The tip of a left-sided polyvinylchloride endobronchial tube was twisted in the left main-stem bronchus, leading to partial stenosis of the left airway.

for right lower lobectomy. Fiberoptic bronchoscopy revealed a normal trachea and major bronchi.

Following induction of anesthesia, the tip of a well-lubricated 37-Fr left-sided polyvinylchloride endobronchial tube (Rusch, West Germany) was inserted into the trachea, and the tube was rotated 90° counterclockwise and advanced until moderate resistance was encountered. The bronchial and tracheal cuffs were inflated with 2 and 4 ml of air, respectively. The lungs were easily ventilated, and chest auscultation revealed bilateral breath sounds; unilateral breath sounds were heard by alternate clamping of the tracheal and bronchial tubes. A fiberoptic bronchoscope passed down the tracheal lumen of the DLT provided an unobstructed view of the tracheal carina and the proximal edge of the bronchial cuff just below the tracheal carina. At this point, patency of the bronchial lumen was not checked by the fiberoptic bronchoscope. The lungs were ventilated with a fractional inspired oxygen concentration of 0.3; airway pressure was 20 cmH_{2}O.

After the patient was turned to the left lateral decubitus position, the position of the tube was rechecked with the fiberoptic bronchoscope passed down the tracheal lumen.

Ten minutes after the start of the surgery, or 20 min after tracheal intubation, a right thoracotomy was performed. To facilitate surgery, the right lung was collapsed by clamping the tube leading to the tracheal lumen. At this point, increased inspiratory pressures were noted. The pulse oximeter showed a rapid decrease in arterial hemoglobin oxygen saturation (SpO_{2}) from 100% to 89%. The tracheal lumen was unclamped and the right lung was ventilated, resulting in a rapid increase in SpO_{2}. Fiberoptic bronchoscopy of the left bronchial lumen revealed a torsion of the bronchial tube within the left bronchus, partially obstructing the bronchial lumen (fig. 1). The DLT was withdrawn into the trachea and properly reinserted under observation with a fiberoptic bronchoscope. The remainder of the anesthesia was uneventful.

Although the exact mechanism for this torsion is unclear, I speculate that the torsion occurred because of malrotation of the DLT during its insertion. This presumably happened because the trachea was too small for the tip of the DLT to rotate properly within the trachea, even though it advanced into the left mainstem bronchus. Lack of lubrication on the DLT could have contributed to the malrotation; however, this is unlikely because the DLT was well lubricated in this case.

I recommend that fiberoptic bronchoscopy of both lumens of the DLT be routinely performed when the DLT is used.

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REFERENCES

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Postherpetic Neuralgia: A Possible Application for Topical Clonidine

To the Editor—Recently, Davis et al. reported that a clonidine patch applied to the skin decreased hyperalgesia of four patients with reflex sympathetic dystrophy. In those patients, the effect of clonidine was limited to the borders of the patch, and the authors questioned the potential therapeutic benefits of the clonidine patch, given the limited area covered. In our experience, the effects of transdermal clonidine spread beyond the borders of the patch. We treated a patient in whom topical application of clonidine relieved the symptoms of postherpetic neuralgia without producing side effects.

A 75-yr-old man complained of burning, stinging pain with superimposed episodes of shooting, lancinating pain, and jabs along the distribution of T6–T9 on his left side, for approximately 3 months. A trial of carbamazepine and amitriptyline produced daytime sedation but no pain relief. On examination, the patient presented with findings of postherpetic neuralgia with healed vesicles in the distribution of T6–T9. In addition, he exhibited limited range of motion of his left arm, allodynia, and hyperpathia.

Our initial treatment consisted of two intercostal blocks and two epidural steroid injections with local anesthetic, which provided only temporary pain relief. Because the pain persisted, we applied a clonidine patch 0.1 mg (Catapres-TTS-1) in the center of his hyperalgesic area. There was a substantial reduction in hyperalgesia to mechanical stim-
ulation and dysesthesia and a noticeable improvement in range of motion of the left upper extremity within 48 h. A clonidine patch was applied every 3 days for 20 days of treatment, and then the patch was removed. The patient's pain and limitation of movement returned in 2–3 days. When the patch was reapplied, the patient experienced pain relief and improved range of motion within 48 h. Because no sedation or other side effects were observed, two patches (each 0.1 mg) were applied; these resulted in nearly complete relief of pain without side effects. After the 4th month of transdermal clonidine therapy, a trial of oral clonidine produced some relief of his pain but caused intolerable daytime sedation.

Patients with postherpetic neuralgia may suffer from sympathetically maintained pain syndrome.5 It is likely that the localized effects of clonidine are due to a reduction in the release of norepinephrine at sympathetic terminals.5,4 Although a placebo effect may have contributed to the therapeutic benefits of clonidine, it is noteworthy that the therapeutic benefits of clonidine are realized only in patients with reflex sympathetic dystrophy that is sympathetically maintained pain syndrome, and not in patients with sympathetically independent pain.5 In addition, the time required for clonidine to take effect and its duration of action do not appear to follow those of a placebo, which tends to have an immediate onset of action and is short-lived.6 In contrast to the report by Davis et al.,1 the effects of clonidine appear to spread beyond the borders of the patch, and patients exhibit improved range of motion of their affected extremity.6 We have no clear explanation for this difference. However, physical therapy is an effective treatment in most cases of reflex sympathetic dystrophy. We could speculate that the decrease in hyperalgesia decreased the localized pain caused by stretching of the skin, which facilitated movement and caused a further decrease in hyperalgesia.6

In conclusion, application of the clonidine patch to the skin has been shown to be a relatively benign procedure with therapeutic potential. We hope that this report will serve as an impetus for further studies on topical clonidine and its role in the diagnosis and treatment of pain syndromes where sympathetically maintained pain syndrome is involved.

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Designing Legible Slides for National Meetings

To the Editor—Illegible slides remain a vexing problem for audiences at national meetings.1 Compared to an auditorium, relatively low ceilings limit the size of the projection screen in typical meeting rooms. The distance from the furthest seat to the projection screen as it relates to screen width (distance:width ratio) provides a useful measure for determining the character size necessary for slide legibility.2 To provide recommendations for slide preparation that would guarantee legible slides under conditions typical of a national meeting, we measured the dimensions of the meeting rooms at the American Society of Anesthesiologists' Annual Meeting held in Las Vegas, Nevada October 18–25, 1990.

We measured the width of the projection screen and the distance from the screen to the furthest seat in all rooms used for refresher course lectures, panel discussions, and scientific presentations. We prepared sample text slides produced with 42, 36, 30, and 24 point black Helvetica type on a white background using a 26 × 17-cm (10.25 × 6.75-inch) template on letter-size paper. The projected x-height (height of the lowercase letter "x") of each of the four point sizes on

<table>
<thead>
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<th>Point Size</th>
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<th>Maximum Lines per Slide</th>
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Table 1. Maximum Distance:Width Ratio as a Function of Type Size at which Legibility Can Be Maintained