In the circumstances we still feel that exposing to fluroxene anesthesia patients whose levels of microsomal enzyme activity may have been increased by previous medication is exposing such patients to an unwarranted hazard, a hazard over which the clinician in the present state of knowledge has no control. The drug armamentarium of the anaesthetist is sufficiently wide and versatile today to allow adequate alternate choice where use of a particular agent might be hazardous to the patient.

GAISFORD G. HARRISON, M.D., F.F.A.R.C.S.
*Associate Professor and Principal Anaesthetist*
*Department of Anaesthetics*
*Medical School Observatory*
*University of Cape Town*
*Cape Town, South Africa*

REFERENCES

1. Harrison GG, Smith JS: Massive lethal hepatic necrosis in rats anesthetized with fluroxene, after microsomal enzyme induction. ANESTHESIOLOGY 39:619–625, 1973
2. Wardell WM: Fluroxene and the penicillin lesson (editorial). ANESTHESIOLOGY 38:309–312, 1973
3. Reynolds ES, Brown BR, Vandam LD: Massive hepatic necrosis after fluroxene anesthesia. N Engl J Med 286:530–531, 1972
4. Tucker WK, Munson ES, Holaday DA, et al: Hepatorenal toxicity following fluroxene anesthesia. ANESTHESIOLOGY 39:104–107, 1973
5. Harris JA, Cromwell TH: Jaundice following fluroxene anesthesia. ANESTHESIOLOGY 37:462–463, 1972
6. Wallman SB, Surks SN: Hepatic damage after fluroxene anesthesia. Anesth Analg (Cleve) 52:942–945, 1973

*(Accepted for publication September 12, 1974.)*

## Overinflating Low-pressure Cuffs to Prevent Aspiration

*To the Editor:*—Our department has switched to the newer high-volume, low-pressure cuffed Portex endotracheal tubes. When we inflate these cuffs, we add air until reaching the point of no "leak" with positive pressure applied to the airway. When testing for respiratory force and vital capacity in awake intubated patients in the recovery room, I have noticed on several occasions that there has been an apparent discrepancy in test measurements, that is, a very poor (only slightly negative) inspiratory force, but a good (expired) vital capacity. I believe that when these patients inspire, the dilation of the trachea normally seen with inspiration seems to allow them to breathe around as well as through the tube. In fact, when the tube was deliberately occluded, they were able to get some air in, but rarely could force air out around the cuff.

In light of this, I have been deliberately overinflating the cuff in patients who are prone to aspirate during the intra- or postoperative period.

JACK EGNATINSKY, M.D.
*Attending Anesthesiologist*
*Crouse-Irving Memorial Hospital*
*Syracuse, New York 13210*

*(Accepted for publication May 10, 1974.)*