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LETTER TO THE EDITOR

Airway management in critically ill patients. The need to adapt guidelines to our reality and adhere to them

El manejo de la vía aérea en el paciente crítico. Necesidad de adaptar las guías a nuestra realidad y nosotros adherirnos a ellas

Dear Editor:

Albillos-Almaraz et al. addressed relevant aspects of airway (AW) management in critically ill patients and proposed a highly appropriate classification of difficult airway (DA).

They argue that the guidelines for the management of DA diverge from the daily reality of the critically ill patient.¹ However, we must acknowledge that all these clinical practice guidelines set forth a series of mandatory recommendations that we often overlook in practice—capnography in waveform format being one of them.^{2,3}

The INTUPROS study shows that in more than 80% of patients in Spanish intensive care units (ICUs), the position used during intubation is supine; preoxygenation is performed with a resuscitation bag; the first device used is the laryngoscope; neuromuscular blockers are not administered in all patients; and the use of capnography is limited.⁴ In contrast, the strong recommendations of the guidelines advocate elevating the head of the bed, preoxygenating with noninvasive ventilation (NIV), using a videolaryngoscope as the first device, administering appropriate neuromuscular blockade, and routine waveform capnography.^{2,3}

Preoxygenation for 3 min with a ventilator in noninvasive mode (FiO₂ 100%, PEEP 5 cm H₂O, pressure support 5–15 cm H₂O to achieve a tidal volume of 6–8 mL/kg)³ delivered via a conventional face mask should be the method of choice for all patients categorized by Albillos-Almaraz et al. as elective or emergencyt DA.¹ Manual ventilation with a resuscitation bag and face mask should be applied only as bailout therapy in the event of failure of the first AW isolation plan,³ in those patients fitting the description of emergent DA,¹

or cautiously during the apneic phase of rapid sequence intubation.²

To achieve an appropriate success rate with videolaryngoscope intubation, it is essential to complete the recommended learning curve for each device and avoid their use in unfavorable circumstances (e.g., presence of secretions or blood obscuring the lens). Regarding supraglottic devices, we consider that the FastrachTM laryngeal mask should always be available as a bailout option in the event of failure of initial AW isolation plans, as it permits ventilation and blind intubation with a high success rate and minimal prior training.

The rate of severe adverse events during intubation of critically ill patients ranges between 40% and 45% according to studies,^{2,4} and failure to use waveform capnography has been identified as one of the causes.⁵ Therefore, routine use of capnography should be a key area for improvement, especially since INTUPROS data show utilization in our ICUs < 12%.⁴

We believe that the first step to improving one of the procedures associated with such a high rate of severe complications should be adherence to the recommendations of the major management guidelines.

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