open cholecystectomy to saline or magnesium nebulization groups. The authors concluded that nebulized magnesium before the induction of anaesthesia is an effective method for decreasing the incidence of POST and are to be commended for presenting a novel prophylactic treatment for a familiar problem.

I would like to highlight the following issues regarding POST. As the authors discussed, POST is a common cause of patient dissatisfaction. However, it has been demonstrated previously that POST has several risk factors including female sex and younger patient age. Unsurprisingly, anaesthetic management has also been implicated. This goes beyond the airway device and design and includes airway suctioning and the use of succinylcholine.

Any randomized study evaluating a new therapeutic intervention should consider the multifactorial nature of POST in its design in order to increase the validity of its findings. This should include steps to extensively match not only patient factors but also the specific anaesthetic management in both the control and the treatment group.

**Declaration of interest**

None declared.

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**Reply from the authors**

Editor—We thank Dr McCarthy for this correspondence regarding our study. He is correct in stating that postoperative sore throat has several risk factors like female sex, younger age group, anaesthetic technique, airway device, use of succinylcholine, etc. In our study, the male:female ratio and age were comparable in both the groups. In both the groups, the anaesthetic technique was standardized and tracheal intubation was performed. Before extubation, suctioning was done under the direct vision to avoid trauma. We used vecuronium bromide, and not succinylcholine, in all patients. All patients in whom more than one attempt at tracheal intubation was needed were excluded from the study. We ensured that the tracheal tubes used were from the same company, and cuff pressure was maintained in a narrow range for all patients.

**Declaration of interest**

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**Use of the Aintree intubation and airway exchange catheters through LMA-ProSeal for double-lumen tube placement in a morbidly obese patient with right main stem bronchus tumour**

Editor—Anaesthesia literature is replete with respect to different lung isolation strategies in patients with a difficult upper airway. This is in contrast to the paucity of published reports on lung isolation in patients with lower tracheobronchial pathology. A review of literature indicated that in the majority of cases of iatrogenic traumatic endobronchial tumour dislocation, the outcome is fatal. We report a new approach for left double-lumen tube (DLT) placement in a patient with a difficult upper airway and a right main stem bronchus tumour.

A 31-yr-old morbidly obese female patient (BMI 41) was admitted to the Emergency Department with diabetic ketoacidosis, hypertension, and diminished air entry over the base of the right lung. After resuscitation, radiological investigations including computed tomography (CT)-guided biopsy and laboratory work-up suggested a diagnosis of a right lower lobe carcinoid tumour extending into the right main stem bronchus. The patient was undergoing right lower lobe sleeve resection and possible pneumonectomy. Difficult airway was suspected on preoperative assessment due to a short neck with limited extension and a Mallampati score class III.

The choice of DLT for lung isolation was based on the anatomical location of the bronchial tumour and the surgical intervention to perform sleeve resection. The primary objective of the airway and lung isolation plans was to reduce the possibility of accidental tumour injury by a misplaced left DLT.

Ranitidine 150 mg was given orally on the evening before and on the morning of surgery for aspiration prophylaxis. After the induction of anaesthesia using propofol, fentanyl, and rocuronium, direct laryngoscopy revealed a Cormack