

Valdinger and Norris' thought-provoking letter [1] crystallises the different approaches to airway prediction and management, which are likely to become the intellectual battleground of further debate in this field.

Not intending to misrepresent, we summarise their approach as follows. They view Plan A as a generic technique, albeit conducted optimally; eg, pre-oxygenation, intravenous induction and then an airway (supraglottic, or tracheal tube after paralysis), all using 'standard' equipment. They argue that when conducted carefully, such a Plan A is likely to succeed in the vast majority of patients and they rely then on an efficacious Plan B, C, etc, as outlined in the Difficult Airway Society (DAS) guidelines to provide suitable and safe rescue for those tiny minority of patients in whom Plan A fails. They would apply a generic Plan A even to 'plausibly difficult' patients, reserving advanced techniques (noticeably distinct from their Plan A methods) only for the most obviously difficult.

We concede that probably the vast majority of anaesthetists currently ascribe to this approach. For them, the DAS guidelines are not for the truly unanticipated difficult airway, but rather '*guidelines for when the plausibly difficult airway fails routine management*'. We suggest this is akin to treating all fevers blindly with penicillin, reserving other treatments only for those who don't respond.

Our approach is decidedly different [2]; akin to diagnosing the likely cause of fever and selecting the most suitable treatment. For us Plan A is not simply the 'generic' induction technique applied to all patients, but is the plan judged to be the most efficacious for the given case. Hence our Plans A differ between patients, especially in those plausibly versus implausibly difficult [3]. In our approach, the DAS algorithms are '*guidelines for the failure of a customised Plan A*'.

This brings into sharp focus one important limitation of the DAS guidelines, namely that they say nothing about what to do with the anticipated difficult airway (ie, they do not tell us how to customise Plan A, for any given case). They are relevant only for when Plan A fails, regardless of what that Plan A is [4,5].

Our debate in this correspondence is therefore about whether Plan A should be customised or generic for the plausibly difficult airway. To Valdinger and Norris, tragic cases (like Bromiley and Ewing) had poor outcomes *primarily* because the

principles of DAS guidelines were not adhered to. While that is in part true, these cases also highlighted the risks of not customising Plan A. Continuing the analogy, a febrile patient generically treated with penicillin might succumb to malaria before the correct treatment takes effect. In contrast, we wish to make the initial approaches even safer by arguing that tailored selection of Plan A in the first place would make the employment of those DAS guidelines as emergency rescue less frequent. McAfee's letter [6] underlines the need for customisation of Plan A since patients' airways are difficult in very specific ways.

We do not know if our Pandit-Heidegger approach is safer or more effective than that of Valdinger-Norris. More importantly, we do not know which psychological factors would cause an anaesthetist to favour one over the other. Differing context, attitudes to risk, experience of adverse outcomes, dexterity, or affinity for complex equipment may all be relevant. The investigation of these things, and the clarification of the two contrasting approaches are central to the philosophy of difficult airway management.

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References

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