

Respiratory Medicine Symposium

4 March 2020

Breathlessness: from bodily symptom to existential experience - Professor Havi Carel

Q. Have you defined any specific therapeutic approaches as a result of your research?

A. One of the Life of Breath team members, Kate Binnie, has developed an intervention called 'breath body mind integration'. Contact me or her for more details.

Management of pleural infections: past, present and future - Dr Rahul Bhatnagar

Q. Can 'sign of damp earth' replace thoracic ultrasound for targeted procedures in DGHs?

A. ABSOLUTELY NOT! The sign of damp earth is an ancient Greek method for guessing where to insert a lance and involves smearing wet mud onto a patient's chest. It has no role in modern medicine. In my opinion (and that of the British Thoracic Society), no pleural procedure for fluid should be undertaken without the assistance of thoracic ultrasound, regardless of whether a hospital is a DGH or not.

Q. Is co-amoxiclav the right treatment option for pleural effusion ?

A. The choice of antibiotic for pleural infection should always be guided by local policies. In our practice, however, co-amoxiclav is often considered a 'good' first line antibiotic for pleural infection as it has a reasonable degree of anaerobic coverage.

Q. How often would you recommend flushing a chest drain to try to prevent blocking? At least twice per day. We prescribe three flushes per day.

A. Does empyema requires an emergency chest drain? If not how long can we wait ? There is no definitive answer to this I'm afraid. Patients with pleural infection will almost always require drainage as soon as possible but, in many cases, if sepsis is controlled with antibiotics, drainage can be delayed until it can be performed within normal working hours by someone with adequate training. Typically this will not mean waiting for more than 12-24 hours. There will undoubtedly be situations when a patient needs an 'emergency' chest drain for pleural infection but, in my experience, this is relatively rare.

Q. How would you treat a multiloculated pleural effusion ?

A. Referral for decortication or drainage for largest locule with prolonged antibiotics? Our practice is to use chest drainage +/- intrapleural fibrinolytics alongside antibiotics and only refer for decortication in the event of treatment failure. However, as discussed in my talk, this practice may vary depending on what local facilities there are. Sites with thoracic surgery available may wish to consider decortication sooner.

Q. What is the optimal timing for giving intrapleural fibrinolytic?

A. There is no 'optimal' timing defined. However, our practice is to consider the use of fibrinolytics 24-48 hours after drain insertion if there is evidence of ongoing loculation and/or insufficient drainage.

Smoking cessation interventions - Dr Gareth H Jones

Q. Is your assertion that smoking is a significant addiction requiring medical intervention not undermined by the apparent ability of patients to stop when paid?

A. Financial incentivisation (be that reward or penalty fines) to comply with recommendations extends beyond smoking cessation (indeed there is depressingly few things people won't do for money). I think the important point particularly is that itself pregnancy is a very powerful "teachable moment" i.e. individuals are more motivated to quit if they are having a child as evidenced by higher cessation rate in the non-intervention arm compared to usual quit rates and that younger people particularly aren't motivated to quit by warnings of "potential to develop illnesses in 40years time" but by other things such as finances - so use cost saving calculators with this group of individuals.

Q. Is vaping with smoking worse than just smoking as does vaping also has potential unknown carcinogens?

A. Overall it is estimated that vaping would increase lifetime cancer rate but only very slightly ~1% which compared to smoking is a massive harm reduction. Obviously no long-term data on this available for many years yet and will be confounded for a long time by the fact that most people currently vaping have been (or remain) users of conventional cigarettes as well. Unclear on any potential synergistic effects but as long as ENDS replace Conventional cigarette use they can be considered a form of harm reduction – if ENDS are used to circumvent smoking restrictions and the same number of conventional cigarettes are smoked in any given day then this is clearly not harm reduction and could plausibly be considered a very slight increase in exposure.

Q. What would your advice be when discussing smoking cessation with a patient and they say "I'm just not ready to quit"?

A. Could explore why they feel like this (previous unsuccessful attempts and why these failed, potential maladaptive coping strategy to use cigarettes to calm anxiety, teachable moments tests, hospital visits, diagnosis etc) but VBA is useful here to plant seed in a non-judgemental way – best chance of quitting is with support and treatment both are available from me/local cessation service. In this circumstance I would encourage an individual to start cutting down as this will make a cessation tempt easier in future and give the patient something positive to focus on. Don't stop bringing it up and reoffering treatment/support!

Q. Some patients complaints that smoking abstinence causes constipation... Is there any explanation of this?

A. I'm genuinely not sure of a direct mechanism but there is a lot of data to show most patients experience weight gain post-quitting (not all some lose weight particularly if smoking cessation is part of a more generalised health kick) – it is important to acknowledge (a particular issue driving smoking rates in teenage girls) talk about this and ways of maintaining healthy weight and the added health bonuses. The weight gain post-quitting is generally not excessive and brings smokers back to the mean weight for their demographic as a general rule

Q. Can you recommend resources that provide evidence for the different Types of NRT? Inhalators recently taken off our formulary and patients not happy.

A. Not much in the way of head to head comparisons but for estimates of different classes of products please see West R, Owen L (2012) Estimates of 52-week continuous abstinence rates following selected smoking cessation interventions in England. www.smokinginengland.info Version

2. Importantly it should probably be thought of as akin to assessing someone's inhaler technique in asthma – the class of drug is the same (NRT in our case) but being able to correctly use the device is crucial to avoid non-intentional non-adherence. The CURE Manchester experience has been that despite a protocolised approach which advocated a particular short acting product initially (lozenges) they ended up issuing a wide range of different forms of NRT and this choice was crucial.