Cally be easier to treat; since the hook prevents excess caudal movement, if the tube becomes dislodged, it should merely be advanced until gentle resistance to movement is felt, indicating that the carinal hook has been reseated. I found these tubes a bit more difficult to pass than the Broncho-Cath®, but not excessively so. Of course, a bronchoscope can still be used to confirm proper tube position. However, if a bronchoscope is not available, I believe this tube may offer an increased margin of safety when blindly positioning (or repositioning) a left-sided double-lumen tube.

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REFERENCES


(Accepted for publication April 1, 1988.)

In Reply:—Dr. Alfery suggests that the addition of a carinal hook to a left-sided double-lumen tube may protect against left upper lobe obstruction and may provide a solution to the problem of not having an appropriately sized fiberoptic bronchoscope for positioning double-lumen tubes. I have three difficulties with this line of reasoning. First, I believe that hospitals (however large) in which double lumen tubes are used should have a fiberoptic bronchoscope that fits down the lumens of double-lumen tubes. Second, the carinal hook is set approximately 8 mm proximal to the cephalad surface of the endobronchial balloon, thereby allowing an 8 mm deeper insertion into the left mainstem bronchus compared to having the cephalad surface of the left cuff just below the tracheal carina; this may increase the incidence of left upper lobe obstruction. Third, and as Dr. Alfery hinted, double-lumen tubes with carinal hooks are harder to insert. In summary, the best chance of not causing left upper lobe obstruction is to see the cephalad surface of the blue left cuff just below the tracheal carina with a fiberoptic bronchoscope.

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(Accepted for publication April 1, 1988.)

Anesthesiology
69:150–151, 1988

Is Coronary Vascular Reserve Really Not Affected by Volatile Anesthetics?

To the Editor:—Hickey et al.1 have recently described coronary blood flow autoregulation and coronary vascular reserve in dogs. The advantage of the study is, as the authors point out, that chronic instrumentation allowed determination of physiologic pressure/flow relationship in the coronary vasculature in normal, awake animals, which was then compared with recordings obtained during halothane, enflurane, and isoflurane anesthesia. However, several questions and a few reservations are raised with respect to their conclusions. The authors measured coronary reserve as the absolute increase in left circumflex coronary artery (LCCA) blood flow during adenosine infusion at a diastolic LCCA pressure of 40 mmHg. Using their mean values for baseline and peak flow during maximum coronary vasodilation (their tables 2, 3), I have calculated the ratio...