CORRESPONDENCE

TRAINING IN FIBREOPTIC LARYNGOSCOPY

Sir,—I read with interest the editorial on “Training in Fibreoptic Laryngoscopy” [1]. I propose a solution to some of the ethical and practical problems which were outlined so thoroughly by Dr Vaughan.

For the past year, we have conducted a joint diagnostic bronchoscopy list with physicians. Bronchoscopies are performed in the presence of a trainee anaesthetist, a senior anaesthetist familiar with fibroptic techniques and a physician. Two main techniques are used; both are performed through the mouth and under sedation after preparation of the airway with local anaesthetic spray and a cricothyroid puncture. The first “unaided” technique involves a standard oral intubation with the fibroptic bronchoscope with subsequent “railroading” of a tracheal tube into the trachea. The second “aided” technique involves the insertion of a Laryngeal Mask Airway with the patient awake, followed by fibroptic bronchoscopy through that airway [2]. General anaesthesia and other techniques are used occasionally where indicated on clinical grounds.

This list has advantages to all parties. For the patient the passage of a tracheal tube or laryngeal mask airway permits better oxygenation; the presence of the anaesthetist contributes to better immediate care, the physician gains exposure to airway management methods, and in difficult cases can concentrate on the procedure itself. The advantage to the trainee anaesthetist is that he can learn the basics of fibroptic bronchoscopy and become familiar with a technique for awake intubation. In addition, the trainee gains exposure to patients with poor respiratory function and may learn something about bronchial anatomy. Finally, this list has allowed us to forge better relationships with our physician colleagues.

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REFERENCES

Sir,—We read with interest the recent editorial by Dr R. S. Vaughan [1]. We also are interested in the reasons why British anaesthetists have been so slow in embracing fibreoptic technology, and we question his statement “the main reason for such delay [in embracing fibreoptic technology] has probably been the cost of each specialized piece of equipment”. We have contacted the Chairmen of all Anaesthetic Departments in the South West Thames Region, initially by letter, to ascertain what facilities and training programmes in fibreoptic intubation were available. All non-responders were contacted by telephone. The following questions were asked:

(1) Does your department have access to a fibreoptic endoscope suitable for intubation purposes? If not why not?
(2) Are there problems with the care and maintenance of the endoscope?
(3) Is there a permanent member of staff in your department who is skilled at awake fibreoptic intubation?
(4) Do you have a formal training programme for junior anaesthetic staff to become skilled in the use of the fibroscope? Does this include training on: (a) a mannekin; (b) anaesthetized patients; (c) awake patients?

Of the 14 hospitals in South West Thames through which anaesthetic juniors rotate, 11 possess a fibroscope designed specifically for intubation purposes. All hospitals without a purpose-designed scope stated that lack of funds was the reason they did not have one. No hospital reported problems with the care and maintenance of the equipment. All 11 positive responders reported that they had a permanent member of staff skilled in awake fibreoptic intubation.

Despite the presence of suitable equipment in the majority of hospitals and a member of skilled staff, only five reported that they had established training programmes. In all five institutions, this included teaching in anaesthetized patients; three provided training in awake intubation, whilst two reported that they possessed a mannekin suitable for training purposes. Thus it appears that, in the majority of hospitals in the South West Thames Region, there is both the practical skill and the equipment available for fibreoptic intubation, but a paucity of formal teaching programmes.

The ability safely to secure the airway is fundamental to the practice of anaesthesia. Fibreoptic intubation is an important additional skill to possess, particularly when one is faced with a “difficult airway”. It has a high success rate compared with other techniques [2] and, more importantly, has a high degree of patient safety. All anaesthetic trainees should be proficient at awake fibreoptic intubation, as are their American counterparts at the end of their much shorter (3-year) training programme.

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P. R. Rawle
London

REPORTING OF DEATHS

Sir,—The report of the tragic death of a 26-year-old woman [1] prompts me to write to you with a suggestion. This death was not reported to the National Confidential Enquiry into Perioperative Deaths because of some local difficulties in the system which have resisted our attempts at solution. Nevertheless, the management of this patient was exemplary and the report informative; it is unfortunate that the case is omitted from the central audit system. Adverse reactions to drugs should be reported in addition to the Committee on Safety of Medicines through the yellow card system.

Editors of journals associated with our specialty might like to agree informally to encourage reporting by the simple expedient of asking authors of reports submitted for publication to do so, perhaps in their notice or guide to contributors.

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REFERENCE