geal mask during emergence from anaesthesia. *Anaesthesia* 1998; 53: 540-4.

- 3 Nair I, Bailey PM. Use of the laryngeal mask for airway maintenance following tracheal extubation (Letter). *Anaesthesia* 1995; 50: 174-5.
- 4 Glaisyer HR, Pany M, Lee J, Bailey PM. The laryngeal mask airway as an adjunct to extubation on the intensive care unit (Letter). *Anaesthesia* 1996; 51: 1187-8.
- 5 Costa e Silva L, Brimacombe JR. Tracheal tube/laryngeal mask exchange for emergence (Letter). *Anesthesiology* 1996; 85: 218.
- 6 Asai T. Use of the laryngeal mask during emergence from anaesthesia (Letter). *Eur J Anaesthesiol* 1998; 15: 379-82.

REPLY:

We thank Dr Asai for his interest in our paper.¹ We would like to make the following points.

First, we submitted our paper to the *Canadian Journal of Anesthesia* in March 1998 before Dr Asai's paper² was published in June 1998. He was, therefore not cited in our work. Second, Dr Asai's "novel" idea of placing a laryngeal mask airway before tracheal extubation has been in common use at our institution, the Royal National Throat Nose and Ear Hospital since 1994.

Furthermore, it is interesting that Dr Asai notes the similarities between the photographs in both articles. Our photographs were presented by the senior author (PMB) at Dr. Asai's institution, University Hospital Cardiff, in December 1995.

Daryl P. Dob FRCA
Paul M. Bailey FRCA
London, United Kingdom

References

- 1 Dob DP, Shannon CN, Bailey PM. Efficacy and safety of the laryngeal mask airway vs Guedel airway following tracheal extubation. *Can J Anesth* 1999; 46: 179-81.
- 2 Koga K, Asai T, Vaughan RS, Latto IP. Respiratory complications associated with tracheal extubation. Timing of tracheal extubation and the use of the laryngeal mask during emergence from anaesthesia. *Anaesthesia* 1998; 53: 540-4.

Misleading end-tidal CO₂ tensions

To the Editor:

I have recently read the article by Drs. Wahba and Tessler¹ and there is an important error in Figure 1. The triangle representing the gradient of ventilation is inverted: they indicate that ventilation is higher at the

apex and lower at the base but the reverse is the correct situation.

Both ventilation and perfusion are higher at the base and lower at the apex but the $\dot{V}/\dot{Q}$ ratio is higher at the apex because the perfusion gradient is steeper than the ventilation gradient.

Kerry Brandis FANZCA
Queensland, Australia

Reference

- 1 Wahba RW, Tessler MJ. Misleading end-tidal CO₂ tensions. *Can J Anaesth* 1996; 43: 862-6.

REPLY:

It is, of course, gratifying for us that our article is still being read three years after publication.

The arrow indicating the directional change in $\dot{V}/\dot{Q}$ shows that the latter increased up the lung. The triangles were meant to depict alveolar size and perfusion head at rest i.e. FRC. Apical units are largest at FRC and expand comparatively little with breathing. Their contribution to expired CO₂ thus is also smaller. That was the intended message.

Richard Wahba MD FRCPC
Michael Tessler MD FRCPC
Montréal, Québec

Every endotracheal tube needs a Murphy eye!

To the Editor:

The Murphy eye is a hole at the tip of the endotracheal tube to prevent tube obstruction if the beveled end of the tube is obstructed by mucus or sealed by contact with the tracheal wall.¹ All endotracheal tubes have the Murphy eye except for some spiral tubes. We encountered complete tube obstruction when we used a J-shaped endotracheal spiral tube (JSETST) without a Murphy eye.

A 60-yr-old man underwent radical neck resection. We inserted a JSETST (ø-con, Fuji systems, Tokyo, Japan) into the trachea via the tracheostomy. Two hours later, we suddenly could not ventilate the lungs because the beveled end of the tube was obstructed by the dorsal tracheal wall as the surgeon accidentally pulled the tube by the elbow (Figure 1).

Because the JSETST has a coil in its soft silicone wall, part of the tube stands in the tracheal cavity. The JSETST's beveled end is cut at a right or narrow