

# Respiratory Intermediate Care Unit or Intensive Care Unit

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At this issue of Turkish Respiratory Journal and April 2001 issue of *Toraks Dergisi*, pleasingly, we see articles related to new field of interest of Turkish respiratory physicians, critical care medicine. Gürkan et al., (1) from Ankara University Chest department, evaluated outcomes of their recently founded respiratory intermediate care unit. In a two-year period, 84 patients received noninvasive ventilatory support and 23 patients were invasively ventilated in their unit. As discussed by the authors it's impossible just to practice noninvasive mechanical ventilation and as soon as this application fails these patients should be intubated and invasively ventilated. They also took care of respiratory failure patients transferred from other departments. In the western countries the main difference between intensive care units and intermediate care units is the number of nurses per bed which should be 1-2 nurses per bed in an intensive care unit and 4-6 nurses per bed in an intermediate care unit and application of invasive procedures like pulmonary artery catheters and invasive mechanical ventilation in intensive care units. Intermediate care units are helpful to apply noninvasive mechanical ventilation and intensive care unit patients with prolonged weaning problems can be followed there. The authors took care of their most complicated patients in this unit they call respiratory intermediate care unit and did not transferred their sicker patients to another unit which may be called general intensive care unit. This terminology is preferred by anesthesiology based intensivists in our country and in Europe. In these units you can see trauma, postoperative, pediatric, COPD and medical patients side by side. When there is a weaning problem in these units they prefer to transfer the patient to so called step down unit or intermediate care unit, which may be run by a chest doctor.

In Ceylan et al.'s article from Dokuz Eylül Faculty of Medicine (2), we see another example of Intensive Care Unit organization in our country. As in the United States of America, they have a postoperative intensive care unit run by anesthesiologist and a medical intensive care unit run by chest physicians and internist. In this unit pulmonary patients, internal medicine and neurology patients with critical problems but mainly patients with respiratory failure are taken care of. In most

other institutions in our country chest physicians are not directly involved in pulmonary problems of internal medicine and neurology patients, these patients either suffer from no support or wrong therapies or they are supported by anesthesiologist in general intensive care units. A recently published study demonstrated how noninvasive mechanical ventilation improved survival of immunosuppressive patients (3). Our internist colleagues will obviously look for our expertise in this field and when chest physicians are involved they have the opportunity to learn from pulmonary and systemic problems of these complicated cases.

In the third article from Gaziantep Faculty of Medicine (3), Dikensoy et al., applied noninvasive mechanical ventilation with bilevel mechanical ventilator in a standard hospital room with successful results. This probably is how most chest physicians in our country are involved with therapy of respiratory failure.

I believe, with this new momentum gained by noninvasive mechanical ventilation, in the near future chest physicians will dominate the field that belongs to them, respiratory failure, as renal failure is dominated by nephrologist. We should never forget that most of the patients with respiratory failure originate from internal medicine and neurology wards and we should combine our expertise with them in well coordinated intensive care units directed towards nonsurgical adult critical patients and in these units, if we are mostly taking care of critical patients, they should be named intensive care units, not intermediate care units.

## References

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## Hemoptysis in a Patient with Oral Ulceration: Should Not be Missed in Turkey!

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Behçet's Disease (BD) is a systemic vasculitis of unknown etiology (1). Although there are differences due to the speciality of the clinics reporting, main manifestations of BD are oral (97-100%) and genital (80-90%) aphthous ulcerations, skin (80%) and eye (50%) lesions. These manifestations are included in the International Study Group (ISG) criteria, which is commonly used for classification purposes (2). Other manifestations of BD such as vascular, articular, neurological and gastro-intestinal involvement, although some of them quite specific for BD, are not included in the ISG criteria for their low sensitivity.

In this issue of Turkish Respiratory Journal, Uçan *et al.*, report a review of BD cases with thoracic manifestations reported by Turkish authors, both in foreign and Turkish literature (3). They should first be congratulated for this extensive task which require a search of Turkish literature with important indexing problems. However, some of the other problems with BD literature is also evident with this review. Although case reports are sufficiently detailed for a combined analysis of clinical, radiological and laboratory findings, six case series are quite limited in their information. An important aneurysm series from Cerrahpaşa Medical Faculty is also not reported (4). As most cases are not prospectively followed-up and some are from the pre-CT era, CT findings are confined to only 35 of 63 case reports. Therapy regimens and outcomes are also insufficiently reported.

However, with all these shortcomings, the review shows that, although not very frequent, thoracic manifestations of BD

can have a poor prognosis. Pulmonary arterial aneurysms, although might regress with immuno-suppressive treatment (5), can have a very high early mortality (50%) (4). The authors underline the fact that every patient with massive hemoptysis and mucosal ulcerations should be carefully evaluated to exclude BD in Turkey. As other pulmonary manifestations, pleural effusions are reported in 36%, pulmonary emboli in 29%, nodules and masses in 23% with chest X-ray and 11% with CT. However, the clinical and pathological features of these findings are insufficiently reported to comment on the frequency of the pulmonary parenchymal involvement in BD, which is rarely clinically significant.

As a conclusion, this review highlights the necessity for further studies of thoracic involvement in BD. As a country with a very high BD prevalence and enthusiasm in the medical community, other studies from Turkey are especially waited.

### References

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