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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New York

REFERENCES
1. Inoue K, El-Banyosy A, Stolarski L, Reichelt W. Vecuronium-induced bradycardia following induction of anaesthesia with etomidate or thiopentone, with or without fentanyl. British Journal of Anaesthesia 1988; 60: 10-17.

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.

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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 $P_{CO_2}$ while others display the difference between inspired and expired gas. When rebreathing occurs, the latter types display a decreasing "$P_{CO_2}$", with no indication that inspired $P_{CO_2}$ is greater than zero. Could this have been the case? Presumably the occasions when $P_{ECO_2}$ was greater than $P_{ACO_2}$ 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 I. Postanaesthetic "A, B, C of recovery" score. Patient is fit to leave the recovery room when score is at least 8

<table>
<thead>
<tr>
<th>Physical signs</th>
<th>Score for response</th>
</tr>
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<tbody>
<tr>
<td>Airway</td>
<td>3</td>
</tr>
<tr>
<td>Patient can cough or cry</td>
<td>Maintains clear airway without holding the jaw</td>
</tr>
<tr>
<td>Behaviour</td>
<td></td>
</tr>
<tr>
<td>Patient can lift head</td>
<td>Can open the eyes and show tongue</td>
</tr>
<tr>
<td>Consciousness</td>
<td></td>
</tr>
<tr>
<td>Fully awake, can talk, well orientated</td>
<td>Awake but needs support</td>
</tr>
</tbody>
</table>