The important decision one has to take during the planning of tumor excision and lid reconstruction is what anesthesia would be suitable for a peaceful, painless, and comfortable surgery.

The case selection for mode of anesthesia will depend on multiple factors. First of all the age of the patient, the size of the tumor, the amount of tissue mobilization as well as the probable surgical time.

**General anesthesia**

General anesthesia is usually necessary for all children. It should be the mode of anesthesia if one is planning big rotational flaps like the Mustarde’s Cheek rotation. Most lid tumors are in the older age group. One may have to undertake most small or medium sized tumors of the lid under local anesthesia. Even if a lid tumor excision has been planned under general anesthesia, a small amount of infiltration of 2% lidocaine with adrenaline (epinephrine) 1:200,000 solution to the surrounding area helps in two ways. First it reduces per operative oozing by its vaso constructive effect, and secondly by reducing the post surgical pain, following general anaesthesia.

**Local anesthesia**

Local anesthesia is adequate for most adults and is much preferred for most types of biopsies as well as small to medium sized lid tumor excision. Adequate anesthesia can be obtained with a simple subcutaneous injection of 1.5-2 ml (2% with adrenaline1:200,000) of anesthetic across the breadth of the lid. A lidocaine-bupivacaine mixture provides adequate anesthesia for a slightly longer duration. Approximately 0.5-1.5 ml of lidocaine is injected subcutaneously across the lid at the level of the lid crease.

**Regional sensory blocks**

The Supra trochlear, Supra Orbital, Lacrimal, Infratrochlear, Zygomaticotemporal, Zygomaticofacial and Infraorbital nerve, gives a relatively good localized sensory anesthesia, without causing much localized tissue edema, at or around the site of dissection, especially during lid reconstruction.

**Infiltration anesthesia**

Infiltrative anesthesia is used as local anesthetic technique. The anesthetic agent is infiltrated directly into the surgical site by means of either intradermal injection, subcutaneous or sub conjunctival injection.

The orbicularis muscle is innervated primarily by the zygomatic branch of the facial nerve laterally and by the buccal branch of the facial nerve medially. These branches join to form a plexus of nerves that penetrate the deep surface of the muscle in a segmental fashion. So an infiltrative anesthesia in the periocular region is applied in suborbicularis plain.

Direct subconjunctival infiltration is applied at the site of incision. This is useful especially if the tumour involves only the tarsal aspect, and patient still complains of pain in spite of regional anesthesia.

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Regional block

Regional block is the most commonly used local anesthetic technique. The anesthetic agent is infiltrated directly over the sensory nerve as it leaves the orbit, by means of either deep subcutaneous injection. Take care not to injure the accompanying artery & vein which also passes along with the nerve it.

Lacrimal nerve Block

It innervates lateral part of upper eye lid and located near the lateral orbital margin. One or 1/2 inch needle is inserted at the superior lateral orbital margin taking care that the needle does not go behind the peristeum. Usually 0.5 - 2ml anesthetic injection is sufficient. Anesthesia of lacrimal gland, conjunctiva & overlying skin is obtained.
mid line of the skull. It lies approximately at the superior orbital margin, on a line with the pupil, with the eye looking straight. Inject 1-1.5 ml just superior to the supra-orbital notch.

**Supra trochlear nerve block**

It supplies more medial portion of upper eyelid & forehead overlapping with supra orbital nerve. The trochlea is traced along the superior medial orbit. Injection (1-1.5 ml) is given above the trochlea about 1/2" behind orbital rim.

**Infra trochlear nerve block**

It supplies the medial canthal area. The trochlea is traced along the superior medial orbit. Injection (1-1.5 ml) is given below the trochlea and above the medial canthal ligament, ½ inch behind orbital rim.
**Zygomaticotemporal and Zygomaticofacial nerve block**

They innervate inferolateral part of lower eye lid and located near the inferolateral orbital margin. Injection is given at the inferolateral orbital margin taking care that the needle does not go behind the periosteum.

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**Infraorbital nerve block**

It supplies the central part of the lower lid and per orbital area. The nerve emerges on the face from the infraorbital foramen on the maxillae. It is felt as a small depression below the inferior orbital rim, on a line with the pupil, with the eye looking straight. Needle is inserted till orbital margin is felt and 1-1.5 ml of anesthetic agent injected.