Bronchoscopic Closure of Tracheoesophageal Fistulas

To the Editor:

We want to congratulate Dr Green and colleagues [1] for their expertise to deal with this difficult clinical situation.

The use of cardiac septal occluders for closure of airway fistulas has led to two ongoing trials at our institution. One trial for closure of bronchopleural fistulas using a metallic occluder [2]. The second trial for closure of tracheoesophageal fistulas using an alternative model of this device [3].

Although the double-disk metallic septal occluder used by Green and colleagues [1] has good stability after being deployed, it has a high profile, and it protrudes into the lumen of the airway or the esophagus, as demonstrated in Figure 3 of Green and colleagues’ [1] article.

We reported the use of this model of device, the Occlutech Figulla ASD N Occluder (International Occlutech AB, Helsingborg, Sweden) with good results for closing a total bronchopleural fistula [4].

Different from the tracheoesophageal fistulas, the bronchopleural fistula is at the distal portion of the bronchus, so the high profile of the prosthesis is not a problem.

Alternatively, we have used a Gore Helex Septal occluder (W.L. Gore & Associates, Inc, Flagstaff, AZ) for closing a benign tracheoesophageal fistula [5].

Although more work is necessary to establish what is the best way to endoscopically treat these difficult conditions, we would like to congratulate Dr Green and colleagues [1] for their valuable contribution.

We would like to thank Dr Evelinda Trindade for her assistance with the English language.

Miguel L. Tedde, MD, PhD
Helio Minamoto, MD, PhD

Thoracic Surgery Department
Heart Institute (InCor) and Hospital das Clinicas of São Paulo Medical School
05403-900 - São Paulo, Brazil
e-mail: tedde@usp.br

Paulo R. Scordamaglio, MD
Ascedio Rodrigues, MD
Eduardo G.H. Moura, MD, PhD

Respiratory Endoscopy Service
Endoscopy Unit
Hospital das Clinicas of São Paulo Medical School
05403-000 - São Paulo, Brazil

References

Carlos A.C. Pedra, MD, PhD
Catheterization Laboratory for Congenital Heart Diseases
Instituto Dante Pazzanese de Cardiologia
04012-180 - São Paulo, Brazil

References

Dr Pedra discloses that he has financial relationships with AGA Medical USA and W.L. Gore & Associates.

Wondrous Oxygenation During Awake Upper Airway Surgery

To the Editor:

We congratulate Dr Macchiarini and his team to their remarkable article [1]. Their work seems to present the long-desired solution for upper airway surgery.

Fortunately, The Annals of Thoracic Surgery also published the discussion of the presentation during The 45th Annual Meeting of The Society of Thoracic Surgeons in that Dr Lanuti from Boston commented that the respiratory effort is depressed with the described regimen. He also asked if the field was insufflated with oxygen or if the O2 tension in the room was increased. Macciarini’s answer was: “You don’t need to. The only thing that you need to do is to ask the patient to stay awake [. . .] and say, ‘Please breathe deeply,’ and you will see that the trachea moves and takes oxygen from below.”

When deep breathing increases Pao2 then Paco2 has to decrease. In contrast, Table 3 shows that the Pao2 increases intraoperatively during resection and reconstruction from 118 ± 15 mm Hg to 132 ± 9 mm Hg, but Paco2 also increased from 42 ± 5 mm Hg to 58 ± 10 mm Hg. Perhaps the Paco2 values were obtained before, and the Pao2 values after waking up the patients. If these values were measured in the same blood sample, then this relatively elevated Paco2 indicates a pronounced hypoventilation and a simultaneous improvement of oxygenation under such a degree of depressed respiratory efforts is only possible when the Pao2 is increased.

Dr Miguel L. Tedde discloses that he has financial relationships with AGA Medical USA and W.L. Gore & Associates.