

Use of Video Laryngoscopy for Rapid Sequence Induction

Sir,

Video laryngoscopy (VL) is a novel method of achieving endotracheal intubation and there is evidence to show that visualisation of larynx can be improved using VL for rapid sequence induction (RSI).¹ VL has been shown to improve first attempt success compared to direct laryngoscopy in many clinical settings including intensive care unit (ICU) and emergency department (ED). Also, the application of cricoid pressure can distort the glottic view obtained by direct laryngoscopy and consequently impair or delay endotracheal intubation.¹

We conducted an online survey involving all Difficult Airway Society (DAS) members to evaluate their opinion about the use of VL for RSI and inclusion of VL on difficult airway trolley in the theatres. The survey was sent electronically via survey monkey after approval by DAS and was open for one month in May 2014. After 15 days of initial request, a reminder was sent electronically to all the members to improve the survey response rate.

Most of the respondents were experienced anaesthetists; consultants, 70% (n=225), and ST3-7 anaesthetists 23% (n=75). Majority (89%, n=285) supported the view to consider VL for RSI for elective and emergency cases in future. Half of the respondents (51%, n=164) had already used VL for RSI. About 83% (n=265) of the participants agreed to consider using VL for RSI in a patient with anticipated difficult airway. About 84% (n=270) agreed that VL should be the mandatory equipment on difficult airway trolley. Three quarters (73%, n=234) would like to see VL incorporated into the upcoming DAS guidelines for RSI. Of these, 89% (n=208) would like it to be the part of plan A, while the rest 11% (n=26) opted for it as a part of plan C. However, almost all of them (94%, n=220) thought that VL could

form the non-existing plan B of the DAS guidelines for RSI.

Time to intubation with VL can be one of the limitations. Some studies report increased duration of intubation in comparison with conventional laryngoscopy,² whereas other studies have found shorter intubation time with VL.³ The DAS guidelines for RSI published in 2005 do not specifically include the use of VL, as VL was not widely available for use when these guidelines were published.

Our results show that majority of the respondents believe that VL should be used for RSI, especially in patients with anticipated difficult airway. It should be a mandatory part of the difficult airway trolley and it should form the part of upcoming DAS guidelines for RSI.

REFERENCES

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