Reply to the Letter to the Editor

Reply to Leonicini

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Received 29 May 2010; accepted 31 May 2010

Keywords: Endotracheal intubation; Tracheal laceration; Iatrogenic disease; Fibrin glue; Conservative treatment

We appreciate the great interest expressed by Leonicini [1] in our report on tracheal lacerations after endotracheal intubation [2]. The recent experience with 23 tracheal lacerations reported by the author from San Martino Hospital in Genoa [3] seems to be an external validation of our morphological classification. Indeed, Leonicini is right in taking into account the clinical condition of the patients and we fully agree with him; however, we would like to stress that it has been clearly stated in our article [2] that the bronchoscopic findings determine further treatment provided that (1) the patient has stable vital signs, (2) pneumothorax has been resolved and (3) adequate respiratory status has been achieved (spontaneous or mechanical). On the other hand, we believe that the most important take-home message from our article is that the depth, and not the length, of tracheal injury represents the most important factor for the evaluation of such difficult patients.

Furthermore, preventing of mediastinitis is a key goal of thoracic surgeons dealing with postintubation-tracheal lacerations, and we do not agree with Leonicini’s statement that if mediastinitis is not present, a conservative management can be accomplished. A wait-and-see policy, in the presence of a level IIIa lesion (complete laceration of the tracheal wall with an oesophageal or mediastinal soft-tissue hernia without oesophageal injury or mediastinitis), could be acceptable only if the physicians have a great experience in dealing with such patients, but could be a disaster if clinicians are not ready to detect any minimal clinical change because in the presence of clear signs of mediastinitis, the mortality is very high (40–50%) [4]. The last sentence of Dr Leonicini’s letter deserves a word of caution: time to diagnosis is very important. In our experience, diagnosis and treatment took place within 24 h of sustaining injury. Delayed diagnosis is not at all a favorable factor, except in the presence of level I injury (mucosal or submucosal tracheal involvement without mediastinal emphysema and without periesophageal injury), which easily resolves spontaneously. In an attempt to provide correct guidelines for the management of tracheal injuries, we would like to stress the importance of broad-spectrum antibiotic therapy and parenteral nutrition. The role of bronchoscopic instillation of fibrin glue (Tissucol, Baxter Healthcare, Deerfield, MA, USA), routinely performed in our Unit to promote tissue sealing and regeneration of tracheal lacerations, has not yet been clearly understood and needs further investigations.

References


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doi:10.1016/j.ejcts.2010.05.042

Letter to the Editor

Pore size is significant in hemofiltration

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Received 9 April 2010; accepted 13 June 2010; Available online 31 July 2010

Keywords: Hemofiltration; Inflammation; Cardiopulmonary bypass

We have read the study of Musleh et al. with great interest [1]. In the study, no correlation was stated among pore size, size of interleukin (IL)-6 molecule and hydrostatic pump pressure. However, it was only declared that hemofiltration was conducted as a total amount of 15 ml kg⁻¹ (body weight)⁻¹ during cardiopulmonary bypass. The pore size and pumping pressure influence directly the passage of the IL-6 molecule. This relation is crucial [2].

References


* The authors of the original paper [1] were invited to reply to this Letter to the Editor but they did not respond in time.

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doi:10.1016/j.ejcts.2010.06.014