found to project sharply into the pleural cavity in most of a
group of young patients undergoing thoracotomy for treatment
of recurrent pneumothoraces, and it was suggested that this
was in some way related to the cause of the pneumothorax.5
Undoubtedly many cases of pneumothorax are associated with
underlying lung diseases including asthma, chronic bronchitis,
emphysema, cystic fibrosis, tuberculosis, lung cysts and
abscesses, staphylococcal pneumonia, bronchial neoplasm,
and honeycomb lung. Other rare causes are Marfan’s syndrome
and endometriosis.

Apart from universal agreement that a tension pneumothorax
should be relieved immediately there is no consensus of
opinion about the best way of treating spontaneous pneumo-
thorax causing less severe symptoms. When a pneumothorax
occurs in association with lung disease the patient is usually
breathless, but prompt relief occurs after inserting an inter-
costal drain with an underwater seal. Subsequently, chemical
or surgical pleurodesis may be considered, but the choice in
the individual case will be influenced by the severity of the
underlying disease; whether the patient has had previous
pneumothoraces; and in part on the previous experience of
the physician or surgeon.

The treatment advocated for an uncomplicated pneumo-
thorax in an otherwise healthy young adult varies widely.
Some authors adopt a conservative, non-invasive policy for
all but the most resistant cases.6 Others advise prompt invasive
treatment for all patients.7 The rate of reabsorption of air
from a pneumothorax without intervention is about 1-25% of
the total radiographic area per day, so that a moderate
sized pneumothorax may take 4-6 weeks to resolve.8 The rate
of resolution can be increased up to fourfold by administer-
ing large quantities of oxygen for long periods,8 but this treatment
may be uncomfortable for the patient. As it is normal to
advocate rest during resolution conservative management
necessitates a lengthy period of unemployment, which may
be unacceptable for a young man with dependants. For this
reason it is common to proceed directly to intercostal intuba-
tion with an underwater seal or a Heimlich flutter valve10 for
all but small pneumothoraces.

Modern plastic intercostal tubes are easy to insert, but the
traditional red rubber tube is more irritant and may stimulate
adhesions, making a recurrence less likely. The tube should be
inserted in the second intercostal space in the midclavicular
line or in a lower space in the mid-axilla, where it may be more
comfortable. The choice of site depends in part upon the site
and size of the pneumothorax. About 90 mm of tube should
be inserted, and the tip should be directed to the top of the
pneumothorax. In many cases the lung will then expand fully
within 24 hours, and most pneumothoraces will have resolved
within five days. Once the lung is fully expanded the tube
should be clamped, and if the pneumothorax does not recur
the tube may then be removed. If the lung fails to expand
fully a negative pressure of 2-4 kPa may be applied with a
simple vacuum pump.

Failure of resolution within 5-7 days indicates that surgical
repair of a bronchopleural fistula, with or without pleurodesis,
is likely to be necessary. A pleural effusion or haemothorax may
occasionally complicate a pneumothorax requiring a second
intercostal tube for drainage, and for a haemothorax prompt
surgical repair may be advisable.11 Recurrent spontaneous
pneumothorax should be treated by pleurodesis, and in most
centres partial parietal pleurectomy or abrasion pleurodesis
is preferred to chemical pleurodesis by instillation of kaolin or
silver nitrate. The latter treatment may be very painful and is
frequently only partly effective.

7 Klassen, K P, and Meckstroth, C V, *Journal of the American Medical
Association*, 1962, 182, 1.

### Saving money by self-help

Are general practitioners’ surgeries crowded with patients
wasting everyone’s time with their trivial complaints? This
question always provokes violent disagreement among doctors.
Some apply objective tests and believe that the only good
patient is an ill one, who ideally should have a serious, treatable
organic disease; others argue that any patient who believes
he needs a doctor should have access to medical reassurance
and advice. The controversy has been given new life by the
recent NHS economy drive, with Mr David Ennals asking
GPs to prescribe less and every health authority desperate to
save money.

Should we, then, encourage patients to treat themselves?
Is self-help a medical virtue? Last week the open section of
the Royal Society of Medicine agreed that it was, and several
speakers also suggested that doctors were themselves to blame
for much of the dependency shown by their patients. When a
patient comes into the consulting room with a self-limiting
illness or injury we all know that any prescription is just a
placebo; but we also know that it is quicker and easier to
prescribe than to explain that no treatment is necessary.
Furthermore, every time a doctor takes the easy way out he
reinforces the patient’s belief that there is a “pill for every ill.”

Attitudes cannot be changed overnight, and it would be
unrealistic to expect habit and beliefs established over thirty
years to be eradicated easily. The first need is for more
and better health education, especially in schools. Most people
are still unaware of the natural history of common and recur-
rent disease and its likely response to treatment. There is
enormous popular interest in health and medicine, but sadly
the popular media concentrate only too often on nine days’
wonders, new wonder drugs, technical advances, scare stories,
or controversial issues such as the safety of pertussis vaccine,
to the exclusion of discussions of a healthy life style and simple
self-treatment. If we are going to encourage patients to take
more responsibility for their own health, then we must be
prepared to spend more time talking to patients—and listening
to them. It may take longer to explain the nature of his illness
and its management to a patient, but one session of explanation
may prevent a whole lifetime of visits for self-limiting disease.
Fewer “instant prescriptions” may save money; more im-
portant, surely, are the other benefits of self-help—less
iatrogenic disease and a return to the old virtues of self-reliance
and independence.