ophthalmic Service
Kimberly Rivello BSN CRNA
Panel Discussion Leader
Participant Objective: Discuss management, staffing, patient care and other issues specific to ophthalmic surgical services

5:00 Adjourn

Sunday, October 3

7:45 Annual Membership Meeting
Steven Gaynor MD MBA

8:00 Treatment for Blind and Seeming Painful Eyes
Leonid Skorin MD
Participant Objective: Discuss nonsurgical modalities of treating patients with painful eyes

8:45 Questions and Answers

9:45 Break

10:00 Anesthesia Case Discussion Panel
Gary L. Fanning MD, Moderator
Participant Objective: Summarize complications, therapies, and results from problem cases submitted by the membership and audience

11:15 Discussion

12:00 Adjourn
# Annual Meeting Registration Form

**Ophthalmic Anesthesia Society • 18th Annual Scientific Meeting**  
October 1 – 3, 2004 • The Westin Michigan Avenue Hotel, Chicago

Send this form with registration fee to:

**OAS**  
793-A Foothill Blvd., pmb 119  
San Luis Obispo CA 93405  
Info@EyeAnesthesia.org

805 534 0300 phone  
805 534 9030 fax  
www.EyeAnesthesia.org

<table>
<thead>
<tr>
<th>Name (as you wish it to appear on your badge)</th>
<th>Degree</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Specialty</th>
<th>AANA# (for CRNAs)</th>
<th>Last 4 Digits SS # (for MDs)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Affiliation/Company</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>email</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Before Sept 1</th>
<th>After Sept 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>$225 OAS Member (MD/CRNA)</td>
<td>$300</td>
</tr>
<tr>
<td>$400 Non-Member (MD/CRNA)</td>
<td>$475</td>
</tr>
<tr>
<td>$100 RN Member</td>
<td>$175</td>
</tr>
<tr>
<td>$175 RN Non-Member</td>
<td>$250</td>
</tr>
<tr>
<td>$50 Resident/Student</td>
<td>$50</td>
</tr>
</tbody>
</table>

TOTAL ENCLOSED $________

Registration fees must be paid by check or money order in US funds drawn on a US bank; credit card payments cannot be accepted for the registration fee. Refunds will be made if cancellation is received in writing prior to September 15, 2004. For more information, call the OAS Administrative Office: 805 534 0300.
Voluntary medical work at St John’s Eye Hospital, Jerusalem

The Order of St. John was first founded in Jerusalem. They established the St John Ambulance Service in Britain, and the St John Ophthalmic Hospital that was opened in Jerusalem in 1882, the first Eye Hospital in the Middle East. A new building was erected in East Jerusalem in 1959 (see picture). Today nearly 60,000 outpatients are seen each year and of these, 5000 will undergo surgery: cataract, squint, lids, corneal grafting, vitreoretinal.

I went to this place for a few weeks last year and this year as a volunteer to do retinal surgery. They do have permanent medical members of staff (4 consultants, 4 juniors, 1 anaesthetist) but they also rely on visiting doctors – both for general ophthalmic care and subspecialty skills. For example, last year they had no retinal specialist at all; this year they have a local part-timer only.

The hospital’s mission statement is to provide ophthalmic care for the people living in the ‘holy land’, irrespective of race, religion or ability to pay. In practice, most patients attending live in Jerusalem or in the West Bank. The latter group find it increasingly difficult to travel in and out of Jerusalem. The hospital is located in East Jerusalem, a 20 minutes’ walk from the Old City. Website: [http://www.sjeh.org/](http://www.sjeh.org/)

The hospitaller (Anthony Chignell, a retired vitreo-retinal surgeon) at the supporting office in London (address see below) has asked me if I know of an anaesthetist who would consider going there too. They have only one anaesthetist who is always on, and it would be good for him to have a break, as well as working with a colleague from a different country. Also, the staff always take great encouragement from having visiting doctors. The workload is not that different from doing eye lists in the UK. The working day is usually from 8 am to 3 pm (sometimes longer). There are two eye theatres running in parallel. Most cataract- and glaucoma surgery and some of the VR is under local, but most squints, children and corneal grafts are under GA. Because of the difficulties with travel, nearly all patients stay in overnight. The nursing staff are well trained and motivated. I can’t tell you the specification of the anaesthetic equipment, but perhaps you can make that out from the pictures! If the ophthalmic equipment is...
anything to go by, then it is pretty much up to Western standards but do be prepared to work with something slightly less flashy than what you might take for granted is this country.

The hospital's supporting office in London will pay your air ticket Heathrow – Tel Aviv. The hospital will send their minibus to collect you from there to Jerusalem. They will be delighted with any amount of time you are able to give, but preferably not less than 2 weeks. The hospital has (married) accommodation and will provide board. I went by myself last year, and with my wife and 2 children this year. It was hard work but there was also plenty of time to go seeing places. Some areas were a bit tense but on the whole the security situation wasn't an issue. If you are at all interested in the country’s history and current developments, there is more to see than you could manage to get round in months!

I will be happy to answer further queries if you might be thinking of going – my contact details are:

Mr Chrisjan Dees, FRCS
Consultant Ophthalmologist
The James Cook University Hospital
Marton Road
Middlesbrough TS4 3BW
Tel. 01642 282687
Fax 01642 854909
E mail chrisjan.dees@stees.nhs.uk

Alternatively, the hospitaller’s details are:

Anthony Chignell
Priory House
25 St. John’s Lane
Clerkenwell
London
EC1M 4PP
Tel +44 (0)20-7253 2582
Fax +44 (0)20-7253 2612
Email exec@stjohnyehospital.org
BOAS Members: standing order

Dr. Mark Adams, SHEFFIELD  
Dr Kursh Ahmed, MONK FRYSTON, N. YORKS  
Dr Musa A Ali, CARDIFF  
Dr Keith Allman, EXETER,  
Dr. Tarek A.A. Ammar, WAKEFIELD  
Dr Vincent Argent, EAST SUSSEX  
Dr Julie Ashworth, STAFFORDSHIRE  
Dr. Ramesha Avatgere, STOKE ON TRENT  
Mr K. Barber, WORCESTER  
Dr. Frederick Barton, KINGSTON UPON THAMES  
Dr. Joy Beamer, STRATFORD UPON AVON  
Dr. N.C. Bhaskaran, CRANBROOK, KENT  
Dr Graham Bruce, AUSTRALIA  
Dr Mike Burbidge, BEDFORD  
Dr Raju Chabria, MIDDLESBROUGH  
Dr Surinder Pal Singh Cheema, HUDDERSFIELD  
Dr Falguni Choksey, WARWICK  
Mr Louis Clearkin, WIRRAL  
Dr. Nicholas Coker, ROMFORD  
Dr. John H. Cook, EASTBOURNE  
Dr. David Cranston, HERTS  
Dr. Damien Cremin, PONTYCLUN  
Dr Steven Cruikshank, NEWCASTLE UPON TYNE  
Dr D.J. Dalgleish, DORSET  
Dr Allan Dark, BUCKS  
Dr Thavamanidevi De Silva, WAKEFIELD, WEST YORKS  
Dr. S. Dhileepan, SUTTON  
Professor Christopher Dodds, MIDDLESBROUGH  
Mr Timothy Dowd, MIDDLESBROUGH  
Dr. Maurice Dunstan, LONDON  
Dr. Karen Eagland, BIRMINGHAM  
Dr. Tom Eke, NORFOLK  
Miss Christine Ellerton, MIDDLESBROUGH  
Dr Ruth Eustace, DERBYSHIRE  
Dr Peter Robert Evans, CHESTER LE STREET  
Dr Michael Fish, ROXBURGHSHIRE  
Dr. Angus Fraser, CONWY  
Dr Gary Fanning, Sycamore, USA  
Dr Sharon Goh, BARNESLEY  
Dr John David Greaves, NEWCASTLE UPON TYNE  
Dr. Kevin Haire, LONDON  
Dr Roy C Hamilton, Calgary, Canada  
Dr. Monica Hardwick, WORCESTER  
Dr Babak Hedayati, WIRRAL  
Dr. Miles Holt, WARWICKSHIRE  
Dr R.B.S. Hudson, DERBY  
Dr. Elizabeth Hunt, BIRMINGHAM  
Dr. Peter James, BASINGSTOKE, HANTS  
Dr Shankaranand Jha, SCUNTHORPE,  
Dr Ruth M. Jones, CAMBRIDGE  

Dr Prashant Shivaji Kakodkar, NORTHAMPTON  
Dr Reshma Khopkar, READING  
Dr M.S. Kokri, MIDDLESBROUGH  
Dr. Elena Kourteli, LONDON  
Prof. Chandra M. Kumar, MIDDLESBROUGH  
Dr. Morag Lauckner, NEWCASTLE UNDER LYME  
Dr Mun Seng Lee, GLASGOW  
Dr Stephen Robert littler, LONDON  
Dr Mohammad Musa Lone, SOMERSET  
Mrs Evelyn Low,  
Dr. Oxnana Maher, DEWSBURY, W. YORKS  
Dr Stephen J. Mathier, BRISTOL  
Mrs. Shelagh Mayer, MANCHESTER  
Dr. Kelly McDaid, LONDONDERRY  
Dr Bartley McNeela, MIDDLESBROUGH  
Dr Carl Michael Hugh Miller Jones, KENT  
Dr Andrew Mitchell, BIRMINGHAM  
Dr. Christine Moore, LONDON  
Dr Manian Murali-Krishnan, NORTHAMPTONSHIRE  
Dr. Rajasekharan Nair, KIEGLEHY  
Dr. Stephanie Nicholl, EASTBOURNE  
Dr James Nickells, LONDON  
Dr. Pinakin Patel, STANMORE, MIDDLESEX  
Dr Sally Pilkington, SOUTHAMPTON  
Dr. Simon Poulter, MID GLAMORGAN  
Dr Allan Badgett Powles, LINCOLN  
Dr. Edward Andrew Proctor, MARGATE, KENT  
Dr Saratha Rajah, HERTS  
Dr Raju Reddy, BIRMINGHAM  
Dr. David W. Robins, HOOK, HANTS  
M.J. Rooney, DORRIDGE, SOLIHULL  
Dr. Anthony P. Rubin, LONDON  
Dr. David M. Ryall, MIDDLESBROUGH  
Dr Amir Alphonse Samaan, N.E. Lincs  
Dr. S.J. Seddon, STOKE ON TRENT  
Dr. R. Sharawi, GRASBY,  
Dr. Fatehsingh Shekhwat, COVENTRY  
Dr Roger Slater, MANCHESTER  
Dr. Peter Stoddart, BRISTOL  
Dr. Peter Sweet, WORTHING  
Dr Andy Taylor, NOTTINGHAM  
Dr. Manuel Simao Barreto Teixeira, PORTO, LISBON  
Dr. Malcolm Thompson, LONDON  
Dr. Thelma Tipping, VALE OF GLAMORGAN  
Dr Ashwinkumar Liladhar Vaidya, LANCASTHIRE  
Dr Sashi Bala Vohra, BIRMINGHAM  
Dr. L.M. Walton (Hardie), DUNDEE  
Dr Emert White, WARWICK  
Dr Sean Williamson, MIDDLESBROUGH

One-year membership from April 2004 – March 2005

Dr. Wendy Adams, UK  
Dr Mahvash Agah, Iran  
Dr. Robina Akhtar, UK  

Dr. Jeya Anandanesan, UK  
Dr Mohammed Haroon Arif, UK  
Dr Patrick Aubry, France

Ophthalmic Anaesthesia News, Issue 6, June 2002  
Email: secretary@boas.org  
Website http://www.boas.org
Dr Himadri S Babla Jadhav, UK
Dr Mariyappan Balasubramanian, UK
Dr Harold Bernitz, Australia
Dr Peter Brook, UK
Dr Sara Bustamante, UK
Dr O Chalkeidis, UK
Dr Cherian Karuthedathu Cherian, UK
Miss Anne Cook, UK
Dr Jo Dako, UK
Dr Gemini E De Silva, UK
Dr Bruce Dewar, UK
Dr Ian Edmiston, Australia
Dr Norma Enriquez, UK
Dr Sriskandarajah Logarajah, UK
Dr Conan McCaul, Ireland
Dr Andrea Melber, Switzerland
Dr Mallika Mills, UK
Dr Fauzia Mubashir, Switzerland
Dr Velaiatham Muralitharan, UK
Dr Tin Ohn Myint, UK
Dr Sajjad Ahmed Orakzai, UK
Dr Kaggere Paramesh, UK
Dr Jine Perera, UK
Dr Suzanne Powrie, UK
Dr Lynne Prophet, UK
Dr Fotna Reda, UK
Dr Charles Rich, USA
Dr Neil Ross, USA
Dr Chakralvar Sathyanarayana, UK
Dr Franca Serafini, UK

Dr Mamdouh Fatehy, Saudi Arabia
Dr Rola Hammoud, Lebanon
Dr Lynn Hauser, USA
Dr Jadhan Hemakumar, UK
Miss Shirley Jones, UK
Dr Med Vrcelj Jovan Vrcelj, Germany
Dr Salalitha Katam, UK
Dr Palvinder Khanna, UK
Dr David Kirkbride, UK
Dr Mare Kubbaj, Estonia
Dr Karen Lazarus, UK
Dr John Lethbridge, UK
Dr Stanley Ling, UK
Dr Beryl Magrath, UK
Dr Z P Shah, UK
Dr Julie Sherwin, UK
Dr Younan Sirian, UK
Dr Patricia Slater, UK
Dr Janet Smith, Australia
Dr Indra Srikantharajah, UK
Dr Carol Stableforth, UK
Dr Raj Thillai, Jersey
Dr Richard Thompson, UK
Mr N Toumia, UK
Dr Louise Vella, UK
Dr Nicola Suzanne Wallace, UK
Dr Sonia Wartan, South Wales
Dr Nicky Williams, UK
Dr Vanda Yazbeck-Karam, Lebanon
Local Anaesthesia for Ophthalmic Surgery
Friday, 11th February 2005, Middlesbrough

A CME approved meeting for anaesthetists and ophthalmologists on Local Anaesthesia for Ophthalmic Surgery will be held in the Education Centre, The James Cook University Hospital, Middlesbrough on Friday, 11th February 2005. The meeting will include lectures and live demonstration of orbital blocks. Attendance is limited to 50 participants. Application form and information from Mrs Elaine Tucker (Course Administrator 01642-854601 email: elaine.tucker@stees.nhs.uk. Registration fee is £250 (BOAS Members £225) (inclusive of catering). Cheque payable to Ophthalmic Anaesthesia Education Trust Fund.

PROGRAMME

09.00-9.25 Registration

9.25 Welcome: Prof Chris Dodds, Middlesbrough
Chairman: Dr Robert Johnson, Bristol
9.30-10.15 Anatomical considerations for ophthalmic block
Mr David Smerdon, 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
Prof Chris Dodds, Middlesbrough
12.00 - 12.30 Complications of eye blocks
Dr Joseph Bayes, Boston, USA

12.30-13.45 Lunch

13.45 -17.00 Live Demonstration of Orbital Blocks
Demonstration co-ordinators: Drs Anthony Rubin, Robert Johnson, Prof Chandra Kumar, Mr Chrijan Dees, Mr Tim Dowd, Mr David Smerdon & Prof Chris Dodds

Retro and/or peribulbar
Prof Chandra Kumar, Middlesbrough
Dr Anthony Rubin, London
Dr Grainne Nicholson, London
Dr Sean Tighe, Chester
Dr K L Kong, Birmingham
Dr Sean Williamson, Middlesbrough
Dr Joseph Bayes, Boston, USA

Sub-Tenon’s
Stevens’ Cannula, Inferonasal
Prof Chris Dodds, Middlesbrough
Dr Hamish McLure, Leeds
Kumar-Dodds Cannula
Dr Raju Chabria, Middlesbrough
Greenbaum’s Cannula
Prof Chandra Kumar, Middlesbrough
Ultrashort Cannula
Mr Bartley MacNeela, Jersey

17.00 Closing remarks
Prof Chris Dodds, Middlesbrough