

Letters to the Editor

To the Editor,

With reference to Soo et al.'s case report, "Successful Management of Membrane Oxygenator Failure During Cardiopulmonary Bypass—The Importance of Safety Algorithm and Simulation Drills" (*JECT* 2012;44(2):78–80), a similar case arose in our department that did not require an oxygenator change out. While on cardiopulmonary bypass (CPB), a much higher flow rate was required to oxygenate the patient and to maintain ventilation to reduce the $p\text{CO}_2$. Our normal sweep rate is 4 L/min to maintain the $p\text{CO}_2$ at normal value while on CPB. In one instance, a sweep rate of 10 L/min was necessary for normal $p\text{CO}_2$ during CPB. The patient subsequently exited from bypass uneventfully and no patient sequelae ensued. On examination it was discovered that the seals on the Tec 7 vaporizer (Datrex Ohmeda Inc., Madison, WI) was not correctly positioned and gas was leaking at this point. Our vaporizer was installed on a customized bracket but was resting on the pump console. This caused the seals to malfunction with resultant gas leak. Because the recommendation from the Society of Perfusionists of Great Britain and Ireland (SOPGBI) is for a scavenging device to be installed on the pump console, vapor fumes were not apparent (1). Similar cases with anesthetic machines have been reported

by Hyo et al. (2) and Lee et al. (3). We now use an electronic gas blender, Maquet EGB 40 (Maquet Ltd., Sunderland, UK), which we can use prebypass to check for leaks and obstruction in the gas delivery to the oxygenator. Our report together with two others reporting failure of the oxygen delivery were published online on the SOPGBI website (www.sopgbi.org) Web report.

Martin Hargrove, FCCP
T. Aherne, FRCSI
Cardiothoracic Surgery Unit
Cork University Hospital
Wilton, Cork, Ireland

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