tubing, and in our institution, we try to run both types of tubing together for as long a distance as possible. However, we feel that the benefits significantly outweigh any risks associated, and that cases such as this should not be used as an excuse to avoid capnography monitoring on ICU. Avoidable airway deaths continue to occur on ICU and capnography, with audible alarms, will lead to early identification of airway obstruction or displacement. None declared.

**Declaration of interest**

None declared.

F. E. Kelly*
A. Georgiou
Bath, UK

*E-mail: fiona.kelly@doctors.org.uk

1 Kingston EEV, Loh NH. Use of capnography may cause airway complications in intensive care. Br J Anaesth 2014; 112: 388–9
6 Cook TM, Kelly FE, Goswami A. Hats and caps capnography training on intensive care. Anaesthesia 2013; 68: 421
7 Georgiou AP, Gouldson S, Amphlett AM. The use of capnography and the availability of airway equipment on Intensive Care Units in the UK and the Republic of Ireland. Anaesthesia 2010; 65: 462–7
doi:10.1093/bja/aeu289

**The (Correct) use of capnography will reduce airway complications in intensive care**

Editor—While there is an undoubted safety message in the short report from Drs Kingston and Loh,1 it is concerning that the title and tone of the letter could be misleading. In response to the recommendations that the authors refer to, waveform capnography is thankfully increasingly common in UK intensive care units (ICUs), although still not universally available.

Any new monitor or device when introduced to a complex environment such as a critical care unit must only be used by staff who are competent to safely set up, use and troubleshoot the equipment, and interpret its output. Capnography is invaluable in detecting the potential displacement of airway devices during passive or active patient movement and changes in the waveform would be the first sign of a displaced device in exactly the scenario described. Set up and used appropriately, capnography should be no more likely to contribute to device displacement than anything else connected to the airway. There may be subtleties between different types of monitoring, and continued adverse event analysis may further clarify which procedures are consistently associated with the highest risks of device displacement. Participation in continuous quality improvement projects such as the Global Tracheostomy Collaborative2 would be expected to improve standards of care, improve patient safety, and facilitate shared learning.

ICUs should be strongly encouraged to have capnography available (and used) at the bed spaces of every patient with an artificial airway device. There are clear training implications for our multidisciplinary staff, but this should not cloud the main safety message: the (correct) use of capnography will reduce airway complications in intensive care.

**Declaration of interest**

B.A.M. is the Chair, UK National Tracheostomy Safety Project and European lead, Global Tracheostomy Collaborative.

B. A. McGrath
Manchester, UK

E-mail: brendan.mcgrath@manchester.ac.uk
doi:10.1093/bja/aeu284

**Doses and effects of levobupivacaine and bupivacaine for spinal anaesthesia**

Editor—We have read and paid much attention to the article by Mann and colleagues.1 We found that it was a very interesting paper as it offers further information about levobupivacaine and bupivacaine usage in spinal anaesthesia.

The authors describe spinal blocks with a low dose of both local anaesthetic agents for lower limb arthroplasty surgery. Mann and colleagues used 7.5–10 mg of bupivacaine 0.25%, and the identical volumes of levobupivacaine. In the bupivacaine group, a satisfactory sensory block was achieved for the duration of arthroplasty surgery. However, they reported failure to achieve adequate sensory block and fast block regression in the levobupivacaine group, so they had to use 12.5–15 mg of levobupivacaine to compensate for this failure.

Several studies have compared the potencies of both local anaesthetics. The authors comment on one of them, and state that there is a minor discrepancy between the $ED_{50}$ of...