



**ORIGINAL RESEARCH PAPER**

**Anaesthesiology**

**IS IT SKILL OR EQUIPMENT IN ANESTHESIOLOGY, THAT MATTERS? CATASTROPHE PRECLUDED**

**KEY WORDS:** Anesthesiology, has evolved from blind procedures to real time imaging. But if things go wrong despite best efforts, then during crisis who is to be blamed for – the skill or the equipment.

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**ABSTRACT** Perfection is always desired, but is against the law of nature. Since time immemorial, humans have left no stone unturned to reach 100% perfection. Innumerable discoveries have been made. Changes at the genetic level have created wonders. Robots have come next to humans. As ages have passes, humans have strived for near perfection, both by improving their skills and technology including equipment<sup>1</sup>. Anesthesiology too, has evolved from blind procedures to real time imaging. Simulation has played a key role in improvements. But if things go wrong despite best efforts, then during crisis who is to be blamed for – the skill or the equipment<sup>2</sup>

**INTRODUCTION:**

This is a rare case report which narrates a recent event in a tertiary care government hospital where it is difficult to point whether quality of equipment takes over the skill of an anesthesiologist.

**CASE HISTORY:**

A 3 year child was posted for cleft lip surgery. Apart from difficulty in verbal articulation, there were no complaints and basic investigations were normal. Monitors were attached and vitals were HR 116/min, BP 98/62 and SpO2 99%. Child was preoxygenated with 100% O2 for 3 minutes and induced with propofol 30 mg and 30 mcg fentanyl alongwith 1.5 mg vecuronium. Intubation was done with uncuffed ETT 3.5mm

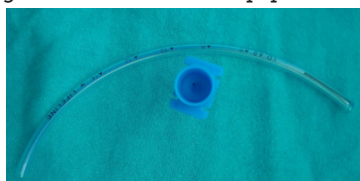
To everyone's despair no chest rise was seen and auscultation revealed a silent chest. ETT position was checked with D/L again but in vain. The beep of the saturation started diminishing and also the HR. HR came to 78 and SpO2 80. Child started turning blue. Immediately tube was removed. Bag and mask ventilation was done, which was perfectly normal and all vitals normalized. Again D/L performed and intubation done, but again lungs could not be ventilated. It was thought that there might be some undetected congenital anomaly involving trachea because of which ventilation was not successful. Again, the tube was withdrawn and bag and mask ventilation done. As vecuronium was already administered, the airway was secured with LMA and PPV was normal.

Incidentally, it was observed that the connector of the ETT had a very narrow lumen (Figure 1). It was because of this that PPV could not be done.

**DISCUSSION:**

It is said 'Practice makes a man perfect', but what if one is almost perfect and it is the equipment that fails him. Our Country is now crossing the definition of a developing country and is soon to be a developed nation. It is high time that healthcare standards of mankind be raised and certain minimum quality check be imposed. It is also time to think whether it is appropriate to revise the policy of lowest cost tenders for government setups or minimum quality benchmarks.

So to think again- is it the skill or the equipment that matters.



**REFERENCES:**

1. Gaba DM; What Makes a "Good" Anesthesiologist?. Anesthesiology 2004;101(5):1061-1063
2. Smith MC, Kamdar N; Longnecker DE, Cooper JB. Safety and Quality: The Guiding Principles of Patient-Centered Care. Anesthesiology 3ed