

The clinical entity of heparin-induced thrombocytopenia is now better appreciated and clinicians must be aware of its existence.<sup>3</sup> Any patient who has thrombocytopenia or further emboli develop while being treated with heparin may have heparin-induced thrombocytopenia and should be evaluated for this condition.

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### Possible Pharmacologic Trespass in Pheochromocytoma Patients

*To the Editor:*—With reference to a recent clinical report on the use of magnesium sulfate in the anesthetic management of pheochromocytoma,<sup>1</sup> we would like to comment on the three drugs used in this patient.

Histamine<sup>2</sup> has been shown to provoke the release of catecholamines from chromaffin cells and to produce substantial rises in blood pressure in pheochromocytoma.<sup>3</sup> It has in fact formed the basis of provocative tests that are now regarded as dangerous.<sup>4</sup> Papaveretum is capable of releasing histamine and therefore should be avoided.<sup>5,6</sup>

The anticholinergic action of scopolamine will promote uninhibited sympathetic activity, which will contribute to the increased catecholamine drive.

It is apparent from a number of case reports in the literature that although droperidol can induce hypotension in normal individuals, it may cause severe hypertension and tachycardia in some patients with pheochromocytoma.<sup>7,8</sup>

In a recent study,<sup>2</sup> it was shown that droperidol promotes the efflux of catecholamines from adrenal medullary cells via a nonexocytotic mechanism by inhibiting catecholamine uptake in the chromaffin granules.

Although this patient seemed to be satisfactorily controlled up to the day of surgery, three drugs with the potential for aggravating the manifestation of pheochromocytoma were given before the operation and possibly accounted for the acute hemodynamic disturbances that occurred. Traditionally, the short-acting sodium nitroprusside has been used to manipulate the

acute circulatory changes associated with surgery for resection of a pheochromocytoma. While the use of magnesium sulfate represents a novel approach, it would be preferable to assess its value in circumstances not complicated by potentially detrimental pharmacologic agents.

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*In reply:*—Papaveretum may release histamine in some patients, but it had been used previously in this patient without causing any disturbance and was therefore considered to be a suitable premedicant agent in this patient in view of the excellent sedation that it produces. The preoperative cardiovascular disturbances were temporally related to the physical movement of the patient to the operating room and not to the giving of the premedication, and I consider it most unlikely that this agent contributed to the tachycardia and hypertension found before induction, although this possibility cannot be excluded entirely.

The comment regarding anticholinergic agents would be appropriate for atropine, but not for scopolamine. In the dosage used, this agent produces "sedation, amnesia and bradycardia"<sup>1</sup> because of its partial agonist effect and it has been widely recommended as a premedicant agent in patients with pheochromocytoma.<sup>2,3</sup>

Although there are a few case reports of droperidol causing hemodynamic disturbances in patients with pheochromocytoma, the agent has been widely used without causing problems.<sup>4</sup> In this patient there was no evidence whatsoever that this drug contributed to the hemodynamic disturbances, as these were present before use of the agent and were not affected by its administration.

It seems unlikely, therefore, that the agents referred to significantly complicated this case, and I can see no

reason to alter my conclusion that magnesium may be a useful agent in the management of pheochromocytoma. Since writing this case report, I have had the opportunity to use magnesium sulfate in another very similar case in which none of the three drugs referred to above were used and in which magnesium exerted an almost identical effect.

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## The Origination of Common Eponyms Used in Anesthesia

*To the Editor:*—Many of the items we use everyday in anesthesia bear the name of the person who invented the particular device. It would seem that your readers would find a brief review of some of these "everyday eponyms in anesthesia" of interest.

**Bain Breathing Circuit:** J. A. Bain of London, Ontario. He described this streamlined breathing system in 1972.

**Berman Airway:** Robert A. Berman of Far Rockaway, New York. This is a plastic oropharyngeal airway, described in 1950, similar

to the Guedel airway. It has a center bar, rather than a solitary cavity.

**Bier Block:** Karl Gustav August Bier, 1861-1949. He devised spinal anesthesia in 1899 and intravenous regional anesthesia in 1909, and worked in Kiel and Berlin.

**Bizzarri-Guiffrida Laryngoscope Blade:** Devised by Dante V. Bizzarri and Joseph G. Guiffrida, both of New York City. This laryngoscope is a modification of the Macintosh laryngoscope blade. The flange has been removed, making it easier to insert into the mouth past the teeth. It was described in 1958.