event when the turning of the head towards the ipsilateral side as the lower jaw touches the anterior chest wall will not work effectively, the catheter can be easily pulled back and be re-inserted.

We would support the development of this technology in two sectors: to increase the production and potential cost reduction, and the development of sensors that can be re-sterilized.

Declaration of interest
None declared.

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Training for tracheostomy
Editor—The 4th National Audit Project (NAP4) has highlighted several important areas for improvement in airway management. Some of its inspirational closing words read ‘Airway management is a fundamental anaesthetic responsibility and skill; anaesthetic departments should provide leadership and support a focus on teaching and training to optimize management of the entire organisation’.1 One of the key findings was the inaccuracy of the Trust Tracheostomy Policy. The average score for the true/false questions regarding tracheostomy equipment and weaning was 10/17 (4/5 vs 6/44). This was reflected in their increased levels of knowledge and confidence in both caring for tracheostomy patients and making weaning decisions (none of the dual ICM trainees felt ‘not at all confident’ in either of these situations).

The anaesthetic registrars who were also training in intensive care medicine (ICM) (five trainees) were far more likely to have received formal training (4/5 vs 6/44). This was reflected in their increased levels of knowledge in both caring for tracheostomy patients and making weaning decisions (none of the dual ICM trainees felt ‘not at all confident’ in either of these situations).

There was an average overall score of 10/17 for the true/false questions regarding tracheostomy equipment and weaning. This average incremented appropriately with grade and experience. However, these answers revealed some striking deficiencies in the knowledge and understanding of the details of tracheostomy care. Alarmingly, 29 out of 49 trainees believed a trial of speaking valve could be considered before a trial of cuff down. Thirteen out of 49 trainees did not realize that fenestrated tubes were no longer used within the Trust, and 12 out of 49 trainees did not know that humidification was an essential component of tracheostomy care.

Our findings would suggest that training in tracheostomy care remains a worrying deficiency in the current curriculum, particularly for those trainees who are not on the ICM training programme. This is apparent in the levels of confidence among the trainees. It may contribute, if left unaddressed, to further adverse incidents. Our strategy to deal with this lack of confidence and training has been to develop and run a comprehensive training day. In addition to rehearsing emergency algorithms, there was a focus on general tracheostomy care and equipment. There was input from the physiotherapists and speech therapists, to ensure that communication,
weaning, and swallowing were also adequately covered. The inaugural pilot day was very well received by the trainees and we hope this will improve their practice in the future.

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Pain management: a global perspective
Editor—I read with interest the recent BJA postgraduate issue on Managing Pain: Recent Advances and New Challenges. I had hoped for mention of the crisis of acute and chronic pain in low-income countries. Pain is acknowledged as a global health problem\(^1\)\(^2\) and pain management is considered inherent to the highest attainable standard of health as promised by the Universal Declaration of Human Rights.\(^3\) While as many as 10–20% adults are estimated to suffer from pain in low-income countries, where the fewest options for pain management exist, pain, especially chronic pain, may occur in a higher percentage of the population and is likely an important contributor to disability. It is within these same low-income countries that a shift in epidemiology has occurred such that trauma and cancer rank among the leading causes of disability and premature death,\(^4\) and with very little surgical intervention or other treatments available for these disease states, a prolonged and painful disease course is the norm. Tragically, the perfect storm of few trained anaesthesia providers, limited access to non-steroidal anti-inflammatory drugs and narcotics,\(^5\)\(^7\) and an absence of adjuvant therapy for severe pain result in unbearable pain for most of these patients.

The scale and prevalence of pain is largely not known in low-income countries. The international literature reveals only a handful of studies evaluating pain even in middle-income countries,\(^5\)\(^7\) so certainly the possibility of raising awareness, encouraging further analysis, and improving pain management in these settings represents a grand challenge. The BJA has often focused articles on such crises and challenges, and with this in mind, I bring you my comments on the excellent July issue on pain management.

Fig 1 Responses from the trainees regarding their training and level of confidence in dealing with airway emergencies in tracheostomized patients.

ct, core trainee; st, specialist trainee.