second patient had coronary artery bypass grafting. The pericardium had been closed in the former case and it was left open in the latter. The left atrial pressure monitoring catheter fragmented when an attempt was made to remove it from the second patient. On both occasions the anchoring stitch was successfully divided with the help of the mediastinoscope and the catheters were easily removed.

With the patient under general anaesthesia the lower part of the median sternotomy wound was opened. The mediastinoscope was then negotiated behind the xiphoid through the previously detached diaphragmatic attachment and cautiously introduced into the pericardium. The pericardium, although it was closed in one patient, did not prove to be a barrier to its insertion. The mediastinoscope was then passed along the residual left atrial pressure line, which was traced to its source from the left atrium. The offending suture was cut and the line was withdrawn. The lower part of the wound was then resutured.

The technique is easy and simple and it obviates the need for repeat sternotomy. It can be performed safely in the intensive care unit in a short time without the need to move the patient to the operating theatre; either local or light general anaesthesia is used. No additional instruments, other than those routinely used for cervical mediastinoscopy, are required.

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Lung abscess resulting from grass inflorescence

SIR,—An 11 year old girl underwent right lower lobectomy for a chronic lung infection of interesting aetiology. At the age of 7 she had inhaled what she steadfastly maintained was an ear of barley. She was unavailingly given antibiotics for pyrexia, cough, and shoulder tip pain and after five days was admitted to hospital with right lower lobe pneumonia. Neither *x*-ray examination nor bronchoscopy revealed a foreign body, though the right main bronchus was haemorrhagic and oedematous. Five months later she was readmitted with haemoptysis and pyrexia. Repeat bronchoscopy and a bronchogram showed a diseased right lower lobe. Thoractomy was considered, but rejected because of her age and lack of definite evidence of inhalation. For four years she was symptom free and gained weight normally. Three months before thoracotomy she suffered cough, pleuritic pain, and haemoptysis. At operation there was gross inflammation of the lung, which was adherent to the diaphram. A right lower lobectomy was performed; the excised specimen contained a 35 mm abscess in and around the right lower lobe bronchus, at the centre of which was an ear of grass identified as *Hordeum murinum* (wall barley). She made a good recovery and remains well.

The ears of the grass family have spikelets and on inhalation these may act as barbs preventing backward movement. They may lodge locally causing airway obstruction with hyperinflation and infection. A chest radiograph may show the appearances of consolidation, collapse, or emphysematous change. Frequently it is normal. Grasses can migrate distally causing abscess formation, even penetrating the chest wall.[1] Bronchoscopic removal is preferred to physiotherapy and postural drainage.[2] If this fails, early thoracotomy before abcess formation has occurred may allow bronchotomy rather than lung resection.

The diagnosis of radiolucent foreign bodies beyond the reach of the bronchoscope relies on acceptance of a history of inhalation. We believe that the accounts given by children are usually accurate and a more ready acceptance of their veracity may well avoid unnecessary delay and complications.

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