anaesthesia and neuromuscular block may be more appropriate. If cricothyroidotomy is anticipated to be a likely option then we agree that infiltration of local anaesthetic with vasoconstrictor and preparation of equipment such as diathermy is a wise precaution, in this situation we would also recommend calling an ENT surgeon.

The guidelines have been produced to support decision making in the face of unanticipated difficulty with airway management. When plans A to C have failed to maintain oxygenation and the decision has been made to move to plan D, the situation has become time critical. The technique required for accessing the airway through the front of the neck is necessarily different to the way an ENT surgeon would perform an elective or urgent tracheostomy, and needs to provide the anaesthetist with the best chance of restoring oxygenation rapidly.

The recommended 8-10cm vertical incision will increase bleeding, but this is only advocated in patients where the cricothyroid membrane is not palpable or where the default technique (a single transverse stab incision through skin and cricothyroid membrane) has failed. Urgent surgical review of the cricothyroidotomy site (after an airway has been established) is explicitly recommended in the guidelines - in the UK this would usually be undertaken by an ENT surgeon, with access to a full set of surgical instruments and ancillary equipment such as diathermy.

Declaration of interest
None declared.

References

DAS guidelines: the end for pre-paralysis mask ventilation check?

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Editor—I read with interest the article by Dr Frerk and colleagues’ outlining the new Difficult Airway Society (DAS) guidelines for the management of unanticipated difficult intubation in adults and the accompanying rationale for their implementation. I wholeheartedly support the simplified and didactic nature of the guidelines and agree that, in times of extreme stress, clinicians need fewer recommendations to consider, not more.

One could not help but notice, however, a thread that may radically alter the way we all induce anaesthesia and teach our trainees to do so.

Following the new guidelines through to their logical conclusion in each scenario, the requirement for adequate neuromuscular block (NMB) is deemed essential at every step. This may seem counterintuitive to many as to preclude the option of ‘bailing out’ and waking the patient up in the event of failure to oxygenate. The 2015 guidelines only guide the clinician to wake the patient up after an adequate airway and oxygenation have been established, and in order to achieve this, NMB is advised throughout.

If this approach is to be adopted, one should ask if, as things get more fraught and the oxygen saturation tone gets lower, I am being asked to give more NMB agent, why wouldn’t I just administer it to the patient as early as possible? Doing so would reduce the likelihood of plans B, C and D being required in the first place and also negate the need to consider it again at step C, provided an adequate dose had been given at the outset.

A quick straw poll of the consultants in our department still puts pre-NMB ‘checkers’ way ahead of ‘non-checkers’, a view that is further emphasised when they were asked what advice they would pass on to a trainee.

This view is in agreement with both historical and current teaching and one would imagine reflects wider practice however, if universally accepted, the 2015 guidelines may cause us all to re-think the logic of checking mask ventilation before administering NMB, once and for all.

Declaration of interest
None declared.

Reference