Conflict of interest

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Percutaneous tracheostomy: prospective practice

Editor—We read the prospective evaluation of 6 yr carried out by Dempsey and colleagues.1 The authors called for auditing at the national level to warrant the safety of the procedure. We would like to contribute our experience and update the prospective evaluation at the local regional hospital. Over 11 yr, 666 tracheostomies were performed in a mixed medical/surgical ICU. Of these, 610 were percutaneous, 558 with a Griggs forcep, 57 with a Percutwist dilator, and seven with a single dilator. Most of tracheostomies were performed utilizing an LMA as airway management device, after extubating the patients. We confirm the experience of our colleagues in terms of low incidence of early and late complications, and the high rate of success within the first attempt (97%) or second (99%). The conversion to an open tracheostomy was decided early in the process of preparation, based on landmarks and positioning of the guiding needle (under direct bronchoscopic visualization) and resulted in no cases of failed percutaneous cannulation requiring open tracheostomy. Maintaining direct visualization and strict selection and preparation protocols make the technique safe and successful. This may also be the reason of low rate of long-term complications. Important is also the contribution of clinical simulation and mentored training, in order to attain fast competency.

Conflict of interest

None declared.

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Reply from the authors

Editor—We thank Professor Cattano and colleagues for their comments on our study.1 While we accept that patient safety is paramount during any invasive procedure, we do not feel this is necessarily achieved by the use of the laryngeal mask airway (LMA) during percutaneous dilatational tracheostomy. The risk of difficult airway management is high in the general critical care population with difficult intubation described in 8–12%2 3 and severe life-threatening complications in up to 28%.3 Additionally, in our patient cohort, there was an over-representation of head and neck and upper gastrointestinal surgical patients, at higher risk of difficult intubation and gastric aspiration, respectively. Consequently, it is our opinion that maximum patient safety is achieved not with the LMA but utilizing the definitive airway that is in situ at the start of the procedure. We feel that this opinion is borne out by the results presented within our paper.1

With respect to the utility and safety of the Percutwist technique, we have no direct experience. We believe, however, our paper has more than adequately demonstrated the safety profile of the single tapered dilator technique in our patient population.

Conflict of interest

None declared.

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