RCPE Hybrid Symposium: Respiratory Medicine
Thursday 23 March 2023

Indications and outcomes in lung transplantation – Dr Gerard Meachery

Question: Does severity of COPD preclude from treatment for PAH?

Answer: It would need to be evaluated very carefully with assessment with a pulmonary hypertension service.

Indications and evidence for domiciliary NIV – Dr Swapna Mandal

Question: Swapna, what about patients with recurrent admissions with acute type 2 whose CO2 returns to normal post-admission. Do they benefit from NIV?

Answer: These are a difficult group of patients, there is no evidence to suggest they benefit from NIV, however in clinical practice we undertake sleep studies on all of these patients and consider treatment based on the phenotype from the sleep study and symptoms.

Infective complications of lung transplantation – Dr Anna Reed

Question: Thank you for an excellent talk - When would you consider switching from S/T mode ventilation to AVAPS?

Answer: not relevant to Dr Reed's talk

Question: Does this mean you never start hNIV post acute admission until review at 4 weeks, and then dependent on co2? Same if 2nd or 3rd admission for T2 failure? Thanks.

Answer: not relevant to Dr Reed's talk

Question: What do you think of inhaled antifungals?

Answer: I believe inhaled antifungals have a significant role in therapy for fungal lung diseases.

We use nebulised amphotericin frequently and are involved in the trial of a novel inhaled azole. Opelaconazole.

Diagnosing and treating aspergillus lung infections – Dr Caroline Baxter

Question: How do we differentiate between subacute invasive aspergillosis and ABPA for commencing steroids?

Answer: The diagnostic criteria for these two conditions will aid the differentiation. One is an infection, the other an allergy. History and symptoms are therefore different. Radiological CT features, IgE and serum GM help the most.

"highly effective modulator therapies" in cystic fibrosis – Dr Robert Gray/ Dr Nicola Robinson

Question: The reduction in CF exacerbation rate occurred at the same time as everyone was self-isolation and fear may have improved compliance rates for standard therapy. Do we know yet how much this was responsible for the above vs the new drugs?
Answer: Clinical trials undertaken pre Covid showed a 65% reduction in exacerbation frequency, so much of this change is likely to be drug related rather than just shielding/increased compliance. It will take several years before we can understand the impact on exacerbations.

Question: Is the on-treatment weight gain fat, muscle or balanced?
Answer: Body composition studies weren't undertaken as part of our work.

Question: What will happen to CF units built and staffed on the assumption of high admission rates?
Answer: We don't know the long term impact of these drugs as yet, so admissions may vary with time. With improved longevity of these patients, outpatient numbers will also increase.

Question: Surely the shorter life expectancy in women with CF is due to having smaller lungs than men of the same height. i.e. they have less reserve lung function?
Answer: This has never been fully explained, but there are a number of different hypotheses that are more likely to be sex hormone linked than lung function related.

Review of British Thoracic Society clinical statement on pulmonary sarcoidosis – Dr Chris Atkins

Question: In view of gadolinium toxicity, do you have a rule of thumb regarding number of previous MRIs when to favour PET over MRI for suspected cardiac sarcoid?

Answer: No strict rule of thumb, although the majority of patients that I am involved with tend not to have repeat MRI scans because of subsequent device implantation. Unless there is an initial MRI performed which was negative, then subsequent development of signs or symptoms suggesting cardiac sarcoid involvement, in which case a repeat MRI is needed; but in truth, once the cMR supports the diagnosis of cardiac sarcoid there is little need to do repeat MRI testing with gad enhancement given that a PET scan will give you info about active myocardial disease. This would be a question best asked of a radiologists or cardiologist with a special interest here for a more defined answer, though…

Question: Can I presume any patient receiving wake-promoting agents for fatigue has had a full in-patient polysomnogram and been seen by a sleep specialist first?

Answer: Yes. Sarcoid-associated fatigue is really a diagnosis of exclusion – including the exclusion of sleep disorders, so they should be referred to a specialist sleep clinic for assessment of this. The ability to perform a full inpatient polysmnogram is going to be different around the country. I wouldn't say full inpatient polysomnography is mandatory for neurostimulants (though I agree that in an ideal world it would be) but a review by a specialist sleep consultant is, which will include a sleep study (though this may be a domicillary one without full EEG monitoring).

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Lessons from the COVID pandemic, what to expect next time – Professor Mark Woolhouse

Question: Do you think covid deaths and icu admissions were best indices of efficacy of policies?

Answer: Both metrics are problematic. As is widely known, attributing cause of death is not always straightforward and without agreed unless internationally agreed guidelines are applied death counts may not be comparable. Attempts to estimate under-reporting of deaths have been published but are controversial. ICU admission is highly context-dependent so even less useful. My own view is that there is merit in more holistic indicators such as QALYs, but those are even more difficult to apply.