

Letters to the editor

OVERVIEW

Please submit letters for the editor's consideration within three weeks of receipt of *Clinical Medicine*. Letters should ideally be limited to 350 words, and sent by email to: clinicalmedicine@rcplondon.ac.uk

Surgical approaches for lung volume reduction in emphysema

Editor – We read the article on lung volume reduction surgery (LVRS) by SJ Clark *et al* (*Clin Med* April 2014 pp 122–7) with great interest.

The data reported – relatively small numbers of patients carefully selected and treated over a 12-year period within a highly developed multidisciplinary service for patients with chronic obstructive pulmonary disease (COPD) – may not be representative of the surgical mortality and complication rates achievable if all of the 16,000 individuals that are potentially eligible for LVRS undergo this procedure across the UK. However, the data is compelling and does serve to highlight the safety, availability and surprisingly poor uptake for a procedure targeted at a group of patients where, until relatively recently, interventions carrying a survival benefit have been lacking.

The question as to why so few people are undergoing LVRS is a critical one. The authors hypothesise that perceived concerns regarding surgical mortality and morbidity may be contributing to low LVRS rates, and their study looks to address this hypothesis. We feel that although British Thoracic Society guidelines recommend confirmation of bullous lung disease in primary care followed by referral to thoracic surgical units,¹ there seems to be a lack of awareness of LVRS among clinicians working in the community where these patients are increasingly being managed. Additionally, the long-recognised therapeutic nihilism among clinicians treating patients with COPD, and COPD patients themselves, may be a bigger factor.

A recently conducted UK-wide study on the prevalence of COPD based on the new Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines,² with their focus on symptoms in combination with lung function rather than lung function alone, may help to identify a different patient population for more extensive investigation. This could potentially improve the number of patients referred for consideration of LVRS and related surgical and bronchoscopic procedures, but until attitudes and awareness of available treatments for patients with COPD change, the number of patients treated with LVRS are likely to remain depressingly low. ■

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References

- 1 British Thoracic Society Standards of Care Committee. BTS statement on criteria for specialist referral, admission, discharge and follow-up for adults with respiratory disease. *Thorax* 2008; 63(Suppl 1):i1–i16.
- 2 Haughney J, Gruffydd-Jones K, Roberts J *et al*. The distribution of COPD in UK general practice using the new GOLD classification. *Eur Respir J* 2014;43:993–1002.

Recovery after critical illness; when, how and who should be involved?

Editor – The potential for physical and psychological illness following a stay in the intensive care unit (ITU) are well known. National Institute of Health and Care Excellence (NICE) guidelines for recovery following critical illness suggest a rehabilitation pathway to identify and appropriately treat patients following discharge from ITU. Rehabilitation should start 'as soon as clinically possible'.¹ However, we can't help but ask: when, how and who should be involved in the rehabilitation pathway?

When?

Perhaps when a patient is identified as a 'survivor'? Or should it be as soon as the patient can mobilise? Physical rehabilitation is usually initiated when a patient is deemed 'stable', but what does this actually mean and how can we overcome this subjective hurdle?

How?

How should we wake patients with a reduced conscious level? Comfortably, with background analgesia? Slowly, allowing time to become familiar with their surroundings? Once