Acronyms, pneumothoraces and the impact of international health on the NHS

I read the latest Issue of Thorax with amusement and frustration.

I could not resist your challenge in your Editorial, ‘Pre-drainage tension’, triggered by letters from Drs Simpson and Leigh Smith1 to make a ridiculous acronym.3

My understanding of pneumothorax was that it is due to a loss of the negative intrapleural pressure that overcomes the elastic recoil of the pulmonary tissues. Once this vacuum is lost then air is free to enter the lungs or intrapleural space with impunity. The actual amounts will vary according to many factors, including the strength of elastic recoil of pulmonary tissues, exact sites of leak and depth of inspiration. Perhaps we need an engineer to explain this?

However, on first reading of the letters I was concerned that all texts on the issue including life support and trauma courses would have to be REPRINTED (Rapidly Expanding Pneumothorax Requiring Immediate Needle Thoracic Elimination to avoid Death), or worse still would Stop Casualties Receiving Appropriate Pneumothorax Procedures to Eliminate Death (SCRAPPED).

Having tried to be ridiculous I was then struck by the juxtaposition of Kevin Southern’s article on cystic fibrosis screening2 and Dr Zarir Udwadia’s article ‘MDR, XDR, TDR tuberculosis’.3 Both were excellent articles but their proximity raised issues of global health economics that must be addressed. Cystic fibrosis is a disease that has a very large budget, possibly larger with the advent of promising new treatments, but that affects relatively few. The tuberculosis figures from India are frightening. In the age of international travel it might be totally drug-resistant (TDR) tuberculosis that provides the West with a huge public health and mortality problem. When debating NHS reforms the impact of other healthcare systems on ours has not even been considered. Is it time to admit a national health service is not only possible but necessary? Is there a role for the British Thoracic Society to start public debates on these issues?

Thanks for a thought-provoking read.

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Hyperoxia in acute asthma

We read with interest the recent article ‘Randomised controlled trial of high concentration versus titrated oxygen therapy in severe exacerbations of asthma’ by Perrin et al4 and the accompanying editorial. We note that data presented in the online supplement suggest, unsurprisingly, response to treatment at 60 min in terms of respiratory rate and forced expiratory volume in one second, probably explaining the rise in transcutaneous partial pressure of carbon dioxide (Pco2) in this population. Therefore, it cannot be assumed that the Pco2 levels would have continued to rise after 60 min as the authors suggest.

We are unconvinced by the implication that the levels of normocarbia and hypercarbia (up to 50 mm Hg) demonstrated in this study are deleterious in acute asthma. Life-threatening respiratory failure in asthma is multifactorial, with ventilation–perfusion mismatch, lung hyperinflation and an increased work of breathing leading to respiratory muscle fatigue all being contributory factors.4 A degree of ‘permissive hypercapnea’ is now regarded as best practice and a safe approach in the management of mechanical ventilation for respiratory failure in critical care, including in the management of severe asthma. Conversely, hyperoxia is known to cause excess reactive oxygen species causing oxidative stress and free radical damage in exposed tissues,5 and has been implicated in worsening myocardial and cerebral ischaemia.4 Maintaining hyperoxia may also result in delays in recognise clinical deterioration.

We are in full agreement with current guidelines that therapy should target physiological levels of oxygen, but would argue that hyperoxia per se may be more harmful than the predominant normocarbia found in this study population of acute exacerbations of asthma.

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