should be concerned because the cost can be formidable. Interventional radiology routinely uses the technology available be it ultrasound for thoracentesis, or computerized tomography for chest tube placement or transthoracic needle aspiration biopsy of the lung. There is little documentation that these technologic devices improve outcomes. Expenditures for diagnostic x-ray studies indeed are one of the fastest rising components of healthcare services.

Patients should be concerned because these three procedures have a potential for significant complications. Few radiologists, in my experience, are proficient in intubation, cardiopulmonary resuscitation, or chest tube insertions. Moreover, these procedures become an isolated event in the management of patients.

Clinicians should be wary because official radiology reports can encourage self-referral and trap the attending physician. Clinicians frequently "get run over by the bandwagon."9

The attitude that "imaging guided catheter techniques provide heretofore unsurpassed precision and accuracy in performance of these procedures"2 should be tempered. I fear that interventional radiology is yet another example of fractionated healthcare and occasionally a detriment to the best interest of the patient. Interventional radiology will soon begin to face the rigors of technologic assessment, hospital credentialing committees, and peer review organizations. The concept of informed consent and other legal ramifications that radiologists have avoided in the past will need to be addressed. I have reservations that these practitioners "flounder along in an aimless fashion, never able to gain any accurate conception of disease ... hitting now the malady and again the patient, he himself not knowing which."4 Their intrusion into the clinical arena prompts this caveat emptor.

William A. Dull, M.D., F.C.C.P.,
Iowa City, Iowa

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Laceration of the Cuff of an Endotracheal Tube During Percutaneous Dilatational Tracheostomy

To the Editor:

The technique of percutaneous dilatational tracheostomy described by Ciaglia et al12 appears to be gaining popularity and has been the subject of several recent reports.2-4 It is well recognized that the cuff of the endotracheal tube is at risk of puncture during first placement of the guidewire needle, and it is recommended that the tube be withdrawn to a position immediately before the cords prior to insertion of the needle.

We wish to report a case in which the cuff was, not simply ruptured, but unwittingly torn such that two separate fragments were left in the trachea during an otherwise uneventful tracheostomy (Fig 1). The defect in the cuff was discovered only on withdrawal of the endotracheal tube, and bronchoscopy was needed to recover the fragments.

Figure 1. Lacerated endotracheal tube cuff with the two fragments.

We now remove the endotracheal tube from the trachea before the procedure begins, leaving only the tip between the cords, using the inflated cuff as an obturator above the cords in order to ventilate the lungs. This works satisfactorily and removes the cuff from risk of puncture and laceration.

Charles Day, M.B., Ch.B.,
Nigel Rankin, M.B., B.S.,
Department of Intensive Care,
Middlemore Hospital,
Auckland, New Zealand

Bronchial Responsiveness to Methacholine in Insulin-Dependent Diabetic Patients With Autonomic Neuropathy

To the Editor:

The bronchomotor tone is determined by the synergism-antagonism of several systems: the parasympathetic system, the sympathetic system, and a third nonadrenergic-noncholinergic system. We can suppose that in diabetic patients with autonomic diabetic neuropathy demonstrated at the cardiovascular level, compromise of the vagal tone can be present. The data in the currently available literature are conflicting: a reduced bronchial response to hyperventilation of cold air and inhalation of methacholine (MTH) have been reported,1,12 but so has an increased reactivity to histamine.4 These discrepancies might be due to confounding factors, such as smoking habits and genetic differences of the studied individuals related to the type of diabetes.

To evaluate the presence and type of alterations in the autonomic nervous system of the diabetics in diabetic disease, we studied the reactivity to a bronchial stimulating test with MTH in 20 insulin-dependent diabetic patients (aged 38 ± 14 years) without personal and/or familiar anamnesis of bronchial hyperreactivity. Patients were subdi-