

## Authors' Response

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Dear Editor,

We thank Dr. Amore *et al.* for the comments [1], and suggestions that allowed us to discuss “The surgical approach of late-onset tracheoesophageal fistula in a tracheostomized COVID-19 patient”, published in Monaldi Archives of Chest Disease by our group [2]. Amore *et al.* suggest an alternative surgical treatment of tracheoesophageal fistula (TEF) in mechanical ventilator-dependent patients, performing a complete cervical tracheal transection, fol-

lowed by direct esophageal fistula repair and subsequent direct repair of the tracheal defect without resection; they treated two women with this technique, performing in both patients a tracheostomy at the end of the surgical procedure followed by placement of a permanent Montgomery T tube [3]. The authors concluded that their technique may be a viable alternative to standard treatment of TEF. We agree with them about their surgical approach; however, in our opinion, their described technique may be helpful in selected cases, as well as in mechanical ventilator-dependent patients or when the segment of trachea to resect is too long.

In our case, we scheduled a standard surgical procedure according to the Grillo technique [4], following a multidisciplinary board discussion, because the tracheostomized post-COVID-19 patient was in spontaneous breathing before surgical treatment. The patient's good pre-operative conditions allowed us to plan a standard surgical treatment of TEF without performing a post-operative tracheostomy. According to the literature, the standard procedure proposed by Grillo and validated by Mathisen [4,5], based on one of the largest cases of treated patients in the world, remains the procedure of choice for TEF repair. The advantages of the Grillo technique include excellent visual access to the fistula and a very low risk of tracheal devascularization. Therefore, they suggest that post-operative tracheostomy should be generally avoided after surgical treatment of TEF [5]; likewise, they recommend early extubation to reduce post-operative difficult-to-treat complications.

However, in our specific case, anesthesiologists were unable to wean the patient from mechanical ventilation at the end of the surgical repair of TEF. This unexpected post-operative complication, which occurred at the time of extubation in the intensive care unit, was managed by placing the orotracheal tube cuff distally to the tracheal suture, taking care to maintain low cuff pressures. The patient was extubated on post-operative day 15, fortunately without any complication and no need for tracheostomy or intratracheal devices.

In our opinion, every single case must be assessed individually by a multidisciplinary board. The Grillo technique remains the gold standard of treatment [4,5]; even though pre-operative ventilator dependence should not be considered an absolute contraindication to the surgical closure of the fistula [6], according to the Grillo procedure, other techniques can be considered in selected cases.

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Key words: tracheoesophageal fistula, COVID-19, tracheal resection and reconstruction, prolonged mechanical ventilation, esophageal repair.

Contributions: all authors have significantly contributed to the paper and have read and approved the final version of the manuscript and agreed to be accountable for all aspects of the work.

Conflict of interest: the authors declare no conflict of interest.

Ethics approval and consent to participate: not applicable.

Patient consent for publication: not applicable.

Availability of data and materials: all data underlying the findings are fully available.

Funding: none.

Received: 18 October 2023.

Accepted: 2 November 2023.

Early view: 9 November 2023.

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Monaldi Archives for Chest Disease 2024; 94:2826

doi: 10.4081/monaldi.2023.2826

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