because of failure to utilize therapy with supplemental oxygen.

In this illustrative case, two teeth were aspirated into the peripheral airways of the right lower lobe following trauma and a difficult intubation. With the use of a fiberoptic bronchoscope, a Fogarty balloon catheter, and a wire basket, these aspirated foreign bodies were easily removed, eliminating the need for therapeutic thoracotomy in a high-risk situation. We believe that this is the first case report of a foreign body removed from the tracheobronchial tree using a wire basket inserted through the channel of the flexible fiberoptic bronchoscope.

At the present time the rigid bronchoscope is recommended for removal of most aspirated foreign objects; however, with proper training in utilizing the newly developed tools for extraction and with full knowledge of how to avoid potential complications, it is conceivable that the flexible fiberoptic bronchoscope may become a front-line instrument for removal of foreign bodies in adults. Nevertheless, until we have gained much more experience, it is indeed wise to have a rigid bronchoscope readily available.

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REFERENCES


Staphylococcal Aortic Pseudoaneurysm*

Treatment Employing Ascending Aorta-Abdominal Aorta Bypass Graft

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An adult patient developed infection of the anastomosis after resection of an isthmic coarctation, with subsequent formation of a pseudoaneurysm. He was treated successfully by an ascending aorta-abdominal aorta bypass graft. The graft was placed retrosternally and passed through the diaphragm into the retroperitoneal space. After surgery the patient developed systolic hypertension. A faint murmur was heard over the chest and abdomen, caused by the turbulent flow through the graft.

Infection of the anastomosis of a resected aortic coarctation is a serious postoperative complication. The sudden formation of a pseudoaneurysm may aggravate further the patient's condition.

A patient was treated by employing an ascending aorta-abdominal aorta bypass graft. Interruption of the descending aorta with resection of the infected pseudoaneurysm was performed 15 days later.

CASE REPORT

A 26-year-old man was admitted in the Italian Hospital, Buenos Aires, with a history of throbbing occipital and frontal headaches. Approximately 16 months before admission, he began to have shortness of breath with moderate exertion and angina pectoris.

On physical examination the patient appeared to be in nonacute distress. The pulse rate was regular at 90 beats per minute, and the blood pressure was 150/90 mm Hg. The femoral pulses were absent. The cardiac impulse was dynamic and indicated moderate enlargement. A grade 3/6 systolic ejection murmur was heard in the upper left sternal border and in the left interscapular area.

The electrocardiogram revealed left axis deviation and left ventricular hypertrophy. The chest x-ray film disclosed mild cardiomegaly with specific left ventricular enlargement. Rib notings were seen in both sides of the chest.

At cardiac catheterization, the aortic pressure was 150/80 mm Hg; the rest were within normal limits. Angiocardiographic studies demonstrated normal function of the mitral and aortic valves and revealed a typical isthmic aortic coarctation.

Surgical correction was performed on July 18, 1975; the coarctation was resected, and an end-to-end anastomosis was performed. After the operation, femoral pulses were present.

After the sixth day the patient's postoperative course was complicated with high fever. From the chest wound, Staphylococcus aureus was isolated, and the incision was partially drained. The patient was treated with cephalothin (12 gm/day in four intravenous doses) and gentamicin (240 mg/day in three intramuscular doses). On Aug 10, 1975, 22 days after the operation, the patient was discharged, apparently in good condition; however, his clinical course was complicated with intermittent high fever and persistent cough.

On Dec 17, 1975, the patient was readmitted with a fever of 39°C (102.2°F) to 40°C (104°F), repeated hemoptysis, and sudden aphonia. A chest x-ray film disclosed a shadow in the left upper lobe (Fig 1). Cultures of blood demonstrated S aureus. The incision from the left thoracotomy was completely healed. The patient was treated with cephalothin and gentamicin. Since the patient exhibited an allergic reaction with leukopenia, cephalothin was discontinued and instead...
mecillin sodium (6 gm/day in four intravenous doses) was administered.

On Dec 23, 1975, an angiocardiogram revealed an area of opacification filling from the descending aorta and corresponding to the shadow on the chest x-ray film. Antibiotic therapy was continued.

Surgical Treatment

On Jan 15, 1976, the patient was taken to surgery; an ascending aorta-abdominal aorta bypass graft was performed. Through a median incision the abdominal aorta below the renal arteries was exposed first. A plane of dissection was established on the left aspect of the aorta and extended between the renal vein and the renal artery. The blunt dissection proceeded cephalad toward the diaphragm.

Through a median sternotomy the pericardial sac was incised. On the left of the midline, a 2 cm disk was removed from the pericardium and the diaphragm. From there, taking a posterior and slightly caudal direction left of the aorta, the previous abdominal tunnel was reached.

The ascending aorta was partially clamped. An end-to-end anastomosis, employing an 18 mm Dacron woven graft, was performed. The graft was carried from the pericardial sac to the abdominal aorta following the contour of the lateral aspect of the right atrium and the acute margin of the right ventricle. Heparin (1.5 mg/kg of body weight) was given, and the hypoplastic abdominal aorta was cross-clamped. An end-to-end anastomosis was performed. All of the clamps were removed, and protamine (2 mg/kg) was administered.

On Jan 23, 1976, eight days after surgery, cardiac catheterization was repeated. The patency of the graft was demonstrated (Fig 2).

On Feb 3, 1976, the patient underwent resection of the pseudoaneurysm and definitive closure of the descending aorta (Fig 3).

Through the fourth intercostal space the left side of the chest was entered. The thin-walled pseudoaneurysm was closely adherent to the left pulmonary artery. The descending aorta was dissected proximally and distally from the aneurysm and was cross-clamped. The pseudoaneurysm was opened, and a dehiscence in the medial aspect of the anastomosis was demonstrated. The isolated aortic segment was divided and excised. The proximal and distal aortic stumps were closed with 3-0 polypropylene sutures. The left thoracotomy was repaired in a routine manner.

On Feb 26, 1976, twenty-three days after the last operation, the patient was discharged. The pedal and posterior tibial pulses were present in both extremities. The long postoperative stay in the hospital was necessary because of an increase in blood pressure. It averaged 200/80 mm Hg, with extreme peaks reaching 300/50 mm Hg. The patient was treated with a diet low in sodium, oral therapy with furosemide, and a ganglionic blocking agent (methyldopa). A faint systolic murmur was heard at the third and fourth intercostal spaces along the right sternal margin and radiated to the abdomen. It was due to turbulent flow through graft.

The patient’s clinical course since discharge from the hospital has been excellent, and when he was last seen in the outpatient clinic on May 12, 1976, the blood pressure was 140/80 mm Hg. The femoral and distal pulses were present.

Discussion

Ascending aorta-abdominal bypass graft has been used as a palliative method in a patient with recurrent
Atypical Radiographic Findings in Neonates with Absent Pulmonary Valve and Tetralogy of Fallot*

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At birth, three infants had typical to-and-fro murmurs and laboratory features suggesting tetralogy of Fallot with absent pulmonary valve. Initial posteroanterior chest x-ray films were atypical for the condition because of the apparent absence of dilation of the proximal pulmonary arterial tree. Lateral chest x-ray films invariably demonstrated a large hilar mass. Radiographic findings on the posteroanterior chest x-ray film considered pathognomonic for the complex lesion may not evolve until later during the first year of life.

Partial or complete absence of the cusps of the pulmonary valve is a rare congenital cardiac malformation which usually occurs in association with tetralogy of Fallot. The existing literature on this subject states that

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