DIFFICULT AIRWAY SOCIETY

Issue 6

February 200

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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.

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INSIDE THIS ISSUE

Difficult Airway Society Meeting, Manchester Nov 2000

This was my second year at the annual DAS meeting, and after Edinburgh, my expectations were high. The conference was held at the Weston Building, UMIST. The physical surroundings were solid, and very functional, but any formality was easily dispersed by that fire-alarm on the first morning. The spectacle of 300 anaesthetists leaving and re-entering the building three times in the first lecture did not bode well. That hiccup aside, the rest of the meeting went more or less to schedule. Lunch and refreshments were of a high standard, but the age old problem of queuing while being served hot food, is always irksome. The Americans address this issue by having cold snacks prepackaged, and thus avoid the queuing. Something for next year perhaps?

The programme covered a range of topics from the difficult airway in trauma, paediatrics, and ENT/laser surgery. Sadly the keynote speaker, Dr Alan Brown, was unable to attend for health reasons, but his replacement, Dr Thierbach, (Mainz University) stood in admirably. Probably the most memorable statement made by our German colleague, and one that elicited gasps of surprise (giving way to envy) was his confession to having only 50 fibrescopes available in his department. It is always educational to have the perspective of our overseas guests – helps to enlarge our own vision and expectations.

Four workshops were 'available' at the conference, but bizarrely occurred at the same time as the plenary sessions. I applied, but failed to secure a place at any of the workshops. However, in view of their timing, I was rather relieved. Dr Strang and his team are to be congratulated for running these workshops, and coping with the large number of delegates who had an opportunity to attend it.

The annual dinner was held in the Town Hall, a formidable Victorian structure. The food was excellent, but the ambiance of such a grand Hall was lost on the meagre numbers of people who attended the dinner – I counted less than 100. Considering many partners attend these meetings, it probably attracted only a quarter to a third of it's potential to the dinner. The absence of any post meal entertainment (dance, karaoke) may have contributed to this, in part.

The free papers presentation were of high standard, and it was good to see that our commercial supporters had dug deep in their pockets to ensure good quality prizes for these. Dr Maclachlan, from the Royal Berkshire Hospital won the Free Papers prize. The posters were of good quality, but notable mainly by the extreme scarcity. A national meeting that attracts only three or four posters needs some explaining.

The annual meeting of the DAS elected a new secretary – the shy and retiring Dr M Popat (Oxford) – and appointed Dr J Henderson (Glasgow) to work on the difficult airway protocols/guidelines. Both appointments appeared to be popular choices.

The final event of the meeting was to review the whole idea and practice of guidelines for the difficult airway, and to consider the definition of core skills. Both attracted wide comment and contribution from the floor, which gave Dr Henderson much to chew on over the next few months.

Personally, high points of the meeting – Glaswegian ENT surgeons lecture on laser, good accommodation and ease of parking, annual general meeting. Low points – certain speakers wandered well off the difficult airway track, poor interest in presenting research or audit.

Edinburgh was a hard act to follow, but Manchester managed it nonetheless. Dr Horseman and her team are to be congratulated for their organisation and effort in maintaining the high standards set by previous meetings. The delegates are to be congratulated for making it to Manchester in the trough of the railway chaos which swept our country. It's up to Dr Popat and his team in Oxford to keep up the momentum.

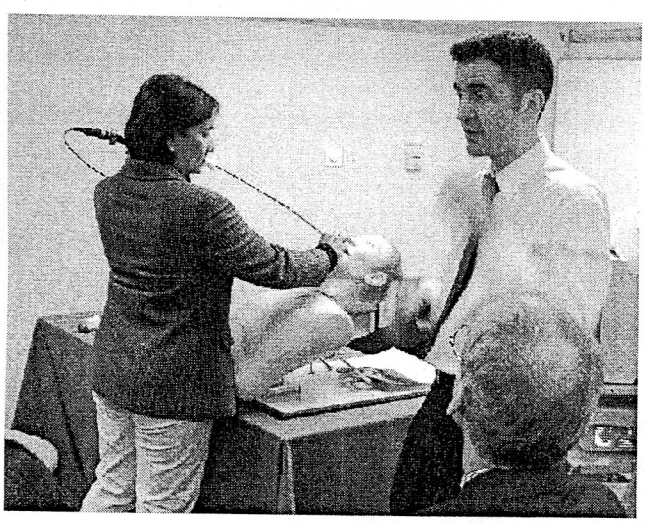
Stuart Benham
Consultant Anaesthetist
Oxford.

MEETING OF THE DIFFICULT AIRWAY SOCIETY
MANCHESTER CONFERENCE CENTRE
NOVEMBER 23RD –24TH 2000

I always find the meetings of the DAS both interesting and entertaining, as the difficult airway is one area where all of us have experience – we are all, in one way or another "experts" – This gives rise to plenty of audience participation!
This year's meeting was no exception. The proceedings started off memorably as poor Dr Ian Turnbull made 3 attempts to start his lecture on "Imaging and the Difficult Airway" in between the audience having to stand outside in the Manchester drizzle whi the fire brigade investigated a fire alarm – twice. Fortunately, for the sanity of the course organisers, the proceedings suffered n unplanned interruptions after this. Topics of particular interest to me on the first day were the lecture on the benefits of Transtracheal jet ventilation – a subject which seemed to arouse strong emotions from the floor – followed by two talks on difficult airway mangement in children. Both these interesting lectures left me, and I suspect most of the audience, with a strong sensation of "rather them than me". The management of these children is really not for the faint-hearted. Lively discussion of t day's events continued over dinner at the splendid Manchester Town Hall.
Friday's session opened a discussion on British and European guidelines for the difficult airway. The European viewpoint was provided by Dr Thierbach from the University of Mainz, Germany. Following this the abstracts of 6 papers were presented to th meeting by SpRs from throughout the country. The standard of content and presentation was extremely high, and the winner wa Dr Karina McLachlan for her study comparing tracheal intubation through standard or intubating laryngeal masks. The afternoo session consisted of lectures on laser physics (really putting the old grey matter through its paces on a Friday afternoon) and anaesthesia for laser and sub-glottic surgery. I was particularly interested to see Dr Howell's video of her spontaneous ventilatio technique for anaesthetising children for laser surgery of laryngeal polyps, avoiding tracheal intubation and its concurrent laser risks altogether.
Some of the highlights of the meeting were the workshops – beginners and advanced on difficult airway management. Both proved extremely popular. The advanced workshop which I attended involved hands on (sadly only on a mannequin) practice a transtracheal jet ventilation, and demonstrations of awake fibreoptic techniques and management of difficult paediatric airways.

All in all the course was both enjoyable and of high educational value. Difficult airways are phenomena which both frighten anaesthetists and kill patients – anything which increases our ability to deal with them successfully must be worthwhile.

Kathy Teale, Consultant Anaesthetist Manchester



From The Editor: Thank you to both contributors above (one spontaneous one commissioned). Continuing the Manchester theme Dr Carl Gwinnut has sent various pictures of the workshops which proved so popular. To the left Dr Strang can be seen running a hand jive workshop while one of the delegates has the temerity to use a fiberscope behind his back. More photos inside – you may see yourself or your friends (they are in colour on the website).

Remember, 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 ever encourage consultant colleagues to join!

In the papers you may have missed there's a historical perspective on Baird – the discoverer of fibreoptic technology, a couple on local techniques for awake intubation, the paper in Todays Anaesthetist is actually worth wading through to find the arguments fo doing awake intubations in every obstetric GA! Also if your girlfriend / wife is on the pill and she finds a condom in your wallet the perfect excuse for you is to be found in Anesthesiology this issue! As usual our contributors have asterixed papers they consider particularly interesting – thank you to them all.
If you have any suggestions for style or content of this publication let us know – the address is on the front 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 like on the sports page let us know.

Chris Frerk

AIRWAY PAPERS YOU MAY HAVE MISSED

Journal of the Royal Society of Medicine

John Logie Baird – fibreoptic pioneer. 2000; 93:438-9

Todays Anaesthetist

Church of the Fibreoptic 2000 :15 ; 80-86

European Journal of Anesthesiology

Nothing terribly exciting airway related

Anesthesiology Sept - Dec 2000

Tubular fiberoptic laryngoscope (WuScope) and lingual tonsil airway obstruction. 2000; **93:** 904-5.
Insertion of a Fogarty catheter through an endotracheal tube for one-lung ventilation: A new method. 2000; **93:** 909.
Patient in "sniffing position". 2000; **93:** 1365-6.
Original method for *in situ* repair of damage to endotracheal tube. 2000; **93:** 891-2.
A novel technique for conversion of nasotracheal tube to orotracheal. 2000; **93:** 911.
Intraoral separation of a reinforced endotracheal tube. 2000; **93:** 908.
** Historical perspective of the "sniffing position". 2000; **93:** 1366-7.
Notes: Kirstein first used sniffing position
Emergence from anesthesia in the prone *vs* supine position in patients undergoing lumbar surgery. 2000; **93:** 959-63.
Chronic pain as an outcome of surgery: A review of predictive factors. 2000; **93:** 1123-33. Not airway paper, but important review
An improved technique of placing a coaxial endobronchial blocker for one-lung ventilation. 2000; **93:** 1563-4.
Fiberoptic laryngoscopy (WuScope) for double-lumen endobronchial tube placement in two difficult intubation patients. 2000; **93:** 906-7.
Use of a condom as a blade cover for laryngoscope. 2000; **93:** 906.
Notes: Use of $0.06 condom routine in Taiwan hospital since July, 1999 *Useful precaution*
Accuracy & reliabililty of self-inflating bulb to verify intubation in out-of-hospital cardiac arrest. 2000; **93:** 1432-6.
Paradoxical vocal cord adduction. 2000; **93:** 894-5.

Anesthesia and Analgesia Sept - Dec 2000

Reinforcement of laryngeal mask airway cuff position with endotracheal tube cuff for airway control in a patient with altered upper airway anatomy. 2000; **91:** 1303-5.
Respiratory Efficacy of Subglottic Low-Frequency, Subglottic Combined-Frequency, and Supraglottic Combined-Frequency Jet Ventilation During Microlaryngeal Surgery. 2000; **91:** 1506-12.
Cervical spine motion during airway management: A cinefluroosciopic study of the posteriorly destabilized third cervical vertebrae in human cadavers. 2000 ; **91:** 1274-8.
The laryngeal mask for percutaneous endoscopic gastrostomy. 2000; **91:** 635-6.
Aspiration in transtracheal oxygen insufflation with different insufflation flow rates during cardiopulmonary resuscitation in dogs. 2000; **91:** 1431-5.
The utility of three-dimensional computed tomography in unanticipated difficult tracheal intubation. 2000; **91:** 752-4.
The effect on intracuff pressure of various nitrous oxide concentrations used for inflating an endotracheal tube cuff. 2000; **91:** 708-13.
** Work of Breathing During Spontaneous Ventilation in Anesthetized Children: A Comparative Study Among the Face Mask, Laryngeal Mask Airway and Endotracheal Tube. 2000; **91:** 1381-8.
Does the ProSeal Laryngeal Mask Airway prevent aspiration of regurgitated fluids? 2000; **91:** 1017-20.
Thermosoftening treatment of the nasotracheal tube before intubation can reduce epistaxis and nasal damage. 2000;

91: 698-701.
The efficacy and safety of EMLA ® cream for awake fiberoptic endotracheal intubation. 2000; **91:** 1024-6. *Don't try this at home*
Anesthesia for Tracheal or Bronchial Foreign Body Removal in Children: An Analysis of Ninety-Four Cases. 2000; **91:** 1389-91.
Balloon Versus Conventional Laryngoscopy: A Comparison of Laryngoscopic Findings and Intubation Difficulty. 2000; **91:** 1513-9.
The Use of a Bronchial Blocker To Rescue an Ill-Fitting Double-Lumen Endotracheal Tube. 2000; **91:** 1370-1.
The Intubating Laryngeal Mask Airway (ILMA) is assisted by an old device. 2000; **91:** 1561-2. *Whistle used*
Potential hazards of radiolucent body art in the tongue. 2000; **91:** 1564-5.
Reinforcement of laryngeal mask airway cuff position with endotracheal tube cuff for airway control in a patient with altered upper airway anatomy. 2000; **91:** 1303-5.

CANADIAN JOURNAL OF ANESTHESIA – Sept -Dec 2000

Intubating laryngeal mask for fibreoptic intubation – particularly useful during neck stabilization. 2000; **47**: 843-848
The intubating LMA: a comparison of insertion techniques with conventional tracheal tubes. 2000; **47**: 849-853
Tracheal intubation after induction of anesthesia in children with propofol – remifentanil or propofol-rocuronium.2000; **47**: 854-9
Variations in ILMA external diameters: another cause of device failure. 2000; **47**: 886-889.
Light-guided tracheal puncture for percutaneous trachescomy. 2000; **47**: 919-920.
Intubating LMA guided awake fibreoptic intubation in severe maxillo-facial injury. 2000; **47**: 989-991.
Video-intuboscopic monitoring of tracheal intubation in pediatric patients. 2000; **47**: 1202-1206.

ANESTHESIA AND INTENSIVE CARE. – Sept Dec 2000.

The McCoy Laryngoscope, External Laryngeal Pressure, and Their Combined Use. 2000; **28:** 537-539.
* Use of a Fibreoptic Stylet to Visually Evaluate Tracheal Intubation Technique. 2000; **28:** 552-555.
* Awake Intubation Made Easy and Acceptable. 2000; **28:** 556-561.
Airway Management for Carinal Tumour Resection. 2000; **28**: 570-572.

International Anesthesiology Clinics.

A good overview of all airway topics including anatomy and management. 2000; **38:** 3. Summer ed. 1-242
The traumatic airway; The Anesthesiologist's role in the emergency room. 2000; **38:** 4. 87-104.

Acta Anaesthesiologica Scandinavica.

Comparison and technical aspects of jet ventilation for endolaryngeal procedures. 2000; **44:** 1273-4
The Combitube® for failed intubation-instructions for use. 2000; **45:** 127-8

Forthcoming Meetings

23rd & 24th November 2000 — Difficult Airway Society meeting Oxford

Telephone 01865 221590 Fax 01865 220027
Email maguerite.scott@orh.anglox.nhs.uk

Call for Papers

Abstracts are required for the Poster and Free Paper sections Of the Difficult Airway Society Annual Meeting

Oxford 22nd –23rd Nov 2001

* Editors n
This is the correct date
not 2000
not 23rd /24th

Details of how to apply are available from:

Pat Millard
Department of Anaesthesia
John Radcliffe Hospital
Headley Way
Headington
Oxford
OX3 9DU

Email pat.millard@nda.ox.ac.uk

"What do Papers mean"

"Papers mean Prizes" not to mention prestige so send off today or get someone in your department to send off. The more submissions we have the more interesting the meeting will be!

Correspondence

Sports Page Case DAS October 2000

Having read your Sports Page case report (*the patient who could not be ventilated by LMA or facemask post induction)* I feel I must make some comments.

Lymph node biopsy in the neck is in my opinion a positive indication to use a tracheal tube and not an LMA. Movement of the head and surgery in the neck can both be a cause of displacement of an LMA.
Why was suxamethonium given? Administration of a relaxant when there is an undiagnosed respiratory obstruction is extremely hazardous. The correct procedure would have been to look first with a laryngoscope, providing additional jaw relaxation with propofol if necessary. Having seen an unobstructed larynx then relaxant could be given to assist intubation.
Why use a 9.0 tube? A 7.5 is large enough for any male. The consultant consequently intubated with a 'good hard push'?!! This is surely not the way to pass a tube? If one size will not pass, use smaller sizes until the correct size is found. If the laryngeal inlet or diameter had been only 4mm, there would have been signs and symptoms preoperatively, so a 5.0 should have passed.
Finally, I cannot understand the comment 'Aren't you glad it wasn't on your list? Surely it is cases such as this that make life in anaesthesia worthwhile?
Dr D.H.Enderby, Consultant Anaesthetist
Royal National Throat Nose & Ear Hospital

Thank you for writing (Ed), I agree with most of what you say – I just publish as I get sent. This is what jobbing anaesthetists do around the country and I suspect many members of DAS too. My comment aren't you glad it wasn't your list was meant to reflect bailing someone else out at short notice. I entirely agree that taking on challenging airway cases from scratch is what makes anaesthesia fun and worthwhile. Interesting to note that from an ENT hospital you seem to be advocating smaller tubes than are customarily used elsewhere. At a previous DAS meeting it was suggested that laryngeal morbidity could be reduced by the use of smaller tubes. I hinted at the time that someone may like to think about a study looking at that – so far as I know noone bit the bullet.
Any other comments regarding this or other Sports page cases are welcome – if they don't get discussed practice will never change!

Howkins book and CD rom
I didn't find this at the Manchester DAS meeting. If you know what's happening regarding this let us know

Left sided Macintosh
Last issue we had a request for help in sourcing left handed laryngoscopes. Help has flooded in (see below) so if you have a problem and no-one else can help – maybe you should call the DAS team:
Dear Andrew, I prefer the term "left-entry", and I agree that it is a very important blade-it is the first which I bought personally as most of my work locations didn't have them. Penlon (www.penlon.com) have a size 3 Macintosh with conventional bulb. Another choice is a Green system fibrelight laryngoscope, and Timesco (www.timesco.com) (02075111234) make them in size 3 & 4. I would suggest the size 4 as it is more versatile. Best wishes
Dr John Henderson, Consultant Anaesthetist
Western Infirmary, Glasgow

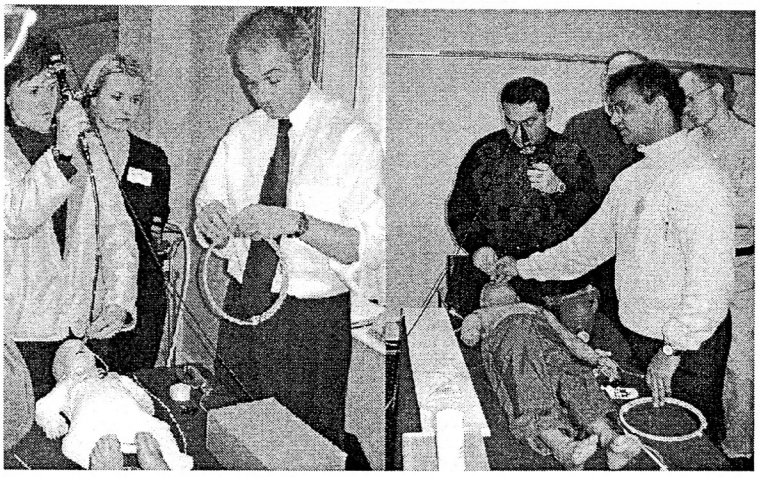
COMPETITION TIME

In the last issue there were 4 photographs of layngoscopes, we wanted to know what they were? The prize winning letter (From Dr Steve Yentis) is published below:

Dear Editor
Hmmm, difficult one. Bottom left is Bellhouse – my favourite last-ditch blade. Bottom right is the left-handed/sided (both incorrect: it's held in the right hand and inserted in the right side of the mouth!) Macintosh. Top right looks at first like a Wisconsin, but I wonder whether in fact it's an elusive and rare lesser spotted Henderson? Top left is the difficult one; looks at first like a Soper but the tip appears a bit more curved than usual; it's not a good quality shot but the tip looks almost bifid which suggests a Bowen-Jackson, but I think the latter is curved, not straight. Don't tell me it's a Frerk blade!
Look forward to seeing the answers. Is the whole picture a close-up of Adrian Pearce's tie?
Regards
Steve

Steve is the winner as he was closest. Below is a picture of Dr Frerk presenting him with his prize (well actually it's Dr Frerk giving his secretary the prize to post to Steve but you get the idea). It' a light wand with spare wandy bits. And if you don't want to use them to intubate patients with you can always use them to read comics (or journals) at night under the sheets.

Steve was mainly correct, the blades were Bellhouse, the back to front Macintosh (see letters - a left entry Mac held in the right hand but surely inserted into the *left* side of the mouth but I know what you meant), the Henderson and the last one I've no idea. It was made by Penlon but our Penlon rep didn't know what it was I've got it down as a modified Soper or modified Robertshaw. If you've lost / recycled your last issue of the newsletter the pictures should still be on the website.As for the Adrian Pearc tie comment, Adrians lawyers state that he would not be seen wearing anything as gawdy as this. So I hope that's cleared that up. Look out for another competition next issue.



The final two pictures (above) show the "difficult airway mangement in children" workshop at Manchester.which proved highly popular.
Left – Dr Walker takes two delegates through airway management in babies. *Right* – a queue forms to try to intubate the slightly older one armed child.

SPORTS PAGE

Weekday lunchtime a consultant anaesthetist was asked to urgently review a 50 year old lady on the medi ward. She had had stridor for 36 hours which had been responding to nebulised adrenaline up till 1 hour previously. ENT review at admission had revealed an undiagnosed subglottic stenosis using a nasendoscope. The consultant sent a trainee to review the patient while arranging theatre and staff for intubation and transfer to ITU. Five minutes later a "crash call" was put out for the consultant to go to that medical ward. It turned out fairly **sporting,** the stridor was moderate, sats were 89% on oxygen and the woman was panicking although shifting reasonable tidal volumes. It was clear that she would not tolerate any procedure without either sedation or general anaesthesia.

How do you manage that one?

The consultant decided to take the lady to theatre rather than try and manage a difficult airway on the ward. Transfer to theatre was uneventful. With ENT surgeon standing by the patient was anaesthetised in theatre with 8% sevoflurane in oxygen. Respiratory drive continued well and the patient became deep quite quickly with minimal airway obstruction. Laryngoscopy revealed a good view of the cords and no obvious subglottic lesion. A size 7.0 oral tube was passed easily and needed air in the cuff to get a seal. The patient was transferred to ITU and was ventilated for 5 days and was susequently uneventfully extubated after ENT examination.

The anaesthetists fall back plans were: wake the patient up and start again with a different plan if the airway obstructed. IPPV via a laryngeal mask if it had not been possible to intubate or transtracheal access by the ENT surgeon (accepting that a subglottic lesion may make this less than ideal.

Although the first plan worked this time it was nice to see a well thought out series of fall backs – all within the skillbase of the team.

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 Mansukh Popat, Dept Anaesthesia, John Radcliffe Infirmary, Headley Way, Headington, Oxford OX3 9DU. Or email him secretary@das.uk.com

Name .....

Address .....
.....
.....

email .....

Grade **Cons SpR SHO Staff Grade Other**.....

In which specialty do you meet difficult airways .....