

## CORRESPONDENCE

residual activity that is frequently in excess of  $2 \mu\text{V}$ , *i.e.*, it really is not "isoelectric" by anybody's definition. Nonetheless, we all have a common understanding of what we are describing when we use the term.

Finally, Jäntti describes circumstances in which activity can be elicited during anesthetic-induced maximal suppression (?) of the EEG. He provides references to support several of his suggestions though not for his assertion that somatosensory evoked responses to median nerve stimulation can be elicited during EEG suppression. I am pleased to provide references to support that assertion as well, in part to assure Jäntti that this phenomenon was well known to me.<sup>4,5</sup>

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## A Novel Use for the Pulmonary Artery Catheter

*To the Editor:*—I would like to report a novel use for the pulmonary artery catheter.

The patient was a 58-yr-old man involved in a high-speed motor vehicle accident. After initial evaluation and stabilization, including tracheal intubation, he presented to the operating room for open reduction and internal fixation of bilateral femur fractures.

During attempts at inserting a right internal jugular venous catheter, I found that the vein could be cannulated readily with a 20-G catheter, but the "J" tip guidewire could not be advanced without meeting moderate resistance. The left internal jugular vein then was cannulated with a 20-G catheter, and the "J" tip guide wire was advanced without resistance. An 8.5-French catheter (Arrow-Flex Sheath, Arrow International) subsequently was inserted over the guidewire. After full insertion, however, air was aspirated from the three-way stopcock. The catheter then was slowly withdrawn while negative pressure aspiration was maintained. When the catheter was approximately 50% withdrawn, blood was aspirated easily from the three-way stopcock.

At this point, a Swan-Ganz Thermodilution Pacerport catheter (Baxter Healthcare) was inserted through the 8.5-French catheter. With the balloon inflated, the pulmonary artery catheter was advanced sequentially into the right atrium and through the right ventricle into the pulmonary artery. The 8.5-French catheter then was inserted

## References

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2. American EEG Society: Guideline three: Minimum technical standards for EEG recording in suspected cerebral death. *J Clin Neurophysiol* 3:144-149, 1986
3. Michenfelder JD: Anesthesia and the Brain: Clinical, Functional, Metabolic, and Vascular Correlates. New York, Churchill Livingstone, 1988, p 99
4. Drummond JC, Todd MM, U HS: The effect of high dose sodium thiopental on brain stem auditory and median nerve somatosensory evoked potentials in humans. *ANESTHESIOLOGY* 63:249-254, 1985
5. Drummond JC, Todd MM, Schubert AK, U HS: The effect of acute administration of high dose pentobarbital on human brainstem auditory and median nerve somatosensory evoked responses. *Neurosurgery* 20:830-835, 1987

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"over" the pulmonary artery catheter. After full insertion, blood was aspirated easily from the three-way stopcock.

It is not clear why air was aspirated initially from the three-way stopcock after full insertion of the central venous catheter. I was concerned that the guidewire may have exited the venous system through a small disruption at the junction of the left internal jugular vein and left subclavian vein and that the central venous catheter tip was located within the mediastinum. This hypothesis is not unreasonable considering that the patient had been involved in a high-speed motor vehicle accident and the difficulty encountered in attempting to advance the guidewire through the right internal jugular vein. This may have been the case even without a traumatic disruption, because inadvertent placement of a central venous catheter into the mediastinum *via* the left internal jugular vein approach has been reported.<sup>1</sup> In general, venous perforation caused by central venous catheter placement is more likely when the left internal jugular vein approach is used rather than the right internal jugular vein approach.<sup>1</sup> I thought that using the pulmonary artery catheter with the balloon inflated, which is blood-flow directed, instead of using the guidewire, which is not blood-flow directed, would initially allow passage of the pulmonary artery catheter into the right side of the heart and then serve as a "guidewire" for passage of the central venous catheter past the junction of the left internal jugular vein and left subclavian vein.

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**Reference**

1. Sheep RE, Guiney WB: Fatal cardiac tamponade: Occurrence with other complications after left internal jugular vein catheterization. *JAMA* 248:1632-1635, 1982

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**ANNOUNCEMENT**

The American Board of Anesthesiology will administer its written examination for certification of CONTINUED DEMONSTRATION OF QUALIFICATIONS on Friday, May 5, 1995. Diplomates of the ABA who are interested in participating in the *voluntary* CDQ program may request an application by writing to the Secretary, American Board of Anesthesiology, 100 Constitution Plaza, Hartford, Connecticut 06103-1796. The deadline for receipt of completed applications in the Board office is November 15, 1994.

**ERRATUM**

Reference 4 in the Clinical Investigation by Rout *et al.* (Rout CC, Rocke DA, Levin J, Gouws E, Reddy D: A reevaluation of the role of crystalloid preload in the prevention of hypotension associated with spinal anesthesia for elective cesarean section. *ANESTHESIOLOGY* 79:262-269, 1993) contained an error. The reference should read: 4. Clark SL, Cotton DB, Pivarnik JM, Lee W, Hankins GDV, Benedetti TJ, Phelan JP: Position change and central hemodynamic profile during normal third-trimester pregnancy and post-partum. *Am J Obstet Gynecol* 164:883-887, 1991.