Reply to the Letter to the Editor

Reply to Leocnini

Giuseppe Cardillo *, Luigi Carbone, Francesco Carleo, Massimo Martelli
Unit of Thoracic Surgery, Ospedale Carlo Forlanini, Azienda Ospedaliera San Camillo Forlanini, Rome, Italy
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We appreciate the great interest expressed by Leocnini [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, Leocnini 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 Leocnini’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 IIa 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 Leocnini’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


* Corresponding author. Address: Ospedale C. Forlanini, Via Portuense 332, 00165, Rome, Italy. Tel.: +39 0658702680; fax: +39 066638734.
E-mail address: gcardillo@sacmilloforlanini.rm.it (G. Cardillo).
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Letter to the Editor

Pore size is significant in hemofiltration

Mert Kestelli, Ismail Yurekli *, Murat Aksun, Ali Gurbuz
Izmir Ataturk Education and Research Hospital, Basin Sitesi, 35360, Izmir, Turkey

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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.

* Corresponding author. Address: 6436 Sok 82/3, Karsiyaka, Izmir, Turkey. Tel.: +90 505 5251202; fax: +90 232 2431530.
E-mail address: ismayurekli@yahoo.com (I. Yurekli).
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