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In Reply:

I thank Professor Grocott for his comments on my editorial¹ on emergency cricothyrotomy. I fully agree with his statement that the major reason for failure in emergency cricothyrotomy is difficulty in identifying the cricothyroid ligament (as I wrote in my editorials^{1,2}).^{1–4} I also agree with his statement that we all should be trained to be competent in identifying the cricothyroid ligament, and I pointed out that training using ultrasonography is effective.^{3,5}

I further agree with Professor Grocott’s comments that there is an ongoing evolution in understanding of how to best manage the “cannot intubate, cannot oxygenate” situation, and that there is a swing in opinion away from needle cricothyrotomy to an open scalpel-driven technique. Having said that, I did not intend to advocate abandoning percutaneous route. I stated in my editorial¹ that a clear answer cannot be obtained as to whether or not percutaneous cricothyrotomy is truly less effective than surgical cricothyrotomy because randomized controlled studies are lacking. My point was that, in the era of evidence-based medicine, we should make recommendations based on the current state of knowledge and that studies have indicated that percutaneous cricothyrotomy is less effective than surgical cricothyrotomy. In particular, there is growing evidence that the use of jet ventilation through a small-bore needle is frequently ineffective and is associated with a higher incidence of life-threatening complications.^{6,7} What I pointed out was that “the main

reason for choosing surgical cricothyrotomy in an emergency situation is to identify the cricothyroid ligament correctly and quickly,” and I recommended a “hybrid” method: when identification of the cricothyroid ligaments is difficult due to a thick tissue over the larynx, we should incise the skin (and subcutaneous tissues) until we can identify the cricothyroid ligament and then puncture the ligament, using a Trocar-type “percutaneous” cricothyrotomy kit.¹

Lastly, I am sure that Professor Grocott would agree with my conclusion remarks made in my editorial¹ that “[e]vidence is still insufficient to conclude which method of cricothyrotomy is more reliable than another” (and thus it is too early to dismiss percutaneous method yet), but “[n]evertheless, the current state of knowledge indicates that surgical cricothyrotomy is more reliable than percutaneous cricothyrotomy as a rescue method in ‘cannot intubate, cannot oxygenate’ situation.”

Competing Interests

The author declares no competing interests.

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