Bedside Pulmonary Angiography: Some Criticism

To the Editor:

Dougherty et al (Chest 1980;77:43-6) report their experience with bedside pulmonary angiography utilizing an existing Swan-Ganz catheter. Although they reserve their method for critically-ill patients who could not be transferred to the radiology department, I, as an angiographer, would like to sound a warning note.

From the technical point of view the method they describe presents several shortcomings. In current radiologic literature there seems to be agreement on how to perform pulmonary angiography. Although they reserve their method for critically-ill patients, one may be skeptical as to the benefit of the procedure in those circumstances.

In their article the authors do not mention pressure measurements before performing their examination. In a recent report of complications of pulmonary angiography, the authors strongly advise pressure measurements in the right atrium, right ventricle and pulmonary artery in order to eliminate those patients where the angiographic technique.

In conclusion, the points raised are both appropriate and valid. I trust this response will clarify any questions regarding this limited angiographic technique.

James E. Dougherty, M.D.
Hartford, CT

Two-dimensional Echocardiography as a Diagnostic Aid in Central Vein Catheter Embolization

To the Editor:

Catheter emboli are well recognized complications of percutaneous subclavian vein catheterization. Catheter retrieval is almost invariably indicated in view of the dangers of infection or thromboembolic phenomenon. The position of the embolized catheter segment may influence the urgency and type of intervention. In the intensive care setting, the usual portable x-ray equipment does not always demonstrate the catheter position accurately, even in those with radiopaque markers. Two-dimensional echocardiography, easily performed at the bedside, allows prompt and accurate localization of the catheter. The following case illustrates the successful use of this approach.

CASE REPORT

A 55-year-old obese woman with known mild mitral stenosis and atrial fibrillation presented with rapidly progressive claudication and rest pain in both legs over a six-week period. Angiography showed marked atherosclerosis of the aorto-iliac region with complete infrarenal aortic occlusion. An urgent aortofemoral bypass operation