



anaesthetics, a balance of risks (aspiration) and benefits (preventing desaturation). Given the available evidence, routine exclusion of ventilation from a rapid sequence induction does not seem justified. Indeed it may have significant advantages in many patient sub-groups. Anecdotally, this technique is increasing in our region, something we plan to investigate more formally.

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Rapid sequence induction: an evolving beast

Koerber et al.'s [1] survey illustrated some interesting points about variation in the practice of Rapid Sequence Induction. These included the fact that consultants tended to deviate from the textbook 'preoxygenate-thio-sux-cricoid-tube' technique and that the majority of Welsh anaesthetists were using opioids as part of their induction. Furthermore, a loose definition of Rapid Sequence Induction needed to be adopted in their survey, namely a 'tracheal tube-cricoid pressure' technique, suggesting that a wide variety of techniques are being employed in patients deemed at risk of aspiration.

We completed a similar survey (between October and December 2008) in two large teaching hospitals in the East of Scotland with an 82% response rate (138 replies). Interestingly, pre-oxygenation was not universal, with 20% of consultants and 7% of trainees confessing to not always performing it. This deviates from Morris and Cook's findings, who found 100% pre-oxygenation in their national survey of 2001 [2]. Similarly, there was variability cricoid pressure use in 'Rapid Sequence Induction' patients and in the choice of induction and neuromuscular blocking agents.

Of particular note was the fact that we too found the trend towards opioid use in Rapid Sequence Induction, with 70% 'usually or always' administering one. Interestingly, this included junior trainees, despite it being explicit in our 'new-start' handbook that only thiopentone and suxamethonium were to be used. It is still widely believed that junior trainees should describe a 'traditional' technique when discussing Rapid Sequence Induction in the Primary examination of the Fellowship of the Royal College of Anaesthetists, in the United Kingdom. Both our survey and the Welsh one raise the obvious question: Is more guidance required on the teaching and practice of the (non-evidence-based) Rapid Sequence Induction to reflect the change in current practice? Ninety percent of all our respondents thought so.

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The lipid resuscitation story: past and future

I commend the editors of *Anaesthesia* for publishing two studies in the February 2009 issue [1, 2] on the clinical use of lipid resuscitation and an accompanying editorial [3] on the current state-of-the-art. Indeed, I've already cited the survey by Picard et al. as evidence for the general acceptance of this treatment, at least for local anesthetic toxicity. Furthermore, I praise Drs Picard and Harrop-Griffiths for their editorial and entirely concur that the Association of Anaesthetists of Great Britain and Ireland deserves credit for the rapid spread of lipid use in the United Kingdom. However, I would like to point out two aspects of the development of this story that were missed in this excellent editorial.

First, it was Dagleish and Kathavaroo [4] who authored the letter to *Anaesthesia* that first pointed out the experimental literature supporting the use of lipid in severe local anesthetic toxicity. This letter was '...read with glee' at the time by Drs Picard and Meek, and provided the impetus to stock lipid emulsion at their respective facilities and to 'exhort others to do the same.' Therefore, I would like formally to acknowledge the important contribution of Drs Dagleish and Kathavaroo in getting this ball rolling.

Next, I will mention what I see as an unwarranted nationalistic tone in the