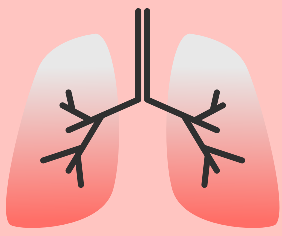
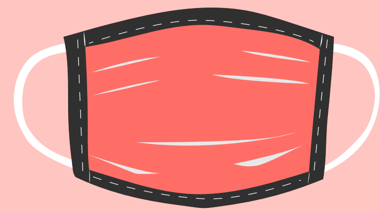
PNEUMOTHORAX



Aetiology

Primary
- rupture of underlying pleural bleb
- most common in tall, thin males
- history of smoking

Secondary
- underlying lung pathology
- COPD, asthma, bronchiectasis, malignancy, infection, pulmonary fibrosis



History

Pleuritic chest pain
- sudden onset, unilateral

Progressive Dyspnoea
- often worse in 2° than 1°
- disproportionate to size of pneumothorax

Can be asymptomatic or mild

Examination

↓ expansion on affected side

↓ breath sounds on affected side

Hyper-resonant on percussion

Tracheal deviation → **tension pneumothorax**

Diagnosis

Erect CXR PA
- displacement of pleural line

Classified as:
Small - <2cm chest wall to lung edge

Large - >2cm chest wall to lung edge

Management

Primary Pneumothorax

<2cm and no SOB
- **discharge** with OP review

>2cm or SOB → **aspirate**
- if unsuccesful → **chest drain**

Secondary Pneumothorax

<1cm and no SOB
- High flow **oxygen** and admission

<2cm and no SOB → **aspirate**
>2cm or SOB → **chest drain**

Aspiration of Pneumothorax

Site of aspiration - **2nd intercostal space, mid-clavicular line**

-Infiltrate area with local anaesthetic
-Attach Venflon to 5ml syringe of sterile water
- Insert venflon at right angles → bubbles in syringe as entering pleural cavity
- Remove syringe and metal needle
- Attach to connecting tubing and 50ml syringe
- Aspirate air (maximum 2.5 litres)
- Expel to room air via 2-way tap
- Repeat CXR