Letters to Editor

Assessment of spontaneous pneumothorax in adults in a tertiary care hospital

Sir,

We would like to thank the authors for showing interest in our study and raising concerns regarding the management of patients with recurrent pneumothorax.

In our study, out of the 60 cases of spontaneous pneumothorax (SP), eight patients (13.33%) had recurrent pneumothorax and among these eight cases, pleurodesis could not be done in only two cases of secondary
spontaneous pneumothorax (SSP) (one had tubercular etiology with past history of ipsilateral pneumothorax and the other had chronic obstructive pulmonary disease with past history of contralateral pneumothorax). Both these cases had pneumothorax of less than 1-cm size and were conservatively managed successfully with high flow oxygen and observation. However, these two patients were not willing to undergo intercostal tube thoracostomy or any other surgical procedure and hence did not give consent for the same. Therefore, pleurodesis was out of question in these two patients. The British Thoracic Society (BTS) guidelines, that the authors have referred to, also recommends pleurodesis in only inoperable cases of recurrent pneumothorax.\cite{1} The recurrence rate even after instillation of a sclerosing agent through chest tube may be very high as compared to surgery.\cite{2,3}

As regards to the other queries, neither did we clamp the intercostal chest tube, nor did we apply any suction (even the BTS guidelines do not recommend suction routinely in all cases of tube thoracostomy)\cite{1} and we did not observe immediate recurrence in any of our cases after removal of the intercostal tubes. Routine application of suction has not been shown to improve the outcome.\cite{4} The practice of clamping the chest tube has also been discouraged by the American College of Chest Physicians (ACCP).\cite{5} Regardless of whether the tube is clamped or not, most treating physicians would repeat a chest radiograph after 24 hours of the last evidence of air leak to ensure the absence of pneumothorax recurrence.

We have already mentioned the mean duration between insertion of chest drain and its removal (6.63 ± 0.41 days) and the chest drains were removed after 24 hours of complete expansion of lung. This gives an idea about the time to stoppage of air leak. Ours was just an observational, cross-sectional study over a period of 1 year only, where the main emphasis was on the etiology, clinical profile and management of SP and as evident from the methodology, long-term follow-up and outcome has never been our objective. This was perhaps the major limitation of our study.

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