over two years, we have been using an alternative protocol that we think is worth sharing:

- 1 Parents apply EMLA® cream to their child's hands one hour before the procedure.
- 2 The child receives 0.75 mg·kg⁻¹ midazolam *po* 30 min before the procedure.
- 3 The child sits on the parent's lap for the procedure while breathing room air. The usual paediatric monitors are applied. Oxygen and resuscitation equipment are always available.
- 4 The anaesthetist removes the EMLA®, inserts a 24 G intravenous cannula in the hand and gives 0.01 mg·kg⁻¹ glycopyrrolate with 2 mg·kg⁻¹ ketamine.
- 5 The dermatologist proceeds with the ablation. Usually only a single bolus of ketamine is required for a treatment session. Repeated 1 mg·kg⁻¹ boluses of ketamine are occasionally required for a large lesion. If intravenous access is unsuccessful, the anaesthetist reverts to an *im* injection of 5 mg·kg⁻¹ ketamine with 0.01 mg·kg⁻¹ glycopyrrolate.
- 6 At session's end, the patient is transported to the recovery room with mask oxygen, a pulse oximeter and Ambu® bag.

Intravenous ketamine has not caused apnoeas in our patients. Oxygen saturations have been constantly 97–100%. Others using propofol by infusion with fentanyl boluses admit to frequent episodes of apnoea requiring intervention.² Our patients receiving *iv* ketamine recover quickly and are usually discharged within one hour of their recovery room admission. Patients requiring *im* ketamine take longer to wake.

Children with seizures still receive general anaesthesia. However, for the majority of our children with port-wine stains, boluses of *iv* ketamine have eliminated the need for general anaesthesia with all its attendant risks and costs.

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Do "Venflon" sideport valves leak?

To the Editor:

Syringes can become contaminated with blood when used to inject into intravenous giving sets,¹ but can injections into the sideport of a "Venlon" intravenous cannula (BOC Ohmeda AB, Helsingborg, Sweden) result in similar syringe contamination?

We studied three groups of "Venlons". These were inserted into silastic tubing containing 5 mmol·L⁻¹ saline, filled by aspiration, and then capped. Then, 2 ml ultrapure water (resistivity, 18 MOhms) were injected through the sideport from a

FIGURE Scattergram of sodium concentration (mean of two estimates) in the 5 ml of ultrapure water after washing the syringe tip.

syringe whose tip was then washed in a further 5 ml ultrapure water. This water was then analysed for sodium by atomic emission spectrophotometry. In the Control Group the tubing contained ultrapure water, and in the Blank Group the 5 ml aliquots of ultrapure water were tested for sodium. The sodium concentrations ($\mu\text{mol} \cdot \text{L}^{-1}$) in each group are plotted as a scattergram (Figure) and recorded as median and (interquartile range) below:

Blank group 0.35 (0.30–0.40)

Control group 0.30 (0.05–0.60)

Study group 0.50* (0.50–1.25)

Sodium concentrations near $10 \mu\text{mol} \cdot \text{L}^{-1}$ were recorded in the Study Group in 9% of trials. If this sodium resulted from reflux through the sideport valve, the volume of saline involved would have been about 0.01 μl . A similar volume of blood is involved in the needlestick injury, which carries a risk of transmitting infection (e.g., hepatitis B and HIV).^{2,3}

Although blood behaves differently from saline, this study provides evidence that syringes may become contaminated with blood after injection into such sideports.

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*Significant differences between control and study groups at $P < 0.01$ using Mann-Whitney test.