**LETTER TO THE EDITOR**

**Post-intubation membranous trachitis after endotracheal intubation**

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We read with interest the paper entitled ‘Spontaneous expectoration of an obstructive fibrinous tracheal pseudomembrane after tracheal intubation’ from Fiorelli et al. [1]. Membranous trachitis is a rare complication after tracheal intubation; however, it may pose several diagnostic and therapeutic problems if misdiagnosed. In particular, both benign tracheal strictures and simple granulation may be erroneously suspected. Direct endoscopic observation may be difficult due either to the presence of the endotracheal tube in place, or, in the case of spontaneously breathing patients, to respiratory distress. Radiological evaluation with computed tomography (CT) may also be difficult for the same reasons.

We have observed this complication in four patients during the last years. In all cases, the intubation time was less than a week long and the suspect of tracheal obstruction was raised on the basis of difficulties to extubate the patient notwithstanding optimal functional parameters. In all patients, inexperienced endoscopists made the diagnosis of fibrous tracheal strictures; in one case, the erroneous diagnosis was confirmed at CT performed with the patient still intubated. All patients were still intubated when they were referred to our unit for a more careful endoscopic evaluation through the rigid bronchoscope, potential initial treatment with mechanical debridement and/or laser, and subsequent tracheal or laryngo-tracheal resection [2]. In all cases, the thick fibrous membranes required careful mechanical debridement to be removed with the tip of the rigid bronchoscope, with the patient under deep sedation and spontaneously breathing; after the removal of the pseudomembranes, a bleeding airway wall was observed. All the lesions were at the level of the tracheal tube cuff. All patients were immediately extubated. Cultures showed the presence of Candida in two cases. After 1 month, fiberoptic bronchoscopy showed complete mucosal healing. This complication should always be suspected when extubation is not possible after short periods of mechanical ventilation notwithstanding adequate functional parameters. Bronchoscopy should be performed by an experienced thoracic surgeon familiar with tracheal disorders; the rigid bronchoscope should always be available for immediate treatment. Spontaneous expectoration is extremely rare due to adhesions with the tracheal wall, as reported by Fiorelli A et al.

**REFERENCES**


**LETTER TO THE EDITOR RESPONSE**

**Reply to Anile et al.**

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