

these patients, presumably at lower risk of reinfarction than nonoperated patients, would lower the rate of reinfarction. Exclusion of these patients means that the pre-1976 and post-1977 populations differ importantly.

Could these differences in population rather than differences in anesthetic technique, monitoring, or intervention account for the lower reinfarction rate?

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In reply:—In response to Rooke *et al.*, I would like to clarify that in our report, neither group included patients who sustained myocardial infarction and had a coronary revascularization procedure.¹ Patients in both groups sustained myocardial infarction and, either due to the emergency nature of the noncardiac operation or the patients' coronary status (inoperable distal lesions or no other lesions detected other than the lesion in the vessel supplying the infarcted area or lesions in other vessels too small to be bypassed), did not undergo coronary revascularization. Thus, patients in both groups are comparable and the difference in outcome between the two groups is *not* because of differences in population.

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Complication of Fiberoptic Bronchoscope

To the Editor:—We wish to report a complication associated with the use of a fiberoptic bronchoscope. The patient was a 68-year-old woman with a tumor of the right lower lobe who was scheduled for bronchoscopy and right thoracotomy. The patient was induced with a balanced anesthetic technique and intubated orally with an 8.0 mm Hi-Lo National Catheter Endotracheal Tube.[®] The patient then was placed on the ventilator and a Portex Swivel Adapter[®] was interposed between the endotracheal tube and the breathing circuit.

The surgeon then proceeded with the fiberoptic bronchoscopy utilizing an Olympic[®] Adult BF type 4B2 fi-

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REFERENCE

1. Rao TLK, Jacobs KH, El-Etr AA: Reinfarction following anesthesia in patients with myocardial infarction. ANESTHESIOLOGY 59:499-505, 1983

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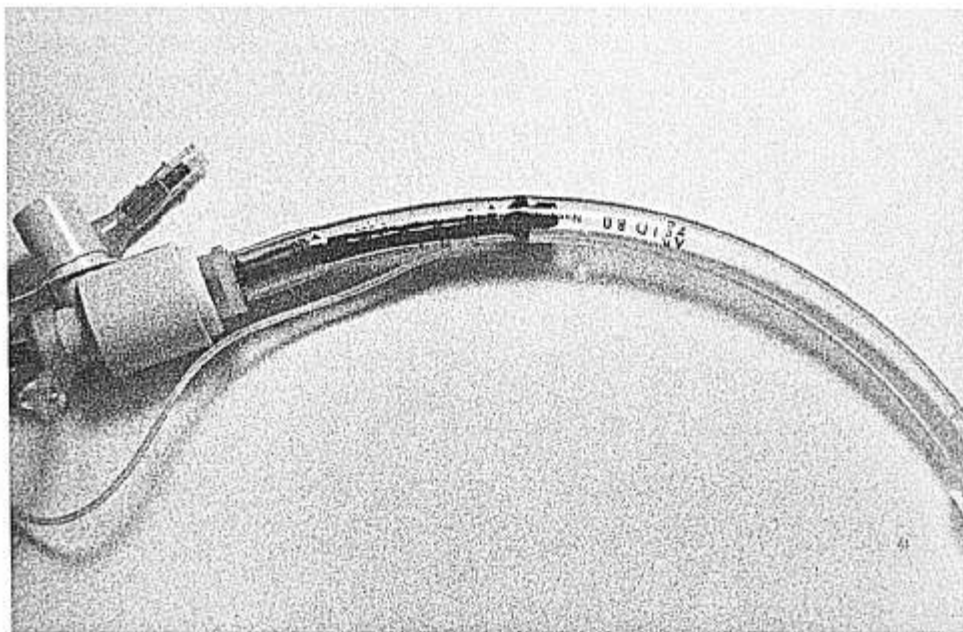
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1. Rao TLK, Jacobs KH, El-Etr AA: Reinfarction following anesthesia in patients with myocardial infarction. ANESTHESIOLOGY 59:499-505, 1983

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beroptic bronchoscope, which had been lubricated with surgilube. The bronchoscope had just been returned from the company after repair. The bronchoscopy proceeded without incident until the surgeon began withdrawal of the unit. The bronchoscope had been withdrawn to approximately 13 cm when it suddenly became impossible to withdraw it any further. There was no change in circulatory parameters, the high-pressure alarm on the ventilator did not sound, but, a significant gas leak was noted where the bronchoscope passed through the Portex adapter. The cuff of the endotracheal tube immediately was deflated, and under direct vision the endotracheal

FIG. 1. Endotracheal tube with bronchoscope *in situ*. Note doughnut-shaped intussusception.



tube was removed with the bronchoscope in place. The patient was reintubated and the procedure continued uneventfully.

As is shown in the photograph, upon withdrawal of the bronchoscope, the tip of the unit had intussuscepted into the covering sleeve of the bronchoscope, folding back the sleeve to the point where it completely occluded the lumen of the endotracheal tube and jammed in place. An attempt to remove the fiberoptic unit was made after the endotracheal tube was out of the patient, but it could not be done without destroying the unit.

We would recommend that if any difficulty be encountered in removing a fiberoptic bronchoscope from an endotracheal tube, that the endotracheal tube be removed, preferably under direct vision, as rapidly as pos-

sible with the bronchoscope in place and without the delay attendant upon further attempts to withdraw the unit. This mechanical failure also should be a part of the differential diagnosis whenever ventilation is interfered with during bronchoscopy.

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A Simple Solution for Determining Shunt Flow during Carotid Endarterectomy

To the Editor:—The question of shunting during carotid endarterectomy previously has been discussed in the literature. To our knowledge, no one has yet discussed the question of accurate assessment of carotid flow during shunting. Because the appearance of a shunt in place gives no indication of the amount of flow, our cardiovascular surgeon (August Tomusk) devised a simple solution to this question.

By simply cutting the Javid shunt in half and inserting

a 3-mm cannulating Statham® flow probe (fig. 1) and connecting this to a Statham® 2204 blood flow meter, you can easily achieve an on line accurate determination of carotid shunt flow, while maintaining excellent field working conditions.

The above equipment usually is used in institutions performing coronary artery bypass surgery, and, hence, no added expenditures are necessary.

During the first three cases, I had two instances of