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LETTER TO THE EDITOR

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

Respuesta a: ''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:

We are writing in response to the letter submitted by our colleagues Pampín-Huerta et al.[1] expressing their interest in our recent publication Äirway Management in the Critically Ill Patient. Need for a New Approach''[2]. We are pleased that our colleagues share our concern about improving airway management in critically ill patients and agree with their self-critical perspective on the data of the INTUPROS[3] study.

Capnography is widely used in ICUs throughout Spain, and is essential for verifying correct placement of the tube within the airway. Therefore, we strongly recommend using this tool to intubate all critically ill patients.

However, the evidence found in the literature does not allow us to be so definitive with other assertions, and further research is needed. Recent studies suggest that pre-oxygenation with noninvasive ventilation (NIV) reduces hypoxemia in critically ill patients requiring endotracheal intubation[4] and that the combination of NIV and apneic oxygenation in patients with prior severe hypoxemia is superior to NIV alone in preventing hypoxemia.[5] Conversely, it is unclear whether ventilation before laryngoscopy increases the risk of bronchoaspiration. However, it does reduce the incidence of hypoxemia,[6] leaving the door open to a paradigm shift.

The INTUPROS study reports a notoriously low percentage of supraglottic device use.[3] The Fastrach® laryngeal mask is a perfectly feasible option; however, the current market offers a broad range of equally valid alternatives, such as the i-gel® mask and the AuraGain®, which are second-generation devices equipped with a gastric aspiration channel. Moreover, they allow intubation to be performed through them with the help of a fibroscope.

Other key aspects that are often overlooked include the use of bougies, patient positioning, hemodynamic optimization, medication choice, teamwork, and anticipating possible failures of the original approach used.

In sum, and continuing with the comments in the original article,[2] we consider it necessary to modify the approach to airway management in the critically ill patient. In this regard, it is essential to strike a balance between guidelines that adequately adapt to daily practice and available evidence specifically related to critical patients. Additionally, the obvious need for the recommendations to be applied by all of us once they are adequately defined must be acknowledged. To do so, we must continue to pursue a generalized safe airway culture. Our colleagues expressed this intention in their letter, and we thank them for it.[1] It is essential to acquire adequate training, and it is crucial to continue investigating and maintaining a self-critical perspective.

Declaration of competing interest

The authors declare that they have no conflicts of interest.

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