and the total deaths of the no-LVAD group resulted from a follow-up of 19 years. Hence, it is not surprising that, in terms of death counts, the initial 30 days in the LVAD group included a much higher percentage of total deaths than in the no-LVAD group; this is simply because 30 days weigh much “more” in comparison to 6 years than in comparison to 19 years.

Thus, we welcome a re-presentation of this important finding, in the manner we have mentioned above, no matter if the new *P* value will remain, as we expect, far from the level of statistical significance.

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Reference

1. Cleveland JC, Grover FL, Fullerton DA, Campbell DN, Mitchell MB, Lindenfeld J, et al. Left ventricular assist device as bridge to transplantation does not adversely affect one-year heart transplantation survival. *J Thorac Cardiovasc Surg.* 2008;136:774-7.

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Reply to the Editor:

We thank Drs Messori and Trippoli for their interest. They have critically examined our statistical methods regarding early deaths (30 days) following cardiac transplantation with and without left ventricular assist devices (LVADs). From a purely statistical argument, they are correct: as the LVAD group had shorter follow-up, 30 days provided a greater influence in 6 years versus 19 years of follow-up. Upon reanalysis with the “traditional presentation,” of the 294 no-LVAD subjects, 23 (8%) died early. Of the 23 LVAD subjects, 4 (17%) died early. This difference was indeed, not significant (*P* = .11).

As clinicians, we believe that important observations can be learned from our reported experience.¹ Although we acknowledge this important statistical correction, we do not believe that transplantation with an LVAD is the

same operation as transplantation without an LVAD. Our bedside observations in caring for these patients have indicated that when patients transplanted from an LVAD develop problems, these problems often occur early in the posttransplant period. This occurrence likely reflects the surgical complexity of explanting the LVAD. Our primary finding of this report—no difference exists in 1-year survival after heart transplantation with or without LVAD—stands.

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Reference

1. Cleveland JC, Grover FL, Fullerton DA, Campbell DN, Mitchell MB, Lindenfeld J, et al. Left ventricular assist device as bridge to transplantation does not adversely affect one-year heart transplantation survival. *J Thorac Cardiovasc Surg.* 2008;136:774-7.

doi:10.1016/j.jtcvs.2008.12.002

NONOPERATIVE MANAGEMENT OF AN EXTENSIVE TRACHEAL INJURY IN AN 860-g PRETERM NEONATE

To the Editor:

We read with great interest the report of Denlinger and colleagues¹ on nonoperative management of large tracheal injuries in adult patients. Neonatal airway complexities are extremely rare and are usually associated with congenital tracheal stenosis rather than iatrogenic complications. Due to the neonate's tracheal diameter, injuries in neonates most commonly occur in the subglottic anterior wall or cricothyroid junction in contrast to the common posterior wall injury in adults. Because the management decisions in our patient were extrapolated from the experience with older patients, Denlinger and associates¹

article is an excellent segue to share an extremely rare complication of an iatrogenic posterior wall tracheal injury in a premature neonate from orotracheal intubation.

A preterm neonate born spontaneously at 25 3/7 weeks of gestation, weighing 860 g and measuring 33 cm, had been orotracheally intubated for respiratory failure. The infant had worsening failure with progressive bilateral pneumothoraces and a pneumomediastinum and was transferred to our institution. Chest roentgenogram (Figure 1) showed the distal portion of a 2.5-mm endotracheal tube below the diaphragm. Bronchoscopy revealed the entire membranous and a portion of the cartilaginous trachea to be disrupted at the carina for nearly two-thirds the total tracheal circumference. The endotracheal tube was positioned 1 cm above the injury, and low-pressure ventilation was provided until the patient was initially extubated 36 hours later before being reintubated several days later. Pleural drains were placed and broad-spectrum antibiotics were continued for 28 days. Repeat bronchoscopy at 9, 12, and 20 days revealed progressive healing without evidence of stenosis. There was never evidence of mediastinitis, and the mediastinal emphysema resolved. Twenty days after initial presentation, a persistent patent ductus arteriosus contributing to pulmonary overcirculation was ligated. Surgery was uneventful via a left posterolateral thoracotomy with normal-appearing mediastinal anatomy. The neonate was discharged at 118 days of age.

There are no recommendations for membranous and/or cartilaginous tracheal injuries in premature neonates. In older individuals, the literature supports a conservative nonoperative management strategy with good results for membranous injuries with less optimal outcomes for cartilaginous injuries.² However, tracheal surgery has significant risk and morbidity in extremely low-birth-weight premature