Predictors of difficulty in bedside percutaneous dilatational tracheostomy: pilot study

Preditores de dificuldade em traqueostomia percutânea à beira do leito: estudo piloto

INTRODUCTION

Percutaneous dilatational tracheostomy (PDT) is now one of the main procedures performed in an intensive care unit (ICU). Technological evolution has been able to transform the tracheostomy, formerly feared and prohibited\(^1\), into a procedure performed with a percutaneous technique outside the operating room environment. Despite being an elective procedure, with low complication rates\(^2,3\), the technique involves handling the airway of a critical patient, and failures in this management can be fatal\(^4\). However, there are no well-defined indicators of technical difficulty for the performance of PDT. Drawing a comparison with the procedure of orotracheal intubation and mainly with the predictors of difficulty to perform it, the lack of equivalent parameters when carrying out PDT is noteworthy.

Although the occurrence of complications related to PDT is uncommon\(^4\), significant adverse events are described, mainly related to injuries in structures adjacent to the trachea, such as the vascular network, with consequent hemorrhage or failure to insert the tracheal cannula\(^5\), with impaired patient ventilation. It is also worth remembering that, despite being a controlled environment, the intensive care unit is not routinely prepared for critical complications that may occur during surgical procedures\(^5,7\).

In the current literature, there is a great relativization of the contraindications for the percutaneous tracheostomy technique, and clinical practice is directed to the individualization of cases. Several factors, mainly anatomical, can cause difficulties, such as kyphosis, scoliosis, tracheomalacia, tracheal calcification, anatomical variations, airway deviations for various reasons, obesity, among others\(^4,8\). Based

ABSTRACT

Introduction: percutaneous dilatational tracheostomy is currently one of the main procedures performed in an intensive care unit (ICU). However, there are no well-defined indicators of technical difficulty in performing the procedure. Objectives: to define predictors of difficulty in performing bedside percutaneous dilatational tracheostomy. Methodology: prospective cohort study encompassing 21 patients who underwent bedside percutaneous dilatational tracheostomy in the ICU at a single center. Results: Sternohyoid (SH) distance shorter than 7 cm is associated with a 50% increase in the risk of technical difficulty (OR 0.44 and p <0.03). Conclusion: the reduction in (SH) distance is related to an increased risk of difficulty in performing percutaneous dilatational tracheostomy in the ICU bed.

Keywords: Tracheostomy. Airway Management. Intensive Care Units.
on this premise, we propose to analyze the patients’ intrinsic factors that may cause difficulties in performing PDT. With established predictors, it will be possible to avoid catastrophic procedures in the ICU and redirect these patients to the operating room, with structured apparatus to perform the procedure, usually using the conventional open surgical technique.

**GOALS**

To define predictors of difficulty in performing percutaneous dilatational tracheostomy.

**METHODS**

This is an observational prospective cohort study, in which we included 21 patients who underwent bedside percutaneous dilatational tracheostomy in the ICU at a single center.

A trained head and neck surgeon, with experience in PDT, performed the procedure. In all cases, the tracheostomy was guided by bronchoscopy (performed by a bronchoscopist or another head and neck surgeon trained in bronchoscopy). All procedures were performed in the ICU bed.

We collected data on age, sex, obesity, time of orotracheal intubation, size of the orotracheal cannula, sternohyoid (SH) distance, sterno-cricoid (SC) distance, presence of calcified trachea, tracheomalacia, thyroid goiter, and palpable trachea (Table 1).

The head and neck surgeon determined the presence of obesity, thyroid goiter, tracheomalacia and calcified trachea by clinical evaluation.

We measured the sternohyoid (SH) and sterno-cricoid (SC) distances with a flexible ruler, in a straight line, with the patient in horizontal supine position, in cervical hyperextension (Figure 1) (Figure 2).

We considered a difficult procedure the one displaying at least one of the following items: prolonged time; more than one tracheal puncture; dilation difficulty; and difficulty of the procedure referred by the surgeon.

We collected data on complications related to the procedure until the seventh postoperative day.

We used the REDCap software for the collection and management of clinical data.
Statistical analysis

We entered the data into the Stata IC v16 for Mac software.

We performed univariate analysis by logistic regression of all variables collected, to verify association with the outcome. The variables with p<0.20 were selected for multivariate analysis.

We then performed a multivariate analysis by logistic regression, and chose the best model using the technique described by Hosmer and Lemeshow - Purposeful selection of covariates. We considered associations with p<0.05 as statistically significant.

RESULTS

We included 21 patients, with a mean age of 60 years, 16 (76%) of whom were male, and 5 (24%), female. The mean time of orotracheal intubation was 14
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days (Table 1).

During follow-up, only two patients displayed complications in the first seven days, both having postoperative bleeding without clinical repercussion and without the need for surgical re-approach, resolved with a compressive dressing. There were no reports of other complications.

Age, sex, time of orotracheal intubation, obesity, thyroid goiter, tracheomalacia and calcified trachea did not present a statistically significant association with the difficulty of the procedure, either by univariate or by multivariate analysis.

The SH distance had no statistically significant association by univariate analysis. However, in the multivariate analysis it was a predictor of reduction in difficulty, and SH distance shorter than 7 cm increased the probability of difficulty by 50% (OR 0.44, p<0.03) (Graphic 1).

The other variables displayed no significant association. However, due to the reduced sample size, it is not possible to exclude them as predictors. We believe that SC distance is also an important predictor and we are expanding the study to include more patients and other centers. Another limitation was the subjective analysis of some variables based on the surgeon's assessment (obesity, goiter, tracheomalacia and calcified trachea). Despite being subjective, these variables were determined by a specialist in head and neck surgery and were chosen to increase the feasibility of the study, since the patients were clinically severe and, ideally, diagnostic procedures should not be added.

Current literature on the subject is scarce. There are no predictors of difficulty in PDT and the contraindications for it vary between different authors3,8,11,12. Tracheostomy is a routine procedure in intensive care units and its performance has been increasing over the last decades in parallel with the increased use of mechanical ventilation and the longer survival of critically ill patients2,11,13.

Despite the low rate of complications associated with the method11, complications during the performance of the tracheostomy can cause death. The complications most frequently associated with the procedure are hemorrhages and failure to insert the tracheostomy cannula8.

Finding predictors for percutaneous tracheostomy is essential to minimize fatal risks. Patients with an SH distance of less than 7 cm are at increased risk for difficulty and, therefore, the attending team should consider preparing for the eventual conversion to open surgery. In addition, all tracheostomies performed in this study were guided by bronchoscopy, and for this reason, we consider it appropriate to use a method to guide the procedure (ultrasound or bronchoscopy), especially for patients with reduced SH distance.

CONCLUSION

Short SH distance is related to an increased risk of difficulty in performing bedside percutaneous dilatational tracheostomy at the ICU.
INTRODUÇÃO: a traqueostomia percutânea é hoje um dos principais procedimentos realizados em unidade de terapia intensiva (UTI). Não há, contudo, indicadores bem definidos de dificuldade técnica na realização do procedimento. **Objetivos:** definir preditores de dificuldade para realização de traqueostomia percutânea.

**Metodologia:** estudo de coorte prospectivo no qual foram incluídos 21 pacientes submetidos a traqueostomia percutânea à beira do leito, na UTI, em um único centro. **Resultados:** distância EH menor que 7 cm está associada a aumento de 50% na chance de dificuldade técnica (OR 0,44 e p<0,03). **Conclusão:** a redução da distância EH está relacionada com aumento do risco de dificuldade em realizar a traqueostomia percutânea à beira do leito, em UTI.

**Palavras chave:** Traqueostomia. Manuseio das Vias Aéreas. Unidades de Terapia Intensiva.

REFERENCES


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