

Yorkshire and Humber Neonatal ODN

Identification and management of Pneumothorax Guideline

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Date written: May 2017

Review date: May 2020

DEFINITION

Pneumothorax is a collection of air or gas in the chest or pleural space that causes part or all of a lung to collapse.

In the newborn it most commonly occurs as a birth injury or as a result of positive pressure ventilation (by mask, CPAP, high flow therapy or endotracheal ventilation). It is more common in preterm infants, meconium aspiration syndrome and pulmonary hypoplasia.

A tension pneumothorax occurs when air continues to accumulate in the pleural space with no escape. Intra-thoracic pressure increases leading to increased central venous pressure and a decrease in venous return. The resulting decreased cardiac output may lead to bradycardia, hypotension and hypoxaemia and death.

CLINICAL FEATURES

Pneumothorax may be asymptomatic. Symptoms may appear acutely.

Clinical features include

- Respiratory distress (grunting, recession etc)
- Increasing oxygen requirement
- Cyanosis
- Pallor and hypotension (shock) may be present in a tension pneumothorax

Clinical findings

- Asymmetric chest movement
- Decreased breath sounds on the affected side
- Shift of the apex beat away from the affected side

DIAGNOSIS

Pneumothorax should be suspected in any newborn with the sudden onset of respiratory distress. The level of suspicion should be high in a mechanically ventilated infant with an unexplained deterioration in oxygenation, ventilation, or cardiovascular status.

Transillumination — with a high-intensity fibreoptic probe (“cold light”) in a darkened room will light up the affected side when placed against the chest wall.

In a life-threatening situation, the air can be immediately evacuated (needle thoracocentesis, see below).

If the infant is stable or findings are equivocal, the diagnosis should be confirmed by chest x-ray before an intervention is made.

Chest x-ray —

- air in the pleural space outlining the visceral pleura
- flattening of the diaphragm on the affected side,
- mediastinal shift away from the affected side.
- the affected side may appear hyperlucent (air accumulates anteriorly when the is supine).

Smaller pneumothoraces may be more difficult to appreciate and may be improved by a lateral decubitus x-ray, with the affected side up.

MANAGEMENT

Small, asymptomatic pneumothorax:

If a baby has no signs of respiratory distress and is stable consider a period of close observation, with supplemental oxygen to maintain saturations. The air leak should resolve spontaneously within 1-2 days. There is no evidence to support the use of high inhaled oxygen concentrations to hasten resolution of spontaneous pneumothorax^{1,2}.

If a pneumothorax is diagnosed in a ventilated baby, efforts to reduce mean airway pressure should be made.

Symptomatic pneumothorax.

Needle aspiration (thoracocentesis) may be required in an emergency situation. For procedure see below.

Tension pneumothorax and pneumothorax in a ventilated patient

These will need a formal chest drain. For procedure see below. The chest drain is connected to a flutter valve or an underwater seal and usually placed under suction at 10-15cm of water. Chest x-ray should be used to confirm position of the drain. Full resolution should occur in 2-3 days although the air leak may recur.

PROCEDURES

Emergency thoracocentesis

Should only be used if the situation is life-threatening and tension pneumothorax is suspected.

1. Identify site of drainage - 2nd anterior intercostal space in the mid-clavicular line.
2. Strict aseptic non-touch technique should be used.
3. Clean skin according to local guideline.
4. Insert 21G butterfly (a cannula may be used instead)
 - a. perpendicular to skin,
 - b. just above third rib (to avoid neurovascular bundle)
5. Other end of plastic tubing should be placed underwater (a small bottle of sterile water can be used).
6. Observe for bubbling.
7. Syringe aspiration of the pneumothorax through the butterfly is not usually recommended. The aim of thoracocentesis is to relieve pressure, not fully drain the air leak. Full drainage may make chest drain insertion more difficult and the butterfly needle may damage the underlying lung.
8. The butterfly should be removed before chest drain insertion.

Note: if an emergency thoracocentesis is attempted and the patient does not have a tension pneumothorax there is a 10-20% risk of causing pneumothorax. Patients that have had this procedure should have a chest x-ray.

Chest drain insertion

A pig-tail chest drain is the drainage tube of choice. It is inserted using a Seldinger technique.

See pictorial guide: appendix A.

Pain relief should be used for this procedure. Lignocaine should be used to infiltrate the insertion site and a bolus of morphine may be considered.

Removing the drain

- Leave drain in situ for 24 hours after bubbling has stopped
- The drain may be clamped for a period (4-6 hours) before removal. If, however, the transparent drain tubing contains static fluid it is effectively clamped and additional measures may not be needed. If the baby is asymptomatic the drain may be removed with out imaging, although some units may choose to x-ray before removal. If there is no reaccumulation then proceed to removal.
- Gather equipment:
 - sterile pack,
 - sterile gloves,
 - Steristrips,
 - Tegaderm.

- Clean the area, gently removing the Tegaderm.
- Remove the drain, immediately occluding the incision site (consider sending tip for culture)
- Close incision site with Steristrips, applying Tegaderm over this
- Consider re-x-ray after 2 hours unless clinical deterioration before.

References.

1. Fernandes CJ. Pulmonary Leak in the Newborn. UpToDate accessed 26th July 2016.
2. Clark SD, Saker F et al. Administration of 100% oxygen does not hasten the resolution of symptomatic spontaneous pneumothoraces in neonates. J Perinatol. 2014 Jul;34(7):528-31
3. Shaireen H, Rabi Y et al. Impact of oxygen concentration on time to resolution of spontaneous pneumothorax in term infants: a population based study. BMC Pediatr. Aug 2014;14:208

Also with thanks to neonatal units across the Y&H ODN for submitting their own guidelines and Dr Liz Pilling & Dr Sharon English, for their original pictorial guides .