

Correspondence

Pneumothorax and barotrauma in invasively ventilated patients with COVID-19

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Dear Editor,

We read with great interest the article by Chopra et al. recently published on *Respiratory Medicine* [1].

In their multicenter study, the Authors present incidence, clinical characteristics and outcome of pneumothorax in critically ill patients with coronavirus disease 2019 (COVID-19). They found that pneumothorax rate among invasively ventilated COVID-19 patients is 80/594 (13%), and mortality rate for patients who developed pneumothorax is 50/80 (62%). On the contrary, among 160 randomly selected invasively ventilated COVID-19 patients without pneumothorax, mortality was 78/160 (49%).

We recently published a systematic review on rate of barotrauma among invasively ventilated COVID-19 patients [2]. Our pooled analysis included data from 13 studies and 1814 patients [3–15] and we found that pooled estimate of pneumothorax rate was 10.7% (95% confidence interval [CI] = 6.7%–14.7%), while overall rate of barotrauma event was 16.1% (95% CI = 11.8%–20.4%). In addition, we found an overall mortality rate for COVID-19 patients who developed barotrauma of 61.6% (95% CI = 50.2%–73.0%), as compared with a mortality of 49.5% (95% CI = 41.1%–58.0%) for COVID-19 patients who did not develop barotrauma.

We are pleased to read that our findings are further reinforced by another study, that confirms that pneumothorax rate among mechanically ventilated COVID-19 patients is between 10 and 15%. Indeed, after including the study by Chopra et al. in an updated meta-analysis, the pooled pneumothorax rate is 11.1% (95% CI = 7.4%–14.8%) (Fig. 1), while the overall barotrauma rate is 15.4% (95% CI = 11.7%–19%) (Fig. 2). Furthermore, the study by Chopra et al. also confirms a mortality rate above 60% for COVID-19 patients with barotrauma

(updated pooled estimate = 61.4%; 95% CI = 52.1%–70.7%) (Fig. 3), as compared with a mortality lower than 50% for patients who did not develop barotrauma (updated pooled estimate = 49.5%; 95% CI = 42.8%–52.3%) (Fig. 4).

Collectively, these data confirm that barotrauma occur frequently in COVID-19 patients requiring mechanical ventilation, and is associated with a worse outcome and a very high mortality risk. Interestingly, the study by Chopra et al. is one of the few studies that identified worse lung mechanics at start of mechanical ventilation as a risk factor for development of barotrauma [2]. Most of previously published studies reported no significant differences among mechanical ventilation settings/parameters between patients who developed barotrauma and those who did not. They also found a trend towards lower age and higher use of steroids in pneumothorax patients, which were also suggested by other Authors [2,16].

Interestingly, in a recent study by our group, we identified Macklin-like radiological sign [17,18] detected on chest computed tomography (CT) scan as potential predictor of subsequent development of barotrauma about 12 days in advance [3].

Considering the high mortality rate associated with development of barotrauma in COVID-19 patients, and the ongoing debate on optimal timing of intubation in these patients [19–21], we believe that it might be justified to avoid intubation in patients with Macklin-like radiological sign on chest CT, and prefer early support with alternative techniques including awake prone positioning and extracorporeal membrane oxygenation [22–25].

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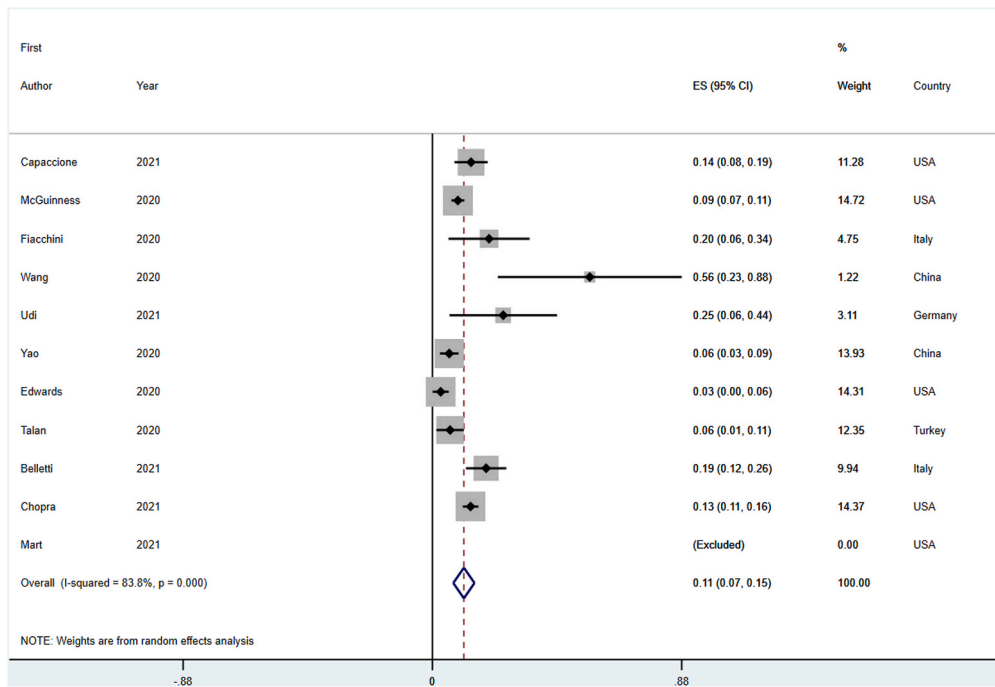


Fig. 1. Forest plot for pneumothorax development in invasively ventilated COVID-19 patients.

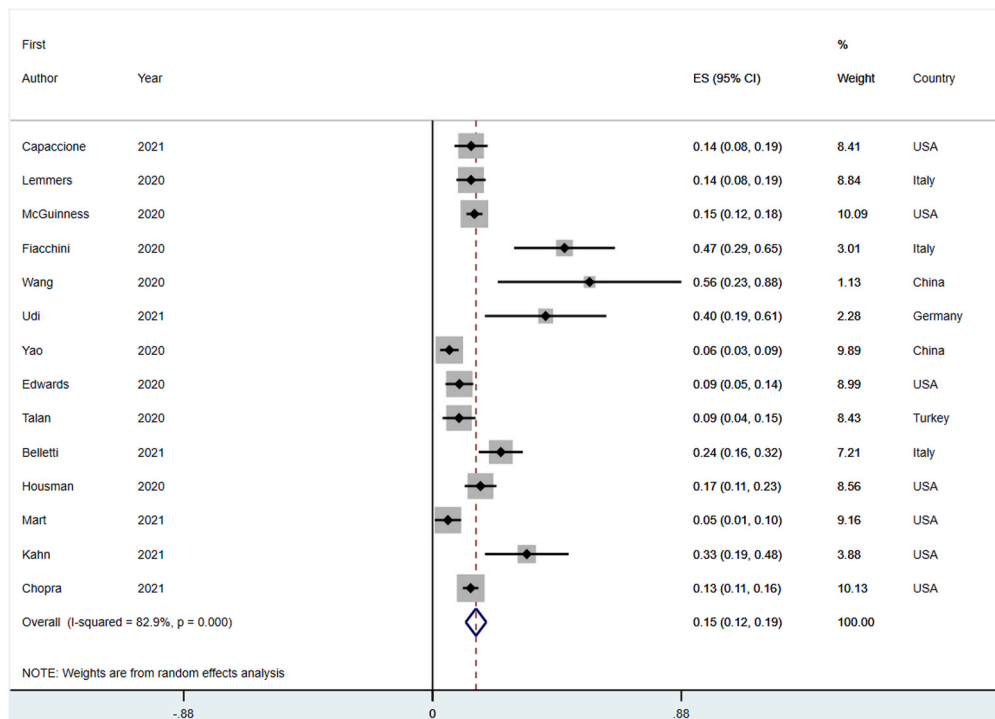


Fig. 2. Forest plot for barotrauma development in invasively ventilated COVID-19 patients.

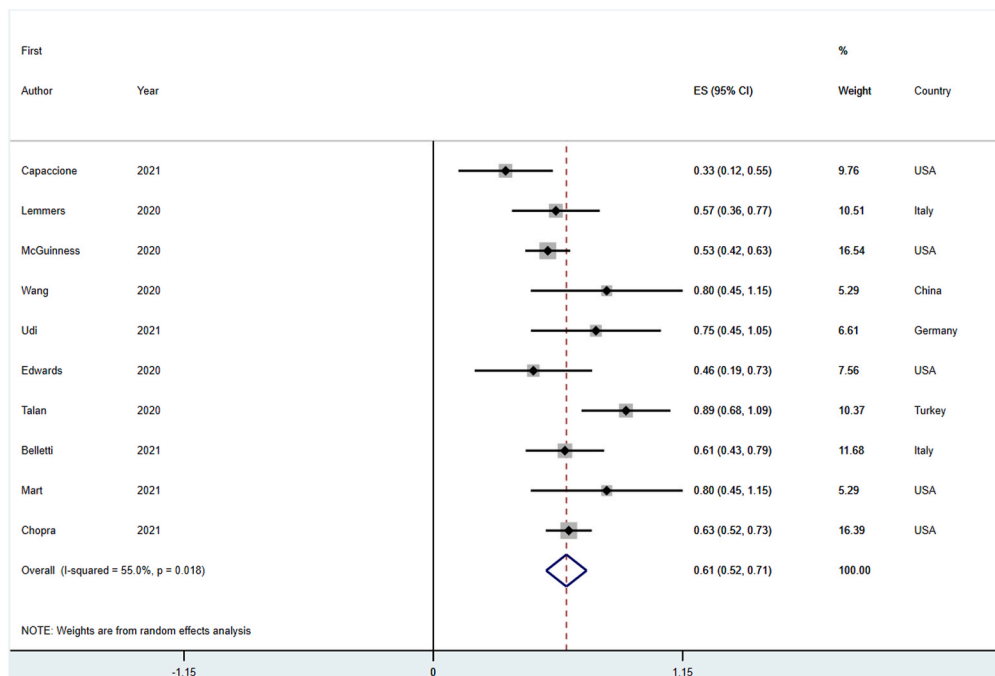


Fig. 3. Forest plot for longest follow-up mortality in invasively ventilated COVID-19 patients who developed barotrauma.

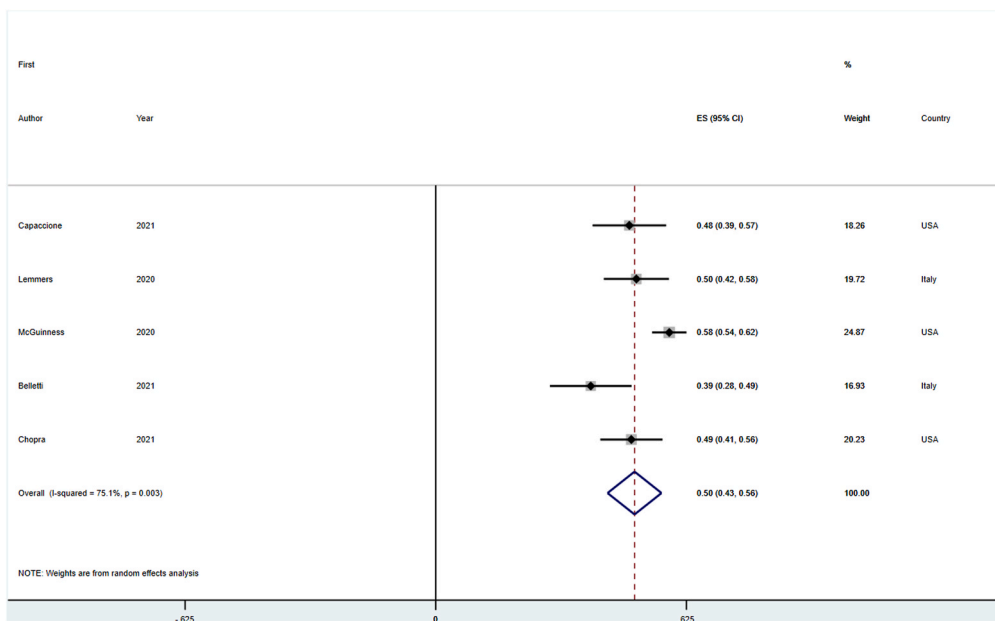


Fig. 4. Forest plot for longest follow-up mortality in invasively ventilated COVID-19 patients who did not develop barotrauma.

Declaration of competing interest

None.

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None.

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