NIV guidelines

We congratulate the British Thoracic Society (BTS) Standards of Care Committee on their excellent guidelines on non-invasive ventilation (NIV) in acute respiratory failure. The guidelines are timely in that many district general hospitals (DGH) are setting up an NIV service. If our DGH experience is typical, others may be surprised how quickly NIV takes off. Our DGH serves a catchment area of about 200,000 people and use of NIV has increased from 51 patients in the year 1998/9 to 227 in 2000/1. Whereas in 1998/9 78% of all the NIV treated patients were on the intensive care unit (ICU), in 2000/1 71% were treated on wards. The keen involvement of the ICU anaesthetists has been pivotal in setting up the service.

We would query the statement that all patients started on NIV should be transferred to the care of a respiratory physician as soon as possible. In 2000/1 65 patients were treated on the ICU with NIV, many of these surgical patients being weaned off ventilators. Similarly, 28 “surgical” patients were treated on the wards with NIV. Should chest physicians really have to take over hospital care of all these patients?

The guidelines do not address the issue of the use of NIV in palliation of breathlessness. In acute exacerbations of chronic obstructive pulmonary disease (COPD), breathlessness settles more rapidly with NIV than with conventional treatment.1 In patients with severe respiratory distress who refused endotracheal intubation, anecdotally NIV was effective in reducing breathlessness.2 It is not surprising that the role of NIV in treating breathlessness is unclear, given the uncertainty over the efficacy of other interventions which have been available for many years such as oxygen, benzodiazepines, morphine, or breathing exercises. We have found NIV useful in reducing dyspnoea in some patients with end stage respiratory disease, and agree with the guidelines that it is vital it be clearly documented whether NIV is being used with palliative or curative intent, and whether or not to proceed to invasive ventilation.

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References

Author’s reply

In response to the criticism that it is unnecessary to transfer all patients on non-invasive ventilation (NIV) to the care of a respiratory physician as soon as possible, these are guidelines not rules. I am unhappy with the suggestion that NIV should be managed by surgeons, although clearly there may be hospitals where the surgeons have sufficient training and experience in NIV for this to be acceptable. I agree that NIV can be used to palliate breathlessness, but I did not specifically address this area of use in the guideline.

In answer to the question as to whether it would be ethical to use NIV if there is no intensive care service available, I agree that in special circumstances this would be entirely reasonable.

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CORRECTION

GM-CSF therapy in pulmonary alveolar proteinosis

In the letter by M G de Vega et al entitled “GM-CSF therapy in pulmonary alveolar proteinosis” which appeared on page 837 of the September issue of Thorax (Volume 57, No 9), the name of Dr A Romero was inadvertently omitted as the first author. The authors of the letter should have been: A Romero, M G de Vega, A Sánchez-Palencia, A Ramírez and S Cervera. The publishers apologise for this error.