Letters to the Editor

OCULAR DEVIATIONS-IS ANAESTHETIC TO BLAME?

Dear Editor,

The article on ocular deviations following cataract surgery was interesting and thought provoking. I have the following queries and observations:

If anaesthetic myotoxicity is primarily responsible for ptosis and ocular deviations then there should have been deviations in some of the 12 patients who underwent a repeat block.

One of the most important causes of post-operative ptosis is the induced uveitis. That's why one invariably finds cases of Acute Iridocyclitis manifesting ptosis. Some degree of ptosis is evident in cases who undergo phacoemulsification through a clear corneal incision and under topical anaesthesia. In this situation conjunctival

flaps and anaesthetic myotoxicity are eliminated.

Though ocular deviations persisted in 6 cases only 3 of them had diplopia which again is inconsistent with their assumed myological origin.

The authors have concluded that incidence of myotoxicity decreases by the end of 12 weeks whereas in their study 75% of the vertical deviations, 66.6% combined deviations and 60% of "ptosis and deviations" persisted. Only horizontal deviations recovered significantly.

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REPLY

In 12 patients who underwent repeat blocks, 2 patients developed post-operative ptosis and one developed an ocular deviation, which resolved by 12 weeks. In none of the earlier studies, there is any mention of an association of repeat blocks with ptosis. Only 4 case reports have been published of deviations after cataract surgery with repeat blocks. Moreover in these blocks, adrenaline was used along with bupivacaine (0.75%) which potentiates the effect of the anaesthetic. Recent studies indicate that there may be some degree of direct trauma to the muscle with the needle and some amount of intramuscular injection of LA would lead to more muscle damage and scarring with subsequent ocular deviation.

Out of the 6 patients with ocular deviation, only 3 had diplopia. Three patients had significant lenticular opacities in the non-operated eye with vision <6/60 which could explain the absence of diplopia in these cases.

As seen in the table, if we take deviations alone, there were 10 at the end of first week which had decreased to 3 at the end of XII week. But as pointed out, deviations associated with ptosis as well as vertical deviations have a slower recovery and need careful

follow-up for a longer duration. Moreover in vertical deviations the effect of LA could be compounded by direct surgical trauma to the muscles itself and these cases may need surgical intervention later.

If there are any further queries, I would be glad to answer them.

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HIV: CHANGING SCENARIO AND NEW CHALLENGES

Dear Editor,

This is with reference to Editorial "HIV: changing scenario and new challenges" [1] and your reply to the letter "HIV: Scenario in Andaman and Nicobar Islands" [2].

From our unit two HIV positive cases have been reported in last two years. One of them gave history of receiving blood transfusion in Tripura and other gave a history of sexual contact with a prostitute while on temporary duty in Meghalaya. Both are serving soldiers, one from Kerala and other from Uttaranchal.

REFERENCES

1. Sancheti PC, Rai R. Editorial HIV: Changing scenario and new challenges. *MJAFI* 1998;54:91-2.
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ECG DIAGNOSIS : SUPRAVENTRICULAR TACHYCARDIA

Dear Editor,

This 30-year old lady presented with palpitation. Her ECG (Fig-1) revealed regular heart rate of 214/min with cycle length of 280 msec. P-wave morphology was negative in inferior leads and upright in lead I, aVR and aVL with caudocranial activation pattern.

P-R interval (80 msec) was less than fixed R-P interval (200 msec). QRS complexes were narrow with duration of 40 msec. QRS alternans was present in lead V₅ and V₆. She was treated initially with injection deltiagem (Repeated three times) without any response. Three DC shocks of 50, 50 and 100 joules had no effect on her