In Reply—We apologize for having missed the article by Davies et al.\(^1\) in our literature search. In it, there is an explanation of the two peaks in our graph of vapor concentration.\(^2\)

We did, in fact, remove the filling device from the bottle, replaced the screw-top on the bottle, and then placed the filling device in a drawer in the anesthesia machine. Although Davies et al.\(^1\) showed that leaving the filling device in situ leads to negligible pollution if the bottles are at rest, our practice is such that the anesthesia machines and other potential resting places for bottles are frequently moved so that there is potential for spillage and, hence, even greater pollution from the vapor.

E. Lynne Williams, M.B., B.S., F.F.A.R.C.S.
Department of Anesthesiology

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Continuous Monitoring of Intracuff Pressures in Endotracheal Tubes

To the Editor—The relationship between high intracuff pressures in endotracheal tubes to tracheal wall pressure and to tracheal ischemic injury has been well documented.\(^1\)\(^-\)\(^3\) The contributions of inspired oxygen and nitrous oxide (N\(_2\)O) to cuff gas volumes over time have also been well documented.\(^4\)\(^-\)\(^7\)

With automated oscillometric or intra-arterial blood pressure monitoring during surgery, the sphygmomanometer gauge mounted on most anesthesia machine consoles becomes an unnecessary option. This unused sphygmomanometer can provide a simple method for continuous intracuff gas pressure monitoring during long operative procedures (fig. 1).

A double male-ended rubber hose will connect the sphygmomanometer gauge to the pilot balloon of a cuffed endotracheal tube (fig. 1). The sphygmomanometer gauge will then display intracuff pressure. A three-way stopcock may be inserted somewhere along the rubber hose to allow for syringe deflation of excessive intracuff gas volumes when intracuff gas pressures exceed 18–25 mmHg. This simple technique will allow for continuous manometric monitoring of intracuff pres-