Letters to the Editor

Postextubation dysphagia in critically ill trauma patients. Are necessary new screening methods? Some practical comments

To the Editor:

Reintubation after extubation in trauma patients is associated with prolonged mechanical ventilation (MV), hospital and intensive care unit stays, and high risk of aspiration pneumonia.1 In this association, postextubation dysphagia (PED) and swallowing difficulties are key factors.2 However, studies published have shown variable rates, methodology bias, and overall very low quality of evidence.3

We have read that Kwok et al4 described an observational series in trauma patients whose PED was 42% (3% to 62%). This interesting study confirms some previous observations and clinical implications in PED. However, some aspects need clarification.

First, Kwok et al4 enrolled patients with low levels of neurologic function using Glasgow Coma Score at admission and this can influence the rate of PED. It is remarkable that the patients included in the study had moderate damage to head and neck. Patients with neurologic or major damage required prolonged MV and high risk of PED and this difficult extrapolation with other series.5 Also, this influence of low mortality was reported (1 and 270 times) to be lower than in other studies in the same field as MV. Finally, the use of index severity score or Glasgow Coma Score is not related directly to dysphagia. How authors evaluated these aspects need clarification.

Second, association of age and PED needs evaluation. The maximum age of the patients included is 64 years; it is possible that if older patients were included this rate would be more frequent.5,6

Third, diagnosis assessment of dysphagia diagnostic method as silent aspiration has proved to be less sensitive and specific than other instrumental tests and probably underestimates the existence of patients with dysphagia. Additionally, (1) did not include a dysphagia severity scale; (2) excluded patients undergoing MV for less than 24 hours; (3) information time for recovery dysphagia;7 and (4) implications of cough is a reliable sign of swallowing disorder, how authors interpreted this aspect in silent aspiration and contraindicates oral feeding.8 Authors reported that a silent aspiration was found in 37% of patients with PED.

Fourth, the rate of aspiration pneumonia needs evaluation. They provided an infectious complication rate in patients diagnosed with PED, but only reflect 2 cases of “aspiration pneumonia” (not defined what it considers as such). Nor do we know the total number of infection respirators PED group (aspirational or not aspirational) and we cannot compare it with the group not diagnosed with dysphagia. It is very interesting that after the implementation of PED screening protocol, there was a significant low incident of infectious complications; it would be relevant to know what kind of strategies they implemented after PED diagnosis, including dysphagia therapies, time to initiate oral feeding, and so on. They comment that after the diagnosis of dysphagia was made 55% patients were kept nil per os, while the rest were started on a modified diet without further evaluation. How was it determined if oral diet was beginning or not? When did they re-evaluate the presence of dysphagia?9

We consider that further prospective large studies are needed to clarify and evaluate implications of silent POD and implications to outcomes in trauma patients, as well as to determine if it is necessary to implement other screening methods in high-risk patients.

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We may question but cannot abandon mesh repair for inguinal hernias

To the Editor:

I have read with great interest the article entitled “Hernia repair: why do we continue to perform mesh repair in the face of the human toll of inguinodynia?” by Professor Fischer. He wrote an outstanding article including not only the principles of Lichtenstein repair and treats the nerves delicately. Unfortunately, many young surgeons today do not appreciate the importance of anatomy knowledge properly in the era of open mesh repair, which seems to be a superficial and very easy surgical procedure. Yet a little effort can make meaningful contributions to the young colleagues’ anatomy knowledge and competence about inguinal nerves. Professor Fischer’s article will create a great awareness on colleagues after a careful reading, and the kingdom of mesh repairs may be discussed again. Nevertheless, a definitive proposal like “Mesh repairs should be abandoned and the transversalis or Shouldice repair be adopted” still seems to be a bit strongly worded. The author compiled the data about both prophylaxis and treatment of inguinodynia by employing selective or triple neurectomy, however, did not investigate the comparison of open mesh repairs and Shouldice operation regarding chronic pain thoroughly.

Open mesh repairs and Shouldice operations have been compared many times, but a well-designed clinical comparison regarding postoperative clinical pain is rare. There is only one randomized clinical study in the literature in favor of Shouldice operation which reported that it resulted in a slightly lower rate of chronic pain than Lichtenstein repair has (4.2% vs 56%); however, 2 patients with severe pain were in the Shouldice group. A German study revealed that chronic pain and physical strain correlated pain somewhat more frequently after Shouldice repair in comparison with Lichtenstein repair. Swedish and Danish Hernia Data Base made a comparison of open mesh and nonmesh techniques in 2004 and stated that there was no difference in the chronic pain rates. A recent Cochrane Database Systematic Review also revealed that the recurrence rate with Shouldice repair is higher than mesh repairs,