DIFFICULT AIRWAY SOCIETY

Issue 10 Circulation 741 April 2003

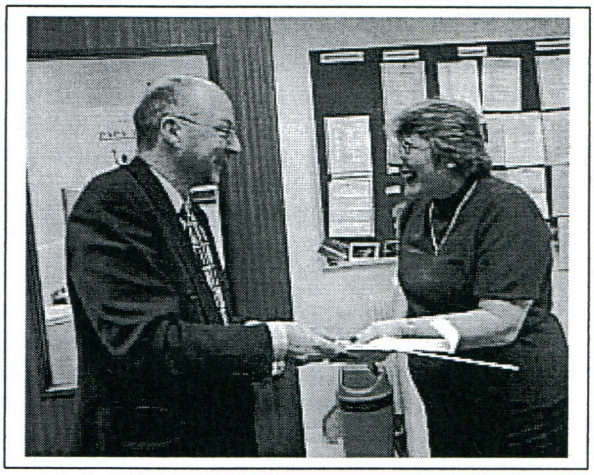
Chairman

Dr Mansukh Popat

Department of Anaesthesia

John Radcliffe Infirmary, Headley Way, Headington

Oxford OX3 9DU chairman@das.uk.com



Honorary Secretary

Dr John Henderson

Dept Anaesthesia, 30 Shelley Court, Gartnavel General Hospital

1053 Great Westen Rd Glasgow G12 0YN

secretary@das.uk.com

Treasurer

Dr Chris Frerk

Department of Anaesthesia

Northampton General Hospital, Billing Road, Northampton

NN1 5BD treasurer@das.uk.com

INSIDE THIS ISSUE

Newsletter

This newsletter was written by members of the Difficult Airway Society. The opinions expressed are those of the individual members and do not represent necessarily the view of the Society.

Any feed-back on this Newsletter, submissions for future editions or correspondence should be sent to;

Dr Chris Frerk

Department of Anaesthesia

Northampton General Hospital

Northampton NN1 5BD

Telephone 01604 545671 Fax: 01604 545670

newsletter@das.uk.com

www.das.uk.com

From The Editor:

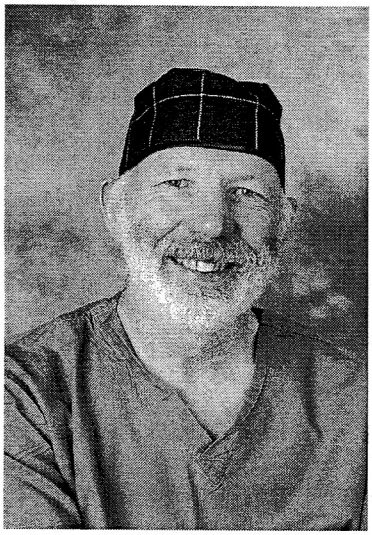
Well hello, after a longish pause another issue of DAS newsletter lands on your doormat. What news of change, well those of you who were at the Annual meeting in November may remember that it was election time. Adrian Pearce was stepping down from being chairman and Peter Latto was stepping down from being treasurer. Elections were duly held and your new committee is featured below. The new crew arrived full of enthusiasm and some of the plans are included in this issue, anything else you want them to do on your behalf (remember it's your society) let them know.. in print or via email.. the adresses are on the front cover.

If you have any suggestions for style or content of this publication let us know – the address is at the top of this page. Letters are more than welcome – if you are sending them via email it would help if you could send stuff as attachments in word. If you know of meetings / courses that need publicising or you've got a clinical conundrum or a story of a particularly scary / hairy airway case let us know.

Remember, as always, when you've read as much as you want of this leave it in your juniors room, they may fancy joining DAS, the application form is on the back, you could even encourage consultant colleagues to join!

Chris Frerk

1st off it's welcome to your new chairman Dr Popat from Oxford, he sent a couple of pictures and said I could choose... read into that what you may. Dr Popat is a consultant in Oxford and a prolific trainer in fibreoptic intubation with a case series to match any UK enthusiast. His team organised the very successful DAS 2001 meeting and he runs training days in Oxford and London. He was secretary to DAS for three years and has been credited with expanding the membership significantly (I like to think it was a team effort & I'm sure he would agree!)



This is Dr Henderson, he's the new secretary for DAS and works north of the border in Glasgow. He's another chap who works extremely hard (and productively) in matters airwy. He was projects officer for DAS and has been working (with others) on guidelines both for the UK and has been developing European links. A transferrable characteristic that Dr Henderson has in spades is fastidiousness (if there is such a word) … it stands you in good stead when dealing with airways and I'm confident it'll stand our society in good stead too. There follows a piece written by John (Dr Henderson) demonstrating that he also travels further afield than this continent in search of experience and information sharing:

Advanced airway training in East Africa

I had the privilege to contribute to the 10th Annual Meeting of the Kenyan Society of Anaesthesiologists held in Nairobi between 31st July and 2nd August 2002. The principal theme of the meeting was "The Shared Airway". There were interesting presentations on a number of others subjects, such as hypotensive anaesthesia as a means of reducing blood loss (blood is in very short supply, and patients are very reluctant to receive blood). The choice of airway management as the principal theme of the meeting attracted a record number of delegates, including some from Uganda. I contributed lectures on "The Difficult Airway" and "The Straight Laryngoscope", and ran workshops on two afternoons.

I had been advised that fibreoptic intubation was not a relevant subject. This turned out to be an oversimplification. Anaesthesia in East Africa is provided in several different ways. In the teaching hospitals anaesthesia is provided by trainee anaesthetists, supervised by consultants. Many anaesthetists in the cities are engaged only in private practice. In the district hospitals, much of the anaesthesia is administered by Clinical Officers who receive one year training in anaesthesia after a 3 year training in medicine and surgery. There is no anaesthetic nurse training in Kenya, but nurses who have received this training in Uganda or Tanzania work in some mission hospitals. The meeting was attended by all these groups, and by medical students and theatre nurses.

Several presentations (including surgery of the temporo-mandibular joint, plastic surgery, and mediastinal masses) were given by surgeons whose work involves the shared airway. All presentations were of a high standard, and were based on very considerable clinical experience. All emphasised safety, use of series of plans, and good teamwork between anaesthetist and surgeon. There were several presentations by anaesthetists on airway management. A superb lecture on facial injury repeatedly emphasised the basic principle of not giving muscle relaxants until it was certain that tracheal intubation could be achieved. An equally good lecture on burns management discussed use of retrograde and blind nasal intubation. There was again great emphasis on having a series of plans, and teamwork involving anaesthetists and surgeons with special skills.

My presentation on the difficult airway included low-tech as well as high-tech management techniques. Core topics were: causes of difficult tracheal intubation; use of awake intubation as a means of achieving maximum safety when serious difficulty is anticipated; prediction of difficult intubation; use of the flexible fibreoptic laryngoscope; low-tech awake intubation techniques such blind nasal and retrograde; use of alternative techniques of tracheal intubation when the larynx cannot be visualised with the Macintosh laryngoscope and the bougie technique has failed; and development of guidelines. There is no doubt that there are deaths in Kenya, as in the UK and elsewhere, from the "can't intubate, can't ventilate" situation, and use of ATLS-type cricothyroidotomy was discussed. The need for improved training in a range of airway techniques was emphasised.

Initial informal discussion about the straight laryngoscope met with scepticism similar to that experienced when the technique was re-introduced in the UK. My presentation on the straight laryngoscope included: the mechanism of the greater efficacy of the straight than the Macintosh laryngoscope; the evidence base; and the drawback of the commitment required to master this more demanding technique. The presentation was well received. One member of the audience reported that he always used the straight laryngoscope with success whenever he had difficulty with the Macintosh laryngoscope, echoing similar experience of an increasing number of anaesthetists in the UK.

Workshops had not been run at anaesthesia meetings in Kenya previously. Ambu and Laerdal manikins were produced, but they had seen a great deal of use, and were no longer suitable for training in direct laryngoscopy. There was no fibreoptic laryngoscope or bronchoscope available. I ran 4 "workshops" with up to 20 delegates in each group. These consisted of informal presentations, the group gathering round a PowerPoint presentation on a laptop computer. Simplification of fibreoptic techniques with the use of conduits such as the Berman airway (sample brought

from UK), LMA and split nasopharyngeal airway was discussed. However the principal theme was simple, effective techniques of local anaesthesia of the airway. The workshops were well received, and there is great scope for development at future meetings.

During the workshops and discussions it became clear that several anaesthetists in Kampala had developed expertise with fibreoptic intubation in the awake patient. There was a clear commitment of the Kenyan medical community to provide, in the city hospitals, a standard of care equal to the best in the world. Both anaesthetists and surgeons were determined that skills in fibreoptic intubation would be developed as soon as possible.

Discussions after papers were of a high standard. Questions from district medical officers reflected careful airway management throughout Kenya. Determination of the safest series of plans for management of the difficult airway in each individual patient was debated in detail. There was some expertise in retrograde intubation, but less than I had expected. There was also expertise in blind nasal intubation, using breath sounds as a guide, but a desire to move toward intubation under vision with the fibreoptic scope. Many of the airway problems in East Africa are very demanding, caused, for example, by late presentation of head and neck tumours and by trauma. I was asked how I would manage a patient with airway compromise and severe facial swelling, thought to be due to anthrax. The patient's car had collided with a cow which had died from anthrax.

The whole meeting was very stimulating. Every presentation was given with good humour, and I have never seen so many smiles at a meeting.

The final member of the DAS committee, the treasurer, is your current editor. Sadly the digital camera in our department has been "borrowed" and so I'm unable to give you an up to date piccy of myself (tsh tsh tsh for shame I hear you cry) so that's why theres an archive photo on the front page. My credentials for being on the team – well I was on holiday when the voting took place at the last AGM so I couldn't nobble enough people to vote for someone else. I've got through all my appraisals on the probity section so the societies money should be safe (and we need 2 signatures to get the cash out) so alls safe and secure. I'm looking forward to working with the above two rogues and their drive will give me a lot to live up to – hoping I'm up to the challenge I'll give it my best shot.

Free Money to members of the DAS! (*can it be true?)*

Have you got a good idea for a research project related to the airway, Need funding. Maybe DAS can help.
We have funds available in the form of research grants to assist you in furthering the knowledge base in our favorite field.

How to apply (it couldn't be easier).....No complicated forms, no need to be a big wig (tho bigwigs aren't excluded)
Send a copy of your research proposal with your funding needs to the committee (via the chairman secretary or treasurer). All submissions will be considered at scheduled meetings of the committee. The decision to fund any project will be entirely at the discretion of the DAS committee, further information regarding details of any project may be sought to assist in the decision making process

Forthcoming Meetings / Courses

Difficult Airway Management Education Course

Three day symposium on Difficult Airway Management Education for anaesthetists - consultants and trainees.
St. Mellons Hotel, Cardiff. Course organisers: Drs. Turley, Stacey and Morris.

Information available from: Michele Jones, Anaesthetic Department, Llandough Hospital, Penarth, Vale of Glamorgan CF64 2XX. Tel. 029 20716860. Fax. 029 205312. Email: Michele.Jones@UHW-TR.wales.nhs.uk.

Dates: 7th - 9th May 2003, and 1st - 3rd October 2003

Difficult Airway Society Annual Meeting

3rd 4th and 5th December 2003 In Glasgow

Wednesday 3rd December
Full day of workshops at Anatomy Department and Hunter Halls, University of Glasgow

Thursday 4th and Friday 5th December: Scottish Exhibition and Conference Centre and Moat House Hotel, Glasgow

Free Papers
Debates:
- Tracheal intubation in suspected cervical spinal injury
- Management of "Can't Intubate, Can't Ventilate" situation
- Airway problems in thoracic anaesthesia

Guest lecture: "The Bougie" Peter Latto
Guest lecture. Airway Management in Patients with Noma (Cancrum Oris): Ulrich Braun

Social Programme: includes dinner and ceilidh on Thursday 4th December

Full details will be available shortly at: www.das2003.com

If you've got any topics you feel should be covered at future DAS meetings – suggested lecturers etc then drop us a line at newsletter@das.uk.com and we'll see that the organising committee get to hear about it. It's your society help it do what you want.

Current "to do list"

Below are just some of the things the new committee are planning on taking a stab at on your behalf (in their *spare ho ho* time). **Any** suggestions of things you think they should be doing for the DAS will be most welcome and given due consideration, scored according to a complicated set of points given a ranking and then added to the "to do list" if we like the look of them!

So far:

Continue to develop / distribute national guidelines for failed intubation / ventilation.

Revamp the website

Investigate the possibility of developing a CD style archive of airway related material (for training / posterity / entertainment).

Promote and support coordinated research into airway topics, (evaluation of devices, theoretical research etc)

Expand networks of contacts for the society outside the UK

Canvass professional bodies as appropriate

Support the Annual meeting

Develop and,or support regional meetings / training courses.

And much, much, much, much more.

SPORTS PAGE

A 6 month old infant underwent uneventful cleft lip and palate repair and after extubation at the end of the procedure there were no problems initially. He had been easy to mask ventilate at the start of the procedure and had been a grade 1 laryngoscopy. In recovery, the wound began to ooze. The child was initially distressed, coughing and crying continually, but settled down with judicious intravenous morphine. The bleeding, however, continued and two hours post-operatively had not abated.

The child was not haemodynamically compromised though no fluid had been given as the IV cannula had become kinked. It was decided to take the baby back to theatre.
How would you proceed from here? Think of it as a nasty bleeding tonsil in a 6 month old with a palate full of sutures!

Remember no rights or wrongs.. shown below is how this one was actually managed:

Standard monitoring was instituted and preoxygenation was performed with the child in the lateral head down position. The help of a second consultant was sought and gained. The cannula was 'rescued' and a colloid bolus given. A sleep dose of thiopentone was given followed immediately by a big dose of atracurium (0.7mg/Kg). Gentle mask ventilation was performed for one minute, sats still 97% at this point. Laryngoscopy was performed with a Robertshaw blade, blood and clot were seen and the oesophagus intubated. A bougie was passed but the anaesthetist was unable to railroad a size 4 RAE tube. Sats started falling, and despite further mask-ventilation the sats remained poor. A gastric tube was passed and oxygenation improved. At repeat laryngoscopy the view was better and a bougie was passed immediately followed by successful railroading of a plain tube.

Contoversy: Why was atracurium used in a known likely difficult airway. The thought was that in the event of difficulty with intubation, wake up was not an option hence a non-depolarising agent would have to be given at that point. The only advantage of sux was perceived to be rapid onset, and the anaesthetists involved felt intubating conditions could be achieved nearly as rapidly in the way described with the advantage (in this particular situation) of the paralysis not wearing off.

Eds views: 2 things worthy of note. Stomach decompression always useful, and two consultants always nice in a difficult airway case.

Application Form For Membership of Difficult Airway Society

If you would like to join the DAS, a non threatening, non expensive society then just photocopy this form fill it in and return it to the membership secretary: Dr John Henderson Western Infirmary Anaesthetic Dept, 30 Shelley Court, Gartnavel General Hospital1053 Great Westen Rd Glasgow G12 0YN. Or email him secretary@das.uk.com

Name .....

Address .....

.....

.....

email .....