Correspondence

Cricoid pressure

To the Editor:

The recommendation to apply a force of 20N to awake patients in applying cricoid pressure¹ is bound to be controversial. Disadvantages of awake cricoid pressure are that it (i) may increase patient discomfort and anxiety, (ii) may cause nausea or retching,² (iii) may cause airway obstruction,³ (iv) may decrease lower oesophageal sphincter tone,⁴ (v) is difficult to estimate the recommended force (20N), and (vi) offers incomplete protection against regurgitation (even when properly applied).

Cricoid pressure may prevent oesophageal intubation⁵ and, although no studies have addressed this issue, I have found that an endotracheal tube can be easily passed into the oesophagus if it is directed to either side of the midline. The unknown number of oesophageal intubations performed while cricoid pressure was applied seem to indicate that cricoid pressure cannot reliably prevent oesophageal intubation.

Some standard texts still recommend that cricoid pressure be maintained during failed intubation. Partial relaxation, or total release, of cricoid pressure should form an integral part of the management of failed intubation. It should be performed before reaching for additional blades or stylets, and even before calling for help or the difficult intubation cart. In addition, laryngeal pressure should be used during the initial laryngoscopy. Cricoid pressure should be briefly released during difficult mask ventilation to ascertain if there is any benefit in doing so. Cricoid pressure should also be released during insertion of the laryngeal mask airway or the Combitube®.

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REPLY

We would like to thank Dr Haridas for drawing attention to Woodhall's possibly incorrect supposition that cricoid pressure (CP) impedes oesophageal intubation,¹ and for re-emphasising that there is uncertainty that 20 N is the correct force to apply to awake patients. There is anecdotal evidence that CP does not completely obliterate the oesophageal lumen² and it is not surprising that oesophageal intubation is still possible if the tracheal tube is directed to either side of the midline. Unfortunately, the CP literature is dominated by similarly conflicting data, yet recommendations are required since CP is a standard of practice. We consider that 20 N is the current best estimate and continue to recommend this for the awake patient.³

Interestingly, two new trials have added further to the CP controversy. Vanner et al. have shown that CP improves the view at laryngoscopy⁴ and Yentis et al. have shown that double handed CP is better than single handed CP.⁵ These findings are in direct contrast to some studies discussed in the review.⁶ It is clear that much research will be required before many critical questions can be answered about CP. It will be interesting to see if the anaesthetic community regards CP as sufficiently important to support the research effort required to make more scientifically valid recommendations.

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