**Laryngotracheoplasty in a low birth weight preterm newborn**

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**INTRODUCTION**

Stenosis is undoubtedly the most severe and most feared of airway injuries caused by endotracheal intubation. Retrospective studies have reported incidences of post-intubation subglottic stenosis in neonates ranging from 0.6 to 8.9%. For laryngologists, stenosis of the larynx is one of the most challenging and complex conditions to treat. Management of subglottic stenosis in neonates remains controversial in spite of several therapeutic options.

**CASE REPORT**

A female patient with a gestational age of 29 weeks and weight at birth of 1,035 g required endotracheal intubation at 10 hours of life due to sustained apnea. Endotracheal intubation was in place for three days. At 22 days of life, the patient was again intubated because of apnea. Eight days after removal of the endotracheal tube the patient presented tachypnea and a biphasic stridor. Direct laryngoscopy revealed a grade 2 (Myer-Cotton) subglottic stenosis (Figure 1-A).

Laryngotracheal reconstruction was the treatment of choice. At this point the patient was aged 1 month and 16 days of life, and weighed 1,670 g. Endotracheal intubation was done instead of tracheostomy. The patient was placed in a supine position that extended her neck, the surgical site of a tracheostomy. The patient was placed in a prone position with the perichondrium facing the anterior wall of cartilage, the posterior wall of cartilage was also opened.

The graft was prepared and placed first on the posterior wall with its perichondrium facing the anterior wall. A Penrose tube was placed and the wound was closed. The patient remained intubated postoperatively; direct laryngoscopy on the seventh postoperative day showed a good laryngeal lumen (Figure 1-B). The tube was removed and the patient had no respiratory dysfunction.

The patient was discharged 20 days after the procedure; at this point she weighed 2,090 g. Revision direct laryngoscopies on the 1st and 3rd months postoperatively showed that there was no stenosis. The patient currently is aged 3 years and is symptom-free.

**DISCUSSION**

We reported the case of a neonate weighing less than 2 Kg that presented subglottic stenosis; from our perspective, the choice of treatment for a safe airway was laryngotracheal reconstruction or tracheostomy until the child achieved more weight and age.

Until the 1950s, tracheostomy was the only treatment described for subglottic stenosis. Cotton argued that tracheostomy was the procedure for keeping the airways safe in neonates with subglottic stenosis until they achieved more weight and grew to withstand reconstructive surgery. However, tracheostomy in neonates is risky because the cannula gauge is very small, and there is a high possibility of obstruction due to secretions. Furthermore, because of poor social and economic status among the population seen at public hospitals in Brazil, management of children with tracheostomy at home may be very difficult.

There are few published papers on the surgical management of subglottic stenosis in neonates and lactating infants.

Agrawal et al reported their experience with laryngotracheal reconstruction in 37 children aged from 3 to 66 months; the mean stenosis grade in these cases was 2.5. The authors did not report the mean weight of the subjects. Their reported rate of surgical success was 89%.

Triglia et al reported their experience of 141 surgeries to treat subglottic stenosis in infants; the procedures included the anterior cricoid split procedure, laser surgery, laryngotracheal reconstruction, and laryngotracheal resection. Their sample had no children under 2 Kg. Their general success rate was 94%.

We chose to carry out laryngotracheal reconstruction in the case, even though we found no published reference on children with such a low weight. This choice was made because of the risks of tracheostomy in this patient.

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