Why I like flexible bronchoscopy as a difficult airway option and Boston Cream donuts

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I am bored, have 20 minutes before my next case, I have just finished a week of vacation and I am using any excuse to procrastinate before going to the endoscopy suite.

This article has an interesting title, albeit a bit misleading. I have to admit, I read the article for two reasons: you sent it, and it had a catchy title. In the discussion section the authors use more modest language about whether or not awake VL should replace awake FOB. I think the user context is important here, so in a mixed email group like ours, I think it's relevant to distinguish airway managers who have FOB skill and those who don't. When I teach AIME, this is also important, since my students my be rural EPs (likely no FOB skill), urban EPs (possibly some FOB skill), or critical care practitioners (possibly a lot of FOB skill).

When I was a resident in Halifax, I once asked Orlando why we had all of these different airway toys, and why one really, really good toy hadn't been invented that trumped them all. He thought for a second, smiled and responded, "Difficult airways are difficult for different reasons, so how could I use the same device to solve different problems?" Then we ate a donut, and I was happy. I always remember this sage reflection when I walk into any airway scenario, and, in the case of considering the thesis of this article, I am reminded of the same thing. In my opinion, IF I am comfrotable using the FOB, then there is very little (nothing) awake VL can accomplish, that awake FOB cannot accomplish. However, and this is the key for me,I do not believe that the reverse is true. Capiche? What I'm trying to say is that if I am equally good at awake VL and awake FOB, the FOB is a more capable device for difficult anatomy. What if I am not good at awake FOB? Then I do believe I would call someone with awake FOB capability, or as a second option, develop awake VL skills. If I have no one in my hospital with awake FOB skills, then I would very urgently develop awake VL skills.

So why do I like FOB so much? I actually don't. Of all my skills it is the one I do the least, and I actually go out of my way to practice it (routinely in asleep patients, and find excuses to do it in awake ones). It's a huge pain in the ass. But what makes the FOB so frustrating is also its greatest strength: it is annoyingly flexible. Strictly speaking, VL solves the issue of "peaking around the corner" where DL cannot, thereby solving one possible dimension in the multidimensional difficult airway paradox. But, as Orlando said, "Difficult airways are difficult for different reasons..." What if the difficult anatomy of my difficult airway scenario may not be simply peeking around the corner? I can peak around the corner with the FOB and my VL equally well, however, if the anatomy is more

complex than that, then FOB offers advantages. For example, as I had to deal with a knife wound to the neck with associated hematomato recently, the anatomy was pushed posteriorly and laterally, or in two directions if you will. Could awake VL have solved this? Sure, possibly. But in this situation, it could not. I tried. Then got the FOB and was able to do it. Maybe I suck at awake VL. Maybe not.

So what's my point? First, Orlando Hung is a smart guy. Second. Donuts are awesome, especially Boston Cream. Third, there is a not-so-secret movement to elevate VL into the first pass, any pass, last option, all options, for all airways. I disagree. "Difficult airways are difficult for different reasons, so how could I use the same device to solve different problems?" I cannot make VL the only tool I use, for my RSI, for my first look, my second look, my third look, and then my awake techniques. It won't work. It's impossible. I have to learn multiple, complimentary, alternative techniques. I have the luxury that in my practice, I can learn and maintain the skill of awake FOB. It will remain a part of my skill set, and a valuable asset for patients who come to any hospital I work at. If I get called by my EP colleagues to the ED, I will bring this skill as part of my bag of tricks on offer because I believe it still offers something that does not exist in the VL scope of ability. As an educator, I will teach awake FOB to anyone who a) wants to learn it and b) can reasonably maintain the skill. Otherwise, I will teach awake VL to all others, with the firm warning that awake VL also has limits.

I'm late for endoscopy.

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