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Urgent endotracheal intubation: reply to Moss and Venkatesan

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Dear Editor,
We read with interest the remarks of
Dr. Moss and colleagues [1] regard-
ing the use of cricoid pressure during
urgent endotracheal intubation (UEI).
We refer Dr. Moss to an interesting
summary of the subject [2]. We have
concerns about the Sellick manoeu-
vre, as follows:

1. Anatomic considerations. The Sellick manoeuvre is designed to occlude the oesophagus by application of force to the laryngeal apparatus (targeted on the cricoid). This presupposes that the oesophagus is positioned posterior to the point of force application. This may not be the case [3].

2. Performance considerations. The proper performance of the Sellick manoeuvre is a potential point of quality failure. The controlled environment of the operating room with the presence of a highly qualified anaesthesiologist is very different than that of a front-line intubation in the intensive care unit (ICU). There is marked variation of technique in how to perform the manoeuvre and how intensivists are trained to perform it [4]. It has been reported that attempts at the Sellick manoeuvre degrade visualization of the vocal cords during intubation [2].
3. Lack of evidence. We are not aware of any study that documents the efficacy of the Sellick manoeuvre when performed in the context of ICU-type UEI. This is reflected in regional differences in its use. It is not widely used in France [5]. In our experience, it is not commonly used by ICU teams in the USA.

Regarding concern about the time delay and risk of emesis with insertion of a gastric tube following ultrasonographic identification of gastric fluid, we respond that the decision is always driven by clinical circumstance. The key issue is that the airway team is able to identify the potential for lethal complication(s) of the UEI by rapidly identifying gastric fluid. How the team responds to that information requires risk assessment of nasogastric tube insertion.

Whenever possible, we drain the stomach. In the circumstance where the risk outweighs the benefit, the knowledge that a patient has gastric fluid still allows the team to take specific steps in anticipation of emesis during UEI. This may include the Sellick manoeuvre, extra suctioning capability, and assignment of a highly skilled operator to be the primary intubator (i.e., this is not a case for the trainee).

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