Targeting European Respiratory Society group activities: a survey of the Noninvasive Ventilatory Support Group

To the Editor:

According to the European Respiratory Society (ERS) philosophy, the Assemblies and their Groups are the ''beating heart'' of the Society so that ''joining one and participating in its activities are among the most significant benefits of membership'' [1]. Likewise, one of the missions of the ERS Assembly activities is to gather all cultural stimuli from its members with the aim of producing scientific data, educational materials, and new ideas to improve research and its translation into clinical practice in different environments worldwide. In other words, the ERS Groups (should) act as a ''catalyst'' of different minds, working together to increase communication among each other.

Moreover, the ERS Groups also intend to build-up active strategies, thus attracting the interests of new members through the dissemination of exciting activities. This is particularly true when the Group is built on the interest of a ''transverse'' technique, such as noninvasive ventilation (NIV) [2]. NIV has re-written the history of mechanical ventilation and, most importantly, is handled by different specialists (pulmonologists, intensivists, emergency medical doctors, neurologists, cardiologists, *etc.*) and different professional figures (medical doctors, nurses, physiotherapists and technicians) using different tools (machines, circuits and interfaces) in different clinical scenarios (acute, chronic and acute-on-chronic respiratory failure). Furthermore, physicians dealing with different fields of respiratory medicine (*e.g.* infective diseases, diffuse lung diseases, chronic obstructive diseases, interventional pulmonology, paediatrics, oncology and palliative care) may be interested in the ''NIV world'' due to its huge, and still increasing, field of diagnostic and therapeutic applications.

On behalf of the Respiratory Intensive Care Assembly, we recently conducted a survey about the interests, professional attitude and characteristics of the members of the Noninvasive Ventilatory Support Group. The specific aims of this survey were to: improve the ''link'' between the large number of members and the programme activity of the Group; and increase the visibility of the Group activities for clinicians associated with the other ERS Groups.

Of the 377 members, the response rate was 46% (table 1). Most of the respondents were Europeans of young to middle age working as medical doctors in pulmonary departments with or without a respiratory intensive care unit (RICU). This was not surprising as NIV is a typical ''landmark'' of different levels of RICUs [3]. In terms of intensity of nursing care provided, the majority of them belonged to an ordinary ward. Again, this finding is in line with published data corroborating the possibility of using NIV in an ordinary ward to manage less severely ill acute patients, as well as to care for the adaptation to domiciliary NIV [4, 5]. The choice of the setting for acute application of NIV is dependent on the type and severity of acute respiratory failure (ARF), the expertise of the staff, and the intensity of care and monitoring provided [4]. The heterogeneity of the environment where the surveyed members work is not unexpected given the key relevance of NIV in different clinical areas [2]. This also reflects the timing of the ''usual'' applications of this ventilator technique (*i.e.* prevention of impending ARF, avoidance of endotracheal intubation, and an alternative to invasive mechanical ventilation) [6], as well as the so-called ''unusual indications'' of NIV (*e.g.* cardiopulmonary interventional procedures, post-operative ARF, chest trauma and palliative care) [7].

The number of departments with at least five medical professionals who were familiar enough with NIV to be able to autonomously perform this support at any time for ARF was 59% for nurses, 56% for medical doctors and 18% for physiotherapists. This finding is not surprising as, at least within Europe, NIV is largely performed by nurses [8]. More specifically, the members stated to have been able to perform NIV without supervision in only 30% and 36% of patients receiving ventilation for acute and chronic respiratory failure, respectively. This data highlights the crucial role of team training for successful NIV application in ARF according to the ''learning curve'' needed to acquire adequate experience [9]. Thus, the activities of the Noninvasive Ventilatory Support Group and the Respiratory Intensive Care Assembly have focused on educational aims by promoting: ERS Postgraduate courses; the respiratory critical care medicine HERMES (Harmonising Education in Respiratory Medicine for European Specialists) syllabus [10]; Task Forces (*e.g.* RICU

TABLE 1 Respiratory Intensive Care Assembly survey

Survey items	Response %
Respondents	46.0
Male	74.0
Age years	
<35	28.8
35–50	52.7
51–60	17.8
>60	0.7
Continent	
Europe	85.8
Asia	6.4
Oceania	5.7
America	2.1
Africa	0.0
Professional role	
Medical doctors	91.8
Physiotherapist	7.5
Nurse	0.7
Institution	
University/teaching hospital	67.1
District hospital	15.8
Hospital	13.0
Rehabilitation	4.1
Department	
Respiratory unit without RICU	47.3
Respiratory unit with RICU	41.1
ICU	11.6
Number of beds in the department	
<10	13.1
10–25	28.3
>25	58.6
Type of bed in the department	
ICU	18.0
RICU	10.5
Ordinary ward	74.7
Sleep laboratory	11.0
Number of medical doctors in the department able to perform NIV for ARF	
0	4.1
<5	39.7
5–10	38.4
>10	17.8
Number of nurses in the department able to perform NIV for ARF	
0	15.1
<5	26.0
5–10	28.1
>10	30.8
Number of physiotherapists in the department able to perform NIV for ARF	
0	45.2
<5	37.0
5–10	11.0
>10	6.8
Number of patients receiving NIV in the department in 1 year preceding the survey for ARF, acute-on-chronic failure and CRF	
<25	19.2
25–50	18.5
50–75	21.7
75–100	15.6
>100	25.0
Number of patients receiving NIV in the department in 1 year preceding the survey for CRF#	
<25	29.5
25–50	18.5
50–75	16.4
75–100	7.5
>100	28.1
Management of CRF with NIV in the department in 1 year preceding the survey	
By yourself	36.0
With supervision of an expert	64.0
Management of ARF with NIV in the department in 1 year preceding the survey	
By yourself	30.0
With supervision of an expert	70.0

RICU: respiratory intensive care unit; ICU: intensive care unit; NIV: noninvasive ventilation; ARF: acute respiratory failure; CRF: chronic respiratory failure. #: both newly initiated and monitored on long-term NIV.

features and ethical issues in RICU) [3, 11]; fellowships; and the Junior Members Committee within the Long Range Planning Committee.

In conclusion, the findings of our survey depict the characteristics of the Noninvasive Ventilatory Support Group members as a heterogeneous pool of subjects, showing a different degree of expertise with a predominance of pulmonologists who manage patients in low-intensity settings with both acute and chronic respiratory failure. Current and future activities of the Group and its Assembly are directed to increase the awareness of all ERS members to the central role covered by NIV in respiratory medicine and to coherently improve the skills of old and new members.

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Survey showing ERS NIV group is heterogeneous with different degree of expertise and predominance of pulmonologists http://ow.ly/tAa0D

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Chronic thromboembolic pulmonary hypertension complicating long-term cyproterone acetate therapy

To the Editor:

Chronic thromboembolic pulmonary hypertension (CTEPH) is the most severe delayed complication after pulmonary embolism. Known risk factors of CTEPH include acute pulmonary embolism, the degree of