CLINICAL TOPIC REVIEW

Is cocaine needed in topical anaesthesia?

S Bush

The current medical literature for effective agents that do not contain cocaine.

Are non-cocaine containing topical anaesthetics as effective as cocaine containing topical anaesthetics in the management of lacerations? This review examines the current medical literature for effective agents that do not contain cocaine.

"Pain hurts".

The standard local anaesthesia technique used in UK practice before suturing is infiltration with 1% plain lignocaine (lidocaine). This method is painful but does give good anaesthesia.

Topical anaesthesia (TA) has been used in the United States for two decades. The rationale behind its use was to avoid the needle prick and pain of infiltration while producing effective anaesthesia. There is also no tissue distortion with topical anaesthesia unlike subcutaneous infiltration.

The original mixture used for topical anaesthesia was TAC—0.5% tetracaine, 0.05% adrenaline (epinephrine), and 11.8% cocaine although a number of departments use different concentrations of the three drugs.

Application of TAC is less painful than infiltration of lidocaine in wounds of the face and scalp the anaesthetic effectiveness of TAC is equivalent to 1% lignocaine. Some studies have demonstrated equivalence with extremity wounds but other publications report that TAC is inferior to 1% lidocaine in this situation. Wound complication rates are similar for both drugs. Most comparisons with lidocaine have been made only in children but some have included adults.

There are a number of drawbacks associated with the use of TAC. TAC is expensive and as a controlled drug, it is inconvenient to store and use. The most significant problems with TAC, however, are the rare but catastrophic complications of its use. There are several reports of seizures associated with its use in children. There is also a case report of the death of a child that has been attributed to the rapid absorption of cocaine via mucous membranes. Cocaine has been detected in the plasma of children treated with TAC. The majority of departments that use TAC avoid its use on mucous membranes but not all.

Reducing the concentration of cocaine in TAC has been proposed to improve its safety profile but the safety issues remain, as do the cost and inconvenience factors. It is logical, therefore, to seek an agent that does not contain cocaine but is as effective in topical anaesthesia as TAC. The purpose of this review is to examine the literature for evidence of such an agent.

METHODS

The Medline database (1966–2000) was searched using the Ovid search engine. MeSH headings of "Anesthesia, local", "Anesthetics, local" and "Administration, topical" were used. Searches were also made using "topical anaesthesia" and "topical anaesthesia" as keywords. The results generated were combined with those from the MeSH headings "Wounds, nonpenetrating" and "Wounds, penetrating" and the keywords "laceration" and "incision". The combined articles were limited to "English language" and "randomised controlled trial".

Another electronic search was made of Medline using the Internet Grateful Med search engine. The query terms were "topical anaesthesia or topical anaesthesia" with limitation to "Human" and "Randomised Controlled Trial". The databases EMBASE, COCHRANE LIBRARY and BEST EVIDENCE CD were also searched in a similar manner. The internet was searched for "topical anaesthesia" and "topical anaesthesia" using the Dogpile site.

All of the references of the chosen papers were examined to identify other relevant papers. The journals Annals of Emergency Medicine and Journal of Accident and Emergency Medicine were hand searched from 1994–2000.

RESULTS

Tables 1, 2, 3, and 4 show the results of the literature search.

Sixteen relevant papers have been identified by the search strategy. Five studies compared an agent comprising lignocaine, tetracaine, and vasoconstrictor with either TAC or 1% lidocaine infiltration. In all but one study the agent performed at least as well as the control. Application of the topical agent is less painful than infiltration. Tetracaine, TAC is inferior to 1% lidocaine in this situation. Wound complication rates are similar for both drugs. Most comparisons with lidocaine have been made only in children but some have included adults.

There are a number of drawbacks associated with the use of TAC. TAC is expensive and as a controlled drug, it is inconvenient to store and use. The most significant problems with TAC, however, are the rare but catastrophic complications of its use. There are several reports of seizures associated with its use in children. There is also a case report of the death of a child that has been attributed to the rapid absorption of cocaine via mucous membranes. Cocaine has been detected in the plasma of children treated with TAC. The majority of departments that use TAC avoid its use on mucous membranes but not all.

Reducing the concentration of cocaine in TAC has been proposed to improve its safety profile but the safety issues remain, as do the cost and inconvenience factors. It is logical, therefore, to seek an agent that does not contain cocaine but is as effective in topical anaesthesia as TAC. The purpose of this review is to examine the literature for evidence of such an agent.

Abbreviations: TA, topical anaesthesia; TAC, tetracaine, adrenaline, cocaine
Bupivanor\textsuperscript{7} is as effective as TAC and lidocaine infiltration. The wound infection rate was low in all studies.

**DISCUSSION**

**Principal results**

Fourteen different non-cocaine containing topical anaesthetics have been studied. Of these, agents with 4% or 5% lidocaine,\textsuperscript{4} 5\% bupivanor,\textsuperscript{7} and tetraphen\textsuperscript{14} have similar effectiveness to TAC or 1% lidocaine infiltration.

There have been no significant complications reported in any study.

**Strengths and weaknesses of the search**

The question chosen was one that was clinically relevant to A&E practice in the UK and should allow a number of papers to be identified.

Multiple electronic databases were used using a variety of search engines. Keywords were used in addition to MeSH headings in an attempt to improve sensitivity. Alternative spellings of certain keywords further increase the sensitivity. By using the references of the articles chosen to generate further papers and hand searching the two journals thought most likely to be relevant, more articles were found.

Despite this strategy, it is unlikely that all the relevant papers will have been chosen. There may be other journals that may produce a relevant article but that may be unavailable for hand searching. It is impracticable to attempt to hand search every title that possibly has a useful paper and electronic searches, though extremely useful, do not identify every paper.

**Strengths and weaknesses of the papers**

The studies were all prospective in design and almost all used a “gold standard” control of either VAS for TAC or 1% lidocaine infiltration. One paper,\textsuperscript{18} however, was a case series, and another\textsuperscript{9} used sterile water as the control.

\begin{table}[h]
\centering
\caption{Agents using strong lignocaine (lidocaine)}
\begin{tabular}{|c|c|c|c|c|}
\hline
Group & Agents & Population & Score & Results \\
\hline
Ernst et al\textsuperscript{25} & 3 ml of TAC v 3 ml of LAT (4% lidocaine, 1/2000 adrenaline, 1% tetracaine) & Adults, Wound <7 cm on face or scalp. & VAS of suturing by patient + physician. & LAT caused fewer painful sutures p=0.034. Median VAS for TAC + LAT by both groups = 0 \\
& Applied for up to 30 minutes. & & Number of painful sutures by physician. & \\
Ernst et al\textsuperscript{26} & 1% buffered lidocaine with epinephrine v 3 ml LAT gel (4% lidocaine, 1/2000 adrenaline, 0.5% tetracaine) & 5 years and older, Wound 1.5–10 cm and linear. & VAS of application and suturing by patient + physician. & VAS for application strongly favours LAT p=0.001. 13% sutures caused pain with LAT, 6% with lidocaine P=0.28 No difference in VAS for suturing \\
& Gel applied for up to 20 minutes. & & Number of painful sutures by physician. & \\
Schilling et al\textsuperscript{27} & 3 ml of TAC v 3 ml of LET (4% lidocaine, 1/1000 epinephrine, 0.5% tetracaine) & Children, Wound covered by 2×2 cm gauze on face or scalp. & Adequacy of anaesthesia. Duration of anaesthesia. & Equivalent adequacy of anaesthesia (TAC 79.5%, LET 74.4% p=0.45). Equivalent numbers with complete duration of anaesthesia (TAC 75.9%, LET 82.4% p=0.18). No difference in number of painful sutures (TAC 13%, LAT 18% p=0.51). No difference between LAT and TAC ranked sum ratings for physicians (p=0.85) or patients (p=0.71). \\
& Applied for 15 minutes. & & & \\
Ernst et al\textsuperscript{28} & 3 ml TAC gel v 3 ml LAT gel (4% lidocaine, 1/1000 adrenaline, 0.5% tetracaine) & Children 5–17 years, Wound <7 cm on face or scalp. & VAS of suturing by patient or parent and physician. & No difference between LAT and TAC ranked sum ratings for physicians (p=0.85) or patients (p=0.71). \\
& Applied for up to 30 minutes. & & Number of painful sutures by parents or patients. & \\
Resch et al\textsuperscript{29} & 3 ml LET (4% lidocaine, 1/1000 epinephrine, 0.5% tetracaine) solution v 3 ml LET gel. & Children, Wound covered by 5×5 cm gauze on face or scalp. & Adequacy to needle probe Efficacy of anaesthesia & No difference in adequacy between solution and gel (95% CI –8% to 13%) Similar numbers with complete effectiveness (95% CI –3% to 22%) \\
& Applied for 20 minutes. & & & \\
Blackburn et al\textsuperscript{30} & 10 ml TAC v 10 ml TLE (5% lidocaine, 1/2000 epinephrine) & 2 years and older, Wound of face or scalp. & Facial effective scale (9 points) by physician or older child. & Similar results TAC mean score 2.66, TLE 3.29 (p=0.33) Both scores within “complete anaesthesia” range \\
& Applied for 20 minutes. & & & \\
\hline
\end{tabular}
\end{table}

\begin{table}[h]
\centering
\caption{Non-cocaine TAC derivatives}
\begin{tabular}{|c|c|c|c|c|}
\hline
Group & Agents & Population & Score & Results \\
\hline
Schaffer et al\textsuperscript{31} & 2 ml TAC v 2 ml TA (No cocaine) & Children 10 years and younger. Wound above the neck. & Physician effectiveness. & More in the TA group required extra infiltration 27.5% TA v 8.9% of TAC (p=0.01). 82% TAC had completely effective anaesthesia, 65% TA (p=0.13) \\
& Applied for 10 minutes. & & & \\
White et al\textsuperscript{32} & 5 ml 0.5% tetracaine v 5 ml TAC & Over 18 years, Wound <5 cm & VAS of procedure. Not scored if infiltration used. & 36% TAC required extra infiltration, 59% tetracaine TAC group had less pain, Mean VAS TAC 1, tetracaine 3.7, (p=0.05). \\
& Applied for up to 10 minutes. & & & \\
\hline
\end{tabular}
\end{table}
Table 3 Other agents

<table>
<thead>
<tr>
<th>Group</th>
<th>Agents</th>
<th>Population</th>
<th>Score</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith et al</td>
<td>3 ml tetracilophen (TLP) (1% lidocaine, 2.5% phenylephrine, 1% tetracaine) v 1% lidocaine infiltration.</td>
<td>Children over 1 year Wound &lt;3 cm on or near mucous membrane.</td>
<td>VAS of procedure by suturer, observer, video observer, and patient. Likert scale by all except patient.</td>
<td>VAS scores of suturers, observers and video observers higher with TLP than lidocaine. Trend favouring lido from scores by patient and parent. Likert scores of suturers, observers, video observers and parents favour lido.</td>
</tr>
<tr>
<td>Wase et al</td>
<td>Up to 5 ml of XAP (1% lidocaine, 1/40000 norpinephrine, 0.5% tetracaine)</td>
<td>‘Minor lacerations’ 192 XAP. No controls</td>
<td>Infiltration rate</td>
<td>16% required infiltration.</td>
</tr>
<tr>
<td>Zempsky et al</td>
<td>3 ml TAC v 5 g EMLA cream (2.5% lidocaine, 2.5% prilocaine)</td>
<td>Extremity lacerations &lt;5 cm. EMLA for up to 60 minutes.</td>
<td>VAS of procedure by suturer, patient, and parent.</td>
<td>55% of TAC wounds required infiltration, 15% of EMLA (p=0.03). No significant difference of VAS scores by any group.</td>
</tr>
<tr>
<td>Smith et al</td>
<td>3 ml prilocaine (3.56% prilocaine, 1/1000 phenylephrine) v 1% lidocaine infiltration.</td>
<td>Children over 1 year. Wound &lt;3 cm on or near mucous membrane.</td>
<td>VAS for suturing by suturer, observer, video observer, and patient.</td>
<td>VAS scores lower with lidocaine than prilocaine by suturers (p=0.003) and video observer (p=0.02). No difference with observer, patient or parent. No significant difference in the additional infiltration rate, 1% lido, 3% prilocaine (p=0.60).</td>
</tr>
<tr>
<td>Smith et al</td>
<td>3 ml mepivacaine (2% mepivacaine, 1/100000 norpinephrine) v 3 ml TAC v 1% lidocaine infiltration.</td>
<td>Children 2 years and older. Wound &lt;3 cm on face or scalp.</td>
<td>VAS for suturing by suturer, observer, video observer, and patient. Likert score for suturing by parent and suturers.</td>
<td>VAS scores lower with lidocaine than TAC or than with mepivacaine by suturers and observers. No difference with video observer, patient or parent. Likert scores by parents were higher with mepivacaine than with lidocaine or TAC (p=0.02).</td>
</tr>
</tbody>
</table>

Likert scale is a 7 point pain scale.

Almost all the trials included here have been performed in the United States and the unfamiliarity with topical anaesthesia in the UK may both contribute to and result from this. The reasons given, together with the case reports of serious harm with the use of TAC and the inconvenience of its use, have resulted in the almost universal use of lidocaine infiltration in the UK. It is unlikely that further USA based trials of topical anaesthesia will affect the management of patients in the UK as 20 years of USA research have had little effect on UK practice.

Topical anaesthesia should be used in the UK for the suturing of lacerations in children. The reluctance to use this technique in the UK may be to some extent reduced by the use of non-cocaine containing agents. The most effective agents available are ones that contain strong lidocaine and it is one these that should be introduced into UK practice. There has been recent correspondence in this journal of the use of such an agent in a UK A&E department. Other promising agents include bupivacaine or tetraphen. All of these agents are not commercially available but may be manufactured and used as part of a trial. This trial is needed to identify that a genuine alternative to lidocaine infiltration exists and demonstrate its suitability in UK A&E practice.

**FUTURE RESEARCH**

Two areas have been identified. Firstly, as mentioned above, a UK based trial of a non-cocaine containing agent compared with infiltration. This should be a prospective randomised controlled trial of one of the above mentioned agents with lidocaine. The study should have well defined inclusion and exclusion criteria, blinded randomisation, clear treatment policy, and blinded outcome variables. If the agent is shown to have similar anaesthetic properties to 1% lidocaine infiltration and is less painful on

All papers had clearly defined inclusion and exclusion criteria but many recruited convenience samples, which could introduce selection bias. Random number generators were generally used but some papers may have suffered bias because of the “arbitrarily assigned vials” and the use of the patient’s unit number for randomisation. A number of papers introduced blocking to maintain similar numbers in each group as the trial progressed. Bias could therefore have resulted if the number of patients in each block was known. The randomisation process resulted in similar groups in the vast majority of papers.

Double blinding was the rule in those studies whose design allowed it. In those that compared infiltration with topical anaesthesia, a blinded video observer was used. Well defined outcome measures were used to assess the results of the papers. Not all papers used previously validated scales however. Several papers excluded patients after randomisation without further analysis.

Topical anaesthesia was introduced in an attempt to avoid the pain associated with lidocaine infiltration. It is surprising, therefore, that of the five studies comparing topical agents with infiltration only one compares the pain of application separately from the pain of suturing. The serious complications with the use of TAC have been associated with its use on mucous membranes. Only two studies allowed wounds on or near mucous membranes to be included. As a result of this (understandable) caution, there are a paucity of data relating to the safety of managing wounds in these areas where TAC is contraindicated.

**Implication for practice in the UK**

Few A&E departments in the UK use topical anaesthesia before wound suture. The reasons given include “topical anaesthesia ineffective” and “no experience”. There is little evidence in the literature for the first conclusion.
application, there would be a compelling reason for its use in routine UK practice. If this does occur, surveillance of safety is essential as even with TAC use, complications are rare and are unlikely to be identified in a single trial.

Secondly, wounds near mucous membranes may need suture. The concern with absorption of anaesthetic is attributable to the nature of the tissue, not the wound. Topical anaesthesia is routinely and safely used on intact mucous membranes. It is logical to suspect that agents that have similar efficacies to TAC and do not contain cocaine would be safe and effective when used on mucous membrane wounds and therefore may be studied in larger trials.

### REFERENCES


---

**Table 4 Multiple agents**

<table>
<thead>
<tr>
<th>Group</th>
<th>Agents</th>
<th>Population</th>
<th>Score</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith et al6</td>
<td>3 ml prilophen (1/1000 phenylephrine) v 3 ml bupivacaine (0.67%, bupivacaine, 1/1500 phenylephrine) v 3 ml TAC.</td>
<td>Children 1 year and older. Wound &lt;5 cm. 60 TAC 60 Prilophen 60 Bupivaphe</td>
<td>VAS for suturing by suture, observer, and parents &gt;3 years. No significant difference in VAS scores between TAC and prilophen by any group. Bupivaphe VAS scores higher than TAC and prilophen by suturers, observers and parents.</td>
<td></td>
</tr>
<tr>
<td>Smith et al6</td>
<td>3 ml prilophen, 0.99% phenylephrine v 3 ml tetralidophen (1%, lidocaine, 2.5% phenylephrine, 1% tetracaine) v 3 ml of TAC.</td>
<td>Children 1 year and older. Wound &lt;5 cm. 60 TAC 60 Prilophen 60 Tetraphen</td>
<td>VAS for suturing by suture, observer, and parents &gt;3 years. Likert score for suturing by parent, observers and suturers. Anaesthetic effectiveness by suturers.</td>
<td></td>
</tr>
<tr>
<td>Smith et al6</td>
<td>3 ml Bupivaphe (0.48% bupivacaine, 1/26000 norepinephrine v 3 ml etidoran (0.95% etidocaine, 1/26000 norepinephrine v 3 ml meviparan (1.9% meviparan, 1/26000 norepinephrine v 3 ml prilophen (3.81% prilophen, 1/62000 norepinephrine v 3 ml TAC v 1% lidocaine infiltration. ) Solution applied for 20 minutes.</td>
<td>Children 2 years and older. Wound &lt;5 cm. 60 Lid 60 Prilophen 30 Bupivaphe 30 Etidoran 30 Mepivaran 30 Prilophen</td>
<td>VAS for suturing by suture, observer and patients &gt;5 years. Likert score for suturing by parent and suturers. RICDRS distress behaviour for suturing by suturers. No difference with any scale by any group between TAC and lidocaine.</td>
<td></td>
</tr>
<tr>
<td>Smith et al6</td>
<td>3 ml Bupivaphe (0.48% bupivacaine, 1/26000 norepinephrine v 3 ml etidoran (0.95% etidocaine, 1/26000 norepinephrine v 3 ml meviparan (1.9% meviparan, 1/26000 norepinephrine v 3 ml prilophen (3.81% prilophen, 1/62000 norepinephrine v 3 ml TAC v 1% lidocaine infiltration. ) Solution applied for 20 minutes.</td>
<td>Children 2 years and older. Wound &lt;5 cm. 60 Lid 60 Prilophen 30 Bupivaphe 30 Etidoran 30 Mepivaran 30 Prilophen</td>
<td>VAS for suturing by suture, observer and patients &gt;5 years. Likert score for suturing by parent and suturers. RICDRS distress behaviour for suturing by suturers. No difference with any scale by any group between bupivaphe and TAC or lidocaine except anaesthetic effectiveness by suturers. Complex matrix of comparisons between agents using the 4 scores by the 4 groups. All other agents had some statistically significant poorer results than TAC or lidocaine.</td>
<td></td>
</tr>
</tbody>
</table>

**RICDRS = restrained infant and child distress rating scale.**


---

**New EMJ online submission and review system**

The Editors of Emergency Medicine Journal are pleased to inform authors and reviewers of its new online submission and review system, which will be available from 15 May 2002. Bench>Press is a fully integrated electronic system which uses the internet to allow rapid and efficient submission of manuscripts, as well as the entire peer review process to be conducted online.

Authors can submit their manuscript in any standard word processing software. Graphic formats acceptable are: .jpg, .tiff, .gif, and eps. Text and graphic files are automatically converted to PDF for ease of distribution and reviewing purposes. Authors are asked to approve their submission before it formally enters the reviewing process.

To access the system click on “SUBMIT YOUR MANUSCRIPT HERE” on the EMJ homepage: http://www.emjonline.com/, or you can access Bench>Press directly at http://submit-emj.bmjjournals.com/.

We are very excited with this new development and I would encourage authors and reviewers to use the on-line system where possible. It really is simple to use and should be a big improvement on the current peer review process. Full instructions can be found on Bench>Press http://submit-emj.bmjjournals.com/, and EMJ online at http://www.emjonline.com/. Please contact Natalie Davies, Project Manager, ndavies@bmjgroup.com for further information.

**Pre-register!**

We would be grateful if all Emergency Medicine Journal authors and reviewers pre-registered with the system. This will give you the opportunity to update your contact and expertise data, allowing us to provide you with a more efficient service.

**Instructions for registering**

1. Enter http://submit-emj.bmjjournals.com
2. Click on “Create a New Account” in the upper left hand side of the Bench>Press homepage
3. Enter your email address in the space provided.
4. Choose a password for yourself and enter it in the spaces provided.
5. Complete the question of your choice to be used in the event you cannot remember your password at a later time.
6. Click on the “Save” button at the bottom of the screen.
7. Check the email account you registered under. An email will be sent to you with a verification number and URL.
8. Once you receive this verification number, click on the URL hyperlink and enter the verification number in the relevant field. This is for security reasons and to check that your account is not being used fraudulently.
9. Enter/amend your contact information, and update your expertise data.
10. Please note: You only need to create a new account once. If you submit to another BMJ Publishing Group journal you can use the same email address and password.
Is cocaine needed in topical anaesthesia?

S Bush

_Emerg Med J_ 2002 19: 418-422
doi: 10.1136/emj.19.5.418