driven in until it strikes the trachea, it is then withdrawn 0.5 cm and directed in the same direction as the trachea. Figure 3 in the article makes this point easier to follow. It is possible then to have a bicarotic and a superior vena caval cannula in the one animal.

I am interested to hear that little postoperative respiratory trouble occurs in experimental pigs in England. This is probably related to better husbandry in that country. Most of our pigs are purchased from farms outside our establishment; this means, of course, that we have no control of parasitism, endemic infections, etc. The use of non-volatile anaesthetic becomes more important under these conditions.

S. C. Hopcroft
Woodville, South Australia

SYSTEMIC EFFECTS OF NITROUS OXIDE WHEN USED WITH HALOTHANE AND OXYGEN ANAESTHESIA AT NORMAL BODY TEMPERATURE

Sir,—In the paper by Dr. Maurice Bloch (Brit. J. Anaesth. (1966), 38, 119) the assumption that nitrous oxide has some influence on halothane anaesthesia would be hard to question, but the data he presented are totally unacceptable as evidence for proving this point, in my opinion. The number of variables interspersed among the few patients he used for his observations preclude drawing valid conclusions. If he re-did this study, even with ten patients of a similar age group, same sex, same premedication and induction agents, no relaxants and same maintenance (in a non-rebreathing system) he might be able to prove what he believes to be true.

ALLEN B. DOBKF
Syracuse, New York

The above letter was forwarded to Dr. Bloch, who replied as follows:

Sir,—Thank you for permitting me to see Professor Dobkin's letter. My two papers on nitrous oxide refer to observations made in the absence of surgery, at normal and at reduced body temperature (Brit. J. Anaesth. (1963), 35, 631), and during thirty-five routine operations performed at normal body temperature (Brit. J. Anaesth. (1966), 38, 119). In a proportion of patients increase in concentration of nitrous oxide in the inspired gas mixture was followed by decrease in arterial pressure, heart rate and tidal volume, and increase in respiratory rate. These changes became reversed following withdrawal of nitrous oxide, whether the latter was replaced by air or by oxygen (1963). Oxygen concentration did not fall below 70–80 per cent at any time during anaesthesia. These were observed events. They are not assumptions, and I suggest Professor Dobkin would be hard put not to accept them as evidence that nitrous oxide has "some influence" on halothane anaesthesia, whatever the coincidental variables.

It must be obvious, the observations having once been made, that they must be compared with the results of an extensive and rigidly controlled study in order to confirm them, to understand how these effects are brought about, and to establish the frequency with which they occur. I stated quite clearly that "full evaluation ... must await a more extensive investigation" (1966), and this view has merely been repeated in his letter by Professor Dobkin. It is doubtful whether it would be possible to prove anything very convincing in this field from a study of ten patients, however well controlled. At the most this might yield suggestive evidence that, similarly to that obtained from my study of thirty-five patients, would need to be examined in the light of a more extensive investigation.

Incidentally, the inference (not assumption) drawn in my paper was not that nitrous oxide has some influence on halothane anaesthesia, but that nitrous oxide per se might produce the changes observed in this study, independently of the action of halothane (or ether, methoxyflurane or trichloroethylene).

MAURICE BLOCH
London

THE CHARLES KING COLLECTION OF HISTORICAL ANAESTHETIC APPARATUS

Sir,—The Association of Anaesthetists has done me the honour of appointment as Curator of the Charles King Collection of historical anaesthetic apparatus which Mr. King presented to the Association some years ago, and which now is housed in the Royal College of Surgeons of England, through the courtesy of the President and Council, and of the Curator of Instruments, Sir Eric Riches.

This is a fine basic collection of antique apparatus, supplemented by several beautiful replicas (for instance, John Snow's ether apparatus) made by Charles King himself.

I feel that the time is opportune to ask anaesthetists not to discard any older anaesthetic apparatus without first considering its historical value. The rebuilding of hospitals and removal of anaesthetic departments with clearance of old stores make it likely that much which may be valuable and interesting will come to light, and I would urge senior anaesthetists either to establish their own collections for teaching purposes, or to consider donation of suitable material to supplement the King Collection.

Needless to say, considerations of display and storage space may make it difficult to accept larger apparatus, but I should be most grateful to hear of any pieces which might be available and which might otherwise be destroyed. Items of any period, even to modern times, would be welcome, even though it might be necessary to store them for some time.

All members of the specialty will have heard with regret of the recent death of Charles A. King, to whom anaesthesia in this country owes a larger debt than many anaesthetists realize. One can only be sorry that he did not live to see his collection housed in the way he intended, but I am sure that with this as a nucleus, and with the help of anaesthetists everywhere, the collection can be increased to be a worthwhile possession of the Association, and a tribute to the memory of the friendly, courteous and gifted gentleman who commenced it.

K. Bryn Thomas
Reading