

Chest Drain Summary Page.

-Nontraumatic:

-Pneumothorax

- primary; small or uncompromised; ok to monitor out of hospital
Compromised: aspirate/drain
Big; drain/aspirate
recurrence/failed aspirate/>2.5L of air; small bore drain
- secondary; small; observe in hospital, low threshold for drain
large/symptomatic; small bore drain.
- tension; decompress immediately (obviously) Needle vs finger
thoracostomy. Then drain formally.
Probably better in the 4/5th space anterior axillary line.

- Pleural Effusion

- malignant; drain properly/dry; 50% will reaccumulate. Likely to need repeat procedure earlier if just aspirated/incompletely drained. Clamp at 1.5L for 2 hours.
Probably should do pleurodesis either straight away or if reaccumulate;, bedside talc slurry pleurodesis, but lung re-expansion needs to be confirmed first.
- parapneumonic; drain unless small and uncomplicated
- loculated effusion; intrapleural fibrinolysis can help based on a few small RCTs,
- Empyema needs drained, small bore probably OK. If you can't drain it (with or without intrapleural thrombolysis, should refer for VATS

Ultrasound guidance is good; (0% vs 33% failure rate/ 18% vs 3% pneumothorax)

-Trauma:

- Simple Pneumothorax; convention says drain it, but occult pneumothorax (seen on CT but not CXR) can probably be managed conservatively (even with positive pressure ventilation)
Convention says surgical drain, but small bore seldinger drain probably OK.
- Open Pneumothorax; cover/close the wound. Drain if you need to (though a new hole or by re-opening the dressing)
- Haemothorax: drain it, smaller drains, (including seldinger) are probably OK. More the 1.5L or 200 mL/hr; discuss with cardiothoracics
- Haemo-pneumothorax; drain it. Again, probably with whatever type of tube you want.