ARAN

Resuscitation Views

Separating the truth from the rhetoric

The latest 2021 Airway (Guideline 4) from the ARC now contains pictures of invented methods with no clinical evidence or any proof of efficacy.

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Message from the Editor

The end-user of recommendations set out in guidelines is the eventual tester and arbiter of what constitutes their efficacy. Notionally, guidelines are meant to provide evidenced advice on successfully managing emergency situations. If they fail to live up to this promise, there is no recourse, checks or balances in Australia to investigate or to rectify this.

If a person dies or suffers serious injury after faithfully following the recommendations of "experts", there is no accountability nor is there any process in place to examine the method used to determine if the recommendation or method is flawed. The underlying belief of the ARC is that if the measures fail it is all down to non-compliance but it could never result from its unevidenced opinions or recalcitrance in responding to new evidence and outcome data.

Disappointingly, not only is the guideline development process in Australia (and outcome) not peer-reviewed, nor is there any meaningful public consultation but there is no input or criticism accepted from outside the organisation. This position includes the use of unconscionable conduct and influence to denigrate any perceived threat to the organisations notion of its (unlegislated) authority in Australia.

THE ARC HAS DECIDED TO UPDATE ITS ANZCOR AIRWAY GUIDELINE 4, BUT IS IT AN IMPROVEMENT OR MORE OF THE SAME?

While we are all aware that the "public consultation" phase of the ANZCOR guidelines is not a genuine process that has any influence on the "fait accompli" as presented, however let's examine the latest offering critically and determine where improvements have been made and where unscientific parochial rhetoric is still the major influencer in guideline development and "made-up" methods are recommended without evidence.

Whilst the ARC has acknowledged for the first time that many of its "suggestions" are only "good practice statements" i.e. where these is no or poor evidence, where there is supposed to be local special factors or the developers simply wish to be exempt from a GRADE evidence review. Any inference that the ANZCOR guideline reflects the ILCOR CoSTR and evidence review, is profoundly and deliberately misleading. A line-by-line critical examination of the document reveals many issues.

Summary Page 1 – Recommendations (2)

"In an unconscious person, care of the airway takes precedence over any injury, including the possibility of spinal injury."

While this statement is ideologically true in the ultimate sense, what is not revealed is that the ARC chose not to include the "jaw-thrust" method of airway management in the BLS guidelines (for spinal and other more typical arrests), solely because they believe that "anyone who does BLS, lacks the mental capacity to learn anything other than head-tilt" [BLS Meeting Minutes] i.e. the absence of an effective method in the BLS guidelines is a result of arbitrary determination of intelligence, rather than need, risk or evidence. This places patients at risk.

Summary Page 1 – Recommendations (4)
"To clear the airway the mouth should be opened and the head turned slightly **downwards** to allow any obvious foreign material (e.g. food, vomit, blood and secretions) to drain"

This description is ambiguous by the previous point that the airway should be managed in the "position the person is found". The term "downwards" is therefore made meaningless to the reader.

Summary Page 1 – Recommendations (5)
"If the person is unresponsive and not breathing normally… "
This terminology is used throughout the ANZCOR guidelines, however the interpretation of how to determine this in Australia has no clinical evidence as being an effective deferential diagnosis of unconsciousness. Techniques described of "gently squeezing the shoulders" and "asking a question" have no basis in clinical practice or evidence anywhere in the world as determinates for resuscitation. Response to painful stimuli does and is evidenced-based and safe. The AVPU criteria is well established.

General Principles – Page 2 (Paragraph 4)
This paragraph is completely ambiguous and contradictory by the absence of a methods such as "jaw-thrust" to alleviate neck movement in the airway management of a suspected spinal injury.

General Principles – Page 2 (Paragraph 5)
"The person should not be routinely rolled onto the side to assess airway and breathing—leave them in the position in which they have been found. This has the advantages of simplified teaching, taking less time to perform and avoids movement. The exceptions to this would be where the airway is obstructed with fluid (water or blood) or matter (sand, debris, vomit). Here, the person should be promptly rolled onto their side to clear the airway".

Again, the ANZCOR guideline uses confusing and unevidenced terminology to describe what should be a simple process. There is no evidence that water (salt or fresh) in a person's airway or lungs must be removed to significantly improve outcome. Delayed non-cardiogenic pulmonary oedema unresolved by positive ventilation is largely a myth perpetuated by lifesavers. The guideline makes no differentiation between "trace" and "frank" blood as indications for rolling patients. The only indication for the log-rolling of a person (and only in the ventilation is required) is the presence of vomitus.

General Principles – Page 2 (Paragraph 6)
"Case series reported the finger sweep as effective for relieving foreign body airway obstruction (FBAO) in unconscious adults and children aged >1yr. However, five case reports documented harm to the person's mouth or biting of the rescuer's finger[2]."

This paragraph of the guideline fails to provide the reader i.e. end-user with any practical advice as to the use of "finger-sweep". The text begs the reader to come to their own conclusions. If this is the view of the ARC the paragraph could have been omitted as it for practical purposes, useless.

Airway Management – Page 3 (Paragraph 1)
"For lay rescuers performing compression-only CPR, there is insufficient evidence to recommend the use of any specific passive airway manoeuvre."

It is timely that the ARC finally acknowledges that "compression-only" CPR is a valid approach. However, there is still the assumption that for "trained' (presumption of expert status) individuals, ventilations have universal efficacy in improving long-term survival rates.

Children and Infants Page 4 (Paragraph 1-2)
"An **infant** is defined as younger than one year, a **child** as one to eighteen years of age (or up to onset of puberty if the age is unknown). In both cases the principle is to maintain an open airway.
Children
Children should be managed as for adults."

So much wrong with this "good practice" statement. The notion that a child is the same as an adult is contradictory to all other ANZCOR advice and will create much confusion. The notion that "18 years old or the onset of puberty" is equal is not based on human anatomy or physiology. This would mean a premature infant of 15 months and the size of a 10-month-old is equivalent to a 60-year-old. Size and age are not equivalent.

Infants Page 4 (Paragraph 3)
While it is not uncommon for illustrations to depict the "neutral head position" as a "flat-face position" this is not how it is anatomically described. The guideline should have included a description of the anatomical position, rather than relying on a poor illustration.

Management of Foreign Body Airway Obstruction Page 5 (Paragraph 1)

Chest thrusts or back blows are effective for relieving FBAO in conscious adults and children with low risk of harm (only 4 observational studies report harm from back blows and 5 observational studies report harm from chest thrusts).[3-5] Life-threatening complications associated with use of abdominal thrusts (including the Heimlich Manoeuvre) have been reported in 52 observational studies.[3-5]

We will have to back-up the rhetoric truck here to unload all the historical, misleading and divergent opinions expressed in this section.

There is no supporting references or evidence listed for the statement that "Chest thrusts or back blows are effective for relieving FBAO in conscious adults and children" statement, because there is no supporting or any relevant evidence for this divergent view or methods described. It should be stated here that this view is contrary and divergent form the ILCOR position after a more detailed CoSTR evidence review in 2020. The methods may have low evidence of harm but they also have no evidence of efficacy. Safe but dead is not

The suggestion that the number of study reports have anything to do with the risk assessment process is ludicrous. Quantity does not equal quality, that is what science is supposed to be about. ILCOR also assessed these observational studies and came to the conclusion that the risk is not significant. If it were the ARC needs to produce the clinical reports that must be coming in every day of serious harm or death using the abdominal thrusts.

Page 7 – Illustrations

There is no evidence, clinical trials, research or documented case studies that any of these methods work. Compressions with the person supine has only shown efficacy in deceased patients. The other two methods i.e. one-handed compressions and up against the wall methods are both inventions of the ARC. There is only one "chest-thrust" method that has shown efficacy and that is one described as an alternative for abdominal thrusts in pregnant or obese patients where the chest-thrusts are delivers from behind the patient with 2 hands. One of the most significant deceptions perpetrated by the ARC has been the inappropriate use of the term "chest-thrusts" to describe any technique they choose, without any specific or relevant evidence. The divergent views of the ARC on choking management are the issue when they lost all credibility as "following ILCOR". These illustrations have more than likely added in response to the ARC's recent embarrassing failure to subvert the decision of the TGA in approving the listing of a suction-based airway clearance device (LifeVac) in Australia; but this is the subject of a future newsletter

Conclusions

The ANZCOR reviewers had the opportunity to make this guideline more useful and to change it to reflect the evidence, but alas it would seem politics and rhetoric have again won out over science in Australia.

There were individuals on the review panel that should have known better, however the development of ANZCOR guidelines comes with several caveats:

1. That the political and financial interests of member organisations are the primary consideration in determining the final content.
2. That the content must not threaten the traditional and historic view of resuscitation on which an organisation is founded.
3. That the opinions of individuals in positions of power in the organisation are to be considered strong evidence.
4. That reviewers are not the arbiters of the final publication. Despite claims made in regard to the formulation of guidelines, there cannot be and clearly, they are not, a result of any "unanimous" consensus. They are ultimately decided by a national executive that has the power of veto over all guidelines.

Can we improve the efficacy, utility and evidence base for the guidelines in Australia? It is possible, but it is increasingly clear that the ARC is not the vehicle for this. While being a member of the ILCOR, the ARC arbitrarily decides (independently) when to follow the science and when to just "make up" stuff and recommend its own divergent and unevidenced methods. As a non-government and voluntary body there is regrettably no oversight in Australia that has any jurisdiction to hold the ARC accountable for failures and questionable practices when dealing with valid criticism.

We are under no illusions about how this critique will be viewed by the ARC. Like any external commentary or suggestions, these will be rejected without any consideration on a purely political and partisan basis. Closing down any genuine debate or discussion is part and parcel of the operation of the ARC, including restricting content at conferences it has influence over so as to only present a pro-establishment dialogue. This attitude is not designed to improve the safety and efficacy of guidelines or outcomes for patients, but to re-enforce the self-proclaimed "authority" of the organisation.

The real losers in all this are the end-users, who have blindly placed their trust in the ANZCOR guidelines as providing a level of assurance and safety for their work colleagues, family members and fellow citizens.

ARC member coffee mugs now available.