SESSION 1
HOW DO I MANAGE…?

Dr M Muers, Consultant Respiratory Physician, Leeds General Infirmary, Professor JA Wilson, Professor of Otolaryngology, Head & Neck Surgery, Freeman Hospital, Newcastle-upon-Tyne, Dr C Shovlin, Senior Lecturer and Honorary Consultant, Respiratory Medicine Unit, Hammersmith Hospital, London.

Three major topics that often present complex management issues were discussed: solitary pulmonary nodules, palatal surgery for snoring, and pulmonary arteriovenous malformations.

Solitary pulmonary nodules are <3 cm diameter lesions usually found incidentally on the CXR and the key is to exclude lung cancer. Contrast enhanced CT scanning is routinely recommended. Low risk lesions should have repeat CT at 6, 12 and 24 months. Intermediate risk lesions should be considered for histological diagnosis. High risk lesions should be discussed at multi-disciplinary team meetings and PET scanning is recommended to assess possible malignancy as well as exclude local and distant metastasis. Localised cases should be referred for surgical resection, without histology, but patients cautioned that not all lesions will be neoplastic.

The role of palatal surgery for snoring was reviewed. Examination should involve calculation of BMI, ease of visualisation of the posterior pharyngeal wall, (Mallampati or Freidman scores), assessment of tonsil size and nasal obstruction. Cephalometry, although currently predominantly a research tool, may be useful in identifying those who are likely to benefit from palatal surgery.

Lifestyle issues should be addressed, but surgical treatment options include soft palate coblation (‘spot welding’ of the palate to shorten and stiffen it), tonsillectomy ± uvulectomy or uvulopalatopharyngoplasty. Such procedures can be effective but may have significant morbidity, to the extent that in a Swiss study, 27% of patients said they would not undergo uvulopalatopharyngoplasty again.

Pulmonary arteriovenous malformations affect 1 in 10,000–15,000 people in the UK. Despite severe hypoxaemia, the majority are asymptomatic. Investigations should include CXR, erect and supine oxygen saturations, 99mTc perfusion scanning (to quantitate shunt size) and CT chest scan. Data from the Hammersmith Hereditary Haemorrhagic Telangiectasia Team suggests that, if left untreated, 1 in 3 will develop a brain abscess by age 70, and almost 50% will have had an ischaemic stroke by age 65–70. There are no known features of pulmonary arteriovenous malformations to predict such sequelae. All patients should receive embolisation and antibiotic prophylaxis for dental or surgical procedures. Transplantation is not advised and confers a poor prognosis.

Screening and counselling for family members is recommended as 90% have hereditary haemorrhagic telangiectasia.

SESSION 2
PULMONARY EMBOLISM

Professor G Lowe, Professor of Vascular Medicine, University of Glasgow, Professor A Perrier, Head, Service of General Internal Medicine, Hôpitaux Universitaires de Geneva.
The role of hereditary risk factors in venous thromboembolism was discussed, and Professor Perrier delivered the Robert W Philip Memorial Lecture on the diagnosis of PE.

Pulmonary embolus accounts for approximately 25,000 hospital admissions annually and has a 10% mortality rate. Approximately 5% of the population have a hereditary (autosomal dominant) thrombophilia. The most common genetic mutations cause Activated Protein C Resistance (Factor V Leiden and Factor II mutations), and, less frequently, a deficiency of coagulation inhibitors (antithrombin III, Protein C and S).

For all thrombophilias, actual events are determined by interaction with environmental risk factors. Routine screening of the general population is not recommended. However, in those who have had a DVT or PE, the less common hereditary thrombophilias increase the risk of a recurrent event. New British haematological guidelines on who should be tested for hereditary thrombophilias are awaited.

Investigation of suspected PE should include assessment of the clinical probability using validated prediction rules such as the Wells criteria or the Revised Geneva Score. D-dimer levels are commonly measured and its clinical utility is to safely exclude a diagnosis of PE with D-dimers in the normal range.

In multislice CT scans, accuracy studies have been slightly disappointing with 83% sensitivity. However, combining CT scans with clinical probability scores, patients with a negative CT result and a low or indeterminate clinical probability have an extremely low risk of PE.

Professor Perrier concluded that the diagnosis of PE should be a combination of clinical assessment and select, validated tests, determined by local availability.

**SESSION 3
LINKS BETWEEN RHEUMATOID DISEASE AND THE LUNG**

Dr N Foley, Consultant Respiratory Physician, Royal United Hospital, Bath; Dr B Griffiths, Consultant Rheumatologist, Freeman Hospital, Newcastle-upon-Tyne.

Pulmonary manifestations of Rheumatoid Arthritis and the pulmonary complications of disease modifying anti rheumatic drugs were explored.

A broad spectrum of pulmonary manifestations may be present in up to 58% of rheumatoid arthritis patients. Interstitial lung disease has a radiological prevalence of up to 44%, mirrors usual interstitial pneumonia histopathologically but has a significantly better prognosis than usual interstitial pneumonia. Obliterative bronchiolitis is rare and rapidly progressive. The prognosis is poor since few effective therapies are currently available. Organising pneumonia is infrequent, but usually steroid responsive with a good prognosis.

Pleural disease and lung nodules are common. The latter are largely asymptomatic, but radiologically indistinguishable from cancer, often resulting in surgical excision.

Bronchiectasis is also associated with rheumatoid arthritis but may predate joint symptoms by up to four years.

Methotrexate is a well tolerated potent anti-inflammatory, but has a 1% prevalence of pneumonitis — this is seen only rarely with other disease modifying anti rheumatic drugs such as anti-TNFα therapy and leflunomide. Pre-treatment investigations should include CXR and detailed pulmonary function tests. Pneumonitis typically occurs within six months of commencing therapy, and is thought to be a hypersensitivity reaction. A differential diagnosis should always be considered, especially progressive interstitial lung disease or atypical infection. Mortality rates of 13% are reported, but most patients recover fully following drug withdrawal, and, if necessary, steroid therapy.

**SESSION 4
ASTHMA: THE PRIMARY–SECONDARY CARE INTERFACE**

Dr G Douglas, Consultant Physician, Chest Clinic, Aberdeen Royal Infirmary, Dr H Pinnock, Research Fellow in Primary Care, and Principal in General Practice, Whitstable Medical Practice, Kent, Professor N Thomson, Professor of Respiratory Medicine, Division of Immunology, Infection & Inflammation, Gartnavel General Hospital, Glasgow.

This session was devoted to current and future strategies for asthma management.

Asthma is a common, chronic disease with significant morbidity and mortality. It is often poorly controlled with false patient belief, low patient expectation and disparity between patients’ and doctors’ approaches to disease. Personalised self management plans may be an answer to effective disease control. Action plans based on either symptoms or peak expiratory flow rate monitoring allows patient autonomy and better perception of disease stability. Such plans can achieve a significant improvement in symptoms and may reduce future hospital admission rates.

Growth of evidence-based guidelines, a recognition of inequalities in delivery of care and political will have prompted the development of Quality and Outcomes Framework within the new General Medical Services primary care contract. The speaker gave a detailed
explanation of these initiatives emphasising their role in asthma management. Outcomes from the past two years were presented and an overview of the anticipated future consequences was discussed, including the administrative, financial and clinical implications.30

Professor N Thomson presented key studies supporting the use of non-invasive biomarkers (induced sputum cell counts and exhaled nitric oxide) in assessment of severe asthma and monitoring airways inflammation.31–34 Such techniques may in future be used to assess therapeutic response to existing and new therapies.35 An overview of potential new therapies was given including anti-IgE therapy,36 anti-TNFα therapy37 and the new non medical therapy thermoplasty.38 This involves direct application of radiofrequency energy to the airway wall to reduce the amount of smooth muscle. These therapies may be useful in severe asthma but further studies are needed.39

REFERENCES

32 Leuppi JD, Salome CM, Jenkins CR et al. Predictive markers of


Forthcoming symposia for 2007/2008

All symposia are held at the Royal College of Physicians of Edinburgh unless otherwise stated. Further symposia may be added at a later date.

2007

- Improving End of Life Care in the 21st Century 26 October
- Gastroenterology 1 November
- Preston symposium 7 November
- Dundee symposium: moving points in medicine 8 November
- Changing Professional Practice 14 November
- E-Health 23 November
- Scottish Paediatric Society St Andrew’s Day Symposium (in association with RCPE, RCPCH, RCPSG, SACCH) 23 November
- 47th St Andrew’s Day Festival Symposium 6–7 December

2008

- Respiratory Medicine 1 February
- Haematology 29 February
- Geriatric Medicine 29 May
- Infectious Diseases 18 June

Also coming up in Spring/Summer 2008:

- Treating patients with cancer: individualising care Date to be confirmed

Programme details available at: [www.rcpe.ac.uk/education/events/index.php](http://www.rcpe.ac.uk/education/events/index.php)
or contact the Symposium Co-ordinator, Tel: 0131 225 7324 Email: e.strawn@rcpe.ac.uk