

Tracheal stenosis and keloid scar

Estenosis traqueal y cicatrización queloide

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Mr. Editor,

The frequency of tracheal stenosis after orotracheal intubation varies between 10% and 22%, depending on the consulted series; however, severe stenosis occurs in only 2% of cases¹. Keloid or hypertrophic scarring, which has an incidence of between 4 and 16% in the Mexican population, is a recognized risk factor for tracheal stenosis that often goes unnoticed². With the idea of highlighting this serious complication, we present a prototype case.

A 27-year-old woman with a history of the previous intubation for 9 days secondary to a suicide attempt 21 months earlier was admitted to hospital for stridor and dyspnea with a 34-week pregnancy complicated by symptomatic preeclampsia. During her evaluation, subglottic stenosis with 5-mm airway caliber was corroborated by neck computed tomography (Fig. 1); radiological evaluation included the thoracic surgery department. On physical examination, multiple keloid scars on forearms from self-inflicted injuries stood

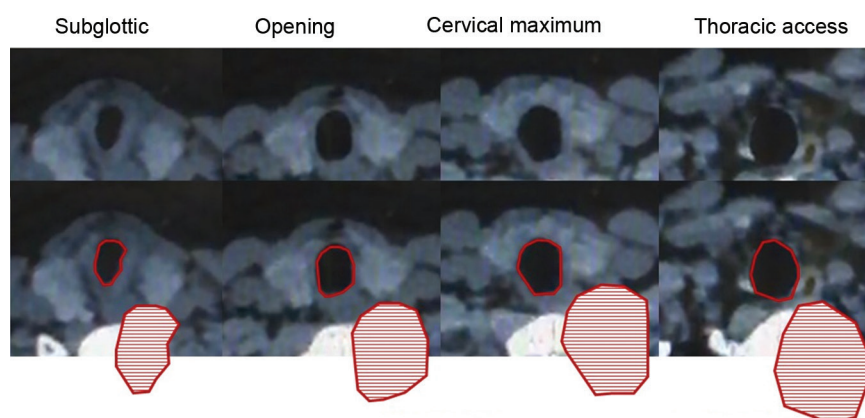


Figure 1. Tracheal diameters comparison. Tracheal, subglottic stenosis, sudden 40% opening of effective thoracic diameter, and 50% of cervical diameter.

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out. Due to her obstetric condition, emergency cesarean section was performed after securing the airway by tracheostomy. Patient evolution was uneventful and she was discharged to continue follow-up on an outpatient basis and to schedule elective tracheoplasty. The biopsy report ruled out other pathologies.

Due to its frequency, keloid scarring identification should be taken into account by all physicians involved in airway management to try to avoid orotracheal intubation with laryngeal cannulae³. When this is not feasible, the goal will be to remove the orotracheal cannula as early as possible^{4,5}.

Conflicts of interest

The authors declare that there are no conflicts of interest.

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