tion of the procedure by the operator could be done from either the right or left sides of the table.

As this patient had situs inversus totalis, there were no abnormalities of venous drainage, such as persistent superior vena cava or reversal of great vessels or cardiac chambers, to further confuse cardiac manipulations. However, the heart in situs inversus totalis can be expected to develop disorders usually seen in the normally positioned heart. Cardiac catheterization with multiple catheter placements, left ventricular angiography, and selective coronary arteriography by the same technique can be accomplished readily from the left arm in a patient with situs inversus totalis with simple adjustments in technique in a well-designed cardiovascular laboratory.

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REFERENCES

To the Editor:

The method suggested by Dr. Miller for increasing the fractional concentration of oxygen in the inspired air (FIO2) by means of a single nasal oxygen catheter should certainly prove adequate provided that the arterial oxygen pressure is satisfactorily normalized. Although we have not found that the oxygen mask seriously interferes with manipulation of the bronchoscope, the other advantages listed by Dr. Miller are certainly worthwhile. The only disadvantage is perhaps that the FIO2 cannot be as accurately ascertained as with the Ventimask for purposes of calculation of the alveolar-arterial oxygen pressure gradient.

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Maximal Midexpiratory Flow as an Index of Acute Airway Changes

To the Editor:

We read with great interest the recent article entitled “The Unreliability of the Maximal Midexpiratory Flow as an Index of Acute Airway Changes” by Dr. Newball (Chest 67:311-314, 1975). However, we wonder if Dr. Newball’s findings justify his generalization regarding the “unreliability” of the maximal midexpiratory flow (MMF) deter-