vide analgesia reliably and safely to the majority of our postoperative patients.

To recommend that "concentrations of bupivacaine > 0.06% are not warranted and should be abandoned in the delivery of postoperative epidural analgesia" is not based on sound evidence. Perhaps ropivacaine,¹⁰ with its motor sparing qualities, may offer some solution. Vigilance, frequent monitoring, titrated rather than constant infusions¹¹ and appropriate management of motor block should be an integral part of continuous epidural infusion care.

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Detecting endobronchial intubation during breast surgery

To the Editor:

A 69-yr-old lady (weight 79 kg, height 148 cm) was anaesthetised for breast reduction surgery. After induction, intubation, and the institution of mechanical ventilation, vital signs, recorded on a Datex AS3 monitor, were stable (see Table below). Breath sounds were normal and equal, so the low oxygen saturation was accepted, given her age, weight and smoking history. After 12 min, well into the dissection of the left breast, a decrease in oxygen saturation, increase in airway pressure, and decrease in compliance, all pointed to endobronchial intubation.

Before retracting the endotracheal tube, I wished to confirm the diagnosis by auscultation. However, all of the front and sides of the patient's chest were prepped and draped, and part of the surgical field.

Previously, the surgeon had discussed this as a hypothetical situation and the solution suggested was to place a stethoscope in a sterile bag. A clear plastic instrument pouch was provided by the scrub nurse, who positioned the stethoscope in each axilla. No breath sounds were heard on the left side, confirming the diagnosis. The endotracheal tube was pulled back 2 cm, breath sounds returned, and the vital signs returned to their previous values.

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TABLE

Time	SpO ₂ %	P _{ET} CO ₂ mmHg	Compliance ml·cmH ₂ O ⁻¹	PAirway cm H ₂ O	Heart bpm	BP mmHg
08:25	93	46	32	23	81	128/80
08:37	86	45	21	26	75	181/109
08:42	93	46	32	23	99	168/94