Anesthesia for Open Eye Surgery

To the Editor:—In his letter, Dr. Bourke\(^1\) compliments Libonati \(\text{et al.}\)^2 on their recent article supporting the use of succinylcholine in open eye surgery. He adds that, based on his own survey of ten ophthalmologists, “only a small percentage of patients with penetrating eye injuries recovered any useful sight in the injured eye” and that only two of 27 patients who had lost an eye considered monocular vision a handicap. We believe that these limited surveys seriously underestimate both the potential for useful vision postoperatively and the advantage of binocularity.

In a series of three reports on a total of 1,077 patients who had perforating eye injuries,\(^3\) the prognosis for useful vision after surgery was encouraging: 40–65% had vision of 20/40 or better; only about 20% of eyes had no useful vision. The prognosis was affected by several factors, especially by whether the injury involved the anterior and/or posterior segment of the eye, whether there was uveal prolapse, and whether intraocular reaction resulted.\(^3\)–\(^6\)

Recent advances in retinal surgery have demonstrated increased the salvage of vision after severe traumatic injuries to the posterior segment, i.e., techniques to treat vitreoretinopathy, use of long-acting intracocular gases, silicone oil tamponade, intraoperative endophotocoagulation, and the use of retinal tacks.

Libonati’s study, a retrospective report without a control group for comparison, is without statistical validation. The only endpoint in the study is whether the surgeon complained of extrusion of eye contents. No mention is made of difficulty with uveal prolapse, bleeding, or reformation of the globe. There is no information regarding
the degree of preservation of useful vision afterward. The fact that some of the most serious eye injuries result from scleral rupture, after which one may be unable to observe extrusion of eye contents until after exploration of the globe and orbit, is not discussed.

Before surgery for penetrating eye injury, adequate examination is often not feasible until after the patient is anesthetized, prepped, and draped. Prolapase of eye contents is not unusual. Just because the surgeons in Libonati et al.’s report did not complain of extrusion after anesthetic induction and use of succinylcholine does not mean that there was none or that there was no additional loss of contents.

We are fortunate to have alternatives to use of succinylcholine for intubation. Given the potential for good visual outcome, we feel that the literature supports evidence for avoidance of use of succinylcholine in penetrating eye injuries.\(^7\)\(^8\)

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**ASSAY FOR SERUM SUFENTANIL LEVEL IS NOT SENSITIVE**

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**ASSAY FOR SERUM SUFENTANIL LEVEL IS NOT SENSITIVE**

**To the Editor:**—We agree with Weldon et al.\(^1\) that there are no assays that allow one to estimate accurately the elimination clearance of sufentanil after small standard doses. Unfortunately, their capillary gas chromatographic method, as it is presented,\(^4\) does not seem to change this situation and may actually lend confusion to what might otherwise have been a straightforward clinical report.\(^5\)

The most serious deficiency in the report of this new