Magnesium has been shown to blunt the pressor response to intubation in hypertensive pregnant patients [2]. As administration of fentanyl and the use of magnesium may inhibit the release of catecholamines by different mechanisms, it seems likely that the two drugs used in conjunction would enhance cardiovascular control. It is possible, therefore, that the favourable results reported by Lawes and colleagues [1] were at least partly the result of a combination of fentanyl, droperidol and magnesium, and not the fentanyl–droperidol combination alone. It is a pity that serum magnesium concentrations were not available at the time of intubation.

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REFERENCES

LONG TERM USE OF THE VOCALAID TRACHEOSTOMY TUBE FOR TRACHEAL TOILET

Sir,—I have read the letter by Dr Manara and Park [1] on the use of the Vocalaid tracheostomy tube for tracheal toilet, and feel that further comment is required.

With large volume–low pressure cuffs, it is possible to seal the airway with extremely low expiratory cuff pressures. However, resting intracuff pressures as low as 1 kPa do not necessarily protect against aspiration, particularly as these large volume cuffs are prone to produce longitudinal foldings of the cuff material, forming channels through which liquid may travel down the trachea [2, 3]. There is no reference in the letter regarding the exact intracuff pressure used in their "suxamethonium" group at 10, 20 and 30 min, in their "suaxamethonium" group at 10, 20 and 30 min, or in their "pancuronium" group at 20 and 30 min and in their "suxamethonium" group at 10, 20 and 30 min. It is possible, therefore, that longitudinal folds of the cuff material were still present in their patient despite this precaution, but pulmonary aspiration was prevented by the regular aspiration of a suction channel above the cuff, preventing the accumulation of food or saliva.

While measuring intracuff pressure is highly desirable, for the reasons Dr Mehta states, it is neither a practical nor a feasible proposition in a patient being looked after long term by different nurses, both at home and while travelling abroad. Presented with this patient, it was essential to keep things simple yet effective. This aim was achieved by our use of the Vocalaid tracheostomy tube as described, since the patient has not developed any clinical or radiological evidence of pulmonary aspiration over a 2-year period.

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REFERENCES
The validity of this assumption could be tested by performing tracheal intubation in a group of similarly premedicated and anaesthetized subjects (not necessarily cardiac patients), after topical anaesthesia of the pharynx and larynx without previous administration of vecuronium, and observing heart rate and arterial pressure in the ensuing 30 min. Until such studies have been performed, the only justifiable conclusion is that vecuronium has no chronotropic or other cardiovascular effect and, therefore, it does not antagonize the bradycardia caused by other drugs or sleep.

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REFERENCES

TRANSFER FROM RECOVERY ROOM TO WARD
Sir,—From the anaesthetic point of view a patient can be discharged from the recovery room: (1) when he is able to maintain adequate alveolar ventilation and can clear his airway; (2) when he is awake, alert, well orientated in space and time, and can make his wants and needs known; (3) if he is able to maintain adequate tissue perfusion, without continuous monitoring and support of his cardiovascular system; patients with an unstable cardiovascular system should not be moved.

From the surgical point of view, if the patient is not expected to need close surgical surveillance he can be transferred. A trained nurse preferably should accompany the patient whenever necessary.

The author’s recovery score (table I) assesses three physical signs: “A, B, C of recovery” (Airways, Behaviour, Consciousness). A score of 8 is the minimum for discharge from the recovery room in most instances.

We have assessed this score in more than 2000 patients aged from 1 to 80 yr and of both sexes. We found and concluded that this score is an effective guide to the recovery of patients and to the time for discharge to the wards. There was no residual effect of anaesthesia. The patients were awake, well orientated and could make their wants and needs known to nursing staff in the wards. This A, B, C scoring system is simple and helpful to junior staff.

M. Salem
Rawalpindi

FRESH GAS FLOW REQUIREMENTS WITH THE ADE ANAESTHETIC SYSTEM
Sir,—When evaluating the fresh gas flow requirements of the ADE anaesthetic system, Duncan and colleagues [1] observed a poor correlation between arterial and end-tidal carbon dioxide tensions, but did not present an explanation. One possibility depends upon the design of capnometer used; some display absolute P\textsubscript{a}CO\textsubscript{2} while others display the difference between inspired and expired gas. When rebreathing occurs, the latter types display a decreasing “P\textsubscript{a}CO\textsubscript{2}”, with no indication that inspired P\textsubscript{a}CO\textsubscript{2} is greater than zero. Could this have been the case? Presumably the occasions when P\textsubscript{e}CO\textsubscript{2} was greater than P\textsubscript{a}CO\textsubscript{2} represent inherent errors of sampling, or the influence of nitrous oxide on analysers and the “concentration effect” in the lung; these errors should not be greatly influenced by fresh gas flow. Did the authors observe a better correlation in the higher gas flow group, or have they some other explanation? Would they not agree that, when using an

<table>
<thead>
<tr>
<th>Physical signs</th>
<th>Score for response</th>
</tr>
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<tbody>
<tr>
<td>Airway</td>
<td>Patient can cough or cry Maintains clear airway without holding the jaw Holding of jaw needed Holding of jaw and other measures taken to maintain airway</td>
</tr>
<tr>
<td>Behaviour</td>
<td>Patient can lift head Can open the eyes and show tongue Some non-purposeful movements No movements at all</td>
</tr>
<tr>
<td>Consciousness</td>
<td>Fully awake, can talk, well orientated Awake but needs support Responds to stimuli only No response</td>
</tr>
</tbody>
</table>

Table I. Postanaesthetic “A, B, C of recovery” score. Patient is fit to leave the recovery room when score is at least 8