

Anesthesiology
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In reply:—The advocates of Computer Generated Anesthesia Records (CGARs) seem to regard the record simply as a means of data presentation, and if that is as far as the discussion goes, they would seem to be correct. However, CGAR advocates also forget that, particularly in ASA Status I and II patients, where the majority of our malpractice cost lies, major periods of inactivity occur, and vigilance aids are necessary. Charting serves this purpose well, and those who ignore it do so at their own (and their patients') peril. This does not mean that I need literally to enter every piece of data by hand, as may have been implied in my letter.¹ It is my intention that every piece of data pertinent to patient well being should be reviewed prior to being placed in the archive (chart). The

act of charting is a stimulus to vigilance and necessarily includes data review. Allowing recording to occur without review removes one important aid we have to patient care.

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REFERENCE

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Neuromuscular Blockade Variability

To the Editor:—In the recent report by Salzarulo and Taylor¹ on diabetic "stiff joint syndrome," the authors describe a patient in whom a large difference was noted when neuromuscular blockade was assessed by stimulating the facial and ulnar nerves. They attribute this phenomenon to the patient's juvenile onset diabetes mellitus.

Stiffel *et al.*² extensively studied this variability in assessing neuromuscular blockade. They noted that train-of-four stimulation of the facial nerve consistently will show a greater number of twitches than will stimulation of the ulnar nerve in 15 ASA Status I, II, and III patients, regardless of their underlying medical problems. Our own experience confirms this result.

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2. Stiffel P, Hameroff SR, Blitt CD, Cork RC: Variability in assessment of neuromuscular blockade. ANESTHESIOLOGY 52:436-437, 1980

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Placement of ECG Electrodes during Extracorporeal Shock-wave Lithotripsy

To the Editor:—During extracorporeal shock-wave lithotripsy (ESWL), the shock waves are synchronized with the patient's ECG by triggering 20 ms after the QRS complex. This is accomplished by means of a cable carrying the analog ECG signal to the lithotripter, which has

its own QRS detection circuit. Thus a high-quality ECG signal is needed before the treatment can proceed.

Since most of the patient's body is immersed in water, there is limited flexibility in electrode placement. A common and convenient way to keep electrodes on dry skin