been implicated in femoral neuropathies, but their role in the development of neuropathies in our patients is unknown. There may be factors other than retractors associated with perioperative femoral neuropathies. As we have shown, a variety of patient factors, such as very thin body habitus and smoking in the preoperative period, may be associated with lower extremity neuropathies. Three of these four patients had one or more of these factors. Two of the women undergoing vaginal hysterectomy had body mass indexes 20 kg/m² or less and were smokers. The man undergoing resection of a rectal carcinoma was in the low lithotomy position for approximately 5 h and was a smoker. Extremes of either hip flexion or extension also may be associated with femoral neuropathies. Hemorrhage in the ilioinguinal muscle and subsequent compression or ischemia of the femoral nerve also have been reported to occur during the perioperative period.

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References


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Fiberoptic Bronchoscopy in a Patient Requiring Continuous Positive Airway Pressure

To the Editor.—Diagnostic and therapeutic fiberoptic bronchoscopy under topical anesthesia in a patient whose lungs require ventilation using continuous positive airway pressure (CPAP) but in whom the trachea is not intubated, is not easily performed because of difficulties in ensuring an airtight breathing system equipped with oxygen and a PEEP/CPAP valve. Failure to administer CPAP even for a short period may lead to severe hypoxemia. When a Patil-Syracuse mask is not available and positive pressure ventilation and/or oral fiberoptic intubation are necessary, the simple system described by Higgins and Marco1 can be used.

We adopted their method to enable the application of CPAP during fiberoptic bronchoscopy. A large endotracheal tube (ETT), size 9 or 10, is cut short, the tube's cuff is inflated within the connector orifice of a face mask to form a seal (fig. 1), and the ETT is attached to an anesthetic machine equipped within a PEEP valve.

The fiberoptic bronchoscope is inserted through a fiberoptic bronchoscope swivel connector (Portex, United Kingdom) into the ETT and, from there, into the patient's nose or mouth. The face mask is kept tightly applied to the face, while the patient receives continuous oxygen and the desired PEEP.

Fig. 1. A fiberoptic bronchoscope is passed through an endotracheal tube, which is fixed into a face mask by inflating the cuff, permitting administration of continuous positive airway pressure in a spontaneously breathing patient.
With this simple technique, we are able to maintain the patients' prebronchoscopy oxygenation and avoid further worsening of the pulmonary disorder.

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Measurements of Occlusion Pressure during Anesthesia with Volatile Anesthetics in Humans

To the Editor:—Recently, Canet et al., 1 reporting on changes in occlusion pressure and ventilation with different depths of anesthesia using either halothane or isoflurane, suggested that only one study previously analyzed occlusion pressure in humans, at increasing concentrations of a halogenated anesthetic agent and that studies of the occlusion pressure wave are scarce.

In an analysis of the occlusion pressure wave and inspiratory flow patterns of patients anesthetized with enflurane and nitrous oxide, 2 I found that ventilatory depression caused by an increase in inspired enflurane concentration was related solely to a reduction in central drive and not to the peripheral factors more favored by Canet et al. in their discussion. The same study also reported changes in the occlusion pressure and inspiratory flow pattern caused by opioid administration. There was no marked change in estimates of active elastance and impedance, again suggesting that the depression was central. Occlusion pressure also was used in a further study, investigating the findings of Wahba and Sadkova, 3 who found that atropine increased ventilation during anesthesia with enflurane. The effects of atropine administration were studied in patients anesthetized with enflurane and halothane, using occlusion pressure to distinguish central effects from peripheral, mechanical effects. The findings suggested a minor effect after premedication with meperidine, consistent with the possibility of bronchodilation. Atropine caused an increase in inspiratory flow, although occlusion pressure was unaltered. 4

These observations support the suggestion of Canet et al. that further analysis of occlusion pressure waveform in spontaneously breathing anesthetized patients can be helpful to investigate the neural mechanisms of respiratory depression.

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