## 1. Introduction

Tracheal resection for a postintubation or post-tracheostomy stenosis is a well-detailed procedure, but the management of a tracheal or laryngotracheal stenosis caused by an inhalation injury remains a challenge [1–3]. A lesion caused by irritant gases accompanied by heat is generally more extensive and more frequently transmural than one after postintubation stenosis or tracheostomy. We report here on successful multiple costal cartilage grafting (CCG) to treat a full-length complete laryngotracheal stenosis that developed after an inhalation injury.

## 2. Case report

While rescuing neighbors from a burning house, a 22-year-old male suffered severe burns to his airway and was intubated for seven days. Five months later, a slowly increasing stridor necessitated tracheostomy. The fixing T-tube was removed three months later, and the patient had an adequate airway two years after the last procedure. We conclude that multiple cartilage graft reconstruction can be successful even after the development of an extremely long airway stenosis following inhalation burn injury.

**Keywords:** Burn injury; Costal cartilage graft; Laryngotracheal stenosis
that the inflammatory component tends to subside over a period of three to five years [3]. In view of this long recovery period, Eliachar et al. have recommended the long-term use of a T-shape silicone tube to maintain the airway, instead of immediate laryngotracheal resection or reconstruction [4]. The mean T-stenting duration applied by the Boston group was 28 months. If resection was performed, they recommended T-tube stenting as well [3]. We used a long tracheostomal cannula for almost two years before the resection, and permanently afterwards. Re-stenosis nevertheless developed, as a stable anastomosis could not be created in the severely damaged tracheal tissues by removing only the most stenotized area.

Airway dilatation with a rib cartilage allograft was introduced by Rethi in 1955 [5] and popularized by Cotton [6], mainly for pediatric subglottic stenoses [7, 8]. The Boston group mentioned the same single-graft procedure shortly after the burning injury [3], but in both cases re-stenosis developed. In our patient, the distal tracheal stenosis was managed with success 2.5 years after the injury, and the complete glotto-subglottic and upper tracheal stenosis (practically the full length of the upper airway) was also later reconstructed with a similar technique. Besides the timing of the procedure, the size of the graft(s) should be considered because of the expected partial resorption of free grafts in this condition.

Our case demonstrates that re-stenosis of a burn-injured trachea may occur even two years after a thermal injury. A multilevel CCG procedure to dilate the full-length damaged upper airway was successful 2.5 years after the injury. Well-managed and well-timed multiple tracheoplasty could

The distal tracheal re-stenosis was reconstructed through a right-sided thoracotomy (Fig. 2a). The critically narrow site was then found to be 4 cm long, in comparison with 2–3 cm at the first resection. The scarred part of the trachea was opened over a length of 5 cm, and oval-shaped (5 cm×2 cm) rib cartilage (taken from the rib arch) was inserted into the incision and fixed with interrupted absorbable sutures (Vicryl 2-0) to dilate the airway. The tracheoplasty site was covered with an intercostal muscle flap. A long cannula was used as a stent for three months and then replaced by a short one, without re-stenosis.

Following this success, the laryngotracheal part was reconstructed via a collar incision laryngofissure and cricoid laminotomy, and two 6 cm×2–3 cm rib grafts were applied for ‘lumen formation’ by posterior (Fig. 2b) and anterior (Fig. 2c) dilatation of the complete laryngotracheal stenosis. During the same intervention, the middle tracheal segment was expanded with an anteriorly placed 6×2 cm rib graft after longitudinal median incision of the trachea below the tracheostomy site (Fig. 2d). These grafts were secured by interrupted Vicryl 2.0 sutures. The three partially overlapping grafts provided an adequate airway for the larynx, and upper–middle trachea T-tube stenting was used for three months. The control computed tomography scan and tracheo-endoscopy revealed only slight re-stenosis two years after the last procedure (Fig. 1b,d).

3. Discussion

Because of the special etiology, healing of the tracheal wall is very important for the success of any surgical reconstruction or plastic procedure. The Boston group found
be a reliable alternative to tracheal transplantation or techniques based on stem cell technology in these cases.

References


