

CORRESPONDENCE

Peter P.C. Tan, M.D.

Professor of Anesthesiology
Department of Anesthesiology
Chang Gung University and Chang Gung Memorial Hospital
Kweishan, Taoyuan
Taiwan, R.O.C.

References

1. Klein U, Karzai W, Bloos F, Wohlfarth M, Gottschall R, Fritz H, Gugel M, Seifert: Role of fiberoptic bronchoscopy in conjunction with the use of double-lumen tubes for thoracic anesthesia. *ANESTHESIOLOGY* 1998; 88:346-50

Anesthesiology
1998; 89:1283

© 1998 American Society of Anesthesiologists, Inc.
Lippincott Williams & Wilkins

In Reply:—We thank Dr. Cheng for his comments about our study.¹ Dr. Cheng speculates that intentionally not correcting a distally malpositioned double lumen tube after intubation may lead to less proximally malpositioned tubes after patient positioning and may obviate the use of fiberoptic bronchoscopy in most cases. Although we agree that proximal malposition predominates after patient positioning, some points, however, must be kept in mind. First, one would still need a fiberoptic bronchoscope to intentionally but safely insert the tube deeper. Placing a tube intentionally too deep without a bronchoscope may cause serious injuries. Sakuragi *et al.*² report of a rupture of the left main-stem bronchus after the insertion of a left-sided double-lumen endobronchial tube in a 76-yr-old woman in which a fiberoptic bronchoscope was not used. Second, not only proximal, but also distal malpositions, occur after patient positioning.^{1,3,4} Because the very same tubes that are malpositioned distally after intubation are not necessarily those predestined to be malpositioned proximally after patient positioning, a distal malpositioning left undisturbed may predispose the patient to serious injuries if it moves distally during patient positioning.

Dr. Cheng also maintains that, based on his experience of many thousand patients, fiberoptic bronchoscopy is seldom necessary if continuous vigilance is given to bilateral auscultation, cuff palpation, and changes in airway pressure. Our study,¹ and surprisingly, some points of his own study⁵ point to the contrary. Auscultation may be practically impossible after the patient is washed and draped; cuff palpation cannot be performed during video-assisted surgery or in cases in which the nonoperated lung is intubated, and airway pressure may also increase because of other reasons (secretions, blood, surgical manipulation). Fiberoptic monitoring of double lumen tubes, similar to most monitoring measures in medicine, is performed in a majority of patients to avoid mishaps in a small minority. Positive experience in many patients may not be predictive of a negative outcome in the individual patient.

2. Brodsky JB: Fiberoptic bronchoscopy should not be a standard of care when positioning double-lumen endobronchial tubes (letter). *J Cardiothorac Vasc Anesth* 1994; 8:373-5

3. Burk WJ III: Should a fiberoptic bronchoscope be routinely used to position a double-lumen tube (letter)? *ANESTHESIOLOGY* 1988; 68:826

4. Grum DF, Porembka D: Misconceptions regarding double-lumen tubes and bronchoscopy (letter). *ANESTHESIOLOGY* 1988; 68:826-7

5. Cheng KS, Tan PPC: The incidence of double-lumen tubes displacement after positioning of patients during anesthesia. *Acta Anaesth Sinica* 1996; 34:75-80

(Accepted for publication July 7, 1998.)

Uwe Klein, M.D.

Professor of Anesthesiology
Waheedullah Karzai, M.D.
Staff Anesthesiologist
Department of Anesthesiology and Intensive Care Medicine
University Hospital
Friedrich-Schiller-University Jena
Jena, Germany
klein@anae1.med.uni-jena.de

References

1. Klein U, Karzai W, Bloos F, Wohlfarth M, Gottschall R, Fritz H, Gugel M, Seifert A: Role of fiberoptic bronchoscopy in conjunction with the use of double-lumen tubes for thoracic anesthesia: A prospective study. *ANESTHESIOLOGY* 1998; 88:346-50

2. Sakuragi T, Kumano K, Yasumoto M, Dan K: Rupture of the left main-stem bronchus by the tracheal portion of a double-lumen endobronchial tube. *Acta Anaesthesiol Scand* 1997; 41:1218-20

3. Desiderio DP, Burt M, Kolker AC, Fischer ME, Reinsel R, Wilson RS: The effects of endobronchial cuff inflation on double-lumen endobronchial tube movement after lateral decubitus positioning. *J Cardiothorac Vasc Anesth* 1997; 11:595-8

4. Saito S, Dohi S, Naito H: Alteration of double-lumen endobronchial tube position by flexion and extension of the neck (letter). *ANESTHESIOLOGY* 1985; 62:696-7

5. Cheng KS, Tan PP: The incidence of double-lumen tubes displacement after positioning of patients during anesthesia [in Chinese]. *Acta Anaesthesiol Sin* 1996; 34:75-80

(Accepted for publication July 7, 1998.)