

Anesthesiology
68:308, 1988

ASA Award: B. Raymond Fink

To the Editor:—A correction is required in my biographical sketch of B. Raymond Fink, M.D., ASA awardee for Excellence in Research for 1987, which appeared in the October issue of ANESTHESIOLOGY.¹ It was stated that Dr. Fink completed his residency in anesthesiology at the Beth Israel Hospital in Boston. It was, in fact, at the Beth Israel Hospital in New York that Dr. Fink did his clinical training in anesthesiology, under the leadership of Dr. Sol Hershey as Chief of Anesthesiology. Although the incorrect information was derived from a source thought to be reliable, the error is mine in not having checked it directly with Dr. Fink. I can plead only that this was the last period in

Ray's life at which I had not yet met him personally, and regret any embarrassment to him or to Dr. Hershey, or confusion among the readers.

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REFERENCE

1. Epstein RM: ASA Award: B. Raymond Fink. ANESTHESIOLOGY 67:456-458, 1987

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Preservation of Pulse Oximeter Sensors

To the Editor:—For those who use the non-disposable pulse oximeter sensors, apply a small strip of self-adhesive Velcro™ to the top of your pulse oximeter case, and its mate to the finger sensor. Then, when not using the oximeter, stick the sensor to the case with the Velcro™. This discourages the sensor from leaping to the floor and self-destructing. At \$250 per sensor unit, it

can quickly pay for the Velcro™. Furthermore, you can find the little sensor when you look for it.

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Artificially Low Cardiac Outputs Resulting from a Communication Between the Proximal and Distal Lumens of an Edwards Pacing Thermodilution Swan-Ganz® Catheter

To the Editor:—We experienced an interesting problem while providing anesthesia for a 66-year-old female undergoing CABG. Preoperative cardiac catheterization indicated three-vessel coronary artery disease with a dilated severely hypokinetic left ventricle. The cardiac output at catheterization was 5.0 liters/minute, with a stroke volume of 60 ml, ejection fraction of 32%, and a systemic vascular resistance of 1800 dyne·sec·cm⁻⁵. The CVP was 2 mmHg, with a pulmonary artery pressure of 27/14 (18) mmHg, LVEDP of 35 mmHg, and an end-systolic volume of 127 ml.

Intraoperatively, the patient was monitored using a Marquette Electronics® Surgical RA system complete with two simultaneous ECG leads (II, V₅); arterial, pulmonary artery, and central venous pressures, temperature, and cardiac output with hemodynamic calculations. Prior to induction of anesthesia, an Edwards pacing thermodilution Swan-Ganz® catheter was advanced into the pulmonary artery without difficulty, displaying characteristic waveforms, and wedging when the balloon was inflated. The first intraoperative cardiac outputs were in the range of 1.2-1.4 liters/minute using