of TR, mainly transtracheal endoluminal repair through different-shaped anterior tracheotomies. They consider the endoluminal approach "technically complicated owing to limited accessibility and needs a relatively long tracheal injury and complex ventilation management." We agree with this opinion even though semilateral transverse tracheotomy allows better repair in this field.

However, conservative treatment was not discussed, and we consider that the patient could have been managed as follows: prompt placement of a tube in the left side of the chest, microdrainage of subcutaneous emphysema, and advancement of the endotracheal tube distal to the TR to ensure bridging the lesion and mechanical ventilation, which was required to treat the underlying conditions (atelectasis, delirium).

According to the evidence accumulated in the recent literature and our own experience,²⁻⁵ surgical treatment of postintubation TR leads to higher mortality than does conservative management. In patients managed surgically, the initial indication for which the patient was intubated plays a crucial role in postoperative mortality: among patients who underwent emergency intubation for an acute medical event, surgery is usually a high-risk procedure⁴ as compared with conservative management (mortality rate 47% vs 29%).⁵ Such a high mortality for the repair of TR demands that alternatives to high-risk surgery be considered and surgical repair be reserved for patients in whom bridging the lesion is technically not feasible or for patients with TR diagnosed during thoracic surgery.

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doi:10.1016/j.jtcvs.2008.01.024

Reply to the Editor:

We thank Dr. Conti and associates for their comments on our report.¹ We agree that conservative management could be the best method for the treatment of postintubation tracheal rupture (TR), especially in stable and spontaneously ventilating patients. However, we disagree with their remark that surgical treatment results in a higher mortality rate than conservative or mechanical ventilation in TR. According to reports about experience with surgical treatment based on relatively large series of patients,²⁻⁴ there were no operation-related deaths or complications after surgical treatment for TR. The cause of death in TR was not the surgical treatment but the underlying condition that necessitated intubation. Surgical treatment was also safe for patients in stable condition.

In general, conservative treatment is selected for first-line treatment. However, we cannot conclude that conservative treatment can succeed in all patients on the basis of experience from this small series of patients.⁵ If conservative management fails, subsequent surgical treatment would be more complicated and the chance of mortality would increase. Mechanical ventilation (MV) with bridging or selective ventilation also could be applied in patients unfit for conservative care. However, MV needs complicated management and intensive care, which could induce unforeseen complications. MV requires more medical facilities, cost, and time. Treatment failure with MV is also fatal. Of 14 patients treated by MV in the report by Conti and associates,⁵ 1 patient died suddenly on day 3 after an episode of acute hypoxemia, which might be a complication of TR, and 2 patients could not survive despite delayed surgical treatment. Surgical treatment has some advantages over conservative treatment or MV. It is definitive and safe treatment. The success rate

is also high. The duration of treatment is relatively short. A weak point is the invasiveness. However, this could be minimized with various less invasive approach methods such as our method. It is apparent that conservative treatment can be the first choice in patients who are in stable condition and breathing spontaneously after TR according to the experience of recent literature and Conti's work. However, physicians should be able to select the best method and offer tailored treatment for each patient on the basis of clear knowledge about advantages and disadvantages of each treatment modality because TR mostly develops in complicated situation and the failure of the treatment might be fatal. The patient in our report¹ was not suitable for conservative treatment because she was not in stable condition and spontaneous ventilation seemed impossible. We thought that more definitive treatment and a shorter duration of treatment would be better for this elderly patient in poor condition. We already had enough experience with tracheal surgery and confidence about surgical outcome. We selected to use surgical treatment as the treatment of choice.

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doi:10.1016/j.jtcvs.2008.02.031