It would seem that some time elapsed during the workup of the differential diagnoses entertained, and this supposition is supported by the lingering pulmonary embarrassment the patient sustained. The authors use the word "soon" several times to characterize the progress of events. Perhaps this could be quantified. One would think that, if the etiology of the arterial desaturation were promptly identified and corrected, the patient would have quickly stabilized and the planned operation could have been performed.

While I would not impugn the usefulness of advanced technology in the operating room, it seems to me that this report typifies the easy dependence and reliance upon gadgetry that develops at the expense of clinical skills, and to the detriment of patients. While not unknown among anesthesiologists, this "monitor-mania" seems most rampant among insurance-company underwriters. What has happened to "keep your hands on the patient" ("see the tube go through the cords")?

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REFERENCE

(Accepted for publication January 26, 1987.)

In Reply:—Tracheal misplacement of an esophageal stethoscope can be difficult to visualize when the stethoscope curves posteriorly and is obscured by the larger endotracheal tube. We were checking for correct placement of the endotracheal tube, not incorrect placement of the esophageal stethoscope. The latter possibility was not considered because it is not a widely recognized occurrence—something the case report was meant to remedy.

The cause of the hypoxia was identified after the surgery had been cancelled, the esophageal stethoscope removed, and the stat chest roentgenogram returned. The commonly occurring signs of respiratory embarrassment were absent. Appropriate, routine patient care had failed to show the danger that was present, but it was revealed by the pulse oximeter.

The pulse oximeter is a potentially life-saving monitor which provides data about patient well-being that cannot be obtained any other way. To ridicule its use as "monitor-mania" constitutes sloganeering, not thoughtful discussion.

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A New Epidural Needle Modification

To the Editor:—The Touhy-Schiff epidural needle, which became available on the U. S. market in 1985, has features that make it an improvement, both for teaching and for epidural placement.

Historically, in 1960, Dr. J. Alfred Lee described a modification of the Touhy needle with alternating black and metallic surface segments starting 4 cm from the needle tip.1 Although this needle was popular in Great Britain, there has not been a similar modification available on the United States market. The Touhy-Schiff needle

![Fig. 1. The Touhy-Schiff needle.](http://anesthesiology.pubs.asahq.org/pdfaccess.ashx?url=/data/journals/jasa/931388/ on 11/21/2018)
Verapamil May Not be the Drug of Choice for Control of Hemodynamic Changes during Surgical Excision of Pheochromocytoma

To the Editor:—This case shows that iv verapamil can control the hemodynamic changes during surgical excision of pheochromocytoma. However, side effects, such as hypotension, bradycardia, and pulmonary edema, may follow excision of the tumor.

The patient was a 44-yr-old woman, who had bouts of hypertension up to 240/140 mmHg and tachycardia up to 115 bpm. Pheochromocytoma was suspected, and a CT scan of the abdomen revealed a left adrenal mass.

The patient was prepared preoperatively by administration of phenoxybenzamine (30 mg/day) and propranolol (30 mg/day). Both drugs were discontinued the evening before surgery. The morning of surgery, she was premedicated with oral diazepam 10 mg. Before induction of anesthesia, arterial blood pressure (BP) was 140/90 mmHg, ECG showed a normal sinus rhythm at a heart rate (HR) of 80/min, and the CVP was 8 cm H₂O. A bolus of verapamil 0.075 mg/kg was given iv over 2 min, to be followed by 0.01% infusion at a rate of 2 μg·kg⁻¹·min⁻¹. BP decreased to 100/70 mmHg, while ECG showed no change in heart rate or rhythm. Anesthesia was induced with diazepam 0.2 mg/kg, fentanyl 20 μg/kg, and vecuronium 0.2 mg/kg iv, and was maintained with N₂O/O₂, supplemented by incremental doses of fentanyl and vecuronium. Laryngoscopy, tracheal intubation, scrubbing, skin incision, and abdominal exploration caused minimal fluctuations in BP and HR. During manipulation of the tumor, BP was elevated up to 160/100 mmHg, and HR increased to 80 bpm. The increase in BP and HR were readily controlled by increasing the verapamil drip up to 5 μg·kg⁻¹·min⁻¹. Verapamil drip was discontinued immediately after ligation of the left adrenal veins. Throughout the procedure, 2 liters of lactated Ringer’s solution and 2 units of whole blood were infused in order to maintain the CVP at 10 cm H₂O. Following excision of the tumor, BP decreased to 60/40 mmHg, HR to 40 bpm, and CVP to 5 cm H₂O. A norepinephrine infusion was started at a rate of 5 μg·kg⁻¹·min⁻¹. BP stabilized at 90/60 mmHg, HR increased to 55 bpm, and the CVP was 11 cm H₂O. Also, the patient developed pulmonary edema, and intermittent positive pressure ventilation was continued using 5 cm H₂O PEEP. The patient could be weaned off the ventilator and the norepinephrine infusion within 24 h.

DISCUSSION

Verapamil, a calcium channel blocker, may attenuate the release of catecholamines from the sympathetic nerve terminals and adrenal medulla. It can also counteract the postjunctional effects of released epinephrine and norepinephrine on both heart and blood vessels. In our patient, verapamil lowered significantly the control blood pressure, and could prevent the development of cardiac