New Outpatient Management Based on a Respiratory Virtual Clinic. An Effective Measure in Times of Austerity

Una nueva gestión ambulatoria basada en la consulta virtual de neumología. Una medida efectiva en tiempos de «austeridad»

To the Editor:

Specialized care outpatient clinics tend to be inundated by high numbers of patients referred from primary care centers (PCC). This overload seriously undermines the management of waiting lists and delays the evaluation of patients with severe diseases. Long waiting lists are the result of a shortage of human resources, work systems, and interdependency between PCC and specialized care facilities. In the Canary Islands, these problems are compounded by geographical obstacles and the remote location of communities. Tenerife has a surface area of 2034.38 km² and an estimated population of 906,854 inhabitants, making it the most heavily populated island in Spain. Most of the population is concentrated in 3 areas: Santa Cruz de Tenerife, San Cristobal de la Laguna and the municipalities of Arona and Adeje. The latter 2, located in the south of the island, have a resident population of 200,000 inhabitants, and the nearest tertiary hospital is at least 80 km away.

The disperse population in the south of the island and their ensuing transport difficulties led to the implementation in June 2012 of the Respiratory Virtual Clinic, the aim of which was to manage and prioritize pulmonology referrals from PCC. The Respiratory

References


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In less than 3 years, this formula has reduced the overall number of PCC consultations by 14%, and the number of first appointments by 56%. The reduction in work load meant that chronic patients can be more closely monitored, leading to a 61% reduction in the number of hospital admissions to the pulmonology department, while follow-up appointments rose by 15% (Table 1).

Finally, the Respiratory Virtual Clinic increased the number of consultations that could be resolved by the PCC by 19%, underscoring the efficiency of this type of management.

References


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Pleural Empyema in a Pneumonectomized Patient as a Complication of Colonoscopy

Empiema pleural en paciente neumonectomizado como complicación de una videocolonoscopia

To the Editor:

Post-pneumonectomy empyema (PPE) is a serious disease generally associated with high rates of post-operative morbidity and mortality. The most common cause is bacterial contamination from bronchopleural fistula. Infections from other intrathoracic sources, such as mediastinitis, pneumonia, and hematogenic dissemination from extrathoracic sources, are less common.

We report the case of a pneumonectomized patient who developed empyema in the residual chest cavity as a result of bacteremia following video-assisted colonoscopy. To our knowledge, this is the first report in the medical literature of pleural empyema as a complication of colonoscopy.

A 63-year-old man presented with a history of right pneumonectomy by video-assisted thoracoscopy 2 years previously for squamous cell lung cancer, with no evidence of recurrence to date.

Following a video-assisted colonoscopy, the patient developed an episode of fever and bacteremia, associated with pain and edema in the same hemithorax as the pneumonectomy. Pleural fluid was drained by thoracocentesis and blood cultures were performed, revealing empyema and bacteremia caused by Escherichia coli, respectively.

When the patient was admitted to the emergency department of our hospital, he was febrile, and had dyspnea, arterial hypotension, tachycardia and tachypnea, and leukocytosis on blood tests. Chest multislice tomography showed an abscess occupying the entire remaining pleural cavity, impinging on the overlying chest wall (Fig. 1). The patient was hemodynamically stabilized and pleural decortication was performed by video-assisted thoracoscopy. His progress was satisfactory and he was discharged 10 days after surgery.

The main factors associated with PPE are related with post-operative complications, such as bronchopleural fistula, or intra-operative events, such as contamination of the pleural cavity; the condition generally develops in the first few weeks after surgery. Presentation up to 1 year after pneumonectomy, described as late-onset PPE, is extremely rare.2 In this entity, infection of the residual chest cavity due to hematogenic bacterial dissemination from a distant focus of sepsis can be observed. Our patient presented a clinical picture of empyema of the residual cavity due to an episode of septicaemia after video-assisted colonoscopy. The main complications of gastrointestinal tract endoscopies are diverse, the most common being post-colonoscopy pain, perforated gut, and gastrointestinal bleeding.3 Although septic complications have been described after the passage of bacteria from the gastrointestinal tract to the bloodstream,4 these are rare.

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