small airways injury (bronchiolitis). The presence of bronchiolitis could not, however, be confirmed as no lung biopsy was performed.

We conclude that acute exposure to high concentrations of anhydrous ammonia gas leads not only to acute respiratory injury but also to long term impairment of respiratory function.


Expandable metal stents for tracheal obstruction: permanent or temporary?
A cautionary tale

C R K Hind, R J Donnelly

Abstract
An expandable metal stent inserted via a long term tracheostomy successfully relieved life threatening respiratory obstruction due to benign tracheal stenosis. Later the patient’s tracheostomy suction catheter became stuck on the stent and dislodged it. The stent was removed electively, without damaging the trachea, with a rigid biopsy forceps.

Several reports have highlighted the value of expandable metal stents in the treatment of respiratory obstruction due to benign or malignant conditions affecting the trachea or main bronchi.\textsuperscript{1,2} Such stents are usually considered permanent as the fixation of the stent hooks to the mucosal wall is thought to make removal difficult.\textsuperscript{2} We describe a patient whose stent became dislodged two weeks after insertion and was therefore removed, without difficulty, via a rigid bronchoscope.

Case report
A 51 year old housewife presented as an emergency with a three year history of increasing dyspnoea and stridor. Ten years previously she had received external radiotherapy to the neck for a postcrioic carcinoma. Three years later she developed laryngeal stenosis secondary to the radiotherapy, and for the last seven years she had therefore required a tracheostomy tube. On admission she was cyanosed and breathless at rest.

On the day of her admission a flexible endoscope inserted via her tracheostomy site showed a benign looking stricture 3 cm below the tracheostomy site, which had reduced her tracheal lumen to about 2 mm in diameter. An attempt to dilate the tracheal stenosis with a 24 French gauge bougie caused bleeding at the stenosed site, and the patient became increasingly distressed. She was considered too ill to be transferred to the regional cardiothoracic centre and, in the absence of local facilities for rigid bronchoscopy, we decided to introduce a stent.

Two 2.5 x 2 cm self expandable metal stents (Cook Inc, Bloomington, Indiana) were

Figure 1  Detail of chest radiograph after disruption of the stent.
this centre, where rigid bronchoscopy showed that the upper stent not only was disrupted but also now lay above the site of the previous stenosis of the trachea, which in turn was no longer narrowed. By the use of a rigid biopsy forceps the stent was therefore removed (fig 2), with no apparent endobronchial damage.

The patient remained well, though three months later she had to undergo elective endoscopic bougie dilatation because of restenosis at the site of her original tracheal narrowing. At that time the remaining stent was seen to be almost completely covered by bronchial mucosa.

Discussion

The reports of the use of self expanding metal stents in the treatment of tracheal or bronchial obstruction have emphasised that they should be considered only for permanent placement. Such stents have been used to relieve both benign and malignant major airway obstruction, with follow up periods of over 18 months in some cases. Experiments on dogs have shown that the stent becomes covered with respiratory mucosa after a few weeks, making removal impractical. Self expanding coronary artery stents suffer a similar fate.

The in situ disruption of the self expanding stent that we report is, of course, a complication unique to patients who perform catheter suction of their tracheostomy site themselves. This case provides a warning of this potential danger, but also indicates that these stents can be removed within two weeks of their insertion.