Editorial

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Editorial on Chest Physiotherapy

Sandhya Kille*

Department of Microbiology, Acharya Nagarjuna University, Guntur, Andhra Pradesh, India

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***Corresponding author:** Sandhya Kille

sandhyaranikillae96@gmail.com

Department of Microbiology, Acharya Nagarjuna University, Guntur, Andhra Pradesh, India.

Tel: 8801858923

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People with cystic fibrosis often utilise chest physiotherapy to clear mucus from their airways.

Chest physiotherapy (CPT) has a well-established adjuvant role in promoting airway clearance, alveolar recruitment, and ventilation/perfusion matching in mechanically ventilated (MV) patients with pneumonia or recurrent lung atelectasis.

However, there is scepticism about the utility of routine CPT in MV individuals who do not have such lung illnesses.

A narrative review based on a literature search for prospective randomised trials comparing CPT to a non-CPT method in adult patients ventilated for at least 48 hours.

There were six studies that were found to be relevant. The sample size was quite tiny. Body positioning, manual chest manipulation (mobilisation, percussion, vibration, and compression), and particular procedures such as lung hyperinflation and intrapulmonary percussion were all used in the CPT.

The majority of the control participants received general nursing care and tracheal suction.

CPT was generally safe and supportive, however it had a minor or no effect on any relevant patient outcome metric, including pneumonia. In adult MV patients without pneumonia, current evidence does not support “prophylactic” CPT.

Even in the absence of primary or substantial lung illness, chest physiotherapy (CPT) is recognized as a crucial component of respiratory care in all mechanically ventilated (MV) critically sick patients. Intubation of the trachea affects the cough reflex and mucociliary escalator function, causing secretory sequestration and impaction in the lower airways.

Cardiopulmonary this puts MV patients at risk for serious lung problems such as ventilator-associated tracheobronchitis, ventilator-associated pneumonia (VAP), and lung atelectasis, as well as prolonging the weaning process and perhaps increasing mortality.

In MV patients, one of the most important roles of the intensive care unit (ICU) physiotherapist is to aid in the elimination of retained or excessive airway secretions in order to minimise airway resistance, improve lung compliance, and reduce breathing work.

The ICU physiotherapist has a diverse arsenal of breathing methods, manual techniques, and mechanical devices at his disposal for this goal, which can be utilised alone or in combination (3). Despite this potential benefit, CPT practise for this indication is anything but consistent, ranging from as-needed airway suctioning to a more complex “multi-modality” approach to physiotherapist-driven ventilator modification.

When defining the function of such "regular" daily physiotherapy, the constant call for protocolized medicine (e.g., construction of unit-specific VAP preventive "bundles"), as well as concerns about medicolegal duties, must be taken into account.