of control in one of them (an incomprehensible deficiency for a laboratory study) and the fact that only a single animal per drug condition was used in the other are buried rather than highlighted (inclusion of a study with a n=1 per condition into a ‘systematic’ review is, per se, debatable). In contrast, the gloves are off when it comes to methodological criticisms of clinical studies, especially when the study casts doubt on the existence of a relevant toxic effect: their outcome measures (e.g. developmental milestones, learning achievement, academic performance) are dismissed on the grounds that they are too ‘coarse’, disregarding the possibility that these outcomes might in fact be those that matter in real life—as opposed to achievements on arbitrary behavioural scales for rodents or monkeys. Another ground for summarily dismissing inconvenient clinical studies is ‘small sample size’. For example, doubt is cast on the relevance of the study by Bartels and colleagues on the grounds that it included ‘only’ 1143 pairs of monozygotic twins! Small sample size is a valid concern, but the criticism seems to be arbitrary, since the total number of piglets was 42 (39+3 for the two studies cited), and the total number of monkeys enrolled in all seven studies was 91—and of these, only 12 (neither sex-nor otherwise matched) underwent behavioural assessment. In contrast, the unique strength of Bartel and colleagues’ work, that is, comparison of clinically relevant cognitive outcomes between ‘perfectly matched’ (monozygotic twins) populations, is largely ignored. Considering the enormity of the problem that good matching of controls represents, especially for comparing neurocognitive outcomes, this neglect of a unique strength of this study is striking.

One might ask whether this sceptical criticism is justified at all—is not it in the public’s interest of ‘safety’ to assume the potential for toxicity? Should not everybody be alert, watchful, and critically cautious? As Sanders and colleagues note, surgery in children is rarely purely elective. However, it is also important to recognize that clinically relevant science is not insulated in an ivory tower of academic objectivity, where hypotheses are vetted thoroughly and dispassionately before carefully crafted experts’ conclusions, objective and reflecting the pinnacle of wisdom, are released to an obediently waiting, carefully crafted experts’ conclusions, objective and reflecting the specter of derailment. Experience, especially in England with the pertussis and MMR vaccine scares of decades past, teaches us how scientific (mis)information can lead to irrational behaviour in wide swaths of the population. The excess morbidity from the pertussis vaccine panic in Britain has been estimated at 300 000 with 70 deaths. If irrationality of behaviour is proportional to the degree of stress, the potential damage from the ‘anaesthesia threat’ in necessary surgeries delayed or avoided is enormous.

In summary, the authors have provided a very useful collection of pertinent facts from the existing literature in this field. The reader should be aware of the potential bias in the interpretation of the data.

Declaration of interest
None declared.

Use of capnography may cause airway complications in intensive care

Editor—It is widely acknowledged that the incidence of serious adverse airway events is higher in the intensive care and emergency department environments. NAP4 revealed that failure to use capnography has been implicated in poor outcomes after adverse airway events on intensive care units (ICUs). The use of capnography in UK ICUs is now becoming increasingly common, and follows a number of recommendations both nationally and internationally.

We wish to highlight one potential safety implication of the introduction of this unfamiliar equipment to the ICU environment, and report a case where the use of capnography was contributory to the development of an airway emergency.

A male patient was admitted to our neuro-intensive care unit. During his ITU stay, continuous waveform capnography was used as per departmental policy, and a tracheostomy placed to facilitate weaning from the ventilator.

After the change of position of the patient, the end-tidal CO$_2$ (e$_{CO_2}$) line became entangled on the bedside, and despite the staff member taking care to watch the breathing circuit, the tracheostomy was partially displaced due to traction from the capnography line. The incident was managed as per national guidelines, however, the patient still sustained surgical emphysema and bilateral tension pneumothoraces necessitating immediate decompression and intercostal chest drains. The patient recovered from this episode.

Upon further investigation of this event, we noted that the capnography line ran separately to the breathing circuit and was located on the monitoring system, rather than the
ventilator, therefore travelling in the opposite direction to the breathing circuit and increasing the likelihood of traction after movement of a patient.

Analysis of NPSA incident reports regarding airway devices in critical care revealed that tube displacements are associated with turning and moving patients. McGrath and colleagues postulated traction on the capnography line as a potential-specific mechanism for tracheostomy displacement. We believe our case is the first such documented instance which relates specifically to the contribution of capnography to tracheostomy displacement.

The introduction of capnography into ICUs has been shown to reduce the mortality associated with the intubation of critically ill patients, however, critical care staff are often unfamiliar with this equipment and studies have demonstrated the need for their education about its usage and interpretation.

Our case also highlights the need for nursing staff to be aware of the additional safety implications due to the unfamiliar presence of capnography when moving patients.

**Declaration of interest**

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**Transcontinental anaesthesia model**

Editor—I read with interest the article on transcontinental anaesthesia and commend the authors on the use of modern technology in demonstrating successful delivery of remote anaesthesia in the true sense of the word. However, delivering this type of anaesthesia remotely to areas with fewer resources may be associated with problems. For example, anaphylaxis to neuromuscular blocking agents is always a possibility, thus it is important that the remote set-up does not impair the rapid recognition by the remote operator nor the implementation of appropriate local treatment of such an unpredictable event. It is therefore essential to ensure that those individuals (who may not be formally trained anaesthetists) delivering anaesthesia locally via a remote link undergo training in dealing with possible critical incidents, be that anaphylaxis or an unanticipated difficult airway. This perhaps offers a further use for the transcontinental anaesthesia model; providing tutorials and possible remote simulation training, thereby increasing its role in improving both access and standards of care in resource poorer countries.

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