Response

To the Editor:

We appreciate the comment by Dr Ciurzyński et al concerning our recently published data (August 2010) on the potential role of exercise Doppler echocardiography (EDE) as a non-invasive screening tool. We also appreciate the agreement of Dr Ciurzyński et al with our main statements and that their unpublished data support our results.

We agree that currently no definition of exercise-induced pulmonary hypertension (PH) exists. This does not imply that exercise-induced pulmonary artery pressure (PAP) increase at low exercise levels may be especially clinically relevant. A Multicenter Survey of Current Practices


Thoracentesis and Chest Tube Management in Critical Care Medicine

A Multicenter Survey of Current Practices

To the Editor:

Chest tube insertion is commonly performed in the ICU. As with all invasive techniques, adherence to current guidelines and consensus-based practices should reduce potential iatrogenic life-threatening complications. Although recommendations have been published, nothing is known about thoracentesis practices in the ICU.

To investigate these points, a 25-item questionnaire was sent individually to the 634 senior intensivists working in the Ile-de
France area (the region of Paris and suburbs with 11,700,000 inhabitants, covering 18% of the total French population). The list was obtained from the database of the French Society for Intensive Care Medicine. The questionnaire focused on modality of analgesia, details of procedure (including tracking, size of tube, insertion site, and method of insertion), and details of removal procedure (see e-Appendix). Questionnaires were posted in February 2008; two reminders were mailed 4 and 8 weeks later.

The questionnaire was completed by 178 intensivists (28%). Mean professional experience was 12 years, and the mean number of chest drains inserted was 12 per year. Reasons for thoracentesis were pleural effusion (48%) or pneumothorax (52%). The main responses are summarized in Table 1. In the absence of a life-threatening indication for pleural drainage, the median prothrombin time and platelet count required were 50% (interquartile range, 40-50) and 50,000/mm³ (50-80). In the case of pneumothorax drainage, a small-bore tube was the first option for 53% of the physicians. Pleural effusions were equally drained with an indwelling small lumen catheter, small-bore chest tube (± 14 F), or larger-bore tube. Only 62 physicians (35%) were aware of the British Thoracic Society guidelines.

This French multicenter survey, which is the first report dedicated to ICU practices that we are aware of, reveals that the adherence to current guidelines is very heterogeneous. First, pain management seems acceptable, but these findings contrast with a recent study that found that <25% of painful procedures were anticipated. Second, we confirm the increasing use of ultrasound, particularly among young physicians, with >50% of respondents using this procedure to confirm the insertion site. Third, insertion techniques appear dramatically disparate and may lead to severe iatrogenic complications. We highlight some potentially dangerous practices, such as absence of needle suctioning or trocar use for pleural penetration.

These large variations in practice and heterogeneous implementation of guidelines are similar to those of other domains of care in pulmonology or critical care medicine. This survey underlines the need among ICU clinicians for a heightened awareness of current recommendations for chest tube management.

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Additional Information: The e-Appendix can be found in the Online Supplement at http://chestjournal.chestpubs.org/content/135/6/1324.1/suppl/DC1.

REFERENCES