

- 3 Dubin J. Tracheotomia. In: Elsevier (Ed.). Encyclopédie Médico-Chirurgicale. Technique chirurgicale. Chirurgia ORL e cervicofacciale. Paris, France. 1995: 46–430.
- 4 Agrò F, Hung OR, Cataldo R, Carassiti M, Gherardi S. Lightwand intubation using the Trachlight: a brief review of current knowledge. Can J Anesth 2001; 48: 592–9
- 5 Addas BM, Howes WJ, Hung OR. Light-guided tracheal puncture for percutaneous tracheostomy. Can J Anesth 2000; 47: 919–22

Another report of obstruction of a heat and moisture exchange filter

To the Editor:

I wish to congratulate Drs. Williams and Stacey on their report describing occlusion of a Pall heat and moisture exchange filter (HMEF) by pulmonary edema.¹ I would like to report a similar incident involving a Pall BB25S HMEF.

A 54-yr-old, previously well man was undergoing debridement of a leg injury. The patient had been fasting since the time of his injury, 36 hr previously. The anesthetic and procedure were uneventful until emergence, when the patient regurgitated a small amount of bile-stained fluid into the laryngeal mask. The fluid reached the HMEF, but it was not obviously heavily contaminated.

The patient developed signs of airway obstruction and auscultation revealed widespread inspiratory and expiratory rhonchi and coarse crepitations. The patient was treated for bronchospasm secondary to aspiration of gastric contents. There was no response to nebulized salbutamol, and the patient was then intubated because of increasing airway obstruction. Aliquots of adrenaline, 50–100 µg, were given intravenously without effect, to a total of 400 µg.

The breathing circuit was then tested, and the HMEF was found to be occluded. The HMEF was changed and resolution of all obstruction occurred. The HMEF was examined. It was not obviously contaminated, but some regions of the HMEF were a faint yellow colour. The affected HMEF weighed 1 g more than a new filter. The patient did not sustain any long-term sequelae, and did not require any special care apart from supplementary oxygen for 12 hr.

Clifford J. Peady FANZCA
Garran, Australia

Reference

- 1 Williams DJ, Stacey MRW. Rapid and complete occlusion of a heat and moisture exchange filter by pulmonary edema (Clinical report). Can J Anesth 2002; 49: 126–31.

The appropriateness of the pulmonary artery catheter in cardiovascular surgery

To the Editor:

We read with interest the article “The appropriateness of the pulmonary artery catheter in cardiovascular surgery” from Jacka *et al.*¹ At the Montreal Heart Institute, we use the PAC in all cardiac surgery cases and the transesophageal echocardiography (TEE) in more than half of our patients. Jacka *et al.* extrapolate from their results that a trial on the use of the PAC in stable patients during coronary revascularization is unethical. We disagree. Randomized controlled studies in the preoperative surgical setting have shown that a strategy based on the optimization of oxygen transport using the PAC can reduce mortality in noncardiac surgery^{2–4} and in cardiac surgery.⁵ It is also our experience that the PAC as an adjunct to improve oxygen transport is useful. The PAC can be used as either a diagnostic and prognostic tool. However, any type of monitoring can improve the prognosis only when the result is properly interpreted and effective treatment is introduced. Despite numerous retrospective reports of increased mortality associated with the use of the PAC, a recent randomized trial of 201 patients in the intensive care unit (ICU) has demonstrated that its use was not associated with an increase in mortality.⁶ It is inappropriate to directly and totally attribute the excess mortality or morbidity to the PAC because it is used on sicker patients. Bearing in mind that the PAC is a diagnostic and monitoring tool and not a therapeutic device, it would be surprising that it (or TEE for this matter) would greatly reduce mortality. However, we believe that these devices used by trained individuals can alter the therapeutic approach. The PAC and TEE are particularly useful in the hemodynamically unstable patients. The PAC is useful in the postop ICU setting. During the off-working hours, the nonechocardiographist intensivist or the resident on call can readily evaluate the hemodynamically unstable patients using all routine monitoring including the properly and electively placed PAC to assess response to therapy. Moreover, without the PAC, the continuous measure of pulmonary hypertension would not be