

Authors' reply

Sir

At the outset, we thank the concerned reader^[1] for showing keen interest in our article.^[2] The issues raised by the interested reader are relevant. Pitfalls of portable chest radiographs in emergency setting are well known. There can be apparent mediastinal shift due to improper patient positioning. However, it is not difficult to diagnose such a condition on a chest radiograph by a radiologist. Moreover, it is hard to overlook patient positioning-related apparent mediastinal shift in a chest computed tomography (CT) scan, particularly in a multidetector CT (MDCT) as in our case. Also, one can confidently differentiate hyperinflation from oligemia leading to increased transradiance of affected pulmonary parenchyma in an MDCT. Features of hyperinflation of left lung are obvious in the given images [Figures 1 and 2]. If hypoventilation-mediated vasoconstriction

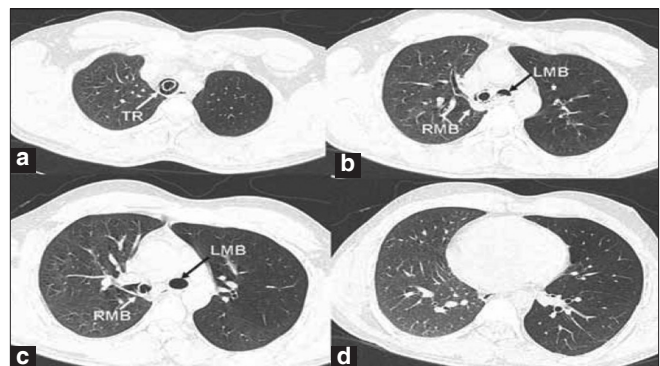


Figure 1: Axial sections at (a) mid thoracic tracheal, (b) carinal, (c) infracarinal and (d) cardiac levels, respectively. Lung window images depict increased trans-radiance of the lung parenchyma with sparse vascular markings on the left side, suggestive of air trapping. The right lung shows normal CT pattern. Also note mediastinal shift to the right side. Given images also depict presence of ETT in the trachea and right main stem bronchus. TR, trachea; RMB, right main bronchus; LMB, left main bronchus.

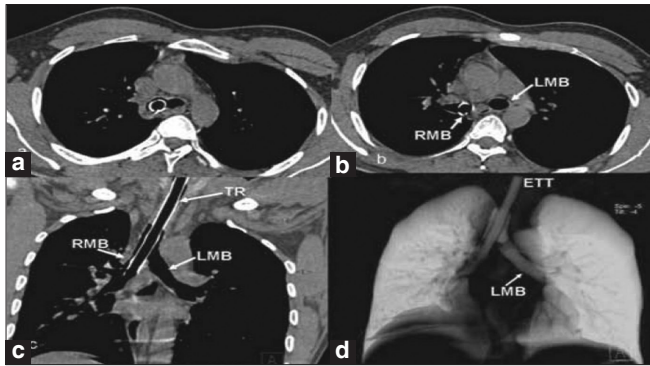


Figure 2: Axial sections (medistinal window) at (a) carinal and (b) infra-carinal levels confirm the presence of ETT in the right main bronchus. Curved coronal (c) reconstruction (mediastinal window) clearly demonstrates the extent of the ETT in the thoracic trachea and right main bronchus. Volume rendered image (d) further confirms findings noted earlier. TR, trachea; RMB, right main bronchus; LMB, left main bronchus; ETT, endotracheal tube.

and oligemia alone was responsible for the increased transradiance of the left lung parenchyma, some amount of ipsilateral mediastinal shift (due to varying degree of absorption of alveolar air) would have been observed rather than contralateral mediastinal shift.

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Reference

1. Panigrahi MK. Contralateral hyperinflation: computed tomography demonstration of an unusual complication of unrecognized endobronchial intubation. *Indian J Crit Care Med* 2011;15:142.
2. Debnath J, Kumar R, Krishna RB, Mathur A. Contralateral hyperinflation: Computed tomography demonstration of an unusual complication of unrecognized endobronchial intubation. *Indian J Crit Care Med* 2011;15:52-4.

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