The ASA D.A Algorithm

Thank you for volunteering and answering my survey regarding your experience and practice with regards to the ASA D.A Algorithm. The reason why I want to dig in further into this topic is because there are talks already of a third revision of the algorithm coming out soon and I want to make you aware of some issues that obviously will impact your individual practices. For starters let state that as with most things the current version has some positive things, some things that are not so good, and some others that need a major makeover. The algorithm is one of the most widely distributed (it is present in almost all OR's in some regard) it is well known around the world, it is respected, and in fact it is the cornerstone and the gold standard of comparison to similar algorithms that are available around the world. At present, Canada, France, Germany, Italy, U.K, South Africa and China have developed their own airway algorithmic approach and if one pays attention to their plan, anyone can see that their starting point is the ASA algorithm. At the same time it has many shortcomings: it is complex, the decision making points are not binary in nature, the end point continues to be intubation and not oxygenation and ventilation, and it applies more for certain conditions such as the operating room in the context of anesthesia, rather than emergency conditions; also some populations like trauma, obstetrics and pediatrics are not really well represented in the current version. There are things that are in need of a repair. Other issues were left out, for example: despite the fact that according to the survey 100% of residents and 93.5% of Attendings at UF Department of Anesthesia follow the algorithm on a regular basis -I am sure most if not all will swear by this-, I ask how many of you pre oxygenate your patients prior to induction of anesthesia? The answer will be close to 100% I bet. Can anyone pinpoint the location in the algorithm where preoxygentaion is discussed? You might say I am crazy and that preoxygenation is a given, and although you might be right, I ask you once again, where is it in the algorithm? IMHO such an important step should have never been left out. Another piece missing from the current version is an extubation algorithm. Many airway mishaps do not happen at the time of intubation but actually at the time of extubation and still we have no guidelines, no protocol or algorithm to follow. Another challenge with the version coming out is what to do regarding the use of Videolaryngoscopes? Where should VL fit in? Should VL be a first option when laryngoscopy is decided, or should they be a rescue option. This is a tough question because even though the majority of literature is positive, the cost of VL is still a limiting factor and there is a lot of responsibility when making statements in guidelines or universal algorithms... think about the medico-legal implications.

But enough of this topic, let us wait and see what happens in the next year or two and see if some of the recommendations that some people gave during the last Airway meeting fell into deaf ears or not. (I have learned that airway topic gurus are one of the most conservative people I know) and let us discuss other issues with regards to the survey: despite the fact that airway plays such an important role in our daily practices in anesthesia, there is more that we do not know, than what we know. For example what is the true incidence of a difficult intubation? what about the incidence of a difficult airway? some might say these two terms are the same, but actually they are not. One can take care of a complicated patient that was for example difficult to mask but easy to intubate or vice versa and this should both count as a difficult airways, but unfortunately they do not. The truth is that we do not know the true incidence of either an emergent cannot ventilate + cannot intubate (CNVCNI), versus a non-emergent can ventilate + cannot intubate (CVCNI) scenarios. Benumof states that the combined literature shows that the incidence of a failed airway attempt leading to injury (usually anoxic brain injury) is 0.01-2 per 10,000 patients, but that actually 100-1,800 per 10,000 post a challenge when intubating.... could this be true? Rose et. al (Can J Anaesth. 2005;52:6) from the Mayo Clinic reported a much higher incidence of intubation failures 0.43%; so what does this mean? Simple conclusion might be that perhaps in Minnesota they do not know how to intubate but in California they do? The answer is that honestly we do not know for real what the real incidence of failed intubation and we still keep saying "difficult airway" when we should not. Let us look at us here in Gainesville based on your responses (I am not going to disclose the n value, because I do not want to make you sad, regarding the poor response I got; assume that I got a good representative response, which once again I did not, but who is whining, and who listens anyway) 80% of the residents and 69% of faculty have experienced a CNV+CNI scenario..... how is this possible? UF is worse than Mayo and UCSD??? or better the literature does not show the true incidence of airway difficulties or emergencies and they both are more common than actually they are? I am leaning toward this last option.

And with this bombshell I an ending this post, hoping to hear and read your comments, critiques, complains etc...

"We must believe in luck. For how else can we explain the success of those we don't like?" J. Cocteau (1889-1963)