R. WILLIAM MCINTYRE, M.D.
Assistant Professor of Anesthesiology
Department of Anesthesiology, AA3094-160

Duke University Medical Center
Durham, North Carolina 27710

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Abolishing Pain on Injection of Etomidate

To the Editor:—We have been impressed with the rapid awakening and clear postoperative sensorium in adult outpatients undergoing anesthetic induction with etomidate. Pain on injection in these alert, unpremedicated patients can be a problem. This incidence is reported to be as high as 50–60%.[1,2]

We have found a simple technique which has so far reduced the incidence of pain on injection to zero. Just prior to induction, 25–100 mg of lidocaine is given through an injection port attached directly to the intravenous catheter. As soon as the injection is made, the intravenous drip is turned off for 30 s. Etomidate is then injected.

Using this technique, we have had no pain on injection through either spontaneous complaint or direct questioning in 30 consecutive patients.

PREYARATT PHITAYAKORN, M.D.
Assistant Professor of Anesthesiology

RAY MCKENZIE, M.D., F.F.A.R.C.S.
Professor of Anesthesiology

Department of Anesthesiology
Magee-Womens Hospital and
University of Pittsburgh
School of Medicine

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Trunk Skin Temperature After Sympathetic Nerve Block—Is the Heat Really On?

To the Editor:—In a recent study, Chamberlain *et al.*[1] concluded, based on measurements of trunk skin temperature by infrared thermography, that sympathetic block can extend up to ten segments above the sensory block with spinal anesthesia. A surprising finding, indeed.

The authors can be congratulated for their provoking and stimulating paper, because it reminds us that we are blind when it comes to evaluation of the extent of sympathetic block with spinal or epidural anesthesia. Our assumption, based upon similar size of fibers carrying sympathetic and thermoreceptor traffic, that loss of temperature discrimination has the same level as loss of sympathetic outflow, may not be valid. Thus, the anesthesia community would receive with enthusiasm any monitor which reliably detects the level of sympathetic block, especially in the unconscious patient. Also, the