



HAEMOPTYSIS IN TUBERCULOSIS

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Introduction

Life threatening haemoptysis is a rare and dramatic scenario in tuberculosis. Thoracic Surgery Centers of developed countries are unfamiliar with the situation. Most likely sources of massive bleeding are ruptured vessels of destroyed lung/caverna wall. Thoracic surgery is challenged usually as a very last resort making operative decisions even more complicated.

Material and Methods

A systemic review failed to reveal any Evidence Based Recommendation above level V (Expert Opinion) Applied anecdotic approach confirms extreme heterogeneity of the scenarios. Protocols followed are defined by local policies, capacities (access to invasive radiology, rigid bronchoscopy) and particular setting/organisational factors. High volume thoracic surgery centers are facing 0-2 cases per year.

Results

Emergency surgery fatalities range between 20 and 50%, where the underlying pathology already have consumed the reserves of the patient. Better chances are offered when invasive radiology/endobronchial haemorrhage control is able to achieve local haemostasis. Contralateral lung parenchyma protection is mandatory. If surgery is unavoidable, a 24-48 hours time window before definitive procedure seems to be optimal.

Discussion

Personal experience is limited and the opinions are seriously divergent. Preoperative orientation (images) is crucial. First line rigid bronchoscopy is the method of choice. Multidisciplinary approach rather than pneumonologist/phtisiologist driven surgery seems to be preferable. Success depends on efficacy of buying time and stability of condition of patient at the time of surgery.

Conclusion

Absolute majority of tuberculous haemoptysis cases are manageable without surgical intervention. A strict protocol, centered around rigid bronchoscopy and airway blocking and multidisciplinary decision making might offer the best chances in a clinical scenario with inherently poor outcomes.