white pepper used in the factory, with stimulation indices of 311%, 244% and 2459%, respectively. The LST were negative for curry powder and ground pepper used in another curry sauce factory. LST using blood samples from three healthy volunteers and the three substances were negative. We therefore concluded that the patient’s lung disease was associated with the spices used in his factory and we advised him not to return to work. Prednisolone and azathioprine were administered but both drugs were discontinued owing to the occurrence of bilateral pneumonothoraces which were surgically treated. Although the consolidations on the HRCT scan did not recur after his isolation from the factory, the subpleural cystic lesions—thought to be caused by a check valve mechanism with bronchiolar constriction—increased in size and number and post-inflammatory pleural thickening progressed (fig 1B). Fourteen months after onset of the disease the patient died from ventilatory insufficiency with hypercapnia.

Although fungi or bacilli in the spices may have induced the lung disease and further investigation is needed to determine the exact elements responsible, we wish to draw attention to the possibility of this type of lung disease. Progressive pulmonary cysts and respiratory failure may happen even after avoidance of pathogenic antigens, as found in pigeon breeder’s lung, and early diagnosis is necessary to improve its prognosis.

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doi: 10.1136/thx.2006.062182

Critical care as part of respiratory medicine training in the UK

Intensive care in the UK has traditionally been delivered by intensivists within the physical boundaries of the intensive care or high dependency unit. The recent adoption of the term “critical care” reflects an increasing focus on the patient rather than the location or attending physician.1 The Joint Committee of Higher Medical Training curriculum in respiratory medicine identifies that experience in “intensive care medicine” is essential for respiratory trainees, and specifies that no less than 60 days should be spent in an intensive care unit recognised by the regional programme director. This is equivalent to 3 months full time training and should ideally be undertaken as a single full time allocation, but can be delivered as blocks of a minimum of 15 consecutive working days, ideally with trainees taking part in the intensive care medicine on-call rota.

The recently formed Respiratory Critical Care Group (RCCG), a subgroup of the Education and Training Committee of the British Thoracic Society (BTS), has identified that one of their primary goals is to focus on the interface between respiratory and critical care medicine. The group therefore undertook a survey of respiratory trainees (RTs) and programme directors (PDs) to establish whether the critical care experience prescribed in the curriculum was being delivered. The RCCG sent out questionnaires to all PDs and RTs registered with the BTS. The overall response rate was 55% (208/389 RT, 16/18 PD).

Reassuringly, 94% of PDs and 96% of RTs agreed that experience in critical care medicine was an essential part of respiratory training. Furthermore, 98% of RTs were allocated to 3 months training in a recognised unit. However, 41% of RTs also covered acute general internal medicine and/or respiratory medicine during this period, and more than half the PDs attributed local limitations on training to a lack of available posts. Despite this, 85% of trainees reported that their regional training programme included sessions focusing on critical care topics. More interestingly, especially when considering future plans for respiratory and critical care training provision, a number of trainees expressed an intention to develop a specialist interest in intensive care medicine (19%), high dependency medicine (32%), non-invasive ventilation (57%), and weaning (13%). Accepting the limitations of questionnaires, there are still some key messages that need to be highlighted. Firstly, there is broad agreement between RTs and PDs on the importance of experience in critical care as part of respiratory medicine training, and the majority of RTs have an opportunity to access it. However, 10% of trainees still have inadequate exposure to critical care, either in terms of length of experience or availability of dedicated training, and many trainees are potentially diluting their critical care experience by having to cross-cover for general internal medicine and/or respiratory medicine.

Secondly, a significant number of trainees wish to be involved in the delivery of critical care outside the intensive care unit. However, full accreditation in intensive care medicine necessary to provide this? Probably not, but a longer period of training in intensive care medicine combined with a period of anaesthetics training and experience in a recognised high dependency unit would be acceptable if a competency-based approach were applied.

The provision of critical care services is no longer the sole responsibility of intensivists. However, for RTs to manage critically ill patients effectively outside the intensive care unit, some adjustments may need to be made to training programmes. The obvious question raised is whether training for sub-specialty service provision in this area should be pursued by the BTS? Although this question goes beyond the limits of the current survey, the results do identify that there are a number of RTs dedicated to pursuing a career in the area. The aims of the RCG will be to support RTs, as many have potential interests in critical care medicine training, and the majority of RTs have an opportunity to access it. However, 10% of trainees still have inadequate exposure to critical care, either in terms of length of experience or availability of dedicated training, and many trainees are potentially diluting their critical care experience by having to cross-cover for general internal medicine and/or respiratory medicine.

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Thorax 2006 61: 1013
doi: 10.1136/thx.2006.064311

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