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Concerning erythromycin, correction pointed out by Wallace and colleagues is quite right. Indeed Wallace et al showed eight of 58 (14 percent) to be susceptible rather than eight of 14. Wallace defined the standard of the 15 µg disk.

Concerning cefoxitin, Cynamon et al reported M fortuitum to be susceptible to cefoxitin when the zone is 18mm or more by disk diffusion and considered resistant when a zone of 14mm or less was present.

Our case report demonstrated changes in susceptibility against erythromycin and cefoxitin when susceptibility testing was carried out by disk diffusion between 5/82 to 8/82. No conclusion could or would be made regarding streptomycin. It certainly would be instructive to obtain MIC data, but unfortunately, the organism is no longer available.

The conclusion that repeat susceptibility testing should be performed in patients that remain culture positive seems to be valid. What the incidence and mechanism of this resistance is will be delineated by future studies.

Lawrence Dall, M.D., Chief, Section of Infectious Diseases, University of Missouri, Kansas City

REFERENCES


Fiberoptic Bronchoscopy via Endotracheal Tube

To the Editor:

Matsushima et al in their recent article (Chest 1984; 86:184-88) demonstrated that various indices of airway obstruction were increased when the fiberoptic bronchoscope is inserted through an endotracheal tube already in place. They, however, correctly pointed out that the advantages of airway control provided by an endotracheal tube may outweigh any drawbacks this must entail.

It should be pointed out that they made their measurements with the cuff of the tube inflated. Under normal circumstances, the cuff need not be inflated during bronchoscopy and thus alleviate any possible upper airway obstruction.

Crawford Chung, M.D.
Medical Director, Adult Intensive Care Unit,
Children's Hospital of San Francisco

To the Editor:

We appreciate the comments of Dr. Chung and recognize that the cuff of an endotracheal tube need not be inflated during routine bronchoscopy. We inflated the endotracheal tube cuff in our study so that the various measurements could be made. The degree of upper airway obstruction would, of course, be less without the cuff inflated.

We calculate that an 8 mm ID cuff-inflated endotracheal tube increases upper airway resistance in an 11 mm ID trachea by more than three times. The increase in resistance of an 11 mm ID trachea caused by a deflated 8 mm ID (11 mm OD) endotracheal tube would be the same as if the cuff were inflated. Of course, there would be less of an increase in Raw with a deflated endotracheal tube if the tracheal diameter were greater than 11 mm. However, the relative resistances of inflated and deflated endotracheal tubes would be almost impossible to calculate since air flowing around the outside of the tube would likely have a turbulent component and would likely follow a tortuous path.

In summary, we agree that a deflated cuff would offer less resistance to airflow and would help alleviate the possibility of barotrauma caused by a high upper airway resistance when a bronchoscope is inserted into the endotracheal tube. However, it would be difficult to calculate the magnitude of any such advantage.

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