

Research data: free-text responses to online survey

Free-text responses to Q16 'Is there anything you would like to add about airway management during IHCA?'

Airway management might be dependent on diagnosis/history

In most hospitals I have worked at - most first responders at IHCA do not have sufficient intubation skills to have equipoise. I personally - as an anaesthetic Reg - still rarely intubate my arrests, the only ones I have done so being either where there is ROSC, or where there is significant airway soiling, or where there is to be a prolonged attempt eg PE or OD. I worry that focusing on intubation takes the focus of the resuscitation team away from the more important task of oxygenation, hence I don't think I have equipped for such an RCT. Also if a patient is intubated it may make appropriate ceiling of care decision making potentially more challenging eg sometimes I have bagged arrests/ROSCS to avoid intubating while more information is gathered/discussions are had as I think it commits a patient to an ICU pathway

Intubating in hospital arrests would be much higher up my agenda if the majority of patients were not those who should have had a DNAR in place, as is currently the case.

[My hospital] has an excellent set-up for airway management during IHCA with the presence of a dedicated ODP. Participation in an RCT would very much depend on what the 'control' was!

Not able to include this info for earlier question: our Trust only provides size 4 i-gel on cardiac arrest trolleys, no other supraglottic airways are available.

There's a disparity of equipment available on wards. I've answered about what is available at all cardiac arrests, but some areas outside ICU do have waveform capnography and videolaryngoscopy. Sometimes I take the VL from ICU to arrests with the transfer bag

Prognostication of patient is major driving factor in airway management decisions

I think unfortunately in the majority of IHCA that I attend, the decision regarding intubation or not is determined based upon the history of the patient, the anticipated likelihood of ROSC and admission to ICU. Often the more pressing problem is the appropriateness of the resuscitation efforts and ongoing management.

I think Airways-2 has answered this. No reason to think it would be different in hospital.

In our hospital anaesthesia/intensive care are not part of the arrest team, we are only called when required, therefore have a skewed view of IHCA within our hospital.

At [my hospital site] there are no i-gels or supraglottic devices of any kind on crash trolleys, and also frequently no EtCO₂ (waveform/colorimetry) which can be seriously problematic.

I would prefer an ODP to be available for IHCA, however it is practice for the CCOT nurse to be present.

So in our hospital a cardiac arrest goes out as a MET call and then they ask for anaesthetic support. On the ward there is: an ambu bag, masks and tubing, Guedels, LMA, MAC blade, boogie and ETT. With the MET call and Anaesthetist call an ODP will come to the ward also. With them they carry a bag which contains: Waters circuit, McCoy, Airtraq, i-gels and Co₂ - number display and waveform for transport (along with all airway equipment mentioned before). This is why I answered that IMMEDIATE equipment available is different to the equipment I use as by the time I arrive the ODP is there also and I use their equipment.

I-gel is our trust's go to and recommended first line airway for IHCA. Intubation is rarely used first line

I think ODP/EAP should be available in emergency

The background and functional status affects which airway adjunct I use in an IHCA ie if they are old and frail or with poor functional status, I am less likely to perform a tracheal intubation if I have good control of their airway with BVM/SGA

Have only ever intubated if specific indication eg aspiration and secretions.

The majority of patients not intubated at an IHCA are due to end of bed assessment, followed by review of notes, as to the patient's pre-morbid status. Those who are deemed to have reasonable reserve are almost always intubated.

This site does not have anyone with advanced airway skills (tracheal intubation) this site has the ability to provide advanced life support skills as taught by the ALSG. Anaesthetics are available but must be contacted separate to the arrest team. Direct and indirect laryngoscopes and a full range of advanced airway devices including CO2 monitoring are available to anaesthesia but are not available on the standard arrest trolley.

[IHCA is a] rare occurrence in my hospital. Any trial would require input from multiple staff members covering the on-call rota.

An experienced ACCP is always present plus/minus the ICU SHO, who may be FY2, CMT trainee, or core anaesthetics trainee (CT1-3)

In our hospital Anaesthetics are not called to all IHCAs. The decision to call us for airway management is made by the senior doctor on the arrest team (usually the medical registrar).

Anaesthetic team not directly on the arrest team and only called if ROSC achieved and / or likely ICU candidate.

Decision to intubate during CPR sometimes depends on Chances for ICU admission after ROSC.

Airway management is quite dependent on the case, if a good seal and ventilation with capnography is achieved with an i-gel then the prehospital evidence suggests that this is acceptable. If ventilation is difficult/other indications for tracheal intubation then of course this should be done.

Was this research about outcomes vs gill/ETT not published last year?

It's very difficult to ventilate using an LMA or I-gel with ongoing chest compressions. So do we need to revisit the guidelines and have 30:2 ratio with i-gel/LMA instead?

If there was vomiting evident I would be keen to secure the airway sooner, if randomised to not intubate I would have concerns about this

[my hospital site] has an extremely low cardiac arrest rate as it is a purely surgical hospital with no medical wards or an A&E. My answers are largely based on my practice in hospitals within my rotation rather than necessarily [this hospital]

I would say that in general my practice would be i-gel 1st line and then if there was ROSC or likely to get ROSC I would then intubate (or I would intubate if no capnography trace with i-gel indicating I was not ventilating the patient)

How often an airway trained person manages the airway. Often managed by other staff prior to anaesthetic arrival

I suspect that there would be no significant difference between LMA Vs ETT during cardiac arrest

No, it is fairly "standard" here

Appropriateness for ITU admission is clearly very important in deciding which airway management technique is utilised at an arrest, and is something I feel people build upon with additional training experience.

We are in the process of acquiring in circuit capnography for our arrest bags as currently it is a large device brought down by the site practitioners so it is frequently not present at initial airway management and slow to arrive for intubation, thus delaying it.

Airway management is often influenced by the perception of whether or not patients would be a candidate for ICU

As ventilation is the key, I personally don't rush for intubation as long as the patient is being adequately ventilated by the presence of capnograph

Waveform capnography is available but has to be requested.