

A Survey about Throat Pack Management in Perioperative Period

Nouman Alvi*

Department of Anesthesiology, Aga Khan University, Karachi, Pakistan

*Corresponding author: Nouman I Alvi, Assistant Professor, Department of Anesthesiology, Aga Khan University, Stadium Road, Karachi, Pakistan, Tel: 923008228356; E-mail: nouman.alvi@aku.edu

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Introduction

Throat packs are documented to cause airway obstruction [1-3]. There have several instances in the literature exploring obstruction of airway and other complications by pharyngeal packs [1-4]. They are commonly associated with throat pain and mucosal injury [4]. Besides their main use to prevent aspiration, throat packs can also lead to complications e.g. retained/forgotten throat packs, oedema, dysphagia, choking & hypoxia. In one randomized controlled trial throat packs were found to cause severe throat pain [5]. It is important to note though that the safety profile and utility of pharyngeal packs is still inconclusive and unproven [1,4]. What is conclusive so far however is that they are responsible for throat pain [4-6].

This survey was conducted to establish a pattern of prevalent practice of throat pack documentation in the perioperative periods in the Anaesthetic Departments in the Merseyside Region in the United Kingdom.

Methodology

A web based questionnaire was forwarded to the medical staff (consultants, trainees and staff grades) through the secretaries of anaesthetic departments of Mersey Region, United Kingdom. Results were collated on Google[®] Drive and analysed utilizing Microsoft Excel^M. An implicit consent was assumed if the respondent accepted to answer the questionnaire.

Results

There were a total of 77 responses to the survey questionnaire. Majority of the respondents were consultant grade 55 (71.4%); while 22 (28.5%) were trainees. 57 (74%) of respondents were aware of recent national guidelines⁶ about throat pack management while 20 (25.9%) were unaware about any such update.

36 (52%) respondents replied yes if throat pack documentation was part of WHO list at their workplace; 33(48%) replied in negative to this query; while seven respondents chose not to reply.

35 (47%) respondents replied yes to the question if Departmental guidelines were in place about throat pack documentation; 40 (53%) replied in negative while two respondents did not reply to this question.

Throat packs were found to be most commonly used in ENT, neuro-anaesthesia, and in prone positioning 41.8%, 23.6% and 32.7% respectively. There was almost no use in obstetrics/gynae, urology and cardio-thoracic surgery.

There was quite an overlap found in the procedures in practice for management and documentation of throat packs during surgeries. The documentation in anaesthetic charts for placement and removal was

67% and 55% respectively. 23.4% respondents made a tie around the tracheal tube as a reminder for throat packs. The throat pack was counted in the total swab count in by 23.4% of respondents.

Discussion

This survey is reassuring in the sense that an overwhelming majority of anaesthetists are aware of the risk management issues surrounding throat packs. However a significant number of anaesthetists were not making formal documentation of throat packs that can make them appear seemingly defenceless in the medico-legal context. On the other hand, whereas WHO Safety List is now being conducted in vast majority as a norm but it remains to be seen that 'throat packs' are also counted, remembered and documented in the total swab count in a uniform, standardised manner. This fact is even more pertinent that in nearly three quarter of places, throat packs were not counted in swab count. That could be a major risk management issue.

Our survey had several lacunae that were ignored at the time of inception. It did not have formal approval from Ethical Committee. There were several patient and respondent factors, which were unaccounted for. Prominently, there is absence of input from maxillofacial colleagues. Ironically that is one area where throat packs are used most commonly. We hope to create awareness of issues surrounding throat packs and then do a second survey to check compliance. This survey can be used as reflective of trends and patterns of throat pack management.

This survey also highlights need for 'Department Guidelines' since vast majority of departments replied in negative to the query if they even had any guideline whatsoever in this respect. Based on the recent literature, review of evidence, the author feels that The, National Patient Safety Authority (NPSA) United Kingdom Guideline issued in 2009 on throat pack management can function as sensible and practical recommendation for Anaesthesia Departments.

Findings from a United Kingdom (UK) based survey disseminated through the National Patient Safety Agency (NPSA) stressed the fact that the responsibility of throat pack rests with the anaesthesia staff [7]. This study also recommended that the pharyngeal packs should be counted among the swab count and therefore active participation of surgical and nursing staff is imperative.

Under reporting of errors associated with throat pack is well documented therefore it is important that protocols are devised on institutional levels to ensure patient safety. Different measures have been suggested; these include using labels on patients [8], airways device being used on the patient or even at the cap of theatre staff [9], attaching the throat pack to the airway device itself [10] and leaving part of the throat pack protruding outwards so it is visibly obvious

[11]. It is therefore prudent that local guidelines are in place and complied.

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