in large measure because any attention given to the persisting problem of unrecognized esophageal intubation in emergency settings cannot but be helpful. Our study was carried out to demonstrate another method of confirming intratracheal placement, not to suggest neglect of other, more time-tested techniques.

We did not recommend placement of a tube tip 20 cm from the incisors. Twenty cm was chosen arbitrarily for the study of cadaver subjects and in each case the cuff at that level was beyond the vocal cords, placed under direct vision.

Since identification of correct placement requires only the recognition of the transilluminated transtracheal light that is readily distinguished from an intraesophageal glow, in the setting of a cardiac arrest auscultation—which involves interpretation of auscultatory findings—would not likely prove as reliable. A redesign of the stylet that allows the light to be seen more readily from the side should increase the intensity of the transilluminated glow and thus the reliability of the technique.

One must be careful not to assume that success with one technique in one medical setting will apply to techniques carried out in all medical environments. Simply stated, auscultation is either impossible or, at best, inaccurate in ambulances, helicopters, and amid the din of resuscitation rooms. Direct visualization may also be difficult in the cramped quarters of transport vehicles, or in patients with facial swelling, trismus, or increased masseter tone. Capnometry and fiberoptic bronchoscopy, the gold standards, cannot be widely adapted to transport environments, emergency department or ICU settings. A small adapter that fits endotracheal tubes and that changes color in the presence of carbon dioxide is being planned and may answer the need in emergency environments.

In short, we are still in need of options that will provide us with reliable confirmation of the correct placement of endotracheal tubes in all medical settings. Reliance on auscultation has proven inadequate in the emergency environment. Transillumination is another technique that can help decrease the risk of the dreadful complication of unrecognized esophageal intubation.

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Hypersensitivity Pneumonitis in a Saxophone Player

To the Editor:

A 67-year-old musician was admitted to a hospital with a two-week history of dyspnea, cough, tightness of the chest and an occasional episode of streaky hemoptysis. A few months before the present episode, the patient had some of the similar symptoms, which subsided spontaneously.

The patient is a member of a local musical concert group; he plays a saxophone. He smoked one pack a day for 26 years, but quit about 13 years ago. He does not abuse drugs or alcohol. He has no known allergies and no occupational exposures. The patient has enjoyed good health until now. The patient was treated with oral cephalosporin and theophylline for two weeks. When he failed to respond, he was referred to us.

Physical examination was normal except for the presence of end inspiratory rales in both lung fields. Chest x-ray film showed diffuse ground glass-like haziness (Fig 1). Laboratory test results, including a complete blood count, liver function and serum electrolytes, were normal. Serum IgM was mildly elevated, but serum IgG, IgA and IgE levels were normal. Legionella, mycoplasma and cold agglutinin titres were within normal limits. A diagnosis of hypersensitivity pneumonitis was considered and the hypersensitivity pneumonitis panel revealed markedly increased precipitin antibodies against Candida; there were no antibodies against Thermoactinomyces vulgaris, Microspora faeni, Avium antigens and Aspergillus species. There was no apparent clue to the origin of the symptom complex and its relationship to Candida antibody titer. The patient refused bronchoscopy and a bronchial biopsy. Finally, we cultured the saxophone mouthpiece. Heavy growth of Candida albicans and Candida famata, and moderate growth of Cryptococcus, were obtained. The patient was given therapy with prednisone 40 mg, daily. His chest x-ray film cleared in about ten days and he was discharged. Eighteen months later he remains well and plays his saxophone with a mouthpiece which is washed with soap and water regularly.

Is this a case of Candida-induced hypersensitivity pneumonitis? The evidence is circumstantial and not supported either by a lung biopsy or a challenge test. However, we believe that such a diagnosis should be considered and pursued if another saxophone player is forced to spend more time in the hospital rather than in a concert hall.

Candida is known to produce an accelerated hypersensitivity reaction through its polysaccharide fraction and delayed type reaction through its fraction.1,2 We believe that, in this gentleman, acute pulmonary hypersensitivity was caused by a Candida species thriving in the humid, warm environment of the saxophone mouthpiece.3,4

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REFERENCES