problems may occur with the integrity of the tube. In this case the integrity of the cuff-pilot balloon system was verified twice, the lack of cuff herniation was also visually confirmed. The ease with which a seal was obtained with the second tube rules out the possibility of tracheomalacia. To our knowledge this is the first time this type of problem with a tracheal tube has been encountered. Certainly when an unexplained leak is present, the integrity of the tracheal tube must be questioned. The tube should be changed and closely examined for any defects in the wall.

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Avoiding unintentional arterial cannulation

To the Editor:

Anaesthetists should be able to access the central circulation consistently and rapidly. The incidence of carotid artery puncture during internal jugular cannulation is approximately four per cent. Diagnosis may be difficult in the patient with hypovolaemia, hypoxaemia or impaired left ventricular function. Residual local anaesthetic in the finder needle syringe may give aspirated blood a bright red colour, further confusing the picture. Avoidance of arterial cannulation is crucial for patients with coagulopathies, planned heparinization or anatomical difficulty in applying direct pressure (i.e., subclavian artery). We describe a rapid, simple technique to verify venous catheter insertion.

A sterile Novex "K53" stopcock/tubing extension (Pharmaseal®) is attached to the 18 SWG needle or catheter prior to inserting the J-wire and introducer sheath. If the vein is cannulated, the tubing will fill and empty by gravity when lowered and raised (Figure). Although we have not found it necessary, the system can be transduced as recommended by Jobes *et al.*¹ We have used this technique without complications for cannulation of the internal jugular, subclavian and femoral veins in

FIGURE "K53" attached to 18 SWG catheter. The venous blood fills and empties by gravity when lowered and raised.

both adult and paediatric patients. It is an integral training tool in our residency program.

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The opinions or assertions contained herein are the private views of the authors and are not to be construed as reflecting the views of the Department of the Army or the Department of Defense.

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Different mechanisms may mediate anaesthesia and analgesia

To the Editor:

Cohen in his recent paper has shown that whilst anaesthesia produced by nitrous oxide can be reversed by compression this is not the case for analgesia caused by the gas.¹ He has concluded from this work that his data