

Guidelines help us to keep calm when facing a difficult airway

Bon-Nyeo Koo

Department of Anesthesiology and Pain Medicine, Yonsei University College of Medicine, Anesthesia and Pain Research Institute, Seoul, Korea

In this issue of the *Korean Journal of Anesthesiology*, Koh et al. [1] report that the incidence of unexpected difficult airway is 5.8% from a retrospective review of electronic medical records at a single university hospital, and that most cases were managed effectively. Among the numerous intubation difficulty scales (IDS) [2], the Cormack–Lehane grade is generally considered the most sensitive measure for predicting difficult intubation. Alternative techniques were required in 74 out of 951 cases (7.8%) to achieve intubation using the following subsidiary manipulations: the additional use of stylet only in 69 cases; use of a lightwand only in two cases; a stylet first and then a lightwand in one case; a stylet, then a lightwand, and finally fiberoptic assistance in one case; and the initial use of a stylet, subsequent use of a supraglottic airway device, and finally a surgical tracheostomy in one case. The last three cases (3/951, 0.3%), which all required two or more alternative techniques, were all difficult cases with an IDS > 5; this compares with an 8% rate of IDS > 5 reported by Adnet et al. [3].

Controlled studies of difficult airways are difficult to conduct due to the emergency nature of a difficult airway. Although there is insufficient scientific evidence to support every recommendation concerning airway management in clinical guidelines, guidance must be based on the best accessible evidence, such as expert consensus.

Since the first edition of the American Society of Anesthesiologists (ASA) Difficult Airway Practice Guidelines for the management of the difficult airway was published in 1993 (updated

in 2013, [4]), several national societies have proposed practice guidelines for difficult airway management, including the Difficult Airway Society (DAS) [5].

The most important development in the ASA Difficult Airway Practice Guidelines over the past two decades has been the introduction of new airway devices into clinical practice, including the laryngeal mask airway (1993–2003) and video laryngoscopy (2003–2013). Both of these have also been included in the new DAS guidelines for successful intubation in patients with a history of difficult intubation in various randomized controlled trials [6].

While the ASA guidelines focus on both the anticipated and unanticipated difficult airway, the DAS guidelines concentrate on the unanticipated difficult airway, an unpredictable problem. The new 2015 DAS guidelines differ from the original 2004 DAS guidelines in that they are more concise and pragmatic and emphasize the preparedness and accountability of the practitioner by optimizing conditions and minimizing patient morbidity in a difficult airway situation. Obtaining proper training on the use of alternative airway devices and accompanying techniques, such as emergency invasive airway access, is not only essential for physicians but is also expected. Given that repeated airway manipulation may lead to airway damage and reduce the ability to ventilate, the number of laryngoscopy attempts with any particular device should be limited. No single technique is better at securing the airway in every situation. Physicians need to be familiar with several different devices and techniques because airway devices have unique properties that may be advantageous in certain situations, yet limiting in others.

Our great enterprise of difficult airway management begins with the implementation of the guidelines in the most accurate manner to manage our patients safely.

Corresponding author: Bon-Nyeo Koo, M.D., Ph.D.
 Department of Anesthesiology and Pain Medicine, Yonsei University College of Medicine, Anesthesia and Pain Research Institute, 50, Yonsei-ro, Seodaemun-gu, Seoul 03722, Korea
 Tel: 82-2-2228-2422, Fax: 82-2-312-7185
 E-mail: koobn@yuhs.ac
 ORCID: <http://orcid.org/0000-0002-3189-1673>

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