Reply to commentary on article M. Łasińska-Kowara et al.: “Complications after using the Airtraq laryngoscope for a predicted difficult intubation”

Magdalena Łasińska-Kowara

Department of Cardiac Anaesthesiology, Medical University of Gdańsk, Poland

Thank you for your comments to the paper “Complications after using the Airtraq laryngoscope for a predicted difficult intubation” published in Anaesthesiology Intensive Therapy, volume 45, no.1, 2013 (pp. 35–37) and for valuable remarks regarding planning and management in cases of predicted difficulties in securing the airway. Moreover, I am grateful for providing me with the newest papers focused on this issue.

I reckon that it is easy to write about our successes but only thanks to the revealed failures and matter-of-fact discussions, further failures can be avoided.

Safe anaesthesia planning comprises not only securing the airway for the surgery but also prediction of difficult situations during the immediate postoperative period. In the case described by us, one of the key aspects was the fact that the surgical procedure involved the high cervical spine, which poses a serious risk of acute respiratory failure at any time during the postoperative 24 hours (or even several subsequent days). It is known that fibreoptic intubation is not the management of choice in emergencies; for the reason you have mentioned, it requires good preparation and patient’s cooperation. Considering this, we decided to check whether the intubation is feasible with the equipment that can also be used in rescue cases. We were aware that the attempt could end in failure. We should probably discontinue our attempts when, despite earlier preparation and administration of local anaesthesia, it became clear that the patient was not going to cooperate during intubation and required deeper sedation.

I do share your opinion (vide the discussion) that scheduled fibreoptic intubation under local anaesthesia is the prime method of securing the difficult airway. It is true that this procedure is included amongst the practical skills in the curriculum of anaesthesiology and intensive therapy specialisation. Unfortunately, in many centres this requirement is neglected. Most likely, this results from the fact that many specialization supervisors trained when intubation fibrescopes were practically unavailable in our country cannot supervise proper performance of fibreoscopic intubation. The case we were faced with happened several years ago. Unfortunately, the changes take place very slowly. The list of specialization courses supervised by the Medical Centre for Postgraduate Education of 2012 and 2013 there does not contain any courses in difficult airway, which would enable the residents specializing in anaesthesiology to learn at least simulated fibreoptic intubations. Such courses are available only as training courses for specialists; moreover, many of them are payable. The recruitment for this year has already been completed.

I believe that the trainings in your centres are worthy popularisation. It is high time fibreoscopic intubation became the practical and not on-paper skill of Polish anaesthesiologists. To achieve this goal, better availability of equipment, simulators and trainings, not to mention the changes in mentality are required.

I do hope that the case described and your comments will contribute to the improvement of the present situation.

Corresponding author: Magdalena Łasińska-Kowara, MD, PhD
Department of Cardiac Anaesthesiology, Medical University of Gdańsk
ul. Dębniki 7, 80–211 Gdańsk, Poland
e-mail: magda@gumed.edu.pl