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*In reply:*—We greatly appreciate the comments of Drs. Guay and Matzke. It would seem logical that increased serum levels of cimetidine produced by decreased intravascular volumes, as seen in their patients with renal disease,<sup>1</sup> might be associated with an increased incidence of cimetidine toxicity. Their group of five patients with severely impaired renal function was young ( $30.2 \pm 4.8$  yr), and although not specifically studied, no mention of cardiovascular toxicity was reported.

As a group our patients did not have markedly depressed renal function (mean creatinine  $1.2 \pm 0.4$  mg%); however, other etiologies of decreased intravascular volume may well have existed in these elderly intensive care unit patients. Peak cimetidine levels would have been very informative, but these were not performed in our study.

The exact etiology of the hypotension seen with iv cimetidine given over 2 min remains unresolved. Renal disease may play an important role in some patients, but it

cannot fully explain our results. As stated in our study, we agree with the recommendations of Drs. Guay and Matzke that cimetidine be given over 30 min to avoid the observed toxicity. Further studies are needed to determine the mechanism(s) involved.

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#### REFERENCE

1. Guay DRP, Matzke GR, Bockbrader HN, Dancik J: Comparison of bioavailability and pharmacokinetics of cimetidine in subjects with normal and impaired renal function. *Clin Pharm* 2:157-162, 1983

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### Use of Transarterial Axillary Sheath Distension as an Aid to Catheter Placement

*To the Editor:*—We wish to call to the attention of our colleagues a useful adjunct to the placement of catheters into the axillary sheath. Catheterization of the axillary neurovascular sheath for continuous local anesthetic infusion to treat drug-induced vasospasm\* as well as to decrease the possibility of postsurgical or posttraumatic reflex sympathetic dystrophy is becoming more common.

Our success rate is improved if the sheath is first distended by the injection of saline. We use a transarterial approach to the brachial plexus and inject 30 ml of normal

saline. This not only distends the sheath, but also helps confirm catheter placement by fluid return from the introducing needle. In addition, the injectate may allow freer dissemination of the anesthetic by breaking adhesions. We maintain manual pressure for at least 7 min following initial injection and again after catheter placement to prevent hematoma formation, a strategy we have found quite effective.

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\* Haynsworth RF, Heavner JE, Racz GB: Continuous brachial plexus blockade using an axillary catheter for treatment of accidental intra-arterial injections. *Regional Anesthesia* 10:187-190, 1985.

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### On Computerized Anesthesia Records

*To the Editor:*—In his recent letter on computerized anesthesia records,<sup>1</sup> Dr. Noel suggests that until the computer can replace the anesthesiologist, computerization can do more harm than good. The reason offered is that

recordkeeping automation would deprive the anesthesiologist of awareness of the course of anesthetic events and the anticipation of further events.

Dr. Noel apparently does not appreciate the fact that