severe pain at the site of infusion; redness and swelling of the arm appeared with the full picture of acute thrombo-
phlebitis which extended towards the axilla. Change of the infusion to the opposite arm created the same reaction, but early withdrawal resulted in a less severe reaction. The signs and symptoms subsided within a week.

CASE 2

A 52-year-old man entered the CCU with an acute myoc-
cardial infarction and intractable supraventricular tachycardia (280/min) resistant to all attempts at conversion with drugs and D-C shock. Amiodarone was given IV as in case 1 and the tachycardia subsided, but soon he developed severe local pain with redness and swelling; acute thrombo-
phlebitis extended up to the axilla. The infusion was interrup-
ted and the local reaction subsided after ten days.

CASE 3

A 45-year-old man suffering from myocardiopathy entered the hospital with a severe attack of supraventricular tachycardia (280/min) and collapse. D-C shocks were only transiently effective in restoring rhythm and blood pressure. All other drugs were either ineffective or created dangerous bradyarrhythmias. Amiodarone IV in the same doses as previously was very effective in restoring rhythm, but soon created severe local reaction with thrombophlebitis, pain, redness and swelling of the arm which necessitated interruption of therapy.

From our experience, amiodarone given IV in doses of 7.5-10 mg/kg is a very valuable antiarrhythmic drug, but with a high frequency of severe local reaction consisting of pain, redness, swelling and acute thrombophlebitis' ex-
tended beyond the site of infusion and which may pro-
hibit its continuous IV use. It is possible and it would be advisable to use a central venous catheter in order to de-
crease or avoid the severe local reactions.

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New Insights into the Airways

To the Editor:

Dr. Rucker (Chest 1981; 80:121) has emphasized the value of smaller flexible bronchoscopes in neonates and quite properly noted some of their limitations. It is indeed encouraging to see the progress made in the development of the smaller instruments and we also are impressed with their usefulness in selected pediatric applications. There are several points in this editorial which we feel deserve comment.

Fortunately, most, if not all, of the limitations of the flexible instruments can be overcome by the skillful appli-
cation of modern fiber-illuminated endoscopes and tele-
scopes. Unfortunately, there seems to be an increasing num-
ber of practitioners whose training and interests are limited to the flexible instrument. In perhaps no other field of medicine does a complete and up-to-date instrumentarium ap-
p lied by one of broad training and mature judgment more often determine the success or failure of a physician's diag-
nostic effort. Without this capability, our pediatric patients especially are ill served.

We have used flexible instruments extensively to evaluate stridor and other problems of the pediatric airway. These instruments are not, however, "almost completely replacing direct laryngoscopic examination" in our practice. Their value is not in question, but we have repeatedly demonstrated the necessity for direct laryngoscopy in order to establish the correct diagnosis, especially in the posterior larynx and subglottis. The posterior commissure web and arytenoid fixation are frequently misdiagnosed as vocal cord paralysis unless the tissues are displaced by direct tech-
niques. The evaluation of subglottic disease is also frequently inadequate if one must limit oneself to the use of flexible instruments.

We are among the most enthusiastic proponents of flexible instruments when they allow us to do a better job. Let us not, however, dispose of instruments of proven value just because we now have a new one whose role is still being ascertained. Our real need is for broadly-trained physicians who understand how and when to apply the most suitable instrument regardless of its configuration.

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To the Editor:

There are certainly points in Dr. Marsh's letter that are well taken and I wish to clarify some of these points.

In the evaluation of upper airway problems, ie, above the vocal cords, we feel that the transnasal fiberoptic approach allows a better representation of the physiologic functioning of these glottic structures as the degree of distortion and invasiveness is much less. Specifically, this is in reference of a lack of need for either general anes-
thesia or local anesthesia directly upon the larynx or the posterior pharynx. It is not necessary to keep the tongue forward or to keep the mouth open, as we are aware.

It is not implied that the small fiberoptic instruments can replace the direct laryngoscope and/or the direct bronchoscope in situations where the fiberoptic broncho-
scope is limited by its physical characteristics. In my edi-
torial I generally agreed with Dr. Marsh's point about sub-
glottic disease being best diagnosed in children by the straight bronchoscope.

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