

Introduction

The fiberopticbronchoscope introduced by Ikeda, has become a versatile tool in pulmonary medicine and has gained wide acceptance over the recent years because its advantages of superior visualization,ease of application compared to rigid bronchoscope(**Weinberger and Drazen, 2005**).

Lidocaine is the most widely used substance as at topical anesthetic in the respiratory tree during bronchoscopy, the maximum dose of lidocaine during bronchoscopy should be limited to 8.2 mg per kg of body weight, with the total dosage any way not exceeding 600mg(**Langmack and Martin, 2000**).

The appearance of hypoxemia is a fairly frequent phenomenon in the course of a bronchoscopy (**Dubrwsky et al., 1975**).

Cardiovascular complications are well known to occur during fiberoptic bronchoscopy as a result of premedication, topical anesthetic and the hypoxemia engendered during the procedure (**Davis et al., 1997**).

Direct tracheal stimulation is the primary cause of cardiovascular response during bronchoscopy(**Xue et al., 2006**).

The cardiovascular changes are of little consequence in patients with normal cardiovascular function but in patients with pre-existing hypertension, coronary heart disease or in elderly patients with accompanying lung disease (*Credle et al., 1974*).

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