HIV-infected patients (12 percent as opposed to 1 percent in noncarriers of HIV antibodies).

In summary, in HIV-infected patients treated with antituberculosis drugs, it is necessary to carry out stricter monitoring of analytical hepatic variables because adverse hepatic reactions are more frequent and serious.

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Endotracheal Tube Cuff Perforation as a Complication of Subclavian Vein Catheterization

To the Editor:

Subclavian catheterization is a common technique with a long list of associated complications that include damage to the lung, pleura, thoracic duct, nerves, and subclavian artery. We recently encountered an unusual complication during infraclavicular cannulation of the right subclavian vein, which could have led to significant morbidity if not identified early.

At the conclusion of a colon resection, central line placement was attempted by the surgeon for hyperalimentation using an infraclavicular approach to the right subclavian vein. Locating the vein was somewhat difficult, and after successful cannulation of the vein, the surgeon told the anesthesia team that he had aspirated air and was concerned about the possibility of a pneumothorax. At the same time the anesthesiologist was experiencing difficulty maintaining an adequate tidal volume because the endotracheal tube cuff required constant refilling with air to maintain a seal. The tube was changed, and a needle hole was observed in the upper part of the endotracheal tube cuff. With a new tube in place, the patient was easy to ventilate and had an uneventful postoperative course. Chest x-ray films showed no signs of pneumomediastinum or pneumothorax.

Reports of endotracheal cuff perforation during subclavian catheterization are lacking. Breen and Kageleta describe damage to a cuffed tracheostomy tube in a chronically ventilated patient with dilation of the trachea during subclavian line placement. Our patient was intubated for only 3 h and had no tracheal abnormalities when his endotracheal cuff was perforated. Because of the large number of intubated patients who undergo subclavian venous catheterization, it can be assumed that others will experience this problem. Endotracheal cuff perforation should be included as a possible complication of subclavian venous cannulation. It may therefore be advisable to have available the equipment necessary to place a new endotracheal tube whenever placing a subclavian line.

In addition, if air is aspirated during a subclavian line insertion, consideration must be given to the fact that the needle may have come in contact with tracheal contaminants. For patient safety, a new needle should be used in subsequent attempts to locate the vein.

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Pulmonary Arteritis With Pulmonary Arterial Thrombosis and Recurrent Endopulmonary Embolization

To the Editor:

We would like to present the following report of an interesting case that we encountered recently.

A 41-year-old woman underwent medical examination because of superficial thrombophlebitis of both legs. Chronic myeloid leukemia was also diagnosed and chemotherapeutically treated. Three weeks later, the patient again exhibited superficial thrombophlebitides of all extremities and symptoms of recurrent mild pulmonary embolization. Phlebography showed no signs of deep venous thrombosis. Despite anticoagulant treatment, the patient died with signs of fulminating pulmonary embolization.

Autopsy revealed a complete thrombotic occlusion of the pulmonary arteries caused by sterile granulocytic pulmonary arteritis (Fig 1) with recurrent pulmonary embolization from parietal truncus pulmonalis thrombosis. In addition, an appositional growth of

FIGURE 1. Autopsy section of the lung (hematoxylin-eosin stain, original magnification X 400). Wall of a branch of the pulmonary artery, the lumen of which is filled with a wall-adherent thrombus, is seen on the left. Extended granulocytic transmural infiltration of the vessel wall spreading into the adjacent lung parenchyma is seen on the right.