

Adult domiciliary oxygen therapy

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We welcome the incisive comments from Cahill Lambert (page 472).¹ The remit of our position statement² was to update our previous evidence-based guidelines for the prescription of oxygen in Australia and New Zealand by reviewing the currently available literature. Informal consultation with consumers was made through the Australian Lung Foundation's COPD (chronic obstructive pulmonary disease) Consultative Group, but no funding was available to seek broader community comment. Our position statement supports the use of ambulatory oxygen as part of continuous oxygen therapy in patients who fulfil criteria for long-term oxygen therapy — both to maximise the duration of normal blood oxygen concentrations and to maximise exercise capacity.

Two of us (AJC, CFM) have been actively involved in research around the issue of quality of life of patients on long-term oxygen therapy.³⁻⁶ It has not yet been confirmed whether ambulatory oxygen is of significant benefit in this area.^{7,8} The unwieldiness of some of the currently available portable cylinders may counteract some of the potential gains of using ambulatory oxygen, but we have not been successful in securing the widespread use of liquid oxygen in Australia. It is yet to be demonstrated that the extra costs associated with a liquid oxygen system are balanced by greater benefits in useability (portability and comfort) and quality of life.

Although we are keenly aware that there are major issues of equity and access to ambulatory oxygen therapy across Australia, as Cahill Lambert correctly asserts, discussing these issues was outside the parameters (and space constraints) of our position statement. While we may consider oxygen to be equivalent to a "drug" for the purposes of this discussion, oxygen, unlike pharmaceuticals, is not a federally-funded commodity but is provided on a state-by-state basis through programs such as the Victorian Aids and Equipment Program (except in the case of war veterans, who are funded through the Department of Veterans' Affairs). Individual state funding arrangements have led to inequalities in the provision of this service. It is our understanding that New South Wales and Queensland do not currently supply portable oxygen to adults requiring long-term continuous oxygen therapy delivered by concentrator. However, Victoria, Tasmania, Western Australia and South Australia provide portable oxygen cylinders to such patients and to others who have demonstrable evidence of desaturation on exertion and measurable benefit from portable oxygen therapy (in terms of improved exercise capacity or reduced breathlessness). There are caps on supply, with only a certain

SEE ALSO PAGE 472.

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number of cylinders allowed per month in most instances. Capping, although understandable in fiscal terms, makes little sense to patients trying to maximise their exercise capacity (and quality of life) by exercising regularly with the help of ambulatory oxygen.

We recommended in our position statement that patients requiring oxygen therapy should be assessed and reviewed on a regular basis. Although not explicitly stated in our position statement, we believe this review should be undertaken by the clinician managing the patient. We agree with Cahill Lambert that there is a potential conflict of interest in the review being conducted by the company supplying the oxygen. We support her call for more advocacy in this area, but assure her that we have personally been advocating for a fairer and more equitable system for many years. Patient advocacy groups, such as those run through the Australian Lung Foundation, as well as organisations such as the Thoracic Society of Australia and New Zealand clearly have an important role to play in ensuring that this issue makes its way onto the political agenda.

We believe that further research is the key to providing more definitive answers to some of the more contentious questions around oxygen provision. Specific areas of research should include portable oxygen use in patients not requiring continuous oxygen therapy, nocturnal oxygen use in patients whose daytime resting arterial blood gas levels would preclude them from receiving continuous oxygen therapy, and the use of palliative oxygen therapy in non-hypoxaemic patients. A more extensive body of data in these areas would allow future updates of our position statement to provide higher levels of evidence, which we hope would translate into a more consistent approach to oxygen provision in Australia.

Competing interests

None identified.

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