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EDITORIAL

National survey: Room for improvement☆

Encuesta nacional: espacio para mejorar

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Management of the airway remains a challenge in the Intensive Care Unit (ICU). The limited functional reserves of patients admitted to intensive care, and their precarious hemodynamic and respiratory conditions, cause orotracheal intubation (OTI) in the ICU to be more difficult than when performed on an elective basis in the operating room. The technique can result in serious complications (hypoxemia, arterial hypotension, esophageal intubation, selective bronchial intubation, etc.) in up to 30–40% of all cases,[1] and this poses an added risk for the already weakened individual. From the study published by Taboada et al. it can be inferred that such complications are not dependent upon the environment, the professional performing the technique or the time of day when OTI is carried out, but on the critical patient. This recent article reported similar complication rates among patients admitted to an ICU staffed by specialists in anesthesia and resuscitation, as well as the same number of complications during both the day and night shifts, and on holidays.[2]

In parallel to publication of the British guidelines on the management of OTI in adult patients,[3] Gómez-Prieto et al.[4] presented a national survey on management of the airway in Spanish ICUs, with the purpose of describing their organization, available resources and teaching programs, as well as to determine whether these aspects differ according to the characteristics of the Units (e.g., size, the presence of experts in management of the airway) or whether they are accredited or not for the training of intensivists. Fifty-six percent of the invited ICUs answered the survey. A number of aspects deserve mention from the data obtained. Firstly, only 44.5% of the Units had an expert or leader in difficult airway management; 54.5% did not record airway evaluation in the clinical history; and little patient bedside use was made of combined simple predictors (e.g., thyromental distance, oral aperture, etc.). Secondly, 77.2% of the ICUs lacked an OTI protocol; and 75.2% lacked protocolization of difficult airway management – though 82% were equipped with a difficult airway cart. Lastly, 51.5% of the Units reported ongoing training in intubation (53.5% with ongoing training in difficult airway management).

On analyzing the data, the authors found that those Units with experts in difficult airway management more often had OTI protocols, videolaryngoscopy/fibrobronchoscopy, and training in difficult airway management. In other words, the presence of well trained staff improved the resources available for management of the airway.

Although the data come from a survey (with the possible limitations and potential sources of bias this implies – particularly a risk of not correctly reflecting the reality of each Unit), a series of questions arise: What is the reason for the disparity of data? Why are there so many differences among Spanish ICUs when training in our country is more standardized than elsewhere in Europe due to the historical inclusion of Intensive Care Medicine as a specialty contemplated by the state resident in training program (MIR)?

The article of Gómez-Prieto et al. invites to reflection upon possible room for improvement. One aspect is the need to ameliorate and expand the existing training systems with a view to optimizing management of the

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airway. Another issue is the need to develop specific clinical guides on difficult airway management, embodying the experience of all Spanish ICUs, and defining the bases or minimum requirements for offering patients the best care possible. The abovementioned British guidelines[3] may constitute a starting point for developing and completing our perspective for the adequate management of these patients.

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