
Thank you for giving the New Zealand Society of Anaesthetists (NZSA) the opportunity to respond and feedback on the draft PS61 2015 and PS61 BP 2015 documents.

It is clear to NZSA that much work and time has gone into developing these documents and we appreciate the care taken and planning involved in creating a professional standard that can be used by anaesthesia practitioners.

About NZSA

The New Zealand Society of Anaesthetists Inc., (NZSA) is a professional medical education society established in 1948. It represents almost 500 medical anaesthetists in New Zealand and works to foster education and research into anaesthesia, and support the professional interests of its members. Members include specialist anaesthetists in public and private practice, and trainee anaesthetists. NZSA is a member society of the World Federation of Societies of Anaesthesiologists (WFSA) and is represented at Executive level on the WFSA.

Feedback

NZSA supports the development of an airway document to facilitate management of the “can’t intubate can’t oxygenate” (CICO) emergency as an important tool for ANZCA Fellows and Trainees. NZSA recognise the value in a locally developed guideline based on international evidence and best practice.

As such, we have circulated draft PS61 widely and also specifically to recognised airway experts in the NZ anaesthetic community.

Draft PS61 BP introduction states “... developing an ANZCA professional document to guide practitioners in airway management of the can’t intubate can’t oxygenate scenario. An algorithm was to form a core part of this document.” With this being the aim of PS61, feedback has focused on how the draft document meets the stated objectives.
The majority of feedback indicated that the content of PS61 did not truly reflect the title, “Guidelines for the Management of Evolving Airway Obstruction: Transition to the Can’t Intubate Can’t Oxygenate Airway Emergency”. Rather, the document has a strong focus on Human Factor issues that are associated with the Management of Evolving Airway Obstruction: Transition to the Can’t Intubate Can’t Oxygenate Airway Emergency.

The overriding opinion was that either the document should be renamed to reflect the narrow scope of the document, or the document needs to contain further information pertaining to the practical management of a CICO emergency. Many anaesthetists felt that there are well researched and clear guidelines already in existence which should be utilised.

The following comments detail some more specific feedback and concerns around the PS61 documents.

Comments:

1. The scope of PS61 BP and PS61 is far too narrow, with excessive emphasis on “human factor” issues. There is no evidence that such a human factors-driven approach to CICO is helpful in isolation from more specific technical airway management guidelines. There is good evidence that simplistic and rehearsed procedural training has the best success rates in securing and infraglottic airway and resolving a CICO emergency.

2. There is very little guidance for the reader when considering different airway management and procedural options (for example, supraglottic airway as a conduit for tracheal intubation, emergency surgical airway technique).

3. The importance and interpretation of capnography or end tidal carbon dioxide as an indicator of an inadequate airway should be emphasised.

4. The basic principles of airway management which include maintenance of oxygenation, avoidance of trauma and calling for help are rarely emphasised. Oxygenation throughout airway management is now promoted and recognised internationally.\(^1\) & \(^2\)

5. Given the key findings of the United Kingdom 4\(^{th}\) National Audit Project 2011 (NAP4) study which were: capnography, aspiration, failed cannula cricothyroidotomy, complications during extubation, failure to assess, failure to plan, failure to manage the airway awake, recognition of obesity as a risk factor, and inappropriate use of supraglottic airways, little attention is applied to these matters.\(^3\)

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a. Patient pathology, poor practitioner judgement and lack of education and training were the major areas associated with airway related poor outcomes. A focus on patient assessment, airway planning and technical airway skills would give the PS61 guideline strength.
b. Human factors were considered contributory to an adverse outcome in a minority of cases only.

6. It is unclear as to which group these documents refer to (adult, paediatric, obstetric). As an example; a leading cause of paediatric airway obstruction and mortality is laryngospasm and the treatment of this condition is not a cricothyroidotomy.

7. Management of the obstructed airway receives little attention including that of lower airway obstruction. There is no recognition or discussion that many patients present with anatomical, functional and structural airway obstruction requiring a variety of treatments depending on the presentation and diagnosis.4

8. Given that these documents focus on CICO, it was surprising to many that a detailed evidence based discussion about the ideal surgical airway technique was missing.5,6 &7

9. Risks associated with the use of an emergency airway were not discussed. Recognised complications such as multiple steps leading to delays; inability to identify anatomical landmarks percutaneously leading to delays in emergency ventilation; failure to progress to an open surgical technique when indicated; cannula kinking or displacement; failure to protect the airway from aspiration following an emergency airway procedure; complications of various emergency ventilation techniques, such as barotrauma are all worthy of describing.

10. While airway assessment is frequently mentioned, the inaccuracy and failings of bedside screening tests are not highlighted. It is important to explain that it may be impossible to reliably identify a difficult airway and a statement about being prepared for an unexpected difficult airway needs including.8

In reviewing the feedback received, the NZSA would recommend that the ANZCA Airway Management Group consider the following summary:

1. Rename these documents as they represent a human factor approach to emergency airway management. Options such as “A Human Factors Perspective on Management of Evolving Airway Obstruction” or “Management of Human Factors as they relate to Evolving Airway Obstruction” could be used. This would then leave the ability to develop a future ANZCA guideline on the more technical aspects of airway management and the CICO scenario.

2. Undertake a comprehensive review of the literature in order to design a local airway management guideline that focuses on airway assessment, a management plan, appropriate equipment and technical skills training. This should include the management of the unanticipated difficult airway.

3. With permission, adopt the Canadian Airway Focus Group guideline, or wait and review the 2015 Difficult Airway Society Guidelines to ascertain if that fulfils the ANZCA requirements.

The NZSA appreciate being able to provide feedback on this important area of anaesthesia crisis management. As a result of feedback received, the NZSA is not able to endorse PS61 in its current form.

If you wish to discuss this submission further. Please feel free to contact me at president@anaesthesia.org.nz.

Yours faithfully,

EW (Ted) Hughes

Dr Ted Hughes
President

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