reasoning, however, lies with the incorrect assumption that laryngeal view is the sole factor governing success or failure. In fact, intubation is a highly complex technical procedure requiring the correct sequencing of many interdependent elements.

Other concepts as equally important as laryngoscopy have never been considered. These include: contour of the laryngoscopic channel, shape of the endotracheal tube and its direction of travel within the airway, controlled guidance of the endotracheal tube tip, and identifying when the endotracheal tube enters the larynx.²

The ultimate goal is to develop an improved technique of intubation that incorporates all rules governing tracheal intubation, and when used routinely, turns most intubations, previously considered difficult, into simple ones. Prevention is still the best treatment, and any change in routine intubation that increases first-attempt tracheal tube placement in most patients with grade 3 and many with grade 4 laryngeal views is worthy of serious consideration.

I take the liberty to expand upon Dr. J. Davies' closing editorial comments.³ Now is the time to broaden our thinking about the current practice of tracheal intubation, to scientifically study all aspects of the intubation process, and to critically evaluate the benefits of new techniques that incorporate all principles governing tracheal intubation.

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- 2 *Stasiuk RB*. Improving styletted oral tracheal intubation: rational uses of the OTSU. *Can J Anesth* 2002; 48: 911–8.
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Abnormal end-tidal CO₂ waveforms

To the Editor:

The publication of the letter "A bizarre end-tidal carbon dioxide waveform"¹ now represents the third discovery of the relationship between a loosely fitting distal end of a CO₂ sampling line and a biphasic capnograph.^{2,3} Indeed, the relationship between the degree of loose fit of the sampling line and degree of abnormality of waveform has been quantitatively studied.⁴ The present publication of the relationship

underscores the fact that some clinical lessons need to be and should be relearned.

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- 3 *Sampson I*. An unusual capnograph tracing. *J Cardiothoracic Vasc Anesth* 1994; 8: 243–5.
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Erratum

The Table in the Correspondence by Loubser (*Can J Anesth* 2003; 50: 620–1) was misaligned in the print edition of the Journal. A corrected version of the Table appears below. The online version of the Table (www.cja-jca.org/cgi/content/full/50/6/620) is accurate.

TABLE Chronology of intraoperative Hb levels during ANH and OPCAB surgery

Event	Hb (g·L ⁻¹)	Response
1st AWB unit complete	128	
2nd AWB unit complete	119	
3rd AWB unit complete	110	
4th AWB unit complete	101	
IMA anastomosis	89	1st AWB unit administered
L Cx anastomosis and myocardial ischemia	86	2nd AWB unit administered and resolution of myocardial ischemia
RCA anastomosis	95	
Post – protamine	94	3rd and 4th AWB units administered
Chest closure	114	auto CS administered
ICU admission	121	

Hb = hemoglobin; ANH = acute normovolemic hemodilution; OPCAB = off-pump coronary artery bypass; AWB = autologous whole blood; IMA = internal mammary artery; L Cx = left circumflex coronary artery; RCA = right coronary artery; auto CS = autologous cell-saver blood; ICU = intensive care unit.