Authors have nothing to disclose with regard to commercial support.

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opening of the DLT without employing pre-OLV apnea (lung collapse) would significantly impair the surgical field. Bussières and colleagues² used the BB after applying pre-OLV apnea. Blocking the opening of the DLT during the lung inflation state will slow lung collapse and be beneficial in terms of PaO₂ without doubt. Blocking the opening of the DLT after employing pre-OLV apnea is not known yet for its effect on PaO₂ and therefore needs to be compared with the contemporary method of leaving it open or our AOI technique for better oxygenation in future studies.

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THE MERIT OF OXYGEN INSUFFLATION DURING ONE-LUNG VENTILATION

Reply to the Editor:

Thoracic surgeons are often faced with patients who have hypoxemia during one-lung ventilation. An elegantly conducted randomized trial by Jung and colleagues¹ recently published in the *Journal* suggests that in patients with preserved lung function, low-flow insufflation of oxygen to the operative side during one-lung ventilation prevents hypoxemia. In this issue of the *Journal*, Grocott's letter to the Editor² comments on Jung and colleagues' trial¹ and suggests that by maintaining the lumen of the operative

side closed, the continued absorption of oxygen from the down lung would decrease the instances of hypoxemia during one-lung ventilation. Grocott² cites a randomized trial by Bussières and colleagues³ as a basis for his hypothesis. Grocott² also argues that a group in which the operative side of the double-lumen tube was closed to room air should have been included in the trial of Jung and colleagues.¹

This is an intriguing proposition, but it is unfortunately not supported by published data. Bussières and colleagues³ conducted a randomized trial comparing one-lung ventilation with a double-lumen tube or a bronchial blocker. The end point of the study was time to complete lung collapse during video-assisted lung resection. The trial showed that time to complete lung collapse was significantly shorter when a bronchial blocker was used for one-lung ventilation than when a double-lumen tube used. Bussières and colleagues³ did not address oxygen levels, nor did they provide any data on oxygen saturation during one-lung ventilation. In fact, 1 of their patients in the bronchial blocker group was excluded from analysis because of the inability to achieve proper oxygen saturation after initiation of one-lung ventilation. I respectfully disagree with Grocott.² The randomized trial by Jung and colleagues¹ was conducted in accordance with the best available evidence on one-lung ventilation. A third group would have obscured their findings and clouded their message. The big question regarding the trial of Jung and colleagues¹ is whether these findings will hold in patients with compromised lung function.⁴ Although the findings of Bussières and colleagues³ are important for teams involved in thoracoscopic lung resection, these concerns are not relevant to the trial of Jung and colleagues.¹

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