Tracheal intubation in the critically ill: just say no to drugs

Editor—The authors are to be commended for evaluating the high-risk procedure of tracheal intubation of critically ill patients as a distinct entity, different from intubation for elective general anaesthesia.1 In this study, as in many others, the intubation procedure is not very different from the procedure performed for elective anaesthesia. In essence, hypoxic and hypotensive patients are administered drugs which have the effect of inducing apnoea and further hypotension. Complications are therefore not unexpectedly high, with a significant proportion experiencing life-threatening hypoxaemia and hypotension and several going on to cardiac arrest.

Fortunately, the majority of intubations were performed by experienced clinicians with a high rate of initial successful placement of the tube. Failed intubation in the paralysed, hypoaemic intensive care unit (ICU) patient is obviously an extremely dangerous occurrence, and very different from failed intubation in the elective anaesthesia patient. There is little expectation that oxygen saturation will normalise when drugs wear off, and correction of hypoxaemia by bag-mask ventilation may not be possible, due to poor lung compliance.

Intubation of the ICU patient while maintaining spontaneous breathing reduces the risk of hypoxaemia and allows time for additional personnel to arrive if initial attempts fail. This should be the approach for any junior trainee faced with emergency intubation in a hypoaemic or hypotensive critically ill patient. Neuromuscular block, although a standard procedure in the elective intubation, seems rather irresponsible in the critically ill patient—removing airway control and spontaneous respiration in a patient with precarious oxygen exchange. Direct laryngoscopic view of the vocal cords is possible in the majority of well patients with minimal sedation.2 Most critically ill patients requiring intubation have a reduced level of alertness due to sepsis, hypoxaemia, or hypercapnia, and can be easily intubated with little or no sedation, using only topical anaesthesia. Avoidance of sedative and paralytic drugs will dramatically reduce the risk of further hypoxaemia and hypotension. ‘Awake’ intubation is an accepted procedure in the patient with an anticipated difficult airway,3 and should be used more frequently in the critically ill.

Declaration of interest

None declared.

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doi:10.1093/bja/aes238