

Centre, London, UK) for their help in critically revising the manuscript for language.

Declarations of interest

The authors declare that they have no conflicts of interest.

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doi: 10.1016/j.bja.2020.06.011

Advance Access Publication Date: 13 June 2020

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Tracheal introducers and airway trauma COVID-19. Comment on *Br J Anaesth* 2020; 125: e168–e170

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Keywords: airway management; bougie; COVID-19; introducer; laryngoscopy; pneumothorax; tracheal intubation; tracheal trauma

Editor—We read with interest the paper by Abou-Arab and colleagues,¹ and we would like to make a number of comments related to airway management in coronavirus disease 2019 (COVID-19) patients. Our experience suggests that any COVID-19 patient should be considered *a priori* as having a difficult airway given the severity of hypoxaemia, difficulties arising from wearing personal protective equipment, and the challenging work environment. Obese patients might be at higher risk of difficult airway management,² and obesity seems to be both a risk factor for developing COVID-19³ and for poorer outcome.⁴ In most COVID-19 patients, tracheal intubation can be performed semi-electively, allowing time for patient assessment, team preparation, and discussion of airway management strategy.³ This includes patient positioning² and primary use of videolaryngoscopy given its efficacy and lower risk of contamination.³ We believe that maximising first-pass success is of paramount importance in COVID-19 patients to reduce the risk of respiratory and haemodynamic complications and airway team contamination. It is unclear from their description to what extent Abou-Arab and colleagues¹ were anticipating difficulty in managing the airway and what preparatory steps were taken.

It appears that noninvasive ventilation was not attempted before tracheal intubation. In addition to aiding the decision about the timing of intubation,³ this mode of respiratory support could have been used for preoxygenation, which is especially effective in hypoxaemic obese patients.^{2,3} Of the two patients presented, one received high-flow nasal oxygen, the role of which is debated in COVID-19 patients,³ and the other was on 9 L min⁻¹ face-mask oxygen. Optimising oxygen delivery before intubation is likely to allow more controlled airway management and minimise the likelihood of an adverse airway event.

The authors¹ reported use of an intubating bougie in conjunction with direct laryngoscopy on both patients with Grade IV Cormack–Lehane laryngeal views. The likelihood of successful tracheal bougie placement with a Grade IV laryngeal view is quite low, whereas the risk of airway trauma as a result of blind bougie insertion is significant, so that use of a bougie in such a scenario is considered contraindicated.⁵ The two reported cases substantiate this concept. Other factors could have contributed to the reported airway trauma. Manikin studies suggest that single-use bougies, depending on construction material, are variably more rigid and likely to cause airway trauma when compared with the Eschmann multiple-use introducer (Smiths Medical, Minneapolis, MS, USA).⁶ This may be exacerbated by the inflamed airway mucosa in COVID-19 patients, which is likely to be frail and more prone to injury. The Chinese experience quotes a 5.9% incidence of pneumothorax during intubation in COVID-19 patients, but no association with bougie use is reported.⁷ The authors did not state if signs for confirming tracheal bougie placement, such as hold-up or tracheal clicks, were used. It was not clear from the report if only the bougie was inserted and withdrawn in the absence of position confirmation, or if the tracheal tube was removed after being railroaded over the bougie in the absence

of tracheal placement confirmation. Such a clarification would facilitate understanding of the airway trauma mechanisms in the two reported cases, which could be associated with the tube as well rather than with the bougie alone.

Should such airway trauma occur, multidisciplinary evaluation is recommended. A conservative approach would be preferable especially in critical COVID-19 patients when indicated (minor tracheal tears above the level of the tracheal tube cuff).⁸ A bougie-induced lesion of the cricothyroid membrane and how that resulted in pneumothorax and pneumomediastinum in the second patient are also difficult to understand. Blind bougie advance against a resistance could explain it. We would advise even more caution than usual when using bougies in COVID-19 patients. It is critically important not to force the bougie advance, either when facing limited laryngeal views or when the bougie has passed the vocal cords. Any bougie advance past the carina carries a high risk of airway trauma⁵; hence, it should not be inserted more than 8 cm past the vocal cords.^{5,9} These precautions might be even more relevant in COVID-19 patients, whose inflamed airways may be more prone to trauma.

The Eschmann angled-tip bougie is exclusively produced by Smiths Medical (Minneapolis, MN, USA; <https://www.smiths-medical.com/products/airway-management/intubation-accessories/intubation-guides-and-stylets/tracheal-tube-introducers-and-guides>), and it is a reusable device, whereas Vygon (Écouen, France) produces a single-use stiffer 70 cm (15 Fr)⁻¹, angled-tip, Pebax[®] hollow introducer (<https://www.vygon.it/catalogo/prodotto/guida-per-sonde-endotracheali-bougie-di-boussignac-1/>) (Fig. 1). The statement that, ‘the use of a bougie probably induced tracheal trauma

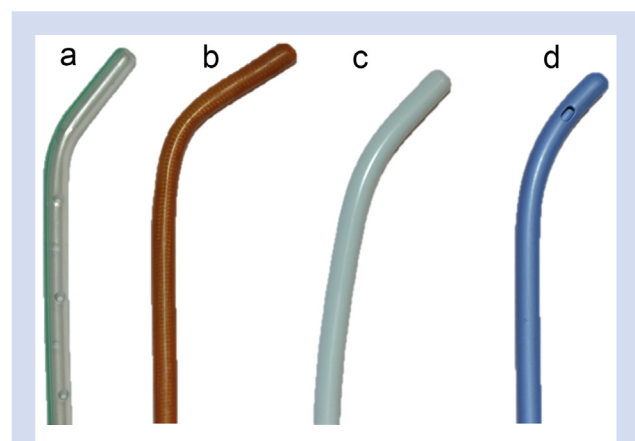


Fig 1. Tracheal introducers available on the market for adult patients. Note different tip curvatures/angles and construction materials: (a) Boussignac (Pebax; Vygon), (b) Venn multi-use introducer or reusable bougie (polyester tissue/resin; Eschmann; Smiths Medical), (c) single-use bougie/introducer (polyvinyl chloride; Smiths Medical), and (d) Frova intubation introducer (polyethylene intermediate density; Cook Medical, Bloomington, IN, USA).

worsening respiratory conditions and leading to urgent ECMO' does not sound correct. Lack of preparation, use of a direct laryngoscope as a primary intubation device, and inappropriate bougie use likely all contributed to such an outcome. This simple device remains a precious adjunct for airway management when carefully used in conjunction with direct or videolaryngoscopy.¹⁰

Declarations of interest

MS has received paid consultancy from Teleflex Medical, Verathon Medical, and DEAS Italia; is a patent co-owner (no royalties) of DEAS Italia; and has received lecture grants and travel reimbursements from MSD Italia and MSD USA. GF has received royalties from Cook Medical (Frova Introducer; Bloomington, IN, USA) and Teleflex Medical (PercuTwist and EasyCric) for his airway device inventions. IH and GC declare no competing interests.

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doi: 10.1016/j.bja.2020.05.013

Advance Access Publication Date: 19 May 2020

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Airway management lessons from case reports of negative outcomes. Comment on *Br J Anaesth*; 125: e168–70

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Keywords: airway management; case report; COVID-19; fiberoptic intubation; obesity; tracheal intubation

Always note and record the unusual ... Publish it. Place it on permanent record as a short, concise note. Such communications are always of value (Sir William Osler).¹

Editor—A forthcoming issue of the *British Journal of Anaesthesia* (BJA) contains a report of two cases of tracheal trauma after difficult airway management in morbidly obese patients with coronavirus disease 2019 (COVID-19).² The authors should be commended for submitting these negative outcomes to the BJA, and the BJA must be congratulated for publishing them. High-ranking journals rarely accept such

reports nowadays, and even though these reports often have major limitations, such as possible over-interpretation, lack of generalisability, or retrospective design,³ we can still learn a lot from them.⁴

Here are six lessons from that report:

- (i) *Airway management is (still) not as safe as we might believe.* It is rare that medical professionals report their own adverse events for at least two reasons: fear of reputational consequences and fear of legal consequences. Thus, there is likely a strong publication bias favouring case reports with positive results. Regarding safety of airway management,