even a poor method is better than no method at all and I would remind Dr. Crawford of the regrettable fact that by far the majority of births in this country take place in the absence of the necessary skill in intubation on the part of those present; so, let us at least face practical facts.

Woolly reference should not be given to unpublished work or work which cannot be quoted properly. Dr. Crawford may be interested to note an article by Coxon (1960), *Lancet*, 1, 1315.

The terms “blue asphyxia” and “white asphyxia” with which I am “chided” are in such common clinical usage that again they cannot be ignored, but if Dr. Crawford will look again I think he will see that I have said, “it would be better to describe this condition (white asphyxia) simply as foetal shock rather than asphyxia pallida since the former term gives a far better picture of what is happening”.

The Apgar scoring system has already been referred to by me in my textbook *Practical Obstetric Problems*, 2nd edition, page 441, which your correspondent may care to look up. It is certainly a good system provided staffing is adequate, which is seldom the case.

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THE FIRST ADMINISTRATION OF CHLOROFORM

Sir,—With reference to Dr. Langton Hewer’s letter in the *British Journal of Anaesthesia*, for May 1960 (page 234), I should like to make the following points. I think it is by no means certain that chloroform was in fact used as early as the spring of 1847. The evidence in support of Dr. Holmes Coote’s precedence is based on a letter written 24 years after the event. It used the expression “chloric ether (which is chloroform plus spirits of wine)”. I am not aware that a solution of chloroform in spirits of wine was ever called “chloric ether”; I suggest that Mr. M. C. Furnell, who wrote the letter, may well have been mistaken. As I pointed out in the article which Dr. Hewer criticizes, “chloric ether was also used in the Middlesex Hospital as early as February 1847”. While, of course, Dr. Holmes Coote’s priority may be a fact, it is my belief that more satisfactory, contemporary evidence is required to prove it.

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THE FIRST ENDOTRACHEAL INTUBATION

Sir,—In his interesting article, “The Evolution of Endotracheal and Endobronchial Intubation”, Dr. White states that Benjamin Pugh was the first to perform intubation. I take leave to doubt this. As I pointed out in my article in the *British Journal of Anaesthesia*, 1956 (page 577), Benjamin Pugh undoubtedly described an air-pipe for the resuscitation of the newly born; It was made of a wire spring, 10 inches long, covered with thin soft leather, and was to be introduced into the infant’s mouth “as far as the larynx”. Even if these last words be discounted, I think it is extremely unlikely that, at that date, a wire spring covered with leather could have been made sufficiently small to be inserted into the larynx of a neonate. In the absence of further evidence, I am not prepared to accept Benjamin Pugh as the originator of intubation, and I believe that the honour for this rests with Charles Kite (1788), acting on the suggestion of “Dr. Munro, Mr. Portal, Mr. le Cat and others”.

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AN ANAESTHETIC HAZARD

Sir,—Robbie and Pearce (1959) drew attention to some dangers associated with latex armoured endotracheal tubes. In the second case they reported, a layer of latex rubber had puckered up inside the tube and occluded the lumen.

I have to report a similar occurrence in conducting rubber non-kinkable catheter mount tubing. The tubing which had been in use for some months was connected to a Magill T-piece. Total obstruction of the airway was immediately apparent and was tracked down to the catheter
mount. A layer of the antistatic rubber had become detached by the introduction of the T-piece and had puckered up, causing complete occlusion of the lumen (fig. 1b). No undue force was required to insert the T-piece.

Although the cause of the obstruction was apparent on examining the catheter mount, it was possible for the rubber lamina to spring back into its normal position on disconnecting the T-piece (fig. 1a).

It would seem that the introduction of metal coiling into rubber, whether latex or antistatic, introduces the risk of layering and, unless a more satisfactory binding of the rubber can be achieved, it might be safer to use a short length of ordinary antistatic rubber of suitable bore and rigidity.

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REFERENCE

![Magnified view of distal end of armoured catheter mount tubing:](image)
(a) Showing separation of inner lamina;
(b) Showing obstruction of lumen.