ROYAL COLLEGE of PHYSICIANS of EDINBURGH

Evening Medical Update: Riddles in Respiratory Medicine
January 2021

Home is where the pleural effusion is; ambulatory management of pleural disease in 2021 – Dr Anna Bibby

Is there any difference in the management of malignant haemorrhagic pleural effusion?

We do not manage haemorrhagic malignant pleural effusion any differently than non-haemorrhagic MPE. Of course, frank haemothorax (usually traumatic or iatrogenic) is a different matter and tends to require surgical intervention and/or wide bore drainage. Haemorrhagic MPE, however, often represents more of a slow ooze from tumour vessels and/or neovascularisation, and so can be managed with either an IPC or talc pleurodesis as with all MPE. You may like to keep an eye on the patients' haemoglobin if they are regularly draining very frank blood from an IPC. There is no formal evidence to suggest that haemorrhagic MPE are more likely to loculate or septate, but anecdotally we think these effusions do tend to clot a bit more frequently the more often they are instrumented, so we really try and go for definitive pleural management as early as possible. There's some interesting early work looking at putting bevacizumab (VEGF antagonist) down pleural catheters to try and "switch off" the inflammatory process driving pleural fluid production in MPE, and conceptually this is all the more appealing in blood-stained MPE as there's clearly some angiogenesis to target as well, but this is a bit further in the future at present!

When did 'fibrosis' get so difficult? A simple guide to interstitial lung disease – Dr Ian Forrest

Is the benefit of anti-fibrotic the same whatever the severity of the disease? Is there any role for a SaO2 during 6 minutes exercise to start anti-fibrotic?

Yes and most importantly the data is there for 'early' stage disease VC>80% where the rate of decline is still halved. When patients are more severely affected VC<50%, whilst these drugs work, often it is the tolerability that limits the 'benefit'. There is no role for exertional desaturation in initiating AF therapy, other than it indicates a poorer prognosis and should be a further prompt to consider transplant referral.

What is your experience/advise on NHFO2 in a deterioration? Our experience is of poor outcomes, but aware there may be symptomatic benefit.

We really like HFNC in AE-IPF as a palliative measure. There is some emergent Japanese data on improved outcomes. However, that is not really the focus, we really believe it is part of palliation and EOLC. Working closely with our regional Home Vent Service has allowed us to get several patient home on domiciliary HFNC for EOLC. More research is needed for sure around HFNC and AE-IPF in general.

Do asbestos plaques provide 100% protection against IPF?

No. It is a challenging dilemma faced each week in the MDT. Plaques are simply markers of some exposure, often minimal. Asbestosis (at least in medico-legal if not biological terms requires high levels of exposure (25 fibre/ml years)). We will often diagnose IPF in those with low levels of exposure and with plaques. Close working with OELD colleagues is vital. The recent IPF-JES work is worth looking up. Where there is equipoise we now tend to favour IPF rather than asbestosis as we can use AF therapies for IPF, and rarely do patients prioritise compensation over treatment.

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