

## Correspondence

### Possible Hazard with the Nephroscope

*To the Editor:*—The nephroscope\* has become a valuable tool that is being used more often in surgery of the biliary tract. One problem that occurred recently has potential for disaster and should be brought to the attention of anesthesiologists and recovery room personnel.

The nephroscope requires constant irrigation with large volumes of fluid during use, and accordingly fluid may pass retrograde from the common duct into the stomach, where it can accumulate and be regurgitated upon extubation, creating a tremendous risk of aspiration. Recently we had a patient who,

upon extubation, regurgitated a large volume of fluid. It is reasonable to expect that passage of a nasogastric tube prior to extubation with emptying of any fluid accumulation of the stomach could prevent this potentially dangerous problem. It is now the usual practice in our institution to pass a nasogastric tube under anesthesia in all cases in which this instrument is used and to empty the stomach of all fluids prior to extubation.

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\* Nephroscope model 2802A, Karl Storz Endoscopy-America, Inc., 658 South San Vicente Boulevard, Los Angeles, California 90048.

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### Methylprednisolone and Renin-Angiotensin Mechanisms

*To the Editor:*—The dramatic changes in arterial blood pressure that commence with cardiopulmonary bypass have been of interest to us as well as to Bailey *et al.*<sup>1</sup> They, like us, have observed an immediate fall, often to pressures as low as 35 mm Hg, lasting for several minutes, with a gradual rise. Later, hypertension can be a problem. These authors found elevated renins, and did not find elevated catecholamines.<sup>1</sup> They cite a rather confusing literature on the subject of catecholamine release during bypass.

We must note, however, that these authors utilized 30 mg/kg methylprednisolone in their pump prime. By our reckoning, this is about equivalent to 10.5 grams of hydrocortisone in a 70-kg patient. Realizing that methylprednisolone is supposed not to have much mineralocorticoid effect, we wonder whether this huge dose might have some effect on the adrenal catecholamine or renin-angiotensin mechanisms. The authors make no mention of this complicating factor in their discussion.

We wonder whether the authors' failure to

observe elevated catecholamines during bypass might not have been due to this massive steroid dose. We presume their reasons for the steroids to be related to hopes of prevention of postoperative pulmonary difficulties. Solid evidence that this is indeed true would be welcome. In the absence of such evidence we will continue to leave steroids out of our pump prime.

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#### REFERENCE

1. Bailey DR, Miller ED, Kaplan JA, et al: The renin-angiotensin-aldosterone system during cardiac surgery with morphine-nitrous oxide anesthesia. *ANESTHESIOLOGY* 42:538-544, 1975

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