given an initial dose of 8 ml 1.5 per cent lignocaine with adrenaline 1:250,000 through a Tuohy needle, after which a catheter was introduced into the extradural space. Analgesia was quite sufficient and all he needed was thiopentone 250 mg to keep him asleep, and vasopressor drugs to keep his systolic pressure above 110 mm Hg.

With a “single injection” used on this patient, he would have received a considerably larger volume which in his case would have been excessive. Using a catheter, smaller judicious doses can be given and, if these are not sufficient to produce a block commensurate with the surgeon’s requirements, additional amounts can be added as necessary.

H. K. DUBE
General Hospital, Southend-on-sea

THE FIRST ENDOTRACHEAL INTUBATION

Sir,—The publication of “Evolution of Endotracheal and Endobronchial Intubation” by G. M. J. White (Brit. J. Anaesth., 1960, 32, 235) was appreciated by this reader. I was rather surprised that neither Davison (1951) nor Mushin and Rendell-Baker (1953) were listed in his references. A letter in your July issue from Dr. Armstrong Davison (1960) reviews his article and further addition is not necessary. Chapter VI of Mushin and Rendell-Baker (1953) covers a large gap in White’s paper and should be mentioned. Perhaps attention should be drawn especially to the plates (figs. 14 and 13, Mushin and Rendell-Baker, 1953) from Curry (1792) illustrating an endotracheal tube in situ and showing a tracheal cannula. Figure 14 in this chapter is the earliest plate I have found of an endotracheal tube in situ—Stanley Sykes may have an earlier reference. Figure 1 herewith is a clearer print of the tracheal cannula taken from the 1815 second edition of Curry. The obvious similarity to a Murphy style tube is striking. Curry states, “an instrument of this kind was originally proposed by M. Coleman, as an improvement upon a much narrower one invented by M. Kite.” Also there is an illustration from the Annual Report of the Royal Humane Society (1806) showing the tracheal tube (fig. 11 in Mushin and Rendell-Baker).

At the Second World Congress in Toronto, the Scandinavian Society of Anaesthesiologists generously presented delegates with a reprint copy of Herholdt and Rafn (1796). The enclosed print (fig. 2) “showing Gorcy’s Double Bellows” is taken from the reprint of Herholdt and Rafn. “h” is a flexible tube and instructions read: “he takes the catheter in his right hand, passes it along the left forefinger across the glottis and turns it carefully down into the windpipe”.

I hope Dr. White and you, sir, will excuse the tardiness of this commentary. Both before and after the Toronto Congress, Boston, U.S.A., was blessed with many visiting savants from the United Kingdom and Commonwealth. We have been slowly recovering from the stimulation of the conversation and catching up on our journal.
reading. If in the travails of travel any of our visitors lost their pictures of Bunker Hill or Concord Bridge, I would be happy to replace them.

JOHN B. STETSON
Boston 15, Mass., U.S.A.

REFERENCES
Curry, J. (1792). Popular observations on apparent death from drowning. Northampton.

MAINTENANCE OF PIPED OXYGEN SUPPLIES
Sir,—Cylinder manifolds feeding oxygen pipelines in hospitals are all fitted with connectors adapted to be coupled to cylinder valves having an outlet in accordance with British Standard 341, which is $\frac{1}{2}$" righthand female thread. This type of valve is fitted to oxygen cylinders of 48 cu. ft. capacity and upwards and also to cylinders in this range which are used for compressed air, nitrogen, helium, helium/oxygen mixtures and oxygen/carbon dioxide mixtures. It is thus possible, for example, for a compressed air cylinder to be inadvertently connected to an oxygen pipeline. Personnel responsible for the maintenance of piped oxygen supplies should be reminded of this fact, and of the recommended code of practice with regard to the storage and handling of cylinders and the system of cylinder identification laid down in British Standard 1319:1955. Cylinders are painted in the characteristic colour according to the colour code shown in this B.S.I standard and of course, also bear a printed label to identify the contents.

H. J. V. MORTON
Honorary Secretary,
Association of Anaesthetists of Great Britain and Ireland

A SPILL VALVE
Sir,—I was very interested in the spill valve described by Maxwell and Grant (*Brit. J. Anaesth.*, 1960, 32, 616) and should like to point out that the inflating valve described by myself in 1958 is exactly the same in principle as that described by Maxwell and Grant, and can be used as they suggest. It can be obtained from Messrs. Charles King.

J. B. SEARLE
Folkestone

Sir,—With reference to the inflating valve described by Maxwell and Grant (*Brit. J. Anaesth.*, 1960, 32, 316), an almost identical valve was described by Searle in 1958. Although it was designed for use in the Magill circuit, I have found it very satisfactory when used in the semiclosed absorption set-up.

The valve may be obtained from the British Oxygen Company.

F. G. ETHERIDGE
Chertsey, Surrey

REFERENCE