

representative of patients. Similar results were obtained by a recent study,⁸ in which more experienced medical staff (senior anesthesiologists) performed the task in a less suitable model of porcine laryngopharynx. Together with these studies, studies in general have indicated that surgical cricothyrotomy is more reliable than cannula cricothyrotomy. I believe that this is why Professor Cook stated in a previous article that “[t]he Difficult Airway Society 2015 guidelines⁹ make a case for a standardized approach to front of neck airway with scalpel cricothyroidotomy because it is judged most likely to be the fastest and most reliable method of securing the airway,” and that “scalpel cricothyroidotomy should be learned and regularly rehearsed by all anaesthetists.”⁵ Therefore, I believe that the view of Dr. Kelly and Professor Cook is the same as mine.

As Dr. Kelly and Professor Cook point out, we need to establish an appropriate simulation training program using a suitable model and setting to reduce the incidence of necessitating emergency cricothyrotomy and to increase confidence in performing this task in a rare occurrence of the “cannot intubate, cannot oxygenate” situation.

Competing Interests

The author declares no competing interests.

Takashi Asai, M.D., Ph.D., Dokkyo Medical University Koshigaya Hospital, Saitama, Japan. asaita@dokkyomed.ac.jp

References

1. Asai T: Surgical cricothyrotomy, rather than percutaneous cricothyrotomy, in “cannot intubate, cannot oxygenate” situation. *ANESTHESIOLOGY* 2016; 125:269–71
2. Heymans F, Feigl G, Graber S, Courvoisier DS, Weber KM, Dulguerov P: Emergency cricothyrotomy performed by surgical airway-naïve medical personnel: a randomized cross-over study in cadavers comparing three commonly used techniques. *ANESTHESIOLOGY* 2016; 125:295–303
3. Duggan LV, Scott BB, Law JA, Morris IR, Murphy MF, Griesdale DE: Transtracheal jet ventilation in the ‘can’t intubate can’t oxygenate’ emergency: A systematic review. *Br J Anaesth* 2016; 117(suppl 1):128–38
4. Cook TM, Woodall N, Frerk C; Fourth National Audit Project: Major complications of airway management in the UK: Results of the Fourth National Audit Project of the Royal College of Anaesthetists and the Difficult Airway Society. Part 1: Anaesthesia. *Br J Anaesth* 2011; 106:617–31
5. Pracy JP, Brennan L, Cook TM, Hartle AJ, Marks RJ, McGrath BA, Narula A, Patel A: Surgical intervention during a Can’t intubate Can’t Oxygenate (CICO) Event: Emergency Front-of-neck Airway (FONA)? *Br J Anaesth* 2016; 117:426–8
6. Szűcs Z, László CJ, Baksa G, László I, Varga M, Szuák A, Nemeskéri Á, Tassonyi E: Suitability of a preserved human cadaver model for the simulation of facemask ventilation, direct laryngoscopy and tracheal intubation: A laboratory investigation. *Br J Anaesth* 2016; 116:417–22
7. Howes TE, Lobo CA, Kelly FE, Cook TM: Rescuing the obese or burned airway: Are conventional training manikins adequate? A simulation study. *Br J Anaesth* 2015; 114:136–42
8. Chrisman L, King W, Wimble K, Cartwright S, Mohammed KB, Patel B: Surgicric 2: A comparative bench study with two established emergency cricothyroidotomy techniques in a porcine model. *Br J Anaesth* 2016; 117:236–42
9. Frerk C, Mitchell VS, McNarry AF, Mendonca C, Bhagrath R, Patel A, O’Sullivan EP, Woodall NM, Ahmad I; Difficult

Airway Society Intubation Guidelines Working Group: Difficult Airway Society 2015 guidelines for management of unanticipated difficult intubation in adults. *Br J Anaesth* 2015; 115:827–48

(Accepted for publication January 26, 2017.)

You Have a Plan B. Should You Have a Plan C?

To the Editor:

I read with interest the article by Ozawa¹ regarding his sailing adventure. Ozawa compares the unexpected event during a sail to what can occur while administering anesthesia. This sailing metaphor is a perfect opportunity to put in a plug for the value of using cognitive aids in unexpected critical events. Cog aids won’t teach what you don’t already know, but may remind you to apply it.

Run Aground

When you’re sailing along, and the wind goes away,
And your motor won’t start when you crank ‘er
And the current is pushing you right for the rocks
THAT’s when to lower your anchor!

Competing Interests

The author declares no competing interests.

Fred G. Davis, M.D., Tufts University School of Medicine, Lahey Hospital and Medical Center, Center for Medical Simulation, Boston, Massachusetts. fredgdavis@comcast.net

Reference

1. Ozawa ET: Run aground. *ANESTHESIOLOGY* 2016; 125:414–6

(Accepted for publication January 27, 2017.)

In Reply:

The esteemed Professor Davis has illuminated one of my key messages embedded into my short story. It goes without saying that having a cognitive aid is half the battle. Practice and proficiency in using the aid is also entirely necessary.

I have not heard the rhyme before that Professor Davis mentions in his letter, but as a cognitive aid it would certainly have been useful during my misadventure!

Competing Interests

The author declares no competing interests.

Edwin T. Ozawa, M.D., Ph.D., Tufts University School of Medicine, Lahey Hospital & Medical Center, Burlington, Massachusetts. edwinozawa@gmail.com

(Accepted for publication January 27, 2017.)