Sub-Tenon’s anaesthesia: an efficient and safe technique

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Abstract

Aim—To evaluate sub-Tenon’s anaesthesia as an alternative to peribulbar anaesthesia.

Methods—109 consecutive patients listed for various eye operations (including cataract, trabeculectomy, and vitrectomy) under peribulbar anaesthesia were operated on under sub-Tenon’s anaesthesia instead. After topical anaesthesia a buttonhole was fashioned through the conjunctiva and Tenon’s capsule 10 mm posterior to the limbus. 1.5 ml of lignocaine 2% was then delivered to the posterior sub-Tenon’s space using a blunt cannula. The surgical procedure was performed immediately after the completion of the anaesthetic procedure. Chemosis, conjunctival haemorrhage, degree of akinesia, and pain scoring were analysed.

Results—There were no anaesthesia related complications. The administration of the block and akinesia was limited when assessed just after the completion of the block and akinesia was limited when assessed after surgery. Chemosis and conjunctival haemorrhage were frequent but caused no intraoperative problems.

Conclusion—Sub-Tenon’s anaesthesia is an efficient and safe anaesthetic technique. It is a good alternative to peribulbar anaesthesia.

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Peribulbar or retrobulbar anaesthesia, while providing excellent analgesia and akinesia, have been associated with rare1 but numerous ocular complications including diplopia,2 orbital haemorrhage,3 globe perforation,4 central retinal vein or artery occlusion,5 brainstem anaesthesia,6 optic nerve trauma,7 and ptosis.8

In addition, preoperative intravenous sedation is often required because patients find the injection painful and frightening. Recently there had been renewed interest in sub-Tenon’s anaesthesia.10–12 It is not a new technique since it was described as early as 1884 by Turnbull.13 This prospective study reports our experience of sub-Tenon’s anaesthesia using a blunt cannula for various anterior and posterior segment eye operations.

Materials and methods

From February 1996 to July 1996, 109 consecutive patients (47 males, 62 females with a mean age of 66) scheduled for peribulbar anaesthesia underwent surgery under sub-Tenon’s anaesthesia instead. Seventy six had phacoemulsification cataract extraction (temporal corneal or scleral tunnel incision), five underwent combined phacoemulsification with trabeculectomy, three pterygium removal, five trabeculectomies, six had a three port pars plana vitrectomy for dislocated fragments of lens in the vitreous following cataract surgery, three a pars plana vitrectomy for vitreous haemorrhage, three had silicone oil removal, one radial keratotomy, one secondary lens implantation, one artificial lens removal for chronic endophthalmitis, two hyphaema evacuation, and three necessitated surgical treatment of iris prolapse following cataract surgery.

Duration of surgery, site of sub-Tenon’s anaesthesia, conjunctival chemosis (0 = no chemosis; + = chemosis involving one quadrant; ++ = chemosis involving two quadrants; +++ = chemosis involving three or four quadrants), subconjunctival haemorrhage (0 = no haemorrhage; + = haemorrhage involving one quadrant; ++ = haemorrhage involving two quadrants; +++ = haemorrhage involving three or four quadrants) were all noted on a chart. Patients were asked to score the pain during the anaesthetic procedure and during the surgery (0 = no pain, no sensation; 1 = slight ‘sensation’ or discomfort but no pain; 2 = slight pain; 3 = moderate pain; 4 = intense pain). Akinesia was assessed by the surgeon just after the completion of the sub-Tenon’s anaesthesia and at the end of the surgical procedure using a subjective four category scale where 0 represents complete movement remaining, 1 moderate movement, 2 slight movement, and 3 no movement.

ANAESTHETIC TECHNIQUE

All the patients were monitored and had intravenous access. Four drops of topical 1% preservative free amethocaine (tetracaine) were applied to the cornea and conjunctiva. The patients were prepared and draped and a lid speculum inserted. The patients were asked to move their eye so as to expose the area to be injected. Using blunt scissors, a buttonhole through the conjunctiva and Tenon’s capsule was fashioned 10 mm posterior to the limbus. A specially designed blunt cannula (Greenbaum sub-Tenon’s flexible cannula for 82 patients, length of the cannula 15 mm, and Visitec sub-Tenon’s rigid cannula for 27 patients, length of the cannula 26 mm) was then passed through the buttonhole and slid 5...
to 7 mm along the bare sclera. A volume of 1.5 ml of lignocaine 2% was then administered. The anaesthetic solution was delivered in one of the four quadrants of the globe delimited by the recti muscles. The best exposed quadrant or the quadrant the further away from the operative section (in cases of scleral incision) was chosen to be the site of injection—50 patients had an inferonasal approach, 10 superonasal, 44 inferotemporal, and five superotemporal.

In all cases the operation was started immediately after completion of sub-Tenon’s anaesthesia without use of oculopression.

Three anxious patients received mild intravenous preoperative sedation (propofol 10 mg).

Results

There were no anaesthesia related complications. No patients scheduled for peribulbar anaesthesia were considered unsuitable for the sub-Tenon’s anaesthesia. In no case was sub-Tenon’s anaesthesia changed to peribulbar anaesthesia.

Figures 1 and 2 report pain scoring during the sub-Tenon’s anaesthesia procedure and during operation. Figures 3 and 4 show the degree of akinesia. Figure 5 represents chemosis and Figure 6 subconjunctival haemorrhage.

Complications during surgery (one capsular rupture during phacoemulsification, one hyphaema following iridectomy during trabeculectomy) were not related to the anaesthetic method. The operating time ranged from 10 minutes to 1 hour and 10 minutes (mean 35 minutes).

Discussion

ANALGESIA

The sub-Tenon’s anaesthesia procedure was painless for 99.1% of the patients (Fig 1); 55% reported no pain or ‘sensation’, and 44.1% only ‘sensations’ during this procedure. The patients’ satisfaction is enhanced by warning them just before the injection that they might experience a mild ‘sensation’ like a pressure or even discomfort but they will not feel pain. Stevens reports a median score of 1 (slight discomfort) on a 0 to 10 graded pain scale for the delivery of the sub-Tenon’s block.

The anaesthetic block was very efficient; 97.3% of the patients (Fig 2) reported no pain during surgery (87.2% reporting no pain nor sensation and 10.1% only ‘sensation’). The deepness of analgesia has been reported by all the authors using this technique for cataract surgery, pan-photocoagulation, retinal detachment and vitreous surgery, and strabismus surgery. The cannula follows the contour of the globe under Tenon’s capsule until posterior to the equator and delivers the...
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sessed 15 minutes after completion of the sub-Tenon’s anaesthesia.

Greenbaum reports good surgery (the time to obtain complete akinesia is

1% and bupivacaine 0.375% mixed with

1.5 mlofan anaestheticsolution of lignocaine

complete akinesia, after a four quadrant injection of

hyaluronidase, in 58 cases of vitreoretinal

surgery (they were all graded 1 or 2). Our

patients who had cataract surgery had good

and 37.6% had no akinesia at all. None of the

patients had conjunctival haemorrhage. Most of the

conjonctivalspace.

Chemosis is frequent; 39.4 % of the patients

had a chemosis involving more than one quadrant (Fig 5). It takes a little practice to limit

chemosis by ensuring that the anaesthetic solu-

tion is truly delivered to the posterior sub-

Tenon’s space and not to the anterior subcon-

junctional space.

Subconjunctival haemorrhage is caused by

eine vessels inevitably severed on making the

conjunctival cut. In our study (Fig 6), it was

frequent; more than half the patients (56%) had conjunctival haemorrhage. Most of the

time it was limited (only one patient had three

quadrants involved), and no patient had sufficient haemorrhage to cause a problem.

Stevens reports subconjunctival haemorrhage

involving at least one quadrant in 32% of the

patients. Some authors advocate using cau-

terisation before making the buttonhole to

lower the incidence of haemorrhage.

The benefits of sub-Tenon’s anaesthesia over

peribulbar or retrobulbar anaesthesia are: it

eliminates the risks of the ‘needle’ techniques

(however, these procedures if performed by

skilled clinicians are not painful and most

complications result from poor training) the

analgæsia is immediate and the anaesthetic vol-

ume being minimal, there is no rise in ocular

pressure and no need for globe compression

no preoperative sedation is necessary.

Yet, because of the poor akinesia we do not

consider sub-Tenon’s anaesthesia to be ade-
quate for patients unable to cooperate (no cases in our study) and for surgery necessitat-

ating a wide opened eye such as in keratoplasty

or manual extracapsular extraction (no cases in

our study).

With cataract surgery, topical anaesthesia is also advocated as a safe andatraumatic tech-

nique. The main advantages of topical over

sub-Tenon’s anaesthesia are the absence of

Tenon’s procedure using a 50:50 mixture of

lignocaine 2% and bupivacaine 0.5% solution) in 27 out of 50 patients who underwent

cataract surgery. Difference in the time of

assessment and in the volume or mixture of

the anaesthetic solution administered can explain the various reports of akinesia depending on

publications.

Some surgeons find difficult to work without

akinesia; however, as reported by many

authors, the lack of akinesia does not cause

intraoperative difficulties. Stabilisation of

the globe is adequate during a two handed

procedure (as during phacoemulsification or

vitrectomy). Most of the time the patients do

not have eye movement. If necessary, un-

wanted movements can be controlled by

forceps fixation. Lack of akinesia can even be

helpful to the surgeon when asking the patient
to look in a particular direction to expose a

desired area. No complications have occurred
during surgery because of ocular motility.

Nevertheless, in cases of patients completely

unable to cooperate (patients suffering demen-
tia or unable to understand the language), we

would rather use peribulbar or retrobulbar

anaesthesia.

CHEMOSIS

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nique. The main advantages of topical over

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chemosis and subconjunctival haemorrhage and a quicker visual recovery. Yet, topical anaesthesia is not as efficient as sub-Tenon’s anaesthesia and spread on the zonules and iris sensitivity sometimes causes ‘sensations’ or even slight pain as reported by many authors.24–28 Fukasaku and Marron,15 comparing sub-Tenon’s and topical anaesthesia, found that 1% of the patients under sub-Tenon’s anaesthesia reported pain as against 31% in the topical group. We still use topical anaesthesia for standard cataract surgery but in cases of very anxious patients or patients whose pupillary dilatation is not sufficient (risk of iris chafing) we favour sub-Tenon’s anaesthesia. During topical anaesthesia, if the patients feel any discomfort, we perform a supplementary sub-Tenon’s anaesthesia.

We did not notice any difference between the two canulas. However, the Visitec cannula is rigid and longer than the Greenbaum cannula. This could be an advantage to ensure reaching the posterior sub-Tenon’s space; however, it could theoretically be more damaging to a vortex vein. We did not find any advantage or disadvantage in the different routes used to infuse the anaesthetic solution: the access and the inconvenience of the block was the same in the four quadrants.

Conclusion
Sub-Tenon’s anaesthesia is a simple, safe,atraumatic technique. Its benefits are numerous. It can be proposed as a good alternative to peribulbar or retrobulbar anaesthesia in anterior and posterior segment eye surgery.