



IDIOPATHIC SUBGLOTTIC STENOSIS

A ROUGH GUIDE

FOR BEGINNERS

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Living with idiopathic subglottic stenosis support community*

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Support: [Facebook.com/groups/AirwayStenosis](https://www.facebook.com/groups/AirwayStenosis) | **X/Instagram:** @SparkySparkler



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Foreword – Welcome to the 'Rough Guide'

Welcome to the 'Rough Guide' – this is designed to be a patient's introduction to subglottic stenosis, aiding your understanding of this diagnosis, busting some myths, and helping you to take control of your health and treatment. We share tips to empower you in your journey; listing the recommended tests your doctor should be doing, questions to ask your doctor in different situations, advice, equipment, advice that will make living with this diagnosis easier, and simple ways to monitor your breathing.

I am Catherine Anderson, and I was diagnosed with idiopathic subglottic stenosis in 2004 after two years of misdiagnosis. I know the relief you feel when you find there IS something wrong with you, followed by the confusion when you try to understand this prognosis.

In 2009 I founded a support community 'Living with idiopathic subglottic stenosis.' Learning from negative experiences with other groups, this one encourages members to collectively learn and keep the discussion fresh and solution focused, avoiding repetitive questions or revisiting things we know the answers to. The community is a big contributor to research by doctors around the world, enhancing knowledge about our disease. This guide is designed to help accelerate new patients' knowledge so they can ask more informed questions as well as join in with research, empowering them to be a part of the solution.

This disease is so rare that many doctors, even those specialising in ear, nose, and throat conditions, often have little experience with it, meaning we patients **have to self-advocate** to ensure we get the right treatment. Everything in this guide has been approved by the most experienced doctors treating this disease, so you are reading and sharing the most accurate information which should help you do just that.

I know this diagnosis can be frightening. Hopefully, this document can ease your fears and help you to live as normal a life as possible, being better informed and working in partnership with your doctor to get the best treatment for you.

Wishing you easy breathing!



Executive summary – the quick guide

While this guide is packed with useful information about subglottic stenosis, we appreciate it can sometimes be too much to read all at once, and details can be missed. Here is the top-line summary of what you should know right now.

What is subglottic stenosis (SGS)?

A **narrowing of your airway caused by the formation of scar tissue just below your vocal cords**. It is rare, with just two people in a million diagnosed each year.

Why have I got this?

There are a few potential causes, including damage from a **prior intubation** (e.g. during a previous operation), damage from **inhaling chemicals or heat**, an **autoimmune disease** (such as GPA or lupus) or from an **unknown cause**. Idiopathic literally means 'cause unknown'. Your doctor should investigate all avenues as the treatment will slightly differ if a cause is detected.

Is it life threatening?

Yes, this must be taken seriously. Your biggest risk is a plug of mucus blocking your airway while narrow. Share information with family and work colleagues that can help save your life if your airway should block.

It's important that you **talk to your treating doctor** about **flagging your record to prioritise your appointments** should you need treatment in an emergency. This disease can be unpredictable, and you do not want to wait weeks for an appointment if you are struggling to breathe. Receptionists and schedulers do not always realise the risks associated with SGS.

How is it treated?

Initially, it is likely you will have a **dilation surgery**. This is usually day surgery where the doctor operates through your mouth to open up the scar. You will wake up breathing well, either right away or within a day or so. You may have a sore throat, and maybe your chest and shoulders will feel a little stiff for a couple of days. Usually patients go home the same day and can be back at work in 2-3 days. **Other treatments** include **steroid injections** (done in your doctor's office) or **more major surgeries such as resection or the Maddern procedure**. Please be certain you are comfortable with your doctor's experience and expertise before following a treatment path. You will need to self-advocate for your airway health.

What should I do to help my airway?

A **nebuliser** (a machine aimed at delivering moist air to your airway) is essential – you can use it with saline to moisten your airway and help move mucus and prevent mucus plugs. A silent, portable one is what most people prefer to use. You can buy these online.

A **peak flow meter** is a cheap and easy way to monitor your breathing at home, without the need for a doctor's appointment and that uncomfortable scope (camera looking at your airway via your nose). There are several apps to help record your readings, and this can help you learn about your airway – what it is like when you are breathing well, and when it is best to contact your doctor.

Keep **hydrated** and eat a **healthy diet**, minimise sugar and processed foods. Ideally follow an anti-inflammatory diet. Within reason, **keep yourself fit** and **maintain a healthy weight** – all will help you cope better with the symptoms of this rare disease.

It is recommended you are **immunized** for flu, pneumococcal and Covid-19. This will help prevent additional complications which could prove life threatening when coupled with subglottic stenosis.

What is idiopathic subglottic stenosis?

So, you have just been diagnosed and it's all very overwhelming. Suddenly doctors are reeling off words you, your friends and family have never heard of, and when you search on the internet there is no or very little insight to be found. Well done for finding this document and hopefully our Facebook support group. We understand where you are coming from and this document will help.

Back to the question in hand. What is idiopathic subglottic stenosis?

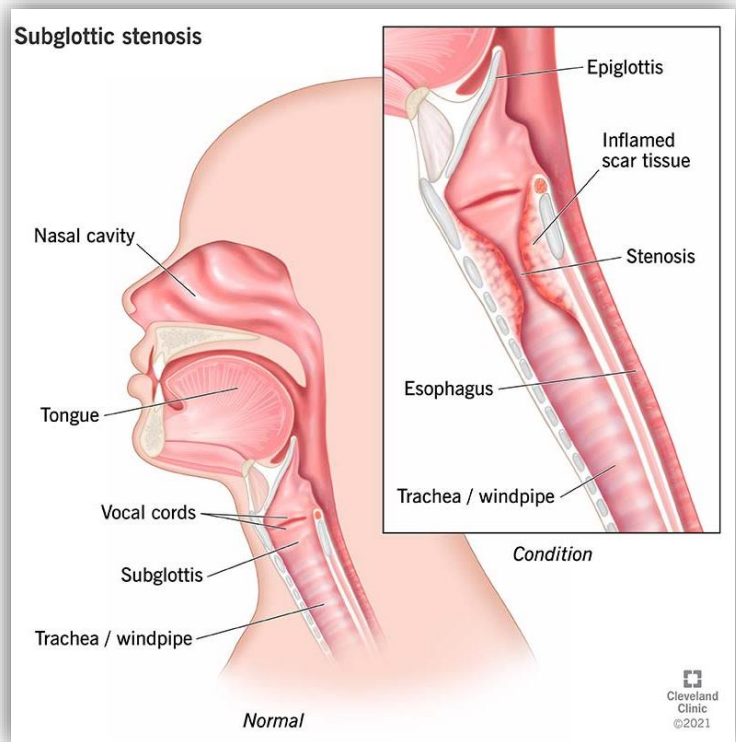
Getting down to basics;

- Idiopathic – is a fancy way of saying 'no known cause'
- Subglottic – is the part of the larynx below the vocal cords (glottis). It connects to your trachea ('windpipe'). You may have been told you have tracheal stenosis – this describes a stenosis is located lower down, within the trachea.
- Stenosis – another fancy word for 'narrowing'.

There are four types of stenosis, all with the same symptoms but different causes. It is important that your doctor rules out the other three types of stenosis before you are sure you are idiopathic. The other types of stenosis may result in different treatment paths.

This document will help you regardless of your stenosis location, and of course, even if your stenosis is not idiopathic, you will still learn a lot here.

As a patient with this disease, you are going to have to get used to being in control of your treatment – make sure you are aware of the treatment options available, the tests your doctor should be doing and **be your own advocate**. If you are uncomfortable with your doctor's level of experience, **please request a referral to another doctor**. Your airway is not to be experimented with. Unfortunately, not all ENT and Thoracic doctors are experts or fully familiar with the best way to treat subglottic stenosis.



The four causes of airway stenosis

Autoimmune stenosis

Your doctor will organise blood tests to check for autoimmune disease. One negative test is not certain, it is recommended annually if you have recurring stenosis.

Autoimmune diseases which can cause airway stenosis include: Granulomatosis with polyangiitis (GPA – formerly known as Wegener’s Granulomatosis), Relapsing Polychondritis (RPC), Systemic Lupus Erythematosus (SLE), Rheumatoid Arthritis (RA), Epidermolysis Bullosa (EB), Sarcoidosis, Amyloidosis or Mucous Membrane pemphigoid (MMP). There may be a more general diagnosis of ‘Vasculitis’.

Doctors may also treat you as autoimmune if your blood tests positive for ANCA (Antineutrophil cytoplasmic antibodies) or if your stenosis ‘behaves’ like an autoimmune stenosis (high levels of inflammation and/or returning rapidly post-surgery).

Polytrauma stenosis

Patients with airway stenosis following documented traumatic injuries – particularly involving the trachea – such as breathing in chemicals or hot or burning air.

Iatrogenic (caused by a medical procedure) stenosis

An airway stenosis following prolonged orotracheal tube ventilation (eg intubation in intensive care) or a tracheostomy – either immediately or within 2 years of intubation (although if you have EVER been intubated, it is certainly worth getting hold of your hospital notes to see whether there were any difficulties – there is a chance your stenosis was caused by the intubation).

Idiopathic (no known cause)

Doctors suggest your stenosis is idiopathic if the other three causes have been ruled out.



What are the common symptoms of SGS?

We all share some common symptoms:

Stridor – this is what we often describe as a wheeze, the sound when we breathe in and out. It will often be silent most of the time but get worse under exertion or in stressful situations. When your stenosis is particularly narrow, you may hear your stridor all the time.

Officially, a stridor is described as 'noisy breathing due to narrowing (stenosis) of the airway at or below the larynx'.

Often, we as sufferers stop noticing this sound ourselves, and it is friends, relatives and work colleagues who might mention it to us. We often describe this as Darth Vader breathing!



Coughing – early on in your condition the coughing might not be too bad, but it tends to get worse over time. This is because the little hairs (cilia) which usually line your respiratory tract are absent where the scarring is. These hairs usually help move mucus smoothly up and down your airway. Where they are missing, you will need to cough the mucus past. The coughing will often get worse when you are talking lots, exercising or in stressful situations.

Breathlessness – it will be a struggle to breathe, talk, laugh, and don't even think about singing! The more constricted your airway, the more challenging it will be. This is often what causes doctors to misdiagnose us with asthma.

Mucus – we generally do not have any more mucus than the average person; rather it becomes harder to shift because of the scar tissue and the narrowing (see diagram). If you have inflammation in your airway, it is likely there is more mucus as the two (inflammation and mucus) come hand in hand. You may also find that you're more prone to getting minor bacterial infections within the mucus as it sits behind the scarring and thickens up. You'll have to cough hard to shift this and it might come up as a 'plug' – often thick white, yellow, or green. If you are concerned, see a doctor, but mostly this clears up. Please see our **tips for thinning and minimizing** mucus and the **section on 'mucus plugs'**.



A narrowed airway requires more rapid airflow to maintain oxygenation. The mucous layer evaporates leaving a dry sticky residue and low mucosal temperature stimulates nerves to cause cough.

Inflammation – all this coughing and shifting of mucus can lead to inflammation. If it gets bad (it can lead to a vicious circle of coughing and more inflammation) you may end up taking a short course of steroids. If you find you are prone to inflammation (your doctor may mention this after a scope), investigate our anti-inflammation tips which may help you avoid medication. Steroids have their own side effects, such as increased appetite (leading to weight gain), moon face (your face looks puffy and round), and with long term use, decreased calcium leading to brittle bones. Not everyone experiences these side effects but be aware. Chronic inflammation can be a sign of autoimmune disease – ensure you are tested annually for the suite of blood-tests detailed later in this document.

Fatigue – as it becomes more challenging to breathe, you are likely to feel more tired. You will feel that your 'get up and go' has 'got up and gone'! Everything you do is likely to feel more of a challenge and you may find yourself feeling tired during the day. This should ease after a dilation – in fact, many patients report temporary feelings of euphoria once they can breathe well.

Inability to concentrate – alongside fatigue, the more you are concentrating on breathing, the less space you will find in your head to concentrate on other things in life – essentially you are in survival mode. After your airway has been opened back up, you should find space in your head for things other than breathing!

If you are like most of us, you were misdiagnosed for some months with asthma, bronchitis, or panic attacks. You are most likely the first patient with this condition your local doctor has ever met. This means **it is up to you to educate them!**

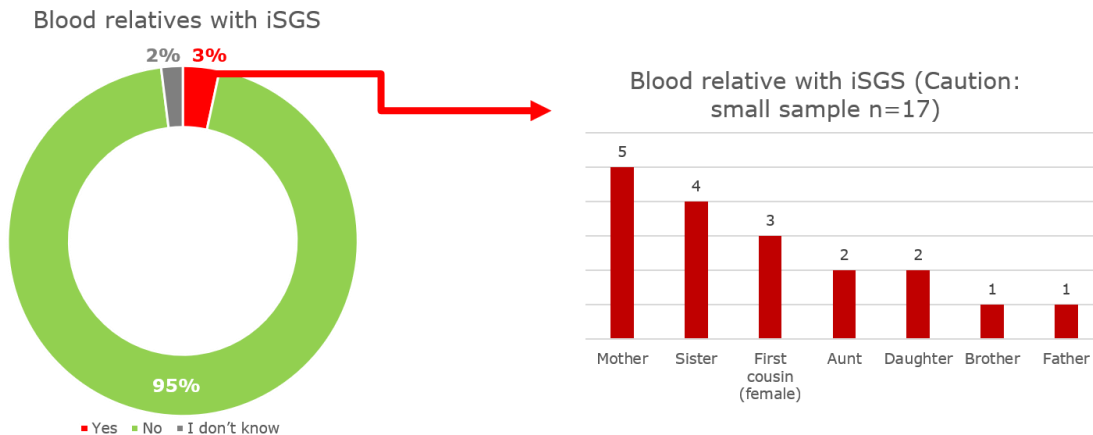
Who gets idiopathic subglottic stenosis (iSGS)?

Idiopathic subglottic stenosis is exceedingly rare – less than one in 400,000 people get this disease (the definition of 'rare') – it is in fact estimated to only impact one person in half a million per year.

If you are female, then you are one of many, as this affects 98% females. If you are male, then you are truly special and part of the 2%.

Many have not yet been diagnosed – as you will likely have found yourself, doctors often tell patients they have asthma or bronchitis, more common conditions. The big message doctors need to get is that with asthma, the wheezing sound is heard when breathing out, with a tracheal/upper airway blockage (rather than a lung) issue, the wheezing sound is also heard when breathing in.

People are often afraid of passing this on to their children – that is very unlikely. Just 3% of iSGS patients have a blood relative with this disease, suggesting this is not something you should be too worried about. If a relative (particularly a female) has similar symptoms to you, then they should suggest this as a diagnosis to their doctor and ensure they get sent to an ENT for investigation.



Q30. To your knowledge, have any other blood related family members been diagnosed with a stenosis (eg brothers, sisters, parents, aunts or uncles who are directly related to your parents, grandparents)? Base: Patients with idiopathic subglottic stenosis, n=502

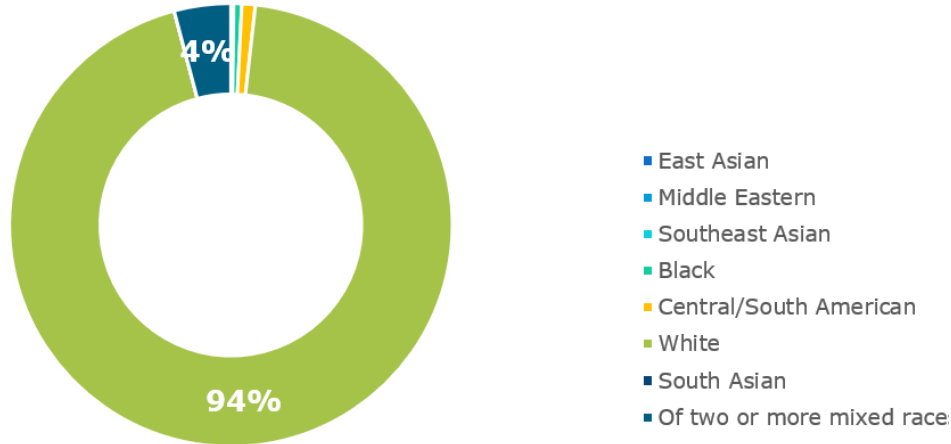
Q31. What type of subglottic stenosis were they diagnosed with? Base: Patients with idiopathic subglottic stenosis who indicated they had a blood relative also with a stenosis n=17

Ethnicity and heritage

More than nine in ten patients describe their ethnic background as white, suggesting there may be a genetic element to this disease:

How would you describe your ethnic background?

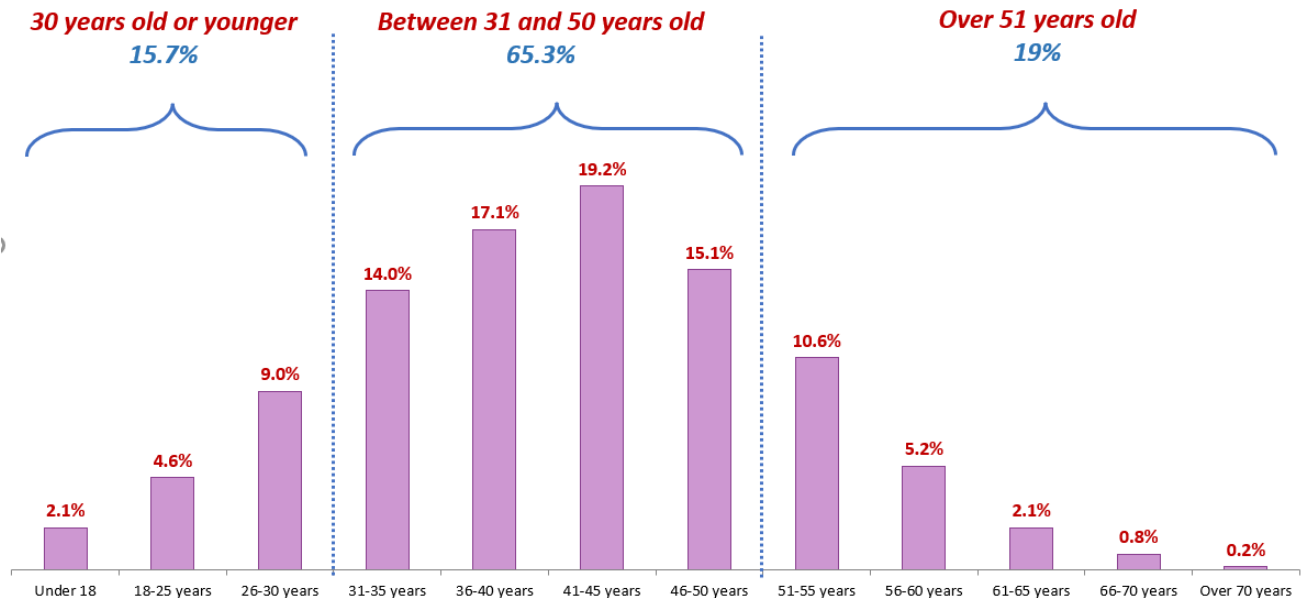
Base: Patients with idiopathic subglottic stenosis n=509



One in two patients experience their first symptoms between 31 and 45 years of age.

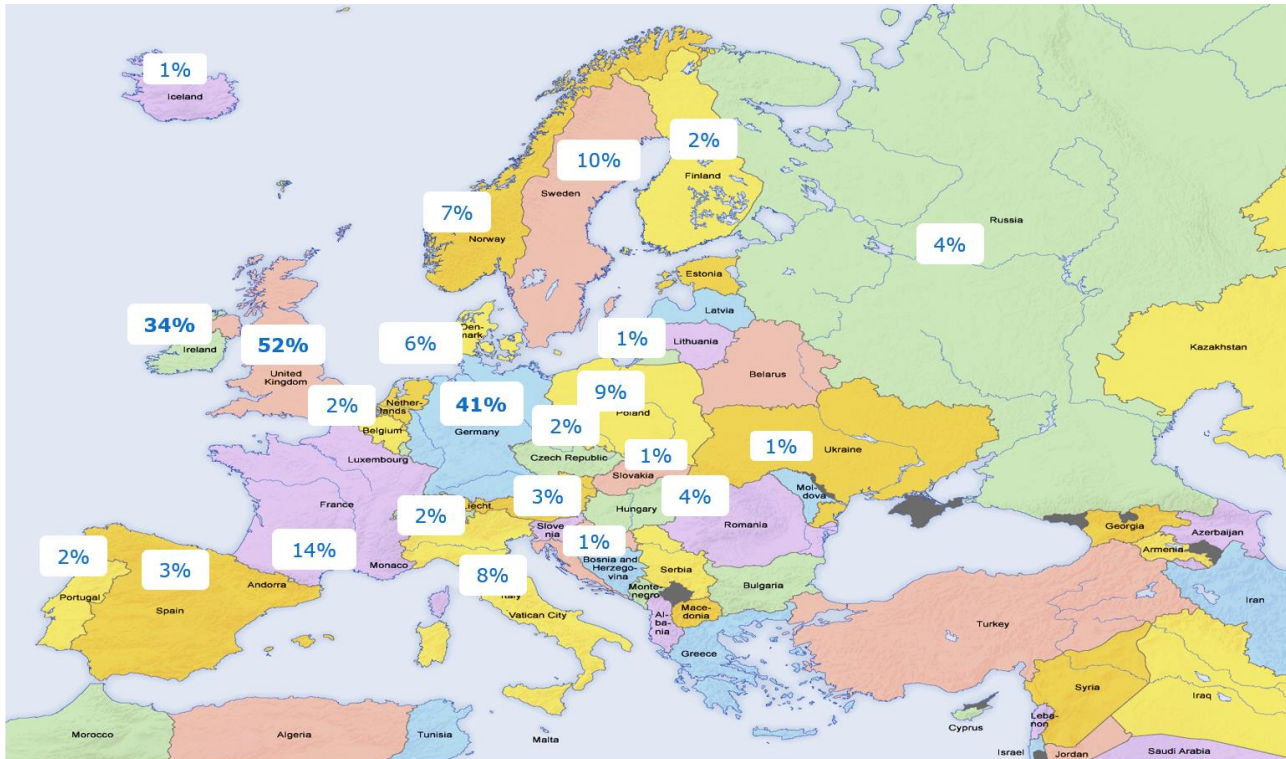
At what age did you first develop breathing difficulties?

Base: Members of 'LWISGS Facebook Group' diagnosed with idiopathic subglottic stenosis n=2725



Patients with SGS are no different from the rest of the population in terms of other health conditions (heart, thyroid, cholesterol etc), and other than breathing (!) are healthy.

More than nine in ten have a European ancestry:



Q11. Please explain more about your European heritage – from which country or countries?
Patients with idiopathic subglottic stenosis with ancestry in Europe n=425

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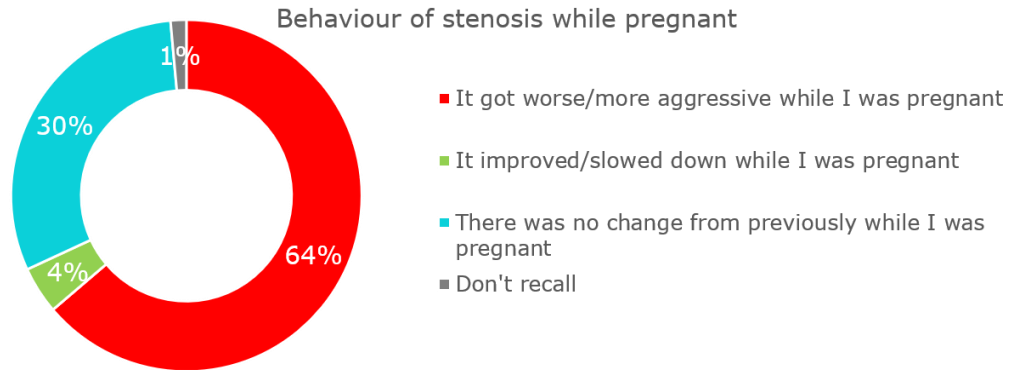
Hormones

One theory is that there is a hormonal link, but that has not been proven or disproven.

17% of women with SGS have never been pregnant, and only one in five (22%) has ever been pregnant while they had SGS. For 26% of women, their stenosis did not appear until after menopause.

The stenosis first appeared for around one in three (30%) while they were pregnant.

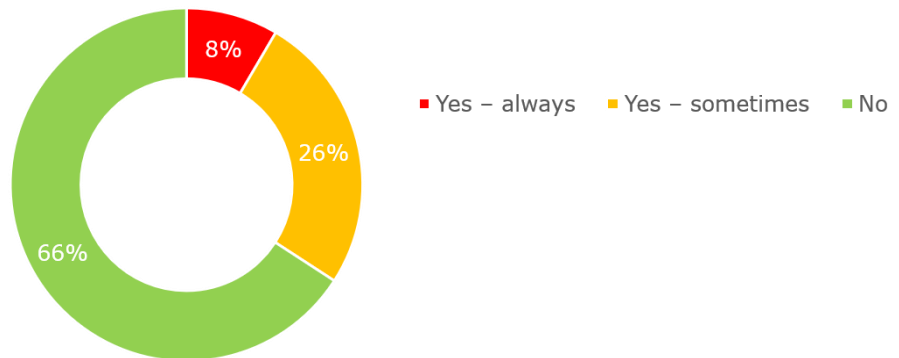
For those women who **already have a stenosis when they get pregnant**, three in five (64%) see the stenosis get worse during their pregnancy. One in three (30%) see no change.



Q51. How did your stenosis behave during your pregnancy? Base: Patients who got pregnant when already diagnosed with idiopathic subglottic stenosis, n=69

Looking only at women who have not reached menopause, around one in three (34%) finds their breathing gets worse around the time of their period. This may be a result of increased CRP levels around the time of women’s periods*.

Worsening breathing around time of period



*Journal of Women's Health VOL. 25, NO. 9 | The Association of Inflammation with Premenstrual Symptoms - Ellen B. Gold, Craig Wells, Marianne O'Neill Rasor - Published Online: 1 Sep 2016 <https://doi.org/10.1089/jwh.2015.5529>

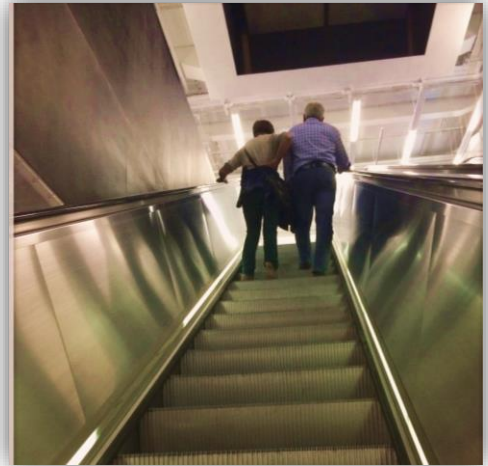
Recent research has found that post-menopausal patients tend to have a slower rate of restenosis post-op when compared to pre-menopausal patients.

Birth control and HRT are generally not seen to impact the rate of restenosis. If they do, it may be worth talking to your doctor about a progesterone only regimen.

Debunking the myths about iSGS

There are so many theories about iSGS and its causes and effects. Sometimes inexperienced doctors are the ones telling you this. Let us nip them in the bud:

“iSGS is caused by reflux” – No. Your iSGS is NOT caused by reflux. Think about it. About 60% of the world’s population has reflux – males as much as females – and yet iSGS only (well 98% of the time) affects women. Reflux is not the cause. It **could be an irritant**, however. If you think this is the case, talk to your doctor about being referred for further evaluation. A variety of diagnostic tests are available (e.g. esophageal pH probe testing, esophageal impedance testing, esophageal manometry, pharyngeal probe testing – called ResTech, pharyngeal pepsin assay, esophageal endoscopy, etc), depending on where you live. Don’t just take reflux medication ‘just in case’ – it causes its own issues such as brittle bones, kidney issues and more (and we really do not need any more health problems, do we?!). There is evidence acid reflux may slow or prevent adequate healing after endoscopic or open procedures, so it is important to diagnose and treat reflux in this situation.



“People with iSGS have more mucus than ‘normal people’” – the fact is we generally have the same amount of mucus as everyone else. The difference is that the cilia (little hairs in our trachea) which normally move the mucus up and down our airway with ease have been interrupted by the scarring. This means we must cough it past the scar. Sometimes mucus can build up and thicken behind the scar and form a mucus plug. This can be quite scary as it can block your narrow airway until you cough it out. Check out our tips to help avoid this, and ensure you **have regular dilations or steroid injections** to avoid the potential of a plug you cannot shift. If you have chronic inflammation present you *may* also have more mucus than normal – reducing inflammation (eg through diet) should also help reduce excess mucus.

“I cannot exercise because I have SGS” Many of us make ourselves continue to exercise despite iSGS. You should not stop exercising – rather it will be beneficial if you keep as fit as possible. So, what if you cough a little and sound like Darth Vader? The fitter you are, the better you will be able to cope with this disease.

Many people with this condition run, walk, swim, or go to the gym several times a week despite a narrow airway – just pick activities which are lower impact. We are superwomen (and rare supermen) – our bodies CAN cope with exercise.

There are plenty of alternatives out there if you look – these days you can get electric bikes which give you some exercise while helping you on the hills, try kayaking with a friend or your significant other in a double so they can help when you run out of steam...just don't give up moving because of SGS.

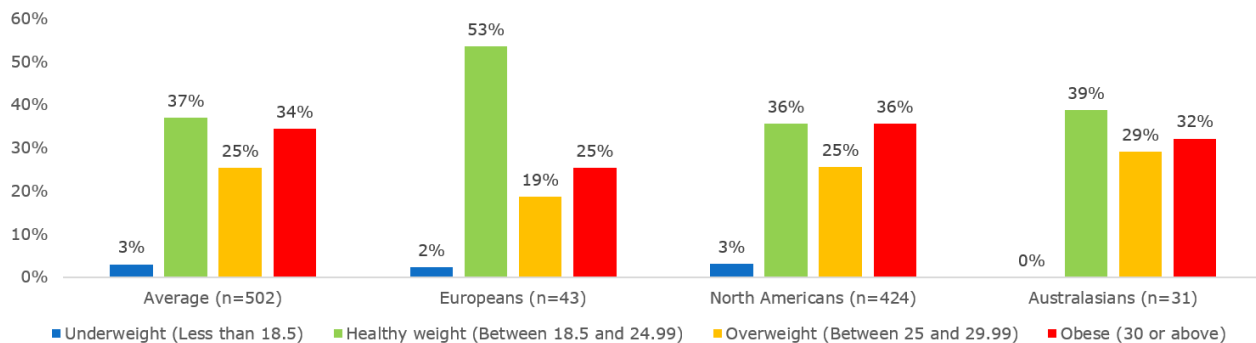
We suggest you start exercising as soon as you are breathing well after a dilation and keep going as long as you can. Just do what you can within your limits and any other conditions you have.

“I am overweight because of SGS” – again, most of the time this is an excuse. Most of us are overweight because we eat too much of the wrong type of food. Again, this is terrible for your overall health – you are putting stress on all your organs, and your SGS is not helping. Work hard to reduce weight naturally – cut back on sugar and processed foods and replace with fresh vegetables.

Body Mass Index (BMI) helps us to understand the general health of people by looking at their weight versus their age, gender, and height. This is important to look at because obesity has a negative impact on health overall*. Obesity is associated with hypertension, dyslipidaemia, ischaemic heart disease, diabetes mellitus, osteoarthritis, liver disease, and asthma. Obstructive sleep apnoea (OSA) is a common problem in the morbidly obese.

When coupled with a chronic disease such as idiopathic subglottic stenosis, risks are increased further. Every time an obese patient goes under an anaesthetic, they are at increased risk of airway collapse – especially if they have had symptoms of sleep apnoea or snoring.

One in three (34%) SGS patients is obese.



Q28. What is your Body Mass Index (BMI)? (Calculator provided) Base: Patients with idiopathic subglottic stenosis, n=502

**National Institutes of Health. National Heart, Lung, and Blood Institute. Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults—The evidence report. *Obes Res* 6(Suppl 2):51S–209S. 1998. Anaesthesia and morbid obesity - Sharmeen Lotia, MBBS MRCP FRCA Mark C. Bellamy, MBBS MA FRCA Continuing Education in Anaesthesia Critical Care & Pain, Volume 8, Issue 5, 1 October 2008, Pages 151–156

Recent research¹ has also found that SGS patients with obesity (particularly with a BMI of between 30.0 and 34.9) are likely to see their stenosis reoccur much faster after a dilation than those patients of healthy weight or underweight. Another good reason to consider reducing your weight.

If you need to calculate your BMI you can use this calculator – you will need your weight, height, age, gender, and an idea of your activity levels - <https://www.nhs.uk/live-well/healthy-weight/bmi-calculator/>

GLP-1 drugs can be considered to help lose weight, and have been found to reduce inflammation as a happy side effect. Anecdotally, around one in five airway stenosis patients find that using GLP-1 medication helps their breathing too – it is not yet known whether this is due to the reduced inflammation or something else at play. Hopefully some research can be undertaken in the next 12 months to determine this.

“SGS is caused by being pregnant or taking hormones” – this cannot be totally debunked but given that around one in five patients with SGS has never been pregnant, that suggests it is not the only reason. One in ten SGS patients has never taken any hormones (e.g. the pill). We also have males diagnosed with SGS who have not been on the pill or pregnant.

“You must not drink alcohol or caffeine with SGS” – in moderation, alcohol and caffeine are fine. We recommend you balance any drinking of alcohol or caffeine with plenty of water – dehydration is a real problem with SGS and can lead to life threatening complications such as mucus plugs. Of course, if you have other medicines or health conditions that require you to avoid these substances, then always listen to your doctor’s advice, otherwise, hydration is key.

“Having major surgery (e.g. resection, Maddern) will cure me of SGS” – Unfortunately, there is no cure to SGS at present. At best, major surgery may put your symptoms into remission, possibly for 10 or more years. You will always live with the diagnosis of subglottic stenosis, and there is a chance it will come back. Your likelihood of achieving a longer time without regrowth is directly correlated to the experience of the medical centre and team performing your surgery – the more experienced the centre, the longer your airway is likely to be stenosis free.

“I don’t need to have blood tests for ANCA, ANA etc because I tested negative in the past” – doctors recommend you have these tests annually even if you have tested negative – ideally when you have noticed your scar growing back or around the time of a dilation. The result can change even after many years. You can usually organise blood tests from your GP/primary health care practitioner.

¹ Evaluating the Association of Clinical Factors With Symptomatic Recurrence of Idiopathic Subglottic Stenosis May 2019 JAMA Otolaryngology - Head and Neck Surgery 145(6) DOI: 10.1001/jamaoto.2019.0707



“Your oxygen levels will be low with subglottic stenosis” – while a difficulty breathing might suggest oxygen would be low, for most airway stenosis patients oxygen is not an issue. Our bodies are simply amazing, becoming very efficient at extracting the right amount of oxygen for survival, despite the narrow airway. If you are experiencing low O₂ levels, there may be another health condition at play that needs investigating.

What tests should my doctor be doing?

There are a range of blood tests that should be regularly run to check for potential autoimmune causes of your subglottic stenosis.

There is not a definitive list of tests, but the following blood tests would be a great start to rule out known causes of scarring in the airway. Make sure you know what your doctor is doing or has done.



- **ESR (Erythrocyte sedimentation rate)** - used to detect and monitor the activity of inflammation as an aid in the diagnosis of the underlying cause.
- **CRP (C-reactive protein)** - used to identify the presence of inflammation, to determine its severity, and to monitor response to treatment.
- **S100A8/A9** – this is a biomarker that is becoming more commonly measured as it is more sensitive than other inflammation indexes, such as CRP, for detecting inflammation activity and response to therapy. Recent research among iSGS patients has shown that an elevated serum level leads to reduced time between operations ie a faster return of the stenosis.
- **RF (Rheumatoid factor)** - to help diagnose rheumatoid arthritis (RA) and Sjögren's syndrome
- **ANA (Antinuclear antibody; fluorescent antinuclear antibody)** - screen for certain autoimmune disorders, such as systemic lupus erythematosus (SLE), polymyositis, and a number of others
- **ACE (Angiotensin converting enzyme)** – screens for sarcoidosis.
- **ANCA** - looks for antineutrophil cytoplasmic antibodies (ANCA) in your blood test for vasculitis related autoimmune diseases, such as Granulomatosis with polyangiitis (once called Wegener granulomatosis), Microscopic polyangiitis and Eosinophilic granulomatosis with polyangiitis (once called Churg-Strauss syndrome).

Your doctor should also take a biopsy of the tissue while under anaesthetic if you are diagnosed as idiopathic. If, when this biopsy is tested for pathogens, it grows staphylococcus (a bacteria), it can potentially indicate the stenosis is caused by Vasculitis/GPA rather than being idiopathic. Further investigation may be required.

It is strongly recommended that blood tests are repeated each time you have an airway review or treatment (at least annually) as results can change many years later. It is also recommended that your doctor take a biopsy every time a dilation is performed.

If your surgeon suspects laryngeal reflux (acid from your stomach reaching your airway) then ask your doctor to refer you for further investigation. A variety of diagnostic tests are available (e.g. esophageal pH probe testing, esophageal impedance testing, esophageal manometry, pharyngeal probe testing – called ResTech, pharyngeal pepsin assay, esophageal endoscopy, etc),



depending on where you live. In the event you test positive, taking 20ml of liquid containing sodium alginate daily has minimal side effects. (In the UK, Europe and Australia use Gaviscon Advance, and in the USA, Reflux Gormet medicine, available at most pharmacies)

Tips to help reduce inflammation, mucus, and coughing

Coughing is a fact of life with SGS. Your airway has scar tissue instead of healthy mucosa. In your airway, the mucus gets stuck in the region of the scar tissue, meaning it becomes thick and can potentially harbour bacterial infections and build up into a mucus plug (see next section). Inflammation is also often an issue for airway stenosis patients which can exacerbate the issue. Fortunately, there are some things you can immediately do to help with this.

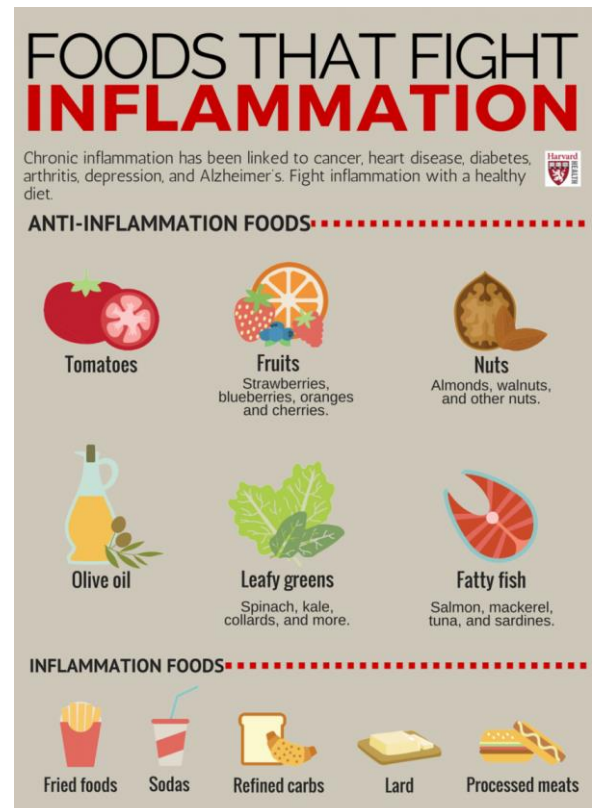
Diet

What you eat has a massive impact on your breathing – both the inflammation and mucus elements. You can search on the internet for the most current advice, but generally:

- Eat a diet rich in fruits and vegetables, especially:
 - Green leafy vegetables – such as kale, spinach, cabbage, water cress, romaine lettuce, Swiss chard, arugula, and endive
 - Dark yellow vegetables – such as pumpkin, yellow peppers, beans, and carrots
 - Whole nuts -
 - Fruits – especially blueberries, pomegranate, orange, cherries, strawberries, apples, and pears
- Drink– tea, coffee, and red wine (in moderation), and water (as much as you like)
- Cook with and dress salads with extra virgin olive oil.
- Fatty fish – e.g. rich in omega 3 fats in sardines, mackerel, salmon
- Nuts – especially walnuts which are high in omega-3 fatty acids. Studies have linked walnut consumption to lower levels of C-reactive protein (CRP), a marker of inflammation.
- Apple cider vinegar (organic, with the mother) – one tablespoon in soda water daily or sprinkled on salad as a dressing. Acetic acid, the primary active compound in ACV, may reduce inflammation by inhibiting pro-inflammatory pathways. It may help decrease the production of cytokines, which are signalling molecules that contribute to inflammation. It also has antioxidant properties, improves gut health and helps regulate blood sugar.

Minimise

- Red meat, processed meat, organ meat (kidney, heart, lungs etc) and refined carbohydrates (white flour and white rice)
- Sweetened beverages (anything with sugar in particular)



- Dairy products and soy – many members notice an immediate difference when cutting out cow's milk and its associated products (i.e. cream, yoghurt, butter, cheese, and products containing milk derivatives such as milk protein, lactose, whey). Soy milk is often portrayed as an alternative to cow's milk but can often result in similar mucus effects.

Other solutions

- Nebuliser - with 0.9% normal saline or cool boiled water - 5ml at a time as often as you need it. Research has found that 7 in 10 SGS patients experience improved mucus symptoms, and 6 in 10 experience improvement in cough (K Tanner, 2019).
- Humidifier in heated or air-conditioned environments

Over the counter medicines

- Medication containing bromhexine - Derived from the Adhatoda vasica plant, it aids in the clearance of excess mucus, improving breathing and reducing cough. Brands such as Bisolven Chesty, Benadryl Chesty Forte, Bisolven in most European countries.
- Medication containing guaifenesin - used to help clear mucus or phlegm from your chest when you have had a cold or flu. Guaifenesin works by making your mucus thinner and easier to cough up, which helps clear chest congestion. Brands include Mucinex, Sudafed Mucus Relief
- Lozenges containing benzydamine – this is an NSAID (non-steroidal anti-inflammatory drug) that reduces pain and swelling (inflammation). Brands include Difflam and Tantum Verde
- Nasal spray containing triamcinolone - contains a steroid to reduce swelling in nasal passages. Can aid airway as well. Do not use long term (due to negative steroid side effects) or when you have a throat infection. Brands include Nasacort (Australia, USA & UK) and Telnase
- Antihistamine can help dry existing mucus and prevent additional formation due to allergy.

Prescription medication

- Prednisolone / oral steroids
- Carbocisteine capsules – 750mg/3 times a day

Techniques to help clear mucus

Deep Coughing: Start by taking a deep breath. Hold the breath for 2-3 seconds. Use your stomach muscles to forcefully expel the air. Avoid a hacking cough or merely clearing the throat. A deep cough is less tiring and more effective in clearing mucus.

Huff Coughing: Huff coughing, or huffing, is an alternative to deep coughing if you have trouble clearing your mucus. Take a slow deep breath that is slightly deeper than normal. Use your stomach muscles to make a series of three rapid exhalations with the airway open, making a "ha, ha, ha" sound. Follow this by controlled diaphragmatic breathing and a deep cough if you feel mucus moving.

Nebulizer Use in Adults with Subglottic Stenosis: A Survey Study, Ann Otol Rhinol Laryngol 2019 Apr;128(4):345-351. Doi:10.1177/0003489418823797. Epub 2019 Jan 14. K Tanner, C Anderson, M Smith

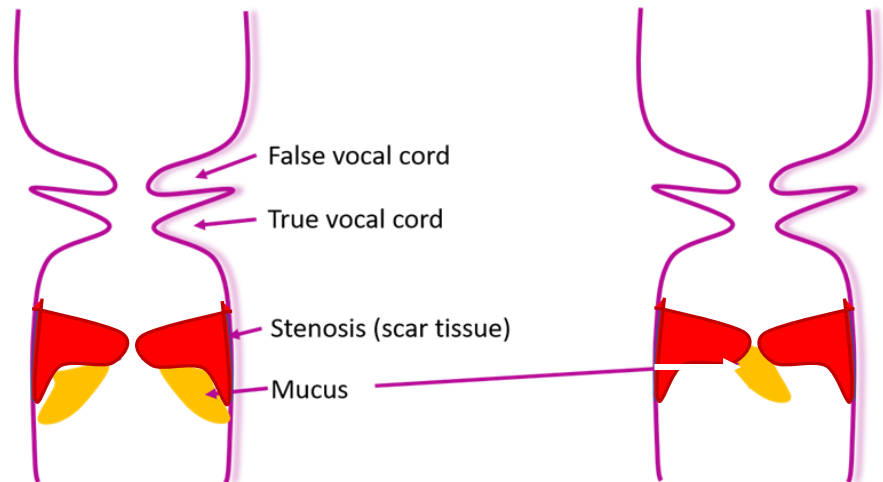
What is a mucus plug and how do I avoid it?

A mucus plug is a potentially life-threatening incident for people with subglottic stenosis and **must be taken very seriously**.

What is a mucus plug?

If you have never experienced a mucus plug, the following diagram attempts to explain what is happening.

Your stenosis is creating an unnatural obstruction in your airway. Even if you have a dilation, the lining of the airway still does not function properly at the site of scar. Scarring damages the delicate cilia that help whisk mucus out of the airway. This can lead to mucus getting stuck in your airway. You will have to cough to make this shift, and ideally cough it out (or swallow it).



Sometimes though, this mucus can get more difficult to cough out. This can happen when you get dehydrated, or when you get sick. If you have an infection you might find that instead of white or clear mucus being coughed up, it is yellow, green, or orange. This is a sign you are at risk of a mucus plug forming. When infected with bacteria, it can become quite thick, sticky, and hard, and is particularly challenging to cough.

When it becomes big enough, there is a risk of this blocking (plugging) your narrow airway. This is quite terrifying when it happens, and usually your survival instinct kicks in and you can manage to somehow cough it out.

Should a mucus plug affect you, you will not be able to speak and tell others what is happening, so it is best to forewarn those around you that this is a risk.

What if I cannot shift the plug?

If you cannot shift the plug, you will not be able to breathe or speak and will fall unconscious. If you have somehow managed to alert someone that you are struggling, they **must immediately** call for emergency medical assistance. Speed is of the essence here, and again it is important people around you are prepared with what to tell medical professionals when they call.

- You are not breathing and are now unconscious.
- Your airway is blocked.

At this stage, the name of your disease is **not** the most important thing, getting air is primary. Make sure they know what number to dial (e.g. 911/000/999 depending on the country they are in) – it is amazing how many people have a mental block to what the correct emergency services number is when they need to call it.

An option those around you can try is the **abdominal thrust** (also known as the 'Heimlich manoeuvre'). This is a first aid technique used to move foreign bodies caught in your airway in an emergency. This may dislodge the plug and can be tried while waiting for emergency services.



If you are alone, you can also attempt this on oneself:



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Mouth to mouth resuscitation can also be attempted by those around you, they can potentially push the plug back down into the airway allowing you to breathe. This can also be tried before you lose consciousness.

1. With the airway open (using the head-tilt, chin-lift manoeuvre), pinch the nostrils shut for mouth-to-mouth breathing and cover the person's mouth with yours, making a seal.
2. Give two **strong** rescue breaths...
3. Proceed with chest compressions to restore circulation.

How do I prevent a plug from happening?

Vigilance is key to prevention. If you notice the early signs, you need to act. These could be one or more of the following:

- Coughing more than usual
- Coughing up small lumps of mucus
- Mucus, which is yellow, green, or orange
- Your peak flow dropping 40%+ suddenly when it has usually been stable.

If you notice any of these, your first step should be to use your saline nebuliser **at least** twice a day. Adding moisture to your airway can help you cough up the growing plug before it becomes unmanageable. Staying hydrated with enough water is also extremely helpful.

In addition, if you have noticed green, yellow, or orange coloured mucus, then consult with a doctor about using antibiotics to help clear any infection.

Finally, keep monitoring your breathing with your peak flow meter – if it remains low despite action, then contact your ENT surgeon, and if you continue to have concerns, go to emergency at your local hospital.

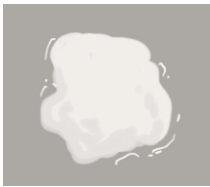
A mucus plug is very serious, and subglottic stenosis patients have died from this.

Should I be worried about my mucus/phlegm?

Not all mucus/phlegm is of concern, so here is a guide to help you understand whether you are potentially at risk from a mucus plug.



Clear: good news, this is healthy mucus. Keep yourself hydrated and nebulise with saline as necessary (every two to three days or more often if you need). Low risk of creating a mucus plug.



White: a virus such as the common cold. Increase your hydration, avoid caffeine and alcohol, and use a saline nebuliser regularly (daily or more often if you need). Not usually a risk for plugging but keep an eye on things – if it thickens or becomes hard to cough up, then increase your nebulising frequency.



Yellow or green: a bacterial infection. Yellow phlegm suggests that immune cells are starting to work at the site of the infection or another type of inflammatory condition. White blood cells are the cells of the immune system that are responsible for fighting germs. As they continue to fight the infection, the phlegm picks them up, giving it a yellowish tinge.

If accompanied by a fever, then see your doctor for antibiotic treatment.

Increase your hydration, avoid caffeine and alcohol, and use a saline nebuliser regularly (daily or more often if you need). Can be a risk for plugging, so vigilance needed to keep it moving with fluids.



Orange or brown: sign of inflammation and dried blood. Increase your hydration and nebulise more frequently with saline. See a doctor if you are coughing up lots of bright red blood, but small smears are not of concern. There are many reasons for blood in the phlegm. A lot of coughing, such as with subglottic stenosis, can sometimes cause small blood vessels in the lungs or airways to break and bleed.

When there is swelling in a person's nasal passage, they can get a nosebleed. This can cause blood to seep into postnasal drip that they then cough out. Can be a risk for plugging, so vigilance needed to keep it moving with fluids.

Texture: Thicker/tackier mucous is of highest risk to airway stenosis patients. This is most likely to increase your risk of a plug. Reducing your risk is about:

- Nebulizing saline – delivers moisture directly to your airway
- Running a humidifier - can help moisten the air you breathe

Both options make it easier to cough and loosen up the phlegm stuck in the airway.

Some individuals may find that gentle walking can help them cough up excess phlegm.

Your essential medical emergency kit

The next section details what **equipment will help daily**, but we also recommend you have an **emergency medical kit** (or prescriptions you can fill quickly) to hand so you can act quickly when required. This is particularly important if you are travelling and don't have access to your usual doctor(s). It is always a challenge to explain this disease to someone who is not an expert, so being self-sufficient is important.

Speed is often of the essence when it comes to keeping you and your breathing safe, and you do not want to have to wait for appointments or calls to be returned.

Vaccinations

Three vaccinations are strongly recommended to help reduce chance of breathing issues:

- **Flu vaccine** - the flu can be serious, leading to complications such as pneumonia, myocarditis (inflammation of heart), neurologic conditions and other bacterial infections – all high risk to airway stenosis patients.
- **Pneumococcal vaccine** - helps protect you against pneumococcal disease. Pneumococcal can cause a fever, pneumonia, meningitis, blood poisoning (septicaemia), ear infections and other airway infections.
- **Covid-19** – complications from Covid-19 are increased if your airway is narrow, or you have another illness such as diabetes, heart disease or are obese. It is recommended you have this vaccine to minimise the chance of developing severe complications.

Prescription medicine

Ideally, your kit at home should include the following:



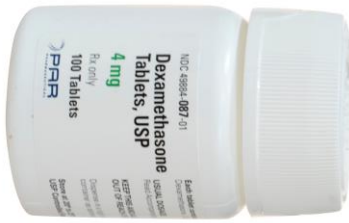
Antibiotics: You can keep these in the fridge and have them quickly on hand to treat any airway infections. It is important to nip any potential mucus plugs in the bud and having these immediately accessible will help you do that. At the very least have a prescription from your doctor that you can quickly fill.



Prednisolone: Inflammation is common with this condition and can cause breathing issues at short notice. Having steroids on hand can help address this quickly.

Make sure the dose is small enough to enable you to taper over a few days. A typical dose would be 20mg for 5 days, followed by 10mg for 5 days, followed by 5mg for 5 days.

We recommend taking additional Calcium and Vitamin D to help support your bone health.



Dexamethasone - corticosteroid medication: An alternative to prednisolone steroid tablets, these also help tackle inflammation.

A typical dose would be 4mg three times a day for three to five days.

If available in your country, insist on **enteric coated** steroid tablets. Oral steroids can exacerbate reflux symptoms. Enteric coated tablets prevent absorption in the stomach (which causes or worsens reflux), and instead the tablet travels further and is absorbed in the small intestine.

If they are not available, ensure you take an alginate (seaweed) based anti-reflux medication (such as Gaviscon) to prevent stomach acid reaching your airway and causing more issues.

We recommend taking additional Calcium and Vitamin D to help support your bone health.



Inhaled steroids: A steroid inhaler can potentially quickly deliver steroids right to your stenosis. Research has shown that budesonide inhalers (eg Pulmicort, Entocort or Symbicort) generally have larger particle sizes compared to others like fluticasone or beclomethasone. Larger particles tend to deposit more in the upper airways and stenosis area rather than reaching the deeper lung tissues, where it will not help.

Make sure you gargle and rinse your mouth out with water after each inhale (usually one or two per day) to prevent oral thrush.

Use this when you feel you are narrowing or post dilation – it can be used in conjunction with a short dose of steroids, or as part of the Mayo Protocol (see specific section on this treatment).

Non-drowsy antihistamine tablets: these are great to have on hand to stop minor allergic reactions – such as sneezing and coughing – in response to an allergen. Anything that helps stop more mucus production and irritation to your airway is a good thing.

Letter from your surgeon for emergencies

If you are travelling and/or do not live near to your treating doctor, it is recommended you ask your surgeon for a letter to have on hand, should you ever need to present to hospital for breathing issues. It should ideally be on your doctor's letterhead with the following message (or similar in their own words).

If you are unable to get this from your doctor, just carrying a printed version of this letter will help in emergency situations.

Dear Doctor

This patient suffers with a recurrent stenosis of her airway which may lead to shortness of breath or stridor.

She is more likely to have mucous plugging especially in the presence of a respiratory infection. Please avoid a tracheostomy unless lifesaving and consult with her airway specialist detailed below:

(Doctor's details including emergency contact number)

Given the small airway diameter, intubating the patient may be very difficult, if not impossible. Attempts at intubating the patient without directly visualizing the subglottis can cause further traumatic swelling and worsen the situation.

Consider preventative management until the subglottis can be visualized or the patient can be taken to the operating room to improve the airway.

- **Steroid injection** either IV or IM (Dexamethasone 10 mg IV, Solu-Medrol IV/IM, or equivalent)
- **Ventilation support** using CPAP, BiPAP, or High Flow O₂ via nasal cannula
- **Respiratory support** with adjuncts such as Heliox and racemic epinephrine inhalation

Hopefully, you never need to use this, but it is better to have on hand. This letter could save your airway from serious damage. **There is also a more detailed letter in the appendix which may help also.**

What equipment will help me?

1. Nebulizer

We **highly recommend** you invest in a nebulizer to help with this condition. A nebulizer is a machine which basically converts liquid into a cloud which you breathe in through a mask. Most of the time all you will need to put into your nebulizer will be 9% normal saline (available from chemists, online or may be provided by your doctor) or cool boiled fresh water (i.e. do not re-boil a kettle – empty it, boil a fresh batch of water, and let it cool).

You may come across nebulisers when you are in hospital – they usually come straight out of the wall, are noisy and involve putting a mask over your face and breathing in. In the hospital, they may be mixed with pure oxygen or just the air in the room, plus saline (makes a gurgly noise as it is turned into clouds!)

How do I use it?

Each model has its own instructions to follow, but generally, you fill around 10ml of saline or cool boiled water into a reservoir, reconnect the device, affix the mask over your mouth and nose, and turn on. Some models come with an alternative mouthpiece if you do not need to be hands free, which allows you to just breathe straight in. Breathe normally, occasionally taking deep breaths to ensure you get the liquid deep down your trachea.

What should I use in it?

0.9% 'Normal' Saline is recommended for everyday use. This is a mixture of sterile water and salt. The 0.9% means there is 0.9 grams of salt per 100ml of solution, like the amount of salt found in the blood and tears. It may also be known as isotonic saline. It can be purchased, or may be prescribed by your doctor, but it is also very easy to make.

If you have more challenging mucous, you may want to try 3% Hypertonic saline. This is much saltier, and will make you cough harder, but attract more liquid to your stenosis and make the sticky mucous easier to shift. Using the recipe for normal saline, instead of 1 teaspoon of salt, you would make it with 2-3 teaspoons.

Rarely, your doctor may recommend using your nebuliser with a drug called albuterol (also known as salbutamol) in your nebuliser. This is usually used in patients with asthma to help relieve spasms or tightening of the muscles in the lungs and airways. This will need to be on prescription, if used.

Why is using a nebuliser useful?

It helps put liquid directly into your trachea, soothing the airway and helping move any mucus that is there, and breaking up any thicker lumps which might be causing a plug. It may make you

Recipe for normal saline

Ingredients:

- 2 cups of tap water
- 1 teaspoon of iodine-free salt/fine sea salt/Kosher salt

Method:

1. Bring 2 cups of water to the boil, and boil covered on stove top for 15 minutes (to sterilise the water)
2. Cool to room temperature
3. Mix in salt until dissolved
4. Use as often needed
5. Store in fridge for 24 hours

cough, but this is good. You are only coughing because something needs to come out – have tissues on hand!

We cannot emphasise enough the importance of nebulising when you need to. Nebulising can help you to avoid a life-threatening situation. Patients have died from incurring a mucus plug they were unable to shift.

What types of nebulizer are there?

There are many on the market, but we highly recommend a quiet nebuliser – it means you are more likely to use it, and **those** recommended below are also portable and can be used while watching the TV or travelling as a passenger in a car or plane, not disturbing anybody.

Examples include:

- **Omron MicroAir U100**
- **Medel Smart**
- **Pari Trek S**
- **Beurer Personal Portable Nebuliser**



Humidifier

A humidifier is a device you fill with water, turn on and it puts moisture back into your atmosphere. Particularly useful where you have air conditioning or heating on where the air is particularly dry.

How do I use it?

Each model has its own instructions to follow, but generally, you fill a reservoir with water and turn on. You leave it somewhere in the room where you are working or sleeping.

Why is it useful?

It moistens the air you are breathing, making it less drying on your trachea and more soothing. Not as effective as a nebulizer but a less invasive way of easing the way.

What types of humidifier are there?

There are many on the market. You should easily be able to find them online – often second hand from parents used them to help young children with croup. **Recommended: Levoit Classic 300S Ultrasonic Smart Humidifier or Beurer LB45 Ultrasonic Air Humidifier**



3. Medic alert bracelet

First responders and medical personnel are **trained to first look for medical identification jewellery**. Medical IDs will alert emergency medical professionals to your critical health and personal information and will speak for you in the event you become unresponsive.

Some people have suggested having a tattoo as an alternative to jewellery – please note this is **not** recommended as this is not commonplace and they are likely to be overlooked in an emergency.

Try not to put too much information on the bracelet or tag – responders are unlikely to take time to follow QR codes or type in numbers or websites to get to your information. Keep the information concise to ensure its easily readable. A good rule of thumb is to prioritize the most critical information that could affect immediate medical decisions.

Suggested wording: Subglottic stenosis; very narrow airway, difficult intubation - use paediatric tube.


Wearing a bracelet or tag on your wrist reduces treatment errors which may result from not having full knowledge of your airway issues during an emergency or upon hospital admission.



4. iPhone users: *Medical ID

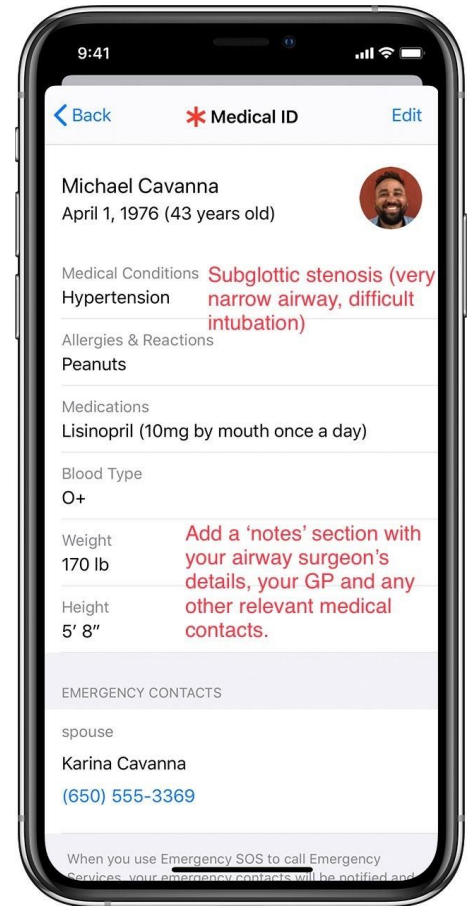
One of the lesser known features of Apple's mobile operating system is a digital "Medical ID," which can provide important personal health related information in the event of an emergency.

How to set up your Medical ID

- Open the Health app  and tap the Summary tab.
- Open the Health app and tap the Summary tab.
- Tap your profile picture in the top right-hand corner.
- Under your profile picture, tap Medical ID.
- To make your Medical ID available from the Lock Screen on your iPhone, turn on Show When Locked. In an emergency, this gives information to people who want to help.
- To share your Medical ID with emergency responders, turn on Share During Emergency Call. When you make a call or send a text to the emergency services on your iPhone or Apple Watch, your Medical ID will be shared with the emergency services automatically.*
- You can make changes at any time. Tap Edit or Add next to the field you want to update. You can add details such as medications, allergies and any conditions you have.

* Enhanced Emergency Data is not available in all countries or regions.

After the Medical ID has been created, you can always go back and make changes at any time through the Health app.



What is a Peak Flow Meter?

A peak flow meter is a portable, hand-held device that measures how well your lungs expel air. It will not improve how you breathe, rather it will help you understand whether you are stable or declining without seeing your doctor for a scope.

It measures your ability to push air out of your lungs in one fast blast by blowing hard through a mouthpiece (i.e., the force of airflow through the bronchi and thus the degree of any airway obstruction). It gives you a numeric reading on a scale; peak flow readings are higher when the airway is open, and lower when the airway is narrowed (constricted).

Once daily use of a peak flow meter at approximately the same time of day helps you to measure breathing trends and detect any airway narrowing before you may feel any symptoms. It can enable you to consult with your physician before your symptoms worsen to organise injections or other intervention to stem the decline.



How do I use my meter?

Take a deep breath, and then puff your air out sharply into the mouthpiece of the meter, making sure the little white marker starts at zero on your first puff. For your second puff, leave the white marker wherever it landed after your first puff. You might be able to move it a bit further. Try a third time, and wherever the marker is after your final puff, record this in an app or spreadsheet.

Obviously, if your peak flow meter is different to the one pictured above, there may be different instructions, so please follow those.

How often should I use my meter?

Ideally once a day but at least weekly if you find it hard to remember each day.

Does it matter if it is not the same time each day?

Try for the same time of day, e.g. when you wake up in the morning – when you clean your teeth. Integrating using your peak flow meter with an existing habit means you are more likely to continue doing it.

My numbers are lower/different to other peoples. Is this a problem?

The data you are recording is individual to you. Everyone has a slightly different expectation depending on their age, height, other health conditions and where their stenosis is located. Men, regardless of their height or age, will always achieve a higher Peak Flow reading than women. It is not useful to compare your result with your brother, boyfriend or husband!

This chart gives you an indication of average normal peak flows for 'healthy' people by age, height, and gender. As you can see, the older you get, the lower your expected PEF is.

Of course, there are other things to consider including other health conditions that may also impact breathing (such as cardiac health, lung conditions), overall fitness. For example, people who maintain a good level of fitness and live at high altitudes can achieve much higher peak flows than expected, whereas someone who has additional health conditions may be expected to achieve a

lower level. If you have issues with inflammation and/or mucous, your peak flow is likely to be lower.

This chart gives you an indication of how closed you might be depending on your peak flow. The higher numbers in each category relate to taller people (eg 6 foot/180cm tall), the lower numbers for shorter people (eg 5 foot/147cm tall).



Peak flow ranges by age.

The taller you are, the greater your peak flow is likely to be. As you age, your peak flow naturally declines.

		Age							
		Under 25	25-35	35-45	45-55	55-65	65-75	75-85	Action
Average peak flow	0-20% closed	310-460	340-470	330-465	310-445	290-425	270-395	245-360	Happy days!
	20-40% closed	185-365	205-375	200-370	185-355	175-340	160-315	145-290	Steroid injections can help open you up
	40-50% closed	155-275	170-280	165-275	155-265	145-255	135-235	120-215	Talk to doctor about scheduling a dilation
	50+% closed	Below 155-230	Below 170-235	Below 165-235	Below 155-230	Below 145-215	Below 135-195	Below 120-180	Urgently organise dilation

My numbers are declining. What does this mean?

If it is in the short term, don't worry, but if you are consistently declining this may be a sign your airway is starting to close, or you have a mucus plug/inflammation.

My numbers remain strong but my breathing is still a challenge. What could be happening?

Peak flow is not a perfect measure as it only shows your outward breathing. If your numbers look good but your breathing is still challenging, you should make an appointment to see your doctor and ask them to investigate other potential issues such as tracheomalacia, problems with your vocal cords when breathing in, or a possible skin flap causing problems in your airway. Always trust your gut feel. If it doesn't feel right, check it out.

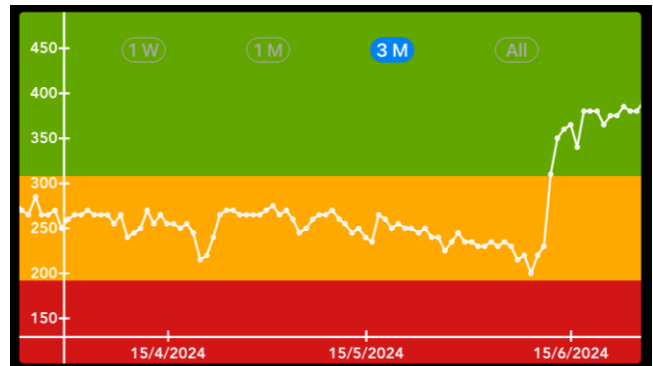
Where should I record my values?

You can record PEF results using specifically designed apps – such as the one provided by AsthmaMD (www.asthmamd.org/)

The AsthmaMD app provides green, amber and red zones set by your age and height to help provide a guideline for your airway health. Once you reach close to 'red' it is very likely you need a dilation surgery.

You should contact your surgeon prior to reaching this level to schedule your next procedure.

iPhone users will also find a tracking feature under the Health app which comes with the phone, or you can track it manually on a paper chart, or spreadsheet.



This chart shows a steady decline following a quick increase (post dilation surgery).

Chart generated by AsthmaMD app

I just had a dilation or other clinical therapy; do I have to use my peak flow meter every day?

Resume use of your peak flow meter when it feels comfortable to do so. It is important to understand how good you are post a dilation or steroid injections (when you are breathing well), as this will help you learn more about your airway health.

Where do I get a Peak Flow Meter?

Peak flow meters are available for purchase at pharmacies, drug stores, and online retailers.

What are the benefits of recording my peak flow data?

You will learn what your airway is capable of when you are breathing well versus less well – you can also monitor how quickly you decline after a dilation or improve after injections.

You can be proactive in making appointments for procedures (e.g a check-up, injections or a dilation surgery) by providing evidence of a continual decline in your airway health.

All evidence is essential to help your specialist offer advice about any potential next steps in your care.

Doctors are very happy when their patients can show evidence of their airway health via a peak flow chart, and there have been many published medical papers in recent years supporting this.

Summary: what interventions are available?

The following pages describe the various surgical approaches in more detail, however, here is a summary of the surgical, medical, and adjunct therapies you may come across in your treatment:

Surgical procedures	Medical therapies	Complementary therapies
<p>ENDOSCOPIC (Using a flexible tube, inserted via the nose or mouth)</p> <ul style="list-style-type: none"> Endoscopic tracheal dilation/dilatation (with or without cuts or laser, with or without topical or injected corticosteroid, with or without Mitomycin-C) Endoscopic resection with laser and medical therapies (e.g., antibacterial, inhaled corticosteroids, anti-reflux) Endoscopic tracheal reconstruction (Maddern technique) <p>OPEN ANTERIOR NECK SURGERY</p> <ul style="list-style-type: none"> Cricotracheal resection Laryngotracheoplasty: <ul style="list-style-type: none"> Cartilage tracheoplasty Slide tracheoplasty Tracheostomy (rare) <p>IMMUNOTHERPY to inhibit immune system response</p> <p>Your doctor may suggest immune suppressant medication if you have inflammation in your airway, and/or a quickly returning stenosis (6mthly or more often) even if you haven't tested positive for vasculitis (e.g. GPA). This may include one or more of the following drugs:</p> <ul style="list-style-type: none"> Rituxan/Rituximab Mycophenolate mofetil (MMF)/Cellcept Methotrexate (MTX) Azathioprine/Imuran Cyclophosphamide/Cytoxan <p><i>Note: This information has been compiled from published journal articles, physicians' recommendations, and personal communications. It presents SGS testing, therapy or monitoring options that patients may be following. It does <u>not</u> intend to endorse or repudiate any SGS testing, therapy or monitoring options.</i></p>	<p>ANTIBIOTICS to tackle bacteria which may be causing inflammation</p> <ul style="list-style-type: none"> Sulfamethoxazole and trimethoprim (eg Bactrim) Azithromycin Erythromycin, if allergic to sulpha drugs <p>CORTICOSTEROIDS to inhibit fibroblast formation and reduce inflammation</p> <ul style="list-style-type: none"> Oral tablet (e.g. prednisolone) Oral inhalation (e.g. nebulized albuterol, budesonide, eg., pulmicort) Injected (e.g., triamcinolone, i.e. Kenalog, between dilations in-office or "awake") <p>PROTON-PUMP INHIBITORS (PPIs) to reduce gastric acid reflux (GERD) if this is an issue for you'. It is not recommended PPIs are taken for longer than 6 months. Please talk to your doctor if you have been taking these for longer – research has shown prolonged use leads to decreased intestinal absorption of calcium resulting in negative calcium balance, increased osteoporosis, development of secondary hyperparathyroidism, increased bone loss and increased fractures. Sodium alginate liquid</p>	<p>HYDRATION to keep mucus thin and slippery (not thick and sticky) and to keep vocal folds moist</p> <ul style="list-style-type: none"> Internal hydration: <ul style="list-style-type: none"> Drink plenty of water Reduce caffeine and alcohol External hydration: <ul style="list-style-type: none"> Steam inhalation Nebulisation with sodium chloride solution Warm air room humidification Nasal rinse Nasal spray <p>MUCOLYTIC THERAPY to help expel mucus</p> <p>Mucolytic medication:</p> <ul style="list-style-type: none"> OTC expectorant cough syrup (e.g., guaifenesin) Throat lozenge with glycerine, pectin, or slippery elm (not menthol or eucalyptus) Amino acid (N-Acetyl Cysteine, NAC): <ul style="list-style-type: none"> OTC oral capsule Oral inhalation (nebulized NAC, i.e., Mucomyst) <p>Airway Clearance Technique or Device:</p> <ul style="list-style-type: none"> 'Huff cough or 'huffing exercise Flutter valve, e.g., Acapella <p>LIFESTYLE CHANGES</p> <ul style="list-style-type: none"> Dietary change, anti-inflammatory diet, anti-reflux diet Weight loss Vitamins, herbs Probiotics Enzymes (e.g. bromelain)

What is a dilation surgery?

Once you have been diagnosed with SGS your surgeon will most likely book you in for a dilation operation (a dilation and a dilatation refer to the same thing – an operation aimed at opening your narrowing). While this does sound quite daunting at first (after all it may be your first ever visit to the theatre without enjoying the show!), hopefully we can help quell the nerves.

I've heard about different types of dilation. What is the difference between these?

Technique	Pros	Cons
Laser dilation (or laser and balloon or laser and manual manipulation of scar)	A precise manner of dilation, particularly in experienced hands allowing the doctor to carefully open the scarring without damage to the rest of the airway	In less experienced hands there is some risk of the laser causing damage to healthy tissue therefore making the scar tissue spread.
Balloon dilation (sometimes with a small blade to do some cuts first)	Not likely to cause problems in other areas of the airway/cause the tissue to grow.	Slightly less precise, using the balloon to 'tear' open the scar tissue. If cuts are done first, then the balloon can open the scar tissue in a more regulated way.
Coblation dilation (Radio-frequency cold coblation) - uses controlled energy delivery to operate at the relatively low temperature of 60-65°C.	This aims to reduce surrounding tissue damage and postoperative pain and to avoid seeding of viral particles during the process. For the doctor, this is a cheaper method of treating you.	Even in experienced hands this is a big device and can be a challenge to control the exact area being treated. Anecdotal findings from doctors suggest there is a risk of this method causing the scar to travel up towards the vocal cords meaning it is not recommended.
Cryotherapy (could be cryotherapy with balloon). This uses a technique whereby the scar tissue is frozen and defrosted before being dilated.	There is limited research suggesting this can be successful among some patients	Not used in the major centres. Key concerns are the inability to direct the cryotherapy only to the scar tissue, opening the healthy airway tissue surrounding it to potentially becoming damaged and scarring. This is thought to cause the scar to travel up the airway closer to the vocal cords (thereby causing permanent loss of voice).

Technique	Pros	Cons
Rigid bronch (use of a set of steel pipes, small to larger, in succession, to stretch the trachea) without balloon.	Doctors with a lot of experience with this technique prefer it to laser or balloon and believe it delivers better results. It is more likely to be used by Thoracic surgeons than Laryngologists.	The surgical view is quite poor with this technique resulting in a less precise procedure. High risk of permanent damage to vocal cords and therefore voice.
CO ₂ laser wedge excision (sometimes referred to as wedge resection)	Using a laser, the doctor will cut wedges out of the scar tissue. The patient will take some medication post-surgery to maximise success rate.	This technique (and associated medication protocol) has high success rates in keeping the airway open while minimising risk to vocal cords.
Argon Plasma Coagulation (APC) - an electrosurgery using flexible endoscopy to treat trachea/bronchial stenosis. APC uses gas discharges to induce thermal therapy with small electrical bolts on soft tissue with no contact, meaning no cutting. This allows the surgeon to carefully destroy the scar tissue.	Minimum bleeding from stenosis removal (though there is little bleeding with other techniques also). Less invasive option for treating stenosis. May be beneficial in removing more difficult scar tissue.	Some surgeons like to perform a series of this procedure (3-4 times every few weeks) to arrive at the best outcome. Whether this is more effective than a single procedure, is uncertain.

Use this information to **ask questions before you have your surgery**. Make sure you know what operation you are having in advance. If you have had one of the 'higher risk' dilations in the past, do not panic - it does not mean your scar tissue is going to travel up towards your vocal cords, but you may want to ensure you have a less risky surgery in the future.

How long does the dilation operation take?

It takes **from 30 minutes up to an hour in total**. Mitomycin C may be administered. **Most doctors inject the treated area with steroids at the end of the operation.**

How will I breathe while I am being dilated?

'Jet ventilation' is the most frequently used technique. This allows continuous oxygenation during the dilatation procedure without intubation.

What is mitomycin C?

Looking it up online can be quite daunting when you find it is a drug used in cancer treatment (chemo). It does not mean you have cancer or are having chemotherapy. It is sometimes applied to your scarring at the end of the dilation in the hope that it will stop the scar cells from growing back. There is little evidence that this works, but most patients do not experience any adverse side effects (you might be able to taste it as a bitter flavour when you cough once you wake up). Some patients experience a longer time between dilations when this is applied. **Most centres have stopped using this due to lack of evidence it does anything (and it is expensive).**

My Doctor mentioned steroid injections with my dilation – what does this mean?

It is becoming increasingly best-practice for steroids to be injected at the site of your scarring once the dilation has been completed. This will be in similar quantities to those injected in office (see section on in-office/awake steroid injections) but administered while you are under a general anaesthetic. It is possible you may experience minor side effects (such as flushing and/or insomnia) from these for the 24 hours following your surgery. You may be able to taste the bitter steroid when you cough for the first 24 hours.

How long will I be in hospital?

Most people are only in hospital for the day with some staying overnight. The reason for the overnight stay is as a precaution for possible swelling in the airway - particularly for people who do not live near the hospital.

How will I feel afterwards?

You will have a sore throat and feel sleepy from the anaesthesia but generally should feel good - within two or three days you should feel the benefit breathing wise.

Some people may have a husky voice for a few days post operation but this will go as any bruising and inflammation subsides.

Your neck and back may feel stiff and sore from the positioning of you during surgery. The longer the surgery, the more prone you will be to be sore. You may also feel aching in your ribs from the air flow in your lungs. All this dies down within a couple of days.

There is a nerve in the airway which links directly to your ear. As this may be irritated during the surgery, there is a chance you will have pain in one or both ears for a short time (up to a week).

You may have a cough for a week or so in response to the healing. This is normal.

A saline nebuliser for 30 minutes a day for a few days post op can help soothe your airway and ease the coughing.

What medication am I likely to be on afterwards?

Some doctors prescribe paracetamol with codeine. This provides pain relief and suppresses any cough for the first few days. Some doctors prescribe a steroid inhaler to use for a month post op.

If you have the endoscopic laser wedge excision/resection you are likely to be asked to use inhaled corticosteroid and trimethoprim/sulfamethoxazole (an antibiotic such as Bactrim, Cotrim or Septra) post the procedure. Some patients are also prescribed antibiotics for 5 days post-surgery.

How long before I should go back to work?

Usually recommend about 3 days away from work to rest post operation, with at least 2 days resting the voice post op. Do not whisper as this strains the vocal cords.

How long until I can resume normal activity or exercise?

Most patients are not given any advice on this - basically do what feels best. The day after your surgery you should be able to manage a short walk, but your throat will be sore so would not advise running or anything too strenuous. Basically, go with gut feel. The anaesthetic will make you feel sluggish for a day or two, after that you should be able to go back. Best advice: listen to your body - if you do not feel like it, then don't do it! Do not over stress yourself and put back your recovery.

How long until I can resume measuring my peak flow?

Like exercising, follow your gut feel. It usually takes up to a week until your peak flow will be at its best, but as soon as you feel comfortable, measure your peak flow as it will help you learn more about your recovery time and how your airway performs right after a dilation.

Will I only need one dilation?

Most patients will have a second dilation within two years, sometimes sooner

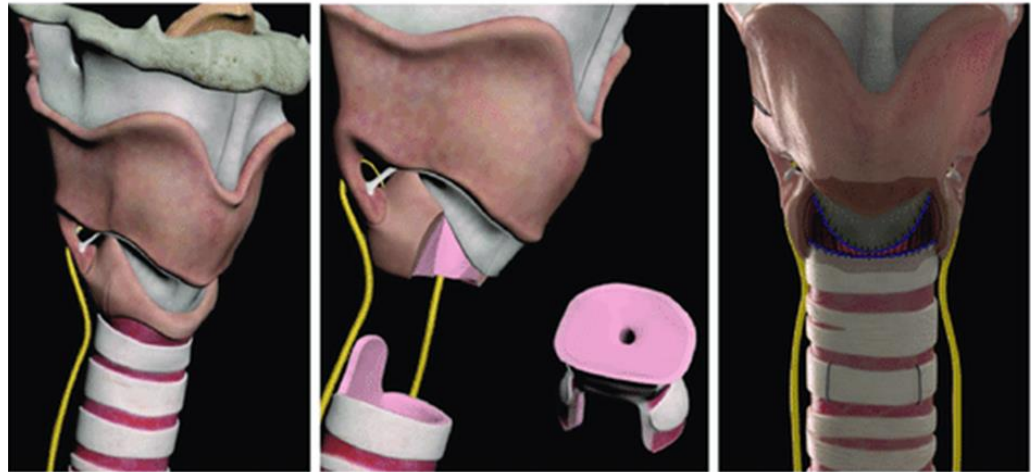
Are there other risks from dilation?

It is possible your tongue could be temporarily injured as part of the surgery. Symptoms can include dryness, loss of sensation, and loss of taste of the front two-thirds of the tongue on the same side. If this happens, let your doctor know right away. They will want to rule out any other causes (such as stroke, haemorrhage, and nerve impingement), but once these have been discounted, the treatment is quite simple. A short course of oral steroids (dexamethasone 10mg for three days) should reduce the inflammation and resolve the issue.



What is a resection (resection and reconstruction) and how is it done?

A tracheal resection is a complex surgery that involves removing a scarred portion of the trachea and reconnecting the healthy ends. You may hear it also called Cricotracheal resection (CTR), Laryngeal Tracheal Resection (LTR) or Tracheal resection



and reanastomosis. All are slightly different but with similarities. For example, when the scarred portion is particularly long, a stent or piece of rib is inserted into the neck to replace the lost cartilage and prevent the neck from collapsing.

What is the success rate of this surgery?

Published articles suggest an 80-95% success rate. On average, a resection will last around 10 years. As with all averages, some last less time, others longer.

Can previous treatments 'mess up' your candidacy for resection?

Most skilled doctors will still be able to conduct a resection no matter how many dilations you have had. There may be other reasons you are rejected for a resection, however.

What exactly are the risks?

The main risk is restenosis. Next is damage to the nerves of the vocal cords. There is about 1% chance of bleeding or infection. Around 5% of patients with a very experienced surgeon will go on to re-stenose within the immediate 3 years.

Most patients will have some permanent change in voice (often deeper) due to changes in laryngeal elevation (needed for a good vocal range, especially in singers). Some may not be able to project their voice or speak loudly.

How bad is the pain? How long are you on pain meds?

Talk to your doctor ahead of time about pain relief and muscle relaxers. Some say the position the chin stitch puts you in (if used) is the greatest pain. The hospital will manage your pain in the best

way for you. Some report experiencing a pain level of maybe 7 out of 10 day one and two, 5 out of 10 day three and then maybe a 2 out of 10 for the final few days.

What is a chin stitch?

The chin stitch can be used to help keep the head in position in the case of long segment stenosis removal, but the trend has generally to be to move away from this technique. If your surgeon plans to use a chin stitch (sometimes called a 'Grillo stitch' after the first doctor who used this technique) **please ensure you are comfortable with their expertise and their reasons for using it.**

Doctors who have been performing many resections with the chin stitch for many years are confident in the safety of this technique. If you are certain with the level of experience of your surgeon, then you should be safe with this technique.

These days, it is more common to have a c-collar/neck brace for a few weeks and keep the neck flexed as much as possible.

Do you have difficulty swallowing after surgery? How long before you can start to eat and drink?

Most patients are on a feeding tube for up to 5 days before being placed on a soft diet. You will likely be given medicine via IV to calm your stomach.

How long after surgery before they have you up and around?

You are encouraged to move around and are likely to be walking within the first two days.

I saw mention of a drain, what is that, where is it placed and for how long?

It comes out from your chest or beside your neck incision and it is in 3 or 4 days, it is more unattractive than painful.

Do you need to have a feeding tube and catheter? If so, for how long?

You are likely to be given catheter. If you can walk, they will let you take it out.

Are you on antibiotics or any other type of meds following surgery? If so, how long?

Some receive steroids to keep swelling down as a daily injection at the hospital and then taken orally on a tapering dose for 2 weeks. You may also be given acid reflux medication as a precaution – **steroids can aggravate acid reflux.**

Are you required to be on voice rest after surgery? If so, how long?

There are varying experiences – some are asked to speak right away, while others are put on voice rest for several weeks.

How long does it take for your voice to get as good as it will get?

This is not known for sure – some patients require voice coaching to strengthen their vocals and return to near previous levels. Others will always have a weaker or raspy voice.

What is the recovery time and what can I do during this period?

Generally, a minimum of 6 weeks off work, and return to work depends on each individual, as everyone feels and recuperates differently. Many patients are told they cannot drive for 8 weeks

How bad is the scar?

The scar is about 7.5cm (3 inches) in length.

Can also have a small 1 cm (half an inch) scar where the drain is located

What is The Maddern Procedure (Endoscopic Resection and Mucosal Reconstitution with Epidermal Grafting)?

This surgery is suitable for patients with an isolated subglottic stenosis in a mature, non-inflammatory phase. Through an endoscopic approach (transoral – i.e., via the mouth), the stenosis is completely removed with the assistance of a soft-tissue shaver. The cricoid is then relined with either a buccal or skin graft, held in place for 2 weeks with a temporary silicone stent. This technique is minimally invasive, has the potential to preserve voice function completely, and may have a curative outcome.

How is The Maddern Technique different to a resection?

In a resection, the affected piece of trachea including the cartilage is removed via open surgery. With this reconstruction, the scarring is removed, and a skin graft placed temporarily into the trachea for 2 weeks to encourage healthy cells to re-grow in place of the diseased tissue.

This operation is endoscopic rather than via open surgery meaning the neck is not cut open. This has several benefits including a minimal risk to the vocal cords and the nerves that control them. Recovery is much faster as there is not a physical cut in the neck, nor a section removed.

Broadly what happens in the operation?

The scarred skin within your trachea is removed – just the skin, no cartilage. A piece of skin is grafted from your thigh, nose or cheek and wrapped around a plastic tube (stent) and inserted orally. This is then stitched in place with two small stitches at the base of the tube. All that is visible on the outside of your neck are the stitches. Depending on where the stenosis is, a temporary tracheostomy may be necessary too.

The stent is left in place for two weeks and then removed. One of the benefits for this method is that there is no scarring from the reconstruction, other than a small scar (about 1cm) from the tracheostomy if that was needed.

If I need a tracheostomy, how long is this for?

The tracheostomy is provided to allow you to breathe while your airway is swollen, and the stent is in. You will have this for around 5-7 days. If you do not bleed too much and your airway can cope well with a size 12+ open stent, then you are unlikely to have a tracheostomy.

When can I get up and walk around?

Usually the following morning after your operation you will at least be able to visit the bathroom (the bed pan is not a fun experience!), and you will feel more and more like exploring as the days pass. Once you are off the feeding tube and IV you will be able to make more extensive journeys to the coffee shop and even outside.

When can I eat and talk normally?

Once a speech and language therapist has visited you and ensured you can swallow properly you should be able to have the feeding tube removed. This depends on when they make it to see you - any time between 1-3 days.

How long am I in hospital?

You are likely to be in hospital for around two weeks, until the stent is removed.

A month later you will need to return for another day surgery to laser 'tidy up' the new skin and so your doctor can check out how it is healing. You may need another final laser 'tidy up' a month later if only 50% is done the first time. Some patients will also need a third and final tidy up.

Will I be in pain?

The hospital is good at managing any pain you have with regular pain medicine (sometimes too regular!) and pain is minimal. Most of the discomfort will be from any stress you have, so ideally learn to recognize this, and use relaxation techniques to calm down.

How long until I feel better post op?

As soon as you are recovered from the general anaesthetic from having the stent removed you will be back to exercising and normal life. You should continue to nebulise daily to help with the healing process.

Some people may still have some difficulty with mucus – after the surgery you will need two 'tidy-ups'- these are to ensure your airway is smoothed.

The graft site on your leg, nose or inner cheek will be the sorest point, so keep this covered and protected. It is important while in hospital to ensure the original dressing is left on and kept dry to aid the healing process. Tape a rectangle of plastic bag over the site when showering to protect it.

How long does it last?

The first patient to have this operation in 2012 is still breathing well with no restenosis.

Latest research suggests 83% of patients continue to breathe well with no restenosis for at least 5 years.

What are in office/awake steroid injections

More and more frequently, SGS patients are choosing to have a steroid injection in the doctor's office. Here is more information about that technique.

Why would I choose to have a steroid injection?

In-office serial intralesional steroid injections (SILSI) provide an option to stabilise airway openness, delay symptoms, and extend time between OR procedures. Studies have demonstrated an up to 8-12 month increase in surgery free interval, saving money as well as the impact on life (compared with increasing breathlessness and the impact of a general anaesthetic). Patients receiving SILSI have reported less breathlessness, a stable, or even improved airway, less voice handicap and improved voice quality of life.

How often would I need an injection?

You are generally seen every four to six weeks for a course of 4-6 injections.

How long does the procedure take?

Including the local anaesthetic applied to your vocal cords and trachea, and the procedure itself, you should expect to be in the office for between 30 and 60 minutes.

Am I sedated or put under a general anaesthetic?

There is no general anaesthetic involved nor sedation (unless you specifically request it). The area is first numbed with an injection of lidocaine, a local anaesthetic. This will cause you to cough, spreading the anaesthetic through the trachea and voice box.

After it is numbed, what will the doctor do?

The doctor will use a bronchoscope to inspect the area, then inject the steroid (triamcinolone, dexamethasone, methylprednisolone, or solumedrol - there are no established differences between reagents) directly in the stenosis.

Does the doctor inject from inside or outside of my neck?

This depends on your airway and the ease of inserting the scope with needle, also the thickness of your scar and the ease of penetrating it with the needle.

Will it affect my voice?

Some have a short-term huskiness while the vocal cords are numbed. This is temporary and usually eases within an hour of the procedure.

What difference would this make to my dilations?

Clinical data has shown that some patients can cope for long periods between dilations, often with higher peak flow numbers than they get with a dilation.

What are the risks of steroid injections?

Recent research finds 65% of patients receiving injections encounter temporary side effects. These included hot flushes, insomnia, injection site pain/bruising, temporarily increased stridor, coughing up small amounts of blood, heart palpitations, fatigue and blurry vision. Side effects requiring additional medical care and/or treatment are rare.

What is the Mayo Protocol?

Several patients are following this regimen, often with good results. You might like to ask your doctor about trying this, or perhaps they will suggest it to you.

The protocol involves taking three drugs:

- Trimethoprim/Sulfamethoxazole (Bactrim/Septra/Co-Trimoxazole) – a sulpha based antibiotic – just small doses regularly. This potentially kills any bacteria in your away – patients with a stenosis tend to often have bacterial infections which build up behind their scarring, causing thickened mucus and the risk of plugs.
- A steroid inhaler – such as Qvar, Pulmicort or Flovent – one inhale per day. This reduces inflammation in your airway.
- Protein pump inhibitors/Acid reflux medicine – such as Prilosec or Nexium once a day. If you have reflux, then this can potentially reduce inflammation in your airway and prevent damage to the skin there from stomach acid.

What are the risks with this protocol?

As with all drugs, these can have side effects.

- Antibiotics: Some people can have negative side effects with taking antibiotics long term, such as thrush and stomach issues. Some people cannot tolerate sulpha based drugs, in which case an alternative is found.
- Steroid inhaler: This can cause oral thrush – you need to wash your mouth out and gargle with water after you take your breath. Some people can find the powder will coat their vocal cords (another reason to gargle), causing a husky or raspy voice
- Protein Pump Inhibitors/acid reflux medicine – if taken long term can potentially cause kidney problems and brittle bones. Recent research suggests PPIs do not have an impact on patients' airways where there is no evidence of GERD. A gentler medication such as Gaviscon may be better in this situation.

How does it help?

It has been found in patients who have been diagnosed with Granulomatosis with polyangiitis (GPA) with subglottic stenosis, 9/10 of their airways tested positive for staph aureus (*S. aureus* - a bacterial growth). The antibiotic may well be treating this in patients who have been diagnosed as idiopathic but may actually have an airway-isolated form of GPA. Treating *S. aureus* helps minimise the potential damage and immune response it can trigger, therefore helping stabilise patients' airways.

What are the benefits with this protocol?

Those patients who have had success while following this protocol have reported:

- Lasting longer between dilations
- Less inflammation, therefore improved breathing
- Less thickened mucus, therefore reduced coughing, and improved breathing

There is no evidence that this stops the scarring, rather it tends to treat the added symptoms surrounding it, **potentially slowing the regrowth of scar tissue.**

How can immunotherapy or immune modifying drugs help my subglottic stenosis?

Immunotherapy medication (or Disease Modifying Anti-Rheumatic Drugs (DMARDs)) is becoming a more regularly used approach for patients who are having frequent dilations – by frequent we mean every six months or more often. Recent research found that 15% of patients diagnosed with iSGS had been provided with this treatment avenue.

There are a number of options available, and commonly used for other health conditions, so the side effects are well known and they are not considered experimental.

Conventional Synthetic DMARDs	Biologics	Targeted Synthetic DMARDs
<ul style="list-style-type: none"> Methotrexate Leflunomide Sulfasalazine Hydroxychloroquine Mycophenolate mofetil (CellCept) 	<ul style="list-style-type: none"> TNF-a Inhibitor: Etanercept Anti TNF monoclonal antibodies: Infliximab, Adalimumab, Golimumab, Certolizumabs pegol B-cell Depletors: Rituximab T-cell co-stimulators: Abatacept IL-17 Inhibitors: Tocilizumab, Sarilumab IL-17 Inhibitors: Ixekizumab, Bimekizumab, Secukinumab 	<ul style="list-style-type: none"> Janus kinase inhibitors: Baricitinib, Tofacitinib, Upadacitinib, Peficitinib, Filgotinib

Methotrexate is the most frequently used (50% of patients), with around one in three patients subjectively finding their breathing better after this treatment. Most common side effects include some dizziness and headache. It may be administered by mouth, intravenously, or by injection.

This is followed by Hydroxychloroquine (24% of patients) which results in improvements for around 26% of patients. Few experienced any side effects, with dizziness and headache most common. This is usually administered as in tablet form.

Rituximab is the third (6%) most frequently used (also known by its brand names of MabThera, Rixathon and Truxima), and around 29% of patients find their breathing is improved with this treatment. Again, few patients experience side effects, with some dizziness and headache most mentioned. This is usually administered as an infusion into your blood.

What should I be asking my doctor before starting on this medication?

Asking questions helps ensure informed decision-making, reduces anxiety, and builds a collaborative relationship with your healthcare provider.

About the Medication

- What is the name of the DMARD you're recommending, and how does it work?
- Why do you think this DMARD is the right choice for me?
- How long will it take before I notice improvements?
- What are the potential side effects, and how common are they?
- Are there any serious risks associated with this medication?

Monitoring and Adjustments

- What kind of monitoring will I need while on this DMARD (e.g., blood tests, physical exams)?
- How often will I need to come in for follow-up visits?
- What signs or symptoms should I report immediately?
- How will we know if the medication is working effectively?
- What happens if this DMARD doesn't work for me? Are there alternative options?

Interactions and Lifestyle Considerations

- Are there any foods, supplements, or medications I should avoid while on this drug?
- Can I continue my current exercise and daily activities while on this medication?
- Does this medication increase my risk of infections, and how can I minimize this risk?
- Can I receive vaccines while on this DMARD? Are there specific vaccines I should avoid?

Long-Term Use

- What are the long-term effects of taking this medication?
- Will I need to take this medication indefinitely, or is it possible to stop eventually?
- How does this medication affect my risk for other conditions, like osteoporosis, liver issues, or cardiovascular disease?

Special Circumstances

- What should I do if I miss a dose?
- Can I take this medication if I'm planning to become pregnant, am pregnant, or breastfeeding?
- How will this medication affect other chronic conditions I have, (if any)?

Cost and Accessibility

- Is this medication covered by my insurance? Are there generic/less expensive options?

What questions should I ask my surgeon?

At your **very first appointment** with your doctor these questions will help you determine whether this is the right doctor to be treating you. You only get one airway and you want it handled correctly from the start:

<p>How much experience do you have with airway stenosis?</p>	<p><i>Establish how confident the doctor is in this field, given it is a rare area of treatment and many ENTs will have only read about it while studying. The more patients they treat and the longer they have been involved with airway stenosis, the better – you do not want to be their first patient.</i></p>
<p>How many airway stenosis patients do you have?</p>	
<p>How long have you been treating patients with airway stenosis?</p>	
<p>Where/with whom did you do your training in this area?</p>	<p><i>If they trained at a high-volume centre then it is likely they have a lot more experience and therefore you can feel confident they have learnt from the best.</i></p>
<p>What is the average reoccurrence rate of your patients' stenoses? i.e., how frequently do your patients generally have to return for a dilation surgery?</p>	<p><i>Alarm bells should ring if their patients are all returning for surgery every six months or more frequently. This should ideally be the exception rather than the rule.</i></p>
<p>Has any of your airway stenosis patients ever needed to have a tracheotomy? Under what circumstances? What about other complications?</p>	<p><i>Tracheostomy is a rare (but sometimes necessary) occurrence among airway stenosis patients – important to understand what led to this (or other complications) happening.</i></p>
<p>What are your thoughts regarding putting a permanent stent into my airway to keep it open?</p>	<p><i>This is a trick question – any doctor with experience in this area would NOT recommend a stent – there are many risks – including complete blockage (requiring a tracheotomy), movement of the stent and creation of more scar tissue, movement and damage to vocal cords. If your doctor entertains this as an option, seek another opinion.</i></p>



<p>What treatment options do you offer? e.g. steroid injections/dilation/wedge resection/Maddern/resection</p>	<p><i>The treatments offered (and variety of them) will help you understand their experience. More experienced doctors/centres offer more options (or will be happy to refer you to another surgeon and know who to send you to). The more surgeries they have carried out in the past three months, you can infer their skills will be more up to date.</i></p>
<p>How many dilation surgeries have you carried out in the past three months?</p>	<p><i>If your doctor does one thing well (eg dilations) that is great, as long as they are aware of other treatments and where to send you, should you choose that path.</i></p>
<p>Where would you refer more challenging patients to, if anywhere?</p>	<p><i>As an airway patient, the majority of doctors will put a flag on your record to alert their gatekeeper (admin/appointments/secretary) to prioritise your appointments if you need one urgently. It is worth raising this with your surgeon to make sure it is the case so you don't have issues scheduling an appointment. They may also recommend particular hospitals to attend/avoid if you need to present at emergency.</i></p>
<p>What do you propose to be the plan for my ongoing treatment?</p>	<p><i>The doctor should look at your airway using a laryngoscope/bronchoscope which involves a camera going up your nose and down your throat. Usually the doctor is able to sight your stenosis through your vocal cords, and should be able to save a photograph of your stenosis.</i></p> <p><i>If you are able to take a printed copy of this image it gives you something to take to other doctors, should you choose to go elsewhere.</i></p>

When having **dilation surgery**:

<p>How long should I expect to be in hospital?</p>	<p><i>Most dilation surgeries are done as day surgery, but if you are susceptible to swelling, have other potential health issues or have a long way to travel then you may need to stay overnight – either in hospital or within easy reach of the hospital.</i></p>
<p>What can I do to protect my teeth from damage?</p>	<p><i>Many hospitals will insert a mouthguard to protect your teeth from the surgical instruments, but not all. It may be worth getting something specific to fit your teeth, if your surgeon is agreeable to this.</i></p>
<p>What surgery are you planning to perform? A laser dilation? Balloon? Coblation?</p>	<p><i>Understanding what type of dilation your surgeon plans to proceed with is important. For example, coblation is a dilation technique performed at several centres, but anecdotally is not recommended as it increases the likelihood of the scar spreading up your trachea. If your surgeon suggests this technique, then request an alternative or seek a second opinion with a surgeon that does not do this operation.</i></p>
<p>Will you be doing any steroid injections? Applying Mitomycin-C?</p>	<p><i>Being aware of what treatment you are having is important in assessing success rates, side effects and so on, especially if you may potentially see another surgeon at some point.</i></p>
<p>Are you planning to do a biopsy of the scar to test for ANCA? Or take bloods to test for this? Would you consider</p>	<p><i>A test for ANCA (autoimmune disease) is recommended each time you have a dilation. A negative result in the past does not mean there might not be a positive result in the future.</i></p>
<p>If I have any unexpected complications when at home or am worried about my health, who do I call</p>	<p><i>Your doctor should provide a plan of action should you have any unanticipated outcomes or questions, for example if you have unexpected swelling, or your tongue is numb post op</i></p>

At **every appointment** with your specialist:

<p>What is the current diameter of my stenosis in millimetres?</p>	<p><i>Your doctor can best answer this when they have seen your airway under a general anaesthetic, and they can measure it accurately. This will be in millimetres (mm).</i></p>
<p>At which percentage is my airway closed?</p>	<p><i>This is going to be a best guess by your doctor when you are seen with a scope. If you know the diameter of your airway when it is at its most open, you can calculate the approximate diameter in millimetres (mm).</i></p>
<p>What is the current distance of the top of my stenosis from my vocal cords?</p>	<p><i>This will help you to understand any risk to your voice quality from the movement of the scar and may help you make decisions about a change to the type of treatment or surgery you receive.</i></p>
<p>How has my stenosis changed since my last appointment?</p>	<p><i>You are aiming to understand what is happening in your airway – whether the scar is changing – is it moving towards your vocal cords? Is it moving further down your trachea? Is the scar getting thicker or thinner? Is it corkscrewing or remaining the same? Are there any new areas of scarring?</i></p> <p><i>Your surgeon should take regular photos and /or have a detailed description of the stenosis each time to refer to and make comparisons with previous exams.</i></p>
<p>What are my ANCA test results? And when were they last tested?</p>	<p><i>If you have been diagnosed idiopathic (not if you have been diagnosed with GPA or other autoimmune (AI) disease) then it is recommended this is tested annually along with a basic-metabolic profile – your GP/primary care doctor can usually organise these. Even if you have tested negative in the past, the result can still change, and the treatment will be slightly different if you are shown to have an AI disease.</i></p>

<p>Did you take a biopsy during my last dilation? And what did it show?</p>	<p><i>Biopsies should be tested for any signs of ANCA or additional disease, and, based on most recent research, investigate whether there is any bacterial growth – in particular staphylococcus (which may indicate your stenosis is GPA in origin).</i></p>
<p>Do both my vocal cords work as they should?</p>	<p><i>If there are any issues with your voice it is worth understanding whether it is related to your scar, to mucus or whether the vocal cords are not working properly. Knowing this will help you to get a referral to a specialist to help with voice such as a speech and language therapist or otolaryngologist which specialises in voice.</i></p>
<p>Are you aware of any clinical trials or studies I could be a part of?</p>	
<p>Are there other treatment avenues I could possibly be exploring?</p>	<p><i>For example, you may be looking for a recommendation or discussion regarding steroid injections, major surgery or perhaps the use of DMARDs to treat your stenosis</i></p>

When considering **major surgery**:

<p>How many resections/reconstructions have you done? How many on idiopathic patients? How many on non-idiopathic?</p>	<p><i>Help understand your surgeon’s experience in this difficult and delicate surgery. You want a doctor who has done many successful operations, specifically with patients like you. You also want one with an excellent team around them and a recovery department at the hospital which is used to dealing with this type of surgery.</i></p>
<p>What is your success rate? How do you define success?</p>	<p><i>For example, a resection will last, on average, ten years. Does your surgeon consider this a success? What percentage of their patients return for more surgery within a decade?</i></p>
<p>What do you see as the general risks of this surgery?</p>	<p><i>For example Restenosis? Nerve damage? Infection? Trach? Weak voice? Unable to sing?</i></p>

<p>What do you see as my personal risks?</p>	<p><i>Help you understand any potential issues specific to your situation and health – also help you feel comfortable the surgeon has considered all options in recommending this operation for you.</i></p>
<p>How can I personally reduce my risks of complications?</p>	<p><i>For example this may mean gaining or losing weight, cutting out bad habits, doing pre-operative exercises or stretches.</i></p>
<p>How long will I stay in the hospital?</p>	<p><i>You may have work and/or family issues to consider when booking this surgery, so timing can be a consideration in deciding whether to or when to proceed.</i></p>
<p>Can I talk to any of your former patients?</p>	<p><i>Most experienced surgeons will have patients who are willing to share their surgery story and help you decide whether you are comfortable proceeding with the surgeon and procedure.</i></p>
<p>What is your major complication rate? What major complications have you experienced?</p>	<p><i>This will both help you prepare for the worst-case scenario, and help you build confidence in your surgeon’s ability to cope with unexpected issues during a major surgery. If you feel uncomfortable with their answer, then seek a second opinion.</i></p>
<p>What happens during the operation? How long does it last?</p>	<p><i>The more you understand in advance, the more comfortable you will feel about the surgery.</i></p>
<p>What can I expect when I wake up? (e.g. lines, drains, masks, catheter, feeding tube)</p>	<p><i>If you know what to expect when you wake, then you will be mentally prepared to accept your situation and move forwards with healing. You can warn friends and family in advance what to expect if they visit you post-surgery.</i></p>
<p>How will I feel when I wake up? (Pain? If so where)</p>	<p><i>Understand more about managing expectations and how the recovery team will be managing this – through pain killers or muscle relaxers, steroids and so on</i></p>
<p>When will I be able to eat and drink normally?</p>	<p><i>For example moving on from ice chips to solid food or having a feeding tube removed.</i></p>



<p>How long before I can go home?</p>	<p><i>Understand how long you are likely to be in hospital before discharge. If you live a long way away from the doctor and need follow up appointments, it may mean staying somewhere nearby to attend those.</i></p>
<p>What sorts of complications might I encounter after leaving the hospital and how should I deal with those if they occur?</p>	<p><i>It is worth having a plan in place for any difficulties such as challenges breathing, swallowing, or talking, pain in your neck or elsewhere, and how to manage those. Will your doctor share a direct email or phone number for you to contact? Or is there a nurse or registrar you can call if you are concerned?</i></p>
<p>Will I have any restrictions once I go home?</p>	<p><i>For example there may be restrictions on voice (voice rest), driving or exercise. You may need to eat soft food for a while or avoid certain foods or drinks.</i></p>
<p>Am I likely to need to take medication once I am discharged? For how long?</p>	<p><i>These could include steroids, anti-reflux medication or antibiotics for example.</i></p>
<p>Is there any equipment I would need to use at home?</p>	<p><i>For example after surgery you may be told to nebulise three times a day to help keep your airway moist and aid the healing. Others may recommend a humidifier to make dry air (e.g. in heating or air conditioning) easier to breathe.</i></p>

Above all, make sure you never feel bullied into having surgery with a doctor if you do not feel 100% comfortable. It is your right to seek a second opinion, it is your body, you can always say no.

I'm heading into hospital – what should I take?

Going into hospital, even just for a day, is a daunting experience and if we can help make it easier with a checklist of things to take it will remove one more thing from our already busy minds (breath in, breath out!).

Don't forget to pack your patience ...your surgery may have to be rescheduled due to unforeseen circumstances (such as someone who is a higher emergency than you or complications in someone else's operation).



Going in for a day or one night

If you are just planning to go for one day, we would recommend being prepared to spend the night, in case there is some unexpected inflammation or your surgery is late in the day and they are not comfortable with you leaving.

Information

- A copy of your latest peak flow chart (or show it via your app) to show the doctor and anaesthetist when they visit you pre-op – help them be prepared for how your airway might look once you are under an anaesthetic
- Pen and paper or whiteboard in case you need to communicate without using your voice
- Notebook to jot down any info shared with you post op (or be prepared to use the notes in your phone)

Medical essentials

- Reading glasses and case
- A list of all your medications (this can be provided by your pharmacy or Doctor surgery)
 - Bring in 3 days' worth (better to be safe than sorry)
- A list of any herbal remedies and vitamins you are taking regularly
- A note with details of any other medical conditions including details of the medical professional(s) treating you
- Details of any allergies
- Your medical healthcare number and/or health insurance details
- You may also want to bring lozenges for the inevitable sore throat

Clothing

- Wear big knickers, as these will be your only clothes ;) (Apart from those you arrive and leave in of course!)

- If you are afraid of leakages from coughing fits, then pads
- Flip flops or slippers for walking around on cold tiled floors
- Night dress or pyjamas (short sleeves in case you have a drip/cannula)
- A dressing gown or cardigan you can wear over your gown to keep you warm

Toiletries

- Lip balm as the air conditioning is quite dry (make sure it is clear as a tinted one will end up smeared all over your face - not a good look!)
- Hand cream
- Wash (toiletries) bag – you will want to clean your teeth, possibly your own soap
- Tissues
- Night-time routine things - face creams etc
- Eye mask and ear plugs – Bluetooth sleep headphones with inbuilt eye mask have been recommended
- Hair tie and brush/comb
- Rechargeable fan or hot water bottle – depending on the weather!

Entertainment and communications

- Book or tablet for killing time while you wait – games, music etc
- Phone with internet connection so you can keep your 'Living with idiopathic subglottic stenosis' group friends updated and they can keep you company ;)
- Laptop/tablet (especially if the hospital has free Wi-Fi or you can use your phone data!)
- Don't forget your charger with an extra-long lead – the wall plug is usually a long way from the bed and/or a spare battery pack
- Headphones
- Mini speaker if you have a private room

Food and drink

- Any favourite snack that you can cope with eating rather than the hospital food once you wake up
- Your preferred coffee/tea bags

Going in longer term (e.g. a resection or reconstruction surgery)

Same as going in for a night plus

- Several pairs of underwear
- More extensive wash (toiletries) bag - shampoo, conditioner
- Yoga pants/loose trousers
- V-neck loose t-shirts



- Hair ties or clips to keep hair out of eyes
- Load your tablet or laptop with movies and music - bring your headphones
- Magazines (you can ask visitors to bring these too!)
- Any hobbies you can do while in bed (crosswords, knitting, crochet, drawing etc)
- A travel pillow to help support your head and neck
- Sore muscle rub/balm. e.g. Icy/Hot.
- Extension lead with multiple power points for plugging in your laptop/tablet/phone/etc
- Microfibre hair turban and travel hair dryer – for when you have the luxury of showering and washing your hair

Tips to deal with major airway surgery in hospital

If you are heading to hospital for a resection or reconstruction, then definitely take note of this checklist for coping well.

Pre op be as healthy as possible. Lose weight if you have excess, eat healthily, do as much exercise as you can. Many can credit their overall recovery to this regime. Some do a form of fasting diet (e.g. 5:2 or 16:8 – there is a lot of information on the internet about these ways of eating) for some time before their op - this reduces your sugar levels, bad cholesterol and puts your body into repair mode as well as weight loss. Ensure your body is working at its most efficient to help repair the surgery site.

Focus on the end goal, what you want to achieve from the operation and what you want to do with that. Do not dwell on the procedures and how they may or may not make you feel. Never lose sight of what you want from your operation.

Be prepared – ask your doctor about the procedure, talk to other patients who have gone through the same thing, read blogs and books by patients.

Try to recognize progress every day, however small it is. It will motivate and encourage you - e.g. - being allowed to use the bathroom rather than a bedpan, getting your feeding tube removed, being allowed to wash yourself, then shower...even taking fewer pain killers is progress...

Move and sit up - As soon as you can, get out of bed or at least sit up. This will help clear your chest and reduce coughing and risk of infection. If you can walk around the floor a few times this is even better. Get the blood moving and help uplift your spirits.

Wash - As soon as you can shower or at least wash yourself then do. All about empowerment and besides, warm water feels amazing! If you can wash your hair, even better.

Establish your own routines - This is about gaining a bit of your own power rather than being solely at the mercy of the hospital system e.g. get dressed during the day and change into your gown in the evenings, use your own eye cream, lip balm and so on before you sleep.

Communicate - not talking is quite disturbing especially if you can't. People treat you differently and try to assume what you are thinking or trying to communicate. Work out the best way to communicate. E.g. use a Bluetooth keyboard with a tablet - have the tablet on view to your guest/nurse and type away all the things you are feeling and thinking or use a white board and marker.

Sleep - Sleep is a major challenge in hospital. Not only are there nebulisers and machines making noises all over the place, alarms and nurses chatting, but you are also woken for pain meds and blood pressure and so on.

Having some noise cancelling earphones is essential – e.g. Bose ear buds block out 80% of all sound even without playing music, just with the power on. If someone wants to buy you a 'good luck in your operation' present this is what you want!

Eye masks are the other solution. Hospitals are never truly dark, and lights are being turned on all night long. Block out the light if you can.

Finally, strike a deal with your night nurse. You may decide your continuous sleep more than your 1am pain meds – for example organise that you press your button the moment you awake with pain. That can bring you nearly six hours of continuous sleep - absolute luxury!

Take control of your treatment. Understand what you are being given and why. Again, this is about empowerment and interesting. Means that you're part of your treatment rather than just experiencing it.

Share your experience with others who understand – for example your fellow stenosis warriors in the Living with Idiopathic Subglottic Stenosis support group. The support and positive messages will be so uplifting.

Finally **be positive** – there is incredible power in positive thought - think yourself well, laugh, smile, and focus on the good rather than the bad.

I am having non-airway surgery – what should I tell my surgeon?

If you must go into hospital for an operation for something other than your stenosis, then please follow this checklist:

- Advise your airway surgeon of your upcoming operation, and put him or her in touch with your other surgeon – if you can have the surgery at the same hospital your airway surgeon works at then that will be beneficial
- Talk to your surgeon about using a laryngeal mask (LMA) or an epidural rather than being intubated for your operation – avoid anything going down your trachea
- If you need to be intubated, ensure the anaesthesiologist is aware they will need to use a paediatric airway tube – possibly size 4.5.
 - Insist the tube is no larger than a size 5.5 or 6, and they **must** use a cuff manometer to measure cuff pressure.

Preparation is essential – all doctors want to avoid causing you harm, so if you can help this situation by being your own advocate, this will be advantageous.

Here is an example email you may want to use to contact your anaesthetist prior to your surgery. Copy your airway surgeon and your non-airway surgeon to the message:

Dear Dr *[insert name]*

I am having an operation with Dr *[name]* on *[date]* and I understand you are to be my anaesthetist.

I am writing to make you aware that I have a Subglottic Stenosis. I have attached a document which explains more about the disease and how it impacts patients' airways. *[You have permission to share this Rough Guide]*

Ideally, I will not be intubated for this surgery - if possible, I would prefer a Laryngeal Mask Airway. If I do need to be intubated, I respectfully request:

- Intubation with a small tube - preferably no larger than 6.0mm *[smaller if your airway doctor recommends]*
- ETT cuff pressure measurements (suggested 20-30 cm H₂O pressure)
- Glide-scope / fibre-optic intubation, if available.

My breathing is good currently with a peak flow of *[insert latest PEF number]*.

Of course, I defer to your professional expertise in providing me with the safest care possible.

Many thanks, and I look forward to meeting you. If you would like to talk to me prior to *[surgery date]*, my phone number is *[insert number]*.

Kind regards...

Pregnancy and stenosis

It is possible to get pregnant and have a family with SGS - many patients have successfully had children with this disease.

For reasons unknown, pregnancy seems to be a trigger for some patients with SGS. Given that most patients affected by the disease are women, oestrogen is thought to play a role in the development of SGS. Unsurprisingly, oestrogen levels surge during pregnancy. Whilst it can be scary dealing with this condition during pregnancy, the good news is it can usually be managed successfully.



Once your pregnancy is confirmed, it is important to inform the specialist treating your stenosis that you are pregnant, and the person who will be monitoring your pregnancy about your stenosis.

It is a good idea to make sure your specialists for SGS and pregnancy are in contact with one another. It is an added advantage if they are in the same hospital, but this is not always possible. If they are at different hospitals, we recommend you make yourself aware of who will be able to help you in an emergency at both hospitals for both your stenosis and pregnancy, even if they are not currently treating you.

Unfortunately, your SGS specialist may not have experience treating someone with SGS during a pregnancy. To date, there are only 6-7 reported cases of management of SGS in pregnancy in literature. Gynaecologists and Obstetricians may also never have come across anyone with SGS, so you may need to bear this in mind when you are looking at getting advice and treatment options.

Even if you do not have any issues apart from your stenosis during pregnancy, it is advisable to arrange to deliver your baby in hospital. In case you need any kind of surgery for delivery of the baby, you are still an intubation risk and will need specialist anaesthetic care in surgery.

Airway Surgery During Pregnancy

If you need treatment on your airway during pregnancy; Don't panic! Many patients have needed steroid injections or dilation surgery throughout their pregnancy, and these have usually gone smoothly with very few risks to the unborn child.

We recommend you consider a few things to ensure the pregnancy and birth goes as smoothly as possible:

- Talk to your airway surgeon about in-office steroid injections. These do not involve sedation and have proven to be a safe and harm free way to treat patients while they are pregnant.
- If in office steroid injections are not available, speak to your airway surgeon and gynaecologist/obstetrician about the optimal time to have surgery during your pregnancy. This is usually somewhere between 20 and 24 weeks, but it really depends on your individual situation. Bear in mind that this may also be dictated by other factors, especially your airway and how short of breath you are.
- Make sure your specialists are in contact with each other and that your surgeon is aware of any additional information regarding your pregnancy which could impact the operation. Similarly, make sure that any medication they intend to give you during your airway surgery has been checked by your obstetrician to ensure it is as safe as possible.
- Speak to the anaesthetist department before the surgery to double check everything with them. Make sure they are aware of both your stenosis and your pregnancy and have been in contact with your specialists.
- Try to ensure an obstetrician checks the baby before and after the surgery. If you are above a certain number of weeks into your pregnancy it may be necessary to have someone present during surgery to monitor the baby.

Frequently Asked Questions

What is the safest treatment for me while I am pregnant?

Airway stenosis in pregnant SGS patients can be treated in the office with awake, un-sedated injections of steroid medication. Anecdotal evidence from some of the top airway surgeons suggests several patients have got through their pregnancy with injections alone. It may be the safest and most cost-effective way to treat the condition during pregnancy. You may ask your airway surgeon about this option and whether it is available for you.

Patients commonly receive submucosal administration of triamcinolone, dexamethasone, methylprednisolone, or solumedrol directly in the stenosis (there are no established differences between reagents). This is frequently repeated 3-5 times (at 3-week intervals) at which time patients are transitioned into clinical surveillance. Both systemic (i.e. intravenous or oral) and inhaled steroids (both nasal and pulmonary) have an established track record in pregnancy (particularly in asthmatic patients) and are widely regarded as safe in pregnancy.

Do I really need surgery during pregnancy?

This is not always a simple question and is largely based on how well you are breathing and the advice of your ENT/obstetrician. Struggling through if you are really closing and your breathing is not good could put your baby at risk. Something to bear in mind is that it is generally a lot safer to have a carefully planned dilation than to get into any kind of emergency regarding breathing and/or surgery, particularly if in-office steroid injections are not available to you.

Will the anaesthetic and drugs harm my baby?

While there is obviously a risk, nowadays they have made things as safe as possible for surgery during pregnancy. Check with your doctors if you are unsure of anything. Remember that you need this surgery for a reason, and not getting enough air in could be just as harmful to the baby, if not more so. All anaesthetic drugs can theoretically cross the placenta. Yet despite years of animal studies and observational studies in humans, no aesthetic drug has been shown to be clearly dangerous to the human foetus. There is no single optimal anaesthetic technique.

If in office steroid injections are not available to me, can I have steroid injections after my dilation while pregnant?

It is generally felt that directly injecting them into the stenosis is the safest form of administration during pregnancy. Steroid injections may negate the need for further surgery during pregnancy.

My surgeon wants to give me a tracheotomy to get me through my pregnancy. Is this necessary?

While this may be necessary in some cases, the majority of with SGS during pregnancy do not require a tracheotomy during pregnancy. If your surgeon or obstetrician is wanting to place one simply because you are pregnant you may wish to seek a second opinion. The health of you and your baby is of utmost importance. If it does become necessary, it may only be temporary and there will likely be good reasons why you need it.

My obstetrician wants to plan a C-section because I have SGS - do I need a C-section, or can I deliver the baby naturally?

Many SGS patients have delivered babies naturally, so stenosis alone should not necessarily be a reason why you cannot have a natural birth if you choose to. That being said, there may be other additional reasons why a C-section is recommended, and it is important to follow the advice of your doctors on this.

Will I need to be intubated to deliver my baby?

The good news is that most planned surgery for delivery is usually done using other methods such as an epidural, which won't require intubation. However, it is a good idea to get a note from your ENT about what is needed in terms of anaesthesia, specifically, what size endotracheal tube is needed if you must be intubated in the event you need any emergency surgery.

Tips for dealing with SGS during pregnancy

If you are taking any medication for your stenosis make sure that you check with your doctor if it is safe to use during pregnancy. If you have a lot of mucus, nebulising with cool boiled water or saline might help as an alternative to expectorant medication. See our section on reducing mucus naturally.



Make sure you carry a note with brief details of your stenosis and pregnancy, and what to do with your airway in the event of an emergency. Usually, this contains suggestion regarding avoiding intubation, use of a small size breathing tube (4.5-5.5 usually) if intubation is necessary. Remember to include details of your doctors and how to contact them.

If you think you feel out of breath, don't wait to see your doctor. Some patients close quite quickly during pregnancy and you may want to get it checked out.

A few weeks before your due date, have a check-up with your airway doctor so you have an idea of how your airway is looking and how open or closed you are before you deliver. Use of a peak flow meter during your pregnancy may be helpful to track the size of your airway.

Try to relax! While it can be stressful and scary dealing with this condition during pregnancy - try not to get worried about it.

Tracheostomy – your questions answered

Most patients will not require a tracheotomy, and one should not be given to you without prior discussion with your consulting surgeon unless it is deemed potentially lifesaving by the local airway (otolaryngology/anaesthetic/ER consultant) team i.e. an emergency.

However, occasionally patients with airway stenosis need to have a tracheostomy to help them breathe. The thought of this can often feel quite frightening. Hopefully, we can help you feel more at ease.

What is a tracheostomy?

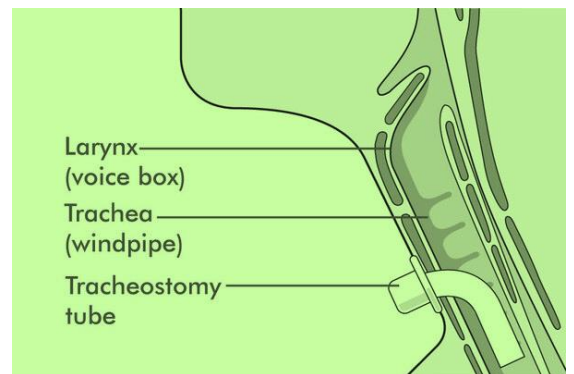
Tracheostomy is a hole that surgeons make through the front of the neck and into the windpipe (trachea). A tracheostomy tube is placed into the hole to keep it open for breathing. The term for the surgical procedure to create this opening is tracheotomy.

Why is a tracheotomy performed?

A tracheotomy is used to help deliver oxygen to the lungs if a person is unable to breathe normally. If you cannot breathe normally it is known as respiratory failure.

A tracheotomy can also be used to bypass an airway that is blocked due to obstruction such as the scar tissue you have as part of your stenosis, swelling, or a mucus plug.

Tracheotomy is most frequently planned and carried out in a hospital environment. But occasionally in the event of an emergency a tracheotomy will be performed outside of a hospital for example the scene of an accident.



Are all airway stenosis patients given a tracheostomy?

No, most patients will never have one. A recent survey amongst airway stenosis patients found that 79% of stenosis patients have never had a tracheostomy, with around one in three of those that have (32%) being temporary (for a month or less), often just as part of a surgery.

How can I avoid needing a tracheostomy?

Sometimes it is unavoidable if part of a major surgery and required as a temporary measure in the event of inflammation. However, on a day-to-day basis there are several things you can do:

- **Monitor your airway** with a peak flow meter so you know when your airway is approaching its next dilation or steroid injection. Do not leave it too long before booking in for your next treatment (operation or injection) – talk to your doctor to ensure you understand the lead time required to book in for a procedure
- **Regularly nebulise** and ensure you are hydrated (water, not caffeinated, sugary or alcoholic drinks) to help avoid mucus plugs

- **Have your emergency medical kit** available at home – if you notice you have an infection or are struggling to breathe, be prepared to take antibiotics and/or a short course of steroids to see you through until you can see your doctor in person
- **Take your emergency letter with you (see resources)** - If you must go to hospital in an emergency for your breathing, ensure you take along the letter from your surgeon (template on page 24)

If you are advised that you need to have a tracheostomy - do not panic.

Is a tracheostomy painful?

Any pain should be short term, usually for the first week after its insertion. Any pain should soon settle down and pain relief can be prescribed by the doctors caring for you in hospital.

There can be a feeling of irritation around the stoma (the hole created to put the tube into), which could be caused by a build-up of new tissue and blood cells (granulation tissue) growing around site or possibly leakage from the tracheostomy. Your medical team should be able to give you advice on treatment if this occurs.

How long does it take to get used to having a tracheostomy?

It can take time to adapt to living with a tracheotomy especially with communicating and swallowing. Usually, you will initially have the support of a Speech and Language practitioner and a dietician to help with the transition. As you settle with a tracheotomy it is possible to enjoy a good quality of life with a temporary or permanent tracheotomy tube.

How can I talk with a tracheostomy?

Speech can be initially difficult with a tracheotomy. Speech is generated when air passes over the vocal cords at the back of the throat. When a tracheotomy is inserted, most of the air we breathe will pass through the tracheotomy rather than through the vocal cords.

A solution to the problem is wearing a speaking valve on the end of the tracheotomy tube. It is designed to temporarily close every time you breathe out. This allows speech by preventing the air leaking out.

Will I be able to eat normally?

Due to swelling after the initial insertion of the tracheotomy tube, there may be some short-term swallowing difficulties. A speech and language therapist will assess you to help offer advice and teach you techniques to improve your swallowing. Initially, you will be asked to take small sips of fluid, before gradually moving onto puree, soft foods and then your regular diet. Eventually your swallowing ability will improve.

Can I do any physical activity with a tracheostomy?

During the initial 6 weeks after having a tracheotomy procedure, all vigorous physical activity should be avoided. Every day activities should be continued. When you are outdoors, the tracheotomy site should be kept clean, dry and a dressing in place to avoid any risk of infection. A loose piece of clothing such as scarf should be worn to prevent any water or dust entering the tracheostomy. There are surgical bibs which can be supplied from your pharmacy or doctor as needed.

Once you are used to having a tracheostomy it is possible to go back to your usual activities (if your doctor advises it is fine to do so). We have long term tracheostomy patients in the stenosis support group who have adapted equipment to even allow them to go swimming and snorkelling.

How do I cough with a tracheostomy?

Mucus is a natural occurrence in airways, and usually it is dealt with without issue. When there is an interruption, such as the scar tissue in the stenosis or the tracheostomy tube, this can become a problem. If there is an infection or an increase in mucus, there is an increased risk of problems such as a blockage. Ensuring the air breathed in is humidified as much as possible plus regular nebulising can help minimise issues. With practice, you should be able to project mucus through the tube by forcefully breathing out or coughing through the tube.

Patients with tracheotomies quite often cannot cough as well as they need to. A process called suctioning can help keep the airways clear. Suction must be administered by medical professionals unless you have been trained in self-suction.

I'm worried about how I will look with a tracheostomy, and what other people will think. How do other patients deal with this?

It can take time to adapt to having a tracheotomy tube inserted. It is a change in your physical appearance, and you need to allow time to adapt living with a tracheotomy tube.

Many patients initially find it traumatic to adapt to living with a tracheotomy. It is advisable to seek counselling and as well as speaking with family and friends. Your local doctor (and where available, the tracheostomy nurse) can help to refer you for counselling.

People may feel a little uncomfortable seeing someone with a tracheotomy. It is helpful to explain to the reason for having a tracheotomy and how it helps to aid your breathing. Generally, family and friends will adapt very quickly to seeing your tracheotomy.

You can find a more detailed document available in the files section of the support group to help you with looking after your tracheotomy.

Research: how can you contribute to a cure?

One of the huge benefits of having such a large and active community of airway stenosis patients is the opportunity to conduct research with high participation rates, meaning results can be relied upon. Since the inception of the Living with iSGS support group in 2009, the number of published papers on the topic of subglottic stenosis has increased substantially.

Your experience can also help contribute to these studies – to join, email Catherine via: airway.stenosis.research@gmail.com (please don't forget to include your name!).

Frequently Asked Questions

Q: What does joining the research panel mean?

A: It simply means that you will be invited to take part in research related to airway stenosis. It is entirely up to you whether you proceed and take part in the study.

Q: Does it require me going to a doctor's appointment, or getting scoped, take drugs or undertake any procedures?

A: No, the majority of our research surveys are online, and require you only to have access to the internet and be able to click on a link. All studies are in English, which may be a restriction for some people.

Generally, studies require little more than you sharing your thoughts, perceptions, experiences and hopes. Sometimes it may require you entering some information about your treatment and particular drugs you take.

Q: I am really new to this disease, surely I have nothing to share?

A: On the contrary, you will have unique perspectives that some of the longer-term patients will have forgotten or no longer see. It is essential that research canvases the opinions of both the longer and shorter term diagnosed people.

Q: How long is the research going to take? I am really busy; I don't think I should join the list as I am time-poor

A: Most of the research takes no more than 10 minutes of your time to complete, and you can do from the comfort of your home at any time of day or night. On some surveys you can even leave the survey mid-way through and return later if you run out of time or need to hunt down some information.

There is usually a deadline of about 3 weeks, so plenty of time to schedule in those 10 minutes 😊

Again, all studies are optional. If you are invited to take part in research when you are too busy or distracted, you can choose not to participate.

Q: If a research study comes from a University in the USA/UK/Canada etc, does it mean it is only open to people who live in that country?

A: No. As airway stenosis is so rare, Doctors are extremely keen to tap into the experiences of patients from all corners of the world. It is one of the key benefits of this research panel.

Q: My stenosis is not idiopathic/subglottic, does that exclude me?

A: Not at all. Most questionnaires will have questions to understand what you have been diagnosed with, where your stenosis (or stenoses) is and cause, if known. Many studies are interested in hearing from all airway stenosis patients, regardless of location or cause.

Q: Will taking part in research impact my insurance or medical records?

A: No. All research is undertaken completely anonymously. You will never be asked your name or personal details. Sometimes a research study will require you to take part more than once, and in this case you may need to share your email address within the study. No data is ever linked back to you or your medical records.

Q: I have only had one dilation and no more treatment /or have had a resection/Maddern Procedure and am not having any other treatment - is it worth me joining?

A: Yes please! While not all studies are relevant to you, you are part of a specialist audience, and your opinions still matter. It is important we represent all patients in research - the good as well as the bad. Everyone has a story to tell.

Q: Who handles this email list?

A: It is kept confidential and stored in a password protected folder only accessible by Catherine Anderson. Doctors around the world can access the database for research via Catherine. It is never shared or sent, will never be sold or distributed. It will not be used for any purpose other than airway stenosis research.

One key benefit of this list being held outside of a medical centre is that research is approved much faster than usual, as people on the list have already given permission to be contacted for research, and results are truly international and representative of all patient experiences, no matter where they live.



Appendix

North American Airway Collaborative (NoAAC)

The North American Airway Collaborative is made up of doctors and medical centres around the world (yes, not just North America!) who have an interest in treating subglottic stenosis. They collaborate to conduct research, trials and share information. **These centres and doctors are considered some of the top places to visit for surgery, if you have the choice.**

Doctors from anywhere in the world who are interested in joining NoAAC should make a request to Dr Alexander Gelbard via director@noaac.net

Dr Alexander Gelbard, Dr David Francis, Dr Catherine Gaelyn Garrett, Dr James Netterville, Dr Otis Rickman, Dr Fabian Maldonado

Dr Jan Kaserbauer, Dr Eric Edell and Dr Dale Ekbohm

Dr Paul Bryson and Dr Michael Benninger

Dr Marshall Smith

Dr James Damiero

Dr Donald Donovan

Dr Alexander Hillel

Professor Guri Sandhu

Dr David Lott

Dr Joshua Schindler

Dr Paul Castellanos

Dr Phillip Weissbrod & Dr Samir Makani

Dr Mark Courey

Dr Matthew Clary & Dr Daniel Fink

Dr Gregory Postma

Dr Henry Hoffman

Dr Andrew J McWhorter

Dr Ramon Franco

Vanderbilt University

Mayo Clinic (Rochester)

Cleveland Clinic

University of Utah

University of Virginia

Baylor College of Medicine

John Hopkins

Imperial College London, UK

Mayo Clinic (Scottsdale)

Oregon Health Sciences University

Lima, Ohio

University of California, San Diego

University of California, San Francisco

University of Colorado

Augusta University

University of Iowa

Louisiana State University

Massachusetts Eye and Ear Infirmary

Dr Robbi Kupfer, Dr Norman Hogikyan and Dr Robert Morrison	University of Michigan
Dr Stephanie N Misono	University of Minnesota
Dr Christopher M Bingcang	University of Nebraska
Dr Rupali N Shah	University of North Carolina
Dr Seth Cohen	Duke University
Dr Ted Mau	University of Texas, SW Dallas
Dr Julina Ongkasuwan, Dr Donald Donovan, Dr Andrew Sikora, Dr Ken Altman	Baylor College of Medicine (Houston)
Dr Albert Merati	University of Washington
Dr David O Francis and Dr Seth H Dailey	University of Wisconsin
Dr David Veivers	University of Sydney, Australia
Dr Brent Richardson	Bastion Voice Institute
Dr Rebecca Howell	University of Cincinnati
Dr Sigriour Sveinsdottir	Landspítali University Hospital, Iceland
Dr Brianna Crawley	Loma Linda Medical Center
Dr Laura Matrka	Ohio State University
Dr Libby Smith	University of Pittsburgh Medical Center
Dr Glenn Shneider	University of Rochester
Dr Ahmed Soliman	Temple University School of Medicine
Dr Joel Blumin & Dr Jonathan Bock	Medical College of Wisconsin
Dr Lindsay Reder and Dr Michael Johns	University of Southern California
Professor Reza Nouraei	Queen’s Medical Centre, Nottingham, UK

Glossary of terms associated with subglottic stenosis

SGS diagnosis and treatment comes with a substantial learning curve and many unfamiliar terms.

Here's an alphabetised list for your reference.

A

AirFlo: AirFlo, an app developed by the North American Airways Collaborative (NoAAC), was a patient airflow monitoring tool (now discontinued) that measured and recorded a patient's peak expiratory flow (PEF) generating data for the Vanderbilt Study.

AmnioFix: This product is an amnion tissue (stem cells) indicated for the treatment of acute and chronic wounds to enhance healing. It is being used by some doctors to try and slow the occurrence of scar tissue. It is still early days for this experimental treatment (around 12 months), so success rates are unknown.

Antinuclear antibody (ANA): ANA is a blood test used to detect the presence of antinuclear antibodies, which may be associated with specific autoimmune diseases such as systemic lupus erythematosus (SLE).

Anti-neutrophil cytoplasmic antibodies (ANCA): ANCA (p-ANCA and c-ANCA) is a blood test for granulomatosis with polyangiitis (GPA, formerly Wegener's granulomatosis).

Awake injections: the common phrase for Awake Serial Intralesional Steroid Injections (SILSI), a procedure pioneered by Dr. Ramon Franco of Massachusetts Eye and Ear Infirmary, where submucosal injections of corticosteroids are made into a stenotic scar with the goal of modifying scars and decreasing operative interventions for SGS treatment (also see Steroid injections). (See The Laryngoscope 2017, Franco et al, "Awake Serial Intralesional Steroid Injections Without Surgery as a Novel Targeted Treatment for Idiopathic Subglottic Stenosis.")

B

Balloon dilation – see Endoscopic tracheal dilation

Bite guard: A bite guard or intubation bite guard is a rigid plastic device inserted in the mouth over the teeth to protect dentition from accidental damage, such as chipping a front tooth, during a surgical procedure. Some SGS patients have had tooth damage and are advised to ensure their surgeon places a bite guard before every airway procedure.

Bronchoscopy: Bronchoscopy is an endoscopic technique of visualizing the inside of the airways for diagnostic and therapeutic purposes using an instrument called a bronchoscopy.

C

Cartilage tracheoplasty: is a form of laryngotracheoplasty.

Chin stitch: A chin stitch (or Grillo stitch, named for the first surgeon to use this), is a now largely-outdated technique to help keep the head in position after a tracheal resection, only still used at a few centres.

Cilia: Cilia are hair-like structures that line the trachea and help move and expel normal mucus. SGS patients do not have any cilia where the stenotic scar is located, making it more difficult to expectorate.

Clinical trial: see Vanderbilt study

Corticosteroids: Corticosteroids inhibit fibroblast formation and reduce inflammation and can be administered orally by a tablet (e.g. Prednisolone), by oral inhalation (e.g. nebulized albuterol, budesonide, i.e. Pulmicort) and by an injection (see Steroid injection and Awake injections). Common corticosteroids used in SGS injection treatment are triamcinolone acetate (Kenalog-40), dexamethasone (Decadron), methylprednisolone (Solu-Medrol) and betamethasone (Celestone).

Cotton-Myer Grading System: This is used to measure the severity of subglottic or tracheal stenosis and is determined with endotracheal tubes demonstrating a leak. It is named after the doctors who first proposed it in 1994.

The grades are:

Grade 0. No or minimal (<10%) discernible stenosis

Grade 1. Discernible obstruction between 10 and 50%

Grade 2. Obstruction between 51 and 70%

Grade 3. Obstruction between 71 and 99%

Grade 4. No discernible lumen

Cricoid cartilage: The cricoid cartilage, or simply cricoid or cricoid ring, is the only complete ring of cartilage around the trachea.

Cricotracheal resection: Cricotracheal resection is a form of open anterior neck surgery. (See: Laryngoscope. 2018 Oct;128(10):2268-2272. doi: 10.1002/lary.27263. Epub 2018 May 14.

'Outcomes after cricotracheal resection for idiopathic subglottic stenosis'. Carpenter PS, Pierce JL, Smith ME.)

C-reactive protein (CRP): CRP is a blood test for inflammation.

Cuff manometer: a device used during general anaesthesia, whether administered using endotracheal intubation or a laryngeal mask airway (LMA), to measure tracheal perfusion pressure (20-30 mmHg). Without a cuff manometer the cuff pressure can increase leading to a situation where tracheal mucosa is no longer perfused, which, in turn, leads to necrosis with subsequent scarring of the tissue and narrowing of the lumen (tracheal stenosis). All patients are advised to request the use of a cuff manometer when undergoing general anaesthesia.

D

Dilation – see Endoscopic tracheal dilation

Direct laryngoscopy: A direct exam of subglottic area via endoscopy (and "in-office scope").

Disease-modifying antirheumatic drugs (DMARDs): immunosuppressive and/or immunomodulatory drugs designed to influence the course of a disease.

Dyspnea: Shortness of breath, also known as dyspnoea, is a feeling like one cannot breathe well enough with sensations including extra effort/work, chest tightness and/or air hunger.

E

Endoscope: a slender, tubular optical instrument used as a viewing system for examining an inner part of the body and, with an attached instrument, for biopsy or surgery.

Endoscopic balloon dilation – see Endoscopic tracheal dilation

Endoscopic resection – see Endoscopic tracheal resection

Endoscopic tracheal dilation: In cases of subglottic stenosis and tracheal stenosis, endoscopic tracheal dilation or dilatation is the mechanical widening, stretching, or enlarging of the opening of the trachea using a balloon dilator or tracheal dilators (with or without cuts or laser, with or without topical or injected corticosteroids, with or without Mitomycin-C).

Endoscopic tracheal reconstruction: Named for Jan Maddern (the first patient to undertake this procedure), "the Maddern" is an endoscopic transoral surgical procedure where the scar is removed, and a skin graft is placed temporarily into the trachea for two weeks to encourage healthy cells to regrow in place of the diseased tissue.

Endoscopic tracheal resection: A multidisciplinary team at Mayo Clinic in Rochester, USA developed this technique which involves transoral resection of the scar tissue using a laser. Longitudinal research by Vanderbilt University and the NoAAC has found this resection technique to deliver long lasting results for patients without compromising voice. It is slowly being adopted by other centres globally. (This technique is described in detail in: Maldonado F, et al. Idiopathic subglottic stenosis: An evolving therapeutic algorithm. *Laryngoscope*. 2014;124:498.)

Endoscopy: An endoscopy is a procedure to look inside the body using an endoscope to examine the interior of a hollow organ or cavity of the body.

Endotracheal intubation: Endotracheal or tracheal intubation, usually simply referred to as intubation, is the placement of an endotracheal tube into the trachea to maintain an open airway or to serve as a conduit through which to administer certain drugs.

Endotracheal tube (ETT): A flexible plastic tube placed into the trachea during endotracheal intubation to establish and maintain airway patency, prevent aspiration into the lungs, i.e. to “secure” the airway and allow for mechanical ventilation. ETT sizes (e.g., 5.5, 6.0, 6.5, etc.) refer to the inner diameter of the tube measured in mm and vary by and within gender. Standard practice is to use a 7.0 ETT for women, but it may be too large for some airways, and improper ETT sizing is known to cause subglottic stenosis. SGS patients may wish to add their recommended ETT size to a Medical Alert ID.

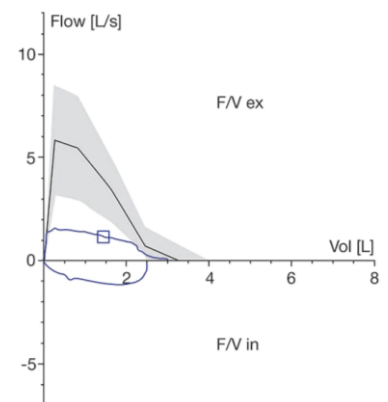
Erythrocyte sedimentation rate (ESR): ESR is a blood test for inflammation.

F

Fibroblast: a cell in connective tissue which produces collagen and other fibres.

Flow Volume Loop: A flow volume loop is a visual representation of spirometry data that shows whether airflow is appropriate for a particular lung volume. SGS patients have “flattened” flow volume loops.

(Right: A typical flow volume loop of a patient with subglottic stenosis – source: Mayo Clinic)



Flutter valve: Flutter valve is an airway clearance device to help expel mucus by combining positive expiratory pressure (PEP) therapy with airway vibrations.

G

Glottis: The glottis is the opening between the vocal folds.

Granulomatosis with polyangiitis (GPA): GPA, formerly Wegener’s Granulomatosis, is an auto-immune collagen vascular disease.

H

Huff coughing: an alternative to deep coughing if you have trouble clearing your mucus. See section on reducing inflammation and mucus

I

Idiopathic subglottic stenosis (SGS or ISS): refers to narrowing of the upper trachea of unknown cause. The disease is rare, with an estimated incidence of 1 per 400,000 person-years. SGS accounts for approximately 19 percent of patients with laryngotracheal stenosis, with the majority having an identifiable cause such as an iatrogenic injury, neck or throat trauma, or an inflammatory connective tissue disease. The exact pathogenesis of ISS is unknown.

IL-23/IL-17A Axis: The relationship between Interleukin-23 (IL-23) and Interleukin 17A (IL-17A), small proteins called cytokines, is referred to as the IL-23/IL-17A axis. The aberrant mucosal immune activation seen in the large airway of SGS patients helps us understand the molecular pathogenesis of SGS and may lead to more directed targeting with drugs (see The Laryngoscope 2016, Gelbard et al, “Idiopathic Subglottic Stenosis is Associated with Activation of the Inflammatory IL-17A/IL-23 Axis”).

Indirect laryngoscopy: uses a small mirror held at the back of your throat. The health care provider shines a light on the mirror to view the throat area. This is a simple procedure. Most of the time, it can be done in the provider's office while you are awake. A medicine to numb the back of your throat may be used.

In-office injections – see Awake injections

Intubation – see Endotracheal intubation

J

Jet ventilation: Used in conjunction with general anaesthesia, jet ventilation is a transoral means of ventilation during laryngeal surgery and procedures on the upper airway.

K

Kenalog – see Corticosteroids

L

Laryngeal mask airway (LMA): also known as laryngeal mask— is a medical device that keeps a patient’s airway open during anaesthesia or unconsciousness and can be used as an alternative to intubation during non-airway surgery.

Laryngoscope: A laryngoscope is a rigid or flexible endoscope passed through the mouth and equipped with a source of light and magnification, for examining and performing local diagnostic and surgical procedures on the larynx.

Laryngoscopy: Laryngoscopy is endoscopy of the larynx, a part of the throat, used to view the vocal folds and glottis.

Laryngotracheal reconstruction: Laryngotracheal (luh-ring-go-TRAY-key-ul) reconstruction surgery widens your windpipe (trachea) to make breathing easier. Laryngotracheal reconstruction involves inserting a small piece of cartilage — stiff connective tissue found in many areas of your body — into the narrowed section of the windpipe to make it wider.

Laryngotracheal stenosis (LTS): Laryngotracheal stenosis, a fixed extrathoracic obstruction, is the abnormal narrowing of the central air passageways, which can occur at the level of the larynx, trachea, carina or main bronchi. SGS patients may also have stenosis at the glottis and/or supraglottic stenosis.

Laryngotracheoplasty: a form of open anterior neck surgery that includes both cartilage tracheoplasty and slide tracheoplasty. It is also known as laryngotracheal reconstruction.

Larynx: The larynx or voice box is an organ in the top of the neck involved in breathing, producing sound, and protecting the trachea against food aspiration. It houses the vocal folds, and manipulates pitch and volume, which are essential for phonation.

Living with Idiopathic Subglottic Stenosis: “Living with Idiopathic Subglottic Stenosis” (www.Facebook.com/groups/IdiopathicSubglotticStenosis) is a Facebook support group for patients and their families started in 2009 by Catherine Anderson, the NoAAC Patient Partner.

M

Maddern – see Endoscopic tracheal reconstruction

Mayo protocol: The Mayo protocol is an SGS treatment approach that combines antibiotics to suppress inflammation (e.g., Bactrim, azithromycin or erythromycin), corticosteroids to inhibit fibroblast formation and reduce inflammation, and proton-pump inhibitors (PPIs) to reduce gastric acid reflux (gastroesophageal reflux disease or GERD).

Mitomycin-C: Mitomycin-C is a chemotherapeutic agent that can be applied to a stenotic scar at the time of an endoscopic tracheal dilation, although there is no scientific evidence of its effectiveness.

Mucus plug: Mucus impaction or plugging occurs when mucus becomes thick and sticky creating a mass that is difficult to expectorate blocking the airway and possibly resulting in death. Mucus plugs can be avoided by respiratory therapy, medication, and mucolytic therapy.

Mucolytic therapy: helps expel mucus, can include a combination of mucolytic medication (Over the counter (OTC) expectorant cough syrup, throat lozenge with glycerine, pectin, or slippery elm not menthol or eucalyptus; amino acid N-Acetyl Cysteine (NAC) or NAC as a capsule or nebulized NAC, e.g. Mucomyst) and the use of an airway clearance technique ('huff' cough 'huffing' exercise) or device (flutter valve).

Mycobacterium tuberculosis (MtbC): MtbC is a pathogenic bacteria in the family Mycobacteriaceae and the causative agent of tuberculosis, yet rather than MtbC, a variant member of the MtbC complex or a closely related novel mycobacterium has been found to be present in SGS tracheal biopsy specimens (see The Laryngoscope 2016, Gelbard et al, "Molecular Analysis of Idiopathic Subglottic Stenosis for Mycobacterium Species").

N

Nebulizer: A nebulizer is a saline and/or drug delivery device used to administer medication (or saline) in the form of a mist inhaled into the airway to thin mucus making it easier to expectorate.

North American Airway Collaborative (NoAAC): NoAAC (noaac.net) is a collective of medical centres who are collaborating to investigate the underlying cause of SGS and seeking to provide patients with information that will improve their quality of life through informed decision making. Its leadership team of multi-disciplinary clinicians, surgeons, patient representatives, and health care research personnel volunteers its time and expertise. NoAAC was founded at Vanderbilt University and its director is Dr. Alexander Gelbard. The NoAAC Patient Partner Catherine Anderson established "Living with Idiopathic Subglottic Stenosis" and the NoAAC Patient Representative Kesi-Dorner Wright established the Tracheal Stenosis Foundation.

O

Open anterior neck surgery: includes four surgical procedures: cricotracheal resection, Laryngotracheoplasty (cartilage tracheoplasty and slide tracheoplasty), REACHER and tracheostomy.

Otolaryngology: Otolaryngology is a surgical subspecialty that deals with the ear, nose, and throat (ENT) and related structures of the head and neck. Doctors who specialize in this area are called otolaryngologists, ENT doctors, ENT surgeons or head and neck surgeons.

P

Patient Centered Outcomes Research Institute (PCORI): PCORI (pcori.org) funds research that can help patients and those who care for them make better-informed decisions about the healthcare choices they face every day, guided by those who will use that information. PCORI funded the Vanderbilt Study.

Peak expiratory flow (PEF): PEF is a person's maximum speed of expiration measured with a peak flow meter.

Peak flow meter: A peak flow meter is a portable, hand-held device that measures how well your lungs expel air. It measures your ability to push air out of your lungs in one fast blast by blowing hard through a mouthpiece (i.e. the force of airflow through the bronchi and thus the degree of any airway obstruction). It gives you a numeric reading on a scale; peak flow readings are higher when the airway is open, and lower when the airway is narrowed (constricted).

Phonation: Phonation is the process by which the vocal folds produce certain sounds through periodic vibration.

Pulmonary Function Test (PFT): PFT, also called spirometry or lung function testing, is a group of tests that evaluate the respiratory system, including the function of lung capacity, chest wall mechanics, etc.

Pulse oximeter: Pulse oximeter is a device placed on your finger to measure oxygen saturation.

R

REACHER (Retrograde, endoscopically assisted cricoid hypertrophic epithelial resection):

REACHER is an open anterior neck surgical procedure pioneered by Dr Robert Lorenz of Cleveland Clinic, Ohio USA, where the diseased lining of the cricoid is removed and the outer cartilage is preserved.

Rough Guide: Idiopathic Subglottic Stenosis – A Rough Guide for Beginners by Catherine Anderson, the NoAAC Patient Partner, is a reference manual for SGS patients and their doctors.

S

Saline: also known as saline solution, is a mixture of sodium chloride in water (vials come in 0.9% and 3.0% strengths) that can be administered orally with a nebulizer.

Slide tracheoplasty: a type of laryngotracheoplasty, is a surgical procedure used for more severe grades of long-segment tracheal stenosis or complete tracheal rings where the narrowed trachea is divided across the middle of the stenosis. The back of the lower tracheal segment and front of the upper tracheal segment are cut, and the opened ends are then slid onto each other and sutured in place to create an airway that is twice as wide and half as long.

SLT/SLP: see speech and language therapist/pathologist

Speech and Language Therapist/Pathologist: Provide treatment, support and care for people who have difficulties with communication, eating, drinking and swallowing.

Spirometry: Spirometry, the most common pulmonary function test, measures lung function, specifically the amount and/or speed of air that can be inhaled and exhaled.

Steam inhalation: Steam inhalation is a method of introducing warm, moist air into the lungs via the nose and throat for therapeutic benefit such as thinning mucus by breathing into a portable device. Essential oils can also be used.

Stenosis: an abnormal narrowing or contraction of a body passage or opening.

Steroid injection: refers to the submucosal injection of corticosteroids into the stenotic scar administered either in an office setting (externally through the neck or via transnasal endoscope) or in an operative setting with or without dilation (under moderate sedation or under general anaesthesia via transoral endoscope or transnasal videoscope).

Stoma: any opening in the body. A patient with a tracheotomy has a stoma in their trachea.

Stridor: Stridor is a high-pitched breath sound (commonly called the “Darth Vader” sound) resulting from turbulent air flow in the larynx or lower in the bronchial tree, caused by a narrowed or obstructed airway.

Subglottic stenosis: Narrowing of the subglottis is known as subglottic stenosis.

Subglottis: the subglottis or subglottic region is the lower portion of the larynx, extending from just beneath the vocal folds down to the top of the trachea.

Supraglottic stenosis: Supraglottic stenosis is narrowing of the airway above the glottis,

T

Trachea: or windpipe is a cartilaginous tube that connects the pharynx and larynx to the lungs, allowing the passage of air, and branches into the two primary bronchi.

Tracheal reconstruction: a surgical procedure to remove a portion of the trachea with a long stenotic scar and to insert a stent or piece of rib into the neck to replace the lost cartilage and prevent the neck from collapsing.

Tracheal resection: a surgical procedure to remove a portion of the narrowed portion of a patient's trachea or windpipe through an incision in the neck and reattaching the upper and lower healthy parts with stitches.

Tracheal stenosis – see Laryngotracheal stenosis

Tracheal T-tube: a silicone stent for the trachea with an external limb.

Tracheal Stenosis Foundation (TSF): TSF is a non-profit organization founded by patient Kesi Dorner-Wright that raises awareness and holds an (almost) annual patient-centered conference in the USA whose speakers include members of the NoAAC leadership team.

Tracheomalacia - a condition where there is softening of the cartilage within the walls of the airways. The cartilage is responsible for keeping the airways open, allowing air to easily move in and out as you breathe. When it softens, the airway wall becomes floppy and partially collapses, restricting airflow.

Tracheotomy: also known as tracheostomy is a surgical procedure that consists of making an incision on the anterior aspect of the neck and opening a direct airway through an incision in the trachea.

V

Vanderbilt Study: The commonly called Vanderbilt Study is an ongoing clinical trial (2015-2018) formally known as the 'NoAAC PR-02 SGS Clinical Trial - Treatment Alternatives in Adult Rare Disease; Assessment of Options in Idiopathic Subglottic Stenosis' (<https://clinicaltrials.gov/ct2/show/NCT02481817>). Dr. Alexander Gelbard of Vanderbilt University is the study's Principal Investigator.

Videoscope: A videoscope, also called a transnasal endoscope or distal chip video esophagoscope, is a medical device that records video of a procedure, such as transnasal steroid injections.

Vocal folds: Vocal folds or vocal cords are composed of twin folds of mucous membrane stretched horizontally, from back to front, across the larynx.

W

Wegener's Granulomatosis (WG) - see Granulomatosis with polyangiitis (GPA)

Reading

Being diagnosed and living with a rare, life-threatening disease can be overwhelming at times. Educating oneself about the disease, past and current research, and evolving treatment options helps to make an informed patient. With knowledge, you can ask your airway surgeon questions and make informed decisions about your treatment.

At the end of each year, I have been summing up the key papers with the most interesting findings, and summarising these in patient language. These are now included here to speed up the learning process.

There follows a more extensive list of SGS-related articles published in academic journals. (The articles appear in reverse chronological order with the most recent publications first.) The list is compiled from various sources including posts on the "Living with Idiopathic Subglottic Stenosis" support community and documents in its "Files" tab. This is not intended to be a full or complete list of all published articles on SGS, but it is a selection of many relevant ones. Each listing includes the title, its authors, publication details (journal name, volume, page numbers, and date of publication), and its Digital Object Identifier (DOI). The DOI alphanumeric string identifies an academic article and provides a persistent link to its location on the Internet. You can go to the DOI website (<https://doi.org>) and enter any DOI to retrieve an article.

We have included the authors' names so you can familiarize yourself with the leading airway surgeons and researchers in this field, many of whom are participating members of the North American Airway Collaborative. You may also recognize many of the authors' names from social media posts as the surgeons who care for many of us. These devoted and talented doctors also conduct SGS research and publish their findings in peer-reviewed journals. We all hope their collective work leads to better understanding of SGS and eventually a cure.

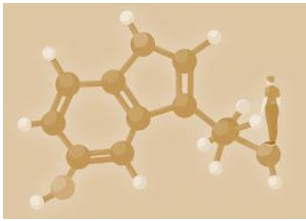
Don't forget, you too can help contribute to the research of next year. Sign up by sending an email, including your name, to Catherine Anderson at airway.stenosis.research@gmail.com. Please see the Frequently Asked Questions in this document if you have any queries.

The articles are technical in nature and you may find yourself wondering how to understand it all. If you read the articles' abstracts and conclusions and then work your way into the science and all the details, you should be able to grasp the overall concepts. Many articles appear in *The Laryngoscope*, which may just become your favourite new reading material.

What we learned: 2024

What we learned

1. Premenopausal patients have a more aggressive disease variant than postmenopausal counterparts



Reading:

“Association between Estrogen Exposure and Idiopathic Subglottic Stenosis”

Nainika Nanda, MD et al
The Laryngoscope, 134(2): 825-830,
February 2024
<https://doi.org/10.1002/lary.31030>

What this means

It has long been speculated that estrogen has a role to play in airway stenosis, particularly given the prevalence of females with the disease, compared to males (98% female to 2% male).

This research has revealed that patients who are peri and post menopause are more likely to have a longer surgery-free period than their pre-menopausal counterparts.

The researchers were unable to determine whether it is due to reduced estrogen, or whether it is more to do with age-related physiology of wound healing and inflammation, regardless of estrogen.

Once you reach peri and post menopause, you can potentially look forward to fewer dilations and an airway that stays open for longer.

What we learned

2. Researchers have found cellular changes in the airways of patients with iSGS



Reading:

"Transcriptional Profiling Sheds Light on the Fibrotic Aspects of Idiopathic Subglottic Tracheal Stenosis"

Martin Direder; Maria Laggner; Dragan Copic; Katharina Klas; Daniel Bormann; Thomas Schweiger; Konrad Hoetzenecker; Clemens Aigner; Hendrik Jan Ankersmit; Michael Mildner

bioRxiv, February 2024

<https://doi.org/10.1101/2024.02.19.580975>

What this means

These findings suggest that ongoing fibrotic (scarring) processes are happening in iSGS and that certain cells, like fibroblasts, Schwann cells, and plasma cells, may play key roles in the disease.

It is hoped that understanding these cellular changes will help in developing better ways to diagnose and treat iSGS in the future.

The researchers identified several important findings:

- **Fibroblasts** (a type of cell that creates scar tissue) were found to be in a "profibrotic" state, meaning they were contributing to the excessive scarring in the airway.
- **Schwann cells**, which are normally involved in nerve function, were also found in the scar tissue, and they appeared to be in a state that promotes fibrosis.
- There was an increased number of **plasma cells**, which are immune cells that produce antibodies and are often involved in inflammation.

The study also analysed changes in the extracellular matrix, which is the material that surrounds cells and provides structural support.

What we learned

3. CO2 laser dilations result in longer periods between surgeries than cold-steel dilations

Reading:



“Laser Versus Cold Steel for Endoscopic Management of Subglottic Stenosis”

Kevin Y. Liang, MD; Katherine M. Miller, MD; Faez Syed, MD; Hong Li, MS; William S. Tierney, MD; Rebecca C. Nelson, MD; Michael S. Benninger, MD; Paul C. Bryson, MD, MBA; Robert R. Lorenz, MD, MBA
 Otolaryngology - Head and Neck Surgery, 171(2): 471-477, March 2024
<https://doi.org/10.1002/ohn.727>

This study compares the effectiveness of two techniques for treating subglottic stenosis: using carbon dioxide (CO2) laser versus cold steel (a traditional surgical technique with sharp instruments).

The study found that the time without needing another treatment was better for those who were treated with CO2 laser compared to those treated with cold steel.

What this means

The study suggests that for patients who have already undergone airway procedures in the past, CO2 laser treatment may be more effective in preventing the need for repeat treatments.

If your doctor suggests using cold steel to conduct your next dilation, respectfully ask them to consider CO2 laser instead.

What we learned

4. Endoscopic balloon dilation during pregnancy is a safe option



Reading:

“Surgical Management of Airway Stenosis During Pregnancy: A Scoping Review”

Katherine M. Miller, MD; Kevin Y. Liang, MD; Neil Nero, MLIS; Michael S. Benninger, MD; Rebecca C. Nelson, MD; William S. Tierney, MD; Robert R. Lorenz, MD, MBA; Paul C. Bryson, MD, MBA
 The Laryngoscope, 134(3): 1014-1022, March 2024
<https://doi.org/10.1002/lary.30994>

This study identified 27 patients who had been treated for airway stenosis while pregnant.

The median gestational age at intervention was 28 weeks. Left lateral positioning and foetal heart rate monitoring were used in nearly every case, along with an endoscopic balloon dilation.

Jet ventilation or trans nasal humidified rapid insufflation ventilatory exchange maintained the airway.

Three women (11%) required tracheostomy prior to labour and delivery.

What this means

Treatment of airway stenosis while pregnant is safe, with careful monitoring of the foetus during the operation.

Balloon dilation is most frequently used for treatment during the third trimester.

What we learned

5. More dilation procedures prior to a cricotracheal resection (CTR) can lead to worse voice quality



Reading:

“The Impact of Previous Endoscopic Treatments on Functional Outcome After Cricotracheal Resection”
 Matthias Evermann; Veronika Kranebitter; Imme Roesner; Clemens Aigner; Thomas Schweiger; Doris-Maria Denk-Linnert; Konrad Hoetzenecker
 European Journal of Cardio-Thoracic Surgery, 65(6), May 2024
<https://doi.org/10.1093/ejcts/ezae105>

What this means

If you have had dilation surgeries prior to considering a resection, be aware you are likely to have some voice handicap post op.

This study followed 65 patients post resection surgery to investigate their voice quality.

Voice-sparing resection techniques were more often possible in patients who had not previously had any dilations.

Patients who had received three or more endoscopic dilations prior to resection had more voice challenges post resection.

What we learned

6. Endoscopic tracheal reconstruction (Maddern) and airway augmentation (reconstruction with rib graft) have better voice outcomes than cricotracheal resection



Reading:

“The Voice and Swallowing Profile of Adults with Laryngotracheal Stenosis Before and After Reconstructive Surgery: A Prospective, Descriptive Observational Study”
 Gemma M. Clunie; Justin W.G. Roe; Chadwan Al-Yaghchi; Caroline M. Alexander; Alison McGregor; Gurpreet Sandhu
 Clinical Otolaryngology, 49(3): 324-330, May 2024
<https://doi.org/10.1111/coa.14138>

What this means

While airway reconstruction is often ‘blamed’ for causing issues with voice and swallowing in patients, in fact this research demonstrates that often patients are struggling with these elements before their operation, and that not all reconstruction surgeries cause damage to the voice.

It supports the need for a multidisciplinary team management and consideration of voice and swallowing throughout the care pathway for airway stenosis – if you are struggling with your voice or swallowing talk to your treating doctor about a referral to a speech and language therapist.

This study followed 20 patients undergoing airway reconstruction at a major centre to monitor their voice and swallowing issues both prior to surgery and afterwards.

The Maddern Procedure preserves the cricothyroid muscle, and those patients who had this procedure did not have voice changes beyond what they had previously.

Laryngotracheal reconstruction involves inserting cartilage (eg rib) into the trachea and also helps preserve voice. Cricotracheal resection involves removal of the whole segment of cartilage

and tissue where the stenosis is located.

What we learned

7. iSGS patients on the Mayo Protocol post dilation have a longer surgery-free period than those who are not



Reading:

“Impact of Procedural Variation in Endoscopic Dilation for Idiopathic Subglottic Stenosis”

Pooja Santapuram, MD; William S. Tierney, MD, MS, MS; Li-Ching Huang, PhD; Sheau-Chiann Chen, PhD; Lynn D. Berry, PhD; David O. Francis, MD, MS; Alexander Gelbard, MD

The Laryngoscope, 134(7): 3260-3266, July 2024

<https://doi.org/10.1002/lary.31393>

This research looked at how thirteen NoAAC centres treated patients with iSGS with endoscopic dilation.

Two centres stood out with patients having longer time between dilations and having higher peak flow levels for longer.

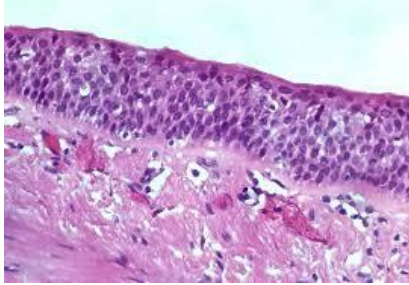
They found the key difference is the medication patients are given after dilation: proton pump inhibitor (PPI – where reflux/silent reflux is suspected), antibacterial agent (e.g. co-trimoxazole), and steroid inhaler – i.e. the Mayo Protocol

What this means

Consider asking your surgeon about starting on the Mayo Protocol for a trial period (see the relevant chapter in the Rough Guide for more information) after your next dilation surgery.

What we learned

8. Abnormal cells found in the airways of 41% of iSGS patients



Reading:

“Idiopathic Subglottic Stenosis Is Associated with More Frequent and Abnormal Squamous Metaplasia”

Yourka D. Tchoukalova, David G. Lott, MD et al Annals of Otolaryngology, Rhinology & Laryngology, 133(2): 214-223, 2024
<https://doi.org/10.1177/00034894231201016>

Gene research has found seven genes have an increased expression in the subglottic tissue of iSGS patients (compared to healthy airways).

These have led to a process called squamous metaplasia – where the normal healthy airway lining becomes thicker and more like skin. This is abnormal in the airway.

The presence of these cells usually means the airway has responded to an injury – an environmental injury (eg acid, bile, cigarette smoke, alcohol) or micro-organisms (such as bacterial, viral or fungal introduction).

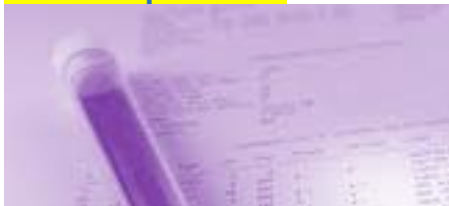
This could be part of the perfect storm which originated the development of the stenosis.

What this means

If a biopsy of your airway reveals these are present, you could potentially benefit from drugs aimed at reversing these cells to normal.

What we learned

9. Patients who test positive for elevated S100A8/A9 have shorter time between dilation operations



“Serum S100A8/A9 Correlates to Surgery-Free Interval in Idiopathic Subglottic Stenosis”

Mafra LM, So RJ, Abd-Elazem I, Collins SL, Chan-Li Y, Lilly G, Lina IA, Gelbard AH, Hillel AT, Motz KM. Laryngoscope. 2024 Nov 27.
<https://doi.org/10.1002/lary.31934>

This research has found a link between elevated Serum S100A8/A9 and increased frequency of surgeries in iSGS patients.

At present this has been conducted with 20 patients. In the future this could be tested with a larger number, to hopefully cement this finding.

What this means

Testing Serum S100A8/A9 levels is done via blood sample. Serum S100A8/A9 test is not widely used in routine clinical practice but is growing in prominence in research and specialised areas related to inflammation, autoimmune diseases, and infection.

If this finding is replicated more widely, it could potentially lead to treatments which lower S100A8/A9 levels in patients which test positive for this elevation, hopefully increasing the time between dilation surgeries.

What we learned: 2023

What we learned

1. Serial Intralesional Steroid Injections (SILSI) can extend time between dilations for subglottic stenosis patients



Reading:

Office based steroid injections for subglottic stenosis

Ramon A Franco

Operative Techniques in Otolaryngology-Head and Neck Surgery, 4 May 2023

DOI:

<https://doi.org/10.1016/j.otot.2023.05.009>

The initial procedure can be performed in the operating room post dilation, with an injection of triamcinolone acetate 40 mg/cc into the subglottis. Subsequent injections are performed in the awake-office setting at 3-week intervals until reaching a total of 6 injections (1 with dilation + 5 in-office).

Nearly three in five patients (58%) only require one round of six injections. Using peak flow to measure their airways, most patients went from 55% open to over 90% open with SILSI. Time between dilations extended to an average of 36 months (3 years).

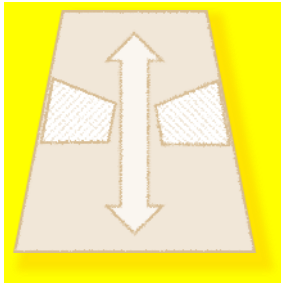
What this means

SILSI is a safe, well-tolerated, and easy to learn (for doctors) who take care of patients with subglottic stenosis. It helps to preserve breathing function and can maximize patient quality of life.

SILSI can be used as a stand-alone treatment or combined with other modalities for the treatment of idiopathic and traumatic airway stenoses. If there is a return of the stenosis, SILSI does not preclude the use of more aggressive surgical techniques.

What we learned

2. Having multiple dilations does not impact the length and location of your stenosis



Reading:

Does Idiopathic Subglottic Stenosis Length and Location Change with Serial Endoscopic Interventions?

Yasine Mirmozaffari, Ameer Ghodke, Rupali N. Shah, Robert A. Buckmire
The Laryngoscope, 03 October 2023

DOI:

<https://doi.org/10.1002/lary.31080>

This paper looked at a total of 52 iSGS patients who had several dilations over a period of 8 years, to investigate whether having endoscopic dilations would cause the stenosis to migrate or lengthen.

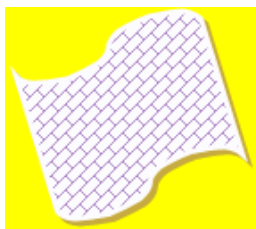
The results revealed that patients have an average of 3.4 procedures (between 1 and 5) over this period, and there was no significant increase in the length and location of the stenosis.

What this means

This suggests that endoscopic dilations are not going to have a negative impact on where your stenosis is located, and are unlikely to increase the length of trachea impacted by scar tissue.

What we learned

3. iSGS patients are more likely to have evidence of a cell change in the tissue lining of their trachea



Reading:

Idiopathic Subglottic Stenosis Is Associated with More Frequent and Abnormal Squamous Metaplasia

Yourka D. Tchoukalova, Tanya N. Phung, and David G. Lott, et al **The Annals of Otolaryngology & Laryngology**, 22 September 2023

DOI:

<https://doi.org/10.1177/0003489423120101>

Comparing the subglottic mucosal tissue between people with healthy tracheas and those diagnosed with iSGS, biopsies found that 41% of iSGS patients have evidence of tissue change (abnormal squamous metaplasia - ASM), compared to 25% of healthy patients.

What this means

Abnormal squamous metaplasia (ASM) may contribute to the development of iSGS. Where they are present in patients' airways, they may respond well to drugs that reverse ASM to normal.

Further trials are required to test this theory.

What we learned

4. When primary care doctors refer straight to an otolaryngologist, iSGS patients are diagnosed much faster



Reading:
Navigating Pathways to Diagnosis in Idiopathic Subglottic Stenosis: A Qualitative Study
 Cara Damico Smith, MPH; Nainika Nanda, MD; Kemberlee Bonnet, MA; David Schlundt, PhD; Catherine Anderson, BA; Sara Fernandes-Taylor, PhD; Alexander Gelbard, MD; David O. Francis, MD, MS **The Laryngoscope**, September 2023
 DOI: <https://doi.org/10.1002/lary.31023>

What this means

Educating primary care doctors about the symptoms of iSGS and encouraging them to refer patients to otolaryngologists will help to reduce the time between seeking help and receiving a correct diagnosis.

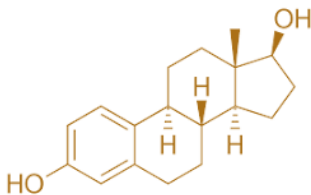
Helping to educate your GP will be valuable, possibly sharing the 'Is it really asthma' flyer we have prepared, which describes symptoms particular to airway stenosis and suggests next steps.

It takes an average of 21 months for iSGS to be accurately diagnosed. On average, patients visit four different health care providers. Specialists were most likely to make an appropriate referral to otolaryngology that ended in diagnosis. However, when primary care providers referred to otolaryngology, patients experienced a shorter diagnostic odyssey.

The most important behavioral-ecological factors in accelerating diagnosis were strong social support for the patient and providers' willingness to refer.

What we learned

5. There is no clear relationship between estrogen exposure and disease recurrence



Reading:
Association between Estrogen Exposure and Idiopathic Subglottic Stenosis
 Nainika Nanda MD, Li-Ching Huang PhD, Sheau-Chiann Chen PhD et al on behalf of the North American Airway Collaborative, **The Laryngoscope**, 05 September 2023
 DOI: <https://doi.org/10.1002/lary.31030>

What this means

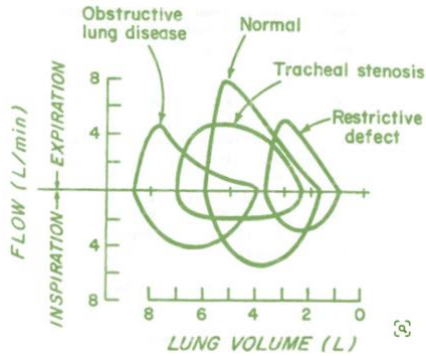
It is possible that patients in peri and post menopause will have a less aggressive disease than their pre-menopausal counterparts.

This paper demonstrates premenopausal patients may have a more aggressive disease variant than their peri- and postmenopausal counterparts.

However, it is unclear as to whether this is related to reduced estrogen in the peri- and postmenopausal states or the age-related physiology of wound healing and inflammation, regardless of estrogen.

What we learned

6. Spirometry is an excellent tool to differentiate airway stenosis patients from those with asthma



Reading:

The diagnostic accuracy of spirometry as screening tool for adult patients with a benign subglottic stenosis

Juliëtta H.C. SchueringIlan, J. Y. Halperin, Maarten K. Ninaber, Antonius P.M. Langeveld

BMC Pulmonary Medicine, August 2023

DOI: <https://doi.org/10.1186/s12890-023-02592-4>

What this means

A spirometry measures how well your lungs work by measuring how much air you inhale; how much you exhale and how quickly you exhale.

This paper demonstrates that this non-invasive tool is more than adequate at identifying airway stenosis patients

If emergency and primary care doctors have access to (and are trained how to use and interpret readings from) a spirometer when patients attend with breathing difficulty, it will be much easier to identify the potential source of the issue.

This is likely to speed up referral to the right specialist for treatment, potentially reducing the diagnostic odyssey.

What we learned

7. There is a new procedure for conducting cricotracheal resections which will spare the patient's voice



Reading:

A novel technique of voice-sparing cricotracheal resection Matthias Evermann, Imme Roesner, Veronika Kranebitter, Konrad Hoetzenecker – **JTCVS Techniques** – November 2023 – DOI: <https://doi.org/10.1016/j.xjtc.2023.11.005>

While a tracheal resection appeals to some for its long-lasting open airway, the risk of impact on voice quality is significant, ranging from a mild to moderate impact for most patients. A standard tracheal resection involves dissection of the cricothyroid ligament and loss of function of the cricothyroid joint. This joint centrally affects the tension of the vocal folds and thus is pivotal in adjusting the voice pitch.

This paper details a new technique which delivers the breathing outcome of a resection, while minimising damage to voice volume or quality. It preserves the cricoid arch and therefore the cricothyroid junction, thus avoiding the damage at this level.

What this means

Developments in resection surgery now mean airway stenosis patients need not necessarily be concerned about damage to their vocal cords and voice.

As this or other voice sparing techniques are adopted, more patients may feel comfortable undertaking this major airway surgery.

As a patient considering tracheal resection, talk to your doctor to fully understand what they are doing to minimise damage to your voice, and encourage consideration of this technique if appropriate.

What we learned: 2022

What we learned

1. Chronic inflammation in subglottic stenosis continues to be studied



Reading:

Luke J. Pasick, Mursalin M. Anis, David E. Rosow

An Updated Review of Subglottic Stenosis: Etiology, Evaluation, and Management.

Current Pulmonology Reports, February 2022; s

<https://doi.org/10.1007/s13665-022-00286-6>

What this means

Previous research identified the presence of interleukin 23 and 17A (IL-23/IL-17A) in iSGS patients. These are responsible for mounting an immune response (inflammation) to bacterial and fungal infections.

That they are present in the airways of people with subglottic stenosis suggests there is potentially an immune response contributing to the stenosis, which could be potentially inhibited through immunotherapy (eg via drugs such as Rituximab, Cellcept, Everolimus and Methotrexate).

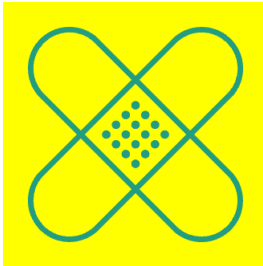
It is still not known what triggers the disease to occur in the first place among idiopathic patients.

Research is continuing.

More research is needed to understand whether inhibiting IL/-23/IL-17A via immunotherapy can help. Initial studies among some populations are showing promising results for some patients.

What we learned

2. Thought to be dysregulated wound healing that promotes growth of scar in airway



Reading:

Delaney J. Carpenter, Osama A. Hamdi, Ariel M. Finberg, James J. Daniero
Laryngotracheal stenosis: Mechanistic review. Head & Neck. 2022;1-13.

<https://doi.org/10.1002%2Fhed.27079>

What this means

There is a need for further research, potentially a larger scale, and each area could potentially involve some drug trials in the future.

It is likely it is a mix of issues which will need to be addressed to truly slow the progress of iSGS.

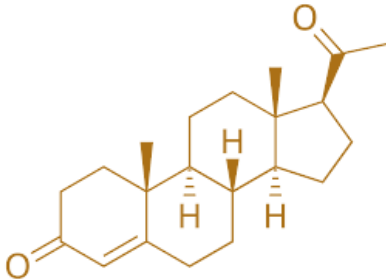
It is suggested that atypical wound healing processes contribute to iSGS.

A literature review points to several elements contributing to this:

- Inflammatory markers – including IL-23/IL-17A (see above)
- Laryngopharyngeal reflux – ie stomach acid which reaches your airway – some studies support its impact while others disagree – most suggest it is an irritant rather than causal
- Microbiology – a distinct form of Mycobacterium (bacteria) was found in the airways of iSGS patients (not in healthy airways) – though whether it is the cause of iSGS or there because of iSGS it is not known

What we learned

3. There is a higher intensity of progesterone receptors found in progressive iSGS compared with non-idiopathic SGS



Reading:

Ivana Fiz, Wiebke Antonopoulos, Jan-Constantin Kölmel, Christian Sittel et al
Hormone pathway comparison in non-idiopathic and idiopathic progressive subglottic stenosis
<https://doi.org/10.1007/s00405-022-07615-0>

What this means

While further research is needed, these findings suggest that a targeted treatment for progressive iSGS could be developed.

Doctors have looked at the scar tissue and airways of patients with progressive (active) iSGS and compared them with non-idiopathic patients.

They found the scar tissue in idiopathic patients showed a higher amount of progesterone hormone, while the surrounding marginal tissue had a reduced amount of the hormone (possibly compensating for the higher amount in the scar).

It is suggested this means there is a hormonal mechanism at play in the development of iSGS.

What we learned

4. Use of a stent in treating subglottic stenosis is not recommended, rather a Montgomery T-tube is a better solution if needed



Reading:

Y N XingH J LiC H ZhongS Y Li

Clinical application and progress of airway stent in subglottic stenosis - Chinese journal of tuberculosis and respiratory diseases 45(11):1140-1146
<https://europepmc.org/article/med/36344231>

What this means

If your doctor suggests using a silicone or metal stent long term (not just a week or two e.g. as part of a major surgery) then point them towards this paper, advocating instead for a T-tube.

The use of stents or tracheostomy in patients with airway stenosis is generally avoided at all costs, however in emergencies they may be considered necessary.

These doctors reviewed 51 papers published globally over the past 29 years. These revealed that silicone and metal stents, when used long term, have a high complication rate in patients with subglottic stenosis.

In contrast the Montgomery T-tube is more suitable and has a higher success rate.

What we learned

5. When shortness of breath worsens, people are more likely to experience anxiety and depression



Reading:

Hannah F. Case, David G. Lott, Amy L Rutt
DO Anxiety and Depression in Patients with Idiopathic Subglottic Stenosis
 Journal of Voice, March 2022

<https://doi.org/10.1016/j.ivoice.2022.02.020>

What this means

Seeking prompt treatment for your stenosis with a doctor you are confident in is important to ease feelings of anxiety and depression.

If these feelings continue once you are breathing well, it would be worth seeking additional counselling and help.

Research found that any person with worsening shortness of breath/trouble breathing experiences feelings of anxiety and depression.

This finding was regardless of the cause of their shortness of breath and was not isolated to airway stenosis patients.

What we learned

6. A new style of resection spares damage to the cricoid, consequentially minimising voice and muscle impact of this major surgery



Reading:

Kevin Y. Liang, Rebecca C. Nelson, Paul C. Bryson, Robert R. Lorenz. **High Tracheal Resection With Intralaryngeal Extension as an Alternative to Cricotracheal Resection for Treatment of Subglottic Stenosis.**

January 2023 Otolaryngology Head and Neck Surgery.

<https://doi.org/10.1002/ohn.180>

So far only conducted at Cleveland Clinic, early signs are that a new method of resection surgery can spare damage to and lowering of the voice, one of the major issues with the most common method of resection surgery.


This surgery is found to work best where the patient's scar tissue is found predominantly on the back of their trachea (posterior stenosis).

Reading - also see - <https://my.clevelandclinic.org/departments/head-neck/outcomes/872-high-tracheal-resection-with-intralaryngeal-extension-for-treatment-of-subglottic-stenosis>

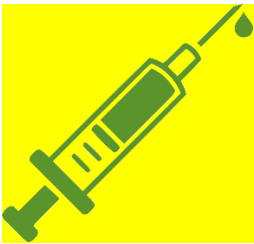
What this means

These results offer hope that in future, a scar-free airway and easy breathing might be achieved with a resection surgery without sacrificing voice.

What we learned: 2021

What we learned		What this means
<p>1. Resection surgery does not require a chin stitch (it may even cause issues)</p>  <p>Reading:</p> <p>Schweiger T, Evermann M, Roesner I, Frick A-E, Denk-Linnert D-M, Klepetko W et al. Laryngotracheal resection can be performed safely without a guardian Chin stitch—a single-centre experience including 165 consecutive patients. Eur J Cardiothorac Surg 2021; https://doi:10.1093/ejcts/ezab092</p>	<p>A guardian chin stitch has been used to stitch a patient’s chin to their chest to prevent potentially damaging movement of the head/neck after a resection surgery.</p> <p>While many resection surgeries are no longer conducted with use of a chin stitch, others continue to use this. Possible complication from use of the stitch includes para-/tetraplegia (inability to voluntarily move the upper and lower parts of the body ie paralysis).</p> <p>This paper supports the use of a head cradle rather than a chin stitch, based on 165 resection surgeries.</p>	<p>If you decide to proceed with a resection surgery, talk to your doctor about their planned technique. If a guardian chin stitch is part of the plan, discuss whether this is necessary or whether a head cradle can be used instead.</p> <p>Point your doctor towards this paper for further reading if appropriate.</p>

What we learned		What this means
<p>2. Execution and success rates of the Maddern Procedure</p> <p>Reading: Ruth J. Davis, MD, Ioan Lina, MD et al Endoscopic Resection and Mucosal Reconstitution With Epidermal Grafting: A Pilot Study in Idiopathic Subglottic Stenosis American Academy of Otolaryngology–Head and Neck Surgery Foundation June 2021 https://doi.org/10.1177/01945998211028163</p>	<p>Endoscopic Resection and Mucosal Reconstitution with Epidermal Grafting – also known as the Maddern Procedure (after Jan Maddern, the first patient to have this operation) has been conducted on airway stenosis patients since 2012.</p> <p>While a major surgery, this is conducted endoscopically, meaning there is minimal risk to vocal cords and voice. As an operation it has a low complication rate and offers a long-term solution to breathing issues.</p> <p>If the surgery fails, a resection (CTR) remains an optional solution.</p>	<p>This procedure is recommended as an option for patients who are having frequent dilations and want a longer-term solution.</p> <p>It is suitable for patients for whom:</p> <ul style="list-style-type: none"> • Disease is restricted to the mucosa (not including the cartilage) • The scar is not dense (which is more challenging to remove) – (cricotracheal resection (CTR) is more suitable in this situation. <p>Post operatively, while the airway remains open, patients do complain of excess mucus. Use of cheek grafts rather than thigh grafts could offer a solution to this.</p>

What we learned		What this means
<p>3. Recipients of steroid injections should be monitored for side effects</p>  <p>Reading: Neeve J, Schuman A, Morrison R, Hogikyan N, and Kupfer R. Serial Intralesional Steroid Injection for Subglottic Stenosis: Systemic Side Effects and Impact on Surgery-Free Interval. OTO Open 2021 Oct-Dec 2021.</p>	<p>Last year we heard how successful steroid injections have been at increasing the time between surgeries for patients</p> <p>This paper looks at the potential side effects patients can have from these injections, following 19 patients over a four year period.</p> <p>They found that 91% of their patients extended their surgery-free time by an average of 4.6 months.</p>	<p>For many patients, steroid injections can extend the time between surgeries. They are relatively quick and do not involve a general anaesthetic, making them an appealing alternative to dilation surgery.</p> <p>Surgeons need to remind patients of the potential risks, however, so they can be monitored. These include:</p> <ul style="list-style-type: none"> • Temporary facial acne and rash • Temporary hives • Central serous chorioretinopathy (fluid behind the retina of the eye)

DOI: 10.1177/2473974X211054842

Around one in three patients had some kind of side effect from the injections.

- Cushing’s syndrome (Common symptoms of Cushing's syndrome include more body fat on your chest, tummy, neck, or shoulders. Your face may also be red and puffy.)

What we learned

4. Cough and mucous are a major quality of life issue for patients with airway stenosis



Reading:

Clunie GM, Anderson C, Savage M, Hughes C, Roe JWG, Sandhu G, McGregor A, Alexander CM. "A Major Quality of Life Issue": A Survey-Based Analysis of the Experiences of Adults With Laryngotracheal Stenosis with Mucus and Cough. *Ann Otol Rhinol Laryngol.* 2022 Sep;131(9):962-970. doi: 10.1177/00034894211050627

While the primary focus by doctors is (and should be) breathing, cough and mucous are also a concerning side effect experienced by many (84%) patients, and rarely addressed by doctors.

Many patients experience psychological impacts from this, impacting their overall self confidence, and work and personal relationships. In addition, mucous plugs have killed airway stenosis patients in the past, so it needs to be an issue taken more seriously.

There is a lack of clear advice offered to airway stenosis patients regarding how to manage their cough and mucous.

What this means

Patients should make sure they raise the issue of cough and mucous with their doctor, if it concerns them, and get advice regarding approaching and reducing this. This may be as simple as a recommendation of nebulising, with details of what to use (eg normal saline or hypertonic saline) and how frequently to do so.

These are important issues to address and should not be downplayed because they do not have a surgical solution.

What we learned: 2020

What we learned

1. How COVID-19 (coronavirus disease 2019) impacts patients with idiopathic subglottic stenosis



Reading:

Anderson C, Sandhu G, Yaghchi CA. **Impact of the COVID-19 Pandemic on Patients with Idiopathic Subglottic Stenosis.** Ear, Nose & Throat Journal. December 2020. doi:10.1177/0145561320977467

As a subglottic stenosis patient, you are at no greater risk than average the average person of contracting and getting sick from C19, unless:

- **Your airway is already narrow**
- **You are taking immune suppressant medication**
- You are classified as obese (BMI of 30+)
- You have other illnesses (co-morbidities) that place you at high risk

What this means

Do not delay having your next injection or dilation surgery if your breathing is declining.

Follow the precautions recommended by your government's health department – wear a mask when in crowded places, wash your hands frequently, carry and use hand sanitizer where hand washing is not possible, practice physical distancing in situations where you may catch C19.

If you catch the virus, monitor your symptoms. If you are concerned, advise your airway doctor of your situation for more specific advice.

What we learned

2. Peak Expiratory Flow (PEF/Peak Flow) is important to measure to monitor your airway health



Reading:

Song SA, Santeerapharp A, Choksawad K, Franco RA Jr. **Reliability of peak expiratory flow percentage compared to endoscopic grading in subglottic stenosis.** Laryngoscope Investigative Otolaryngology. 2020;1–7. <https://doi.org/10.1002/liv2.492>

It's an excellent method of monitoring your airway health without the need to be scoped in your doctor's office. Not only is it easy and affordable, but it provides factual evidence of how quickly your airway narrows, and with regular recording allows you to provide visual evidence to support a remedying injection or dilation surgery.

What this means

Purchase a Peak Flow Meter online and start measuring. Record your number in an app, spreadsheet or just a notepad if that is easiest for you. There's a spreadsheet template available at the Facebook support group 'Living with idiopathic subglottic stenosis', and the latest Rough Guide gives details of apps you can use.

Make it your new habit!

Sungjin A. Song, MD ; Guri Sandhu, MD;
 Ramon A. Franco Jr, MD **Should We
 Routinely Use Pulmonary Function
 Testing in the Management of Subglottic
 Stenosis?** Laryngoscope. 2020;
<https://doi.org/10.1002/lary.28678>

What we learned

**3. How doctors can execute the
 Endoscopic Wedge Excisions
 Technique**



Reading:

Dale C. Ekbom; Semirra L. Bayan; Andrew
 J. Goates; Jan L. Kasperbauer, **Endoscopic
 Wedge Excisions with CO2 Laser for
 Subglottic Stenosis** Laryngoscope, 00:1-
 5, 2020:
<https://doi.org/10.1002/lary.29013>

Gelbard A, Anderson C, Berry LD, et al.
**Comparative Treatment Outcomes for
 Patients with Idiopathic Subglottic
 Stenosis.** *JAMA Otolaryngology Head Neck
 Surg.* 2020;146(1):20-29.
<https://doi.org/10.1001/jamaoto.2019.3022>

Last year we heard that the
 surgery which appeared to
 have the most successful
 outcome for patients
 (longevity of surgery free
 time PLUS minimal impact on
 voice) was the endoscopic
 wedge technique (plus
 adjunct medication).

Similar to a dilation, it is done
 down the throat, so no
 cutting open the neck or
 removing segments like in a
 resection, but research has
 found it lasts a lot longer
 than a dilation. Initially the
 operation was only done at
 Mayo Clinic in Rochester. This
 year, the technique was
 shared so it can be adopted
 more widely

What this means

Talk to your doctor about
 this technique as an
 alternative to traditional
 dilations – feel free to
 share the paper with
 them.

Chat to other patients
 who have had this
 procedure in the group if
 you have questions.

What we learned

4. Steroid injections have a significant impact on surgery-free intervals



Reading:

Debbie R. Pan; David E. Rosow, **Office-Based Corticosteroid Injections as Adjuvant Therapy for Subglottic Stenosis** Laryngoscope Investig Otolaryngol. 2019 Aug; 4(4): 414-419. <https://doi.org/10.1002/lto2.284>

Steroid injections have been used for airway stenosis for around a decade but have really taken off over the last five years. More and more papers and studies are being conducted to understand what works.

In group discussions, we also learn that different doctors use different techniques (such as externally vs internally injected) and quantities of steroid injected.

Anecdotally, Kenalog-80 (80 mg per cc) appears to have the most positive result.

What this means

If you have not yet tried steroid injections, talk to your doctor about trying these.

If you have tried injections and they have not worked, then talk to your doctor about potentially applying a different technique (externally for example) or injecting more of the steroid (80mg rather than 40mg for example).

What we learned

5. Your BMI has an impact on the frequency you need dilations



Reading:

Deanna C. Menapace, Dale C. Ekbom, David P. Larson, Ian J. Lalich, Eric S. Edell, and Jan L. Kasperbauer **Evaluating the Association of Clinical Factors With Symptomatic Recurrence of Idiopathic Subglottic Stenosis** JAMA Otolaryngol Head Neck Surg. 2019 Jun; 145(6): 524-529 <https://doi.org/10.1001/jamaoto.2019.0707>

Research has found that one in three (34%) of us is in the obese category when it comes to weight.

This research from Mayo Clinic has also found that iSGS patients with obesity (particularly with a BMI of between 30.0 and 34.9 - our research suggests 18% of us sit in this category) are likely to see their stenosis reoccur much faster after a dilation than those patients of healthy weight or underweight.

What this means

This may be another good reason to consider reducing your BMI during 2021.

In addition to increasing your surgery frequency, having a BMI over 30 increases your risks under anaesthesia and during surgeries, particularly when coupled with sleep apnoea. It also increases risk of complication should you contract COVID-19.

Published papers

2024

"Acquired Laryngeal and Subglottic Stenosis Following COVID-19 - Preparing for the Coming Deluge"

Sarah Allgood, PhD, RN; Jessica Peters, DNP, MS, ACNP-BC; Andrew Benson, DNP, CRNA, FAAN; Carol Maragos, MSN, ACNP-BC, CORLN; Kimberly McIltrout, DNP, CPNP, CWOCN, CNE, FAANP, FAAN; Tammy Slater, DNP, MS, ACNP-BC; Lee Akst, MD; Simon R. Best, MD; Panagis Galiatsatos, MD, MHS; Martin B. Brodsky, PhD, ScM, CCC-SLP; Michael J. Brenner, MD, FACS; Vinciya Pandian, PhD, MBA, MSN, RN, ACNP-BC, FAANP, FAAN

Journal of Clinical Nursing, 33(1): 6-10, January 2024

DOI: 10.1111/jocn.15992

"Airway Disease Decreases the Therapeutic Potential of Epithelial Stem Cells"

Lisa Zhang; Natalie Kelly; Kimberly M Shontz; Cynthia L Hill; Jacob T Stack; Jazmin Calyeca; Laura Matrka; Audrey Miller; Susan D. Reynolds; Tandy Chiang

Respiratory Research, 25(28), January 2024

DOI: 10.1186/s12931-024-02667-8

"Do We Need Another Quality-of-Life Instrument?"

Karla O'Dell, MD

Chest, 165(1): 7-8, January 2024

DOI: 10.1016/j.chest.2023.09.027

"Association between Estrogen Exposure and Idiopathic Subglottic Stenosis"

Nainika Nanda, MD; Li-Ching Huang, PhD; Sheau-Chiann Chen, PhD; Lynne D. Berry, PhD; Edward Ryan R. Talatala, BS; Evan Clark, BS; Wenda Ye, MD; Alexander Gelbard, MD; David O. Francis, MD MS

The Laryngoscope, 134(2): 825-830, February 2024

DOI: 10.1002/lary.31030

"Navigating Pathways to Diagnosis in Idiopathic Subglottic Stenosis: A Qualitative Study"

Cara Damico Smith, MPH; Nainika Nanda, MD; Kemberlee Bonnet, MA; David Schlundt, PhD; Catherine Anderson, BA; Sara Fernandes-Taylor, PhD; Alexander Gelbard, MD; David O Francis, MD, MS

The Laryngoscope, 134(2): 815-824, February 2024

DOI: 10.1002/lary.31023

"Predictors of Response to Endoscopic Management of Subglottic/Tracheal Stenosis in Patients Without Tracheostomy"

David Ahmadian; Claire M. Gleadhill; Nader Wehbi; Billie A. Bixby; Helena T. Yip

American Journal of Otolaryngology, 45(1): 104055, January-February 2024

DOI: 10.1016/j.amjoto.2023.104055

"Bibliometric and Visualized Analysis of Scientific Publications on Subglottic Stenosis Based on Web of Science Core Collection"

Yaping Zhang; Zhanqiu Dai; Qixin Xia; Yufeng Wu; Tingxiao Zhao; Qi Chen; Chen Xia; Jun Zhang; Jiongnan Xu

Journal of Cardiothoracic Surgery, 19(55), February 2024

DOI: 10.1186/s13019-024-02515-2

"Transcriptional Profiling Sheds Light on the Fibrotic Aspects of Idiopathic Subglottic Tracheal Stenosis" Martin Direder; Maria Laggner; Dragan Copic; Katharina Klas; Daniel Bormann; Thomas Schweiger; Konrad Hoetzenecker; Clemens Aigner; Hendrik Jan Ankersmit; Michael Mildner
bioRxiv, February 2024

DOI: 10.1101/2024.02.19.580975

"Laser Versus Cold Steel for Endoscopic Management of Subglottic Stenosis"

Kevin Y. Liang, MD; Katherine M. Miller, MD; Faez Syed, MD; Hong Li, MS; William S. Tierney, MD; Rebecca C. Nelson, MD; Michael S. Benninger, MD; Paul C. Bryson, MD, MBA; Robert R. Lorenz, MD, MBA

Otolaryngology - Head and Neck Surgery, 171(2): 471-477, March 2024

DOI: 10.1002/ohn.727

"Surgical Management of Airway Stenosis During Pregnancy: A Scoping Review"

Katherine M. Miller, MD; Kevin Y. Liang, MD; Neil Nero, MLIS; Michael S. Benninger, MD; Rebecca C. Nelson, MD; William S. Tierney, MD; Robert R. Lorenz, MD, MBA; Paul C. Bryson, MD, MBA

The Laryngoscope, 134(3): 1014-1022, March 2024

DOI: 10.1002/lary.30994

"The Impact of Previous Endoscopic Treatments on Functional Outcome After Cricotracheal Resection"

Matthias Evermann; Veronika Kranebitter; Imme Roesner; Clemens Aigner; Thomas Schweiger; Doris-Maria Denk-Linnert; Konrad Hoetzenecker

European Journal of Cardio-Thoracic Surgery, 65(6), May 2024

DOI: 10.1093/ejcts/ezae105

"The Voice and Swallowing Profile of Adults with Laryngotracheal Stenosis Before and After Reconstructive Surgery: A Prospective, Descriptive Observational Study"

Gemma M. Clunie; Justin W.G. Roe; Chadwan Al-Yaghchi; Caroline M. Alexander; Alison McGregor; Gurpreet Sandhu

Clinical Otolaryngology, 49(3): 324-330, May 2024

DOI: 10.1111/coa.14138

"Impact of Procedural Variation in Endoscopic Dilatation for Idiopathic Subglottic Stenosis"

Pooja Santapuram, MD; William S. Tierney, MD, MS, MS; Li-Ching Huang, PhD; Sheau-Chiann Chen, PhD; Lynn D. Berry, PhD; David O. Francis, MD, MS; Alexander Gelbard, MD

The Laryngoscope, 134(7): 3260-3266, July 2024

DOI: 10.1002/lary.31393

"Transcriptional Profiling Sheds Light on the Fibrotic Aspects of Idiopathic Subglottic Tracheal Stenosis"

Martin Direder; Maria Laggner; Dragan Copic; Katharina Klas; Daniel Bormann; Thomas Schweiger; Konrad Hoetzenecker; Clemens Aigner; Hendrik Jan Ankersmit; Michael Mildner

Frontiers in Cell and Developmental Biology, 12, July 2024
DOI: 10.3389/fcell.2024.1380902

“Idiopathic Subglottic Stenosis in Non-Caucasian Women”

Amber Suk, BA; Salem Dehom, PhD; Nihal Punjabi, BS; VyVy N. Young, MD; Priya D. Krishna, MD, MS; Lindsay Reder, MD; Karla O'Dell, MD; Grant E. Gochman, MD; Ethan Simmons, BA; Sunil P Verma, MD; Matthew Harmon, MD; Philip A. Weissbrod, MD; Jin Yang, MD; Shanalee Tamares, MLIS; Brianna K. Crawley, MD

OTO Open, 8(3): e180, July-September 2024

DOI: 10.1002/oto2.180

“Surgical Management of iSGS In Pregnant Patients: Survey Among North American Expertise Centers” Laurence Gascon; Sarah Benyo; Radhika Duggal; Daniela Schmulevich; Rebecca Chota Nelson; Michael Benninger; Paul Bryson; William S Tierney

Otolaryngology - Head and Neck Medicine and Surgery, 45(6): 104459, November-December 2024,

DOI: 10.1016/j.amjoto.2024.104459

“Idiopathic Subglottic Stenosis Is Associated With More Frequent and Abnormal Squamous Metaplasia”

Yourka D. Tchoukalova, MD, PhD; Tanya N. Phung, PhD; Maeve M. Kennedy, BSE; Danielle Miranda-Grandjean, PhD; Emanuel Becquer, MS; Longwen Chen, MD, PhD; Nan Zhang, MS; Valentin Dinu, PhD; Melissa A. Wilson, PhD; David G. Lott, MD

Annals of Otology, Rhinology & Laryngology, 133(2): 214-223, 2024

DOI: 10.1177/00034894231201016

“Oral Everolimus Following Dilation in Idiopathic Subglottic Stenosis: A Phase 1 Nonrandomized Clinical Trial”

So RJ, Collins SL, Collins S, Mafla L, Chan-Li Y, Lina I, Gelbard A, Motz KM, Hillel AT. *JAMA Otolaryngol Head Neck Surg*. 2024 Nov 1;150(11):1029-1033. doi: 10.1001/jamaoto.2024.2886. PMID: 39325463; PMCID: PMC11428025.

“Serum S100A8/A9 Correlates to Surgery-Free Interval in Idiopathic Subglottic Stenosis”

Mafla LM, So RJ, Abd-Elazem I, Collins SL, Chan-Li Y, Lilly G, Lina IA, Gelbard AH, Hillel AT, Motz KM.

Laryngoscope. 2024 Nov 27.

DOI: 10.1002/lary.31934

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“Balloon Dilatation is Superior to CO₂ Laser Excision in the Treatment of Subglottic Stenosis”

Eleftherios Ntouniadakis; Josefin Sundh; Anders Magnuson; Mathias von Beckerath

European Archives of Oto-Rhino-Laryngology, 280: 3303-3311, March 2023

DOI: 10.1007/s00405-023-07926-w

“Can the Remote Use of a Peak Flow Meter Predict Severity of Subglottic Stenosis and Surgical Timing?”

Meredith Park, BS; Kevin Tie, MD; Heather Davis, MA, CCC-SLP; Joseph Hall, CCC-SLP; Robert A. Buckmire, MD; Rupali N. Shah, MD

The Laryngoscope, 133(3): 628-633, March 2023
DOI: 10.1002/lary.30257

"Prevalence of Anxiety During the COVID-19 Pandemic in Patients Diagnosed with Subglottic Stenosis" Eleni A. Varelas; Young Jae Kim; Michael Eggerstedt; Inna Husain
American Journal of Otolaryngology, 44(2): 103737, March-April 2023
DOI: 10.1016/j.amjoto.2022.103737

"Is There Something Wrong With Your Voice? A Qualitative Study of The Voice Concerns of People With Laryngotracheal Stenosis"
Gemma M. Clunie; Athina Belsi; Justin W.G. Roe; Guri Sandhu; Alison McGregor; Caroline M. Alexander
International Journal of Language & Communication Disorders, 58(2): 376-389, March/April 2023
DOI: 10.1111/1460-6984.12794

"Tracheal microbiome and metabolome profiling in iatrogenic subglottic tracheal stenosis"
Fan, Z., Zhang, L., Wei, L. et al..
BMC Pulm Med 23, 361 (2023). <https://doi.org/10.1186/s12890-023-02654-7>

"Idiopathic Subglottic Stenosis Arises at the Epithelial Interface of Host And Pathogen"
Alexander Gelbard; Meghan H. Shilts; Britton Strickland; Kevin Motz; Hsiu-Wen Tsai; Helen Boone; Wonder P. Drake; Celestine Wanjalla; Paula Marincola Smith; Hunter Brown; Marisol Ramirez; James B. Atkinson; Jason Powell; John Simpson; Seesandra V. Rajagopala; Simon Mallal; Quanhu Sheng; Alexander T. Hillel; Suman R. Das
May 2023
DOI: 10.21203/rs.3.rs-2945067/v1

"Comparative Treatment Outcomes for Idiopathic Subglottic Stenosis: 5-Year Update"
William S. Tierney, MD, MS, MS; Li-Ching Huang, PhD; Sheau-Chiann Chen, PhD; Lynn D. Berry, PhD; Catherine Anderson, BA; David O. Francis, MD, MS; Alexander Gelbard, MD et al
Otolaryngology - Head and Neck Surgery, 168(6): 1570-1575, June 2023
DOI: 10.1002/ohn.190

"The Diagnostic Accuracy of Spirometry as Screening Tool For Adult Patients With a Benign Subglottic Stenosis"
Juliëtta H.C. Schuering; Ilan J.Y. Halperin; Maarten K. Ninaber; Luuk N.A. Willems; Peter Paul G. van Benthem; Elisabeth V Sjögren; Antonius PM Langeveld
BMC Pulmonary Medicine, 23(314), August 2023
DOI: 10.1186/s12890-023-02592-4

"Serial In-Office Steroid Injections for Airway Stenosis: Long-Term Benefit and Cost Analysis"
Karla O'Dell, MD; Valerie Huang, MD; Joseph Acevedo, MD; Lindsay Reder, MD; Michael Johns, MD; Li Ding, MS
The Laryngoscope, 133(10): 2673-2679, October 2023
DOI: 10.1002/lary.30578

"The Evolution and Outcomes of the "Maddern Procedure" for the Treatment of Subglottic Stenosis"
Robert R. Lorenz, MD
The Laryngoscope, 133(11): 3100-3108, November 2023
DOI: 10.1002/lary.30752

"Mapping Genetic Susceptibility to Stenosis in the Proximal Airway"

Kayvon Sharif, BA; William S. Tierney, MD; Ruth J. Davis, MD; Elizabeth Wohler, MS; Nara Sobreira, MD, PhD; Alexander T. Hillel, MD; Samuel Collins, PhD; Marisol Ramirez-Solano, MS; Quanhu Sheng, PhD; Alexander Gelbard, MD

The Laryngoscope, 133(11): 3049-3056, November 2023

DOI: 10.1002/lary.30718

"A Novel Technique of Voice-Sparing Cricotracheal Resection"

Matthias Evermann, MD; Imme Roesner, MD; Veronika Kranebitter, MD; Doris-Maria Denk-Linnert, MD; Johanna Bauer, MD; Thomas Schweiger, MD, PhD; Konrad Hoetzenecker, MD, PhD

JTCVS Techniques, 18(23): 161-169, November 2023

DOI: 10.1016/j.xjtc.2023.11.005

2022

"Presentation, Diagnosis, and Management of Subglottic and Tracheal Stenosis During Systemic Inflammatory Diseases"

Jennifer Catano, MD; Yurdagul Uzunhan, MD, PhD; Romain Paule, MD; Jérémie Dion, MD; Alexis Régent, MD; Paul Legendre, MD; François Gonin, MD; Emmanuel Martinod, MD, PhD; Pascal Cohen, MD; Xavier Puéchal, MD, PhD; Véronique Le Guern, MD; Luc Mouthon, MD, PhD; André Coste, MD, PhD; Christine Lorut, MD; Candice La Croix, MD; Sophie Périé, MD, PhD; and Benjamin Terrier, MD, PhD

Chest, 161(1): 257-265, January 2022

DOI: 10.1016/j.chest.2021.07.037

"Idiopathic Subglottic Stenosis in Saskatchewan Hutterite Population"

C. Holmes; K. Aravinthan; R.A. Murphy; R. Gore-Hickman; S.P. Nair; A.R. Sharma

The Journal of Laryngology & Otology, 136(6): 554-558, February 2022

DOI: 10.1017/s0022215122000445

"Molecular Mechanisms and Physiological Changes behind Benign Tracheal and Subglottic Stenosis in Adults"

Alessandro Marchioni; Roberto Tonelli; Alessandro Andreani; Gaia Francesca Cappiello; Matteo Fermi; Fabiana Trentacosti; Ivana Castaniere; Riccardo Fantini; Luca Tabbi; Dario Andrisani; Filippo Gozzi; Giulia Bruzzi; Linda Manicardi; Antonio Moretti; Serena Baroncini; Anna Valeria Samarelli; Massimo Pinelli; Giorgio De Santis; Alessandro Stefani; Daniele Marchioni; Francesco Mattioli; Enrico Clini

International Journal Molecular Sciences, 23(5): 2421, February 2022

DOI: 10.3390/ijms23052421

"The Effect of Subglottic Steroid Injection on Blood Glucose in a Cohort of Patients With Subglottic Stenosis"

Bensoussan Y, Martinez E, Van Der Woerd B, Johns M, Nguyen C, Watts S, O'Dell K.

Laryngoscope. Sep 27 2022.

DOI: 10.1002/lary.30392.

"'Is there something wrong with your voice?' A qualitative study of the voice concerns of people with laryngotracheal stenosis"

Gemma M Clunie, Athina Belsi, Justin W. G Roe, Guri Sandhu, Alison McGregor, Caroline M. Alexander

International Journal of Language and Communication Disorders, September 2022

DOI: 10.1111/1460-6984.12794

“A Major Quality of Life Issue”: A Survey-Based Analysis of the Experiences of Adults with Laryngotracheal Stenosis with Mucus and Cough”

Gemma Clunie; Catherine Anderson; Justin W.G. Rose; Guri Sandhu; Alison MacGregor; Caroline M. Alexander

Annals of Otology, Rhinology & Laryngology September 2022

DOI: 10.1177/00034894211050627

“New Treatment Strategy for Subglottic Stenosis Using the Trachealator, a Novel Non-occlusive Balloon”

Leonie G. M. Wijermars, MD, PhD ; Carlijn E. L. Hoekstra, MD, PhD; Thao T. T. Nguyen, MD; Markus F. Stevens, MD, PhD; Frederik G. Dijkers, MD, PhD

The Laryngoscope, May 2022

DOI: 10.1002/lary.30234

“Endoscopic Resection and Mucosal Reconstitution With Epidermal Grafting: A Pilot Study in Idiopathic Subglottic Stenosis”

Ruth J. Davis, MD; Ioan Lina, MD; Kevin Motz, MD; Alexander Gelbard, MD; Robert R. Lorenz, MD; Guri S. Sandhu, MD; Alexander T. Hillel, MD

Otolaryngology - Head and Neck Surgery, 166(5): 917-916, May 2022

DOI:10.1177/01945998211028163

“An Updated Review of Subglottic Stenosis: Etiology, Evaluation, and Management”

Luke J. Pasick, Mursalin M. Anis, David E. Rosow

Interventional Pulmonology, February 2022

<https://doi.org/10.1007/s13665-022-00286-6>

“Idiopathic Subglottic Stenosis Arises At The Interface Of Host And Pathogen”

Alexander Gelbard; Meghan H. Shilts; Britton Strickland; Kevin Motz; Hsiu-Wen Tsai; Helen Boone; Wonder P. Drake; Celestine Wanjalla; Paula Marincola Smith; Hunter Brown; Marisol Ramirez; James B. Atkinson; Jason Powell; A. John Simpson; Seesandra V. Rajagopala; Simon Mallal; Quanhu Sheng; Alexander T. Hillel; Suman R. Das

BMJ, February 4, 2022

DOI: 10.1101/2022.02.02.22270308

“Persistent Throat Symptoms Should Not Be Treated With Pills That Reduce Stomach Acid”

James O’Hara

Ear, Nose and Throat, January 13, 2022

DOI: 10.3310/alert_48810

“Dilation Versus Laser Resection In Subglottic Stenosis: Protocol For A Prospective International Multicentre Randomised Controlled Trial (AERATE Trial)”

Thibaud Soumagne; Nicolas Guibert; Ihab Atallah; Yves Lacasse; Hervé Dutau; Marc Fortin

BMJ Open, 12:e053730, 2022

DOI: 10.1136/bmjopen-2021-053730

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Delaney J. Carpenter, MD; Osama A. Hamdi, MD; Ariel M. Finberg, BS; James J. Daniero, MD, MS
Head & Neck, 1–13, Basic Science Review, 2022
DOI: 10.1002/hed.27079

“The Development of a Patients Concerns Inventory for People Diagnosed with Airway Stenosis (PCI-AS)”

Justin Roe; Catherine Anderson; Gemma Clunie; Lindsay Lovell; Chadwan Al Yaghchi; Guri Sandhu; Mary Wells; Simon Rogers
Imperial College London, September 2022
Conference paper

“A Case of Severe Tracheal Stenosis After Short-Duration Mechanical Ventilation”

Zachary S. Anderson; Adnan Khan; Sakina Batool; Bireera Muzaffar; Ramsha Zafar
Chest, 162(4): A1877, October 2022
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Is it really asthma? Flyer to share with your GP

Please share this document with your primary care doctor/GP

Is it really asthma?

Do you have an adult female patient aged between **25-70 years**

(but especially 35-45 years) where...

Asthma medication does **not** seem to **make any difference** to her breathing

She started to struggle with breathing **as an adult** with **no prior history** of breathing difficulties

She has a **stridor** (wheezes when she breathes in) rather than just a wheeze (when she breathes out)

Sounds like she may have **croup**, maybe describes as 'breathing like Darth Vader'

Coughs or clears her throat regularly

Shortness of breath is **constant** but **worsens on exertion** or with exercise. There is **no 'attack'** as with asthma.

If this sounds like any of your patients, please strongly consider referring her to an **ENT/Otolaryngologist** AND **insist they use laryngoscope** to inspect her airway looking for a blockage **below her vocal cords**.

It could be subglottic stenosis.

Subglottic stenosis is a build up of scar tissue in the trachea just below the vocal cords for no known reason.

98% of patients with this disease are **female**, with symptoms starting in their 30's or around times of hormone spikes (eg pregnancy and menopause).

96% of patients are **misdiagnosed** – usually with asthma or allergies. Left untreated or undiagnosed the airway can close or block, potentially leading to death.



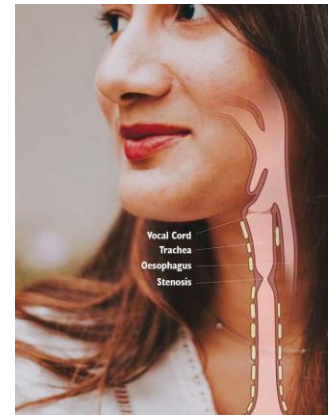
Dear Doctor, I have subglottic stenosis....

The following page is designed to help provide an explanation of your airway disease for a doctor who may not be familiar with treating someone with subglottic stenosis – such as a new general practitioner or perhaps a doctor in an emergency room (even if they are an ear, nose and throat specialist). You can complete the relevant details and bring it with you to explain your condition when you might see a clinician other than your usual specialist.

Dear Doctor

This patient has a rare airway disease, **idiopathic subglottic stenosis**. They may be presenting to you today because they have **issues with breathing** and are unable to see their usual treating otolaryngologist consultant immediately.

Idiopathic subglottic stenosis (SGS) is a rare disease consisting of upper airway obstruction which nearly universally occurs in adult, Caucasian women. Symptoms vary from dyspnoea, stridor, dysphonia and cough. There is no known cause for this, though it could be related to autoimmune disease (e.g. GPA), hormonal sensitivity or previous intubation if there is history.



The stenosis (scar tissue) is located just below the vocal cords, but it is possible for it to spread to other areas of the trachea, including within or above the vocal cords, or lower down in the trachea. A stenosis which is often quite stable, needing only annual intervention can suddenly become inflamed, or more aggressive and close rapidly without apparent cause. It is important to investigate before sending this patient away.

Typical treatments include a balloon dilation and steroid injections into the affected area.

Please do not consider a tracheotomy without prior discussion with the patient’s consulting surgeon unless it is deemed potentially lifesaving by the local airway (otolaryngology/anaesthetic/ER consultant) team i.e. an emergency. This could potentially cause further damage to the airway and worsening stenosis longer term.

There are potentially several different reasons for their current breathing issues, which could be assessed:

Issue	Explanation
Non-COVID 19 Infection	Given the area of narrowing in her trachea, there is a high risk of upper airway infection. This increases risk of a life-threatening mucus plug if left untreated.
COVID-19 Infection	SGS patients may be more at risk of complications from coronavirus infection due to impaired mucociliary clearance and unknown immune abnormalities. Breathing problems should not be assumed to be due to the stenosis, and tests to rule out COVID 19 infection carried out. Management of SGS patients with coronavirus infection should follow local and national guidelines for

	<p>patients without such stenosis. Consideration of 2-3 week delay before deciding to perform elective tracheostomy should be made, in accordance with guidance, in the unlikely event of ventilation being required.</p>
Mucus plug	<p>Mucus builds up behind the scar tissue and can become thickened. If left untreated this can block the stenosis, restricting airflow and potentially leading to asphyxiation.</p> <p>Assess immediate risk of airway compromise and consider urgent referral to an otolaryngologist/ ENT surgeon for bronchoscopy and/or removal of plug.</p> <p>Frequent saline nebulising potentially with an expectorant (e.g. Guaifenesin, Robitussin or Mucinex) designed to break down mucus.</p> <p>Most airway stenosis patients have a saline nebuliser at home which could be used regularly in this situation.</p>
Haematoma	<p>If the patient has had recent airway treatment such as steroid injections into the stenosis, this may have triggered a bleed. Confirm with CT and observe or drain as required. If draining under GA, use a small tube (eg size 5).</p>
Inflammation	<p>Inflammation can be triggered by two factors:</p> <ol style="list-style-type: none"> 1. Due to the potential autoimmune impact of this disease, airway inflammation is common in SGS patients and can occur for no obvious reason. This can further constrict an already narrow airway. 2. SGS patients can be at increased risk of laryngeal reflux which can lead to inflammation in the throat.
Closure of stenosis	<p>In some patients, the scar can close rapidly (often sometimes within weeks of an otherwise successful dilatation surgery). The signs of this are a rapid and consistent fall in PEF rate, significant stridor, and respiratory distress.</p> <p>Assess immediate risk of airway compromise and urgently refer to an otolaryngologist/ ENT surgeon for management. Alert the consultant anaesthetist on-call.</p>
New stenosis	<p>Occasionally patients will develop a second stenosis. The patient may notice a change in their breathing which is perhaps different to before.</p> <p>This can be most accurately diagnosed with a bronchoscopy or a fine slice CT of the neck.</p>



Key details about this patient:

Name				
Age/DOB		Height		Weight
Expected Peak Expiratory Flow (PEF) for age/height/gender if healthy (a)		Current PEF (b)		
Name of usual treating otolaryngologist		Contact details		
Current medications				
Additional conditions				

Explaining subglottic stenosis to family

I have subglottic stenosis



This means I have a very narrow airway that makes it difficult to breathe....



It is known as a chronic disease – this means I have this condition **long term**.



It is **very rare** – **only two people in a million** have subglottic stenosis, and mostly women.

Nobody knows what causes it. Some people get this from having a tube down their throat during an operation, or breathing in chemicals or hot air, but this is not the case for me.

It appears to be like an **autoimmune disease** – this means my immune system is wrongfully attacking healthy cells in my airway and causing scarring, which then narrows my airway. This will cause me to **cough frequently**, to move any mucus. It is **not contagious**.

It sounds a little bit like I have asthma, but **inhalers will not help** me. It is **not caused** by allergies, weight, diet or reflux. Exercising more will not fix it.

It might surprise you to learn my blood **oxygen levels** are always **very good**, so an O₂ tank will not help my breathing, even when I am struggling.



When I have an operation in hospital, this **temporarily** opens my airway, hopefully putting the disease into **remission**... but so far **there is no cure**, it is very likely to come back.



The disease impacts the inside of my **breathing tube**, known as the trachea. This is different from the tube which food goes down, known as the oesophagus.

Fixing my airway with a stent or pipe will not work – in fact it could be very dangerous for me.



Subglottic stenosis is life threatening. When the scar has built up, it could be possible my airway will block and stop me breathing. It is therefore important that you remember to tell doctors I have a **narrow airway**, should something happen to me and I need to go to hospital. You don't need to remember what my disease is called.

Want to learn more and/or provide more support? Then join the Living with iSGS support group at:

www.facebook.com/groups/airwaystenosis

Help other patients find support

Please print out this page and cut out the individual cards to share with your treating doctor, and other patients you might meet while at the hospital waiting for an airway operation, so they might too find support.



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