these patients, presumably at lower risk of reinfarction than nonoperated patients, would lower the rate of reinfarction. Exclusion of these patients means that the pre-1976 and post-1977 populations differ importantly.

Could these differences in population rather than differences in anesthetic technique, monitoring, or intervention account for the lower reinfarction rate?

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REFERENCE

1. Rao TLK, Jacobs KH, El-Etr AA: Reinfarction following anesthesia in patients with myocardial infarction. ANESTHESIOLOGY 59:499–505, 1983

(Accepted for publication March 2, 1984.)

Anesthesiology
61:214, 1984

In reply:—In response to Rooke *et al.*, I would like to clarify that in our report, neither group included patients who sustained myocardial infarction and had a coronary revascularization procedure.[1] Patients in both groups sustained myocardial infarction and, either due to the emergency nature of the noncardiac operation or the patients' coronary status (inoperable distal lesions or no other lesions detected other than the lesion in the vessel supplying the infarcted area or lesions in other vessels too small to be bypassed), did not undergo coronary revascularization. Thus, patients in both groups are comparable and the difference in outcome between the two groups is *not* because of differences in population.

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REFERENCE

1. Rao TLK, Jacobs KH, El-Etr AA: Reinfarction following anesthesia in patients with myocardial infarction. ANESTHESIOLOGY 59:499–505, 1983

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Complication of Fiberoptic Bronchoscope

To the Editor:—We wish to report a complication associated with the use of a fiberoptic bronchoscope. The patient was a 68-year-old woman with a tumor of the right lower lobe who was scheduled for bronchoscopy and right thoracotomy. The patient was induced with a balanced anesthetic technique and intubated orally with an 8.0 mm Hi-Lo National Catheter Endotracheal Tube.® The patient then was placed on the ventilator and a Portex Swivel Adapter® was interposed between the endotracheal tube and the breathing circuit.

The surgeon then proceeded with the fiberoptic bronchoscopy utilizing an Olympic® Adult BF type 4B2 fiberoptic bronchoscope, which had been lubricated with surgilube. The bronchoscope had just been returned from the company after repair. The bronchoscopy proceeded without incident until the surgeon began withdrawal of the unit. The bronchoscope had been withdrawn to approximately 13 cm when it suddenly became impossible to withdraw it any further. There was no change in circulatory parameters, the high-pressure alarm on the ventilator did not sound, but, a significant gas leak was noted where the bronchoscope passed through the Portex adapter. The cuff of the endotracheal tube immediately was deflated, and under direct vision the endotracheal