Reply to Huang et al.
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Referring the Letter to the Editor ‘contraindications to percutaneous tracheostomy due to anomaly of aortic arch branches origin and running’ by Huang et al. [1] we think that nothing is impossible! We agree that percutaneous dilatational tracheostomy (PDT) is the procedure of choice and that the surgical option is still valid in particular selected cases, but in general, minimally invasive procedures should never endanger the safety of the patient. There is not a good ideal timing for the execution of a specified tracheostomy yet (ET: early tracheostomy; IT: intermediate tracheostomy, LT: late tracheostomy) [2,3]. There is also the Fantoni trans-laryngeal tracheostomy (TLT) that allows, through maneuver ‘in-out’, to remedy the problem of skin infection [4,5]. In the specific case we described in our article [6], to perform a tracheostomy, it would be needed to perform a surgical repositioning of supra-aortic vessels, but we preferred a conservative approach and at the end an appropriate weaning followed 27 intubation days. Since 1998, in our department, we have been carried out about 617 tracheostomy (403 TLT and 214 PDT) with use of surgical tracheostomy in approximately 10% of cases. Among the major complications we mention a case of death because of decubitus in innominate artery and two tracheal-esophageal fistula (when we routinely used the Fantoni TLT). We conclude by stressing once again that all tracheostomy options, even in very complex cases, are possible but our choice is always minimally invasive procedure (PDT and TLT). We use the surgical approach only in very special selected cases.

We believe that the ideal timing is ‘early tracheostomy’ and that the patient safety is one of the important factors in the choice of the method. In our case the wait-behavior allowed the good solution of the problem without major surgery.

REFERENCES


Lessons from a mathematical hypothesis: modification of the endoventricular circular patch plasty

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Adhyapak and Parachuri [1] present very interesting and important findings with regard to surgical ventricular restoration (left ventricular volume reduction surgery (LVVRS)). An operative mortality of 0% and 100% 2-year survival have to be congratulated in this difficult group of high-risk patients. However, a number of issues need addressing.