



In reply: Airway management strategies in patients with halo vest fixation devices

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To the Editor,

We thank Dr. El-Orbany for his correspondence regarding airway management in patients with halo vest fixation devices.¹ He raised several salient points regarding airway management in this patient population. Although an awake bronchoscopic intubation is one of the most effective methods of reducing the risk of airway compromise during intubation, we agree that it is not a fail-safe technique, as our case report illustrates – indeed, there is no such technique. The practice of airway management is complex and nuanced and underpins the role of the anesthesiologist as an airway expert.

We acknowledge that there have been reports of successful airway management of patients in halo fixation after induction of general anesthesia, particularly as a rescue maneuver. Nevertheless, in general, we should not advocate for the induction of general anesthesia as a bridge for difficult intubation techniques. The difficult airway guidelines put forth by the American Society of Anesthesiologists recommend that an awake technique be used in the setting of a known or suspected difficult airway.² The recommendations of the Canadian Airway Focus Group similarly suggest that general anesthesia be used in an anticipated difficult airway only if success of the chosen device can be predicted in a maximum of three attempts.³

Although an awake tracheostomy obviates the need for upper airway topicalization, such cases are considered high-risk tracheostomies.⁴ First, the presence of the halo

device interferes with the tracheostomy operative field. Second, patients in halo fixation devices cannot be placed in neck extension and cannot be positioned optimally for a tracheostomy.³ Nevertheless, during airway management of patients in halo fixation, it is important to have alternative back-up airway devices available as well as personnel present who are prepared to manipulate the halo fixation device and perform a surgical airway if necessary. These personnel should be present once airway management begins, as airway loss can occur at any point during the intubation, even during topicalization.

Fortunately, the incidence of adverse neurologic outcomes is quite rare during airway manipulation in patients with halo fixation devices.⁵ A study comparing the safety and efficacy of various airway management strategies would therefore require such a large patient population that it would not likely be feasible. Regardless of the technique, airway management in patients with halo fixation can be extremely challenging and requires a great deal of preparation by the anesthesiologist. Radiographs should be reviewed, and an appropriate strategy should be employed involving close communication with the surgical team. Most importantly, the limitations of the technique should be known, and a back-up plan should be well established ahead of time in the event that the initial plan is unsuccessful.

Conflicts of interest None declared.

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