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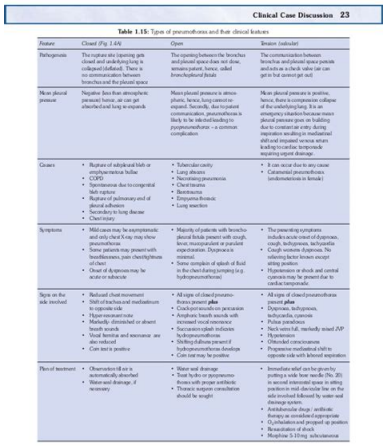

Clinical Case Discussion 23

Table 1.15: Types of pneumothorax and their clinical features

Feature	Closed (Fig. 1.4A)	Open	Tension (valvular)
Pathogenesis	The rupture site (opening) gets closed and underlying lung is collapsed (deflated). There is no communication between bronchus and the pleural space	The opening between the bronchus and pleural space does not close, remains patent, hence, called *bronchopleural fistula*	The communication between bronchus and pleural space persists and acts as a check valve (air can get in but cannot get out)
Mean pleural pressure	Negative (less than atmospheric pressure); hence, air can get absorbed and lung re-expands	Mean pleural pressure is atmospheric, hence, lung cannot re-expand. Secondly, due to patent communication, pleural space is likely to be infected leading to pyopneumothorax – a common complication	Mean pleural pressure is positive, hence, there is compression collapse of the underlying lung. It is an emergency condition in which mean pleural pressure goes on building due to constant air entry during inspiration resulting in mediastinal shift and impaired venous return leading to cardiac tamponade requiring urgent drainage
Causes	• Rupture of subpleural bleb or emphysematous bullae • COPD • Spontaneous due to congenital bleb rupture • Rupture of pulmonary end of pleural adhesion • Secondary to lung disease • Chest injury	• Tubercular cavity • Lung abscess • Necrotising pneumonia • Chest trauma • Barotrauma • Empyema thoracis • Lung resection	• It can occur due to any cause • Catamenial pneumothorax (endometriosis in female)
Symptoms	• Mild cases may be asymptomatic and only chest X-ray may show pneumothorax • Some patients may present with breathlessness, pain chest/thorax of chest • Onset of dyspnoea may be acute or subacute	• Majority of patients with bronchopleural fistula present with cough, fever, mucopurulent or purulent expectoration. Dyspnoea is minimal. • Some complain of splash of fluid in the chest during lumping (e.g. hydropneumothorax)	• The presenting symptoms includes acute onset of dyspnoea, cough, tachypnoea, tachycardia • Cough worsens dyspnoea. No relieving factor known except sitting position • Hypotension or shock and central cyanosis may be present due to cardiac tamponade
Signs on the side involved	• Reduced chest movement • Shift of trachea and mediastinum to opposite side • Hyper-resonant note • Markedly diminished or absent breath sounds • Vocal fremitus and resonance are also reduced • Cuts test is positive	• All signs of closed pneumothorax present **plus** • Coarse/wet sounds on percussion • Amphoric breath sounds with increased vocal resonance • Succussion splash indicates hydropneumothorax • Shifting dullness present if hydropneumothorax develops • Cuts test may be positive	• All signs of closed pneumothorax present **plus** • Dyspnoea, tachypnoea, tachycardia, cyanosis • Pulse paradoxus • Neck veins full, markedly raised JVP • Hypotension • Obtunded consciousness • Progressive mediastinal shift to opposite side with lobored respiration
Plan of treatment	• Observation till air is automatically absorbed • Water-seal drainage, if necessary	• Water seal drainage • Treat hydro or pyopneumothorax with proper antibiotic • Thoracic surgeon consultation should be sought	• Immediate relief can be given by putting a wide bore needle (No. 20) in second intercostal space in sitting position in mid-clavicular line on the side involved followed by water seal drainage system. • Antitubercular drugs / antibiotic therapy as considered appropriate • O_2 inhalation and propped up position • Resuscitation of shock • Morphine 5-10 mg subcutaneous

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