

coded, inversion of the bottle collars may lead to confusing and potentially hazardous bottle adaptor mismatch.

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Use of Spinal Anesthesia in Patients with Idiopathic Hypertrophic Subaortic Stenosis

To the Editor:—Without question, the patient with undiagnosed idiopathic hypertrophic subaortic stenosis (IHSS) who was given a spinal anesthetic tolerated it poorly.¹ However, without knowing the level of the spinal block, which was not stated in the report, and from this one must conclude that it was not measured, it is impossible to know the mechanism(s) for the untoward events that occurred following completion of the block. Furthermore, by publishing this report, Drs. Loubser, Suh, and Cohen and the Editorial Board of ANESTHESIOLOGY imply that spinal anesthesia may be hazardous in patients with IHSS. Such an implication is unjustified. The presence of IHSS may have had nothing to do with the untoward events that occurred.

The symptoms of chest pain and nausea; the signs of diaphoresis, vomiting, hypotension, tachycardia; and ECG changes denoting ischemia can occur in elderly patients who do not have IHSS if the level of spinal block is sufficient to produce a near total chemical sympathectomy. Even the rapid onset of the symptoms and signs after the block does not preclude this possibility. Supposing the patient had not been found to have IHSS when evaluated following the spinal anesthetic, which is altogether plausible and, in fact, a much more common event than spinal plus IHSS, then the diagnosis would have been an adverse

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response to high spinal anesthesia, and the case would not have been reportable.

The point of raising this issue is twofold. First, it is imprudent to conclude that because something unexpected is found after an untoward event, that that caused or even contributed to the event, particularly when the event is well known to occur in the absence of the unexpected finding. Such is the situation in this case report. Second, this gives me the opportunity to reemphasize the value of continuous spinal anesthesia in situations such as this one. The insertion of a catheter into the subarachnoid space makes the technique highly controllable and quite appropriate in elderly patients with all varieties of heart disease requiring anesthesia for lower extremity surgery.

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Concerning the Antiemetic Efficacy of Metoclopramide

To the Editor:—The results reported by Cohen *et al.*¹ confirm a finding from this Department concerning the brevity of action of metoclopramide.^{2,3} In patients premedicated with morphine or meperidine with metoclopramide and having minor gynecologic operations with a standard anesthetic technique, we found a minimal re-

duction in postoperative vomiting unless a second dose was given at the end of operation. Our doses were 10-20 mg, and these had a short therapeutic but also minimal toxic effects. We would suggest caution with higher doses of metoclopramide, as these can produce extrapyramidal side effects.