...a date for your diary!

Difficult Airway Society Annual Conference

12th – 14th November 2008
Britannia Adelphi Hotel

www.happen.co.uk/das2008

08 Liverpool EUROPEAN CAPITAL OF CULTURE

DIFFICULT AIRWAY SOCIETY ANNUAL CONFERENCE, LIVERPOOL
12TH – 14TH NOVEMBER 2008

DIFFICULT AIRWAY SOCIETY

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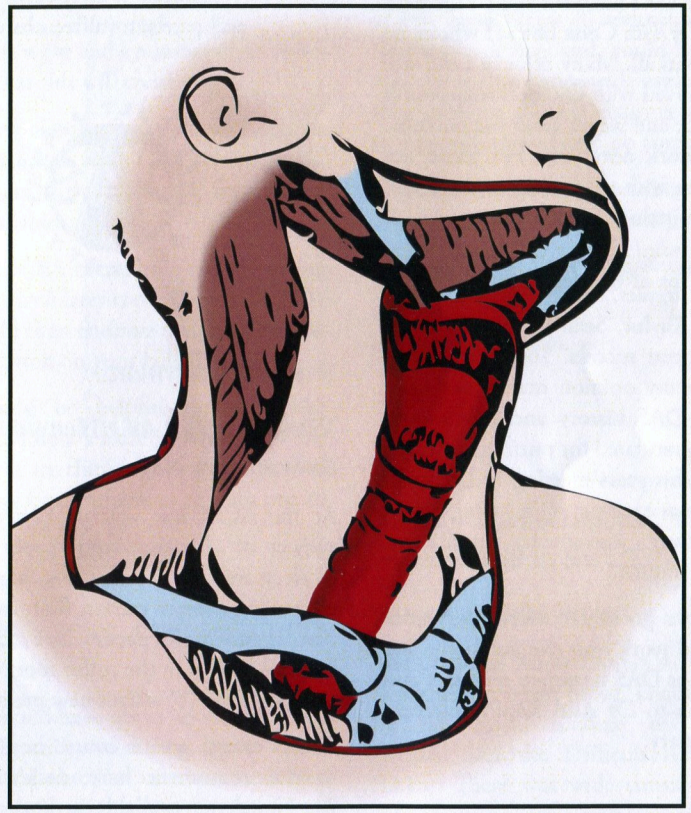

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Welcome to the DAS 2008 Newsletter

This edition of the newsletter contains information on DAS features, changes in personnel, case reports, Radio 4, airway meetings and the most important airway audit to be undertaken in the UK - National Audit Project 4.

The audit project conducted jointly between the RCOA and DAS has been lead by Dr Nick Woodall and Dr Tim Cook both of whom are well known to us all. Many of us in DAS will have been involved with the local snapshot of current practice and we all await the outcome of this vital work next year. For those not entirely familiar with the project a very useful guide has been included in this copy.

The last DAS meeting in Portsmouth organised by Denise Carapiet, Kathy Torlet, Andy Macleod, Ian Taylor, Sean Ellott and Andy Norris was a great success. The medico legal session was in my opinion one of the most impressive in DAS history and Portsmouth should be congratulated for putting on such a good 'show'. This years meeting in Liverpool promises to be as exciting, with a programme including airway assessment, paediatrics, obstetrics and trauma.

A special thanks go to Dr Mary Mushambi for all her hard work over the years who has stepped down as DAS honorary secretary and congratulations to Dr Atul Kapila our new honorary secretary.

Dr Anil Patel
Editor

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 views of the society.

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From the Chairman...

Would you like an e'Newsletter rather than a paper one?

At the AGM last year in Portsmouth, the subject of changing from paper newsletter to electronic was raised again. Arguments for electronic = lower carbon footprint & lower cost, arguments for paper = it's a nice reminder, you can leave it in the coffee room at work for others to read (& attract new members).

The 2 camps are of course both right and so the committee have decided to make the Newsletter available in both formats. If you wish to continue to receive the paper newsletter on your doormat at intervals then you need do nothing. If you would prefer to change to an electronic version only the please email busola@aagbi.org (busola maintains our DAS member database) saying that you would prefer to be taken off the paper newsletter mailing list and we will make it so, and make an e version available to you in the future.

ACCEA awards

I know we haven't had the results of the last round of ACCEA awards yet – (we'll let you know if DAS has any successes again this year) – but……..

If you are thinking that this year could be your time to apply for a national award be it Bronze, Silver, Gold or even Platinum! Then remember DAS support for your application could give it that final little nudge into the successful pile.

Over the years we've had a number of successes & we hope that this will continue.

Start thinking about who could write you a citation relating to your DAS related work, approach them early. Guidance for citation writers is available on the ACCEA website.

The DAS ACCEA committee will be sifting and ranking candidates come December 2008 and we would then endorse the citations that have been written on your behalf.

Also it would be helpful for the DAS committee to know a little in advance of the process if you are thinking of applying with our support as it will enable us to assist you to the best of our ability.

Radio 4 programme about an airway death.

Many of you will have heard about the death of Elaine Bromiley resulting from failed ventilation at induction of anaesthesia for routine elective surgery.

Radio 4 are broadcasting a programme "To Err is Human" discussing the case (and the things that have been going on since to improve safety in medical care).

It was broadcast on the 11th August.

Videolaryngoscopy can you help?

DAS is putting together a project looking at evaluating new laryngoscopes to see if they match or improve upon the performance of our current "Gold Standard" – the Macintosh.

Two bright young anaesthetists are developing software for DAS that will enable us to collect and collate information from lots of anaesthetists like you and me who are using videolaryngoscopes in our daily practice.

If you have access to videoscopes or other intubation devices and would be prepared to contribute to a nationwide evaluation project then drop me a line at chairman@das.uk.com to express interest (with no commitment).

Hopefully inside a year we should have loads of data on how these devices perform & will start to be able to provide information to the anaesthetic community at large (success rates, ease of intubation etc) that will help us in our choice of intubation aids.

Chris Frerk
Chairman DAS.

Major Complications of Airway Management in the UK

National Audit Project 4

The National Audit Project 4 (NAP4) is an ambitious project being conducted jointly by the Royal College of Anaesthetists (RCoA) and the Difficult Airway Society (DAS). There was wide consultation before embarking on this project which has gained support from the Association of Anaesthetists of Great Britain and Ireland (AAGBI), the Association of Paediatric Anaesthetists (APA), the Association for Perioperative Practice (AfPP), the College of Emergency Medicine (CEM), the College of Operating Department Practitioners (CODP), the Intensive Care Society (ICS), the Intensive Care National

Audit and Research Centre (ICNARC), the National Patient Safety Agency (NPSA), the Obstetric Anaesthetists Association (OAA) and the Paediatric Intensive Care Network (PICANet).

This project closely follows the model used for the successful NAP3 audit of central neuraxial blockade. NAP4 will start on 1st of September 2008 and run for one year. It will determine the incidence of major complications of airway management in the UK. To achieve this objective it will be necessary to undertake a snapshot of current airway management practice, providing the denominator and a year-long data collection of major complications to provide a numerator.

Snapshot of current practice

The snapshot will enable annual usage to be calculated for the number of; intubations, facemask anaesthetics and supraglottic airways. This should take place in September/ October 2008. The exact timing in each hospital will be determined by the Local Reporter. The snapshot should provide an interesting and valuable insight into current airway management practice.

Prospective data collection of airway management complications over one year

Data will be collected on all patients in whom airway management problems result in:

- Death
- Brain damage
- Emergency surgical airway or needle/ cannula cricothroidotomy
- Unanticipated ICU admission resulting from a complication of airway management

Airway problems with these endpoints are likely to be:

- Difficult or failed ventilation (via facemask, airway or tracheal tube)
- Difficult or failed intubation
- Tracheal tube misplacement or displacement
- CICV - the can't intubate can't ventilate scenario.

Data will be used to calculate the incidence of major airway complications in UK anaesthetic practice and to look for problem areas. Events occurring in the emergency room and ITU should also be submitted but they will not be used to calculate the incidence of these complications in the practice of anaesthesia. Analysis of cases will be educational and used to promote cross specialty learning.

NAP4 airway event notification and data submission

In order to ensure complete confidentiality data collection on airway management complications will be a two part process; 1/ Notification and 2/ Data submission.

1/ The RCoA will be notified of an event. 2/ The Local Reporter will be issued with an event specific username to enable on-line data submission via the DAS website.

Notification

It will be possible for anyone to notify or inform the RCoA of a case fitting the inclusion criteria shown above. Notification should be by email to tcook@rcoa.ac.uk . The only information required will be the date and time of the event and the hospital name. The identity of the person informing the RCoA will also be required in order to prevent malicious reporting. *The identity of the patient must not be sent and the identity of the anaesthetist is unnecessary and unwanted.*

Local Reporters

Local Reporters may be unaware that an event has occurred in their hospital but when supplied with information on the date and time of an event the Local Reporter will locate the clinicians involved. The Local Reporter will support these clinicians and aid the data collection process. It will be possible for the Local Reporter to submit information on behalf of another anaesthetist if that person is unable or unwilling to do so. In addition the Local Reporter will coordinate the snapshot of activity.

Local Reporters were vital for the NAP3 project. Their work and support has been greatly appreciated by the RCoA. Many have agreed to continue in this very important role to support this new project, others have passed this task to DAS members. All UK hospitals have a Local Reporter in place. It would be very useful if all DAS members would locate their local reporter via their Audit Lead anaesthetist and offer help and support. Alternatively if you do not know the identity of your local reporter please contact Shirani Nadarajah of the Professional Standards Directorate at The Royal College of Anaesthetists by email at: snadarajah@rcoa.ac.uk .

On-line data submission

After notification of an event the Local Reporter will work with the anaesthetists involved in the patient's care. For each event a specific username will be supplied to the Local Reporter by the RCoA. This will enable secure password protected access to part of the DAS website. Before submitting data the person submitting data will need to create their own password. The combination of a username and password will ensure that only the person entering data has external access. The DAS project lead will be able to read the entered data and judge if more data is required, but the RCoA will not. If more data is needed, the DAS project lead will ask the College (using the username for identification) to inform the Local Reporter that more data is needed on the web-based form. When a report is complete the log-on code will be destroyed and the link between the log-on code and the submitted data will be broken which will mean that there is no longer an identifiable connection between RCoA reporting and data on the DAS website.

Confidentiality

The RCoA will have access to the date and hospital location of every notified event. The College or its representatives will be prevented from linking these data to events within the database by the password selected by the individual submitting data. The DAS will have access to the username and specific details within the database but will have no information on hospital location, identity of the patient or of the doctors. No data identifying a patient or anaesthetist will be requested, and if entered it will be removed. Neither organisation will be able to link the two without active co-operation of the other. No attempt will be made to identify patients or doctors involved.

Data collection forms

To enable the audit team to gain a clear picture of the event the data collection form is extensive. Questions are not posed to judge colleagues or to imply criticism. Questions are framed to seek the information we believe will allow us to determine themes and learning points arising from these challenging cases.

We are aware that anaesthetists engaged in this process may have suffered trauma themselves, on account of the incident they report. We thank all those reporting these data for their generosity and honesty in reporting their cases.

We have attempted to make this process as simple and straightforward as possible whilst remaining robust and maintaining confidentiality. When data collection is complete the link with the original notifying data will be broken.

Moderator

Dr Ian Calder will act as a moderator. His role will be to advise Local Reporters if they are unsure about inclusion criteria or the data to be submitted. He will be independent both of the RCoA and DAS and may be contacted by telephone on 0207 829 8711 or by email at nap4moderator@rcoa.ac.uk.

Data analysis

The reported cases will be analysed by the DAS and RCoA with input from other specialist societies.

Project Approval

This project has the support of the Chief Medical Officers of England, Scotland, Wales and Northern Ireland. The project is also supported by the Medical Defence Union and the Medical Protection Society. The process also has the approval of the National Research Ethics Service and the National Research Ethics Service (NRES) and the Patient Information Advisory Group (PIAG).

Additional information

Supplementary up-to-date information on the process will be made available from the both the DAS and RCoA websites. Information packs will be sent to the Local Reporters but will also be downloadable from the DAS and RCoA web-sites. Information can be located on the internet by searching for NAP4 + airway. The DAS and RCoA URL's are listed below.

DAS: www.das.uk.com/nataauditproject
RCoA: www.rcoa.ac.uk

Powerpoint presentation

You will find a Powerpoint presentation with speaker notes is downloadable from the RCoA and DAS web sites. The same presentation was sent out electronically to the DAS members for whom we have an email address and to Local Reporters. It would be useful if you would contact your Local Reporter and arrange for one of you to present this at an audit meeting within your Department.

Thank-you for your help.

Dr Nick Woodall
nicholas.woodall@nnuh.nhs.uk

Dr Tim Cook
tcook@rcoa.ac.uk

Co-Audit Leads, 4th National Audit Project

Speaking to Cousin SAM

An email entitled "How do you feel about a trip to the States?" should normally have intercepted by my spam filter, but Chris Frerk's suggestion that I might like to speak on behalf of DAS at the SAM (Society for Airway Management) 2007 meeting in Houston made it through to my in-box. Being asked to speak is always an 'honour', but then again you always know people who could do it much better. However those people, (Ian Calder and Steve Yentis) duly gave me the encouragement to go and speak.

SAM is our sister organisation in the USA, and in fact our own Chandy Verghese is the current president. Like DAS, it supports projects and collaboration into airway research together with an annual meeting. This year's theme was supra-glottic airways and my fellow key note speakers would include Archie Brain, and Joe Brimacombe. I was advised to speak on a different topic. So I chose ethics, and the thorny issue of consent, or rather what to do if a patient refuses a safe proposal such as fibreoptic intubation.

"Some people 'just want to go to sleep'. We can accede to their wishes and proceed into danger, or we can override their refusal, and hope they support us later. Either way there are ethical issues to consider. As long as we have explained the risks, the principal of respect for autonomy suggests that the patient should decide. Any attempt to overrule their wishes represents paternalism or even coercion. However, on some matters at least we should be able to judge what would be in a patient's best interests. If we believe they have made a really bad decision, leaving them to its consequences can look like abandonment, or might compel us to go against our personal ethics. Doctors still have a duty not to do harm, and also professional rights of our own.

Ethical dilemmas like this can also require time for deliberation that is unavailable in a deteriorating airway scenario. It gets more difficult, because uncertainty dominates much of our decision making. Our predictive tests of airway difficulty can be unreliable, and it is also hard to assess how much information we should give to patients, and whether or not it has been understood. Most patients probably can not imagine what the consequences of an airway complication would actually be like, all of which casts doubt on whether consent can ever be truly informed.

Life however tends to be understood backwards, (as Kierkegaard said) and this is how our decisions will be also judged ethically. In retrospect, most uncertainties will be resolved. If things have gone well, patients may be grateful that we persuaded them into something (though not always!). Conversely after a complication, the suspicion of poor practice is harder to avoid. Experts, courts and patients can all change their opinions in the light of outcome, while memories of warnings are often unreliable, and the biases of hindsight are well known.

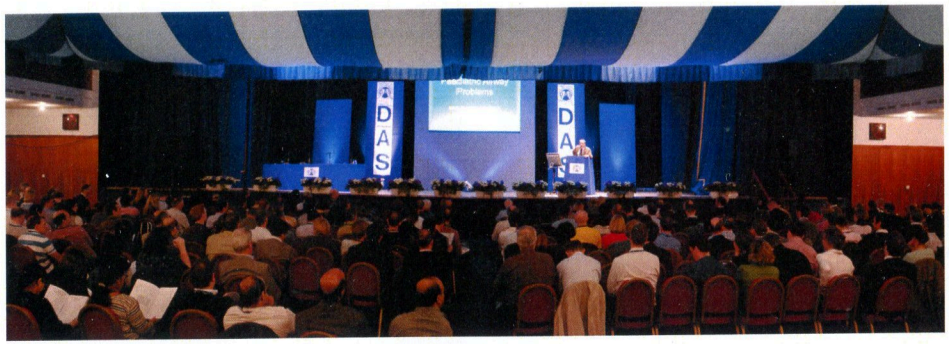
Patients usually do give their consent, and also remember little afterwards. If they do express reluctance at first, an aptitude for presenting risk combined with some sympathy can hopefully avoid a stalemate. However, our actions as doctors will always be to some extent vulnerable to what philosophers term 'moral luck', one more uncertainty we unfortunately have to live with".

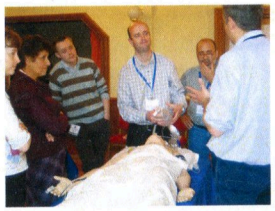
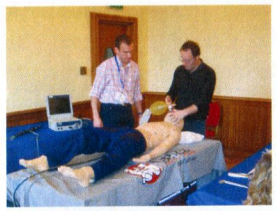
So I hope all this went down well, although I imagine that the legal aspects of this dilemma are equally prominent in the minds of many American anaesthesiologists. All the same, I got some kind words afterwards, and then had the rest of the meeting to enjoy and some Texas hospitality to make the most of. The conference dinner stated that the dress code would be 'western'. Cowboy hats and bandanas were supplied (square dancing optional), all accompanied by local food and music, and a good time was had by all. (see photo of Chandy's presidential serenade to Professor Hagberg!)

I'm very grateful to Carin Hagberg and David Ferson of MD Anderson for hosting me, and to the LMA Company for supporting my travel. SAM runs great meetings, with ample opportunities to meet other clinicians at the workshops, and seminars. The meeting in Houston did explore the topic of supraglottic airways thoroughly, and put to rest any notions that American anesthesiologists are reluctant to employ new airway devices. Other sessions covered airway radiology, complications and their medicolegal aftermath, and plenty more. I would encourage DAS members to consider going to future meetings, and with the strength of the dollar there is even less excuse right now. The 2008 meeting was held in Boston 19th – 21st September, and full details can be found on the SAM website at www.sam.zorebo.com

Andy McLeod
Royal Marsden Hospital

Difficult Airway Society Meeting Portsmouth

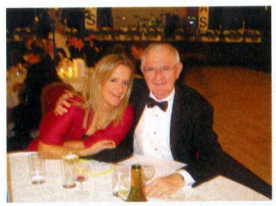


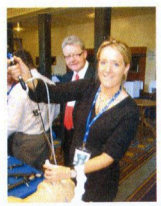













Airway management is an essential skill for ODPs, Anaesthetic Nurses and Paramedics

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Operating department practitioners (ODPs) in Torbay Hospital are experienced and enthusiastic in helping anaesthetists in the management of cases with difficult airway on routine theatre lists. Their expert assistance increases patient safety. We started a new course1 targeting ODPs and Anaesthetic Nurses in the UK, to share our experience of improved teaching and training in airway skills. To our knowledge there was no similar course for non-medical practitioners in the UK.

The aims of this course are to:

- consolidate the basic foundations of knowledge
- develop a common understanding about potential problems with difficult airways
- educate them in the technical skills needed to undertake and give assistance in following Difficult Airway Society (DAS) guidelines/algorithm2
- familiarise non-medical practitioners with commonly used airway adjuncts and teach them how to clean, sterilise, set up and check equipment required for fibre-optic intubation

The skills to be learnt on the course were face mask ventilation, insertion of supraglottic devices, optimising direct laryngoscopy and performing endotracheal intubation.

The corresponding author has been an active member of the DAS for nine years and has been involved in co-organising difficult airway courses in Torbay Hospital for the last eight years. Many of our ODPs are active in the organisation of these courses. We have two logically arranged difficult intubation trolleys, four fibrescopes, which are used almost every day, and a wide variety of airway adjuncts, which are used regularly. We have a core group of anaesthetists who practice and teach difficult airway management every week during routine lists.

Three years ago, ODPs and anaesthetic nurses in our hospital who were not familiar with difficult airway management expressed keen interest, which inspired us to conduct an in-house pilot course in March 2005. As a result, more of them have grown confident not only in assisting anaesthetists with difficult airway cases but also feel confident in helping and teaching in our workshops. Now we have an even bigger pool of staff that is capable of assisting us. Encouraged by this improved awareness, we conducted our first external course with 18 delegates, in October 2006. Since then we have conducted courses in July 2007 and Feb 2008 and July 2008.

The emphasis of this course is on interactive, hands-on, practical work-stations, where the delegates get to see and use airway equipment under the guidance of experienced faculty.

The course starts off with short lectures covering anatomy, assessment of the airway, endotracheal intubation, difficult airway algorithm and airway management in challenging circumstances, for example C-spine fracture. There is also a guest lecture delivered by a speaker of national eminence. Then we have an airway management scenario, role played on a medium fidelity simulator, followed by analysis, discussion and tips providing a real patient experience.

The rest of the day comprises of interactive sessions and practical work stations such as setting up a difficult intubation trolley,

cleaning and care of a fibrescope, setting up the cart for management of a potentially difficult airway, bag mask ventilation, use of video laryngoscope and endotracheal intubation, use of different types of supraglottic devices and the use of a variety of laryngoscope blades and endotracheal tubes. Also, basic handling of the fibrescope and cricothyroid puncture techniques 3are introduced, so the practitioners are not unfamiliar when assisting the anaesthetist.

The analysis of the feedback and follow-up questionnaire was:

1. 94% said it gave them the confidence to assist in difficult airway cases.
2. 88% said it made them more familiar with the difficult airway equipment.
3. 100% said it improved their job satisfaction.

Some of the comments from previous courses:

- "appropriate for all grades of staff attending"
- "came away with some interesting points"
- "am more confident in airway management"

The results show that this is a well rounded, well received hands-on course. It should prove to be useful for practitioners involved in the management of patients with anticipated or unanticipated difficult airway. Familiarisation with varying equipment and techniques will improve their dexterity and knowledge base resulting in improved patient safety.

References:

1. Torbay Difficult Airway Management Course for ODPs, Anaesthetic Nurses and Paramedics.
2. Difficult Airway Society Guidelines.
3. DAS debate at 2006 annual meeting: Cricthyrotomy & fibre-optic intubation are core skills.

Letter from Honorary Treasurer

Dear DAS Member

DAS is continuously seeking ways to improve its administrative systems and services to members. To this effect, and as discussed at the Annual General Meeting at Portsmouth, 2007, the Society is now changing its method of subscription collection from Standing Order to Direct Debit. This method has considerable advantages, not least of which are:

1. Errors arising from multiple payments made to the society by members' account holding banks would be avoided.

2. This is very cost effective under the arrangement negotiated with the Association. All subscription renewals will be completed on two dates a year (either January or July). Any changes in subscription will not require additional forms to be completed ensuring that all the debits are collected at either of the above dates during the year.

3. The administration of membership and subscription collection by one process will simplify matters for the Officers and enable a smooth transfer to new Executive members at the end of their terms of office.

Please find attached a direct debit mandate, which we would ask that you kindly complete and return to the following address as soon as possible.

The Specialist Societies Co-ordinator
Difficult Airway Society
21 Portland Place, London. W1B 1PY

It is anticipated that there will be a complete changeover to this new method by January 2009.

Dr Ravi Dravid
Hon. Treasurer
Difficult Airway Society

DIRECT Debit

Instruction to your Bank or Building Society to Pay Direct Debits

AAGBI
21 Portland Place, London, W1B 1PY, England
Tel: (+44) 207 631 1650 , Fax: (+44) 020 7631 4352
Patron: HRH, The Duke of York, KCVO, ADC

Please complete full name and address of your Bank/Building Society

To The Manager (Bank/Building Society)

Address

Post Code:

SERVICE USER NUMBER

995352

Difficult Airway Society

Ref. No. DAS/.....

Please complete this form to instruct your bank to make payments directly from your account

THE COMPLETED FORM SHOULD BE RETURNED TO: The Specialist Societies Coordinator, Difficult Airway Society, 21 Portland Place, London, W1B 1PY.

1. **Member's name** *(in capitals please)*
   Surname ..... Initials .....
2. Bank account details:
   Name of Account holder .....
   Sort code - - Account Number
   Banks may refuse to accept instructions to pay direct debits from some types of account.
3. Your instructions to the bank, and signature.
   - I instruct you to pay direct debits from my account at the request of **AAGBI (Difficult Airway Society (DAS))**
   - The amounts are variable and may be debited on various dates
   - I understand that the **AAGBI (Difficult Airway Society (DAS))** may change the amounts and dates only after giving me prior notice.
   - I will inform the Bank in writing if I wish to cancel this Instruction.
   - I understand that if any direct debit is paid which breaks the terms of this Instruction, the Bank will make a refund.

Signature ..... Date .....

DIRECT Debit

✂.....

Standing Order Cancellation

Name and full postal address of your Bank or Building Society

To The Manager (Bank/Building Society)

Address

Post Code:

Branch Sort Code: - -

Branch Account No:

With immediate effect, please cancel my/our Standing Order authority payable to Difficult Airway Society (DAS) under

Account Reference No.

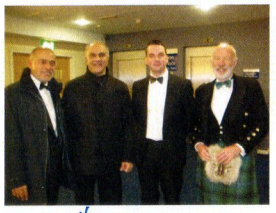
Name(s) of Account Holder(s):

Signature(s)

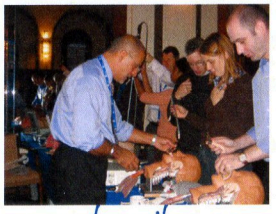
Date: .....

Legal Workshop

DAS Portsmouth Oraganisers



Dr Kapila, Dr Popat, Dr Benham & Dr Henderson.



Dr Atul Kapila

Dr Verghese, guest, Dr Biro & Dr Kristenson

Dr Chandy Verghese & Dr John Henderson

Dr Tim Cook

Dr Chris Frerk

Management of a patient with known tracheal perforation with a Proseal LMA.

A 73year old female patient was scheduled for Cystectomy for recurrent pyocystitis not responding to medical treatment.

Preoperative assessment showed a complex medical history and multiple general anaesthetics before.

In the immediate postoperative period of her last operation, and while in Post Anaesthesia Care Unit the patient coughed and this was complicated by pneumothorax and surgical Emphysema and needed ITU admission. Her postoperative course was further complicated by MRSA and C.difficile infection and she needed a tracheostomy, mechanical ventilation and ITU treatment for approximately one month.

Radiological investigations showed that she had a defect in the 4th tracheal ring posteriorly about 3.5 cm below the vocal cords, and the endotracheal tube was suspected as the cause of the complication.

The patient was worried about another intubation as she was informed that the endotracheal intubation carries the risk of another tracheal perforation (she refused to have endotracheal intubation) and was reluctant to have her cystectomy. Options for securing the airway were discussed with the patient keeping in mind that she was documented as grade 1 Laryngoscopy and she had no factors increasing risk of aspiration: -

1-Routine Laryngoscopy and Intubation, which carried the risk of recurrent tracheal perforation.

2-Intubation using asleep Fibre Optic Intubation ensuring that the Endotracheal tube is above the level of the defect, however there was still a risk of tracheal perforation if the endotracheal tube moved or if the patient coughed during recovery from general anaesthesia.

3-Insertion of a Laryngeal Mask Airway (Classic Vs Proseal). The Proseal LMA was preferred as the drainage tube can minimize the risk of aspiration provided that it is correctly placed.

Suitably assured the patient and anaesthetist proceeded with option three. Anaesthetic technique included intravenous induction of anaesthesia and muscle relaxation, insertion of Proseal LMA size 4, IPPV with TV of 500 ml, RR of 10-12/min, airway pressure was in the range of 17-20 cm H2O. At the same time endotracheal intubation was kept as a back up plan in case of failure.

The operation lasted for three hours, at the end of the operation the muscle relaxant was reversed and the patient started to breath spontaneously and when fully awake the LMA was taken out and patient sent to Post Anaesthesia Care Unit.

Intravenous PCA morphine was prescribed for postoperative pain relief. The postoperative course was uneventful with no complications.

Although tracheal intubation is the standard practice of the author for laparotomy/open Cystectomy, prior experience with the proseal LMA made this a suitable alternative.

Dr.Ezzeldin Atoia,
Anaesthetic SpR, Airway fellow,
Northampton General Hospital.

Difficult Intubation Following Parathyroidectomy

C. Persad[1] and M. Nicholas[2]

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We would like to report on a case of increased Cormack and Lehane layryngoscopy grade 21/2 following parathyroidectomy.

A 59 year old lady presented on our elective ENT list for Left Grommet Insertion and Examination Under Anaesthesia of the Postnasal Space. At the time of preoperative visit, an assessment of the airway was made. She had normal neck and jaw movement, a Thyromental Distance of >6.5 cm and a Mallampati Score of 2. She had an old parathyroidectomy neck scar but no obvious neck swelling or deformity. Exploration of previous anaesthetic charts confirmed a Cormack & Lehane Grade 1 view when larngoscopy was performed for a parathyroidectomy. Of note, CT scans of her neck performed 6 months following surgery demonstrated the absence of the right thyroid lobe and no other abnormality.

Following induction of anaesthesia with a muscle relaxant laryngoscopy was performed. A grade 3 view was obtained. After a repositioning of the neck and the application of cricoid pressure the grade did not change. A third attempt at laryngoscopy by another senior anaesthetist resulted in the introduction of a gum elastic bougie in the trachea and subsequently the passage of an ETT. Laryngoscopy was only able to show the most posterior aspects of the arytenoids. Anaesthesia and oxygenation were maintained during the attempts at intubation. Both Anaesthetists involved confirmed that the larynx and epiglottis were less 'mobile' than anticipated. There was no subglottic obstruction to intubation and examination under anaesthesia did not reveal any supraglottic airway abnormality. Extubation was uneventful.

The events were documented in the notes and the patient was informed.

The change in laryngoscopy view could have been due to:

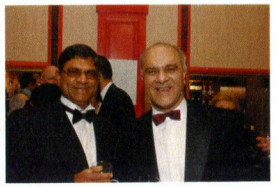
1. Scarring caused by neck surgery, a phenomenon that can occur following thyroidectomy.
2. The onset of osteoarthritis
3. Differences in the technical skills of the anaesthetist.

The patient did not exhibit any symptoms or signs of osteoarthritis. Laryngoscopy was performed by experienced consultant anaesthetists both times (pre- and post-thyroidectomy). We believe that the most likely explanation is scarring from her previous neck surgery.

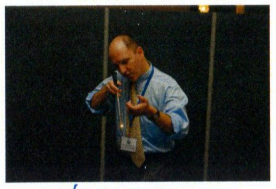
References:

1. Chignell, R M. Iatrogenic Disorders of the Ear, Nose and Throat. Proc R Soc Med. 1972 August; 65(8): 679–681.

Dr Carpiet, Dr Chris Frerk & Dr Kathy Torlot

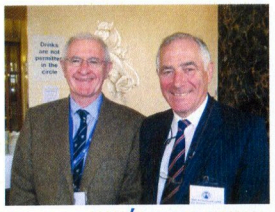


Dr Ravi Dravid & Dr mansukh Popat



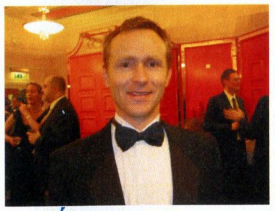
Dr Richard Levitan

Dr Mary Mushambi & Dr Barry McGuire

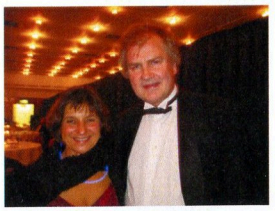


Dr Ian Calder & Dr RS Vaughn

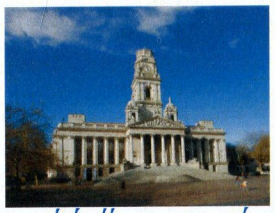
Dr Kathy Torlot & Dr Denise Carpiet



Dr Shaun Scott



Drs Anne & Jeremy George



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