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شبكة المعلومات الجامعية التوثيق الالكتروني والميكروفيلم



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جامعة عين شمس

التوثيق الالكتروني والميكرو فيلم

قسم

نقسم بالله العظيم أن المادة التي تم توثيقها وتسجيلها
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بعض الوثائق الأصلية تالفة

بالرسالة صفحات
لم ترد بالأصل

Anesthesia for Ophthalmic emergencies

Essay

Submitted for partial fulfillment of master
Degree in anesthesia presented

by

Hesham abdel Badie Ahmed
(M.B; Bch)

*supervised
by*

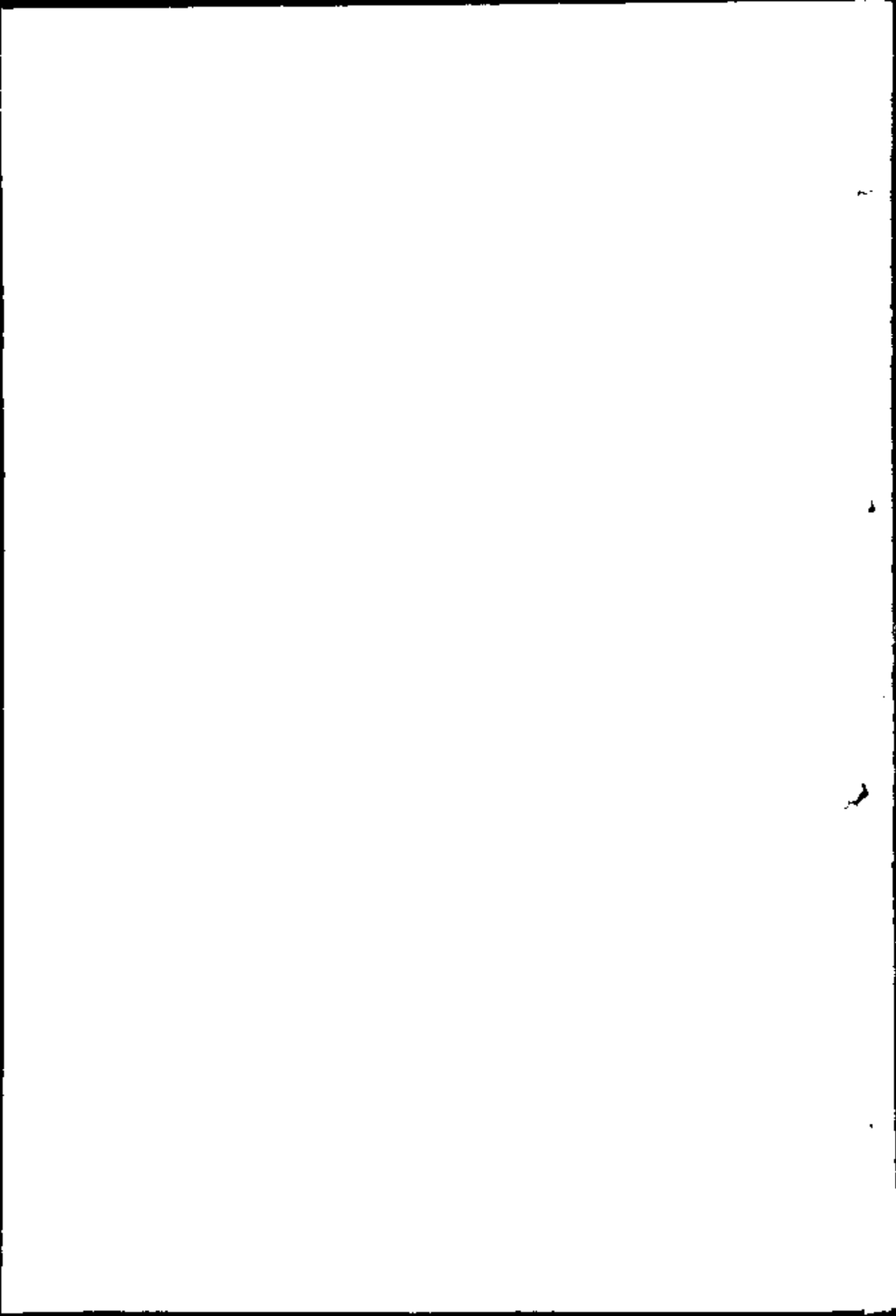
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محضر

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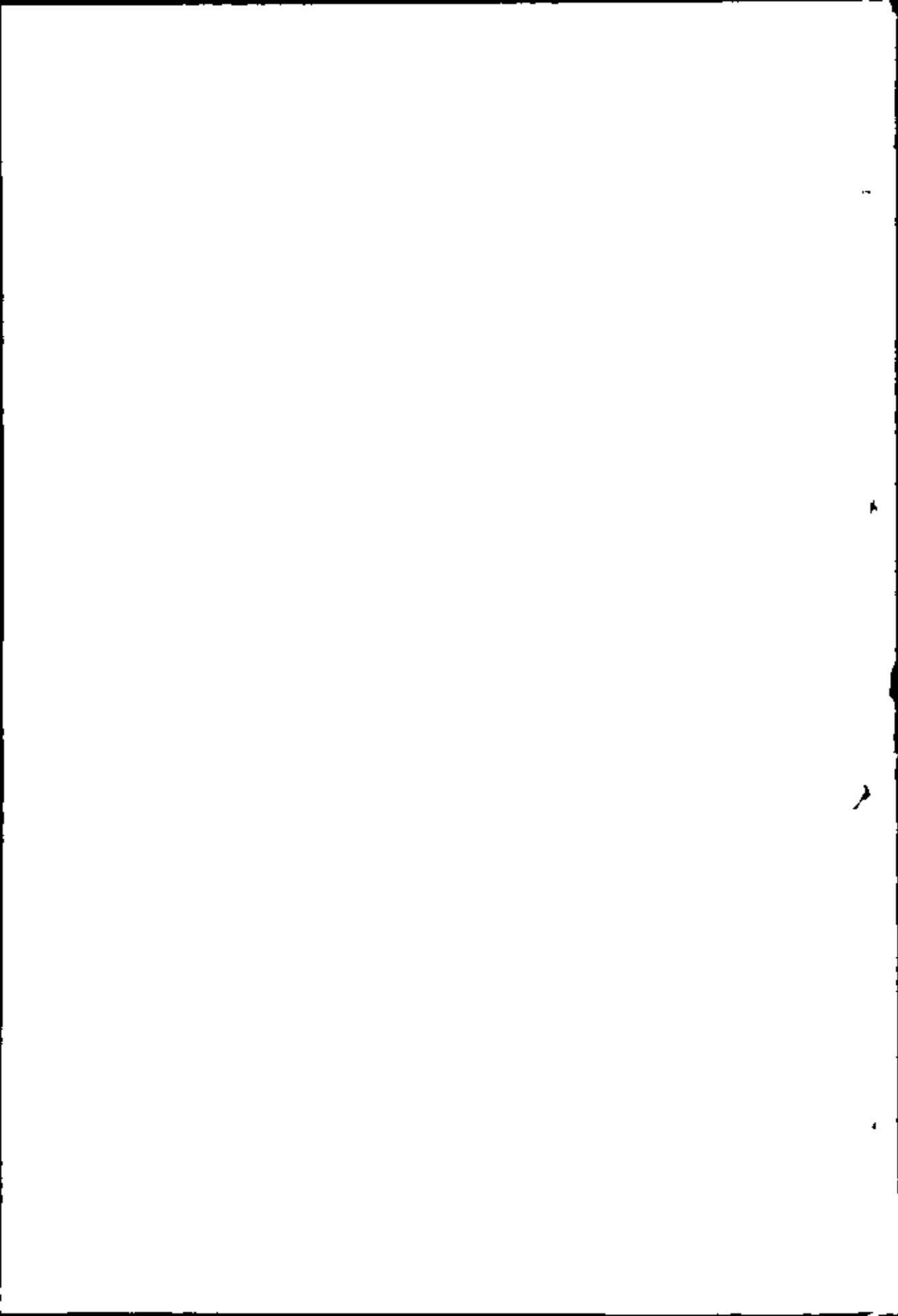
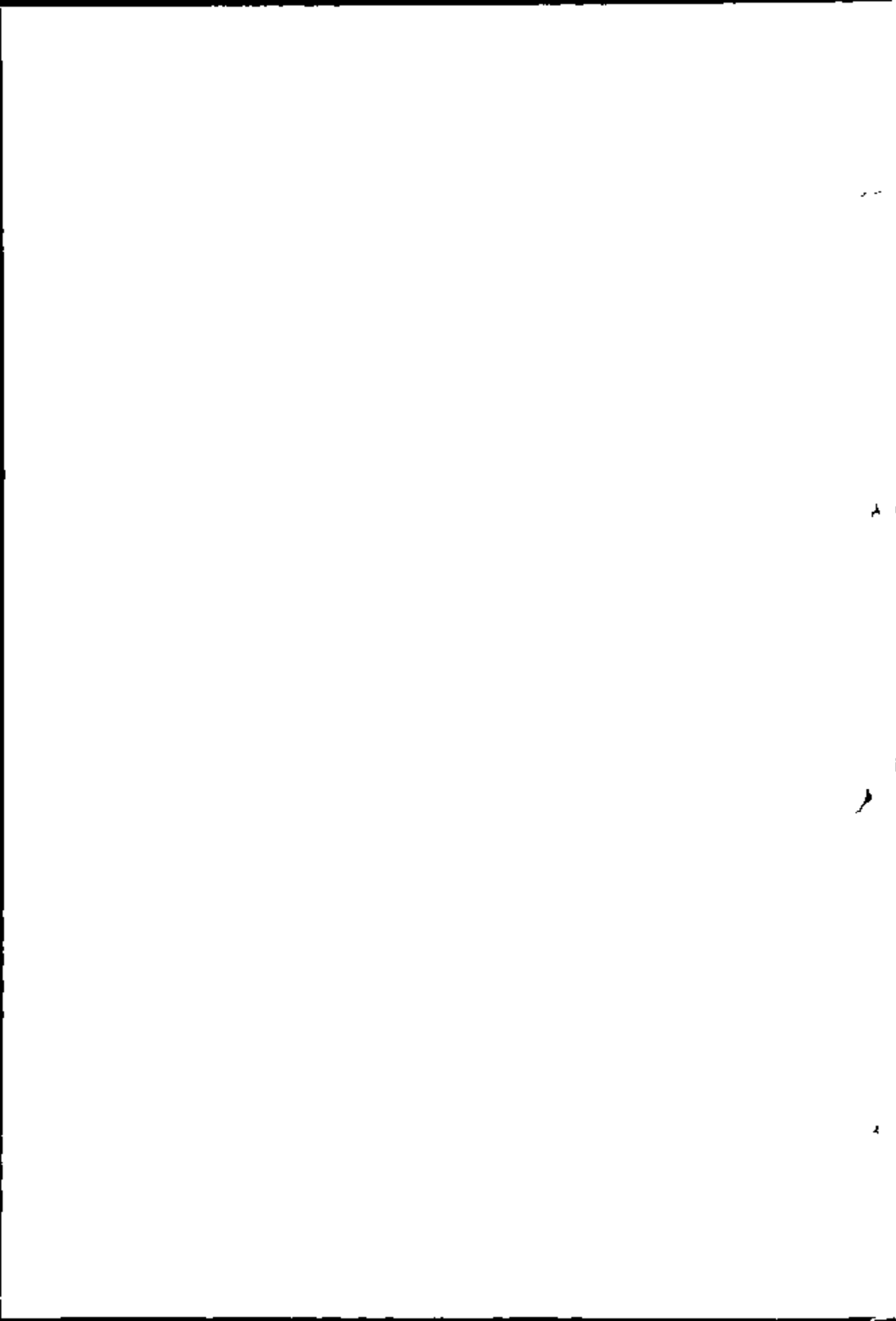


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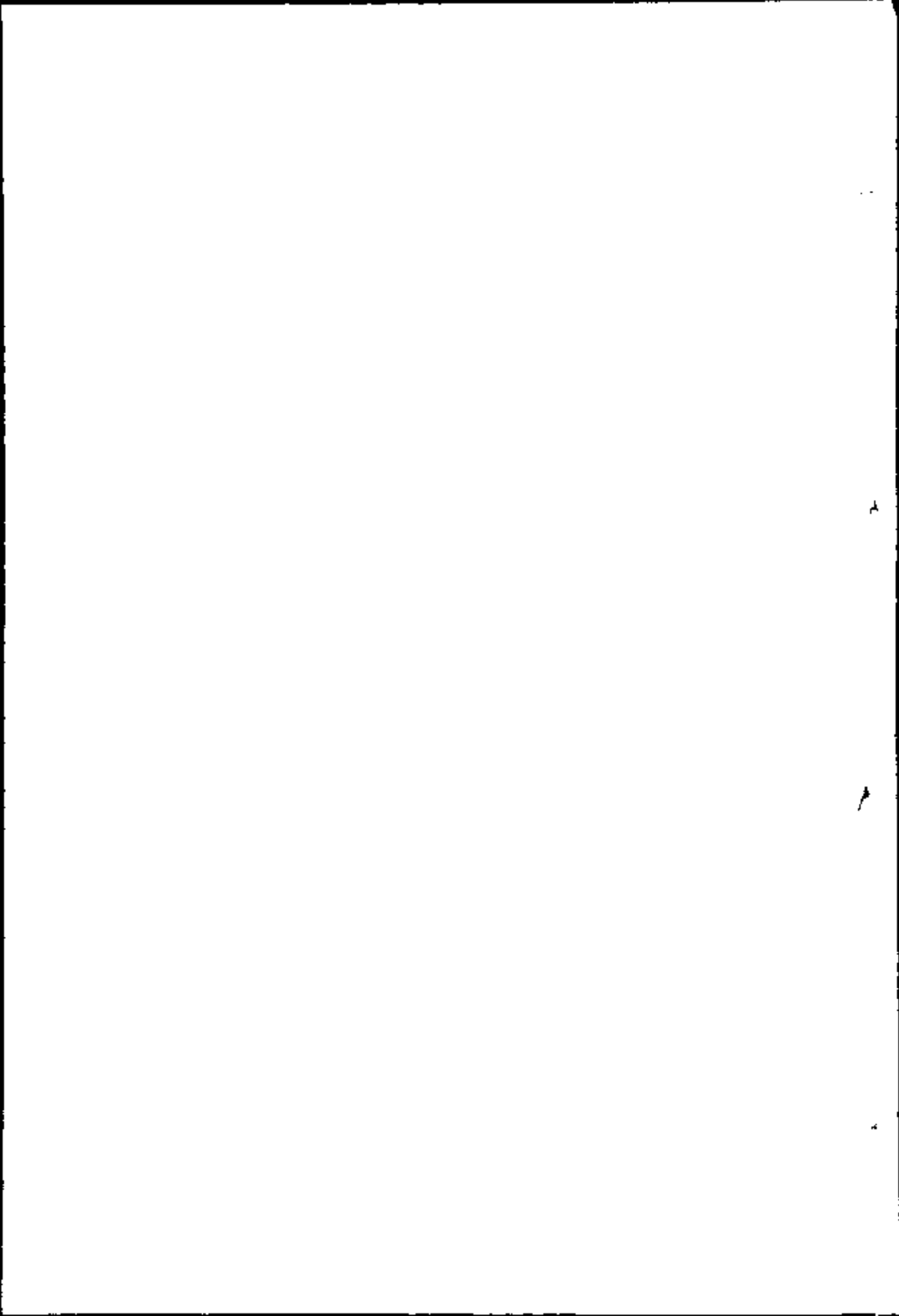
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INTRODUCTION

Ophthalmic emergencies can be classified as minor or major.

Major emergencies can be subdivided thus:

- Those in which the eye is perforated.
- Those in which the eye, although not perforated initially, will be opened during the course of surgery, an example; of this is a drainage operation for acute glaucoma.
- Those in which the eye is, and will remain intact, an example of this being the repair of the lids and /or lacrimal drainage apparatus.

The factor that distinguishes anesthesia for ophthalmic surgery from that for other branches of surgery is the intra-ocular pressure and its control at any time that the eye is open.

Any factor which in a normal eye would causes a rise in I.O.P may cause the contents of an open eye to be extruded.

These factors include:

- Rise in central venous pressure (coughing, straining or bucking on the tracheal tube) .
- As changes in C.V.P are directly transmitted to the orbital veins.
- Rise in Arterial blood pressure.
- Arise in Pa CO₂ causes arise in I.O.P.
- Mechanical compression on the eye (e.g. face mask)

- Anesthetic drugs such as Ketamine or Suxamethonium.⁽⁹³⁾ Management of emergency anesthesia for a patient having a full stomach and an open eye injury requires balancing the need to prevent aspiration of gastric content against prevention of sudden significant increases in I.O.P.⁽²⁸⁾

In our work, we will try to clarify anesthetic environment that optimizes surgical management of ophthalmic emergencies starting from premedication and safe guarding against aspiration, passing by anesthesia induction to blunting cardiovascular and I.O.P responses to laryngoscopy and tracheal intubation, neuro-muscular blocking for tracheal intubation and controlled ventilation.

Securing airway after anesthetic induction, intra-operative control of I.O.P, tracheal extubation by the end of the procedure, together with smooth emergency from anesthesia, special considerations to anesthetic management of pediatric eye injuries would be spotlighted as well.⁽¹⁸⁾