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Letter to the editor

Reply to 'CORONA-steps for tracheotomy in COVID-19 patients: A staff-safe method for airway management' by Ferreli F. et al.



Dear Editor,

We sincerely appreciate the interest of Ferreli et al. in our study and we are grateful for the invaluable comments and feedback which have allowed us to respond with some clarifications [1].

The reply of Ferreli et al. is merely focused on the timing of the tracheotomy, which actually is a marginal aspect of the editorial letter by Pichi et al. [2]. Indeed, the intent of the publication was to provide information to safeguard the operators performing tracheotomy.

Ferreli suggested a delay in tracheotomy or avoiding it based on the evidence in the literature. However, to date, no evidence-based suggestions about the best timing for tracheotomy in COVID-19 patients have been published in literature. In fact, there are no retrospective studies, randomized studies, or meta-analyses on this specific topic; but only expert opinions papers, which are not supported by unequivocal data.

To date, the most convincing paper remains the systematic review published by Adly et al. [3] in 2018 who took into account 43 studies with a total number of 222,641 patients, showing that early tracheostomy (performed within 7 days from oro-tracheal intubation) reduces the clinical complications (i.e. aspiration pneumonia, bacteremia, septic shock, multisystem organ failure), the mortality rate as well as the length of stay in intensive care unit (ICU).

Ferreli et al. however, support the 'late tracheotomy' thesis (14 days or later after intubation) using the manuscript published by Givi et al. [4] which is not referring to a contemporary case series, but uses data published before the COVID-19 spread and in particular the one published by Young et al which includes merely 1032 cases [5]. This study considered 'early tracheotomies' as those performed within 4 days of critical care unit admission and 'late tracheotomies' as those placed on day 10 or later. Furthermore, their conclusions are limited to the findings of 'no difference in terms of mortality and other complications between early and delayed tracheotomy'.

In addition to this, Ferreli et al. support their personal thesis claiming that in a recent retrospective study including 1591 COVID-19 positive patients admitted to the ICU, the median length of ICU-stay was only 9 days (range: 6–13). However, it should be noted that at the last follow-up, 58% of the patients were still admitted in the ICU and consequently the statistical analysis is not representative of the whole sample [6].

Finally, Ferreli et al. cited the experience of a center reporting that no tracheotomies have been performed without any data supporting their thesis (complication rates, intubation duration, ICU median stay, mortality). Even less clear is the cited reference between medulla oblongata involvement, COVID-19 infection and tracheotomy timing [7].

Having said that, given that the COVID-19 pandemic puts us in a pathless and convulsive situation, in which things change very quickly, and in the absence of reliable data, where what is considered true today can be denied by new facts tomorrow, pending new facts it is worth taking into account the older.

Declaration of Competing Interest

The authors declared that there is no conflict of interest.

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