but efforts need to be made to reduce read-
mission rates. Further investigation needs to
be carried out to identify if interventions can
reduce rehospitalisation in the high risk
patients identified by this study and what
these interventions may be.

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ARDS outcomes: a marker of
critical care quality in the UK?

Finney and colleagues’ recent editorial
discussed the results of the UK-based CESAR
trial,2 which investigated extracorporeal
membrane oxygenation (ECMO) in severe
hypoxic respiratory failure. The editorialists
concluded that this trial provided powerful
support for the centralisation of care for severe
acute respiratory failure (ARF) in a limited
number of hospitals, with appropriate exper-
tise and resources, including ECMO. Whilst
this may be true, we suggest that CESAR also
supports the contention that the provision of
critical care services for the management of
severe ARF in UK intensive care units requires
further detailed auditing.

The CESAR trial’s pragmatic design gives
an insight into the prevailing standards of care
for patients with severe ARF. Although lung
protective ventilation3 is a well established,
uncontroversial practice, only 30% of the
patients in the control group received this
modality. It is of concern that 17 of 85 patients
arriving alive at the ECMO centre improved
with what would be generally recognised as
a standard adult respiratory distress
syndrome (ARDS) treatment protocol (tidal
volume 4–8 ml/kg, plateau pressure <30 cm
H2O, FiO2 titration to SaO2 >90%, diuresis to
dry weight, packed cell volume of 40%, prone
positioning and full nutrition). Significantly
14 (82%) of these individuals survived,
suggesting that outcomes in severe ARF in the
CESAR trial are a reflection of the quality of
the critical care process that is delivered.

In this context it is not unreasonable to
to question why there is such a disparity in
critical care provision within the UK. In
Australia and New Zealand critical care
medicine has been a speciality for >25 years
with a faculty, fellowship and, more
recently, a college. Consequently there is less
variability in service provision and the
delivery of care which is central to clinical
governance. This may explain, in part, why
outcomes for many aspects of critical care,
including ARDS, are better in Australasian
centres.3 Unfortunately the UK has fallen
behind this model of service delivery and
critical care has only been recognised as
a speciality since 2002. In the first instance
establishing a faculty of critical care medi-
cine would go a long way towards redressing
the balance.

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ARDS outcomes: a marker of critical care quality in the UK?

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