

## My Laryngoscopy Failed. What Next?

2016

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Dr. Alan Jay Schwartz: Hello. This is Alan Jay Schwartz, Editor-in-Chief of the American Society of Anesthesiologists' 2016 *Refresher Courses in Anesthesiology*, the latest research and education information. The focus of the new online format of the *Refresher Courses in Anesthesiology*'s CME program, and the modules featured, is to educate learners on current developments in the science and clinical practice of the specialty of anesthesiology, critical care medicine and pain management. For the first time ever, we will be speaking directly with individual authors to learn about their expertise, perspective and insight regarding their featured module.

Today, we are pleased to present the following one-on-one conversation with fellow *Refresher Courses in Anesthesiology* Editor, Dr. Laurence Torsher, and author Dr. Richard Cooper. They will be highlighting the module titled, "My Laryngoscopy Failed. What next?"

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Dr. Laurence Torsher: I'm Laurence Torsher, a member of the ASA *Refresher Course* editorial group and a staff anesthesiologist at the Mayo Clinic in Rochester. Our author today is Dr. Richard Cooper, Staff Anesthesiologist and Professor in the Department of Anesthesia at the University of Toronto in Toronto, Ontario, Canada. He has authored the *Refresher Course* entitled, "My Laryngoscopy Failed. Now What?" Dr. Cooper, how has the approach to failed

laryngoscopy changed over the last 14 years since the initial publication of the ASA Difficult Airway Guidelines?

Dr. Richard Cooper: Well, I think perhaps the biggest change has been the availability of video laryngoscopy. That became commercially fairly readily available around 2001, and I think since that time an increasing number of departments and practitioners have become comfortable with the use of this device. It has had a fairly significant impact, I think, on laryngoscopy, inasmuch as many of the airways that had previously been regarded as difficult have now become relatively routine. But it's had another effect. In most centers there have been fewer awake bronchoscopic intubations being performed. So, I think, to some extent, we risk losing our familiarity with that technique, which requires fairly constant practice to maintain our skills.

Dr. Laurence Torsher: Dr. Cooper, what can an individual anesthesiologist do to be better prepared for the failed laryngoscopy?

Dr. Richard Cooper: Well, I think the first thing is to pay careful attention to the patient prior to our anesthetic encounter, and try to identify features that may be predictive of a difficulty with direct laryngoscopy. Unfortunately, the literature indicates that we're only moderately successful at identifying these patients, and we still fail to identify approximately 6% of patients—adult patients—who seem to have normal airway anatomy but prove to be difficult to visualize; at least, to visualize their larynx. So, we continue to encounter patients who surprise us, and we have to be well-prepared to deal with failed laryngoscopy.

I think we now have the tools that enable us to convert most of blind procedures to visually-controlled procedures. And although the evidence isn't yet very compelling, I think that most people believe that visually-controlled intubation is likely to be less injurious to the patient than an intubation that's performed blindly.

But in order to use these skills properly, they have to be practiced on a regular basis, and not reserved for rescue situations, where time is critical and pressure is on us to perform. There is evidence that the more practice one has with these alternative techniques and devices, the more comfortable you are with them under routine circumstances, and almost certainly the more comfortable you'll be when encountering a patient with deteriorating oxygenation.

I think it's also important to maintain our airway skills with other techniques such as flexible bronchoscopic intubation and the use of supraglottic airways. And if we routinely use video laryngoscopy, I think we run the risk of not having an adequate armamentarium, should any of these other devices fail us.

Dr. Laurence Torsher: Dr. Cooper, thank you very much for your insights into this topic. This really is one of the most fundamental things that we do as anesthesiologists. And now back to you, Dr. Schwartz.

Dr. Alan Jay Schwartz: Thank you for joining us today and participating in this insightful conversation with this month's featured author. Be sure to join us for next month's one-on-one author interview, presented in this new, exciting format.

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