

References

1. Sessler DI, Riedel B: Anesthesia and cancer recurrence: Context for divergent study outcomes. *ANESTHESIOLOGY* 2019; 130:3–5
2. Yoo S, Lee HB, Han W, Noh DY, Park SK, Kim WH, Kim JT: Total intravenous anesthesia *versus* inhalation anesthesia for breast cancer surgery: A retrospective cohort study. *ANESTHESIOLOGY* 2019; 130:31–40

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Current Difficult Airway Management: Not Good Enough!: Comment

To the Editor:

The Editorial authored by Asai and Hillman¹ contains the statement “If difficult airway management is predicted, general anesthesia should not be induced before securing the airway.” We believe their statement may be inconsistent with the American Society of Anesthesiologists (Schaumburg, Illinois; ASA) Practice Guidelines for Management of the Difficult Airway.² The ASA Practice Guidelines defines a difficult airway as “the clinical situation in which a conventionally trained anesthesiologist experiences difficulty with facemask ventilation of the upper airway, difficulty with tracheal intubation, or both.” In addition, Asai and Hillman do not define their use of the word “predicted.”

Contained within the ASA Practice Guidelines is a difficult airway algorithm, which recommends that the anesthesiologist consider the relative merits and feasibility of basic management choices:

- Awake intubation *versus* intubation after induction of general anesthesia
- Noninvasive technique *versus* invasive techniques for the initial approach to intubation
- Video-assisted laryngoscopy as an initial approach to intubation
- Preservation *versus* ablation of spontaneous ventilation

The ASA Practice Guidelines provide multiple options to deal with a difficult airway and outline a strategy for intubation of the difficult airway that does not mandate intubation before general anesthesia is induced.

We believe that with the availability and appropriate use of supraglottic airways, video-assisted laryngoscopes, and

flexible fiberoptic scopes, there is a reduced need to secure the airway before inducing general anesthesia. If a previous anesthesia record reveals that mask ventilation is not difficult and conventional rigid laryngoscopy is difficult, then after general anesthesia induction, a video-assisted laryngoscope intubation attempt or an asleep flexible fiberoptic intubation attempt are acceptable options. We believe our opinion is consistent with the ASA Practice Guidelines. The fact that certain practitioners may not follow the ASA Practice Guidelines is not a problem with the guidelines themselves.

Competing Interests

Dr. Marymont has stock options in ImaCor (Jericho, New York). Dr. Vender reports no competing interests.

Jesse H. Marymont, M.D., M.B.A., Jeffery Vender, M.D., M.B.A.
NorthShore University HealthSystem, Evanston, Illinois
(J.H.M.). JMarymont@northshore.org

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References

1. Asai T, Hillman D: Current difficult airway management: Not good enough! *ANESTHESIOLOGY* 2019; 131:774–6
2. Apfelbaum JL, Hagberg CA, Caplan RA, Blitt CD, Connis RT, Nickinovich DG, Hagberg CA, Caplan RA, Benumof JL, Berry FA, Blitt CD, Bode RH, Cheney FW, Connis RT, Guidry OF, Nickinovich DG, Ovassapian A; American Society of Anesthesiologists Task Force on Management of the Difficult Airway: Practice guidelines for management of the difficult airway: An updated report by the American Society of Anesthesiologists Task Force on Management of the Difficult Airway. *ANESTHESIOLOGY* 2013; 118:251–70

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Current Difficult Airway Management: Not Good Enough!: Reply

In Reply:

We appreciate the comments of Drs. Marymont and Vender¹ on our recent Editorial² addressing the

article on a closed claims analysis of difficult tracheal intubation.³ Drs. Marymont and Vender are concerned because our statement in the Editorial² that “[i]f difficult airway management is predicted, general anesthesia should not be induced before securing the airway” may be inconsistent with the American Society of Anesthesiologists Practice Guidelines for Management of the Difficult Airway.⁴

Although our remarks were orientated to an article³ centered on difficult tracheal intubation, our statement regarding securing the airway before induction of anesthesia does not necessarily mean awake tracheal intubation. We prefaced the statement as follows: “It is apparent from these cases that inadequate planning is a core issue. The airway must be assessed preoperatively, not only to predict difficult intubation, but also the risk of difficulty in ventilation through a facemask or supraglottic airway, difficulty in securing a surgical airway and risk of aspiration.”² Clearly, there must be a degree of certainty regarding capacity to “secure the airway” in the unconscious patient (be it by use of a facemask, supraglottic airway, invasive airway, or tracheal intubation) before deciding to induce general anesthesia first. Hence, our statement, which does not mandate intubation before general anesthesia, is not inconsistent with the practice guidelines formulated by the American Society of Anesthesiologists.⁴

Our Editorial² accompanied a compelling article³ that points out that outcomes regarding management of difficult tracheal intubation remain poor despite the considerable ongoing efforts by professional bodies and others to improve them. The main message of our editorial is that we should work together “to lift standards in crisis management for airway difficulties . . . much as has been done for cardiopulmonary resuscitation in recent years.”² To achieve this, “we need to regularly review the guidelines and encourage further research in relationship to these problems.”² In addition, we pointed out that “knowledge of guidelines alone is insufficient to address these problems: skill and judgment are essential ingredients.” Therefore, we also need to establish a system, “with crews [*i.e.*, we clinicians] undergoing regular, systematic simulation training and emergency equipment constantly to hand and regularly checked.”² Only through these steps can we progress toward risk-free airway management.

Competing Interests

Dr. Hillman has received institutional grants from ResMed Inc. (San Diego, California), Nyxoah (Mont-Saint-Guibert, Belgium), Oventus (Indooroopilly, Australia), and Zelda Therapeutics (Perth, Australia). Dr. Asai reports no competing interests.

Takashi Asai, M.D., Ph. D., David Hillman, M.D.
Dokkyo Medical University Saitama Medical Center, Koshigaya
City, Saitama, Japan (T.A.). asaिता@dokkyomed.ac.jp

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References

1. Marymont JH, Vender J: Current difficult airway management: Not good enough!: Comment. *ANESTHESIOLOGY* 2020; 132:1280
2. Asai T, Hillman D: Current difficult airway management: Not good enough! *ANESTHESIOLOGY* 2019; 131:774–6
3. Joffe AM, Aziz MF, Posner KL, Duggan LV, Mincer SL, Domino KB: Management of difficult tracheal intubation: A closed claims analysis. *ANESTHESIOLOGY* 2019; 131:818–29
4. Apfelbaum JL, Hagberg CA, Caplan RA, Blitt CD, Connis RT, Nickinovich DG, Hagberg CA, Caplan RA, Benumof JL, Berry FA, Blitt CD, Bode RH, Cheney FW, Connis RT, Guidry OF, Nickinovich DG, Ovassapian A; American Society of Anesthesiologists Task Force on Management of the Difficult Airway: Practice guidelines for management of the difficult airway: An updated report by the American Society of Anesthesiologists Task Force on Management of the Difficult Airway. *ANESTHESIOLOGY* 2013; 118:251–70

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Measuring Childbirth Outcomes: Comment

To the Editor:

We read with interest “Measuring Childbirth Outcomes Using Administrative and Birth Certificate Data” and applaud Glance *et al.*¹ for creating a composite quality metric that uses both maternal and newborn administrative data. We are proud that Glance *et al.* have chosen to apply their expertise to current challenges in maternity care, and we thank the Editor for publishing. We agree with their recommendation that administrative data be submitted by all hospitals to a national maternal quality improvement database, but we argue that clinical data are superior and obtainable and should also be attempted.

Administrative data alone lack the granularity to provide information as to *why* a hospital is an outlier and to allow providers to determine the changes in the process of care needed to improve outcomes in their population. Clinical data from the electronic health record not only provide this critical piece of the puzzle but also the ability to discern the