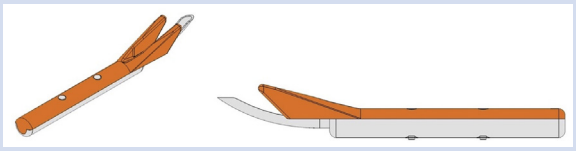

Fig 7 Cric-Guide™.

Thiel cadavers. The first attempt success rate was 12/12 with the median (IQR [range]) procedure time of 41.4 (28.8–47.6 [20.9–82.9]) s. Videoscope images of the tracheal mucosa were assessed by eyes, ears, nose throat (ENT) surgeon. There was no evidence of false passage and one incidence of posterior mucosal damage. Responses to a post-procedure questionnaire were favourable with 75% of participants stating Cric-Guide™ as their device of choice in the future; commenting on its stability in the neck and definite 'give' on entering the airway.

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Tracheostomy performance in critical care; tracking the decline in rate

J. Waiting, C. Trainer, A. Forde and H. Drewery

Royal London Hospital, London, UK

The TracMan Trial[1] in 2013 showed no mortality benefit in performing early tracheostomy in ventilated UK intensive care patients. In 2014 National Confidential Enquiry into Patient Outcome and Death (NCEPOD)[2] published a report reinforcing this message, and showed that only a small proportion of UK critical care patients undergo a trial of extubation before tracheostomy. It advised that all patients have a trial of extubation, or have contraindications clearly documented. These publications may have led to attitude change and a reduction in the number of tracheostomies performed.

The Royal London Hospital has >2000 admissions to critical care each year, including >800 ventilated patients. The tracheostomy rate was reviewed in the years before and after the publication of the NCEPOD report. Numbers of patients with tracheostomy insertion during their critical care stay and total numbers of ventilated patients were ascertained from Intensive Care National Audit and Research Centre data for the Royal London Hospital from 2010 to present. Fisher's exact test was used to compare tracheostomies performed as a proportion of total ventilated patients in 2010–2013 compared with 2015-2018. Relative risk confidence intervals were determined using Koopman's asymptotic score.

The proportion of tracheostomies performed in ventilated patients fell from 19.8% (697/2686) in the 4 yr preceding to 13.1% (473/2756) in the same period after the report ($P<0.0001$). This is a relative reduction of 34% in the periods compared. The rate of tracheostomy in our ventilated critical care patients has fallen after the publication of NCEPOD, the most recent UK publication to offer an accurate annual tracheostomy figure.

Tracheostomy is not without complications; equally there are risks with both prolonged intubation and trial of extubation, which may necessitate expedited/emergent re-intubation. Dysphonia, pain, dysphagia, laryngeal dyspnoea and stridor are all common after extubation[3], with greatest risk after repeated trials of extubation. Anecdotally, we have observed an increase in complications in patients who had one or more trials of extubation before tracheostomy, including a patient who had unexplained bilateral vocal cord palsies after two trials of extubation. This likely represented an injury sustained at repeated intubation and resulted in a prolonged and complex tracheostomy wean requiring glottic surgery and intense speech and language therapy input (patient consent provided).

Further data are needed to ascertain whether our declining rates are observed elsewhere and whether the recommendation to trial extubation is leading to the unintended consequence of glottic and subglottic trauma.

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Emergency front-of-neck airway: an update from the Airway App

L.V. Duggan, T.M. Cook, S.L. Lockhart, E.P. O'Sullivan and P.A. Baker

[1]Department of Anesthesiology, University of British Columbia, Vancouver, BC, Canada, [2]Department of Anaesthesia, Royal United Hospitals Bath, UK, [3]Department of Anaesthetics, St. James Hospital, Dublin, Ireland and [4]Department of Paediatric Anaesthesia, Starship Children's Health, Auckland, New Zealand

Emergency front-of-neck airway (eFONA) is an essential component of advanced airway management, yet for many clinicians performing an eFONA procedure is exceedingly rare.