Problems with the Pneumothorax Catheter

To the Editor:

I read with interest the recent article by Kubitschek and Peters (Chest 1984;86:714-717) on use of a pneumothorax catheter for treatment of pneumothorax as well as drainage of pleural effusions. In my own practice I have used this catheter quite frequently and have found results very similar to those in the study. As they suggested, I have found the catheter to be useful in draining malignant effusions and in completing successful chemical pleurodysis. One problem with the catheter is that during pleurodysis the drainage holes tend to become clogged. However, if the catheter is flushed on a daily basis this problem can be alleviated. I have found that with this technique drainage and pleurodysis can be accomplished with less pain and discomfort to the patient. A second problem has been that the catheter is not easily secured in place. If securely taped, it will not fall out.

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To the Editor:

We appreciate Dr. Binder's remarks about our recent paper. Occasionally, we also noticed occlusion of the original catheter's distal perforations. Additionally, the three-way stopcock and Heimlich valve were sites of fibrinous deposition and occlusion. We requested that the original catheter be modified to have larger drainage holes and we discontinued usage of the three-way stopcock and Heimlich valve. These modifications (found in the TPT-I-Peters-113062 modified pneumothorax set [Cook, Inc]) decreased the incidence of occlusion significantly. However, if occlusion does occur, simple flushing is easily accomplished and can be done on a daily basis until the catheter is removed.

Dr. Binder also notes some difficulty securing the catheter in place. The modified pneumothorax catheter has been shortened so that it can be fully inserted without difficulty. We have also decreased the frequency of inadvertent dislodgement by suturing the catheter in place, securely taping the catheter and plastic tubing to the patient's chest wall (as Dr. Binder suggests), and educating the patient and nursing staff about care in preventing dislodgement of the catheter during transportation.

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A Disadvantage of Velcro as an Endotracheal Tube Anchor

To the Editor:

Longterm stabilization of oral endotracheal tubes has long been a bothersome ICU problem. Recently, a number of hospitals have used the Dale endotracheal tube holder (Dale Medical Products, Inc) to improve on older techniques such as adhesive tape tied around the neck. This new product uses a small Velcro adhesive strip that attaches to the endotracheal tube (Fig 1) and a fabric strap that secures the tube at the Velcro strip and subsequently wraps around the neck for anchoring.

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Correction

To the Editor:

The excellent National Heart Lung and Blood Institute National Conference on Oxygen Therapy (Chest 1984; 86:237-47) contains a significant misprint on page 338. It states, "In the NOTT study, subgroups showing a high PaCO₂, elevated hematocrit, elevated pulmonary artery pressure . . . derived the most benefit from continuous as opposed to nocturnal oxygen." The NOTT trial actually showed the most benefit from continuous oxygen therapy in a group with a normal PaCO₂, a hematocrit less than 47%, and a mean pulmonary artery pressure less than 27 mm Hg.

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REFERENCE