LETTERS TO THE EDITOR

Airway management in intensive care units

Manejo de la vía aérea en las unidades de cuidados intensivos

Dear Editor,

We wish to congratulate Gómez-Prieto et al.1 for their nationwide survey on airway management (AM) and also make a few contributions while insisting on how important it really is.

The NAP4 was a turning point after proving that different factors contributed to AM-induced mortality/brain damage whose incidence rate in intensive care units (ICU) is 55 times higher compared to intraoperative settings.2 We hereby draw a comparison between factors regarding the critically ill patients and findings from the survey shown between brackets.

The human factor – present in up to 4.5 factors on average per case – the lack of prior assessments and deficient planning; several attempts and delays when transitioning to the invasive cervical approach can be found in the most dramatic cases of all. Other contributing factors are the absence of pre-established strategies (protocols, absent in up to 77% of the ICUs surveyed) and sub-optimal training. Clinical guidelines and algorithms have changed the medical practice and stimulated the culture of “planning” and its universal implementation.4

Regardless of the existing heterogeneity in the devices selected for AM among different institutions, today it is recommended to have one device for primary use available plus one alternative only in order to avoid cognitive overload and facilitate the decision-making process. The actual recommendations indicate that video laryngoscopes (53.5%) and second-generation laryngeal masks (%) should be available wherever AM is a common practice.4,5 It is surprising to see that angulated-blade video laryngoscopes are everybody’s choice to the detriment of standard-blade video laryngoscopes. There is evidence that the use of the former (GlideScope® and McGrath® MAC) in critical care may increase morbimortality though.

It is also striking to see that the use of capnography has not been assessed given it is responsible for over 70% of all deaths in the ICU setting2 and its universal implementation in ICUs has been considered the only change that is powerful enough to avoid mortality.2 This is so because it allows us to diagnose early failed intubations and accidental displacements of cannulas and endotracheal tubes.

We need a major overhaul to match the actual practice to the actual recommendations. As professionals from different fields of expertise we have the possibility of meeting Bromiley’s request6 of managing airways safe and securely. Articles such as this one conducted by Gómez-Prieto et al.1 are key if we really want to make a change.

References


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In recent years, some studies have demonstrated the validity of the MACOCHA scale in the ICU
due to the scarce functional reserve and instability of these patients. Instruments such as the Mallampati scale (included in the MACOCHA scale with a high score) may prove difficult to apply. Despite this, and even in emergency situations, the existence of difficult airway predictors must be taken into account.

Capnography is very important for discarding failed intubation by corroborating correct positioning of the endotracheal tube. Although it is widely used in the intraoperative setting, we admit that the lack of an item asking about the availability of capnography is one of the weaknesses of our survey — its use having been recommended since the publication of the NAP4.

In conclusion, while much remains to be done in airway management in the ICU, the fact that recommendations for routine clinical practice are becoming available may imply changes in terms of patient morbidity-mortality. Further studies will be needed to evaluate the impact of these recommendations and to establish new critical airway management protocols.

References