

Airway management: the *sine qua non* of emergency medicine

Peter Rosen¹, Kevin M. Ban¹, Riccardo Pini²

¹Department of Emergency Medicine, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, Massachusetts, USA,

²Department of Critical Care Medicine and Surgery, University of Florence and Azienda Ospedaliero-Universitaria Careggi, Florence, Italy

(Intern Emerg Med 2006; 1 (2): 137-138)

It is our belief that the most important clinical responsibility of our specialty of emergency medicine is the active management of the airway. We certainly utilize all the modern technologies that have been devised for succeeding at this complex and often difficult technical task, but because of the time constraints upon this technical maneuver, and the nature of the profoundly sick patient requiring airway management, there is no way to avoid the "difficult airway". This is independent of any assessment of the patient's anatomy as potential or real airway management difficulty.

Even when the anatomy is straight forward, and easy to visualize, the absence of which is one of the underlying definitions of a difficult airway, we must often undertake active airway management even in the face of a full stomach, and particularly for the patient who cannot protect the airway because of disease, drug or alcohol. It would be nice if we could tell the patient to return after the stomach has been emptied, and the patient is more able to cooperate without struggle or combativeness, but it is especially true that the confused, struggling, combative patient is the one who most needs active airway management.

Starting with this issue of our journal, we will present clinical cases of difficult airway problems, and the best recommended clinical approaches to their management¹. We will discuss new and optimal technologies, but we must always remember that often emergency medicine

responsibilities demand that we intubate a patient away from the technical supports that make the task safer and easier, such as a video monitor and a fiber optic intubation scope. Many of the difficult airways that we must control are filled with barriers such as secretions, blood, dirt and extraneous foreign bodies that prevent effective visualization of the patient's anatomy. Suction devices, especially in the field, often cannot keep pace with the source of contamination. The anatomy is frequently distorted by extraneous masses or hemorrhage.

It is true that the need for surgical airway management is reduced with modern philosophies and technical tools, but there will still be times when there is no other option for active airway control². In this and other issues of our journal, we will offer readers the opportunity to participate in an airway forum where we will present cases of difficult airway management along with a discussion on the best ways to solve a particular problem, as well as attempting to generalize techniques that will make active airway management safer as well as easier³. Our ultimate goal is to share wisdom based on hard experience, and with the aim that ultimately the definition of a specialist in emergency medicine is a physician who is trained, and willing to act to intervene in the patient's life threat. Nowhere is this truer or more necessary than in the face of an obstructed airway.

It is surprising that even after many years of practicing, researching and teaching the responsibilities of airway management, there is still such little evidence to help us make the right decisions. For example, while we now know that it is safe to intubate a multiple trauma patient orally before the cervical spine has been cleared, we still do not know the relative risks of nasal intubation, surgical airway, nor the best rescue techniques in this subgroup of patients⁴.

We hope that our discussions, original research papers, and presentations will stimulate our readers to join us in attempting to obtain the answers to these critical questions.

Please feel free to communicate your own difficult airway experiences, queries, and suggestions for new, safer, and easier techniques of active airway management.

Address for correspondence: Prof. Peter Rosen, Department of Emergency Medicine, Harvard Medical School, Beth Israel Deaconess Medical Center, One Deaconess Road, West Campus Clinical Center, 2nd Floor, Boston, MA 02215, USA. E-mail: psoc1@msn.com

© 2006 CEPI Srl

References

1. Rosen P, Sloane C, Ban KM, Lanigra M, Wolfe R. Difficult airway management. *Intern Emerg Med* 2006; 1: 139-47.
2. Rosen P, Wolfe RE. Therapeutic legends of emergency medicine. *J Emerg Med* 1989; 7: 387-9.
3. Ban KM, Bramwell K, Sakles JC, Davis D, Wolfe R, Rosen P. Airway forum. *Intern Emerg Med* 2006; 1: 151-4.
4. Walls RM. The airway. In: Marx J, Hockberger B, Walls R, eds. *Rosen's emergency medicine: concepts and clinical practice*. 6th ed. Philadelphia, PA: Elsevier, 2006: 2-26.