THE ROLE OF ROUTINE COMPUTED TOMOGRAPHY IN PAEDIATRIC PLEURAL EMPYEMA

A.Jaffe1,2,3, A.D.Calder4, C.M.Owens4, S.Stanojevic2, S.Sonnappa1,2

Author Affiliations:

1. Department of Respiratory Medicine
   Great Ormond Street Hospital for Children NHS Trust, London, UK

2. Portex Anaesthesia, Intensive Therapy and Respiratory Unit
   Institute of Child Health, London, UK

3. Sydney Children’s Hospital, Randwick and University of New South Wales,
   Sydney, Australia

4. Department of Radiology
   Great Ormond Street Hospital for Children NHS Trust, London, UK

Correspondence to:

Dr. Samatha Sonnappa
Portex Anaesthesia, Intensive Therapy and Respiratory Unit
Level 6, Cardiac Wing, Institute of Child Health
30, Guilford Street, London WC1N 1EH, UK
Telephone: +44 20 7405 9200
Fax: +44 20 7829 8634
E-mail:s.sonnappa@ich.ucl.ac.uk

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Abbreviations: CT, computed tomography; USS, ultrasound scan; VATS, video assisted thoracoscopic surgery

Key Words: empyema, children, computed tomography, urokinase
ABSTRACT

Background: The incidence of empyema is increasing worldwide in children. While there are emerging data for the best treatment options, there is little evidence to support the imaging modalities used to guide treatment particularly with regard to the role of routine computed tomography (CT). The aims of this study were to develop a radiological scoring system for paediatric empyema and to assess the utility of routine CT scanning in this disease.

Methods: Children with empyema were prospectively enrolled over a 3-year period into a randomised clinical trial of video assisted thoracoscopic surgery versus percutaneous chest drain insertion and urokinase. All children received a pre-operative chest radiograph (CXR), pleural ultrasound scan (USS) and chest CT. In the urokinase arm the clinician inserted the drain with ultrasound evidence only and did not have access to the CT scan at the time of insertion to reflect clinical practice. A scoring system was developed for each individual radiological modality and utilised to compare imaging characteristics of the pleural fluid collection and underlying parenchyma and to assess the utility of USS and CT to predict length of stay post intervention.

Results: Of the 60 subjects recruited, 46 had USS images available for review, 36 had a CT scan meeting inclusion criterion and 31 had all three radiological measurements (CT, USS and CXR) available for analysis. There was substantial inter-observer agreement for USS grades (κ=0.709) and moderate agreement for total CT scores (κ=0.520). There were weak correlations between ultrasound grade and total CT score as well as CT loculation and density scores. Of the 25 CXRs showing simple opacification of the underlying parenchyma only, CT demonstrated simple consolidation (n=14), necrotising pneumonia (n=7), cavitary necrosis (n=3) and pneumatoceles (n=1). No abnormality was detected on CT scanning which directly altered clinical management. Neither the USS score, nor the CT score, nor a combination of the two, were able to predict length of hospital stay.

Conclusions: CT scanning detects more parenchymal abnormalities than CXR. However, the additional information does not alter management and is unable to predict clinical outcome. This suggests that there is no role for the routine use of CT scanning in children if treated with urokinase and percutaneous chest drain. The omission of routine CT scanning in empyema will reduce the exposure of children to unnecessary radiation and reduce costs.
INTRODUCTION

Although relatively uncommon, the incidence of empyema in children is increasing in many countries.[1–4] The British Thoracic Society guidelines on the management of empyema in children highlighted the lack of grade A evidence to inform best management.[5] Since its publication in 2005 this has been increasingly addressed by the publication of prospective randomised controlled studies.[6,7] The BTS guidelines further highlighted the lack of evidence to inform imaging modalities to assist in management. The consensus was that a posterioranterior (or anteroposterior) chest radiograph (CXR) together with a pleural ultrasound scan (USS) be performed. The expert opinion (level D evidence) was that chest computed tomography (CT) should not be performed routinely but that there may be a role in atypical empyema presentations.

If a parapneumonic effusion contains pus it is called an empyema. The American Thoracic Society divided the empyema process into 3 stages: 1) Exudative, in which the pleural fluid has a low cell content; 2) Fibrinopurulent, in which frank pus is present and fibrin formation begins to cover the pleura with formation of loculations; 3) Organizing phase, in which there is thick peel formation by fibroblasts and the pleural space is characterised by ‘very thick exudates with heavy sediment’. [8] USS has been used to stage this process in children by demonstrating the presence of septations and to guide management [9]; however, the role of routine CT scanning in guiding management in children with empyema is not known. A major limitation of the radiological data available from adult studies is that they are not applicable to the paediatric population.[10] The disease rarely causes death in children, who are generally healthy prior to the onset of infection, compared to adult empyema which has an estimated mortality of 20%.[11]

Management options include the insertion of a drain with or without fibrinolytics, [6,12] limited open decortication [9] or video assisted thoracoscopic surgery (VATS).[13,14] In most cases where a surgical approach is taken, a CT scan is performed pre-operatively. This is particularly true in VATS where the surgeon requires a ‘road map’ to provide greater anatomical delineation and better definition of the underlying lung parenchyma to ensure that the placement of the instruments does not cause a broncho-pleural fistula. In those centres where children are managed with urokinase and percutaneous chest drain insertion, a CT is not routinely performed. There is no consensus on radiological investigations in childhood empyema and practice varies between centres.

The aims of this study were: 1) to develop a radiological scoring system for childhood empyema and 2) to assess the utility of routine CT chest in paediatric empyema.
MATERIALS AND METHODS

This study formed part of a previously published prospective randomised study comparing VATS with percutaneous drain insertion and urokinase. Subjects were recruited from children aged less than 16 years referred to our institution, a tertiary paediatric respiratory centre, for further management of complicated parapneumonic effusion, over a 3 year period. Pre-operative CXR, pleural USS and CT were performed routinely in all patients, irrespective of the treatment group they were randomised to. However, in order to reflect local standard clinical practice the CT scans in the VATS group were made available to the surgeons. In the urokinase group, the radiologist and paediatrician in charge were aware of the CT image findings, however, at the time of insertion the clinician inserting the drain did not have the CT information available unless concerns had been raised by the senior clinician or radiologist. The primary clinical outcome measure used for this radiological study was length of stay in hospital following the intervention.

The comparisons between CT and both USS and CXR were twofold: firstly we compared the imaging characteristics of the pleural fluid collection itself as defined by USS and CT. Secondly we compared the evaluation of the underlying pulmonary parenchyma as demonstrated on CXR and CT as follows:

Pleural Collections
a) Ultrasound evaluation
Patients were referred for a pleural USS examination prior to treatment. See on-line supplement for detailed explanation of ultrasound study methodology. The images were subsequently reviewed by two paediatric radiologists (AC, CMO) blinded to patient data. The effusions were graded according to their internal echostructure (Table 1), using a system based on that described by Kearney et al, but with the addition of an extra grade for highly septated effusions with significant solid components (Figure 1). Scores from both radiologists were used for analysis.

Table 1.
Ultrasound grading system for pleural effusions

<table>
<thead>
<tr>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anechoic</td>
<td>Echoic fluid without septation</td>
<td>Septated effusion</td>
<td>Septations with solid appearing components comprising &gt;1/3 of effusion</td>
</tr>
</tbody>
</table>

b) CT evaluation
CT scans were performed prior to treatment in all patients. We excluded scans from analysis if they were performed without intravenous iodinated contrast material, as intravenous contrast allows visualisation of pleural inflammation which is not normally possible with a non-contrast enhanced scan. We also excluded scans done at a local hospital prior to admission and transferred with a hard copy or performed
following chest drain insertion. See on-line supplement for detailed explanation of CT methodology. Effusions were graded by fluid density, pleural enhancement, subcostal tissue thickening and loculation/effusion shape (Table 2).

**Table 2.**
CT scoring system for parapneumonic effusions (maximum total score is 8)

<table>
<thead>
<tr>
<th>Fluid density</th>
<th>Pleural enhancement</th>
<th>Subcostal tissue thickening</th>
<th>Loculation/Effusion shape</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean density</td>
<td>Absent Score 0</td>
<td>Absent Score 0</td>
<td>Simple: Concave medially, parallels chest wall Score 0</td>
</tr>
<tr>
<td>0 &lt; 20 HU</td>
<td>Present, &lt;2mm thick</td>
<td>Present, &lt;2mm thick</td>
<td>Loculated: convex medially, or lobulated with separation of lobulations by &gt; 10mm of fluid/thickening Score 1</td>
</tr>
<tr>
<td>Mean density</td>
<td>Present, &gt; 2mm thick</td>
<td>Present, &gt; 2mm thick</td>
<td>Incomplete multi-loculation: lobulations separated by &lt; 10mm of pleural thickness Score 2</td>
</tr>
<tr>
<td>&gt; 20 HU</td>
<td></td>
<td></td>
<td>Complete multi-loculation: pockets of fluid separated by normal intervening pleura. Score 3</td>
</tr>
</tbody>
</table>

HU=Hounsfield units

Effusions were graded as follows: Effusion density was taken as the mean of the CT density in Hounsfield units (HU) recorded from three regions of interest drawn in the centre of the thickest portion of effusion, at three contiguous levels, measured by one observer (AC): a density of 0-20 scored 0, a density > 20 scored 1. 20 HU cut-off was chosen, as this is generally the accepted upper limit for the density of water-based lesions, for example in hepatic and renal cysts. The remaining evaluations were performed independently by two paediatric radiologists (AC and CMO).

Parietal pleural enhancement recorded a score of 1, and a score of 2 was given for thick pleural enhancement (>2mm). Thickening of the subcostal tissues was scored similarly.

We devised a scoring system to reflect the degree of loculation of the effusion through the assessment of effusion shape: an effusion whose visceral surface paralleled the chest wall scored 0, an effusion with convexity or lobulation of the visceral surface, with pleura/pleural fluid thickness between the lobulations of greater than 10mm scored 1, and an effusion whose visceral surface showed lobulations separated by less than 10mm of pleural fluid or thickening scored 2 (Figure 2). If components of the pleural collection were separated by normal pleura, the effusion scored 3. The
individual scores were summated to give one total score, and scores from both observers were used for analysis.

**Pulmonary Parenchyma**

*a) Chest Radiograph Evaluation*

Posteroanterior chest radiographs were performed pre-operatively in all subjects. The immediate pre-operative CXRs were included in the study, even if performed at local hospitals prior to referral to our tertiary unit. Parenchymal changes were classified as simple opacification (including collapse and consolidation with or without air-bronchograms) and opacification with cavitation. The chest radiographs were blindly evaluated by 2 independent radiologists (AC, CMO) and one paediatric pulmonologist (SS), reporting in consensus, reaching a conclusion by mutual discussion.

*b) CT Evaluation*

Pulmonary parenchymal changes were classified in consensus by mutual discussion by two radiologists (AC,CMO) as follows, based on the definitions described by Donnelly et al:[16]

- Simple collapse or consolidation: homogeneous opacification and enhancement present with or without air bronchograms, or with fluid filled airways;
- Pneumatocoeles: tubular or cystic areas of air density with thin or imperceptible walls, with no evidence of necrotising pneumonia;
- Necrotising pneumonia: ill-defined areas of poorly enhancing lung comprising more than half of consolidated lung;
- Cavitary necrosis: necrotising pneumonia containing irregular areas of air-density and Pulmonary abscess: well defined area of intrapulmonary fluid density or cavity with air fluid level, with thick (>2mm) enhancing wall.

**STATISTICAL ANALYSIS**

Inter-observer reliability for the CT and USS scores between the two observers was assessed using Cohen’s kappa with linear weighting. Correlation between USS grade and both the total CT score and the individual component scores were calculated using Kendall's rank correlation. The utility of CT and USS scores to predict number of days in hospital post-intervention was assessed using multiple linear regression analysis, adjusted for intervention (VATS vs. urokinase).

**ETHICAL ASPECTS**

The project was approved by the local ethics committee. The trial is fully registered with clinicaltrials.gov (ID: NCT00144950).
RESULTS

Of the 60 subjects randomised to either VATS or urokinase, 46 had USS images available for review. Thirty-six patients had a CT scan meeting inclusion criterion. Exclusions were as follows: CT performed at local hospital n=14; no contrast enhancement due to failure of intravenous access, n=2; performed with drain in situ n=3; unavailable for review n=5. Thirty one patients had all three radiological measurements (CT, USS and CXR) available for analysis.

Pleural collection evaluation

There was substantial inter-observer agreement for USS grades ($\kappa=0.709$), and moderate agreement for total CT scores ($\kappa=0.520$) (Table 3). Agreement between the two observers for CT scores was strongest for the subcostal thickening ($\kappa=0.568$) and pleural enhancement scores ($\kappa=0.459$). Five of 31 effusions showed increased density (score 1 on density score). The majority of effusions showed pleural enhancement (scores 1 and 2: 20/31 for observer 1 and 25/31 for observer 2). Subcostal tissue thickening was present in a minority (scores 1 and 2: 15/31 for observer 1 and 10/31 for observer 2). The majority of effusions showed some degree of loculation (internal convexity and incomplete multiloculation, scores 1-2, 23/31 for observer 1 and 24/31 for observer 2). However, we did not identify any cases of completely multi-loculated collections (score 3 on loculation/shape score) where locules were completely separated from each other by normal intervening pleura.

Table 3a. Frequency of ultrasound grades by observers: $\kappa=0.709$

<table>
<thead>
<tr>
<th>Observer 1 ultrasound grades</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
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<tr>
<td>2</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>2</td>
<td>10</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>15</td>
<td>21</td>
<td>8</td>
<td>31</td>
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</tbody>
</table>

Table 3b. Frequency of total CT scores by observer: $\kappa=0.520$

<table>
<thead>
<tr>
<th>Observer 1 total CT scores</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td></td>
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<tr>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
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<tr>
<td>5</td>
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<tr>
<td>Total</td>
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<td>6</td>
<td>10</td>
<td>8</td>
<td>9</td>
<td>7</td>
<td>8</td>
<td>31</td>
</tr>
</tbody>
</table>
The mean CT score increased across the ultrasound grades for pooled observations (data not shown), with an incremental increase in mean shape, pleural thickening and density score from ultrasound grades 2-4 (only 1 patient had an ultrasound grade of 1 for each observer). There were weak correlations between ultrasound grade and total CT score as well as the CT loculation score and CT density score (Table 4). Despite the positive and statistically significant correlation between USS and CT score, the strength of the relationship is minimal as demonstrated by the low correlation coefficients.

**Table 4.**
Correlation coefficients (Kendall's Tau) between USS grade and CT scores from pooled observations.

<table>
<thead>
<tr>
<th>Correlation</th>
<th>Kendall's tau</th>
<th>95% confidence interval</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>USS grade vs. CT score</td>
<td>0.308</td>
<td>0.118-0.512</td>
<td>0.0035</td>
</tr>
<tr>
<td>USS grade vs. CT density score</td>
<td>0.271</td>
<td>0.0351-0.458</td>
<td>0.0246</td>
</tr>
<tr>
<td>USS grade vs CT pleural enhancement score</td>
<td>0.208</td>
<td>-0.0218 to 0.448</td>
<td>0.0716</td>
</tr>
<tr>
<td>USS grade vs subcostal thickening score</td>
<td>0.188</td>
<td>-0.0475 to 0.402</td>
<td>0.1036</td>
</tr>
<tr>
<td>USS grade vs. CT shape score</td>
<td>0.367</td>
<td>0.132-0.563</td>
<td>0.0014</td>
</tr>
</tbody>
</table>

**Pulmonary parenchyma**

25 of the chest radiographs showed simple opacification of the underlying parenchyma only. Of these 14 had simple consolidation only on CT; in 1 case pneumatoceles were present on CT, in 7 necrotising pneumonia was present and in 3 cavitary necrosis was present (Table 5). Of the 6 cases with cavitation on the chest radiograph, 4 showed cavitary necrosis on CT, 1 showed pneumatoceles and 1 showed simple consolidation only.

No abnormality was detected on CT scanning which directly altered management. In particular we did not identify any cases of pulmonary abscess, although in several cases, areas of cavitary necrosis were very well defined, but lacked an enhancing wall, and therefore did not meet our criteria (Figure 3).
Table 5.
Parenchymal changes detected on CT and CXR

<table>
<thead>
<tr>
<th>CT findings</th>
<th>CXR findings</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Simple</td>
<td>Cavitation</td>
<td>Total</td>
</tr>
<tr>
<td>Simple</td>
<td>14</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Pneumatocoeles</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Necrotising pneumonia</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Cavitary necrosis</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Abscess</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>6</td>
<td>31</td>
</tr>
</tbody>
</table>

Outcome prediction
In the primary study, there was no statistically significant difference in length of hospital stay following intervention between the two treatment groups; median difference (95% CI), 0 (-1, 2) (p=0.311).(6) The small sample size in this study precluded comprehensive evaluation of the predictive abilities of the radiographic modalities; although basic multivariable regression, adjusted for treatment (geometric slope (95% CI), p value), demonstrated that neither the USS score (1.06 (0.72, 1.59), p=0.744), nor the CT score (1.09 (0.96, 1.23), p=0.182), nor a combination of the two (1.08 (0.97,1.19) p=0.151), were able to predict length of hospital stay. Patients with CT findings other than simple consolidation or pneumatocoeles did not have a different outcome. Patients in the VATS arm with simple consolidation (n=7) had a median stay of 5 days, range 4-16 days, and those with complicated parenchymal disease (n=7) a median stay of 5 (range 4-12) days. Patients in the urokinase arm and simple consolidation (n=10) had a median stay of 5 (range 5-9 days), whilst those with complicated parenchymal disease (n=7) had a median stay of 8 (range 5-16) days.

DISCUSSION
We have developed a novel radiological scoring system for children with empyema and demonstrated that CT scans detect more parenchymal changes than chest radiography and that no additional abnormality was detected which directly changed clinical management. Furthermore, neither modality both alone or in combination was able to predict clinical outcome and therefore appear to be poor markers of disease severity, albeit these analyses are based on small numbers. These findings suggest no role for routine CT scanning in the management of children with empyema if managed with percutaneous drainage and urokinase.

Ultrasound is a central investigation in the management of paediatric empyema, offering several key strengths: it is portable, non-invasive, does not use ionising radiation and provides a dynamic assessment of the chest. It is cheap and relatively easy to perform and is able to differentiate pleural fluid from consolidation, estimate the effusion size and guide chest drain placement. It is also able to demonstrate the presence of fibrinous septations within pleural collections.[17-19]
CT has several potential strengths as it is able to provide an examination of the entire thorax, without being limited by the presence of air or bone compared with ultrasound. It is also able to provide an accurate ‘road-map’ of the pleural space for an operating surgeon. CT can provide an accurate assessment of the pulmonary parenchyma beneath an effusion, the assessment of which is often limited on chest radiography by the presence of pleural fluid. However, CT has many disadvantages: it is unable to detect the presence of fibrinous septations, which are usually too thin and of insufficient density to identify [17,19] and requires sedation or anaesthesia in an uncooperative child. The principle weakness of CT however, is its use of ionising radiation. At our institution, the CT dose is estimated to be approximately 115 times that of a chest radiograph [20] and this may be considerably higher in units not using paediatric dose optimisation. Radiation dose reduction is of particular importance in children as they are more susceptible to the risks of radiation and have a substantially increased lifetime cancer risk compared to the older population following a single CT scan.[21] A CT examination in a child can thus only be justified if the result is likely to impact on clinical management. This study has demonstrated that although CTs were able to detect more detailed parenchymal findings compared to CXR in our population, no CT scan detected an unexpected abnormality which directly altered clinical management; for example the detection of an unexpected lung abscess requiring prolonged antibiotics [22] or drainage.[23]

There are no well validated scoring systems for the severity of empyema measured by CT. Donnelly and Klosterman used a simple 4 point system based on pleural and subcostal fat thickening along with changes in the chest wall. They did not assess the density of pleural fluid or loculation/effusion shape and did not perform independent observations with this system (and hence no measure of inter-observer variation was given). This scoring system was unable to distinguish between empyema and transudative effusions.[24] Kearney et al assessed severity of effusions by size, loculation, pleural enhancement, pleural thickening and pleural septation, but did not combine these features into an overall score.[15] In the absence of a validated scoring system, we devised a novel system for scoring CT findings in empyema, based on previously described features of pleural thickening and thickening of subcostal fat, along with assessments of effusion density and loculation. We demonstrated only moderate inter-observer agreement for this scoring system. This partly reflects a difficulty with all CT scoring systems, of reducing a complex three-dimensional dataset to a single score. Some of the components of the score, particularly the shape score, are quite subjective, and hence prone to inter-observer variability. We believe the relatively poor level of agreement achieved further highlights the difficulty of using CT as a measure of disease severity in empyema. Furthermore, CT and USS findings do not appear to show a strong relationship, reflecting the very different basis and strengths of these two modalities.

Neither the ultrasound grade, nor the CT score, nor a combination of the two was able to predict outcome. There are very few studies which have utilised radiology to attempt to predict outcome. In a study of 50 children with empyema who underwent either primary or secondary thoracoscopy the clinical outcome was not predicted by USS when assessed for echogenicity, thickness of the effusion and presence of septations.[25] Similarly, in a prospective randomised study of intrapleural urokinase to treat empyema in children, ultrasound findings were not related to outcome.[12] Kearney et al compared ultrasound and CT in a study of 50 adult patients with
parapneumonic effusions. Neither USS grade nor CT findings of effusion size, pleural thickening or extrapleural fat thickening were able to reliably stage empyema, or predict failure of tube drainage.[15] We have previously published data demonstrating no difference in clinical outcome between VATS or treatment with urokinase. However, the VATS group was significantly more expensive, particularly with the addition of a CT scan.[6] Our study data do not support the use of ultrasound, CT or a combination as a means of predicting the outcome from empyema treatment in children, further supporting the view that the role for routine CT scanning in childhood empyema is questionable.

In our analysis of parenchymal findings, CT demonstrated potentially important findings of necrotising pneumonia or cavitary necrosis in 10/25 patients with apparently simple collapse or consolidation on the chest radiograph. The finding that CT scanning detects more parenchymal changes than CXR supports previous published evidence.[16,19,26] Empyema appears to be a common accompaniment to cavitary necrosis.[16,27] Importantly in our study, patients with cavitary necrosis or necrotising pneumonia on CT in addition to empyema showed no difference in outcome when compared with those with simple consolidation, although we recognise the numbers involved are small.

This study is subject to several limitations. We recognise that our sample size is small. The initial clinical study was powered to detect a difference of 2 days in the primary outcome measure (number of days in hospital post-intervention) between the two treatment groups and was not powered to detect post-hoc differences between radiological modalities. Furthermore only 31 of the 60 patients recruited had a complete set of valid imaging studies available for review in this study. Of particular note is that 14 patients had CT scans carried out at the local hospital prior to referral highlighting the low threshold physicians have for performing CT scans on children with empyema.

Another limitation is the retrospective nature of our radiological analysis, particularly for ultrasound. Ultrasound is a real-time and dynamic examination that can never be fully represented in stored or printed images. The accuracy of our grading is thus open to question. The high level of inter-observer variability obtained from independent observations, does at least partly validate our methodology. Owing to the retrospective nature of radiological analysis, we were not able to analyse pulmonary parenchymal changes or effusion shape on ultrasound, as these require a real time assessment.

A further potential limitation is that we did not directly assess the intervention of CT scanning by randomising subjects to receive CT or not, which we believe would have been unethical. The primary aim of the study was to compare two clinical interventions and the study was designed to reflect standard clinical practice where surgeons routinely request a CT prior to performing VATS, while percutaneous drains are inserted under ultrasound guidance without the need of a CT. Nevertheless, we believe that the study design reflects a pragmatic approach and represents the first study to examine the role of routine CT scanning in childhood empyema providing an evidence base for management of this disease.

In conclusion, using the novel radiological scoring system we identified only weak correlation between CT findings and USS findings in paediatric pleural empyema.
Neither CT nor USS provides a reliable means of predicting outcome. Although CT detects additional parenchymal findings to those identifiable on CXR, these do not influence management in the setting of empyema. This study suggests no role for the routine use of CT in the management of pleural empyema in children if treated with percutaneous drainage and urokinase. This approach will reduce the exposure of children to unnecessary radiation and reduce costs.

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Competing Interests:

AJ is in receipt of an unrestricted grant from Glaxo-Smith-Kline (Belgium) for a study on the epidemiology of childhood empyema in Australia and New Zealand.

Funding: Nil
FIGURE LEGENDS

Figure 1.
Ultrasound staging of empyema. a) Grade 1 effusion showing anechoic fluid b) Grade 2 effusion showing echoic fluid without septations c) Grade 3 effusion showing multiple thick septations d) Grade 4 effusion showing multiple septations with solid appearing components comprising more than 1/3 of the collection

Figure 2.
CT shape score a) Shape score of 1, effusion showing lobulations with intervening pleural space of >10mm b) Shape score of 2 showing lobulations (arrows) separated by narrow bridge of pleural thickening.

Figure 3.
Well defined cavitary necrosis. CT image showing well defined area of non-enhancing lung with cavitation, adjacent to empyema. As this area lacks an enhancing wall, we could not define this as an abscess.
REFERENCES


MATERIALS AND METHODS

Pleural Collections

a) Ultrasound evaluation
Ultrasound studies were performed by the duty radiologist of the day on an Acuson Sequoia machine (Siemens, Erlangan, Germany), using probes appropriate for patient size: for small patients an 8C4 sector probe was used, for larger patients a 6C2 probe was used. Additional high resolution images were obtained using a linear probe, either 8L5 or 15L8, again dependent on patient size. All ultrasound images were stored for review on a dedicated ultrasound picture archiving and communication system (PACS).

b) CT evaluation
CT studies were performed on a 4-detector (Somaton 4, Siemens, Erlangan, Germany) or 16-detector (Sensation 16, Siemens, Erlangan, Germany) machine. Helical acquisitions were obtained following intravenous contrast material administration (Omnipaque 300, 2mls/kg): Typical CT parameters were tube voltage 100 kV, tube current 40 mAs, beam collimation 1.5mls, pitch 1, with parameters adjusted for patient weight.
The role of routine computed tomography in paediatric pleural empyema

Adam Jaffe, Alistair D Calder, Catherine M Owens, Sanja Stanojevic and Samatha Sonnappa

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