

of this preparation is less than 4.0; therefore, both drugs should remain stable.

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The Risk of Tracheal Aspiration of Surgically Produced Foreign Bodies

To the Editor:—A 49-yr-old woman who had undergone craniofacial resection of a fibrodysplastic ethmoid tumor 2 weeks earlier and reoperation for acute cerebral edema and decompression was returned to the operating room for bifrontal craniotomy and repair of a cerebrospinal fluid fistula under general anesthesia. The fistula repair included the placement of fat into the defect. The fat tissue was harvested from the patient's leg and served as a base of support for the fascial graft, which was then placed over the defect in the dura mater.

The course of the general anesthetic was uneventful. At the conclusion of surgery, secretions were suctioned from the posterior pharynx prior to reversal of neuromuscular blockade and tracheal extubation. Two pieces of yellow fat of approximately 2 cm × 2 cm each, were retrieved from the hypopharynx. This represented a portion of the fat that had been used to support the fascial graft in the dural defect. These two pieces of fat had migrated out of the cranium, through the surgical defect in the ethmoid sinuses, and into the posterior pharynx.

If the fat had not been discovered by suctioning at the time of extubation, or if it had migrated to the hypopharynx after extubation, pulmonary aspiration of the fat could have occurred.

In the event of partial airway obstruction, more time could be spent making the diagnosis of fat aspiration. However, the diagnosis would be hampered by difficulty detecting the fat on chest x-ray, because fat is so radiolucent and virtually invisible on x-ray. The radiologic diagnosis would likely be made by inference based on atelectasis with complete obstruction or air trapping, hyperinflation, and possibly mediastinal shift with partial obstruction. Failure to consider fat aspiration in

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Hypoxia among the Experts

To the Editor:—Twice during the past year while serving as an expert witness for the defense, I have had to rebut the testimony of board-certified anesthesiologists who, while acting as experts for the plaintiff,

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the differential diagnosis of airway obstruction would also complicate and delay the institution of therapy.

This case is reported for the purpose of alerting the anesthesiologist to the danger of aspiration of any surgically produced foreign body (fat, bone, blood clots, or synthetic material). The differential diagnosis of unexplained hypoxemia and/or airway obstruction following craniofacial surgery should include aspiration. Based on our experience, we recommend routine laryngoscopy at the end of these types of procedures to rule out material in the pharynx that might be missed by blind suctioning.

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asserted that an esophageal intubation must have occurred based solely on the "hard evidence" of a blood gas obtained during cardiopulmonary resuscitation (CPR): "It is my opinion that these blood gases, even if