and the abductor pollicis brevis. Although EMG responses from the adductor pollicis may be obtained by ventral placement of a surface electrode just distal to the thenar eminence and over the second metacarpal, we believed that the precise placement required for accurate measurements necessitates an attention to detail that may be unrealistic to expect from the casual or infrequent user of this technique. The belly of the hypothenar eminence, on the other hand, is a well-defined "target" and allows a much wider margin for error in electrode placement.

The point Dr. Ali makes regarding the need for additional work to correlate the hypothenar EMG response to mechanical respiratory reserve is, I believe, extremely important.

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Nitroglycerin Improves Venous Cannulation

To the Editor—I wish to call to the attention of my colleagues a useful adjunct to the placement of intravenous catheters. Many patients admitted to hospitals require some form of intravenous therapy but have poorly visible veins. Often the veins of such patients have been traumatized by multiple attempts and failures by hospital staff.

I have found that these veins are easily visualized by placing ½ inch (1.2 cm) of nitroglycerin ointment (Nitropaste®) over the dorsum of the hand or foot in the region selected for the site of cannulation. Before venipuncture, the ointment is removed with an alcohol swab. In all cases there has been an obvious increase in vein size and a resultant minimal difficulty with catheter placement. Heck et al. have also reported that the use of nitroglycerin ointment reduced the difficulty of cannulation.1,2 However, these authors suggested a 2-hour interval between ointment administration and catheter placement, whereas a period of 10 to 20 min has been sufficient in my experience. Neither in their study nor in my experience at this institution have any adverse effects, including significant blood pressure changes, occurred.

In view of the speed of onset, simplicity, and increased efficiency that this maneuver allows, I recommend its use for those patients in whom intravenous catheter placement difficulties have occurred or are anticipated.

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REFERENCES

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Seizure Following Stellate Ganglion Block after Negative Aspiration and Test Dose

To the Editor—Seizures during stellate ganglion block are a well-described complication,1 and even very small doses of local anesthetic, such as 1.5 ml of 0.5% bupivacaine, may cause seizures if injected directly into the vertebral or carotid artery.2 Recommendations to prevent the occurrence of seizures include careful attention to anatomic landmarks, aspiration tests in two planes, and the use of very small volumes of local anesthetic, such as 0.25–0.5 ml before injection of the therapeutic dose.3

We recently had a patient develop tonic–clonic seizure activity during stellate ganglion block despite negative aspiration tests and no apparent response to 0.5 ml of 0.5% bupivacaine given as a test dose. After the test dose, 60 s elapsed before we injected an additional 3 ml of 0.5%