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Damon C. Scales; Niall D. Ferguson

JAMA. 2010;303(15):1537-1538 (doi:10.1001/jama.2010.462)

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Early vs Late Tracheotomy in ICU Patients

Damon C. Scales, MD, PhD

Niall D. Ferguson, MD, MSc

ENDOTRACHEAL INTUBATION IS THE MOST COMMON procedure for airway control for patients requiring mechanical ventilation. Extubation is performed once patients have improved so that mechanical ventilation can be discontinued. For patients who require prolonged mechanical ventilation, replacement of the endotracheal tube with a tracheotomy is often considered. The most common reason for tracheotomy insertion in the intensive care unit (ICU) is to provide access for prolonged mechanical ventilation. From observational data, between 6% and 11% of mechanically ventilated patients receive a tracheotomy after a median of 9 to 12 days; however, there is significant variability around both patient selection and timing.¹⁻³

Tracheotomy practice is variable in large part because what constitutes prolonged mechanical ventilation (ie, the optimal timing for tracheotomy) is not known.⁴ Defining and predicting the need for prolonged ventilation has been a major methodological challenge. Research on tracheotomy timing involves evaluating a 2-part study question. First, is it possible to prospectively identify patients who will require prolonged mechanical ventilation and could potentially benefit from tracheotomy? Second, does tracheotomy actually provide benefit for these patients? The key challenge is to avoid performing tracheotomy on patients who are close to extubation (ie, an unnecessary procedure) or who are not likely to survive (ie, a futile procedure), and instead find patients who might benefit.

The anticipated benefits of tracheotomy for patients undergoing prolonged ventilation include improved patient comfort due to reduced oropharyngeal and laryngeal stimulation (and possibly less damage to the larynx), which may in turn reduce sedation requirements and possibly delirium. These and other posited advantages, including improved pulmonary toilet and decreased resistance to breathing, might accelerate weaning from mechanical ventilation, decrease the risk of ventilator-associated pneumonia (VAP), and perhaps shorten the duration of mechanical ventilation. Thus, early tracheotomy in place of longer-term oral endotracheal intubation could conceivably lead to desirable downstream effects including shorter ICU and hospital stays, reduced costs, or even lower mortality. The problem with routinely performing tracheotomy early is that some patients who do not require tra-

cheotomy undergo an unnecessary procedure. In addition, the presence of a tracheotomy may convey a sense of greater medical vulnerability and need, and could result in such patients being transferred to long-term care facilities, when this otherwise might have been avoided.^{1,2}

In this issue of JAMA, Terragni and colleagues⁵ report the results of a trial of tracheotomy timing from 12 Italian ICUs in patients with ongoing severe respiratory failure 24 hours after intubation. Of 600 patients studied, 419 did not significantly improve or worsen according to standardized criteria evaluated 48 hours after enrollment. These patients were randomized to receive percutaneous tracheotomy after 6 to 8 days (early group) or after 13 to 15 days (late group) of laryngeal intubation. The primary endpoint was development of VAP; there was a statistically nonsignificant trend toward a reduction in VAP with early tracheotomy. However, even if this trend were real (and the trial was underpowered to confirm it), the clinical benefit would appear small; earlier tracheotomy was not associated with reductions in mortality (at 28 days or 1 year) or hospital length of stay.

Although it may be seen as largely negative, this study is important and has several strengths. It is the largest published trial to date to evaluate tracheotomy timing. Monitoring for VAP was standardized and assessed by blinded adjudicators in an effort to minimize ascertainment bias. Compared with previous trials, the algorithm used to predict which patients would require prolonged mechanical ventilation was explicit, stepwise, and reasonably accurate. This is important because the inability to predict which patients will require ongoing mechanical ventilation has led to the premature termination of some trials,⁶ whereas unclear patient selection processes have limited the generalizability of others.⁷ Even in the current trial by Terragni et al,⁵ many of the randomized patients (31% in the early group and 43% in the late group) did not undergo tracheotomy. The reasons they did not were evenly split between actual or impending extubation vs actual or impending death. This reinforces the point that a strategy of early tracheotomy is inevitably a strategy of more vs fewer tracheotomy procedures.

This trial supports the findings of previous studies and meta-analyses suggesting that earlier tracheotomy is unlikely to reduce mortality.^{8,9} Even though ventilator-free days

Author Affiliations: Department of Critical Care Medicine, Sunnybrook Health Sciences Centre, Toronto, Ontario, Canada (Dr Scales); Institute for Clinical Evaluative Sciences, Toronto, Ontario Canada (Dr Scales); Department of Medicine, Division of Respiriology, University Health Network and Mount Sinai Hospital, Toronto, Ontario, Canada (Dr Ferguson); and Interdepartmental Division of Critical Care Medicine and Department of Medicine, University of Toronto, Toronto, Ontario, Canada (Drs Scales and Ferguson).

Corresponding Author: Niall D. Ferguson, MD, MSc, Mount Sinai Hospital, 600 University Avenue, Ste 18-206, Toronto, ON, M5G 1X5, Canada (n.ferguson@utoronto.ca).

See also p 1483.

and ICU-free days (but not hospital stay) were both improved, these endpoints are difficult to interpret and are less important when mortality or overall costs are not reduced. Other researchers have shown that cost savings for reduced ICU length of stay are small, especially if hospital length of stay is unchanged.¹⁰ This trial also suggests that tracheotomy timing does not affect the use of long-term care, at least in the Italian health care system; similar numbers of patients in each group required long-term care after hospital discharge. This finding suggests that previous observations of increased long-term care use by patients who had undergone tracheotomy are more likely associations by indication, rather than causal.^{1,2}

However, the effects of tracheotomy timing on resource use in other health care systems, including the United States in which long-stay ICU patients are frequently transferred to dedicated weaning facilities, is unclear. In the United States, it is possible that the health care system may contribute to the use and timing of tracheotomy. For instance, patients who are ventilated for 96 hours and also have a tracheotomy, are assigned a high-paying diagnosis-related grouping (003 and 004, formerly 483).¹¹ This raises the possibility that an unintended consequence of current compensation schemes may be to create an incentive for performing earlier tracheotomies (ie, on or around day 4 of mechanical ventilation). Given the documented differences in resource use across health care systems for other aspects of critical care,¹² these and other questions related to tracheotomy use remain interesting topics for future research.

Early tracheotomy may be associated with other benefits, such as improved patient comfort, that were not measured by this trial. Clinical experience supports this contention, but objective data have been inconsistent.^{6,13} Thus, if the only remaining benefit of earlier tracheotomy might be improved patient comfort, but the procedure does not reduce VAP, hospital length of stay, or mortality, these factors need to be weighed against procedural risks and other disadvantages. In the trial by Terragni et al,⁵ 39% of patients had procedural complications, although these were mostly minor and none were fatal. However, there is a well recognized but infrequent incidence of serious complications from the procedure, including tracheoinnominate artery fistula, posterior tracheal perforation, and death.^{14,15}

Perhaps the most important finding from the study by Terragni et al⁵ is that despite best efforts to predict which patients will require prolonged mechanical ventilation, many patients were successfully managed without tracheotomy. This creates a compelling argument for waiting at least 2 weeks to be certain that a patient has an ongoing need for mechanical ventilation or assistance with pulmonary toilet before proceeding to tracheotomy. The recently completed but as yet unpublished TracMan trial,¹⁶ in which 900 patients were randomly assigned to tracheotomy within 4 days vs after 10 days, may provide additional information to guide clinical decision making; preliminary communications suggest the results will be congruent with those of Terragni et al.⁵ Future research might establish whether other patient groups would benefit from the procedure, such

as patients with spinal cord injuries or head injuries who require little or no assistance from the mechanical ventilator yet still require airway protection or pulmonary toilet, or patients who have failed an attempt at primary extubation.

The study by Terragni et al⁵ in this issue of *JAMA* represents an important contribution to caring for mechanically ventilated patients. Their algorithm for predicting which patients will require prolonged mechanical ventilation is a step forward, and could be adopted into clinical practice to help with prognostication. The findings also serve as a reminder that in the complex arena of randomized controlled trials in the ICU, correctly defining the target population is equally important as ensuring other key markers of methodological quality. This trial should convince clinicians that routine early tracheotomy most likely will not lead to reduced VAP, shorter hospital stay, or lower mortality. Most importantly, it shows that performing tracheotomy for perceived weaning failure must be tempered by the knowledge that many patients will improve with additional time. Sometimes physicians just need to wait.

Financial Disclosures: None reported.

Funding/Support: Both authors are supported by New Investigator Awards from the Canadian Institutes of Health Research.

Role of the Sponsor: The Canadian Institutes of Health Research had no role in the preparation, review, or approval of the manuscript.

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Early vs Late Tracheotomy for Prevention of Pneumonia in Mechanically Ventilated Adult ICU Patients

A Randomized Controlled Trial

Pier Paolo Terragni, MD

Massimo Antonelli, MD

Roberto Fumagalli, MD

Chiara Faggiano, MD

Maurizio Berardino, MD

Franco Bobbio Pallavicini, MD

Antonio Miletto, MD

Salvatore Mangione, MD

Angelo U. Sinardi, MD

Mauro Pastorelli, MD

Nicoletta Vivaldi, MD

Alberto Pasetto, MD

Giorgio Della Rocca, MD

Rosario Urbino, MD

Claudia Filippini, PhD

Eva Pagano, PhD

Andrea Evangelista, PhD

Gianni Ciccone, MD

Luciana Mascia, MD, PhD

V. Marco Ranieri, MD

TRACHEOTOMY IS A SURGICAL procedure that is performed to replace endotracheal intubation in patients who are expected to require prolonged mechanical ventilation.¹ Advantages of tracheotomy include prevention of ventilator-associated pneumonia (VAP), earlier weaning from respiratory support, and reduction in sedative use.²⁻⁵

For editorial comment see p 1537.

Context Tracheotomy is used to replace endotracheal intubation in patients requiring prolonged ventilation; however, there is considerable variability in the time considered optimal for performing tracheotomy. This is of clinical importance because timing is a key criterion for performing a tracheotomy and patients who receive one require a large amount of health care resources.

Objective To determine the effectiveness of early tracheotomy (after 6-8 days of laryngeal intubation) compared with late tracheotomy (after 13-15 days of laryngeal intubation) in reducing the incidence of pneumonia and increasing the number of ventilator-free and intensive care unit (ICU)-free days.

Design, Setting, and Patients Randomized controlled trial performed in 12 Italian ICUs from June 2004 to June 2008 of 600 adult patients enrolled without lung infection, who had been ventilated for 24 hours, had a Simplified Acute Physiology Score II between 35 and 65, and had a sequential organ failure assessment score of 5 or greater.

Intervention Patients who had worsening of respiratory conditions, unchanged or worse sequential organ failure assessment score, and no pneumonia 48 hours after inclusion were randomized to early tracheotomy (n=209; 145 received tracheotomy) or late tracheotomy (n=210; 119 received tracheotomy).

Main Outcome Measures The primary endpoint was incidence of ventilator-associated pneumonia; secondary endpoints during the 28 days immediately following randomization were number of ventilator-free days, number of ICU-free days, and number of patients in each group who were still alive.

Results Ventilator-associated pneumonia was observed in 30 patients in the early tracheotomy group (14%; 95% confidence interval [CI], 10%-19%) and in 44 patients in the late tracheotomy group (21%; 95% CI, 15%-26%) ($P=.07$). During the 28 days immediately following randomization, the hazard ratio of developing ventilator-associated pneumonia was 0.66 (95% CI, 0.42-1.04), remaining connected to the ventilator was 0.70 (95% CI, 0.56-0.87), remaining in the ICU was 0.73 (95% CI, 0.55-0.97), and dying was 0.80 (95% CI, 0.56-1.15).

Conclusion Among mechanically ventilated adult ICU patients, early tracheotomy compared with late tracheotomy did not result in statistically significant improvement in incidence of ventilator-associated pneumonia.

Trial Registration clinicaltrials.gov Identifier: NCT00262431

JAMA. 2010;303(15):1483-1489

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Author Affiliations are listed at the end of this article.

Corresponding Author: V. Marco Ranieri, MD, Università di Torino, Dipartimento di Anestesia, Azienda Ospedaliera S. Giovanni Battista-Molinette, Corso

Dogliotti 14, 10126 Turin, Italy (marco.ranieri@unito.it).

Caring for the Critically Ill Patient Section Editor: Derek C. Angus, MD, MPH, Contributing Editor, JAMA (angusdc@upmc.edu).

Although the use of tracheotomy has increased in recent years by nearly 200%,⁶ analysis of a large database showed considerable variation in the timing and incidence of tracheotomy.⁷ This observation is of clinical importance because timing is a key criterion for performing a tracheotomy (many clinicians use a specific time window⁸) and patients who receive a tracheotomy require a large amount of health care resources.⁹

A consensus conference recommended performing tracheotomy after 3 weeks of endotracheal intubation.¹⁰ Although this timescale for tracheotomy is widely used,^{11,12} observational studies have reported that tracheotomies performed earlier may be associated with quicker weaning from mechanical ventilation.^{13,14} However, randomized controlled trials have failed to confirm this observation. Rumbak et al¹⁵ showed that tracheotomy within 2 days of hospital admission reduced the mortality rate, occurrence of pneumonia, and length of intensive care unit (ICU) stay compared with tracheotomy performed after 14 to 16 days of endotracheal intubation. Blot et al¹⁶ showed that mortality, duration of mechanical ventilation and ICU stay, and incidence of infections did not differ between patients randomized to receive a tracheotomy within 4 days following onset of mechanical ventilation and those randomized to maintain endotracheal intubation for at least 14 days.

The current study examined the hypothesis that tracheotomy performed after 6 to 8 days of endotracheal intubation compared with tracheotomy performed after 13 to 15 days of endotracheal intubation would reduce the incidence of VAP.

METHODS

From June 2004 to June 2008, patients were recruited from 12 Italian ICUs. Review boards approved the protocol and patients or their proxy (the family or the referring physician not involved in the study) provided written consent.¹⁷

Patients were enrolled in the study if they were older than 18 years, had been mechanically ventilated for acute respiratory failure for 24 hours, had a Simplified Acute Physiology Score II between 35 and 65,¹⁸ had a sequential organ failure assessment (SOFA) score equal to or greater than 5,¹⁹ and did not have a pulmonary infection (estimated by a Clinical Pulmonary Infection Score [CPIS] of <6).^{20,21} Patients were excluded from the study if they had chronic obstructive pulmonary disease; an anatomical deformity of the neck (including thyromegaly) and cervical tumors; a history of esophageal, tracheal, or pulmonary cancer; previous tracheotomy; soft tissue infection of the neck; hematological malignancy; or were pregnant.

Forty-eight hours after enrollment, patients were randomized to receive a tracheotomy after 6 to 8 days of endotracheal intubation (early tracheotomy group) or after 13 to 15 days of endotracheal intubation (late tracheotomy group) if (1) PaO_2 was less than or equal to 60 mm Hg with a fraction of inspired oxygen (FiO_2) of at least 0.5 and a positive end-expiratory pressure (PEEP) of at least 8 cm H_2O ; (2) an attending physician not involved in the study determined that the acute clinical condition requiring ventilatory support was still unresolved; and (3) the SOFA score remained equal to or greater than 5.¹⁹ Patients were not randomized if (1) there was improvement in respiratory conditions (identified as a $\text{PaO}_2 > 60$ mm Hg, a FiO_2 of <50%, and a PEEP of <8 cm H_2O) and the attending physician determined that the acute clinical condition had resolved that had required the mechanical ventilation; (2) pulmonary infection as estimated by the CPIS score was greater than 6^{20,21}; or (3) there was a moribund state or death.

Tracheotomy was not performed if one of the following a priori-defined conditions occurred: improvement in oxygenation (identified as a $\text{PaO}_2 > 60$ mm Hg, a $\text{FiO}_2 < 50\%$, and a PEEP <8 cm H_2O) and the attending physician determined that the acute clinical con-

dition resolved that had required the mechanical ventilation; moribund state or death; intracranial pressure greater than 15 mm Hg and/or cerebral perfusion pressure less than 60 mm Hg²²; or platelet count of 50 000 cells/ μL or less, activated partial thromboplastin time or prothrombin time longer than 1.5 seconds, or bleeding time greater than twice normal in the 24 hours prior to the scheduled tracheotomy. Patients randomized to the early or late tracheotomy group who did not receive the planned procedure were still included in the final analysis due to the intention-to-treat design.

The following adverse events associated with tracheotomy during the 28-day study period were classified as (1) intraoperative: minor bleeding (ie, bleeding that could be controlled by digital pressure), significant bleeding (ie, any bleeding event that required the administration of 1 unit of packed red cells), difficult tracheotomy tube placement (ie, requiring >2 attempts at insertion during primary placement procedure), hypoxemia (ie, oxygen saturation of <90% for >90 seconds), arrhythmia, and cardiac arrest; and (2) postoperative: stoma inflammation, stoma infection, minor bleeding, major bleeding, pneumothorax, subcutaneous emphysema, tracheoesophageal fistula, or cannula displacement or need for cannula replacement.²³

The presence of VAP was defined using the simplified CPIS.²¹ A score of 0, 1, or 2 is given for tracheal secretions, chest x-ray infiltrates, temperature, leukocyte count, ratio of PaO_2 to FiO_2 of 0 or 2 (or evidence of acute respiratory distress syndrome), and microbiology.²¹ A CPIS of greater than 6 was considered to indicate the presence of VAP.^{21,24} The CPIS score was calculated at study entry, immediately before randomization, and every 72 hours until day 28 from randomization.¹⁹ The CPIS also was used before performing scheduled tracheotomy. A clinician blinded to patient allocation looked at the clinical charts remotely and evaluated the nonobjective components of

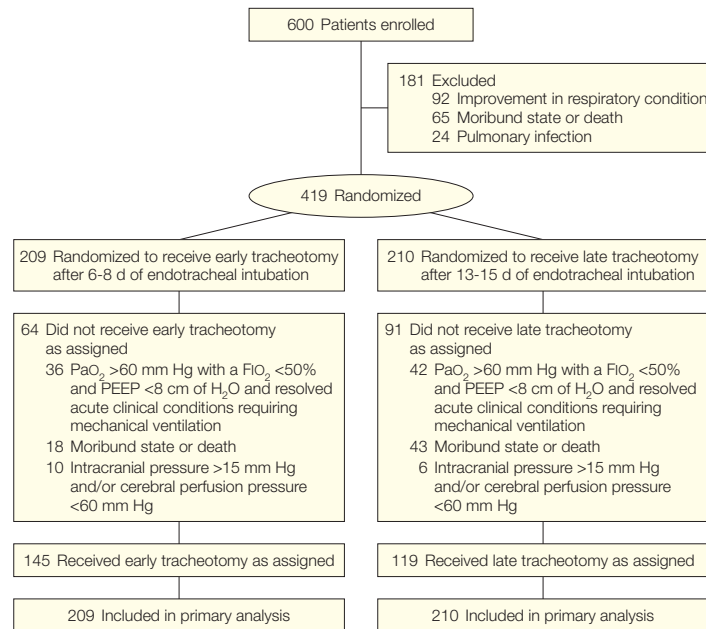
the CPIS (quality of secretions, chest x-ray, evidence of acute respiratory distress syndrome). The SOFA score was calculated using the most abnormal value for each of the 6 organ systems and was calculated at admission and before randomization.

The primary outcome variable was the 28-day cumulative incidence of VAP calculated from the date of randomization. Secondary outcome variables during the 28 days immediately after randomization were number of ventilator-free days (calculated from the date of randomization to the date of the first period of spontaneous breathing that lasted ≥ 48 consecutive hours²⁵); number of ICU-free days (calculated from the date of randomization to the date of ICU discharge); and number of patients in each group who were still alive. Long-term outcome was evaluated in the 2 tracheotomy groups as (1) hospital length of stay and (2) need for long-term care facility after hospital discharge. Mortality at 1 year from randomization was evaluated by attempting to contact study patients who had been discharged alive.

To limit the effects of management heterogeneity among centers on outcome variables, all patients were placed in the semirecumbent position,^{26,27} and weaning from mechanical ventilation²⁸ and use of sedatives and analgesics²⁹ were restricted according to the study protocols. The choice of technique and the location for tracheotomy (bedside vs operating room) were not determined by the study protocol.

Concealed randomization was conducted centrally using a computer-generated randomization schedule. Based on previous data,³⁰ the predicted incidence of VAP was 30%. The trial was designed to enroll 320 patients to demonstrate a 35% relative reduction in VAP from 30% to 20%, with an α level of .05, and a power level of 80%, assuming that some of the patients randomized to each group would not receive a tracheotomy. All analyses were conducted on an intention-

Figure 1. Flow of Patients in the Study



FIO₂ indicates fraction of inspired oxygen; PEEP, positive end-expiratory pressure.

to-treat basis. Values are reported as mean (standard deviation) or median (interquartile range). Comparisons between groups (early vs late tracheotomy) and between different study times were conducted using the χ^2 test, Fisher exact test, paired and unpaired 2-tailed *t* test, and the Wilcoxon signed rank test. Kaplan-Meier curves were compared using the log-rank test. Cumulative incidence of VAP was compared using the Gray test³¹ and death was considered a competing event.³² The hazard ratios were calculated using the Cox and Fine and Gray models. The proportional hazards assumption for the use of these models was evaluated by graphic evaluation of scaled Schoenfeld-type residuals. A probability of .05 on a 2-sided test was regarded as significant. Stata software version 9.2 (StataCorp, College Station, Texas) and R software version 2.5.0 (package *cmprsk*; open source) were used for all statistical analyses.

RESULTS

Of the 600 enrolled patients, 419 patients were randomized to receive an

early tracheotomy (*n*=209) or a late (*n*=210) tracheotomy (FIGURE 1). Of the 209 patients randomized to the early tracheotomy group, 145 patients received a tracheotomy after a mean (SD) of 7 (1) days of endotracheal intubation. Of the 210 patients randomized to the late tracheotomy group, 119 patients received a tracheotomy after a mean (SD) of 14 (1) days of endotracheal intubation. Analyses were conducted on the intention-to-treat population of 419 patients.

Baseline characteristics at admission or before randomization did not differ between the 2 groups. At randomization, type of admission was medical for 40% of the early tracheotomy group compared with 36% of the late tracheotomy group, 8% vs 10%, respectively, for scheduled surgery, 41% vs 45% for unscheduled surgery, and 11% vs 9% for trauma. At randomization, the SOFA score increased and oxygenation parameters significantly worsened in both tracheotomy groups (TABLE 1).

All tracheotomies were performed at the bedside using percutaneous tech-

niques³³ (technique by Griggs et al³⁴ in 72% of the early group and 73% of the late group; and percutwist technique³⁵ in 25% of the early group and 22% of the late group). Adverse events associated with tracheotomy are indi-

cated in TABLE 2. Thirty-nine percent of the patients in both tracheotomy groups (57 patients in the early group and 46 patients in the late group) experienced an adverse event.

FIGURE 2 shows the Kaplan-Meier curves for cumulative incidence of VAP according to whether patients were randomized to early or late tracheotomy. VAP was observed in 30 patients in the early tracheotomy group (14%; 95% confidence interval [CI], 10%-19%) and in 44 patients in the late tracheotomy group (21%; 95% CI, 15%-26%) ($P = .07$).

The numbers of ventilator-free and ICU-free days and the incidences of successful weaning and ICU discharge were significantly greater in patients randomized to the early tracheotomy group compared with patients randomized to the late tracheotomy group; there were no differences between the groups in survival at 28 days (TABLE 3). The hazard ratio of developing VAP was 0.66 (95% CI, 0.42-1.04), remaining connected to the ventilator was 0.70 (95% CI, 0.56-0.87), remaining in the ICU was 0.73 (95% CI, 0.55-0.97), and dying was 0.80 (95% CI, 0.56-1.15).

The median hospital length of stay was 31 days (interquartile range, 17-49 days) in the early tracheotomy group and 32 days (interquartile range, 18-59 days) in the late tracheotomy group. Data on mortality at 1 year and need for a long-term care facility were obtained in 292 patients who left the hospital alive (144 in the early group and 148 patients in the late group). In the early group, 72 patients (50%; 95% CI, 41%-61%) survived to 1 year compared with 63 patients (43%; 95% CI, 34%-52%) in the late group ($P = .25$). Admission to a long-term care facility was required by 56 patients (39%) in the early group and 53 patients (36%) in the late group ($P = .92$).

COMMENT

The present study shows that tracheotomy performed after 6 to 8 days of endotracheal intubation did not result in a reduced incidence of VAP compared with tracheotomy performed af-

Table 1. Characteristics of the Study Population^a

	Early Tracheotomy (n = 209)	Late Tracheotomy (n = 210)
At enrollment		
Age, mean (SD), y	61.8 (17.4)	61.3 (16.8)
Male sex, No. (%)	138 (66.0)	142 (67.6)
SAPS II score, mean (SD) ^b	51.1 (8.7)	49.7 (8.6)
SOFA score, mean (SD) ^c	7.9 (2.6)	7.6 (2.9)
PaO ₂ , mean (SD), mm Hg	123 (50)	123 (54)
FiO ₂ , mean (SD)	0.52 (0.17)	0.53 (0.19)
PEEP, mean (SD), cm H ₂ O	6.1 (3.6)	6.6 (3.4)
Primary organ failure, No. (%)		
Respiratory	96 (45.9)	99 (47.1)
Central nervous system	48 (22.9)	54 (25.7)
Cardiovascular	51 (24.4)	42 (20.0)
Renal	11 (5.3)	10 (4.8)
Coagulation	3 (1.4)	5 (2.4)
At randomization, mean (SD)		
SOFA score	10.1 (1.3) ^d	9.8 (1.5) ^e
PaO ₂ , mm Hg	76 (14) ^d	73 (13) ^f
FiO ₂	0.64 (0.10) ^d	0.68 (0.11) ^f
PEEP, cm H ₂ O	9.4 (1.2) ^f	9.3 (1.1) ^d

Abbreviations: FiO₂, fraction of inspired oxygen; PEEP, positive end-expiratory pressure; SAPS II, simplified acute physiological score; SOFA, sequential organ failure assessment score.

^aComparisons between early and late tracheotomy groups were not statistically significant (χ^2 test, unpaired 2-tailed t test, or Wilcoxon signed rank test).

^bAn index of the severity of illness (score range, 0-163; higher values indicate greater severity).

^cAn index of the extent of organ failure in the respiratory, cardiovascular, hepatic, coagulation, renal, and neurological systems (score range, 0-24; higher values indicate greater severity of organ failure).

^d $P = .04$ (paired 2-tailed t test or Wilcoxon signed rank test).

^e $P = .02$ (paired 2-tailed t test or Wilcoxon signed rank test).

^f $P = .03$ (paired 2-tailed t test or Wilcoxon signed rank test).

Table 2. Potential Adverse Events Associated With Tracheotomy^a

	No. (%) of Patients	
	Early Tracheotomy (n = 145)	Late Tracheotomy (n = 119)
Intraoperative		
Minor bleeding	2 (1)	3 (3)
Significant bleeding	0	0
Tube dislocation	2 (1)	3 (3)
Hypoxemia	7 (5)	5 (4)
Arrhythmia	0	0
Cardiac arrest	0	0
Postoperative		
Stoma inflammation	22 (15)	18 (15)
Stoma infection	9 (6)	7 (6)
Minor bleeding	8 (5)	6 (5)
Major bleeding	3 (2)	3 (3)
Pneumothorax	1 (<1)	0
Subcutaneous emphysema	1 (<1)	0
Tracheoesophageal fistula	0	1 (<1)
Cannula displacement or need for replacement	2 (1)	0
Total	57 (39)	46 (39)

^aComparisons between early and late tracheotomy were not statistically significant (χ^2 test or Fisher exact test).

ter 13 to 15 days of endotracheal intubation.

Prolonged endotracheal intubation is known to be associated with airway tissue trauma, infection, patient discomfort, and need for high doses of sedation.^{36,37} Tracheotomy (the procedure that creates temporary or persistent access to the trachea) is commonly performed to replace endotracheal intubation in ICU patients who are expected to require prolonged mechanical ventilation^{3,4} because it provides access to the airway that is more stable and better tolerated than endotracheal intubation and facilitates pulmonary secretions, oral feeding, and patient communication.^{3,4,38} The National Association of Medical Directors of Respiratory Care recommended that tracheotomy should replace endotracheal intubation in patients who still require mechanical ventilation 3 weeks after admission; and noted that identification of the optimal time for a tracheotomy to be performed is one of the most important criteria when deciding to perform the procedure.¹⁰ Introduction of percutaneous tracheotomy techniques into clinical practice³⁹ has made the procedure possible at the bedside without the need for surgeons or an operating room.²³ Percutaneous tracheotomy techniques also have increased in use in the ICU by nearly 200%.⁶

Analysis of the US National Trauma Databank showed that the rates and timing of tracheotomy varied significantly across ICUs.⁷ A preconceived notion of efficacy (in the absence of any evidence to support an optimal time for a tracheotomy) has been

advocated to explain this discrepancy between the widespread use of tracheotomy and its inconsistent and non-homogenous clinical use.³⁸ This may be of particular clinical importance because patients receiving a tracheotomy require a large amount of health care resources after the procedure.^{9,14,40}

A prospective randomized trial that included 120 patients reported that performing tracheotomy within 2 days of admission was associated with halving the 30-day mortality rate, a reduced occurrence of pneumonia, and a shortened ICU length of stay compared with performing tracheotomy within 14 to 16 days of admission.¹⁵ A later meta-analysis noted that performing a tracheotomy up to 7 days after initiation of endotracheal intubation shortened the duration of mechanical ventilation and length of stay in the ICU but did not affect outcome compared with tracheotomies performed later.⁴¹ A more recent clinical trial that included 123 patients showed that mortality, duration of mechanical ventilation, duration of ICU stay, and incidence of infections did not differ between patients randomized to receive a tracheotomy within 4 days following onset of mechanical ventilation and those in whom endotracheal intubation was maintained for at least 14 days.¹⁶

Our study estimated the need for prolonged ventilation by severity of illness and need for ventilatory support required to obtain predefined oxygenation criteria. These criteria selected patients who at study enrollment had a mean (SD) Simplified Acute Physi-

ology Score II of 50.8 (8.2) and had an increase in SOFA score at randomization and a worsening in respiratory parameters. Ferreira et al¹⁹ recently demonstrated that mortality in patients matching these criteria ranged between 35% and 40%. Under these circumstances and in contrast to previous trials,^{15,16,41} almost two-thirds of the screened patients were randomized and underwent the scheduled tracheotomy. Patients who, although randomized, did not actually receive a tracheotomy were included in the final analysis because of the intention-to-treat design.

We chose the 28-day cumulative incidence of VAP as the primary outcome variable. Occurrence of VAP was evaluated with a score that combines objective (temperature, ratio of PaO₂ to FiO₂, leukocyte count, and microbiology findings) and nonobjective (quality of secretions, chest x-ray interpre-

Figure 2. Development of Ventilator-Associated Pneumonia According to Whether Patients Received an Early or a Late Tracheotomy

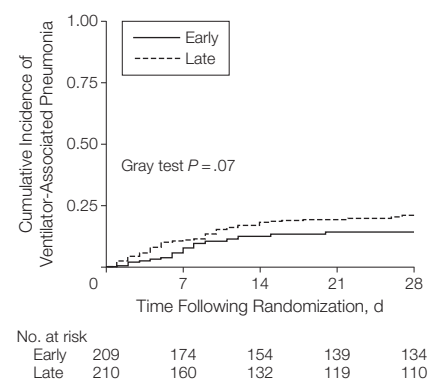


Table 3. Secondary Endpoints in the Early and Late Tracheotomy Groups

	Early Tracheotomy (n = 209)	Late Tracheotomy (n = 210)	P Value ^a
No. of days at 28 d, median (IQR)			
Ventilator-free	11 (0-21)	6 (0-17)	.02
ICU-free	0 (0-13)	0 (0-8)	.02
Successful weaning, No. (%) [95% CI], %	161 (77) [71-82]	142 (68) [61-74]	.002
ICU discharge, No. (%) [95% CI], %	101 (48) [42-55]	82 (39) [32-46]	.03
Survival at 28 d, No. (%) [95% CI], %	154 (74) [68-80]	144 (68) [63-75]	.25

Abbreviations: CI, confidence interval; ICU, intensive care unit; IQR, interquartile range.

^aP values are 2-tailed (Wilcoxon signed rank test, log-rank test, and Gray test).

tation, evidence of acute respiratory distress syndrome) components.^{20,21,24} To minimize the potential bias of the latter on evaluation of the primary outcome variable, we had the nonobjective components of the score evaluated by clinicians who were blinded to patient allocation and who looked at the clinical charts remotely (without physically examining or having contact with the patient).

Thirty patients (14%; 95% CI, 10%-19%) had VAP in the early tracheotomy group and 44 patients (21%; 95% CI, 15%-26%) had VAP in the late tracheotomy group ($P=.07$). This 33% risk reduction was therefore smaller than planned and did not reach statistical significance because the observed incidence of VAP in the late tracheotomy group was less than that predicted. Moreover, only 69% of the patients randomized to the early tracheotomy group and 57% of the patients randomized to late tracheotomy group actually received a tracheotomy.

Another possible explanation is that there is really no improvement from earlier tracheotomy. Results of the present study show that while anticipating a tracheotomy for 1 week decreased the need for ventilatory support and ICU admission, planning an earlier tracheotomy (1) increased the number of patients who received a tracheotomy (69% of the patients randomized to the early group vs 57% of the patients randomized to the late group); (2) did not decrease the incidence of VAP; (3) did not influence hospital length of stay, mortality at 1 year, and need for care at a long-term health facility; and (4) increased the number of patients potentially exposed to the adverse events related to the tracheotomy.

In conclusion, our data show that in intubated and mechanically ventilated adult ICU patients with a high mortality rate, early tracheotomy (performed after 6-8 days of endotracheal intubation) did not result in a significant reduction in incidence of VAP compared with late tracheotomy (performed after 13-15 days of endotracheal intubation). Although the num-

ber of ICU-free and ventilator-free days was higher in the early tracheotomy group than in the late tracheotomy group, long-term outcome did not differ. Considering that anticipation for tracheotomy of 1 week increased the number of patients who received a tracheotomy, and more than one-third of the patients experienced an adverse event related to the tracheotomy, these data suggest that a tracheotomy should not be performed earlier than after 13 to 15 days of endotracheal intubation.

Author Affiliations: Anestesia e Rianimazione 1 (Drs Terragni, Faggiano, Urbino, Filippini, Mascia, and Ranieri), Anestesia e Rianimazione 3 (Dr Berardino), Ospedale S. Giovanni Battista, and Cancer Epidemiology Unit, CPO Piemonte, CeRMS (Drs Pagano, Evangelista, and Ciccone), Università di Torino, Turin, Italy; Terapia Intensiva, Policlinico A. Gemelli, Università Cattolica del Sacro Cuore, Rome, Italy (Dr Antonelli); Anestesia e Rianimazione, Ospedale San Gerardo di Monza, University of Milano-Bicocca, Milan, Italy (Dr Fumagalli); Anestesia e Rianimazione, Azienda Ospedaliera Universitaria San Martino, Genoa, Italy (Dr Pallavicini); Anestesia e Rianimazione, Azienda Ospedaliera CTO, Turin, Italy (Dr Miletto); Anestesia e Rianimazione, Policlinico P. Giaccone, Università di Palermo, Palermo, Italy (Dr Mangione); Anestesia e Rianimazione, Policlinico Universitario, Università di Messina, Messina, Italy (Dr Sinardi); Anestesia e Rianimazione, Ospedale E. Agnelli, Pinerolo, Turin, Italy (Dr Pastorelli); Anestesia e Rianimazione, Ospedale SS Antonio e Biagio, Alessandria, Italy (Dr Vivaldi); Anestesia e Rianimazione, Azienda Ospedaliera Universitaria, Università di Modena, Modena, Italy (Dr Pasetto); and Anestesia e Rianimazione, Azienda Ospedaliera Universitaria, Università di Udine, Udine, Italy (Dr Della Rocca).

Author Contributions: Dr Ranieri had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Terragni, Antonelli, Fumagalli, Ciccone, Mascia, Ranieri.

Acquisition of data: Terragni, Antonelli, Faggiano, Berardino, Pallavicini, Miletto, Mangione, Sinardi, Pastorelli, Vivaldi, Pasetto, Della Rocca, Urbino, Ranieri. **Analysis and interpretation of data:** Terragni, Antonelli, Fumagalli, Filippini, Pagano, Evangelista, Ciccone, Mascia, Ranieri.

Drafting of the manuscript: Terragni, Antonelli, Fumagalli, Pallavicini, Ciccone, Mascia, Ranieri.

Critical revision of the manuscript for important intellectual content: Faggiano, Berardino, Miletto, Mangione, Sinardi, Pastorelli, Vivaldi, Pasetto, Della Rocca, Urbino, Filippini, Pagano, Evangelista, Ranieri.

Statistical analysis: Fumagalli, Filippini, Pagano, Evangelista, Ciccone, Mascia, Ranieri. **Obtained funding:** Ranieri.

Administrative, technical, or material support: Terragni, Antonelli, Fumagalli, Faggiano, Berardino, Pallavicini, Miletto, Mangione, Sinardi, Pastorelli, Vivaldi, Pasetto, Della Rocca, Urbino, Ranieri.

Study supervision: Fumagalli, Mascia, Ranieri.

Financial Disclosures: None reported.

Funding/Support: This study was supported by the Regione Piemonte Ricerca Sanitaria Finalizzata grant 03-08/ACR ASX44.

Role of Sponsor: The granting agency had no role in the design and conduct of the study; collection,

management, analysis, and interpretation of the data; and preparation, review, or approval of the manuscript.

Members of the Early vs Late Tracheotomy Study Group: Alberto Birocco, MD, Cristina Degiovanni, MD, Sabino Mosca, MD (Anestesia e Rianimazione 1, Ospedale S. Giovanni Battista Università di Torino, Italy); Vittorio Mignani, MD, Salvatore Maria Maggiore, MD, Vincenzo Michetti, MD, Giuseppe Bello, MD (Terapia intensiva, Policlinico A. Gemelli, Università Cattolica del Sacro Cuore, Roma, Italy); Antonio Pesenti, MD (Anestesia e Rianimazione, Ospedale San Gerardo di Monza, University of Milano-Bicocca, Italy); Santino Atlante, MD (Anestesia e Rianimazione 3, Ospedale S. Giovanni Battista, Università di Torino, Italy); Enrico Arditi, MD (Anestesia e Rianimazione, Azienda Ospedaliera Universitaria San Martino, Genova, Italy); Daniela Decaroli, MD (Dipartimento Emergenza e Accettazione, Azienda Ospedaliera CTO, Torino, Italy); Salvatore Salemi, MD (Anestesia e Rianimazione, Policlinico P. Giaccone, Università di Palermo, Italy); Antonio David, MD (Anestesia e Rianimazione, Policlinico Universitario, Università di Messina, Italy); Rita Napoletano, MD (Anestesia e Rianimazione, Ospedale E. Agnelli, Pinerolo, Torino, Italy); Fabrizio Racca, MD (Anestesia e Rianimazione, Ospedale SS Antonio e Biagio, Alessandria, Torino); Massimo Girardis, MD, Virginia Lionelli, MD (Anestesia e Rianimazione, Azienda Ospedaliera Universitaria, Università di Modena, Italy); and Paolo Chiarandini, MD (Anestesia e Rianimazione, Azienda Ospedaliera Universitaria, Università di Udine, Italy).

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