Beards and airway complications

Editor—We note with interest in the report of NAP4 1 that serious airway difficulties were encountered more frequently with male patients, but are left wondering about the extent to which beards contributed to this sex difference. NAP4 undoubtedly helps us to shave risks: should it encourage us to shave chins?

M. Davies*
A. Bonnett
Liverpool, UK
*E-mail: mark.davies@rlbuht.nhs.uk

Reply from the authors

Editor—We thank Drs Davies and Bonnett for their interest in the work of the NAP4 project team. 1 Patients with beards are recognized to have an increased risk of difficult mask ventilation. 1, 2 Male patients are also recognized to be at increased risk of both difficult mask ventilation and difficult laryngoscopy. 1, 3

NAP4 identified an excess of males in reported cases of major airway complications: 67% of all patients reported to NAP4, 62% of anaesthesia reports, and 58% of the cohort in intensive care units were male. We did not enquire about facial hair for all reported cases; however, regarding mask ventilation, we asked if this was difficult and if it was whether the cause was a beard interfering with mask seal. Of 131 anaesthesia reports which answered the question about mask ventilation, 77 (59%) reported that it was difficult. In only two cases was this reported to be due to a beard preventing a good seal. These two cases were (i) a case of aspiration likely due to light anaesthesia in an obese patient managed with a laryngeal mask and (ii) post-operative airway obstruction in an obese patient emerging from laryngeal mask anaesthesia for perineal surgery. There were therefore no cases reported to NAP4 where the primary airway event arose from difficult mask ventilation caused by a beard.

The male gender appears to increase the risk of difficult mask ventilation, difficult laryngoscopy, and major airway complications. Having a beard also appears to increase the risk of difficult mask ventilation and perhaps difficult laryngoscopy. However, on the basis of NAP4, we conclude that it is not beardedness per se that leads to most major airway complications in males.

Conflict of interest

None declared.

Factors contributing to successful incident reporting in anaesthesia

Editor—We read with interest the article by Haller and colleagues 3 on the factors associated with incident reporting in anaesthesia. We developed a highly successful personal digital assistant-(PDA)-based anaesthesia incident reporting system, which led to 97% incident reporting with 44% ‘near miss’ incident reporting. 2 We attributed the success of our system to several factors not mentioned, or measured, by Haller’s group. 1, 4 These included a supportive environment in which incident reporting was valued as an ethical accomplishment, the use of mobile computing technology,
and the ease of data entry.3–5 In fact, we suggested that the ability to report an incident in under 5 s was crucial to successful incident reporting in medicine.3

While we are aware that our incident reporting rate represents a high rate of reporting in the healthcare environment, we consider that the principles identified in our reported work can be usefully applied to other work in this area.

Conflict of interest
None declared.

S. Bolsin*
M. Colson
A. Patrick
L. Freestone
B. Creati
P. Bent
Geelong and Hobart, Australia
*E-mail: steveb@barwonhealth.org.au


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Reply from the authors
Editor—We thank Prof. Bolsin and colleagues for their pertinent comments on our article¹ and are, of course, familiar with their excellent work.²–⁴ While portability and user-friendliness can be seen as major advantages of personal digital assistants (PDAs) for incident reporting, there remains some questions regarding incomplete or inaccurate data recording on such devices.⁵ Alternative approaches such as integrating a computer-based incident reporting form directly into the intraoperative computerized recording system offer promises. This results in high completion rates (at least 85%) for all cases, not just incidents, providing useful denominator data to calculate incidence rates and meaningful risk estimates.⁶

It seems we all agree that clinical leadership, a safety culture, and consideration of human and clinical factors are major determinants for the use or non-use of a reporting system. These should also be systematically considered when innovative technical solutions are developed to facilitate incident reporting by clinicians.

Conflict of interest
None declared.

G. Haller*
D. S. Courvoisier
H. Anderson
P. S. Myles
Melbourne, Australia
*E-mail: guy.haller@hcuge.ch

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Ultrasound-guided trigger point injection: first description of changes visible on ultrasound scanning in the muscle containing the trigger point

Editor—Trigger point injection (TPI) is a recognized treatment for regional myofascial pain syndrome. Traditionally, TPIs have been performed by blindly needling or injecting a palpable trigger point. Recently, TPI under real-time ultrasound guidance has been described as a technique for reducing complications and enhancing needle visualization.¹ We provide the first description of the changes visualized in trigger points located in skeletal muscle in patients undergoing ultrasound-guided TPI.

Ten patients with trigger points in the anterior abdominal muscles and a positive Carnett’s sign undergoing TPIs were included in this series. We palpated the trigger point and the skin over the tender point was marked. We scanned the palpable trigger point in both longitudinal and transverse planes using a high-resolution (7–12 MHz) linear array.