be assured only by designing a prospective RCT to test the effect of this variable on muscular strain and workload using two different laryngoscopes. Our primary outcome was the ergonomic superiority of GLS on DL in terms of muscular activation with at least a 50% difference. This assumption is complementary to other studies testing the effects of GLS and DL blade on Cormack & Lehane laryngeal view, time to intubation and success rate and on pressures applied to oropharyngeal soft tissues. The non-inferiority study suggested by the authors adopting quite similar devices, like GLS and Storz D-blade, should be performed to test the expected equivalent performance between the two instruments and in our opinion might be justified only in case of significant differences in purchase prices.

With regard to the possible confounding effect of the assistant sharing the available limited visual field with the operator intubating, we wish to highlight that the assistant, after having passed the tube to the operator, moved from the head of the manikin to check the presence of the tube into the trachea through the exposed trachea-bronchial tree of the manikin.

**Declaration of interest**

None declared.

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**Propofol EC50: an effect of luteal phase core temperature differences?**

Editor—we read with interest the article by Fu and colleagues,1 in which the authors found that patients during the luteal phase recovered faster from general anaesthesia maintained with propofol and remifentanil than during the follicular phase. The authors provided us with two possible explanations for this phenomenon: one is that patients in the luteal phase had less accumulation of propofol in the body than those in the follicular phase at the end of surgery; the other is that effect-site propofol concentration or effect-site remifentanil concentration in patients in the luteal phase declined more rapidly than those in the follicular phase.

We agree with the authors’ points of view in general. Meanwhile, we hold the opinion that patients’ body temperature should not be ignored. In the luteal phase, core temperature is consistently increased when both progesterone and oestrogen levels are elevated. In the presence of high levels of the two hormones, skin blood flow, sweating, and heart rate are likewise all shifted to higher internal temperatures.2 One well-validated finding in women is that core temperature is increased by 0.3–0.5°C in the luteal phase compared with that of the follicular phase.3

It is well known that all general anaesthetics markedly impair normal autonomic thermoregulatory control, especially in the first 30 min after induction of anaesthesia. Patients’ core temperature usually decreases by 0.5–1.5°C, and the difference between the luteal and follicular phase may be increased.

Drug metabolism is markedly decreased by perioperative hypothermia. It has been reported that the blood concentration of propofol in patients with a core temperature of 34°C increased by 28% compared with patients at 37°C using the same dosage.4 Hypothermia also decreases the plasma clearance and prolongs the duration of action of rocuronium.5 Owing to these effects of hypothermia, the duration of postanaesthetic recovery was extended.

Several studies have focused on the effects of hypothermia; tissue metabolic rate is reduced by ~8% per 1°C. In the study by Fu and colleagues,1 the effect of the patients’ body temperature on drug metabolism was not mentioned. We speculate that the difference in body temperature between the two groups may be one of the factors that contributes to the phenomenon. Further research is needed to confirm this hypothesis.

**Declaration of interest**

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