suxamethonium that is colour-coded in a way dangerously inconsistent with the existing colour standard. The international colour-code standard has an additional safety feature specifically for potentially dangerous drugs like suxamethonium, namely the reversed lettering and background of the drug name as way of an alert to the user. Not only does the Aurum Pharmaceuticals prefilled syringe not have this reversed alert text, but the blue colour they have chosen for the syringe label is identical to that for opioids under the international colour standard. We know from a recent large-scale study of over 74 000 anaesthetics that syringe-swap errors *between* drug classes can be significantly reduced by using the new international colour standard because of the drug-class specific colour cues [6]. Why would any manufacturer then use the same colour for two drugs from different pharmacological classes? I can imagine that the 'legal' response from a pharmaceutical company over such a matter might be to point out that it is the anaesthetist's responsibility to read the label (no matter how poorly labelled the drug) and that technically, the international colour-code standard is intended for 'user-applied' drug labels and therefore does not apply to the manufacture of a prefilled syringe which comes already labelled, hence allowing the manufacturer to make the label any colour it likes. The provision of a new prefilled syringe should be seen as an opportunity to increase patient safety by getting the details right, rather than bizarrely creating a new trap or latent system error that will in time inevitably lead to a new kind of error. Over ten years ago I pointed out that ampoule labelling standards are such that ampoule labels could carry colour-coding consistent with the international user-applied labelling standard [7]. This would have significant ergonomic benefits for anyone drawing up drugs from colour-coded ampoules into similarly colour-coded syringes, and there is no reason why such consistency of colour-coding could not also apply to pre-filled syringes. In fact, in our hospital we have had consistently colour-coded prefilled syringes for over ten years [8].

C. S. Webster
University of Auckland
Auckland, New Zealand
Email: c.webster@auckland.ac.nz

No external funding and no competing interests declared. Previously posted on the *Anaesthesia* Correspondence website: http://www.anaesthesiacorrespondence.com.

References

1. Torlot FJ. Coloured drug labels and prefilled syringes – another mistake waiting to happen. *Anaesthesia* 2013; **68**: 308–9.
2. Merry AF, Webster CS. Labelling and drug administration error. *Anaesthesia* 1996; **51**: 987–8.
3. Webster CS. Human psychology applies to doctors too. *Anaesthesia* 2000; **55**: 929–30.
4. Smellie GD, Lees NW, Smith EM. Drug recognition by nurses and anaesthetists. *Anaesthesia* 1982; **37**: 206–8.
5. Anon. *Anaesthetic and respiratory equipment – user-applied labels for syringes containing drugs used during anaesthesia – colours, design and performance (ISO 26825)*. Switzerland: International Standards Organization, 2008.
6. Webster CS, Larsson L, Frampton CM, et al. Clinical assessment of a new anaesthetic drug administration system: a prospective, controlled, longitudinal incident monitoring study. *Anaesthesia* 2010; **65**: 490–9.
7. Webster CS, Mathew DJ, Merry AF. Effective labelling is difficult, but safety really does matter. *Anaesthesia* 2002; **57**: 201–2.
8. Webster CS, Merry AF, Ducat CM. Safety, cost and predrawn emergency drugs. *Anaesthesia* 2001; **56**: 818–20.

doi:10.1111/anae.12314

Clinical evaluation of the Ambu® aScope™

In their recent study, Krugel and colleagues [1] claimed that times to obtain a view of the carina and intubate the trachea were significantly longer with the single-use Ambu® aScope™ videoscope (Ambu UK Ltd., St. Ives, UK) than the re-usable Pentax® flexible fibrescope, and therefore the authors could not support the use of the aScope in place of the fibrescope. Other studies, carried out with manikins and patients [2, 3], suggest that the times to complete particular scenarios were closer between the aScope and re-usable fibrescopes.

When reporting the results of their study, Krugel et al. stated five different times (the median, lower quartile, upper quartile, minimum and maximum) to identify the carina with each device. It was intriguing that the five times quoted for the aScope (28, 22, 46, 16 and 206 s, respectively) were almost exactly double those for the re-usable fibrescope (15, 12, 22, 7 and 110, respectively) in each case. There is clearly something that causes a consistent, systematic difference between the two devices and we are

interested as to whether the authors could give any further information or hypothesise on what this could be? In fact, the authors were perhaps a little fortunate in detecting *exactly* the difference they planned to detect (20 s) in intubation times between the two devices, when their study was actually underpowered: Altman's nomogram suggests a sample size of 100 patients in each group rather than 50 [4].

Jaw thrust was used where necessary (it would perhaps have been more consistent and appropriate to use jaw thrust in every patient), but a majority of patients still did not require jaw thrust in either group (despite many more patients needing this manoeuvre in the aScope group), so this cannot explain the *consistent* difference between the two devices.

The clarity of vision with the aScope was reduced on occasion due to fogging and secretions, but only four patients (of 50) required a second attempt, so this again seems to be an unlikely explanation for the consistent difference. The authors state that the absence of a suctioning channel on the aScope is a deficiency. However, they did not report the number of times suctioning was performed when using the re-usable fibrescope and whether this made a difference to the view obtained. This information would have been helpful in clarifying how useful is the presence of the suctioning channel on the re-usable fibrescope, and therefore how useful the addition of a suctioning channel would be on the aScope, if one was provided. In addition, anti-fogging solutions are available, but were presumably not used in this study [5].

Finally, the tip of the aScope was perceived by the single intubator not to be as manoeuvrable as the flexible fibrescope. However, Vijayakumar and colleagues [2] found that there was little difference in manoeuvrability between the aScope and a flexible fibrescope when tested using a specially adapted manikin.

We therefore remain puzzled at the consistent difference in times between the two devices and we would welcome suggestions as to why this might be so.

I. Hodzovic
A. R. Wilkes
Cardiff University
Cardiff, UK
Email: Hodzovic@cf.ac.uk

Ambu UK Ltd provided, free of charge, equipment for a 2010 study and provided travel sponsorship to AR Wilkes to attend European Society of Anaesthesiology meetings in 2008 and 2009. No other external funding or competing interests declared.

References

1. Krugel V, Bathory I, Frascarolo P, Schoettker P. Comparison of the single-use Ambu aScope 2 vs the conventional fibrescope for tracheal intubation in patients with cervical spine immobilisation by a semirigid collar. *Anaesthesia* 2013; **68**: 21–6.
2. Vijayakumar M, Clarke A, Wilkes AR, Goodwin N, Hodzovic I. Comparison of the manoeuvrability and ease of use of the Ambu aScope and Olympus re-usable fibrescope in a manikin. *Anaesthesia* 2011; **66**: 683–93.
3. Piepho T, Werner C, Noppens RR. Evaluation of the novel, single-use, flexible aScope for tracheal intubation in the simulated difficult airway and first clinical experiences. *Anaesthesia* 2010; **65**: 820–5.
4. Altman DG. Statistics and ethics in medical research. III How large a sample? *British Medical Journal* 1980; **281**: 1336–8.
5. Knauth A, Weiss M, Dave M, Frotzler A, Haas T. Comparison of antifog methods in endoscopy. What really helps. *Anaesthesist* 2012; **61**: 1036–44.

doi:10.1111/anae.12302

Subjective and objective experience of pain

We read with interest the recent article by Moore et al. [1]. Respectfully, we suggest that the laudable intent of only being satisfied with minimal or no pain is overly simplistic and risks sabotaging the very aim they seek to achieve. Excellence in clinical care is not whether a pain score of 6 is treated or not, but is listening to the patient, making a thorough assessment and identifying realistic and acceptable goals. By definition [2], a painful experience, unlike a blood pressure reading or a serum glucose level, cannot be reduced to a number with any real meaning. The authors state that "*a pain score of 6/10 is not mild, but borderline between moderate and severe, and the patient did need something for that.*" '6/10' means different things to different people – not least the patient and his healthcare provider [3, 4]. What if that patient was mobilising well, not bothered by his healing wound and didn't feel he needed further medication? Alternatively, what if, on receiving further medication to reduce a 6/10 pain score, the patient then suffered a respiratory arrest – would the system not have failed him? Whilst we agree

