Pleural ultrasound

David Feller-Kopman

The use of handheld portable ultrasound (US) has probably had more of an impact in the care of patients with pleural effusions than any other development since Light introduced a method for distinguishing transudative from exudative effusions in 1972.1 The advantages of US for the evaluation of pleural effusions include the ability to provide real-time guidance for procedures, the absence of radiation, portability and the ability to perform dynamic evaluations. US is more sensitive than chest radiography for the detection of pleural fluid and may be better than chest CT scanning for differentiating pleural effusion from pleural thickening. The use of US has also been associated with a reduction in “near misses” as well as an increased yield, even in experienced hands.2 Because of these benefits, the use of US by non-radiologists has increased tremendously over the last few years. The American Board of Internal Medicine “strongly recommends” obtaining proficiency in the use of US to guide thoracentesis for fellows in pulmonary and critical care training programmes (http://www.abim.org/ certification/policies/imss/ccm.aspx). Likewise, the American College of Emergency Physicians,3 the American College of Surgeons4 and the Royal College of Radiology5 have all issued statements regarding the incorporation of US in the care of patients with pleural effusions.

There have been several recent reviews of the use of US to guide thoracentesis6 7 and, when compared with historical controls, the use of US is associated with a significant reduction in complications as well as improved yield.8 9 In addition, the sonographic characteristics of effusions have been shown to correlate with underlying pathology. Complex effusions (with or without septae) and homogenously echogenic effusions are usually exudative, whereas anechoic effusions could be either exudative or transudative.10 11 The sonographic characteristics of effusions have also been found to predict the need for pleural intervention in patients with empyema.12 To date, however, only the presence of a pleural mass and the “echogenic swirling pattern” have been suggestive of the presence of a malignant pleural effusion (MPE).13 14

In this issue of Thorax, Qureshi and colleagues,15 by using a systematic approach to the patient with suspected MPE, were able to accurately identify patients with malignant and benign disease (see page 139). Thoracic US was performed without clinical history and considered consistent with MPE if diaphragmatic/parietal pleural nodules, pleural thickening >1 cm or hepatic metastases were found. The inability to resolve the five distinct layers of the diaphragm which are normally easily seen and a diaphragm thickness >7 mm were also associated with malignant effusions. Benign disease was considered present when infection was confirmed or patients had a clinical follow-up of at least 12 months. Thoracic US correctly diagnosed 26/35 patients with malignant disease and 19/19 patients with benign disease (sensitivity 79%, specificity 100%, positive predictive value 100% and negative predictive value 79%) for differentiating malignant from benign disease. In comparison with chest CT scanning as

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Thorax February 2009 Vol 64 No 2

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Traffic-related air pollution, genetics and asthma development in children

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In recent years, air pollution has increasingly become recognised as a major contributor to adverse health effects. Numerous studies have shown that poor air quality can adversely affect those with respiratory conditions such as asthma and chronic obstructive pulmonary disease and, more recently, cardiovascular conditions such as myocardial infarctions and stroke.1 Wherever the location, air pollution has been shown to be associated with deterioration in patients with these conditions, as well as with increased mortality.

In patients with asthma, air pollution increases symptoms, medication use, bronchoconstriction, emergency room admissions and hospitalisations. These effects are linked to pollutants such as ozone, nitrogen dioxide and particulate matter (PM) and, increasingly, the role of traffic-related air pollution has been highlighted. Traffic pollution consists of a complex mixture of particles and gases from gasoline and diesel engines, together with dust from wear of road surfaces, tyres and brakes. The coarse particles from road dust have been clearly associated with worsening of asthma and respiratory symptoms.2 Motor engine particles from diesel engines have been linked with worsening of asthma and increased bronchial hyper-responsiveness.

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Thorax 2009 64: 97-98
doi: 10.1136/thx.2008.107292

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