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In Reply:—Thank you for allowing us the opportunity to comment on the correspondence submitted in response to our published case report.[1] We agree fully with Drs. Lewis and Collard in their suggestion of having more than one anesthesia provider present when faced with the need to deliver a safe anesthetic while performing complicated monitoring procedures.[2] Rather than consider formal guidelines, however, we would suggest prudence on the part of the anesthesia provider as to when extra help might be enlisted. We, too, in the teaching environment suggested, had additional trained personnel to perform both tasks adequately. In the private practice arena, my colleagues are invariably available to help while performing tasks that might take one's attention away from providing safe anesthesia.

Dr. Siegel implies that we advanced our catheter into the right ventricle intentionally and without monitoring distal pressures.[3] Training for this procedure incorporates practice first in dog models and then with trained clinicians provided by Heartport, Inc. and includes all the steps outlined in his letter. Manipulation of the sterile sheath-encased catheters can sometimes be difficult, and the proximity of the entrance of the coronary sinus to the right ventricle is well known. Since this unfortunate incident, Heartport® has changed the coronary sinus catheter provided to one without a protruding guidewire, which would help reduce the incidence of the perforation we described because the distal pressure transduced would give a better indication of the location of the catheter (in conjunction with transesophageal echocardiography and fluoroscopy).

We agree with Drs. Ortega and Hesselvik[4] about the incorrect use of terminology; we placed a pulmonary artery vent (essentially a multi-orificed pulmonary artery catheter without a distal balloon), not a stent. They suggest that decreasing the use of the Endocoronary Sinus™ catheter during mitral valve surgery might be faster and safer; we agree. The case we described, however, concerned stenosed coronary arteries and not the mitral valve. We have subsequently joined them in their technique of placing the coronary sinus catheter first. Finally, we referred to nonpump coronary revascularization as being the impetus to developing minimally invasive techniques. Nowhere in our discussion did we refer to the technique used during this case report. Indeed, there are technologies currently available on the market that do not incorporate extracorporeal circulation, known as minimally invasive direct coronary artery bypass (MIDCAB).[5] Our emphasis concentrated on the difficulty in detecting and treating cardiac perforation.

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Conflict of Interest and the COPA

To the Editor:—We read with interest the article by Greenberg *et al.*,[1] demonstrating equivalent clinical use of the cuffed oropharyngeal airway (COPA) and the laryngeal mask airway (LMA). However, we are now confused to find that the two coauthors of this article, Drs. Brimacombe and Berry, reported contradictory results elsewhere (*i.e.*, the COPA is inferior to the LMA) only a few months later.[2] The latter investigation was conducted at the same two Australian institutions where more than two thirds of the patients in the article by Greenberg *et al.* were also studied. These contradictory reports have led us to suspect that the difficulties with the COPA reported by Greenberg *et al.* occurred predominantly at the two Australian institutions, whereas this device worked well at Johns Hopkins, where the remainder of the patients were studied. Greenberg *et al.* report "adverse events" on a hospital-by-hospital basis, they but do not present institution-specific results of their measurements. Such information would help resolve this issue.

These discrepancies between studies involving the same authors is obviously worrisome. Furthermore, if the results of Greenberg *et al.* contain such interinstitutional discrepancies, the obvious question is why? Dr. Greenberg notes that he refrained from personal involvement