patients, we have employed a feasible tool for the scope for nary disorders.

renders bronchoscopic examination, the procedures are performed in a flexible fiberoptic bronchoscope, we add vocal endoscopic control. By been another Advantage of the Flexible Fiberoptic Bronchoscope

An Easy Tracheal Cannulation in Preparation for Bronchography

To the Editor:

To the growing list of serendipitous advantages of the flexible fiberoptic bronchoscope, we add another. In the cases where bronchographic examination is desired in addition to bronchoscopic examination, the procedures are performed in sequence. By using the flexible fiberoptic bronchoscope as a laryngoscope, the trachea is easily cannulated under endoscopic direction. This technique not only saves time but also renders the introduction of the tracheal catheter more tolerable to the patient.

Technique

Following the completion of transnasal bronchoscopic examination, the tip of the bronchoscope is withdrawn to a level just above the epiglottis. A jelly-coated soft catheter is gently passed through the opposite nares to the supraglottic area, where the catheter is then slowly advanced under endoscopic control. By visualizing the catheter over the glottis, it is very easy to manipulate the catheter through the vocal cords into the trachea. The trachea, having previously been anesthetized for the bronchoscopic procedure, requires only little additional anesthesia.

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Bronchography Combined with Bronchoscopy

A New Method

To the Editor:

The flexible fiberoptic bronchoscope has become an indispensable tool for the assessment of a wide variety of pulmonary disorders. Over the past two years in approximately 25 patients, we have employed a flexible fiberoptic bronchoscope for another purpose, the performance of broncho-

REFERENCE


Another Advantage of the Flexible Fiberoptic Bronchoscope

An Easy Tracheal Cannulation in Preparation for Bronchography

To the Editor:

Approximately one hour prior to examination, the patient is premedicated with meperidine (Demerol) hydrochloride (50 mg intramuscularly) and atropine (0.4 mg intramuscularly). The patient is then taken to the fluoroscopic suite, where a conventional flexible fiberoptic bronchoscopic procedure is performed. A 2 percent solution of lidocaine is used for topical anesthesia.

After the flexible fiberoptic bronchoscopic procedure has been completed, a 0.035-inch guide wire is passed through the aspirating channel of the bronchoscope (Fig 1). Under fluoroscopic observation the guide wire is directed into the area of the lung to be evaluated. The bronchoscope is slowly withdrawn over the positioned and firmly held guide wire. Next, a red Robinson catheter with the closed tip amputated is passed over the guide wire and advanced to the desired bronchial level. The guide wire is withdrawn, and the catheter is now in proper position for instilling contrast material. More selective bronchographic studies can be accomplished with the use of an angiographic catheter. The bronchogram is completed in the conventional manner.

Local anesthetic agent is instilled through the catheter if necessary. The additional time required to prepare the patient and position the catheter is rarely more than five minutes.

discussion

We have found the combined bronchoscopic-bronchographic procedure to be extremely helpful in selected cases because it permits evaluation of airways and parenchyma not directly visualized by bronchoscopic examination alone. Our technique, which in principle is similar to Seldinger's method for arterial catheterization, facilitates the bronchographic procedure.

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