

The connections to the pulmonary artery catheter were verified to be intact, and the transducer was re-zeroed to the reference point; the catheter was still at 50 cm. When the surgical field was inspected, it became apparent that the pulmonary artery catheter came into contact with the cryoprobe, and ice crystals could be seen on the catheter. We were unable to aspirate or inject through the catheter, and the pressures now went off the scale.

Cryoablation was completed, and the catheter was not adherent to the probe. The distal coronary anastomosis was performed under hypothermic bypass (28° C), and the patient was rewarmed while the proximal anastomosis was completed. During rewarming, the pulmonary artery pressures returned to normal values, and it was again possible to aspirate blood freely from the pulmonary artery catheter. The patient was successfully weaned from cardiopulmonary bypass. During this process, a typical pulmonary artery waveform appeared, and cardiac outputs were easily obtainable. The catheter continued to function without problems postoperatively, and it was uneventfully removed 36 h later.

### DISCUSSION

When abnormal pulmonary artery pressures are observed during cardiopulmonary bypass and thought to be due to forcible wedging, it is prudent to pull the catheter back to avoid possible perforation of the vessel. It is conceivable that had this been attempted, the frozen catheter might have fractured due to the extremely low temperature. Early partial withdrawal of the catheter to the right atrium before bypass would prevent this problem.<sup>3</sup> Al-

ternatively, the catheter should be carefully retracted from the site during cryoablation, and the possibility of freezing should be considered if a rise in pulmonary artery pressure is temporarily related to the use of the cryoprobe. In this case, the freezing and subsequent thawing did not appear to result in catheter malfunction.

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## Anesthesia for Acute Epiglottitis

*To the Editor:*—The clinical report, "Two-stage Fiberoptic Nasotracheal Intubation in Infants: A New Approach to Difficult Pediatric Intubation,"<sup>1</sup> that discusses using ketamine sedation and topical anesthesia is of considerable interest. I have used a slightly different technique that may be useful in similar cases, including epiglottitis.

*Case Report.* A 2-yr-old, 12 kg boy with a provisional diagnosis of acute epiglottitis was brought to the operating room where all the emergency equipment had been prepared. Intramuscular ketamine 50 mg was given, an intravenous infusion was established, and the tongue and pharynx were topically anesthetized with lidocaine 2 mg/kg. A flexible fiberoptic bronchoscope (FFB) (Machida, OD 3.9 mm) was introduced orally through a 7-cm Airway Intubator<sup>®2,3,\*</sup> into the pharynx, and the diagnosis was confirmed.

The FFB was removed, and nasotracheal intubation was accomplished using a rigid, straight-blade laryngoscope. In retrospect, much less trauma would have occurred to the already inflamed and edematous tissues if

intubation could have been carried out by passing a nasotracheal tube into the pharynx and directing the tip of the endotracheal tube between the vocal cords by manipulating the tube at the proximal end while observing the vocal cords through the FFB. This technique has now been successfully used in adults, and there seems to be no reason why it would not be equally useful in infants and small children.

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\* Airway Intubator<sup>®</sup> sizes 7 cm and 8 cm will soon be available from 3M Medical-Surgical Division.