

CORRESPONDENCE

References

1. Smith WR, Glauser FL, Jemison P: Ruptured chordae of the tricuspid valve. *Chest* 70:790-792, 1976

2. Boscoe MJ, Lange S: Damage to the tricuspid valve with a Swann-Ganz catheter. *Br Med J*:346-347, 1981

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Use of a Left-sided Double-lumen Tube to Occlude the Right Upper Lobe Orifice

To the Editor:—Morell *et al.*¹ describe their innovative treatment of a patient with massive right upper lobe hemorrhage using an intentionally misplaced right-sided double-lumen endobronchial tube. In their patient, the tube was positioned so that the right endobronchial cuff occluded the right upper lobe bronchus, effectively controlling bleeding from that orifice. Positioning of the tube was facilitated by the use of a fiberoptic bronchoscope.

In their discussion of alternative airway management techniques, the authors correctly state that a left-sided double-lumen tube (used in the conventional manner) would have protected the left lung from contamination but would not have protected the right middle and lower lobes. I would like to add to their comments that a left-sided endobronchial tube can be used to successfully tamponade a bleeding right upper lobe when it is intentionally "misplaced" into the right main stem bronchus. This technique was first reported in 1972 by Carron and Hill²; their paper described the use of a Carlen's tube with the endobronchial lumen passed into the right main stem bronchus to facilitate right upper lobectomy in a patient with massive hemorrhage from that lobe. I have employed a similar technique to control hemorrhage from the right upper lobe in a patient in the intensive care unit. For that patient, I used a modern clear-plastic Robertshaw-configured left-sided tube. To accomplish passage of a left-sided double-lumen tube into the right main stem bronchus, one merely advances the tube rotated 180° from the configuration in which it normally is advanced down the trachea (with the distal left lumen angled to the right). This maneuver results in the main body of the tube bending in the oropharynx away from its preformed angle, which does not seem to cause a problem. One would expect that occlusion of the right upper lobe bronchial orifice would be accom-

plished more easily using a left-sided tube, because there is no venting slot on the left bronchial lumen. Subsequent fiberoptic examination of the right upper lobe orifice for the presence of continued bleeding might necessitate a bit more tube manipulation than when using a right-sided tube, but, it is hoped, the clinical situation would be less urgent at that time.

I draw this technique to the attention of readers of the Journal for those situations in which the clinician cannot adequately visualize structures with the bronchoscope because of massive hemorrhage, a right-sided tube or fiberoptic bronchoscope is not readily available, or a practitioner is more comfortable with the use of a left-sided tube.

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References

1. Morell R, Priclipp RC, Foreman AS, Monaco TJ, Royster RL: Intentional occlusion of the right upper lobe bronchial orifice to tamponade life-threatening hemoptysis. *ANESTHESIOLOGY* 82:1529-1531, 1995

2. Carron H, Hill S: Anesthetic management of lobectomy for massive pulmonary hemorrhage. *ANESTHESIOLOGY* 37:658-659, 1972

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