reservoir bag is suddenly halved. If a compliance loop, such as is available on the Datex AS3 is in use, the point is seen as a sudden halving of the compliance. The other frequent sign is a noticeable resistance to further advancement as the inflated cuff is too large to enter the left main bronchus. Once the point of the bronchial cuff plugging the left main bronchus is identified, the correct position can be easily achieved. The bronchial cuff is completely deflated and the tube advanced a distance equal to the length of the bronchial cuff plus a further centimetre to place it just beyond the carina. The bronchial cuff is then inflated to obtain a seal in the usual way. The same technique can be used with a right sided tube to place accurately a DLT with right bronchial profiled cuffs such as on the Mallinckrodt tube. It cannot be effectively used with right double tubes using two small cuffs such as the Sheridan to span the right upper lobe bronchus because the small cuffs cannot be inflated sufficiently in the trachea to ventilate both lungs effectively. This technique was originally reported in *Anaesthesia and Intensive Care* in 1992 (Russell WJ. A blind guided technique for placing double-lumen endobronchial tubes. *Anaesth Intensive Care* 1992; 20: 71-4) and a further explanatory letter was written on the techniques of detection in 1996 (Russell WJ. Further reflections on "A blind guided technique for endobronchial intubation" *Anaesth Intensive Care* 1996; 24: 123). With this technique, there is no need to use a fiberoptic bronchoscope to place or confirm the position if the left main bronchus has been clearly identified.

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REPLY

We appreciate Russell's comments and interest in our recent letter.¹ Several methods and manoeuvres have been described in the literature for the placement of double lumen endobronchial tubes.² Our method is a faster, practicable and simple way to decrease tube malposition, without changing the usual well-known technique. We regret that Russell's technique^{3,4} was not included in our references but it was not known to us at the time. We are glad to have the opportunity to spread the diffusion of his method.

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Pulmonary embolism and hydrogen peroxide

Pulmonary embolism during surgery is rare.¹⁻³ Recently, we witnessed a case of an unexpected air embolism due to hydrogen peroxide. A 53-yr-old women underwent bilateral pulmonary lobectomy. Preoperative evaluation was unremarkable. Anaesthesia was with general and epidural anaesthesia. Arterial and central venous lines were placed and resection of the two lobes was uneventful with no oxygenation problems.

At the end of the procedure, the open hemithoracic cavity was irrigated with 300 ml hydrogen peroxide. The fluid made a white foam as a reaction with peroxidase. A few seconds later the end-tidal CO₂ concentration decreased by half (4.5 to 2.2%), accompanied by haemodynamic instability, decrease in the oxygen saturation and changes in the ST segment of the ECG. The CVP was not recorded during the event.

Immediately, the patient was placed in a head-down position and rapid pharmacological intervention for hypotension and ventricular tachycardia was successfully performed with 35 mg ephedrine and 100 mg lidocaine. Symptoms disappeared within two minutes.

In this case, the timing of the symptoms with the use of irrigating fluid makes oxygen embolism very likely. How the gas was absorbed remains unclear, but most authors postulate that air entry occurs mainly in the surgical field.^{1,4} In our case, the right hemithoracic cage was nearly completely open with the lower lobe still collapsed.

When using hydrogen peroxide, administration into preformed body cavities should be avoided or made using only small volumes of peroxide.

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