

but efforts need to be made to reduce readmission 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.

**Eleanor M Dunican, Brenda M Deering, Dorothy M Ryan, Niamh M McCormack, Richard W Costello**

Department of Respiratory Medicine, Beaumont Hospital, Dublin, Ireland

**Correspondence to** Professor Richard Costello, Department of Respiratory Medicine, Beaumont Hospital, Dublin 9, Ireland; rcostello@rcsi.ie

**Competing interests** None.

**Ethics approval** This study was conducted with the approval of the Beaumont Hospital ethics (medical research) Committee.

**Provenance and peer review** Not commissioned; externally peer reviewed.

Accepted 4 May 2010

Published Online First 6 September 2010

*Thorax* 2011;**66**:358–359.  
doi:10.1136/thx.2009.125385

## REFERENCES

1. **Cotton MM**, Bucknall CE, Dagg KD, *et al*. Early discharge for patients with exacerbations of chronic obstructive pulmonary disease: a randomized controlled trial. *Thorax* 2000;**55**:902–6.
2. **Skwarska E**, Cohen G, Skwarski KM, *et al*. Randomised controlled trial of supported discharge in patients with exacerbations of chronic obstructive pulmonary disease. *Thorax* 2000;**55**:907–12.
3. **Hernandez C**, Casas A, Escarrabill J, *et al*. Home hospitalisation of exacerbated chronic obstructive pulmonary disease patients. *Eur Respir J* 2003;**21**:58–67.
4. **Davies L**, Wilkinson M, Calverley PM, *et al*. "Hospital at home" versus hospital care in patients with exacerbations of chronic obstructive pulmonary disease: prospective randomised controlled trial. *BMJ* 2000;**321**:1265–8.

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

Finney and colleagues<sup>1</sup> recent editorial discussed the results of the UK-based CESAR trial,<sup>2</sup> 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 expertise 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 ventilation<sup>3</sup> 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 H<sub>2</sub>O, FiO<sub>2</sub> titration to SaO<sub>2</sub> >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 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.<sup>4</sup> 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 medicine would go a long way towards redressing the balance.

**Matt P Wise,<sup>1</sup> Nick Hart,<sup>2</sup> Paul J Frost<sup>1</sup>**

<sup>1</sup>Adult Critical Care, University Hospital of Wales, Cardiff, UK; <sup>2</sup>Lane Fox Respiratory Unit, St Thomas' Hospital, Guy's and St Thomas' NHS Foundation Trust and King's College, London

**Correspondence to** Dr Matt P Wise, Adult Critical Care, University Hospital of Wales, Cardiff CF14 4XW, UK; mattwise@doctors.org.uk

**Competing interests** None.

**Provenance and peer review** Not commissioned; externally peer reviewed.

Accepted 19 May 2010

Published Online First 1 October 2010

*Thorax* 2011;**66**:359. doi:10.1136/thx.2010.140541

## REFERENCES

1. **Finney SJ**, Cordingley JJ, Griffiths MJ, *et al*. ECMO in adults for severe respiratory failure finally comes of age: just in time? *Thorax* 2010;**65**:194–5.
2. **Peek GJ**, Mugford M, Tiruvoipati R, *et al*. Efficacy and economic assessment of conventional ventilatory support versus extracorporeal membrane oxygenation for severe adult respiratory failure (CESAR): a multicentre randomised controlled trial. *Lancet* 2009;**374**:1351–63.
3. **The Acute Respiratory Distress Syndrome Network**. Ventilation with lower tidal volumes as compared with traditional tidal volumes for acute lung injury and the acute respiratory distress syndrome. *N Engl J Med* 2000;**342**:1301–8.
4. **Bellomo R**, Stow PJ, Hart GK. Why is there such a difference in outcome between Australian intensive care units and others? *Curr Opin Anaesthesiol* 2007;**20**:100–5.