mode of mechanical ventilation. We did not utilize the endotracheal tube exchanger as a mode of ventilation, but rather as a safety and security measure (CHEST 1995; 106:572-74).

The endotracheal tube exchanger was placed through a swivel adaptor placed at the proximal end of the endotracheal tube. The patients were ventilated around the endotracheal tube exchanger, not through it. Pulse oximetry was continuous throughout the procedure and at no time were oxygen saturations lower than 100% on 100% fraction of inspired oxygen. Capnography and serial arterial blood gases were not performed.

We do share Dr. Cooper’s concern for the possibility of inadvertent injury by perforation of the tracheobronchial tube with an endotracheal tube exchanger device. We retracted the endotracheal tube to a position where the cuff is just below the level of the vocal cords. Depending on the size of the patient, we then placed the endotracheal tube exchanger 5 to 8 cm below the endotracheal tube tip. This position approximates the position of a normally placed endotracheal tube. Since we do not ventilate through this endotracheal tube exchanger, overdistension of a lung, endobronchial ventilation, and consequent hypoxia are not concerns that we shared with Dr. Cooper.

Not Too Conservative Treatment of Over Anticoagulated Patients

To the Editor:

I read with interest the article by Glover and Morrill (CHEST 1995; 106:987-90) and found it to be most informative. One of their study patients developed gross hematuria, which resolved with no long-term sequelae. No information is provided regarding the cause of the patient’s bleeding. As clinicians we must differentiate between over-anticoagulation and bleeding, because the latter is not synonymous with anticoagulation, nor with conservatism. Any bleeding episode in an anticoagulated patient requires a thorough investigation for the source, regardless of the international normalized ratio.

Bernardo B. Fernandez, Jr., MD, Department of Vascular Medicine, Cleveland Clinic Florida, Ft. Lauderdale, Florida

To the Editor:

Dr. Fernandez correctly points out that hematuria in patients receiving anticoagulants should not be considered benign, nor simply the result of anticoagulation. One patient in our study with an international normalized ratio of 24.1 experienced painless gross hematuria (CHEST 1995; 106:987-90). He was given IV fluids and warfarin doses were held. A urinalysis and culture revealed no infection. He was monitored frequently as an outpatient over the next few weeks without recurrence of hematuria. An IV pyelogram performed 6 weeks after the episode was normal except for a small amount of postvoid residual contrast media in the bladder. Cystoscopy performed 1 week later revealed two urethral strictures with no other disease. Warfarin was discontinued after 4-months treat-

ment for apical hypokinesia post myocardial infarction. The patient has subsequently received several urethral dilations without further hematuria.

Prospective trials have documented a high frequency of underlying major genitourinary tract disease in anticoagulated patients with gross hematuria and microscopic hematuria. All episodes of hematuria during anticoagulation treatment, regardless of intensity, require diagnostic studies to rule out significant genitourinary disease.

Jon J. Glover, PharmD, and Gregory B. Morrill, PharmD, Veterans Affairs Medical Center, Tucson, Arizona

REFERENCES


Check Out This CT!

To the Editor:

Recently a patient was referred to the office for pulmonary consultation because of a cavitating infiltrate as seen on his chest x-ray film. I believe his CT of the chest (Fig 1) is most unusual in that the diagnosis can be made easily by viewing it. (A pack of cigarettes is seen overlying the right chest—likely in the patient’s pocket during his scan!)

Robert M. Borushok, MD, Mark Schwartzner, MD, and Robert Appelman, MD; Hallandale, Florida

Figure 1. CT of a patient complaining of pulmonary problems. Note the light outline of a pack of cigarettes (arrow).