Difficult Airway Society

NEWSLETTER

PROJECTS UPDATES

DAS ASM-TORQUAY

MSF-NOMA PROJECT

TRAVEL GRANT FEEDBACK

AIRWAY LEAD ARTICLE

AUTUMN 2016

EDITORIAL

In this Projects Edition, we learn about some of the projects that DAS is currently involved in. One such project is looking at the decontamination of videolaryngoscopes and flexi scopes; with such a variety of devices coming onto the market, it is confusing to know how to clean them all correctly. The Decontamination Committee hopes to finish its work soon and publish guidelines.

There is an update on the DAS Airway Alert Card and Difficult Airway Database. A pilot project is now underway and with the support of the Airway Leads in a number of hospitals, more and more trusts are granting approval.

The first RCoA-DAS Airway Lead Advisor (Dr Alistair McNarry) has been elected and in collaboration with the RCoA, DAS aims to increase the uptake of Departmental Airway Leads to 100%.

Andy Higgs, our treasurer, describes how the money is being spent on a wide range of activities such as funding research, projects and guideline development, and education. The influence of DAS continues to spread worldwide. The 2015 guidelines for the management of unanticipated difficult intubation in adults and the 2015 guidelines for the management of difficult and failed tracheal intubation in obstetrics continue to generate great interest with over 100,000 downloads and to date translation into five different languages.

DAS is very involved in the development of guidelines for Front of Neck Access. An important development just announced is the joint publication of an editorial regarding Front of Neck Access by the BJA and Clinical Otolaryngology. This is a promising step forward with surgeons and anaesthetists working together to improve patient safety.

In August, there was the very sad news of the sudden death of Dr Sudheer Medakkar who has been a passionate ambassador for DAS for many years. A full obituary is published in this edition.

Next month is the DAS 2016 AGM in Torquay. If you haven't already booked your place, this is your project for the day. Book your place now!

Joy

A Sajayan **Joy Beamer**

newsletter@das.uk.com

PRESIDENT'S PAGE

As I near the end of my first year as President of DAS it seems an appropriate time to reflect on what the society and its members have achieved over the last year.

The 2015 guidelines for the management of unanticipated difficult intubation in adults and the 2015 guidelines for the management of difficult and failed tracheal intubation in obstetrics continue to generate great interest with more than 100,000 downloads and to date translation into five different languages.

The first RCoA-DAS Airway Lead Advisor (Dr Alistair McNarry) has been elected and in collaboration with the RCoA we aim to increase the uptake of Departmental Airway Leads to 100%. To support Department Airway Leads training packages (led by Dr Viki Mitchell) on the DAS guidelines are being developed. At University College London Hospital Dr Mitchell and the Airway Lead Dr Kirstie McPherson have organised training on the recent guidelines for more than 100 consultants and trainees in the space of a few months. This is of course happening in many hospitals but we want to see this happen in all hospitals. Our aim is to make this process as easy and efficient as possible for Department Airway Leads with a package of slides, videos and educational material to support the guidelines.

The first industry grant to DAS to support ADEPT (Airway Device Evaluation Project Team) to study a new second generation supraglottic airway device will allow a multi-centre collaborative clinical trial with centres in Cardiff, Bath, Oxford, Reading and Northampton. It is difficult to imagine a more experienced group of centres with such a history of supraglottic airway device research.

PRESIDENT'S PAGE

This year, it was with great sadness that the society announced the sudden death of Dr Sudheer Medakkar. It was after giving two extremely well-received lectures and heading two airway workshop sessions for DAS at the Kenyan Society of Anaesthetists 24th Congress in Mombasa that Sudheer suddenly collapsed. Despite prolonged resuscitation efforts by four fellow DAS trainers, Sudheer sadly died on the 20th August.

Looking forward, a new 'DAS app' for DAS guidelines has been launched. A number of projects also continue to develop including the Airway Alert Card and Difficult Airway Database, DAS ICU guidelines and decontamination guidelines.

I hope to see many of you at the DAS Annual Scientific Meeting in Torquay, in what promises to be an exciting scientific and social programme.

See you in Torquay

Anil

SECRETARY WRITES……..

Incredibly, it is not too long before the next DAS ASM. The 2016 slot was always going to be a tough gig after the irresistible force that was WAMM Dublin last year. However, the programme looks fantastic and Andrey Varvinskiy and his team have been working very hard to ensure another fabulous meeting. Barring WAMM, I cannot recall a more international list of speakers to whet your appetites.

Torquay

After the summer recess, I perhaps have less to report this time around. DAS has now received its first ever grant for airway research through ADEPT, from Teleflex, and it hopes others may follow suit in promoting multicentre, high quality airway research. Other projects include our Airway Alert Cards and database (for both adult and paediatric patients) and the completion and publication of Guidelines for Airway Management in Critical Care. More projects are planned and all will be revealed soon.

Following the appointment of Dr Alistair McNarry as the new DAS-RCoA Airway Lead Coordinator, DAS is planning a closer liaison with the Royal College in the coming years. The aim is to deliver a more robust and consistent airway management strategy and to set standards with regards to airway training within departments.

The updated DAS Constitution will be discussed at a committee level this month before being placed on the DAS website in advance of proposed ratification at the Annual Members' Meeting in November. Apologies to all for this taking rather longer than planned. We will also appoint a new trainee rep, with a vote at the AGM, to take over from Angus McKnight (thanks Angus) who has completed his term.

The influence of DAS overseas continues to grow. This week there has been a request to translate the 2015 Guidelines into Dutch; this follows translations into Spanish (twice), Croatian, Danish and Chinese. There is considerable interest in South America in DAS – we may see our overseas membership rise considerably in the near future. The Latin American Airway Group, EVA-La, which covers 23 countries, put the translated guidelines on to their website and had 8,000 hits in the first 24 hours! All of this is a complement to the quality and impact of the DAS Guidelines worldwide.

Keep pedalling.

Barry McGuire

Hon Secretary DAS

TREASURER'S REPORT

As I submit the books to the accountant this week, I am struck by how the society's activities can raise both its own profile and that of airway management in general. In keeping with the constitutional aims of the society, we are now an established contributor to nationally appraised research grant awards, local and international charitable activities, guideline development, device evaluation by members with first class track records, member small research projects, patient safety initiatives, educational support for ODPs and direct support for members' educational and development projects.

As the 2015 guidelines are translated into a *5th language* (at the request of our colleagues overseas), there truly cannot be another medical society treasurer who can point to such a bang for his buck. For the price of travel, sandwiches and strong coffee, our society impacts care globally. It is testament to the ethos of British-Irish medicine that our guideline authors contribute to airway safety around the world, but will work for food! (almost). In these post-Brexit times, DAS is helping to make it clear that Britain is still fully engaged internationally. Thanks as ever to Chris Frerk, Mary Mushambi and their teams.

It should be noted that Brexit has had a discernible impact on DAS: before the vote, I had given an undertaking to find a more rewarding home for some of the DAS funds. However, I failed to unearth a sufficiently attractive low risk-high return vehicle for our money. I'm rather glad of this now, as without actually shorting the pound on the evening of 22nd June - and cleaning-up next day as David Cameron resigned - entering the money markets of late remains a depressing experience.

On a happier note, congratulations to Drs Yeow and Groom for securing DAS funding for their respective hospital research projects this year. Please remember any DAS member is eligible to be awarded up to £5000 for an Airway

Small Projects grant. Through the Association of Anaesthetists' IRC, the society has contributed to individual's travel costs to teach in Tanzania and India and we made a direct contribution to Jonathon Downes's team teaching in Jubilee Mission Hospital in Kerala, India. DAS also supported the travel expenses of a team to teach in Mombasa, Kenya, which was very warmly received.

Our society has always believed that first class airway management is a team sport and for the second time in two years, we will be helping with the expenses of 10 ODPs to attend the ASM in November. This is a joint effort with Storz who have decided to continue their commitment to UK airway management by supporting a further 20! Each of the 30 ODPs (or Anaesthetic Nurses) will be eligible for £200 towards their costs. Last year this was expertly administered by Sudheer Medakkar and his death in August is a huge loss to the society. I'm sure his colleagues in Torbay will honour his memory with what promises to be an excellent DAS ASM in Torquay.

I hope to see you all there.

Andy

DAS Treasurer

OBITUARY

Dr Sudheer Medakkar was born in Hyderabad, India in 1951. He qualified as a doctor from Osmania University, Hyderabad in 1974. After stints in India and Iran, he finally settled in the UK and worked at Torbay Hospital since 1991 as an Associate Specialist. He worked tirelessly as part of Registrar on-call rota for a number of years as well as providing anaesthesia for the wide range of elective procedures. His technical skills and clinical judgement were legendary and he was always up for learning new techniques. Life-long learning, empowering others with his knowledge and skills and patient safety were his real motto in life.

Later in his career he developed a passion in the field of difficult airway management. He joined the Difficult Airway Society (DAS) and started to implement many ideas locally. He was instrumental in improving difficult airway care at Torbay Hospital introducing several new types of airway devices. It was due to his efforts that Torbay Hospital became a very early adopter of video laryngoscopy. He took part in creating a new difficult airway trolley well before it was adopted nationally. Sudheer wholeheartedly supported other airway enthusiasts in the department and lots of us still carry his ad memoir on how to perform Awake Fibreoptic Intubation (AFOI). He also co-organised the Torbay Airway Fibreoptic Course which was run free of charge for local trainees in his spare time. He was one of the founding members of the Torbay Difficult Airway Course for doctors since 2000. His greatest contribution was starting the first UK Difficult Airway Course for ODPs, Anaesthetic nurses and Paramedics running it

for around 10 years as a lecturer, workshop leader and director. ODPs of Torbay Hospital are particularly grateful for his efforts to financially support them to attend national meetings using his educational funds.

In 2010 he was duly recognised for his exceptional clinical skills, enthusiasm and expertise and awarded the prestigious Evelyn Baker medal by AAGBI. This medal usually awarded to "Unsung heroes in Anaesthesia" is befitting Sudheer, as he never expected anything in return for what he did.

Sudheer's contribution to further the education and training of ODPs was recognised by DAS and he organised and chaired the inaugural ODP session at the 2014 ASM in Stratford. This was hugely successful and now has become a regular feature of DAS ASMs. We are very proud of the fact the DAS committee has agreed to name this session "Sudheer Medakkar session". Sudheer rightly deserves this legacy.

Many of us who knew Sudheer will remember his infectious smile, his quietly spoken nature and his popularity not only with anaesthetic colleagues but with ODPs and equipment representatives alike. Indeed it was always a pleasure to take part in his workshops where you would be guaranteed that even the minutest details would have been taken care of by Sudheer himself. Of course his hospitality was exceptional and in his relaxed mood after dinner Sudheer would talk endlessly about fast cars, his beloved Indian cricket team and his four grandchildren.

It was after giving two extremely well received lectures and leading two airway workshop sessions at the Kenyan Society of Anaesthetists 24th Congress in Mombasa that Sudheer suddenly collapsed. Despite prolonged resuscitation efforts by four fellow DAS colleagues, Sudheer sadly died on the 20th August 2016.

Our thoughts are with his wife Shailaja, his son and daughter in law, his daughter and son-in-law and his four grandchildren (Siya, Tanisha, Sanya and Shreya) to whom he was devoted.

Prof Mansukh Popat

Dr Andrey Varvinskiy

TRAINEE REP'S PAGE

We hope that you have now settled in to your new jobs and placements. It is now time to apply to be the new DAS Trainee Representative. This is a great opportunity to be part of one of the largest (and in our opinion best!) anaesthetic societies in the U.K. The presence and influence of DAS in the anaesthetic career of a trainee has increased even within the time that we have been training in anaesthesia, and having input from trainees into the committee is more important than ever. DAS influences our training lives throughout, from providing guidelines in clinical practice to recommendations for training in management of the airway and dealing with the difficult airway. The work that DAS does is ubiquitous in the professional life of any trainee. DAS also provides the trainee with opportunities; this may be in the form of facilitating research or in completing an airway related course. If you would like to be a part of the exciting work that DAS undertakes, details of how to apply for the Trainee Representative role can be found on the DAS website.

It is an exciting time in the airway world with the recent editorial on front of neck access jointly published in Clinical Otolaryngology and the British Journal of Anaesthesia. This is the first joint consensus on this matter from the surgical and anaesthetic worlds and represents the trend to establish uniformity and training in front of neck access. Research into airway related topics is going to strength to strength. At the AAGBI annual congress the THRIVE paper was named best paper in 2015 and the ADEPT study is well underway. ADEPT promises to revolutionise how we test airway devices and is an example of an innovative partnership with industry. Further details on all of these projects can be found on the DAS website.

The upcoming DAS ASM in Torquay promises to be a great event. The Local Organising Committee led by Andrey Varvinskiy have put together an excellent programme. There are both workshops, covering various topics such as the use of ultrasound in airway management and apnoeic oxygenation techniques, and a 2 day scientific programme with speakers from around the globe. We hope to see many of you there, not least to see the posters submitted by trainees and hear the top 5 abstract submissions!

Lewys & Angus

DAS MERCHANDISE

Price: Tie £14.00 Cufflinks £6.50 Ladies Scarf £12.00
Lapel Badge £3.50 Tie Clip £5.50

To purchase, please contact DAS@aagbi.org

These will also be available to purchase at DAS ASM Torquay

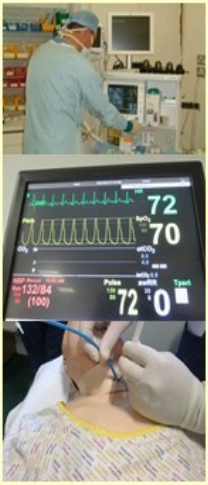
University Hospitals Coventry and Warwickshire NHS Trust

Airway Revalidation Course

Thursday 1st December 2016

Venue: Clinical Sciences Building, University Hospital Clifford Bridge Road, Coventry CV2 2DX

The 3rd Airway Revalidation course will be held on the 1st of December at Coventry. This very sought after course will meet the Airway CPD requirements of anaesthetists. It benefits from DAS standardisation, peer review and quality control. It is based on latest evidence and draws upon the experience and consensus of experts in airway management.



Key topics include

- Airway Assessment
- Practical tips for safe airway management
- Decision making in airway management
- Choosing the right equipment
- CICO scenario
- Extubation
- Human factors and non technical skills
- Airway management outside theatre environment

Registration fee: £ 95 Refreshments and lunch are included in the fee

Approved for 5 CPD credits

The places are limited so please book as early as possible.

For further details please contact Rachel on 024 7696 8722.

E-mail: *courses@mededcoventry.com*

visit ***www.das.uk.com*** *or* ***www.mededcoventry.com***

Approved Courses & Workshops 2016

DAS PROJECT:

Airway Alert Card & Difficult Airway Database

We are pleased to announce that the pilot project of the DAS Airway Alert Card and Difficult Airway Database went live on 1st June. We started off with approval from just one trust. Over the last two months a number of airway leads has shown tremendous interest in the project. We have now got approval for the project from 6 different trusts and the project is being piloted on 12 hospital sites.

1. East Kent University Hospitals NHS Foundation Trust
2. Royal Surrey County Hospital, Guildford
3. Royal Stoke University Hospital
4. St.George's Healthcare NHS Trust , London
5. Warrington and Halton Hospitals NHS Foundation Trust
6. Mid Yorks NHS Trust

Approval is currently being sought in a number of other trusts. DAS is sending out the DAS Airway Alert Card directly to the patients, completely free of charge. While the Alert Card has the critical information about the nature of the difficult airway, more detailed information can be obtained by logging on to the Difficult Airway Database at the DAS website or simply by scanning the QR code printed on the card.

For more details about the project, please visit our website www.das.uk.com/dad. If you would like to participate in the pilot, email us at dad@das.uk.com

K Ponnusamy

J Rangasami

DAS PROJECT: **Decontamination Guidelines for Videolaryngoscopes and Flexible Scopes**

The introduction of videolaryngoscopes in to the gamut of airway equipment has been a welcome change as evident in the Plan A of the new DAS guidelines, which advocates *Laryngoscopy* rather than *Direct Laryngoscopy*. The number of videolaryngoscopes in the market are on the increase, presenting a confusing array of scopes for the user and economic concerns for the procurer. Outside these two concerns is a major concern of cross infection or contamination of these scopes. While manufacturers have diligently tested and recommend disinfecting agents, some similar looking scopes have different recommendations and using the wrong agent can cause damage to the equipment. More importantly, some of the reusable scopes cannot withstand the rigors of routine sterilisation and get damaged. Since some of these currently cost over £15,000, the financial implications are significant. Some of the disposable equipment are totally disposable but many have reusable components with potential for cross contamination. Many studies have isolated pathogens from anaesthetic equipment and from other scopes in use in the theatre complex.

The Decontamination Committee was constituted in September 2015 and has experts from various areas of specialty looking at how best this problem could be resolved. In addition to recommendations as how the reusable parts of these equipment must be processed before use, the committee's recommendations should guide the user, procurer and the manufacturer to make informed, evidence based decisions about the videolaryngoscope manufacture, use and decontamination. A large amount of work has been carried out and over 700 references poured over, and the initial outline of the document is already in place. The coming months should see this project heading towards completion and publication.

Soon a DAS web based discussion forum will be started for the DAS members to comment and contribute towards the document.

Krish
Dr.S.Radhakrishna
Immediate Past Secretary, DAS and
Chair, Decontamination of VL Guideline Committee

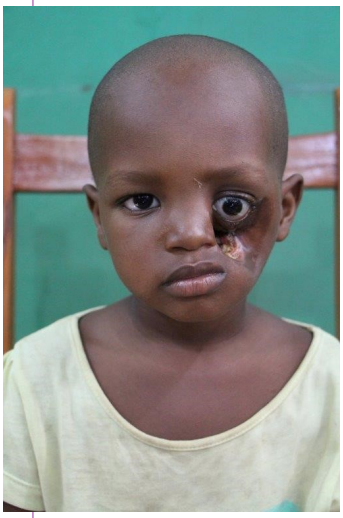
MSF– NOMA PROJECT

As a regular MSF volunteer and airway enthusiast I jumped at the opportunity to join the MSF NOMA project in Sokoto, northern Nigeria in April 2016. Noma is a gangrenous infectious disease affecting malnourished children with a mortality rate of nearly 90%. The survivors are left with facial deformity of varying severity, often with trismus. They require good nutrition, vaccinations, good dental care and facial reconstruction.

Prior to my trip I tried to find out as much as I can about the potential challenges in this project. I spoke to the anaesthetist who had just come back from the mission and was relieved to discover that the Ambu® aScope (my favourite toy) was available. I also looked at the resources from Facing Africa which included videos on YouTube and helpful articles outlining their vast experience. I spoke to an anaesthetic colleague in Kenya who has experience in doing awake blind nasal intubation with ketamine (thankfully that was not necessary). I was also going to be working with another anaesthetist who is experienced in NOMA. This is a luxury as MSF does not usually send two anaesthetists and it was also unusual for them to run an elective surgical project. So far, so good.

In the three weeks I was in Nigeria, we carried out 49 surgical procedures, 20 needed bronchoscopic intubation, many of them paediatric cases with ages as young as three years old. To make it even more challenging they were often small for age but luckily the paediatric Ambu® aScope was available which fits a 4.5mm ETT. All the children received a gas induction with halothane and kept spontaneously ventilated during bronchoscopy until the cords are visualised. Maintaining a good seal with the facemask can often be challenging with the facial defects and some of the children had very poor reserves and desaturated quickly so the aim is a slick intubation. From my time working in East London I know that the Nigerian population hyper-salivate under general anaesthesia and often the IM atropine pre-med was not sufficient – just follow the bubbles. The suxamethonium we had was also unreliable; possibly due to a break in the cold chain. Despite all this we did not have any untoward events.

For two adult patients with complete trismus we carried out awake intubations. Good pre-op patient preparation started with explaining to the patient advocates what AFOI is all about. They are the crucial link to re-assuring the patients in their native tongue. Showing a photo of myself with a nasal tube and a big grin on my face from an AFOI course I went on as a trainee certainly helped convince them that this was not a painful procedure. If having a language barrier was not challenging enough we also did not have the luxury of remifentanil or even anything stronger than 2% lignocaine! The airway was topicalised with a combination of squirting the 2% lignocaine via a suction catheter through the nasal passage, gurgling and cricothyroid membrane puncture. The patients tolerated the scope fairly well and we gave them a GA them once the scope is through the cords and the carina is visualised. Not railroading the ETT whilst the patient was awake was a good trick as often that is the part patients can find most uncomfortable.



I had ideas of using techniques like apnoeic oxygenation (we didn't have the fancy equipment for THRIVE) via the spare oxygen concentrator. I soon discovered that this was not feasible when the patient only has one patent nostril and complete trismus. In fact, we had an additional challenge of extubating the patients when they were safely awake but then having to insert an NG feeding tube nasally before they were too awake. My various sizes of Airtraq kindly donated by a friendly rep were also of no use for our particular patient group but were beneficial to have handy for other cases.

Apart from NOMA cases we also operated on some patients with deformities from trauma, burns and congenital cleft lip and palate. These present with less of an airway challenge and it was nice to be able to use a laryngoscope once in a while.

I wish I could have brought a trainee with me as the number of cases are ideal to get past the learning curve of scope handling in such a focused short period. I really commend Facing Africa for introducing their fellowship.

It was not all work in Sokoto. We had Sunday off every week and despite the security restrictions and 40°C heat we got to see a bit of the city, eat a lot of mangoes, laze around the local pool and even had an audience with the Sultan!

If any airway enthusiasts fancy a challenge, then I would highly recommend this unique MSF project. To join MSF go to http://www.msf.org.uk/working-overseas-applying-msf or drop me an email (nlubis@doctors.org.uk)

Nur Lubis
Consultant Anaesthetist
Whipps Cross Hospital

DAS Travel Grant – **Kerala Airway Workshop**

In August this year a faculty of 7 anaesthetists (2 consultants and 5 trainees) from Whipps Cross Hospital, London were invited by the Jubilee Mission Medical College in Thrissur, India to conduct a one day Airway Course consisting of lectures and workshops which was attended by 45 candidates (consultants and trainees).

We discussed the latest DAS guidelines, commonly used airway equipment in the UK and the Difficult Airway Trolley. We outlined the UK training model including airway fellowships. We introduced the concept of human factors and crisis resource management in difficult airway scenarios. The afternoon session involved a series of 45 minute workshops including: fibreoptic intubation with the Oxford Box, a mannequin and the ORSIM; demonstration of emergency airways using surgical and percutaneous cannula techniques; videolaryngoscopy; supraglottic devices and a low fidelity simulation practising failed intubation drills. The day ended with case based discussions allowing us to share and learn from each other.

As it was our first time teaching on such a course abroad, we were pleased by its success and the positive feedback received. Our aim was to run this as a pilot course with future longer courses planned in late 2017. We were also able to conduct a questionnaire to get an insight into the existing airway practices amongst the candidates.

Discussing the differences between anaesthetic practice in the UK and India was fascinating. Postgraduate anaesthetic training in India is only 3 years in duration, although the case load is significantly higher, especially in the state hospitals. Exposure to advanced techniques is less common, with relatively limited availability of fibrescopes, videolaryngoscopy and costly drugs such as Remifentanil. In a large and diverse country such as India, there are currently no national audits like our own National Audit Projects (NAP). Established national guidelines on difficult airway management do not exist. Some departments have local guidance but in the mainstay it relies on local consensus and individual opinion. There is no universally agreed algorithms or standardised difficult airway trolley. Furthermore, whereas non-technical skills and human factors are established in UK anaesthetic training, the concept is still relatively new to our counterparts in India. Lastly it was very interesting to discuss differences in local practice; for example for Caesarean sections there was wide variation between the use of regional and general anaesthesia as a first line technique, the latter often being performed with Propofol and without the application of cricoid pressure.

Kerala is a beautiful tropical coastal state in South India, with lots of greenery, wildlife including elephants, mountains and of course the beautiful backwaters. We thoroughly enjoyed our time in India. We hope we provided a useful insight into UK airway anaesthetic practice, benefits of standardising drills and equipment as well as the concept of non-technical skills and human factors. We certainly learnt a lot from our colleagues in India and we are indebted to them for their kindness and exceptional hospitality. We would like to thank DAS for kindly supplying us with a grant of £700 towards the costs of our travel expenses.

Dr Jonathan Downes, Dr Katherine Harvey-Kelly, Dr Katherine Grailey,
Dr Stephen Borthwick, Dr Peter Chan, Dr Nurhayati Lubis, and Dr Abdul Nazar

For ODPs/Anaesthetic nurses at the Difficult Airway Society Annual Scientific Meeting

Riviera International Centre TORQUAY (Devon)
16th - 18th November 2016

Great opportunity at a national level to:

- ***Listen***
- ***Learn***
- ***Share***

- There is a dedicated ODP/anaesthetic nurses' session on Friday 18th November
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To book your places go to www.das2016.co.uk/registration

Associate membership is FREE for ODPs/Anaesthetic nurses
Join now at www.das.uk.com

See you in Torquay

For further information Contact:

Martin.brace873@talktalk.net

AIRWAY LEAD ARTICLE

Locally Organised Airway Day: Free, Team Based and Productive

Dr. Bhagyashree Meenu Netke

Consultant Anaesthetist & Airway Lead

The Royal Wolverhampton Hospital NHS Trust

Introduction: *'I hear and I forget, I see and I remember, I do and I understand, I think and I learn.' - Confucius*

Nationwide Airway Days provide a great deal of training by giving learners the opportunity to familiarise themselves with airway equipment in unthreatening surroundings. However, if delegates do not have these airway devices available locally on their DAT (Difficult Airway Trolley), their learning becomes ineffective. Similarly, a lack of regular exposure to advanced airway equipment makes their use challenging in a difficult airway situation. This sentiment was echoed across our department by both medical and non-medical staff. This led to the conception of an Airway Day tailored to our needs.

The Objective: The concept behind NAAD (New Cross Advanced Airway Day) was to train not only the anaesthetists but also the airway team, i.e. ODP's and recovery nurses. I wanted to train the teams using only the airway equipment available on our DAT. The training was designed using workshops and the aim was to deliver it regularly (every year).

Planning: For any course to be successful it requires an appropriate venue, the right tools for training and whole hearted participation by the intended learners. I was confronted with three big questions. How will I deliver a free course? How will I get all Airway teams to attend? And how will I provide it regularly?From the beginning, I was aware that non-medical staff do not have any study budget to go on such a course. This meant the course had to be free in order to maintain their skills. I was successful in engaging the industry to provide manikins

and airway equipment. The industry has a separate budget for training and is more than willing to lease their equipment. The trust's Clinical Skills Department and the industry made it possible to run this course without incurring any cost.

It was important to identify a day where everyone could attend without impacting clinical activity. This was achieved by arranging the training on one of the Governance afternoons. These are normally used for teaching and training. I had to liaise with the theatre managers to get the majority of non-medical staff available for the Airway Day. Once I conveyed what I wanted to achieve, the managers made the task easy for me.

The Airway Day took place in theatres which was beneficial on three fronts: learning could take place in a familiar environment, teams could join in straight after their clinical work and the venue was free of charge.

The Faculty: In our department, we have an 'Airway Interest Group' (A.I.G). As an Airway Lead, I chair the meetings of this group. I proposed that the group took up the responsibility of delivering the training for the course - this was immediately accepted. The group had approved a purpose built DAT (Difficult Airway Trolley) 4 years ago and had recommended what equipment be put on the trolley. Currently the group ratifies the programme for the course according to the needs of the Airway Team. For example, delivering surgical airway skills mentioned in the new DAS guidance. At present, the faculty consists of consultants, senior ODP's, senior trainees and SAS.

The Journey : NAAD is now in its fifth year. The popularity of the course extends from anaesthetic teams to non-anaesthetic airway practitioners e.g. ED doctors and non-anaesthetist intensivists. We train approximately 70-80 candidates every year. The stations on the workshop have evolved over time. For example, identifying the location of DAT and its contents in the first year, to the use of Sugammadex and the surgical airway in recent years. The faculty is growing each year to cater for the expanding candidate numbers.

This has helped to maintain a reasonable group size for the stations as well as allowing the delivery of training within the specified time. Although the industry helps with the equipment, the training is provided solely by the department faculty to avoid a clash of interests. The candidates receive CPD certificates for their attendance. The course forms an important part of revalidation by maintaining airway skills, particularly in Plan D, on a regular basis.

Achievements: The course feedback has been consistently positive. The airway teams feel more familiar and comfortable in using the equipment on the DAT in an unanticipated difficult airway situation. The ODP's and recovery nurses feel confident in assisting with a difficult airway situation. The course is run free of cost which removes the need for the non-medical staff to self-fund or apply for bursaries. As the course is conducted in theatres, it addresses the human factor issues surrounding familiarity with the environment and equipment. The senior trainees get to co-direct the course under my supervision, providing them with organisational and leadership skills. Over the last 5 years, ODP's have also joined the faculty, enabling them to contribute effectively. In turn, the non-medical staff can interact and ask questions without feeling intimidated.

Challenges: The biggest challenge for the course has been managing the growing number of delegates. I have expanded the faculty in order to maintain an acceptable group size. There are more manikins per station so that everyone gets hands on experience. The other challenge has been having a mixed group (medical and non-medical staff). It is difficult to pitch the course at a level to suit both groups. I have addressed this by making separate groups of doctors and non-medical staff. This is less intimidating for the non-medical staff and allows them to interact better.

Conclusion: NAAD is an example of how a locally tailored free training programme can be provided on an annual basis. The afternoon also becomes a team bonding exercise and a platform for discussing issues specific to a certain specialty area - for example maternity ED and intensive care. The course is extremely rewarding personally and a very positive experience at a departmental level.

AGENDA DAS ANNUAL MEMBERS' MEETING 2016

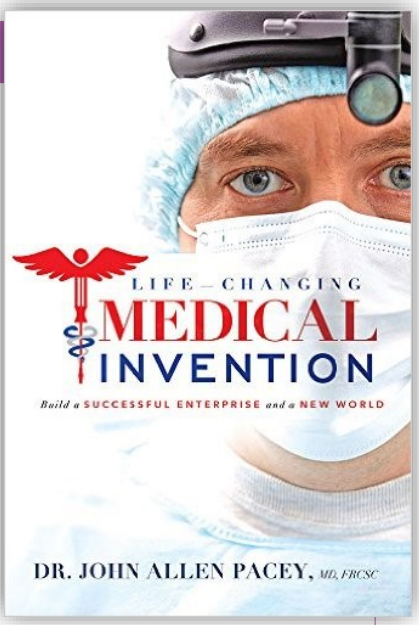
Friday November 18 2016
0930-1030
Torquay ASM

I.	Welcome	
II.	Approval of Last Meeting's Minutes	
III.	President's Report	AP
IV.	Secretary's Report	BM
V.	Treasurer's Report	AH
VI.	Scientific Officer's Report	TW
VII.	Trainee Report	AM/LR
VIII.	Constitutional changes	BM
IX.	New Trainee Rep.	BM
X.	DAS Projects	BM
XI.	Teleflex Proposal	TW/AP
XII.	DAS ASMs 2017, 2018	
XIII.	DAS Medal	
XIV.	A.O.C.B.	

Life-Changing Medical Invention:

Build a Successful Enterprise and a New World

by Dr John Allen Pacey



Dr John Allen Pacey is an honorary Professor at UBC medical school, Canada, cofounder of Saturn Biomedical Systems and ex-president of Verathon Medical Canada.

'Life – Changing Medical Invention' provides his personal insight into invention and innovation in the medical world that led to the development of the well known difficult airway device the 'GlideScope'.

The book begins with a brief account of Dr. Pacey's transition from busy vascular surgeon to innovator and co-founder of Saturn Biomedical Systems. The author reflects on how his father, a relentless innovator with a massive drive to succeed, had a powerful impact on his personal approach to life.

Having spent 20 years as a vascular surgeon Dr. Pacey reflects on his conscious decision to become an inventor of medical technology. In 1998 while waiting to perform a cholecystectomy, Dr. Pacey witnessed anaesthetists struggling to intubate the patient with an unanticipated difficult airway. It was at this moment he recognised that the use of a video assisted laryngoscope would be beneficial to aid anaesthetists when confronted with a difficult airway. From here at his Collingwood Laboratory using outdated endoscopy equipment he began engineering the first GlideScope prototype.

The author attributes the success of the Glidescope to two factors, engineering excellence and device appeal. This formed the basis on which all of the models were produced.

In the subsequent chapters, Dr. Pacey elucidates product marketing, the importance of intellectual property and more generally how to build a business for success. He emphasises that as physicians, our training dictates we involve patients in the decision-making of their diagnosis and management. However as an inventor, a more single-minded approach is necessary, which values proposition. This was evident from the product's infancy as Dr. Pacey recognising his limitations surrounded himself with people outside of the medical world with expertise in business, marketing and engineering.

He draws on lessons learned from other successful medical inventions including the laryngeal mask airway and I-gel. Dr. Archie Brain who developed the LMA in 1982 attributed communication as one of the most important skills to inspire interest in the product.

Dr. Muhammad Nasir, the inventor of the I-gel, worked with limited resources and support from other colleagues to produce the supra-glottic device we all use today. His single-minded approach and willingness to risk all are attributes that Dr. Pacey relates and admires.

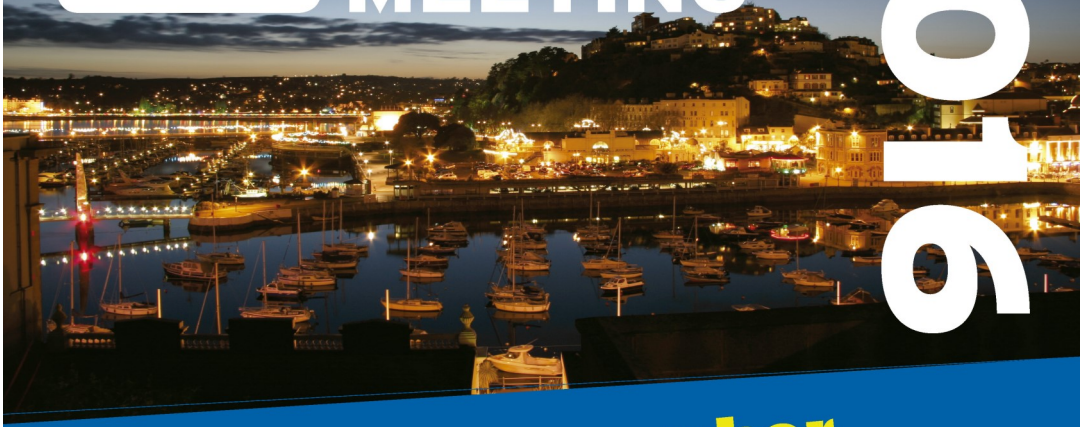
In conclusion, the book provides an interesting overview in the development of the GlideScope that has helped in the management of difficult airways globally. It is targeted to inspire physicians with a desire to explore and advance the world of medical innovation and invention. However, we feel that, the intricate details surrounding product marketing and business development towards the end of the book has affected the opportunity to mesmerize the reader with fascinating real life tales of medical inventions

Dr Ben Wooldridge **Dr. Ajit Walunj**

Good Hope Hospital, Sutton Coldfield

DIFFICULT AIRWAY SOCIETY

ANNUAL SCIENTIFIC MEETING 2016



16th-18th November

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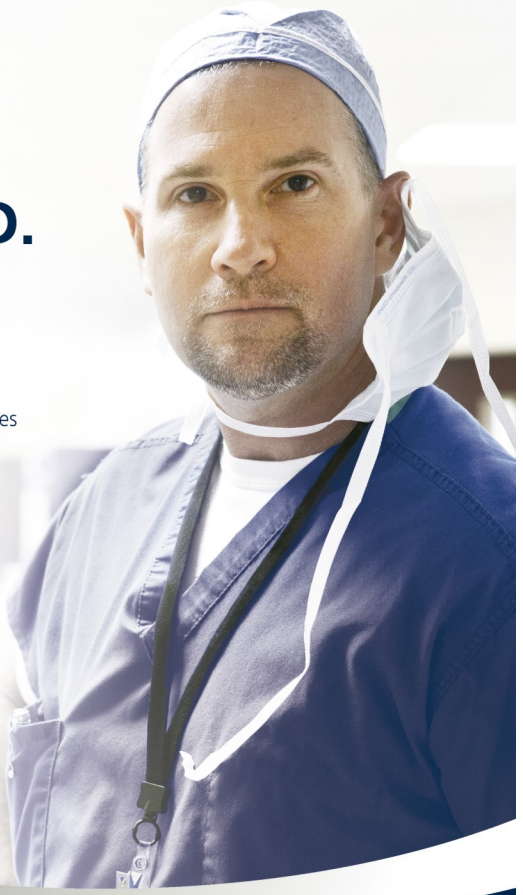

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