SIMPLE PNEUMOTHORAX (Post-Aspiration)

Date ________  Time _______  ED admitting consultant _____________

Inclusion Criteria
- Unilateral spontaneous pneumothorax  
- Requires post-aspiration observation  
- Likely to be discharged within 12 hrs  
- CDU transfer form filled out

Exclusion Criteria
- Unstable vital signs  
- Oxygen sats < 94% on air  
- Failed aspiration OR aspiration > 2.5L  
- Associated haemothorax or pleural effusion  
- Traumatic pneumothorax  
- Bilateral pneumothoraces  
- Major co-morbidity requiring in-patient admission, including chronic lung disease

Investigations
- Repeat CXR at 4-6 hrs post (successful) aspiration:  
  _____________ time

Management
- Analgesia as charted  
- To be reviewed by Dr _____________ at ________ hrs  
- Notify Medical Staff if:  
  o Temp ≥ 38°C  
  o HR < 60 or > 100/min  
  o RR < 10 or > 20/min  
  o Systolic BP < 100 or > 160 mmHg  
  o Sats < 92% room air  
  o Increasing pain

Discharge only if:  
- Improvement in clinical symptoms  
- Lung remains re-expanded on CXR  
- Normal vital signs  
- Can eat / drink normally  
- Normal mobility
• Adequate home supports
• Discharge medications arranged
• Discharge letter completed (to Dr White’s Respiratory Clinic)

**Referral / Consultation**

Admit to Medical team if:
• Still symptomatic
• Re-accumulation of pneumothorax on repeat CXR at 4hrs

Time referred: ________________  Time seen: ________________

Fast Response Team:
• Social Work
• Physiotherapy
• Occupational Therapy

Time referred _________  Time seen __________
Dear Dr ______________

Your patient was admitted into the Clinical Decision Unit following a presentation to the Emergency Department with a R / L sided simple pneumothorax.

Tick as appropriate:
☐ Your patient had the following management:
☐ Aspiration of the pneumothorax
☐ Check CXR at 4-6 hrs following successful aspiration
  CXR result:

Your patient was observed in the CDU and discharged with the following:
☐ TTA medications:
  Analgesia

☐ Instructions to be reviewed by yourself in _______ days
☐ Out-patient referral to the Dr White’s Respiratory Clinic
  (Your patient will be contacted by the Out-Patient Department)
☐ Advice to contact yourself or the Emergency Department should there be any further problems

Thank you

Signed ____________________ Name ______________ ____________ Grade ________