

# Canadian Task Force Studies Difficult Airway

The unanticipated difficult airway strikes terror into all emergency physicians and anesthesiologists. The best working definition for a difficult airway is that a conventionally trained intubator experiences difficulty with mask ventilation (inability to keep oxygen saturation above 90%), difficulty with tracheal intubation (requiring more than two attempts, change in hardware, or use of an alternative device), or both. The incidence in emergency medicine is not known, but anesthesia studies have found a 2% to 8% incidence of poor view during laryngoscopy, a roughly 1% incidence of difficult intubation, a 0.1% to 0.3% incidence of failed intubation, and a 0.01% incidence of failed intubation/ failed ventilation.

The Canadian task force recommends optimizing laryngoscopic view using the BURP maneuver (backwards, upwards, rightwards pressure on the larynx) and optimal patient positioning. If laryngoscopy fails, the operator should quickly change hardware or take other steps to improve success rates. Capability with alternative methods and devices, such as cricothyroidotomy, LMA, alternative laryngoscopes, fiberoptics, and Combitube® is essential.

**Comment:** This lengthy report is based on anesthesiology practice, but has valuable information for EPs. There are many devices for rescue from the failed airway in the ED, and the right decision and device at the right time can make the difference between life and death. An accompanying editorial stresses the importance of formal training in management of the difficult and failed airway.

— *RM Walls*

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## CITATION(S):

Crosby ET et al. The unanticipated difficult airway with recommendations for management. *Can J Anaesth* 1998 Aug 45 757-776.

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