MODIFICATION IN THE SECOND STEP OF LARYNGOTRACHEOPLASTY: TECHNIQUE FOR TRACHEOCUTANEOUS FISTULA CLOSURE

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INTRODUCTION

Different protocols have been proposed for the management of patients admitted to a laryngotracheoplasty reconstruction. The objective of this study is to present our protocol and propose a surgical technique to close the tracheocutaneous fistula in these patients.

PROCEDURE

Once performed LTP with anterior or anterior and posterior graft or a cricotracheal resection, according to the pattern of the stenosis, the patient is kept under sedation in the intensive care unit for 11 weeks with ventilation by tracheotomy and maintenance of a naso-laryngeal stent. The stent is removed after 7-14 days, depending on the level of involvement in the glottic stenosis, and an endoscopic evaluation to assess the correct position of the grafts is performed in the operating room.

RESULTS: Eight closures were performed in accordance with the technique with no complications in the short and long term. Max FV was 60 cmH2O. The skin incision was performed at the anterior wall of the trachea (Fig.4), then approaching the incision in opposite direction of cartilaginous margins of the trachea (Fig.4), then approaching the incision in opposite direction of cartilaginous margins of the tracheal cartilage adherent to the scar. We close the loss of substance of the anterior tracheal wall. The secondary indication for this surgery is the correction of cosmetic result.

CONCLUSION

Based on our protocol for reconstruction of the stoma, we recommend postponing fistula treatment until the grafts have been well-integrated. The anterior wall has reduced spontaneously, and the traumatic effect of intubation might have contributed. Our method for surgical closure has shown to reduce problems associated with these fragile tracheas.

REFERENCES