

(i.e supine to an inclined or reverse case). Second, predetermined conditions prior to intubation may be needed to be controlled and further subgroup analysis would show more clinical implication. Authors already performed age-stratification. Indication for intubation would be the main interest for stratification, too. Respiratory failure indication was more frequent in an inclined position (71.0%) and airway protection indication was more frequent in a supine position (79.7%), as authors already described. The two indications are clinically very different, thus stratified analysis for laryngeal view between inclined and supine position in respiratory failure only group and airway protection only group would be expected to reveal clinical implications. Additionally, subgroup analysis among patients who were anticipated difficult airway and patients who were not would give more detailed information regarding laryngoscopic visualization. Status of secretions, obesity, emesis or blood condition is already collected in this study. It would be useful to inform which conditions would be beneficial for an inclined position than supine position before attempting endotracheal intubation.

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Declaration of Competing Interest

None.

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Reference

- [1] Murphy DL, Rea TD, McCoy AM, Fahrenbruch C, Yin L, et al. Inclined position is associated with improved first pass success and laryngoscopic view in prehospital endotracheal intubations. *Am J Emerg Med* 2019;37(5):937–41.

Response: Inclined versus supine position for endotracheal intubation



We thank Professor Jae Baek Lee and colleagues for their interest in our study. A primary concern expressed was the possibility that patient position was altered throughout the course of care for patients needing more than one intubation attempt to successfully place an endotracheal tube. While other details about subsequent intubation attempts are well characterized in our airway registries, unfortunately the patient position is recorded only for the first attempt at tracheal intubation. We too are interested in the techniques undertaken by paramedics following an unsuccessful attempt at intubation, including patient position.

We agree that analysis of outcome stratified by clinical indication for intubation is of clinical import and would help further ascertain which patient cohorts benefit most from this intervention. We are modifying our airway registry to collect additional information and plan to return to this important question in the future.

The question of evaluating outcomes based on anticipated airway difficulty is interesting. Unfortunately, our airway registries did not

collect information regarding the pre-intubation airway assessment by the team performing the procedure. Airway assessment tools are taught to prehospital providers in our system, but their clinical utility is modest [1], and of uncertain applicability in the emergent prehospital setting where every airway should be approached like a difficult airway.

We agree that there are potential confounders that limit our study findings. We cannot be certain if the improved first pass success rate or view on laryngoscopy among the inclined patients was due directly to positioning or is a confounding characteristic. We would welcome further work utilizing prospective data collection methods that could specifically investigate the characteristics highlighted by the reader.

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Reference

- [1] Detsky ME, Jivraj N, Adhikari NK, et al. Will this patient be difficult to intubate?: the rational clinical examination systematic review. *JAMA* 2019;321(5):493–503.

HVNI vs NIPPV in the treatment of acute decompensated heart failure: Is acute stabilization enough?



To the Editor,

We agree with Haywood et al. that HVNI could be non-inferior to NIPPV in the management of patients with acute decompensated heart failure [1]. As this study is a subgroup analysis of a larger study, there are some key issues that need to be addressed for meaningful clinical extrapolations.

The authors have included patients with a discharge diagnosis of acute decompensated heart failure without differentiating between patients with reduced and preserved ejection fraction. Furthermore, the inclusion of patients was subjective viz. patients requiring escalation of support to NIPPV without further characterization of the severity or etiology of heart failure. This is concerning, as existing evidence suggests that NIPPV may be harmful in patients with cardiogenic shock and may increase risk of acute coronary syndrome [2]. The existence of comorbidities such as chronic obstructive pulmonary disease (COPD) is not accounted for and could impact the findings. Thus, these results may not be applicable to the complete spectrum of heart failure patients.

Secondly, the authors have mentioned initial settings of NIPPV (inspiratory positive airway pressure of 10 cm H₂O and expiratory positive airway pressure of 5 cm H₂O with FiO₂ of 1.0). These initial NIPPV settings are lower than ones used in a previous randomized controlled trial by Gray et al. (IPAP