Non-anesthesiologist-administered Propofol is not Related to an Increase in Transcutaneous \( \text{CO}_2 \) Pressure During Flexible Bronchoscopy Compared to Guideline-based Sedation: A Randomized Controlled Trial

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**A R T I C L E   I N F O**

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**A B S T R A C T**

**Introduction:** Evidence for the use of non-anesthesiologist-administered propofol for sedation during flexible bronchoscopy is scarce. The main objective of this study was to determine whether non-anesthesiologist-administered propofol balanced sedation was related to higher transcutaneous \( \text{CO}_2 \) pressure compared with current guideline-based sedation (combination midazolam and opioid). Secondary outcomes were post-procedural recuperation time, patient satisfaction and frequency of adverse events.

**Methods:** In this randomized controlled trial we included data from outpatients aged 18 years or older with an indication for flexible bronchoscopy in a university hospital in northern Mexico. Ninety-one patients were included: 42 in the midazolam group and 49 in the propofol group. During 60 min of transcutaneous capnometry monitoring, mean transcutaneous \( \text{CO}_2 \) pressure values did not differ significantly between groups (43.6 [7.5] vs. 45.6 [9.6] mmHg, \( P=.281 \)). Propofol was related with a high Aldrete score at 5, 10, and 15 min after flexible bronchoscopy (9 [IQR 6–10] vs. 10 [9,10], \( P=.006 \); 9 [8–10] vs. 10 [IQR 9–10], \( P<.001 \) and 10 [IQR 9–10] vs. 10 [10], respectively) and with high patient satisfaction on a visual analogue scale of 1 (not satisfied) to 10 (very satisfied) (8.41 [1.25] vs. 8.97 [0.98], \( P=.03 \)). Frequency of adverse events was similar among groups (30.9\% vs. 22.4\%, \( P=.47 \)).

**Conclusion:** Compared with guideline-recommended sedation, non-anesthesiologist-administered propofol balanced sedation is not associated with higher transcutaneous \( \text{CO}_2 \) pressure or with more frequent adverse effects. Propofol use is associated with faster sedation recovery and with high patient satisfaction.

**Clinical trial registration:** NCT02820051.

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**R E S U M E N**

La administración de propofol por parte de no anestesiólogos durante la broncoscopia flexible no se relaciona con aumentos de la presión transcutánea de \( \text{CO}_2 \), en comparación con la sedación según las pautas: ensayo controlado aleatorizado

**Palabras clave:** Broncoscopia  
Sedación consciente  
Hipoventilación  
Midazolam  
Bienestar del paciente  
Propofol

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Introduction

Flexible bronchoscopy (FB) is a fundamental procedure in respiratory medicine. Although FB can be performed safely without sedation, 80% of patients prefer sedation during the procedure. Currently, sedation and analgesia are considered the standard of care in patients without contraindication for its administration. Although midazolam is recommended for sedation in most guidelines, propofol has gained popularity, mainly due to its short recovery time. However, evidence for propofol use during FB is scarce, especially when it is not administered by anesthesiologist.

Respiratory depression is a major concern during respiratory endoscopy. While SO₂ monitoring is performed in all patients undergoing FB, CO₂ monitoring is less common. For many years, CO₂ measurement required an arterial blood sample; however, it can now be monitored with transcutaneous capnometry. The transcutaneous pressure of CO₂ (TcPCO₂) is well correlated with PaCO₂, and several authors have used transcutaneous capnometry in patients undergoing different sedation protocols for endoscopic procedures; however, there is little evidence on TcPCO₂ changes in patients sedated with midazolam or propofol who have received concomitant intravenous opioids (e.g., balanced sedation).

In this randomized controlled trial, we evaluated ventilation response measured by transcutaneous capnometry in adult patients undergoing ambulatory FB who received non-anesthesiologist-administered propofol (NAAP) balanced sedation, and compared it with guideline-recommended sedation consisting of combination midazolam and opioid. Our primary outcome was to assess difference between groups in TcPCO₂ values during and after FB. We hypothesized that TcPCO₂ values would not be higher in patients who received NAAP balanced sedation. Secondary outcomes were procedural recovery time measured using the Aldrete scale, patient satisfaction, and frequency of adverse events.

Materials and Methods

Patients and Procedures

Between February and July 2014, we prospectively included ambulatory patients >18 years of age with an indication for FB. Bronchoscopy procedures were performed by respiratory and critical care medicine residents under the supervision of an associate professor in a tertiary-referral university hospital in northern Mexico. Patients with tracheostomy, known allergy to study drugs, psychiatric illness, pregnancy, American Society of Anesthesiologist physical status class IV or V, or capnometry sensor dysfunction were excluded.

Patients were assigned by block randomization to receive midazolam or propofol. In the midazolam group the initial dose was 0.05 mg/kg, and in the propofol group the starting dose was 0.1 mg/kg. Additional doses of the corresponding drug (2 mg of midazolam or 10 mg of propofol) were permitted to obtain a score of 3 to 4 on the observer’s assessment of alertness/sedation scale. All patients received nalbuphine at a starting dose of 2 mg with additional doses of 1 mg if necessary. Lidocaine spray was applied to the pharynx and also to the nasal mucosa when bronchoscope was inserted through a nostril. Endobronchial topical lidocaine was applied using the spray-as-you-go technique, at a maximum dose of 7 mg/kg. Sedation and analgesia were prescribed by the resident responsible for conducting FB and administered by an auxiliary nurse without the support of an anesthesiology specialist.

TcPCO₂ measurement was carried out with the SenTec digital monitoring system (Artemis Medical, Kent, London) by applying a Stow–Severyinghaus (V-Sign sensor) type sensor in the ear lobe. We monitored TcPCO₂ for 1 h from the start of FB, and recorded TcPCO₂ values every 5 min for the first 20 min and every 10 min up to 60 min. All patients received supplementary oxygen and were monitored with periodic non-invasive blood pressure measurements, continuous electrocardiogram, and SO₂ surveillance.

Residual sedation was measured on the Aldrete scale at 5, 10, and 15 min after FB. At the time of discharge from the bronchoscopy suite, satisfaction was assessed using a visual analog scale of 1 (not satisfied) to 10 (very satisfied). One investigator, blinded to the patient’s study group, recorded all procedural data. The bronchoscopist was blinded to TcPCO₂ values.

Sample Size and Statistical Analysis

The sample was calculated for alpha 0.05, beta 0.20, standard deviation of 7.3, minimum TcPCO₂ difference to detect of 5 mmHg, estimated loss to follow-up of 0.20, and two-tailed analysis. According to the above, the sample size was 42 patients per group.

We tested normal distribution with the Kolmogorov–Smirnov test. Data are shown as means and standard deviation for variables with normal distribution, and as median and interquartile range for non-normal variables. We used the t-test, the Mann–Whitney U-test, ANOVA, or chi-square as indicated. We defined a statistically significant difference as a P value <0.05. The analysis was performed using SPSS version 18.0 for Windows (SPSS Inc., Chicago, IL).

Ethical Considerations

All participating physicians received formal training in procedural sedation with propofol from professors of the UANL
University Hospital's Anesthesiology Department before the start of the trial. All residents were certified by the American Heart Association in Advanced Cardiopulmonary Life Support. The study was approved by the narcotics and ethics committees of the UNAL University Hospital (registration number NM13-009). All patients provided informed consent.

Results

We included 91 patients, 42 (46.1%) in the midazolam group and 49 (53.8%) in the propofol group. The process of inclusion and randomization is shown in Fig. 1. There were no statistically significant differences between groups with respect to age, sex, comorbidities, indication for endoscopic study, bronchoscopy insertion route, additional bronchoscopy procedures, or duration of FB (Table 1).

The mean dose of midazolam and propofol was 5.5 (2.2) and 122 (67.7) mg, respectively. The dose of nalbuphine was similar between groups (3 [IQR 2–4] vs. 2 [IQR 2–4] mg, P=.898).

There were no statistically significant differences between groups in mean TcPCO2, minimum or maximum TcPCO2, increase in TcPCO2 (maximum TcPCO2–minimum TcPCO2), patients with TcPCO2 above 50 mmHg, mean SO2, episodes of SO2 less than 90%, or mean arterial pressure or heart rate (Table 2). TcPCO2 did not differ at any time during or after FB (Table 3).

Duration of FB was significantly longer in the 31 patients in whom procedures additional to bronchoalveolar lavage were performed (24.4 [5.8] vs. 14.8 [7.6] min, P<.001). In these patients, TcPCO2 levels (43.62 [7.43] vs. 45.61 [9.56] mm Hg, P=.27), maximum TcPCO2 (47.50 [8.46] vs. 50.35 [12.15] mm Hg, P=.20) and TcPCO2 increase (8.31 [5.59] vs. 9.84 [8.17] mm Hg, P=.30) did not differ between groups.

There were no statistically significant differences in mean TcPCO2 between patients sedated by residents in their first, second, or third year of residency (44.81 [8.76], 42.47 [7.91] and 49.45 [8.88] mmHg, respectively; P=.091).

The most common side effect during the procedure was bronchospasm, in 15 (16.4%) patients; there were no statistically significant differences between groups (8 [19%] vs. 7 [14.2%]) patients, P=.540). Other complications were respiratory depression, in 2 (2.2%) patients (1 [2.4%] vs. 1 [2%] patient, P=1.0), and hypotension corrected after intravenous fluids, in 7 (7.7%) patients (4 [9.5%] vs. 3 [6.1%] patients, P=.699). Composite adverse effects were similar between groups (13 [30.9%] vs. 11 [22.4%] events, P=.44). No adverse effects led to the suspension of FB or resulted in hospitalization. Neither phlebitis nor major arrhythmia were observed in any patient.

The propofol group reported a higher Aldrete residual sedation score at 5, 10 and 30 min after completion of FB (9 [IQR 6–10] vs. 10 [9.10], P=.006; 9 [8–10] vs. 10 [IQR 10–10], P<.001 and 10 [IQR 9–10] vs. 10 [10] points, P=.005, respectively). A larger proportion of patients in the propofol group reported a score of 9 or more at 5, 10, and 15 min (24 [57.1%], 29 [69%] and 33 [78.5%] vs. 42 [85.7%], 47 [95.9%] and 48 [97.9%], respectively, P<.05 for all comparisons).

Satisfaction with the procedure was higher in the propofol group (8.41 [1.25] vs. 8.97 [0.98], P=.03).

Discussion

Non-anesthesiologist-administration of propofol is controversial. However, its use in the field of digestive endoscopy has increased, and the necessity of an attending anesthesiologist during the procedure has been questioned due to the elevated cost this involves. Anesthesiologists, meanwhile, are concerned that adverse effects will increase if sedation is not administered by a specialist. In Europe, NAAP during digestive endoscopy is regulated by the joint guidelines of the European Society of Anesthesiology in conjunction with the European Society of Gastrointestinal Endoscopy and the European Society of Gastroenterology and Endoscopy Nurses and Associates. However, this document is far from being a solution to the NAAP controversy, as at least 21 medical societies in Europe do not agree with those recommendations. In pulmonary medicine, evidence on NAAP is still limited, and to the best of our knowledge there are no specific guidelines for the use of NAAP during FB. Bosslet et al. reported their experience in a university hospital where NAAP guided by trained
Table 1
Demographic and Clinical Data. Data are shown as Number and Percentage or Mean and Standard Deviation, as required.

<table>
<thead>
<tr>
<th></th>
<th>All patients (n=91)</th>
<th>Midazolam group (n=42)</th>
<th>Propofol group (n=49)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years</td>
<td>48.7 (16.2)</td>
<td>51.1 (16)</td>
<td>46.6 (16.3)</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>61 (67)</td>
<td>28 (66.7)</td>
<td>33 (67.3)</td>
<td></td>
</tr>
<tr>
<td>Comorbidities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>1 (1.1)</td>
<td>1 (2.4)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Chronic nephropathy</td>
<td>4 (4.4)</td>
<td>2 (4.8)</td>
<td>2 (4.1)</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>8 (8.8)</td>
<td>6 (14.3)</td>
<td>2 (4.1)</td>
<td></td>
</tr>
<tr>
<td>HIV infection</td>
<td>11 (12.1)</td>
<td>4 (9.5)</td>
<td>7 (14.3)</td>
<td></td>
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<tr>
<td>Interstitial pneumonia</td>
<td>5 (5.5)</td>
<td>1 (2.4)</td>
<td>4 (8.2)</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>6 (6.6)</td>
<td>4 (9.5)</td>
<td>2 (4.1)</td>
<td></td>
</tr>
<tr>
<td>FB indication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemothysis</td>
<td>5 (5.5)</td>
<td>3 (7.1)</td>
<td>2 (4.1)</td>
<td></td>
</tr>
<tr>
<td>Lung infection suspicion</td>
<td>57 (62.6)</td>
<td>26 (61.9)</td>
<td>31 (63.3)</td>
<td></td>
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<tr>
<td>Cancer suspicion</td>
<td>16 (17.6)</td>
<td>8 (19)</td>
<td>8 (16.3)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>13 (14.3)</td>
<td>5 (11.9)</td>
<td>8 (16.3)</td>
<td></td>
</tr>
<tr>
<td>Oral Bronchoscope insertion route</td>
<td>82 (90.1)</td>
<td>40 (95.2)</td>
<td>42 (85.7)</td>
<td></td>
</tr>
<tr>
<td>Bronchoscopy procedure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAL</td>
<td>60 (65.9)</td>
<td>31 (73.8)</td>
<td>29 (59.2)</td>
<td></td>
</tr>
<tr>
<td>BAL and additional procedure</td>
<td>31 (34.1)</td>
<td>11 (26.2)</td>
<td>20 (40.8)</td>
<td></td>
</tr>
<tr>
<td>Duration of FB, minutes</td>
<td>16.2 (9.6)</td>
<td>15.2 (10.4)</td>
<td>16.9 (8.9)</td>
<td></td>
</tr>
</tbody>
</table>

Table 2
Transcutaneous PCO2 Pressure and Vital Signs During Flexible Bronchoscopy by Sedation Group.

<table>
<thead>
<tr>
<th></th>
<th>All patients (n=91)</th>
<th>Midazolam group (n=42)</th>
<th>Propofol group (n=49)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean TaPCO2, mmHg</td>
<td>44.7 (8.7)</td>
<td>43.6 (7.5)</td>
<td>45.6 (9.6)</td>
<td>.281</td>
</tr>
<tr>
<td>TaPCO2 increase (max-min), mmHg</td>
<td>7 (4–10)</td>
<td>8 (4–10.2)</td>
<td>6 (4–10.5)</td>
<td>.737</td>
</tr>
<tr>
<td>Max TaPCO2, mmHg</td>
<td>49.1 (10.8)</td>
<td>47.5 (8.5)</td>
<td>50.3 (12.3)</td>
<td>.210</td>
</tr>
<tr>
<td>Min TaPCO2, mmHg</td>
<td>39.9 (8.1)</td>
<td>39.2 (7.1)</td>
<td>40.5 (8.8)</td>
<td>.439</td>
</tr>
<tr>
<td>TaPCO2&gt; 50 mmHg, n (%)</td>
<td>30 (33)</td>
<td>14 (33.3)</td>
<td>16 (32.7)</td>
<td>.945</td>
</tr>
<tr>
<td>SO2 mean, %</td>
<td>95.3 (2.3)</td>
<td>95.3 (2.6)</td>
<td>94.7 (2.9)</td>
<td>.898</td>
</tr>
<tr>
<td>SO2&lt; 90%, n (%)</td>
<td>27 (19.7)</td>
<td>12 (28.6)</td>
<td>15 (30.6)</td>
<td>.832</td>
</tr>
<tr>
<td>MAP, mmHg</td>
<td>90.7 (12.6)</td>
<td>90.0 (14.4)</td>
<td>91.4 (11.0)</td>
<td>.686</td>
</tr>
<tr>
<td>HR, bpm</td>
<td>96.2 (17.3)</td>
<td>95.0 (15.2)</td>
<td>97.3 (18.9)</td>
<td>.542</td>
</tr>
</tbody>
</table>

Table 3
Transcutaneous CO2 Pressure at Different Time Intervals.

<table>
<thead>
<tr>
<th></th>
<th>All patients (n=91)</th>
<th>Midazolam group (n=42)</th>
<th>Propofol group (n=49)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>TaPCO2 at 0 min, mmHg</td>
<td>40.4 (7.8)</td>
<td>39.4 (7.2)</td>
<td>41.3 (8.5)</td>
<td>.260</td>
</tr>
<tr>
<td>TaPCO2 at 5 min, mmHg</td>
<td>42.7 (8.4)</td>
<td>41.3 (7.3)</td>
<td>44.1 (9.1)</td>
<td>.122</td>
</tr>
<tr>
<td>TaPCO2 at 10 min, mmHg</td>
<td>44.6 (8.8)</td>
<td>43.3 (8.1)</td>
<td>45.8 (9.4)</td>
<td>.205</td>
</tr>
<tr>
<td>TaPCO2 at 15 min, mmHg</td>
<td>46.2 (9.15)</td>
<td>44.8 (8.5)</td>
<td>48.4 (9.4)</td>
<td>.086</td>
</tr>
<tr>
<td>TaPCO2 at 20 min, mmHg</td>
<td>48.8 (11.5)</td>
<td>46.3 (9.5)</td>
<td>51.1 (13.1)</td>
<td>.095</td>
</tr>
<tr>
<td>TaPCO2 at 30 min, mmHg</td>
<td>51.1 (11.9)</td>
<td>47.1 (10.1)</td>
<td>52.3 (13.1)</td>
<td>.138</td>
</tr>
<tr>
<td>TaPCO2 at 40 min, mmHg</td>
<td>49 (10.1)</td>
<td>48.2 (9.1)</td>
<td>49.7 (11.1)</td>
<td>.696</td>
</tr>
<tr>
<td>TaPCO2 at 50 min, mmHg</td>
<td>48.6 (11.8)</td>
<td>50.7 (7.3)</td>
<td>47.2 (14.6)</td>
<td>.666</td>
</tr>
<tr>
<td>TaPCO2 at 60 min, mmHg</td>
<td>41.6 (12.7)</td>
<td>49 (7.6)</td>
<td>33 (15.5)</td>
<td>.667</td>
</tr>
</tbody>
</table>

Data are shown as mean and standard deviation. TaPCO2: transcutaneous CO2 pressure.

The dose of midazolam and propofol in the present study was lower than that used in protocols without concomitant opioid analgesia16,17,18 and is concordant with studies in which opioid use was permitted.9,19 The practice of adding opioids to propofol is not without its detractors; Yoon et al. comparing alfentanil...
plus propofol vs. propofol alone, found no benefit in terms of cough frequency or patient and bronchoscopist satisfaction.\textsuperscript{20} Stolz et al. found no satisfaction differences in patients sedated with midazolam and hydrocodone vs. propofol without an opioid; however, in their study the propofol group presented higher cough frequency.\textsuperscript{18} Finally, Clark et al. noted that propofol was better tolerated than midazolam during FB without transbronchial biopsy; they did not use opioids in any group.\textsuperscript{21} In our opinion, administration of opioids during FB sedation reduces sedation requirements. In our trial, we found no evidence of an increased incidence of hypoventilation among patients who received combination propofol plus opioid.

To the best of our knowledge, there is no firm evidence linking a particular FB sedation protocol with a higher risk of complications. In the first randomized controlled trial of midazolam and opioid vs. propofol, Stolz et al. did not find a higher complication frequency between groups; this is also true for patients with chronic obstructive pulmonary disease.\textsuperscript{18} Propofol has been related with a lower incidence of hypertension and tachycardia.\textsuperscript{13} However, in our trial we did not observe significant differences in this regard. Oztruk et al. observed an increased frequency of major arrhythmias during FB in patients who received midazolam or propofol (8% and 12%, respectively).\textsuperscript{17} We did not observe major arrhythmia episodes in our study, a finding that is consistent with other authors.\textsuperscript{22,23}

Recovery time after procedural sedation is an issue to consider. In the present study, patients in the propofol group had a higher Aldrete post-anesthetic recovery score. This is consistent with findings reported in the literature. A faster recovery time is one of the less controversial benefits of propofol sedation, and has even been documented in geriatric patients with hypoalbuminemia receiving sedation due to regional anesthesia for orthopedic surgery.\textsuperscript{24} Propofolis also superior to benzodiazepines in improving cognitive recovery. Despite the subjective feeling of alertness, cognitive deficit is present up to 3.5 h after midazolam administration, even when patients had received flumazenil for sedation reversion.\textsuperscript{25} In contrast, patients sedated with propofol show faster improvement in cognition response.\textsuperscript{26} We did not perform a formal cognitive evaluation; however, a significantly greater proportion of patients scored at least 9 points on the Aldrete scale at 5, 15, and 30 min after propofol sedation, indicating faster global recovery after the procedure. It is important to mention that a higher total Aldrete score was mainly due to higher motor activity and conscience domain scores, while respiration and circulation domain scores did not differ between groups.

The economic impact of FB sedation is also worth examining. As far as we know, no formal cost analysis comparing propofol with midazolam has been published; however, at least one study found the cost of propofol sedation protocol to be higher.\textsuperscript{15} The higher cost of propofol must be compensated by potential savings in resources, i.e., faster post-procedural recuperation time and no anesthesiologist. Finally, we eliminated 11 (10.7%) patients from the analysis due to TcPCO\textsubscript{2} sensor problems. This proportion of technical failures was higher than the 7.2% described by Heuss et al. in 2012.\textsuperscript{9}

This study has several limitations: (1) it was not blinded. Despite the fact that the investigator recording the information was blinded to the specific drug used during sedation, we cannot rule out bias caused by the bronchoscopist’s knowledge of the study group arm. (2) All patients were ambulatory, with low or intermediate anesthetic risk. In accordance with current recommendations, NAAP is not indicated in high-risk patients. (3) As oral bronchoscopy insertion is associated with faster vocal cord visualization, less use of lidocaine, and no insertion failure,\textsuperscript{27} this is the route of choice for FBs in our center. (4) In our bronchoscopy service, nalbuphine is the only opioid available, therefore, our results cannot be extrapolated to other opioids. (5) All our residents were board-certified specialists in internal medicine and, as part of the Pulmonary and Critical Care sub-specialization program, had been trained in propofol use; consequently, when health specialists with other educational profiles perform NAAP, the outcomes might be different. (6) Finally, as in normal clinical practice, the role of the supervising physician during FB was merely to monitor correct execution of the procedure and provide support in case of complications that cannot be handled by residents. He was not required to intervene in any of the 91 endoscopic studies; however, the supervised environment of a university hospital can increase the safety of NAAP.

In conclusion, the results of this randomized controlled trial suggest that compared with current guideline-based recommendations, NAAP balanced sedation is not related to higher TcPCO\textsubscript{2} levels or a significant incidence of adverse events during or after FB when administered by pulmonary medicine and critical care residents. Propofol also seems to be associated with faster post-sedation recovery and greater patient satisfaction. Additional randomized trials, preferably double-blinded studies, are required to assess the efficacy and safety of this sedation strategy.

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**Authorship**

JEG had full access to all the data in the study, takes responsibility for the integrity of the data and the accuracy of the data analysis, particularly any adverse effects, and assumes full responsibility for the integrity of the submission as a whole, from inception to published article. CA, JEG, JT, RM contributed substantially to the study design, data analysis and interpretation, and the drafting of the manuscript.

**Conflict of Interest**

The authors declare that they have no conflict of interest.

**Acknowledgments**

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**References**


