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Editor—We would like to thank Dr Stewart for his interest in the recently published DAS Guidelines.1 He has identified an area where there may be much discussion over the coming months.

There is evidence that difficult mask ventilation is associated with difficult tracheal intubation2,3 and the guidelines highlight the importance of preoperative airway assessment, indicating that where difficulty with ventilation or tracheal intubation can be anticipated, strategies other than i.v. induction of anaesthesia and neuromuscular block may be more appropriate (e.g. awake fibreoptic intubation).

The guidelines have been produced to support decision making in the face of unanticipated difficulty with airway management; there is an evidence base for improved mask ventilation after neuromuscular block, so considering Dr Stewart’s comments solely in the situation where the airway has been assessed and no difficulty is anticipated the question we need to ask ourselves is:

If facemask ventilation turns out to be really difficult in an apparently normal patient should I...

a) continue attempts at mask ventilation and plan wake up while awaiting return of spontaneous ventilation? or

b) work through the other steps in the guidelines all of which are likely to be more effective in a paralysed patient?

How we answer this question should determine how we teach our trainees to manage induction of anaesthesia, where neuromuscular block is part of the airway management strategy.

Declaration of interest

None declared.

References


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Atracurium — check, ventilation — check

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Editor—The ability to mask ventilate before the administration of long-acting neuromuscular blocking agents has been the subject of much debate. Although failed mask ventilation is an uncommon airway event, it has been associated with a difficult intubation in 25% cases in a large observational study.1 The review panel in the 4th National Audit Project considered that delay or avoidance of neuromuscular blocking drugs (NBDs) contributed to some of the adverse events reported to them.2 The early administration of NBDs before checking mask ventilation is now encouraged.3

In accordance with the new DAS guidelines,4 sugammadex can be administered for the immediate antagonism of rocuronium or vecuronium in the event of failed intubation, where waking the patient up is planned. However, when atracurium is the chosen neuromuscular blocking agent and intubation and ventilation fails, the ability to attempt to wake the patient is not an option and commits the patient to emergency front-of-neck access. We think this highlights the importance of clarifying individual practice when administering non-depolarising neuromuscular blocking agents. We would argue that check-ventilation should continue where atracurium use is planned. Should ventilation fail, a short-acting or immediately reversible long-acting neuromuscular blocking agent could be administered instead to facilitate intubation.5 This would maintain the potential to wake the patient in line with recent recommendations, should intubation then fail.

Declaration of interest

None declared.
References

3. Patel A. Facemask ventilation before or after neuromuscular blocking drugs: where are we now? Anaesthesia 2014; 69: 811–5
5. Pandit JJ. Checking the ability to mask ventilate before administering long-acting neuromuscular blocking drugs. Anaesthesia 2011; 66: 520–2
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DAS 2015 guidelines for management of CICO

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Editor—We commend the Difficult Airway Society (DAS) Intubation Guidelines Working Group on producing guidelines for management of unanticipated difficult intubation in adults.¹ The guidelines recommend that anaesthetists perform a scalpel-bougie technique should they encounter a CICO scenario, but also state ‘there are, however, other valid techniques for front-of-neck access, which may continue to be provided in some hospitals where additional equipment and comprehensive training programmes are available.’ We hope that the authors will highlight their conditional support for these techniques, as we feel that the statement is somewhat at odds with other comments in the text.

The authors refer to an algorithm and techniques for managing the CICO scenario that were developed in Australia² through regular live animal simulation training. The approach is framed around emergency reoxygenation, using techniques that match the anaesthetist’s skill set. It encourages attempts at both cannula and scalpel (a scalpel-bougie technique) if required, in a logical order. This algorithm for managing the CICO scenario has gained widespread acceptance in Australia. It is taught in a standardised fashion, at conferences where CICO training is offered, and an e-learning module has been produced.³ There is also a CICO instructors’ course to ensure quality and consistency of teaching around Australia and New Zealand, and to help departments achieve institutional preparedness. There is now growing support for this approach in regions of the UK: in May 2015 the All Wales Airway Group (AWAG) agreed to standardise the CICO approach in Welsh hospitals along these lines. Currently, 11 of 15 hospitals are actively setting up rigorous training and equipment requirements (Lacquiere D, personal communication, 2015), or have already done so.¹ Three CICO Instructors’ Courses have already been held in Wales,² and standardisation is also being considered in the South West of England by the South West Airway Management Society (SWAMS) (Varvinskiy A, personal communication, 2015) as there is a groundswell of opinion to support it.

We are therefore encouraged that DAS have given their support for ‘other valid techniques’. However anaesthetists in Wales, the South West of England and beyond may feel reluctant to use these techniques, despite having comprehensive training and immediate availability of equipment, given the following statement made in the guidelines regarding the Australian algorithm: ‘Further evidence of the efficacy of this technique in human practice is needed before widespread adoption can be recommended.’ As is mentioned by the authors, current evidence regarding front-of-neck-access does not replicate well the situation faced by anaesthetists in a CICO scenario, but this also holds true for the scalpel-bougie technique recommended by DAS: neither the surgical airways performed in NAP4² nor the pre-hospital studies quoted in the DAS guidelines³–⁵ use the scalpel-bougie technique as described by DAS.

In summary we are concerned that the 2015 guidelines may inadvertently hamper the work being done in the UK towards delivering excellence in CICO care. To prevent this, we ask that the authors reiterate their support for hospitals that wish to use the Australian CICO algorithm, providing they have institutional commitment, together with robust training programmes and the required equipment in place.

Declaration of interest

None declared.

References

4. Mincher N, Richards C. ‘Can’t intubate, can’t oxygenate’ (CICO): A course for practical management. poster presented at world airway management meeting, Dublin; 2015
5. The All Wales Airway Group CICO Instructors’ Course. Available from https://allwalesairwaygroup.co.uk/event/view/22 (accessed 5 September 2016)
6. 4th National Audit Project of the Royal College of Anaesthetists and the Difficult Airway Society. Major