

Home Oxygen Therapy

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Today the health services of many countries have programs for domiciliary oxygen therapy. The patients benefiting from this are mainly those with hypoxaemic chronic obstructive pulmonary disease (COPD). There are in places special respiratory therapists who visit these patients in their homes¹. Reviews have shown that home oxygen therapy improves both the length and quality of life of many hypoxaemic COPD patients^{2,3}. There however are some drawbacks. Patients may remain at home inappropriately during an acute exacerbation, and there is always the hazard of fire in the homes smokers live⁴. But keeping patients at home and out of hospitals or nursing homes has both psychological and economic benefits. Recent developments have enabled patients receiving oxygen therapy to be more mobile allowing them to travel. Lighter and more portable devices are available using oxygen-conserving devices to allow the patient's oxygen supply to last longer⁵.

All this may not sound so familiar in Malaysia but there has been a start. In this issue of the journal, Norzila MZ, Azizi BHO, Norrashidah AW *et.al.* report their experience with home oxygen therapy in 71 children over 9 years from 1992⁶. They did not deal with adults with COPD but rather children with bronchopulmonary dysplasia bronchiolitis obliterans and other diseases. Their program is a continuing one running currently with only 12 machines according to their report. They have a nurse to visit their patients at home and they train the parents of the sick children. Their success will hopefully lead to an expansion of such services and be a model for others to follow.

Doctors seeking funding for such services will have to be innovative. As they report, they started with oxygen concentrators that were donated, but lately they have been able to buy four machines with hospital funds. In trying to expand home oxygen therapy services in the country it may be possible to tap into non-governmental organisations and corporations following the way dialysis provision has developed in this country.

There are also today many individuals in the community who have obtained oxygen concentrators on their own as emergency measures on an ad hoc basis privately. In many cases the patient concern may have died from the terminal cancer or COPD that caused their hypoxaemia. Some machines may lie idle or have been traded off. Those who need such therapy and find it currently may do so without the benefit of trained therapists. The service that the UKM workers have developed with professionals visiting the home and a special clinic for oxygen therapy has much to offer. There is a need for networking among health care professionals involved in home oxygen therapy. Perhaps there is a need for a National Lung Foundation, along the lines of the National Kidney Foundation, Heart Foundation or Liver Foundation. In fact, we have in the National Tuberculosis Council (NTBC) a possible vehicle for such activities. The NTBC is already involved in one major lung disease and can expand its role. The medical profession needs to be at the forefront of advancing home oxygen therapy but there is room here for others to join in.

References

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