Wasting as predictor of survival in CF

Sharma and colleagues report the survival of 584 patients with cystic fibrosis (CF) attending the Royal Brompton Hospital between 1985 and 1996. They report that body wasting, as represented by % ideal weight, was a significant predictor of survival before and after correction for age, sex, % predicted FEV₁, Pao₂, and Paco₂.

In 1997 Hayllar and colleagues reported the survival of 303 patients with CF attending the Royal Brompton Hospital between 1969 and 1993. They found that low blood haemoglobin concentration (HB), low plasma albumin concentration, and short stature were significant predictors of survival although, of these, only height was included in their final predictive model. Other recent reports have shown both weight and height to be significant predictors of survival in CF.

We recently reported the survival of 181 children with CF referred to the paediatric lung transplantation programme at Great Ormond Street Hospital for Children (GOSH). Following Hayllar’s report, we opted to study a wide range of variables including Hb, albumin, and % ideal weight as markers of nutritional status. All three variables were correlated in our population, but Hb and albumin were clearly better predictors of survival than % ideal weight, both before and after correction for age, sex, resting (age corrected) heart rate, and markers of lung function and exercise tolerance. Hayllar and colleagues speculated that failure of stature growth probably reflects a degree of malnutrition. This may explain our findings, as stunting of growth could result in % ideal weight giving an underestimate of malnutrition.

Given the previous report from their centre, it is regrettable that Sharma and colleagues did not include albumin, Hb, and height in their prognostic modelling as they may have discovered a more complex picture. They conclude that % ideal weight should be considered an independent risk factor for prognosis in CF. We welcome and support their conclusion that was additive to that obtained less recently.

The extensive literature in this area indicates that numerous variables can be considered predictors of survival in CF. We suggest that any assessment of prognosis should include spirometric measurements, blood gas analysis in adults, and assessments of nutritional status, exercise tolerance, rate of decline, and possibly some measurement of resting energy expenditure or metabolic rate. Furthermore, in children at least, it appears that young age and female sex result in a poorer prognosis. Basing prognosis upon FEV₁ and % ideal weight alone is unlikely to be sufficient.

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References

Authors’ reply
We welcome the response of Drs Aurora and Wade to our article on the prognostic value of wasting in patients with cystic fibrosis (CF). They suggest that poor nutritional status in general should be considered a risk factor for mortality with particular emphasis on anaemia and hypoalbuminaemia. While we accept that nutritional status is likely to relate strongly to mortality in CF, we disagree that haemoglobin and albumin should be considered more accurate markers of prognosis than % ideal weight. There have been relatively few studies evaluating the prognostic value of haemoglobin and albumin in CF, none of which have shown these variables to be independent predictors of mortality.

In our paper we demonstrate that in a stable outpatient CF population, % ideal weight represents an accurate predictor of survival which is independent of other established prognostic markers such as lung function and arterial blood gases. The addition of % predicted FEV₁ to % ideal weight provides an even stronger model with which to predict survival. We do not propose that these two variables should be the only ones considered when evaluating patients, but that they represent simple and accurate prognostic parameters which can be easily assessed in the outpatient clinic.

With regard to blood gas analysis, in our study this was performed in 58 children (age < 18 years). We found the arterial oxygen tension but carbon dioxide tension to be a significant predictor of survival in this age group (unpublished data). Furthermore, % ideal weight continued to be a strong and independent predictor of survival in children as well as in adults with CF.

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References

Pulmonary rehabilitation
In their paper the members of the BTS Standards Committee state that “Pulmonary Rehabilitation provide a clear statement on the current status of pulmonary rehabilitation in the UK.” Funding for pulmonary rehabilitation has lagged behind cardiac rehabilitation even though the evidence base is stronger and patients are usually more disabled. Let us
On behalf of the BTS Standards of Care Subcommittee on Pulmonary Rehabilitation

we thank Dr Jones for his supportive comments. We would obviously agree that provision for pulmonary rehabilitation has fallen behind that for patients with similar disability from cardiac disease. One of the purposes of the BTS statement is to provide support for the argument for greater resources. We would also agree with Dr Jones that accessibility for rehabilitation is a key component for success and must ultimately take place in a community setting to cater for the potentially large numbers of disabled patients. However, as rehabilitation moves into the community, it will be very important to maintain standards and monitor outcomes to ensure that the process remains effective.

It is encouraging that pilot projects have now begun in the community and we look forward to seeing high grade evidence which can be incorporated in future BTS statements. At present the effectiveness of home based and low session frequency rehabilitation is uncertain. The original Dutch experience quoted by Dr Jones is quite instructive.5 When the original papers are read carefully, it is clear that two supervised exercise sessions per week are conducted within the physiotherapist's home rather than the patient's own home. In fact, other aspects of home based rehabilitation in patients with severe COPD have not been so successful.7 At present also there is inadequate evidence to support the effectiveness of once weekly supervised exercise programmes.8 One further difficulty associated with poor supervision is that many research projects are conducted from a background of clinical inexperience because of the necessity to obtain research funding to start a programme.9

Finally, we would support Dr Jones in his plea for standardisation of process and outcomes. We believe that the BTS statement did give a clear indication as to what outcomes of functional performance and health status might be sensitive and appropriate. The British Thoracic Society and the British Lung Foundation have plans to set up a register of rehabilitation programmes in the UK to assist with this process.

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The key consideration for new services is the area to be served. Some areas might be better placed for providing ongoing support after the programme has finished, while others might be more suitable for providing support while the programme is running. A once weekly programme, initially in hospital, and then in the community, is associated with a high rate of mortality so we suggest that accessibility for rehabilitation is a key component for success and must ultimately take place in a community setting to cater for the potentially large numbers of disabled patients. However, as rehabilitation moves into the community, it will be very important to maintain standards and monitor outcomes to ensure that the process remains effective.

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References


Respiratory disease and proximity to coke works

With reference to the paper by Aylin et al published in the March 2001 issue of Thorax, we would like to raise the following points.

Previous studies have concentrated on acute ill health due to particulate emissions but chronic effects have been neglected. This paper aimed to address this issue, with consideration being given to “at risk” groups. However, only acute events requiring hospital admission were included, with no consideration being given to those patients in the community with established cardiorespiratory disease. All studies have limitations but these should not be so significant as to affect the outcome. The authors recognised many of their limitations, such as socioeconomic factors and hospital variation, but others such as occupational exposure of the older population and emission measurement between the sites and their surrounding industries were not considered. In addition, the authors failed to address major limitations from previous studies and there opportunities presented by such a large study were wasted because previous mistakes were repeated. Overall, these influences are so significant that any outcome cannot be considered valid, and hence no conclusions can be drawn.

We suggest that any follow up studies should take advantage of the effective population criteria used in this study and should include a more concise explanation of study design, time scale, statistical protocol, and emission data.

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References


Embolisation in Behçet’s disease

I read with interest the excellent review of Behçet’s disease by Erkan et al and wish to comment on the treatment of pulmonary artery aneurysms (PAA) with embolisation. Durieux et al reported the first case in 1981, and a further four successfully treated cases have been reported since 1985.11

As reported by others,12 we have found that surgical treatment of PAA in Behçet’s disease is associated with a high rate of mortality so we have started to use embolisation as the first line of treatment for massive haemoptysis in patients with Behçet’s disease. Our first patient underwent embolisation of an aneurysm involving the right middle and lower lobe arteries in January 2000, and a second patient with an aneurysm in the right upper lobe embolised in October 2000 are alive with no apparent haemoptysis and serial control scans show no aneurysm formation. We also had a patient with an aneurysm of unknown aetiology involving the entire pulmonary arterial tree starting from the main pulmonary artery and extending bilaterally towards the lobar branches. Pulmonary angiography did not reveal leakage and embolisation was not attempted as it was impossible to block the huge aneurysm. He
died a week later despite high doses of corticosteroid and azathioprine.

In Behçet’s disease PAA are usually multiple and have a tendency to recur. Immunosuppressants should be the first line treatment as regression is possible. Life threatening massive haemoptysis necessitates intervention. Surgical treatment mostly consists of major anatomical resection rather than preserving lung tissue. Embolisation can be performed in most cases and any recurrence may be re-embolised. Pulmonary infarction has not been observed so far, although it is a possibility. Thrombosis of the great veins is a re-embolised. Pulmonary infarction has not been observed so far, although it is a possibility. Thrombosis of the great veins is a regression is possible. Life threatening massive haemoptysis necessitates intervention. Surgical treatment mostly consists of major anatomical resection rather than preserving lung tissue. Embolisation can be performed in most cases and any recurrence may be re-embolised. Pulmonary infarction has not been observed so far, although it is a possibility. Thrombosis of the great veins is a regression is possible. Life threatening massive haemoptysis necessitates intervention. Surgical treatment mostly consists of major anatomical resection rather than preserving lung tissue. Embolisation can be performed in most cases and any recurrence may be re-embolised. Pulmonary infarction has not been observed so far, although it is a possibility. Thrombosis of the great veins is a regression is possible. Life threatening massive haemoptysis necessitates intervention. Surgical treatment mostly consists of major anatomical resection rather than preserving lung tissue. Embolisation can be performed in most cases and any recurrence may be re-embolised. Pulmonary infarction has not been observed so far, although it is a possibility. Thrombosis of the great veins is a regression is possible. Life threatening massive haemoptysis necessitates intervention. Surgical treatment mostly consists of major anatomical resection rather than preserving lung tissue.

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References

BOOK REVIEWS

Non-Invasive Respiratory Support

The second edition of Dr Simonds’ book gives a comprehensive up to date review of the rapidly expanding field of non-invasive respiratory support. The material covers acute and chronic applications of non-invasive ventilation (NIV), giving an overview of NIV in these settings followed by discussions on specific disease applications. Chapters cover topics such as paediatric NIV, CPAP, medicolegal implications and physiotherapy, nursing, and other treatment during NIV. This book will be of use to all those wishing to practise an evidence-based service, and the evidence is clearly presented and well argued. In line with the significant focus on the practical aspects of running a service, the book deals well with the more widespread issues involved in using NIV.

I particularly liked the practical slant to much of the book, especially the focus on problem solving and application in the acute setting or during procedures. Many colleagues, like myself, will find the answers to most of their (and their patients’) questions here. Having had some insight into the problems involved in setting up an NIV service, I would expect physicians establishing a service to find the initial chapters—detailing equipment, service requirements, and cost implications—informative and constructive.

This readable book gives an excellent overview of the subject, is well referenced, and supported with good illustrations. I would highly recommend it as a basic reference and a practical guide for all respiratory trainees and physicians using an NIV service.

L Turner

Practical Paediatric Respiratory Medicine

It is always pleasing when a new publication devoted to respiratory disease in childhood is published. This text appears to be aimed at children’s respiratory nurses and paediatric trainees, providing a grounding in many facets of paediatric respiratory medicine. The book does not aim to be comprehensive but rather aims to be an aid to those during training. The authors, largely drawn from Leicester, bring their practical as well as their theoretical expertise with a view to producing a pragmatic text that will support those faced with children in a variety of settings. Perhaps the most valuable aspect of this book are the case studies included in each chapter. These are a useful and instructive means of bringing the information within the text to life and highlighting “real” life management issues.

While, in the main, chapters start from the basics and provide a good introduction to those with relatively little experience, a number of chapters go beyond clinical practice into more theoretical areas, reflecting the author’s particular interest. The book will be a useful addition to the library shelves, complementing existing paediatric respiratory texts.

M Everard