FIGURE Trans-tracheal jet ventilation setup including: 14 gauge *in* catheter, 3 cc Becton-Dickinson syringe with plunger removed, 15 mm endotracheal tube connector from 7.5 endotracheal tube, 90 elbow with gas monitoring port, oxygen tubing, and 15 mm endotracheal tube connector from 4.0 endotracheal tube (if using common gas outlet).

and subsequent subcutaneous emphysema is the most commonly reported complication of this procedure.⁵

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Central venous catheters for craniotomies

To the Editor:

Although their case report discusses inotropic therapy for venous air embolism (VAE), Archer *et al.* do not explain why they did not place a central venous catheter (CVC).¹ Meningiomas are vascular tumours, and the parasagittal location suggests that the sinus might be involved. Also, the patient's head was elevated 15°. Given the circumstances, the likelihood of VAE seems high enough to warrant a multi-orifice CVC,² although both the indications for and efficacy of CVCs remain controversial. As the authors cited, Maurice Albin believes that anesthesiologists underestimate the frequency and significance of VAE (? as evidenced by this case).³ If the authors could explain their rationale, it might help others in deciding when to place CVCs for craniotomies.

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REPLY:

We thank Dr. Allen for his helpful and well-founded comments. It is certainly true that some of the features of the case that we presented favour insertion of a central venous catheter (CVC). However, the decision to do so is a clinical one based upon the information available at the time. In the present case, the insertion of a CVC was not considered to be indicated. By presenting this case, we in no way wish to question the insertion of CVC's for aspiration of air, but simply to draw attention to another possible treatment strategy that may be helpful.

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