Noninvasive Positive Pressure Ventilation in the Management of Post-thyroidectomy Tracheomalacia

Mayilvaganan Sabaretnam · Anjali Mishra

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To the Editor,

We read with interest the article by Chi et al. [1]. We congratulate the authors for their novel approach to managing post-thyroidectomy tracheomalacia. Tracheomalacia is a rare entity without established management guidelines. Because most of the available literature advocates tracheostomy a morbid procedure for this condition, use of noninvasive ventilation as a method to avoid tracheostomy and to shorten ICU stay seems a welcome change for the patient as well as the surgeon [2–4]. However, we have few comments and queries.

We would like to know the authors' policy for managing tracheomalacia prior to 2009. They mention that, historically, their patients with tracheomalacia were managed with prolonged intubation (~7 days). We wonder whether the intubations were nasopharyngeal or oropharyngeal? Did the authors ever resort to tracheostomy in such situations? Five of six patients mentioned in the article had malignancy with no loss of cartilage rings. Did these patients have a history of longstanding goiter and/or retrosternal extension? What was the average weight of the gland? Finally, because patients require noninvasive

positive pressure ventilation (NPPV) for 2–4 days apart from postoperative intubation for 1–3 days, was there an appreciable decrease in the intensive care unit (ICU) stay? In our opinion the noninvasive approach described by the authors could certainly avoid the morbidity associated with tracheostomy; however, it seemed to require more intense ICU monitoring.

References

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M. Sabaretnam · A. Mishra (✉)
Department of Endocrine Surgery, Sanjay Gandhi Postgraduate
Institute of Medical Sciences, Raebareli Road,
Lucknow 226 014, India
e-mail: anjali@sgpgi.ac.in; anjali_mishra2000@yahoo.com