Difficult Airway Society

NEWSLETTER

SUMMER 2016

EDITORIAL

DAS airway alert card is currently being piloted at few sites and my trust is one of the 'chosen' ones. So far, the experience of establishing this important patient safety project at the pilot sites have been quite variable. Some of the potential barriers include information governance approval and R & D department verification. This early experience could be quite useful to others when we role out the project nationally very soon.

From this issue onwards, we will be publishing the examples of good practice in airway management across the country, that were presented at the last Airway Leads day. The first of the series is from Dr James Palmer, the Airway Lead at Salford Royal Infirmary. We have also reproduced the full report on the Airway Leads day by Dr Seema Charters from the RCoA bulletin .

We have published a guidance note for DAS members who are involved in organising airway courses in the UK. Hopefully this will answer many FAQs in this regard.

The Torquay ASM programme looks very promising and we are looking forward to see many of you there. Dr Magides from Torquay gives us a glimpse of 'the things to do' in Torquay during the upcoming ASM in November. The very successful ODP session will feature again and we expect many of our 'co-pilots' to take up this wonderful opportunity to be part of the bigger picture.

Hearty congratulations to Dr Alistair McNarry, Dr Cyprian Mendonca and Dr Ronan McCaul for their new roles as the DAS-RCoA Airway Leads advisor, AAGBI Featherstone Professor and the first ever DAS Scholar respectively!

Enjoy your summer

Sajay

A Sajayan **Joy Beamer**

newsletter@das.uk.com

PRESIDENT'S PAGE

As we enter a new chapter in our history following the Brexit vote, on the same day as the referendum results were announced, I was delighted to see correspondence from the European Airway Management Society (EAMS) announcing the 3rd European Airway Congress in Valencia, Spain in early December. I've had the pleasure of attending the previous two meetings and this year's programme looks excellent. I will certainly be supporting our European friends and will be escaping a cold December weekend in London for sunny Valencia, I hope some of you will be able to join us.

I am delighted to announce Alistair McNarry (picture) was successful in recent interviews at the RCoA for the post of RCoA-DAS Airway Leads Advisor. Alistair has been organising the Airway Leads Day and many of you will know him from this. The role is an extremely important one as a point of contact for the RCoA, DAS and Airway Leads. The Airway Leads are the most important group to influence airway practice as we go forward and one of our first tasks is to ensure that every hospital has an Airway Lead.

I'm also very much looking forward to this year's DAS Annual Scientific Meeting in Torquay on the 16th-18th November. Andrey Varvinskiy Chair of the local organising committee and the team have put together an excellent scientific and social programme with speakers from all over the world. All the details are available on the DAS website, book your leave now!

I am also delighted to announce that the first project grant has been made to ADEPT (Airway Device Evaluation Project Team), to look at the safety and efficacy of a second generation supraglottic airway device. The aim of the ADEPT is to establish a process by which the airway management community within the profession can lead a process of formal device/equipment evaluation. We are about to start the first of what will hopefully be many ADEPT projects.

I hope you all enjoy the summer.

Anil

SECRETARY WRITES……..

Hello again. Summer has arrived in Scotland (presumably elsewhere too!) so all is well. DAS is not slowing down yet for a seasonal recess with several exciting projects being launched or continuing to make progress in development. These include an inaugural project grant to support formal evaluation of a new second generation supraglottic airway device under the umbrella of ADEPT (Airway Device Evaluation Project Team); DAS Airway Alert Cards and on-line database; and developments in airway education that we hope will help deliver a consensus approach to airway rescue across disciplines. We have an extremely exciting programme on offer for the ASM in Torquay in November with a distinctly international flavour and Alistair McNarry from the Guidelines Group is off Atlanta, Georgia in September to speak at the Society for Airway Management (SAM) annual meeting on the topic of the 2015 guidelines. I hope they are ready for his razor sharp wit and challenging lecture style!

DAS, through ADEPT, will launch its fantastic Teleflex-sponsored research grant proposal, which is the first of its kind in the UK. This will allow DAS to facilitate a multicentre evaluation of a new airway device. Information is already available on the DAS website. This is an exciting proposal and, hopefully, will encourage other companies to invest in high quality equipment evaluation prior to release of their airway product.

Implementation of the 2015 intubation guidelines continues to develop with many authors, companies and educators requesting permission from DAS to use the algorithms and text in a variety of publications and settings. Airway carts have been reshaped across the country to match the new algorithm. The DAS website has several downloadable and editable versions of new airway trolley drawer labelling and the hope is that members and Airway Leads will use this material to improve the presentation and layout of the airway rescue carts within their trusts. Chris Thompson has done fantastic work in designing these pictorial templates and he would be grateful if any users get in touch with him

to relay their experiences with them and, specifically, the changes they have made to adapt the templates to their place of work (acdthompson@icloud.com)

Some controversy has arisen in relation to DAS's decision to give 'Scalpel-Bougie-Tube' primacy with respect to Front-of-neck-access (FONA) education. DAS insists that all airway interventionists must be trained in this relatively straightforward, albeit extremely stressful, life-saving manoeuvre in the management of a CICO scenario, as it believes that the principles of simplicity, consistency and efficacy are paramount. Specific departments are absolutely at liberty to deliver an alternative FONA approach in terms of education and practice, but DAS would expect this to be in addition to, rather than instead of, training in surgical cricothyrotomy. Furthermore, discussions are ongoing in relation to the training of surgeons in the surgical approach.

If CTM impalpable, consider:
• Ultrasound scan front of neck / discuss with surgeons
• Awake fibreoptic intubation

Plan A
Intubation
Max 3 attempts +1 EXPERT
video/alternative laryngoscope
bougie or stylet
ELM relax cricoid
rotate ETT if hold up
Position
Pre/nasal O_2
ET CO_2
NMB dose + monitoring
BACK
UP
RIGHT
90°

Plan B
Oxygenation via SAD
Max 3 attempts
Declare failed intubation
Call for help
2nd generation SAD
RSI Remove cricoid to insert
Success
Failure
Plan C
STOP THINK
Wake patient up
Keep SAD easy ventilation low aspiration risk
Fibreoptic, Aintree & ETT 7.0

Plan C
Facemask ventilation
Declare failed SAD
Postpone surgery
2 person technique
Success
Wake patient up
Failure
Plan D
reverse NMB
consider Sugammadex

Plan D
Stab, Twist, Bougie, Tube
Scalpel size 10 blade, rotate, bougie, size 6.0 ETT
Ensure paralysis
laryngeal handshake
transverse stab incision
rotate
90°
coude tip vertically down blade
ETT 6.0

Plan D
Scalpel, finger
Impalpable cricothyroid membrane
Optional:
vertical incision 8-10cm
blunt dissection
then, Stab, Twist, Bougie, Tube

This May-June, I updated the DAS constitution to reflect what actually happens in the society in 2016! This will soon be available on the DAS website for the perusal of members prior to proposed ratification at the AGM in Torquay. I don't think there is anything too controversial in there, but that's for you as members to judge. Feel free to comment and/or criticise!

Enjoy the summer.

Barry McGuire

Hon Secretary DAS

Updates from DAS Scientific Officer

DAS is pleased to announce that it is now a full NIHR Partner. This is a very important stage in our development as an independent organisation that supports research. On one level it places us in the 'big league' of those organisations that are recognised as providing research support in approved ways (eg, previously it was only the NIAA with this partner status). At a more practical level, it means that DAS can make direct grant awards, outside of the NIAA, at times and levels of its choosing, and award recipients will automatically have their clinical trials registrable on the NIHR portfolio. In turn this may automatically bring with it additional resource support such as infrastructure, nurse support, etc.

Another important announcement is the election of our first DAS Scholar. Dr Ronan McCaul submitted published works, judged by two professors associated with DAS and ratified by Committee as worthy of election. Ronan will be submitting works for a PhD, mentored by DAS, and update us on his progress. On receipt, he will I am sure deliver a lecture to an ASM! Congratulations to Ronan, and I am also pleased to report there has been further interest in this initiative - so do please review the process at www.das.uk.com

Submissions for 2016 round of DAS Professor awards has closed and we are pleased to report several applications are being considered by an international panel of experts, including lay representation. The DAS Professorship is now an internationally recognised award, the title held in perpetuity, with a robust and competitive process for election. The awardee(s) offer a lecture to the ASM by way of inaugural lecture - in Nov 2016 it will be Professor Ellen O'Sullivan (elected Nov 2015) and Professor Tony Wilkes (elected Nov 2014, but who unfortunately missed his 2015 inauguration). Please consider applying in future years!

Prof Jaideep Pandit

DAS Scientific Officer

DAS approved courses and workshops: a guidance for members

DAS committee appreciates the immense amount of work done around the UK &Ireland by local and national organisers / faculties in delivering airway courses and workshops. The committee hopes that offering 'DAS Approval' will help course development and delegate recruitment to these vital educational resources. We have approved many excellent courses and look forward to many more.

To help members seeking *DAS Approval*, we ask that the following requirements be borne in mind:

(i) Airway course be **based in UK or Ireland**; Main course **organiser should be a Consultant** and **DAS member**.

(ii) **Recognition visits:** a DAS representative does occasionally make visits to courses as part of the approval process in order to receive feedback from local teams & inform approval process.

(iii) **Course material:** reference and exposition of latest DAS guidance [1] should be included in the course material. It is *not* necessary to exclusively teach DAS guidelines, but *DAS Approval* implies that the DAS approach to the relevant area of airway management is included.

(iv) **Front-of-neck-access:** As they are implemented, we hope the DAS 2015 guidelines represent a significant step forward in airway management in the UK & Ireland. In producing guidance, the DAS 2015 guideline expert group were specifically tasked with reviewing the currently available literature to inform practice and distill this down to as straight-forward an approach to CICO as possible. It was felt crucial to give clear advice on how to use an almost universally-applicable technique which can be taught and used by clinicians of all levels of experience. Standardisation is useful in rarely encountered crisis

situations and the DAS 2015 guideline group *selected 'a didactic scalpel technique to promote standardised training'* *.

In recognition of this consensus approach, *DAS Approval* implies that the course makes it clear that the national DAS guideline *gives primacy* to the scalpel-bougie-tube technique. Teaching non-scalpel approaches is also important; DAS recognises this and does *not* insist that the scalpel technique is taught exclusively. But use of other techniques in the CICO situation should be limited to experienced clinicians who use them in routine clinical practice

**Frerk C et al. DAS 2015 guidelines for management of unanticipated difficult intubation in adults. BJA (2015); 115 (6): 827-48*

DAS DIFFICULT AIRWAY DATABASE
and
DIFFICULT AIRWAY ALERT CARD

DIFFICULT AIRWAY
ALERT CARD
Show this card to your anaesthetist if you need an operation.
Name:
DOB: NHS No:
Date of event:
Hospital:
Issued by Difficult Airway Society (DAS), UK
For more information including reporting lost card visit www.das.uk.com/aac

Difficult bag mask ventilation?
Difficult SAD placement?
Difficult direct laryngoscopy?
Difficult tracheal intubation?
ACCESS CODE: (to access more clinical details)
Use above code at www.das.uk.com/aac or Scan above QR Code.
Brief report of airway incident:

Pilot Projects launched

For details visit www.das.uk.com/dad

CONGRATULATIONS

DAS congratulates Dr Cyprian Mendonca on his selection as the **AAGBI Featherstone Professor 2016**. Cyprian is a Consultant anaesthetist at the University Hospitals Coventry and Warwickshire NHS Trust. He was a member of local organising committee of DAS-ASM 2014 overseeing the workshops and a member of the working party developing DAS 2015 guidelines. He is a regular faculty member of DAS airway workshops and Airway Revalidation Course. He organises the Coventry Airway Management course, SMART anaesthesia course and has set up the state of the art Coventry Airway Lab and have provided more than 150 free advanced airway-training sessions so far.

His academic interest involves medical education and airway management. Through sustained commitment to medical education, he published five exam preparation books in anaesthesia over period of four years from 2007 till 2011 and two books for medical students. He is actively involved in airway research and has published several papers in the peer-reviewed journals.

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LAY MEMBER WRITES….

In my humble opinion the introduction of the Friends and Family Test (FFT) into the NHS was huge waste of public money – let's be honest there have been many others; not least the myriad of top down re-organisations we have suffered, but for me it was certainly up there with the best. Virtually all Trusts would have diverted much needed resource (and I suspect across the whole service it runs into millions of pounds) into implementing this meaningless test only to find out it told them absolutely nothing about the patient experience and the quality of the care being delivered and how they might improve it.

What we ended up with was a system designed as a measure of customer or brand loyalty being used as a proxy measure of the quality of care being provided by hospitals. To make this even worse, the NHS did what it always has done and produced 'league' tables of FFT scores and we ended up comparing the so-called quality of patient experience across the whole gamut of acute hospitals, large or small, teaching or DGH, inner city or rural. It was a bit like taking the FFT score for Harrods, Poundland and the local corner shop and using it to decide where you would most like to do your shopping!! This of course also assumes that every Trust was using the same and consistent methodology to collect the data – they weren't.

Publicising the FFT scores also perpetuated the myth that patients had real choice – as you lay in the ambulance with your chest pain were you really going to ask the paramedic to drive you 40+ miles further than your local hospital because their A&E FFT score was better and Auntie Vera recommended it last year? – err NO I don't think so, and I am 99.99% sure the paramedic would have politely ignored you. In addition, the fact that Auntie Vera recommended it, not because the staff were compassionate and were delivering great care but because she preferred the ice cream there, would not have been apparent from the FFT score. The FFT implementation dumbed down what many Trusts were trying to do in capturing the real patient experience and what was important to patients. Of course you can't simply ignore patient feedback on food and car

parking, these things are important to people but what is much more important is to capture whether patients are being treated with kindness and compassion, if they feel safe in your care, have privacy and are treated with dignity and feel well informed about their care amongst other things.

So why I am offloading to you about the FFT? Capturing patient feedback in a way that is more meaningful than useless scores and smiley faces is really important. Providing a system that allows patients to tell us why their experience was positive or negative (and even how we might to do better), does allow us to shape and improve our services. But it is also really important for our staff. I can pretty much guarantee if you capture feedback around kindness, compassion, being treated with dignity and feeling safe it will be overwhelmingly positive – staff deserve to know that. I suspect it may not be quite as positive around communication and information but we can do something about that to improve it. So if you are not capturing this information I urge you to do so, I know it is not as straightforward in your specialty as in other areas but it is possible, seek help from your Quality or Patient Experience Team if you need it. By all means ask the questions that are important to you and your service but please also include the types of areas for feedback I have suggested above, and if possible allow patients (and relatives/carers) to tell you what other things were important to them, it isn't always the things that we think are. By all means capture scores out of 10, it does help you track improvement, but most importantly try and capture the WHY. Good luck !

Paul Martin

Lay member, DAS Committee

TRAINEE REP'S PAGE

A lot has been going on since the last newsletter. To update you on our main project as trainee representatives, we are aiming to create a comprehensive video library of airway management techniques as a resource for teaching. We have been working on our pilot set of videos to see how we can best demonstrate both practical and decision making aspects of managing the airway. We've encountered the expected problems and more but are persevering – expect to see results on the DAS website soon.

We are going to start with the skills outlined in the College's basic syllabus before working on more advanced areas. As there is potentially a large range of techniques to capture, we will also be setting out a specification, a standard consent form, and make standard video segments available. We hope that other trainees will be able to add to the archive easily as part of their advanced training modules. We will also look at using existing videos where appropriate consent is already in place.

In the Society as a whole, perhaps the most exciting development is that the Alert Card and Difficult Airway Database are undergoing pilot testing. I'm sure there will be more about it elsewhere in the newsletter but this straightforward and secure way of reducing risk to patients offers a real opportunity to improve care to affected patients.

Nominations for trainee representative to replace me will be in September – there will be a year's overlap with Lewys Richmond – and the result will be announced at the ASM in November. We were hearing about the organising committee's plans for Torquay this year in the last committee meeting – as expected they have attracted excellent and well-known speakers. The details are now on the conference website, and the abstract submission process has opened – time to think about study leave!

The next committee meeting is in September and if you have any issues or ideas relating to training or trainees that you would like us to raise please email at trainee@das.uk.com

Good luck to everyone moving to a new job in August.

Angus McKnight

DAS MERCHANDISE

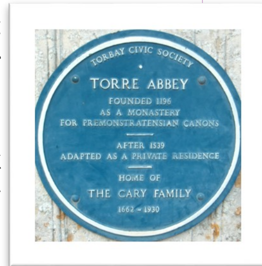
Price: Tie **£14.00** Cufflinks **£6.50** Ladies Scarf **£12.00**

Lapel Badge **£3.50** Tie Clip **£5.50**

To purchase, please contact DAS@aagbi.org

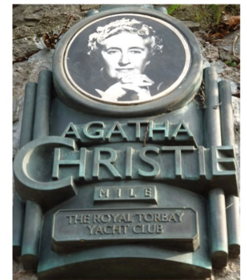
Things to do in Torquay

A warm welcome awaits you in the English Riviera, one of the most popular tourist destinations in the country. Within a short walk of the Conference Centre are many activities suitable for all tastes.



A stone's throw away is **Torre Abbey**, where you can look around the ruins, visit the museum and art gallery or just enjoy a traditional Devon cream tea in the café.

Take a stroll along Torquay seafront past the beach, through **Princess Gardens**, a promenade lined with palm trees, well manicured flowerbeds and an ornate water fountain, to the **Torquay Marina**. The adjacent **Fleet Walk**, the main shopping area of Torquay, is a great place to hunt for the usual and less-usual souvenirs.



Torquay is the birthplace of Agatha Christie and you can walk in her footsteps along the **Agatha Christie Mile**, starting at the Grand Hotel, with many points of interest along the way, including the Torquay Museum, home to the UK's only Agatha Christie Gallery.

Living Coasts on the Harbour side is the excellent all-weather attraction with a fantastic collection of birds and fish, particularly famous for its penguins.

For those of you wishing to venture further afield, Torquay station connects you to a wide selection of local attractions such as **Paignton Zoo**, the beautifully eclectic town of Totnes where you can travel by steam train or ferry to Dartmouth and the cathedral city of Exeter.

Close-by there is a varied choice of cuisine at the new exclusive development at Abbey Sands; from French food at 'Le Bistro Pierre', to South American at 'Las Iguanas', to excellent fish at 'On the Beach'. Alternatively overlooking the harbour is the Michelin starred restaurant 'The Elephant' and 'No. 7' fish restaurant amongst many options, including the traditional seaside fish and chips!

Hopefully you will find this meeting interesting and not just for its academic content. Here's to a memorable meeting

Dr. Andrea Magides,

DAS ASM 2016 Social Secretary

ODP session at DAS ASM in Torquay

ODPs and anaesthetic nurses have an important role in the safe anaesthetic management of the patients. Anaesthetists and ODPs work together so it is appropriate we train together, especially in key areas. The DAS Annual Scientific Meeting gives ODPs a great opportunity to listen to international experts as well as attending the ODP session. You can network with peers from across the country, and exchange ideas. There is also a forum for ODPs on the DAS website for the benefit of ODPs.

It was two years ago that the ODP session was introduced at the DAS annual scientific meeting in Stratford upon Avon organised by Dr Radhakrishna. This session that was run by the ODPs for the ODPs, was a resounding success and was rated the second best session of the conference. The ODP session at WAMM 2015 was also very well received. We hope the ODP session at Torquay is going to be special too.

The conference fees for ODPs is heavily discounted and there is also sponsorship available from Karl-Storz and DAS for the first 30 ODPs to register. To take advantage of this sponsorship, ODPs will need to be associate members of DAS (which is free to join at www.das.uk.com). Sponsorship will not be available if you were already sponsored in the last 2 years.

To register for the ASM, go to www.das2016.co.uk/registration.

Martin Brace, ODP

Sudheer Medakkar, Anaesthetist

Torbay Hospital, Torquay

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
- ***Discounted rate £120*** for two days (17th & 18th Nov) for DAS associate members
- First 30 associate member applicants also get Storz/DAS ***sponsorship of £200***

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:
sudheermedakkar@hotmail.com
Martin.brace873@talktalk.net

DAS-RCoA Airway Leads Day 2016

Lectures, discussions and take-home messages

Dr Seema Charters

Airway Lead, Warrington

(Reproduced with permission from The Royal College of Anaesthetists. Originally published in RCoA Bulletin 2016;98:34–36)

The day started with a warm introduction from College President, Liam Brennan, who commended the Difficult Airway Society for the work on the new intubation guidelines. DAS President, Anil Patel, then chaired the first session and started by congratulating all those involved from the College and DAS on making the day a success.

The session was titled 'Workshop to workplace', a topic close to the heart of many in the audience. Fiona Kelly described the effort required to get a CMAC videolaryngoscope into every operating theatre in Royal United Hospitals Bath. Her talk not only gave ideas for procurement, but also emphasised the training and human factors value of having a videolaryngoscope.

Tony Turley then spoke, not just as an airway expert, but also as a clinical director of a large department. He presented the idea of developing a departmental airway equipment strategy, citing his department's work in changing-over to second generation Supraglottic Airway Devices. He asked a pertinent question: 'do you have a track record of airway service improvement?'. He had lot of useful tips on how to get Clinical Directors 'on your side' so as to develop a hospital-wide airway service for your hospital and certainly didn't deserve his self-chosen lecture title of 'SAD-CDs'.

Rob McCahon spoke on teaching ODPs at Queen's Medical Centre, Nottingham. An initial survey of ODPs identified a lack of knowledge but a strong desire to learn airway management. Rob developed a dedicated theatre area for drop-in sessions and created a YouTube channel (www.youtube.com/user/docrobmc74) with procedural videos mapped to their difficult– airway-trolley equipment.

First discussion session had questions on videolaryngoscopes and how to record the laryngoscopic view at videolaryngoscopy. A lively debate followed on whether the view obtained on Macintosh laryngoscopy needs to be recorded following a videolaryngoscopy aided intubation.

The second session showcased the work done by airway leads from various hospitals. Five leads described how they dealt with various issues in their role. This session provided lots of good ideas that will help new and established airway leads alike.

Susie Baker (Dorset) described a simulation course for the Emergency Department (Fundamental Airway Management in Emergencies) and an annual difficult airway day for anaesthetists. This incorporates simulations, workshops and a clinical governance meeting to update the department about the latest developments.

One interesting idea was to bring in patients who have undergone difficult airway management to tell their story.

Niranjan Chogle from Belfast talked about overcoming barriers for fibreoptic intubation using a standardised minimalistic technique that has achieved an impressive rate of fibreoptic intubations with very few failures. He emphasised the value of ODP training for success with this technique. Performing 600 fibreoptic intubations per year with six fibrescopes meant that the cost per fibreoptic intubation was only £14.69! A challenge for all airway leads who struggle to maintain departmental competency in awake fibreoptic intubation.

James Palmer (Salford) presented a novel low cost course, 'Continuing Scenario Based Anaesthetic Resuscitation Training course'. It has no faculty and no candidates, but peer- to-peer non-threatening interaction (www.cosbart.org). James has also formed an airway strategy management group that helps with future planning. His department provide an annual airway MOT for patients with mucopolysaccharidosis using a planned ideal anaesthetic approach.

Bhagyashree Netke (Wolverhampton) described how to deliver team training in a DGH 'without spending a penny!' The New Cross Advanced Airway Day runs in a theatre complex allowing easy access for ODPs, ICU, ED doctors and nurses. This is a realistic familiar environment for team training. It's a free annual course that is now oversubscribed but manages to teach 50 people in a group of mixed abilities. Involving senior trainees to look after the administrative side of the course worked well, both for the Airway Leads and trainees.

Stephen Tricklebank from Guy's and St Thomas presented his work in critical care on developing an intubation bundle and a standard operating procedure for its use. It is aimed to improve RSI preparation and crew resource management while minimising adverse events. The simplicity of this bundle and the underlying evidence base makes a compelling argument for its adoption while undertaking airway management in critically ill patients.

More animated discussion then followed, focusing on two questions:

1 Should competence in fibreoptic intubation be a requirement for completion of specialist training?

2 Can/does/should videolaryngoscopy remove some indications for fibreoptic laryngoscopy? Airway leads and Ellen O'Sullivan, past DAS President, insisted that it's a core skill and training has to be maintained.

Karthik Ponnusamy, DAS Webmaster, then gave a short presentation on the idea of the DAS Airway Card. DAS is aiming to have a database of patients with difficult airway management episodes and will issue an alert card once a consent form from the website is filled in. Watch the space for further developments.

The afternoon session was on making sense of the new guidelines in your hospital. Mary Mushambi, Chair of the obstetric guidelines group, illustrated the use of the guidelines for decision making with an example clinical case. It was useful to know that the Obstetrics Anaesthetists Association has plenty of information, which includes list of equipment and examples of checklists (e.g. SAFE PIT STOP, HAPPE) related to these guidelines.

Chris Frerk, chair of the intubation guidelines group, explained the principles and rationale of the new guidelines by going through a number of controversial points: Use of suxamethonium vs rocuronium, RSI, why stop and think, what about plan C, why only one didactic plan D. This created numerous queries with Chris's BJA podcast is a good starting point to look for answers. With regards to plan D in the form of scalpel cricothyroidotomy, one view from the audience appeared to be with adequate training and practice; needle techniques can be successful too. The All Wales Airway Group support the Australian CICO algorithm developed by Andy Heard's group that encourages attempts both at cannula and scalpel in a logical order prioritising emergency oxygenation. DAS would however like to audit CICO scenarios to discover what technique has worked. A database of such events is proposed as the next step.

Tim Cook explored where the airway leads should concentrate their efforts: the new guidelines; college curriculum or NAP4 recommendations? RCoA- DAS Airway Leads page on college website now has useful resources about NAP4 report. Tim explained the conflicts between the curricula where requirements are competency based and various DAS guidelines and NAP4, whose recommendations are safety based. The post NAP4 national survey of change in airway practice showed interesting findings related to theatre and ICU airway management. Airway assessment and training represent the biggest gaps needing to be addressed.

The last session of the day, chaired by Alistair McNarry, 'Ensuring NAP4 continues to be relevant' had two important themes. Andy Higgs (DAS treasurer) spoke on influencing practice in ICU and ED. In his role as Tracheostomy Lead he explained the challenges faced while improving tracheostomy care in his local trust. He urged airway leads to learn some airway skills from the ICU setting e.g. percutaneous tracheostomy, use of airway ultrasound and setting up Optiflow. Andy strongly emphasised the value of training the ICU nurses in airway management, especially team training, which is a large part of national courses.

Barry McGuire (DAS secretary) addressed the topic of reviewing airway cases at local level. He described a bespoke anaesthesia module developed in Tayside hospital's electronic Datix system, which enables reporting, review, feedback and follow-up all the incidents within his department. The system is simple, anonymous, no-blame and also encourages the logging of events with no adverse component but simply for educational benefit. The best part of the form is the integrated feedback section for the reporter, that asks for comments about lessons learned and actions taken.

Using the system, common themes in suboptimal airway management were easy to identify allowing key messages to be passed on to colleagues. Future aspirations were to have a national anaesthesia datix system.

The final discussion session dealt with submitted questions to the whole panel on 'What can DAS and the RCoA do for you'? Implementation of new guidelines formed the bulk of the discussion.

Finally, Alistair summarised the take- home messages from the day:

1. Everyone must know 'Scalpel- Bougie-Tube' technique for front of neck access (FONA)

2. Airway leads should be offering this training for all, including surgeons

3. There is need to teach airway management to the entire theatre team

4. DAS and RCoA need to work together to establish the evidence base for FONA

5. They must communicate with everyone about the controversies that came up on the day, i.e. Fibreoptic Skills and Videolaryngoscopy.

The day finished on the positive note that delegates would like to have Airway Leads days every year and the day certainly gave a buzz for everyone to try new ideas in their place of work. If your hospital is not listed in the database of AWLs (http://rcoa.it/b96ys) and you are interested in performing the role in your hospital or trust please contact Jose Lourtie (awl@rcoa.ac.uk) or Alistair McNarry, (althegasman@btinternet.com) for further details

AIRWAY LEAD ROLE

Dr James Palmer

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(Presented at the Airway Leads day– 2016)

I have been the *de facto* Airway Lead at Salford Royal Hospital (SRFT) since my arrival in 2001. My interest in the subject was developed after attendance at the second international symposium on the difficult airway in California in September 1994 and my subsequent involvement with Tim Strang in an educational video in 1995. On my arrival in SRFT I was pleased to find an open and collegiate approach to difficult airway management, and in particular that members of the department were willing to enlist colleagues' help for future cases. The helpful ODPs (ODAs in those days!) were happy to respond to requests for e.g. fibreoptic intubation equipment and the fairly relaxed approach that the trust had to equipment procurement made the setting up of a number of difficult airway carts relatively straightforward, or perhaps time has faded any contrary memories!

Although not entirely airway related the COSBART course which I started in 2006 has airway components. COSBART (Continuous Scenario Based Anaesthetic Resuscitation Training) was created following two 'in theatre' deaths in 2004 when the Trust tried to implement annual ACLS training for all anaesthetists (despite the fact that staff involved had just recertified in this). After examining the available methods for learning, developing, practising and maintaining critical incident management skills worldwide we found that all available courses were costly (hundreds of pounds), usually 'one off' or triennial and directed towards primary cardiac events. After seeing this evidence the Medical Director agreed to our plan.

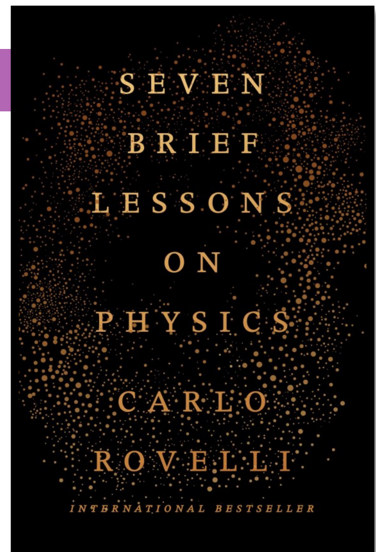
It is a maxim that 'practice makes perfect' although finding evidence of this is surprisingly hard, but we do know that simulation skills deteriorate over time and are almost gone by one year. We therefore created an annual simulation course which all consultants attend during part of one clinical governance day. The course runs in a theatre for maximum fidelity and each course has a pot pourri of scenarios that always include CICO. Current practice is cricothyrotomy using a Ravussin needle, but following the 2015 DAS guidance we are looking at methods to ensure regular practice of the knife-bougie-tube technique. The course is mandatory as it exempts us from annual mandatory BLS training and the estimated cost is about £55 per head (which is what we charge visitors). The website www.cosbart.org explains how to run a course and provides all the necessary educational materials free of charge. The scenarios are based on recognised high risk anaesthetic problems and use standardised methods for addressing them. These are updated annually and added to or modified when adverse incidents suggest. SRFT welcomes visitors to the courses providing space is available.

In about 2010 recognising not only that new equipment acquisition required planning but also that training in airway management and equipment varies within and between regions, I asked other colleagues to ensure that decisions made about difficult airway management were made in a balanced way. This was formalised in 2014 when we formed a group to plan for future equipment acquisition and to implement changes in guidance from DAS and elsewhere. Members of the Airway Strategy Management group include the equipment officer, college tutor and the DAS lead. Since inception in 2014 we have used the enhanced features of the electronic notes to record local risk (R13) codes and ICD10 (T88.4) codes for difficult airways or failed intubation allowing easy recognition of these problems both in-hospital (e.g. during preoperative assessment) and by GPs or other care providers. The R13 is a local code but the T88.4 ICD10 code is attached to the NHS number so visible nationally.

We are currently planning organisation of annual cadaveric front of neck access for all consultants, discussing the future of direct laryngoscopy vs. videolaryngoscopy and how best to approach the problem of increasing numbers of skills but decreasing experience in any one.

Finally, our population of patients with GAG (Glycosaminoglycans) storage disorders who have MPS (Mucopolysaccharidosis) often present significant challenges, not only airway related ones. Recent advances in treatment including enzyme replacement therapy and bone marrow transplant have increased life expectancy and quality so that many patients live into middle age and require transitional and adult care. Salford Royal NHS Foundation Trust is home to the UK registry of all adult patients north of Birmingham and we have some 400 'on the books'. A large proportion of these patients require surgery for a variety of conditions and many request surgery at Salford because they are familiar with the environment. These patients have planned anaesthesia management by at least two members of a specialist group interested in the condition. The group includes representative anaesthetists from several areas including MR anaesthesia. Our current project is the 'Anaesthetic MOT' undertaken when an MPS patient presents for routine review by the metabolic unit. This ensures that every patient has an up to date anaesthetic assessment in place and is aware of their own likely difficulties should they present as an emergency to their local hospital. We try to combine this with the patients' annual Metabolic Medicine Review and use the full gamut of available tests to draw together a realistic picture and anaesthetic plan which could be used if a patient presented either at SRFT or elsewhere. Tests that we rely on include: nasendoscopy, CT thorax, PFTs and flow volume loops (if achievable), blood gases, carotid intimal thickness (to assess accelerated coronary vascular disease), echocardiography and ECG. A typical metabolic review takes two or three days and our part takes half an hour in clinic and then at least an hour or two of test reviews before composing a long and complex letter. Time will tell if this approach will help, but we are optimistic!

BOOK REVIEW



Carlo Rovelli is an internationally renowned Italian theoretical physicist who is currently directing the Quantum Gravity Research Group in France.

His bestselling book **Seven Brief Lessons on Physics** explores the world of physics and aims to educate the reader on some of the most intricate theories and concepts within this fascinating and ever expanding topic. It does this with astounding succinctness, as the author shares with us his lessons on the Einstein's general theory of relativity, quantum mechanics, particle physics, black holes, complex architecture of universe, elementary particles, gravity and the cosmos.

The structure of the universe has been the wonder of civilisation for millennia. Recent advances in the understanding of this, through physics, have lead to the discovery of even more conceptually challenging architectures. The chapter 'Complex Architecture of Universe' does a great job of conveying this, using imaginative analogies and simple diagrams to orientate the reader.

The equally baffling relationship between heat and time is tackled in the penultimate chapter of this book. The complexity of this are reached at a stage in the book where the readers might find themselves nearing the exhaustion of their ability to comprehend; however once again Rovelli guides the reader through using a clever balance of history and fine analogies.

Clarifying intricate information for a lay person

This book does a sterling job of explaining incredibly convoluted and conceptually challenging theories, to a reader with only a humble knowledge of physics.

Within medicine, we are constantly faced with discussions with our patients, often regarding quite complicated subjects. It is our responsibility to make information surrounding treatments and conditions accessible and understandable to our patients and to the lay general public as a whole.

Physics in Anaesthesia

Love it or hate it, physics is an integral part of clinical practice and education within anaesthesia. Much of what we do as Anaesthetists is based upon principles of physics and therefore our understanding of these principles is of huge importance.

It would be unrealistic to suggest that this book could be used as a revision aid for fellowship exams. However, it does display a wonderful insight into the history and integration of some of the most fundamental principles and theories of physics and may prove to be light bedtime reading post exams.

Summary

The ever-expanding world of anaesthesia draws parallels to this world of physics in that much of the science behind anaesthetics is still unknown, waiting to be discovered and doubtless more questions to be unearthed in the process.

This book guides the reader through some of the most involute and intellectual theories of physics whilst maintaining very elegant and almost poetic style that some, more impatient readers may find frustrating. Nevertheless, it does succeed in simplifying these tortuous themes and will invariably leave the reader with a renewed knowledge and perspective on the world around them.
It is a book that is thought provoking to the end and is an admirable framework for scientific, philosophical and even theological discussion.

Dr Timothy Molitor **Dr. Ajit Walunj**

Good Hope Hospital, Sutton Coldfield

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