The question of removing a ventilation bag before defibrillation

EDITOR,—Following an incident in January 1995 in which a patient at Northwick Park Hospital received severe burns resulting from bedding catching fire during defibrillation,1 come, for the purposes of our study, and therefore for the purposes of the study, their “widely understood” definition is irrelevant. Given this fact, all 26 patients were entered into the study appropriately according to the criteria we established.

We do, however, agree that cricoid pressure is an essential component of any emergency intubation drill and should be provided wherever possible. This can be difficult to perform in the pre-hospital situation, however, where skilled assistance may be limited.

It is interesting to see anaesthetists stating that three months’ anaesthetic training is not adequate for undertaking this type of work in critically ill patients. This is despite the fact that in may hospitals inappropriately supervised anaesthetic trainees are first on call for emergencies in A&E, the intensive therapy unit, and theatres after only three months’ training. Surely what is adequate for anaesthetists is adequate for A&E doctors.

Difficult intubation is a problem encountered frequently in A&E, certainly more frequently than the one to 2500 patients quoted. The patient who was impossible to intubate underwent cricthyrotomy appropriately, immediately after the failed intubation attempt. This was the appropriate next step in the failed intubation drill in the circumstances, and rapidly resulted in achievement of the desired goal, namely a secure definitive airway.

The authors reply

The comments made by Speirs and Webster merit further comment. We clearly stated what “rapid sequence induction” meant for the purposes of our study, and therefore for the purposes of the study, their “widely understood” definition is irrelevant. Given this fact, all 26 patients were entered into the study appropriately according to the criteria we established.

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We reiterate the fact that no patient acutely deteriorated as result of these drug assisted acute pre-hospital airway interventions. As such, we feel strongly that pre-hospital rapid sequence induction should be done safely by suitably trained A&E doctors.

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Pre-hospital emergency rapid sequence induction of anaesthesia.

M Speirs and R E Webster

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