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CORRESPONDENCE

Providing quality in anesthesia care in low- and middle-income countries

Thomas J. Coonan, MDCM

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To the Editor,

I read with concern the editorial by Dr. Wilkinson in the November issue of the *Journal*.[1] With all due respect to Dr. Wilkinson, I am surprised by his position. The issue is not whether we would personally opt for blind nasal intubation, all things being equal. The issue is that technology, such as fibreoptics or videolaryngoscopy, is often not an option in very low-income countries. Blind nasal intubation is a valuable alternative that many of us practiced successfully at an earlier time in our careers. It is still necessary in many venues. I think that Dr. Zhang should be congratulated for teaching the technique to anesthesia providers who will be practicing in austere environments.[2] The technique is absolutely necessary in the district hospitals of rural Rwanda and much of the time in the public university hospital in Kigali.[3] Furthermore, mannequin training has been shown to be effective.[4]

Conflicts of interest None declared.

References

1. *Wilkinson DJ*. Providing quality in anesthesia care in low- and middle-income countries. Can J Anesth 2014; 61: 975-8.
2. *Zhang J*, *Lamb A*, *Hung O*, *Hung C*, *Hung D*. Blind nasal intubation: teaching a dying art. Can J Anesth 2014; 61: 1055-6.
3. *Notrica MR*, *Evans FM*, *Knowlton LM*. *Kelly McQueen KA*. Rwandan surgical and anesthesia infrastructure: a survey of district hospitals. World J Surg 2011; 35: 1770-80.
4. *Kory PD*, *Eisen LA*, *Adachi M*, *Ribaudo VA*, *Rosenthal ME*, *Mayo PH*. Initial airway management skills of senior residents: simulation training compared with traditional training. Chest 2007; 132: 1927-31.

Editor's Note: The author of the article: Can J Anesth 2014; 61: 975-8, respectfully declined an invitation to submit a reply to the above Letter to the Editor.

T. J. Coonan, MDCM (✉)
Dalhousie University, Halifax, NS, Canada
e-mail: tjcoonan@gmail.com