The DAS 2015 Guidelines for Unanticipated Difficult Intubation in Adults

The 2015 Difficult Airway Society Guidelines represent not so much a revolution but an evolution- they reflect the changes in anaesthetic practice and equipment since the first set of DAS Guidelines were published in 2004.

They continue to be a series of sequential plans (A-D) to facilitate the management of the unanticipated difficult airway- a point which they emphasize, given how the 2004 Guidelines became the go to guide for all aspects of airway management.

Their primary aim remains patient oxygenation above all other interventions.

There are probably six features of the guidelines which are 'new'

1) A vote of confidence in videolaryngoscopy- a technique which simply was not available in 2004

2) Cricoid pressure and face mask ventilation during an RSI- although the original guidelines allowed for the removal of cricoid pressure, this is a much more explicit instruction in 2015, whilst face mask ventilation early in the algorithm should a) provide useful information to the anaesthetist- this patient is ore is not easy to face mask ventilate and b) decrease the anxiety already present during a RSI or trigger the early seeking of help.

3) Second generation airways and waking the patient up in Plan B. Second generation supraglottic airways are recognised as a) safer than their first generation predecessors and b) provide a higher oropharyngeal leak pressure, ideally facilitating the successful ventilation of larger patients who, as we know from NAP 4, are more at risk of airway misadventure.
   The presence of a supraglottic airway stops any further attempts at laryngoscopy, but also if the airway is maintained with a supraglottic device the guidelines suggest that the anaesthetist and associated anaesthetic team STOP AND THINK- intubation is no longer the principle aim, and unless there is a compelling reason not to, the guidelines encourage waking the patient up as the best option.

4) The explicit role of Human Factors in any evolving airway situation. Various incidents since 2004 have highlighted the fact that any airway crisis requires the entire theatre team to be involved, focused on the task in hand and willing to speak up to ensure the oxygenation is maintained.
   The acronym PACE is advocated for anaesthetic assistant's behaviour, but whilst this is a useful tool, it functions most effectively if the entire department (anaesthetists included) have been trained in its use

5) The choice of a didactic scalpel based technique in Plan D. The scalpel based approach to the front of neck access (FONA) was always the final rescue technique, however as NAP4 suggested performance of front of neck access was done badly, not necessarily because of the failure of any particular technique, but the failure of any technique. Therefore, the Guideline group recognised the importance of teaching not *any particular technique*, but in limiting the number of techniques an anaesthetist would be expected to know when performing front of neck access. Given that a scalpel based approach is the final attempt to save the patient and it seems to have the best success certainly in the out-of-hospital setting, it seemed logical to choose a didactic scalpel based approach that could be taught and learnt by everyone involved in airway management across the country.
   Other techniques do exist and are accommodated in the guidelines if people are skilled and trained in their use. Only a longitudinal data review of all cases of FONA will guide the next revision group towards the answer.

6) New technologies and drugs (Hiflow oxygenation and sugammadex) are mentioned in the guidelines, and although THRIVE appears very promising the author group had to recognise the absence of scientific data in this field. Similarly, sugammadex does offer the potential for immediate reversal of neuromuscular blockade, however the priority of any airway crisis is oxygenation which can be easier to achieve (certainly in plan D) with a paralysed than a non-paralysed patient.

Reading the guidelines, the overriding message of the Guidelines is the need for training in the various techniques- Videolaryngoscopy, 2nd generation supraglottic airway insertion, Aintree exchange techniques and the 19 step scalpel based approach in Plan D to allow their successful deployment in an unanticipated difficult airway scenario. That's a challenge for everyone.

References:

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