Table 1—Cough Capacity Staging

<table>
<thead>
<tr>
<th>Normal cough capacity</th>
<th>Autonomous ability to cough but with difficulty</th>
<th>Need for manually assisted coughing techniques</th>
<th>Need for mechanically assisted coughing techniques*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to cough</td>
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*With mechanical-assist device (Cough-Assist; J. H. Emerson; Cambridge, MA).

directed to expulsing the secretions. We consider noninvasive airway secretion management as important as noninvasively maintaining alveolar ventilation.1 Failing to maintain clear airways results in increased airway resistance to NIV, patient fatigue, and worsening of the arterial-alveolar oxygen gradient, and can precipitate respiratory failure. We agree with Dr. Bach that the most important cause of failure of NIV for patients with neuromuscular disease is failure to properly assist patients in expulsing airway secretions, and not in failure of the NIV methods themselves. Factors such as secretion quantity, consistency, the extent of any glottic or expiratory muscle impairment, or fixed airway obstruction need to be taken into account. Thus, while the audit record of the BTS guidelines5 might be valid for patients with COPD, it is inappropriate when considering NIV failure for patients with neuromuscular weakness.

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REFERENCES


To the Editor:

The letter by Servera and colleagues concerning the inappropriateness of “humping” patients with neuromuscular weakness in with lung disease patients when assessing success or failure of noninvasive mechanical ventilation (NIV) is absolutely correct. The problem is that cough should be objectively rather than subjectively assessed, and Serveras’ “cough capacity staging” will not do this. It is important to understand that patients with neuromuscular weakness have some combination of weakness of inspiratory, expiratory, and...