scopic guidance was tried, again with no success. At this time, the catheter balloon was filled with 2 ml sterile normal saline solution and insertion was tried. With the balloon filled with normal saline solution, the catheter negotiated its way to the ventricle with no difficulty. Right ventricular pressure was 63/11 mm Hg. After ventricular tracing was obtained, normal saline solution was withdrawn and the balloon was re-inflated with 1.5 ml air. Then the catheter was advanced and the pulmonary artery was catheterized showing pulmonary artery pressure of 65/25 mm Hg and pulmonary capillary wedge pressure of 18 mm Hg.

**COMMENTS**

Insertion of a balloon-tipped, flow-directed catheter through the right subclavian vein may be difficult since the catheter has to make a 90° turn to reach the right atrium. However, the change of site and other maneuvers failed in this case probably because the combination of dilated right atrium and tricuspid regurgitation was creating a whirlpool type flow of blood in the atrium that was denying the catheter with inflated balloon entry into the right ventricle. Replacement of the air of the balloon with normal saline solution prevented the catheter from bouncing back. In patients with right heart failure, if difficulty in passage of the balloon catheter from the right atrium to the right ventricle is encountered, we suggest this simple and safe maneuver be tried.

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**Standard Techniques for An Old Disease**

_To the Editor:_

Although I found most of Dr. Wallace’s editorial, “Another new technique for an old disease, the protected brush catheter and bacterial pneumonia” (Chest 1982; 81:532-33) to be quite reasonable, I believe one of his comments is impractical. He suggests that sterile nonbacteriostatic saline should be flushed through the catheter (without the brush) in order to obtain an adequate specimen in situations where no secretions are visible in the airway. Unfortunately, even if the catheter could be adapted for this use, its small size (1 mm external diameter) and length (140 cm) would probably make adequate suctioning very difficult. Fortunately, other satisfactory solutions to the problem exist. The bronchoscopist has the option of either selecting the involved segment of lung and then blindly extending the brush to the periphery to obtain the specimen, or of performing the procedure under fluoroscopic guidance in order to determine that the specimen is obtained from an involved area of the lung. The absence of visible secretions in the central airways does not, in my experience, limit the usefulness of the telescoping catheter brush system.

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