range is $< 2.5\%$,⁴ since, according to an *in vivo* fibre-optic bronchoscopic study,² the probability of occurrence of a less-than-35-mm left main bronchus is > 2 SD from the mean.⁴

It should be remembered that the new technique frequently works at the expense of the margin of safety, and that, though proximal displacements predominate, distal malpositions also occur during the positional change to the lateral decubitus.⁵ We suggest that fibreoptic bronchoscopy should be performed through both the tracheal and bronchial lumen of a DLT to check the position, and repeated after lateral positioning.

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REPLY:

We thank Bahk et al. for their interest in and comments on our article.¹ Our results demonstrated that when using our new landmarks, the final position of left modified double-lumen tube (LM-DLT) seems better than with the classic positioning. We observed less need to reposition the LM-DLT proximally after turning the patient to the lateral decubitus. This technique is a reproducible and easy method to obtain these results.

Despite the fact that the vision is not always direct, we try to obtain the most perfect line of vision by curving the fibreoptic bronchoscope (FOB) as far as we can to visu-

TABLE Margin of safety of L-DLT

Tube	Position	MoS (mm)	Difference in mm
Conventional	classic	22	0
Modified	classic	25	+3
Modified	new	20	-2

Classic position is when the endobronchial is cuff just below the carina. New position is when the carina is midway between the endobronchial cuff and the black line.

Last column: the difference in mm between margin of safety relative to the conventional DLT in the classic position.

L-DLT = left double-lumen tube

alize the carina to assess the position of the LM-DLT following our landmarks. We would like to mention that Figure 3B of our publication is a schematic drawing and that the tip of the FOB should be deeper and curved in the LM-DLT to see the landmarks easily.

Our study found that the incidence of distal displacements and repositioning with our new technique is comparable to the classic technique. The new technique worked effectively at the expense of MoS (Table) but by only 2 mm. It seems quite acceptable to prevent difficult proximal repositioning of the LM-DLT after the patient has been turned laterally.

We agree with Bahk et al. that it is important to perform both tracheal and bronchial lumen FOB after the initial insertion and, mainly, through the bronchial lumen after lateral positioning, as was demonstrated in our study.

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Diagnosing endotracheal tube partial withdrawal vs cuff puncture

To the Editor:

Partial withdrawal of the endotracheal tube (ET) and cuff puncture are not rare occurrences.^{1,2} This *in vitro* study was performed to differentiate these two condi-