

Do we need to have the national airway management guidelines ?

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Difficult airway happens in clinical practice and may lead to catastrophic outcome. The guidelines are promulgated to provide safe, evidence base practice for well-being of patients, physicians and health care system. This is in line with a paradigm shift towards evidence based medicine approach in clinical practice. Such document also helps in judging the standard of care at all levels, raise quality of care and maintain cost benefit. The guidelines and algorithms exists for various nations around the world¹⁻⁵. They have drafted the document based on the local need taking into considerations logistics, infrastructure and the cost, based on evidence.

In clinical practice, a guideline is conventionally referred as a document that aims to streamline the clinical decision with regards to different aspect of management primarily based on evidence. Guidelines documents are different from standards as they remain flexible, systemically developed evidence based statements and thus suits to majority of physicians for their clinical practice. The guidelines are guides to manage and not the dictate for clinical practice. However, a single guideline e.g. an algorithm for airway management may not be suitable universally. This becomes more evident in region like India where wide spectrum of variations is seen in clinical practice. The centers range from well-equipped latest gadgets to meagre presence of very basic airway management tools. Guidelines need to be made which is flexible so that airway managers may tailor it to suit to their clinical practice based on patient requirement. But on the other hand, flexibility should not hamper the basic ethos of the guideline and still should remain evidence based. In spite of these flexibilities or alternate options, the algorithms should be easy to understand and practice, especially when stuck in an emergent situation.

The presence of well-structured guideline and algorithm for airway management would in fact help the clinicians to make the administrators the utility for procuring certain equipments for management of airway in their clinical practice. The various guidelines mention use of 2nd generation supraglottic airway devices, fiberoptic intubation scopes for the management of difficult airway. This is well based on existing evidence. However, it is also known that all these equipment needs to be practiced in normal scenarios so as to get an expertise for their use in difficult cases. In the absence of infrastructure and cost constraint, these tools may not be feasible for regular use and thus limits their use in emergent situations.

When we consider the development of national guidelines, we need data from our own population. The best source of such data would be to have a registry, wherein the airway related data is collected and may be used for guideline development. The registry or a central recording mechanism should store information related to cases of difficult airway, sharing information of airway management on new equipment or a new strategy / technique. Absence of such registry in India remains a major lacuna hampering the local need to be incorporated in guideline. The guidelines also promote use of similar terminology and language when discussing the outcome

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in bigger platform and for formulating a registry. This aids in data collection in a standardized manner and further improving in the revision of the guidelines with more acquisition of the data.

The variation in teaching and training of the airway management is a critical issue. In the absence of structured program, the variation exists at execution of skill during airway planning and management. With the addition of new information, the management plan may also change and thus need of regular training and upgradation of the existing knowledge. The 4th National Audit Project of the Royal College of Anaesthetists and Difficult Airway Society (NAP4) have reported various factors related to the outcome of airway management^{6,7}. The report highlighted issues pertaining to judgement, communication, planning, equipment, and training in spite of availability of airway management algorithm. Hence we need to have a structured teaching and training airway programme.

In addition the acceptability of the guidelines in clinical practice remains a major concern. The critical appraisal of the existing literature is necessary to prevent any conflict of interest or variations in the target population for which guidelines are prepared. Though no data is available from India, but an audit in Sweden revealed that in spite of presence of national airway guidelines, its acceptance was poor⁸. The human factors do play an important role for uneventful airway management. These factors needs to be incorporated suitably in the algorithm related to airway management. This is more of the concern in emergent situation which remains time-critical crisis mandating timely appropriate decision and action. It is normally easy to understand the complexity of the failed difficult airway after the event, but decision taking at the time of management requires better understanding and a structured approach. At times, absence of robust evidence, algorithm uses expert opinion and may differ from opinion of the clinician with regards to clinical practice^{9,10}. The algorithm approach for an airway management is impacted by the cognitive domain and attitude of the airway manager as well¹¹. Delayed call for help may lead to possibility of

airway morbidity. So, we need an attitudinal change for guideline acceptance as well.

To conclude, we do definitely need our national airway guidelines which should be simple, easy to remember but robust so that it is feasible in all level of anaesthesia practice. There is dire need of airway registry to understand our requirements so as to revise the guidelines subsequently based on the collected information.

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