

## Correspondence

### Femoropopliteal Bypass

Sir,

During the construction of an above-knee femoropopliteal bypass we often found the operative field hindered by the proximity of the distal occluding clamp.

To avoid this we now position the distal clamp through a separate stab wound incision. The clamp can then be positioned more distally, avoiding compression on the artery at the outflow angle of the anastomosis, and avoiding the need to extend the incision. As the clamp now is positioned away from the operating field, sutures have less tendency to become tangled up with it. Since we tend to leave a suction drain in the popliteal fossa, we use this same stab wound incision for the drain, so that no additional tissue damage is caused. We found that this little trick makes the construction of the distal anastomosis considerably easier.

**J. C. Breck and R. Rutsaert**  
*Antwerp, Belgium*

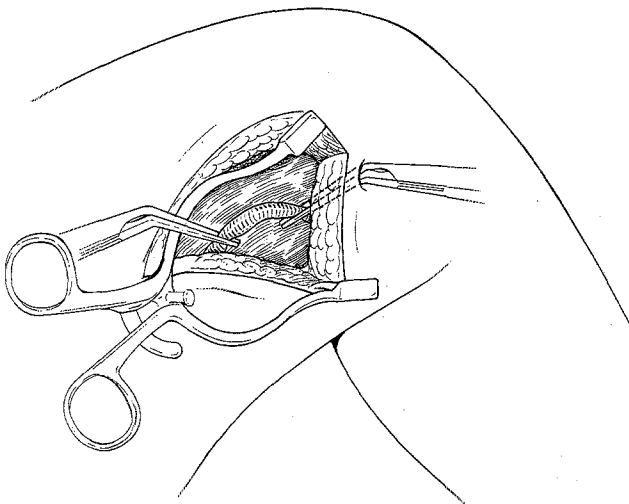


Fig. 1.

### Thoracoscopic Sympathectomy

Sir,

I was interested in the conclusions in the paper by R. D. Sayers *et al.* (*Eur J Vasc Surg* 8: 627-631). The authors state that the majority of patients undergoing bilateral procedures had these done as a two stage operation. This was because of stated fears by their anaesthetists of the potential risk of bilateral pneumothoraces. They mention that they have now started to perform bilateral procedures, and I feel that I should utter a word of warning from my own admittedly limited experience, especially since negative results and complications tend to be under-reported.

I have now performed 10 bilateral procedures for hyperhidrosis, both palmar and axillary, and all procedures have been done under the same anaesthetic, using a double lumen endotracheal tube to allow single lung ventilation and partial collapse of the operated side using one litre of CO<sub>2</sub>. In three out of the 10 cases there has been a marked reduction in oxygen saturation to 70% while operating on the second side and this has required temporary reflation of the lung before proceeding. On one occasion, after an uneventful procedure on the right side, there was sudden profound bradycardia on inserting the trocar and cannula on the left. This reversed with a precordial blow to the sternum and the administration of atropine. The trocar was withdrawn and the left sided procedure abandoned. The patient made an uneventful recovery and had a good result from the right sided procedure but is considering whether to have the left side done again. The presumed mechanism for the bradycardia was a vagal response to pain since not more than a litre of carbon dioxide had been insufflated and halothane, known to cause arrhythmias, was not being administered. With the other cases mentioned it seems likely that even after apparent full inflation of the lung after performing the sympathectomy on one side, there may still be a significant shunt which can prove dangerous when the other lung is collapsed.