Letters to the editor

OVERVIEW

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The association of pleural effusion and pulmonary embolism

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Editor – When pleural effusion occurs as a manifestation of pulmonary embolism, this occurrence should generate an opportunity to implement the ultrasonographic pathway for the workup of suspected pulmonary embolism.[1] The first step in that pathway is to perform thoracic ultrasound (TUS) to ascertain whether or not the pleural effusion is attributable to pulmonary infarction. On ultrasonography, the majority of pulmonary infarcts are wedge shaped, but some may either be round or polygonal. Colour Doppler distinguishes pulmonary infarcts from lesions attributable to pneumonia, metastasis or peripheral lung mass.[2]

Ultrasonographic evaluation of all four limbs (for deep vein thrombosis (DVT)) should be the next step in the ultrasonographic pathway. The association of proven DVT and TUS-validated pulmonary infarction should suffice to justify initiation of anticoagulant therapy, thereby obviating the need for further imaging by computed tomography and angiography. That 'short cut' strategy would be uniquely applicable to the hypothetical patient in Ramjug and Phillips' vignette if his chest pain was pleuritic in nature because, in the context of suspected pulmonary embolism, patients with pleuritic chest pain are the ones most likely to have identifiable pulmonary infarcts on TUS.[3] ■

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Table 1. New complaints to NHS England

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4
2017–2018	26,948	29,152	27,790	30,099
2018–2019	29,349	29,372	28,019	29,507
2019–2020	28,849	29,625	28,474	26,293
2020–2021	14,142	22,682	23,966	23,109

What is the impact of COVID-19 on complaints against doctors?

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Editor – The COVID-19 pandemic is causing unprecedented demand upon healthcare services across the world. This had led to a multitude of changes such as the cancellation of hospital visiting, suspending elective work, redeployment, shielding, working from home etc. Many patients died alone in hospitals, causing tremendous distress and anguish to families. In addition, a significant number of patients died due to nosocomial COVID-19 infection.[1,2] So, what impact did these changes have on concerns against healthcare services? To explore this, we analysed the data available in the public domain on complaints against medical practitioners in the UK.

The number of complaints recorded by NHS England in the first quarter of 2020 (April–June) that coincided with the first peak of the pandemic was significantly fewer than compared with the previous year (14,142 vs 28, 849).[3] However, the numbers gradually increased in the next three quarters, but was still lower than the previous years (Table 1). In Scotland, the number of complaints fell from 32,438 in 2019–2020 to 24,905 in 2020–2021 (Table 2).[4] Also, the number of doctors referred to the General Medical Council (GMC) in 2020 was the lowest reported since 2014.[5] Unfortunately, we were unable to get data for Wales and Northern Ireland despite an extensive search and contacting the relevant bodies.

In view of the terse data available, we could only speculate the reasons behind this pattern. Firstly, at the beginning of the

Table 2. Complaints to NHS Scotland and the General Medical Council

Year	NHS Scotland	General Medical Council
2018–2019	31,802	7,405
2019–2020	32,438	7,464
2020–2021	24,905	7,056

pandemic there was a great sense of appreciation and empathy towards keyworkers, especially for healthcare workers. One example of this was when the nation cohesively stood out once a week to demonstrate their appreciation. Secondly, a reduction in the number of elective activities and fewer interventions meant that fewer complications resulted in fewer complaints. Lastly, when healthcare professionals were redeployed to take on roles that were outside their expertise, the GMC issued guidance on when one should be referred regarding concerns on their fitness to practice.[6]

The initial dip in complaints was followed by a gradual increase due to poor communication; suspended visiting; nosocomial COVID-19 infections; inadequate care due to staff shortages caused by sickness and isolation; frequent last-minute cancellations of procedures; and waning sympathy. The latest report from the GMC revealed that two-thirds (65%) of doctors have struggled to provide a sufficient level of care to patients due to high workload and burnout.[7]

A survey involving primary care clinicians revealed that two-thirds feared facing a complaint and more than a third had already received a complaint related to the pandemic.[8] The commonest reasons quoted were increased waiting times, delays in accessing tests, poor communication and online consultation. It is likely that complaints would continue to increase unless we find an effective way of dealing with the effects of the pandemic. ■

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COVID-19 pneumonia as a risk factor for recurrent pneumothorax

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Editor – The risk factors for primary spontaneous pneumothorax (PSP) and for dystrophic severity score (DSS) now need to include COVID-19-related pneumonia and COVID-19-related pneumatocoele, respectively.[1–4]

The following case reports form the basis for inclusion of those two parameters.

Ipsilateral recurrent spontaneous pneumothorax in a patient previously on mechanical ventilation[2]

In this report, a patient previously on a mechanical ventilator for severe COVID-19-related pneumonia experienced two separate episodes of right-sided PSP, 19 days apart. The first episode occurred 28 days post-discharge, and that was 63 days after the diagnosis of COVID-19-related pneumonia. The patient was finally managed by parietal pleurectomy and mechanical abrasion.

Bilateral recurrent spontaneous pneumothorax in a patient previously on mechanical ventilation[3]

In this report, a patient with COVID-19-related pneumonia presented with cough, breathlessness and diabetic ketoacidosis. Mechanical ventilation was initiated on day 12. While on the ventilator, the patient experienced two separate episodes of right-sided pneumothorax, one of which occurred while an intercostal drain (ICD) was *in situ*. The patient later experienced two separate episodes of left-sided spontaneous pneumothorax, the first one during mechanical ventilation, and the second one while off the ventilator. The patient was finally managed by pleurodesis.

Recurrent left-sided spontaneous pneumothorax in a patient with bilateral pneumatocoeles[4]

In this report, a patient with COVID-19-related pneumonia presented with breathlessness, cough and fever. Mechanical ventilation was initiated on day 1. On day 27, chest X-ray revealed two pneumatocoeles in the right lung. On day 28, the patient developed a left-sided spontaneous pneumothorax complicated by bronchopleural fistula. An intercostal drain was inserted. On day 31, computed tomography showed a new right-sided pneumatocoele and also showed pneumomediastinum. On day 54, the day the patient was weaned off the ventilator, a pneumatocoele was noted in the left lung. While off the ventilator, the patient subsequently developed another left-sided pneumothorax.

Comment

These three case reports show that COVID 19-related pneumonia is not only associated with PSP and pneumomediastinum, but it is also a risk factor for recurrent PSP and for PSP-associated pneumatocoele.[2–5] ■

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