



Gulf Thoracic

مؤتمر الخليج لطب وجراحة الصدر

DUBAI 2014

13-15 MARCH

Grand Hyatt Hotel, Dubai, UAE



The 5th Annual Congress of The Saudi Thoracic Society & The Emirates Allergy and Respiratory Society

Final Program



Organized By:



In Collaboration With:

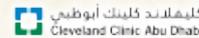
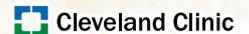


The 16th Annual Meakins-Christie Laboratories International Symposium



Thoracic Oncology Forum TOF2014

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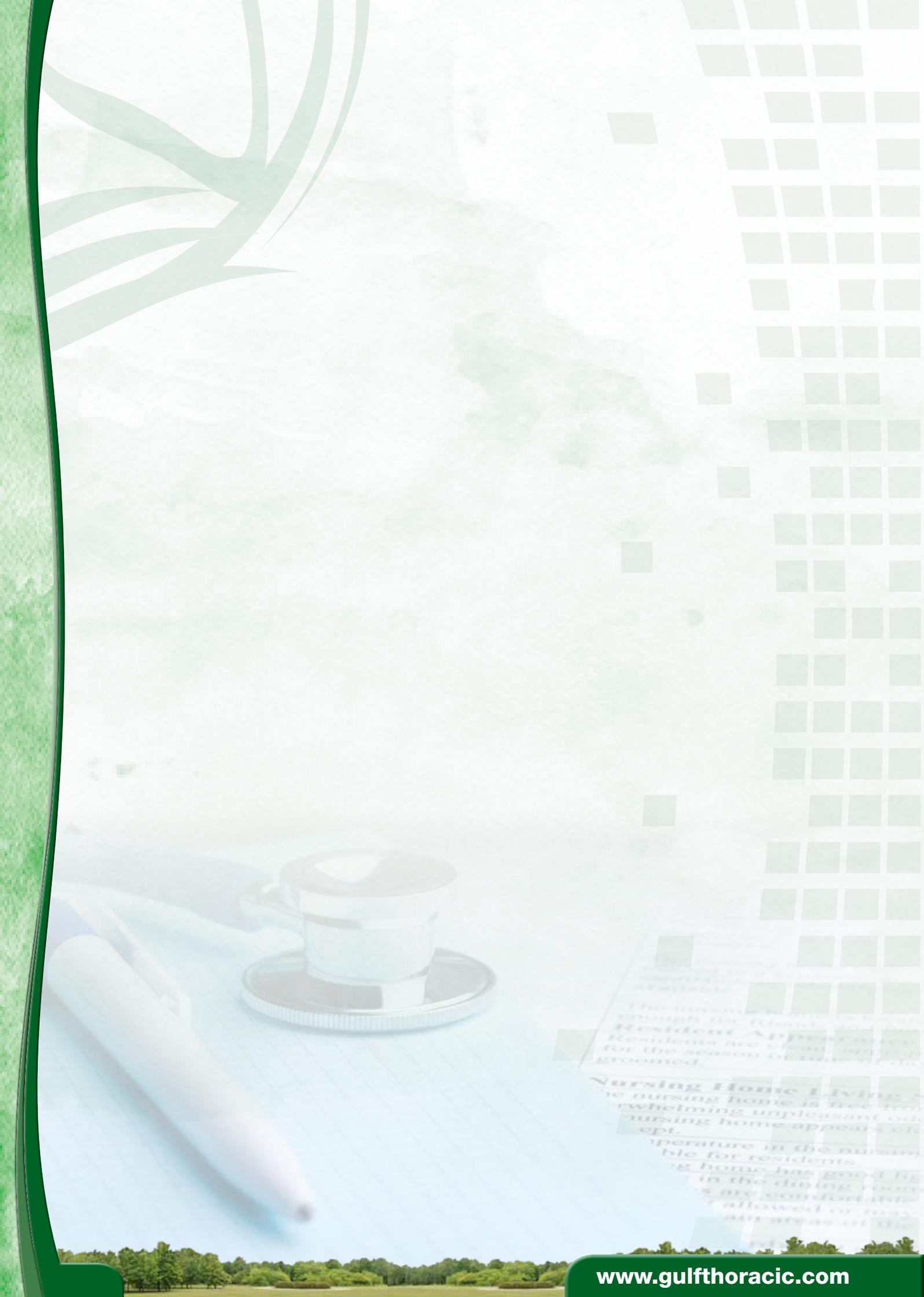




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CHAIRMAN MESSAGE



Dear Colleagues and Friends,

On behalf of the Executive Committee of the GulfThoracic Congress 2014, I would like to extend my warmest welcome to you all, to participate in this international event, which will be held at Grand Hyatt Dubai, UAE on 13-15 March 2014.

The *GulfThoracic Congress 2014* is the fifth joint meeting of the Saudi Thoracic Society (STS), in collaboration with the Emirates Allergy and Respiratory Society (EARS). Collaborating with the American Thoracic Society (ATS), The Pan-Arab Chest Society, The Meakins-Christie Laboratories-McGill University, Canada with special participation from the The Cleveland Clinic Foundation, USA, The Cleveland Clinic Abu Dhabi, The Royal Brompton and Harefield Hospitals, UK, and Papworth Hospital – Part of Cambridge University Health Partners, Cambridge- UK.

By hosting the prestigious annual symposium of the Meakins Christie Laboratories, McGill University, to run simultaneously with the *GulfThoracic Congress* in Dubai is a real testimony of unprecedented proportion for the great achievements made by the *GulfThoracic Congress* over the last few years.

The Scientific Committee is planning a very comprehensive program catering for all specialties of Pulmonary/ Thoracic Medicine that will deliver state of the art lectures, update presentations, postgraduate courses, workshops, panel discussions, interactive sessions, and research abstract presentations. The program covers all fields related to Thoracic Medicine including but not limited to Asthma/ Allergy & immunology, Pulmonary Hypertension, Critical Care Medicine, Lung Cancer, Pulmonary Infections, Thoracic Imaging, Sleep Medicine, Thoracic Surgery, Thoracic Oncology, Respiratory Care, Interstitial Lung Diseases, COPD, Interventional Bronchoscopy, and Pediatric Pulmonology .

The pharmaceutical Industry is also committed in their support of our congress that will host a large exhibit area and many attractive opportunities to share their products and knowledge with the attendees.

Like last year, the Organizing Committee is working hard to make this event a stimulating occasion both scientifically and socially. Undoubtedly, it will be a great opportunity to see other colleagues and friends and to benefit from the wide spectrum of medical topics to be discussed in this congress.

We will meet you in the glamorous city of Dubai, a fast growing beautiful city with many attractions and rich heritage.

For these reasons, we look forward to seeing you in this congress, so please mark your calendar and plan to join us. Your early registration will ensure that you get a lower registration fee and regular updates and information.

My thanks go to everybody who participated in the work for this congress appreciating their dedication, enthusiasm and perseverance to make our congress a great success.

With my best regards,

A handwritten signature in black ink, appearing to be 'MSAH'.

Prof. Mohamed S. Al-Hajjaj MD, FRCP (C)

Chairman, *GulfThoracic Congress 2014*
President, Saudi Thoracic Society
Professor of Pulmonary Medicine & Consultant Pulmonologist
Respiratory Division, Medicine Department
King Saud University & King Khalid University Hospital
Riyadh, Saudi Arabia

SCIENTIFIC COMMITTEE - MESSAGE



Dear Colleagues,

Once again in Dubai ... We would like to welcome you at the the *GulfThoracic Congress "GulfThoracic-2014"* in its 5th year in the period from 13th to 15th March 2014. This annual international multi-disciplinary event is conducted by the Saudi Thoracic Society (STS) and the Emirates Allergy and Respiratory Society (EARS) in collaboration with prestigious institutes: the American Thoracic Society (ATS), USA, the Meakins-Christie Laboratories- McGill University, Canada, the Cleveland Clinic Foundation, USA, the Cleveland Clinic Abu Dhabi, the Royal Brompton and Harefield Hospitals, UK, Papworth Hospital – Part of Cambridge University Health Partners, Cambridge- UK

On this occasion, it is with great honor to welcome you to share and participate in this exciting event. The combined efforts of the organizing and Scientific Committees make this event considered to be of paramount importance to a wide group of clinicians and health specialists. Our scope continues to present up-to-date and comprehensive program for the best benefit of the audience. The scientific program focuses on and ensures covering all specialties of Pulmonary and Thoracic Medicine using state-of-the-art presentations by distinguished international speakers through workshops, symposia, plenary sessions, research sessions and so on.

Educational and scientific sessions are also intended to cover key issues such as COPD, Asthma, Pulmonary Vascular Diseases, Sleep Medicine, Lung Infections, Thoracic surgery and Respiratory Care, etc. The program was developed by engaging different stakeholders in designing the scientific program by receiving proposal that were considered by the scientific committee. The program includes more than 170 activities covered in more than 40 sessions running in 4-5 tracks per a day.

We look forward that all of you have a productive and pleasant time in the astonishing place emerged as a global city and a business hub- the City of Dubai.

Prof. Mohamed S. Al Moamary, MBBS ABIM FRCP (Edin) FCCP

Chairman, Scientific Committee, *GulfThoracic Congress 2014- Dubai*

Vice President, Development and Quality Management,

King Saud bin Abdulaziz University for Health Sciences (KSAU-HS)

Professor & Consultant, Pulmonary Medicine

King Abdulaziz Medical City- Riyadh, Saudi Arabia



MCL - MESSAGE



The 16th Annual Meakins-Christie International Symposium on Asthma and COPD is one of the most popular Respiratory meetings in Canada and the United States. When I started organizing this meeting 17 years ago, I did not imagine that one day it would be held in Dubai. For the third time, this meeting is taking place outside Canada and we are all very excited that this year it will take place in collaboration with the *GulfThoracic Congress* and the American Thoracic Society.

The objective for this meeting was always to spread up to date knowledge and exchange ideas between McGill Respiratory clinicians and researchers with other institutes in and outside North America. We were focussed on basic and translational research in Allergy, Asthma and COPD. However, in the last few years we added new sessions on the changing concept in clinical practice. 50% of our speakers are clinical scientists who are involved in writing guidelines for respiratory diseases. At this year's meeting we have partnered with the *GulfThoracic Congress* and the American Thoracic Society to put together a comprehensive clinical and basic science program that will meet the expectations of audiences from different disciplines and give them the opportunity to interact with faculty members. We are looking forward to interactive sessions and scientific dialogues that will be stimulating to our audience and also constructive and sustainable collaborations between our institute and institutes in the Gulf region.

The Meakins-Christie Laboratories has a 40 year history in Respiratory research and is one of the premier centres in the world with a national and international reputation. We have trained more than 500 fellows from all over the world in respiratory disease and are proud of their achievement and we are happy to accommodate more fellows who are planning to further their career in Respiratory Medicine.

My thanks go out to the President, Executive Director and the chair and members of the scientific organising committees of the *GulfThoracic Congress* for hosting our meeting this year. I would also like to thank the American Thoracic Society staff including the President for collaborating with us to make this meeting a success. I extended my appreciation to all of the sponsors who supported our meeting through the *GulfThoracic Congress*.

I am looking forward to a successful and productive meeting in this beautiful Dubai setting in the United Arab Emirates.

Prof. Qutayba Hamid, MD, PhD, MRCP (UK), FRCP (Canada), FRC Path.

Professor of Medicine
Strauss Chair Respiratory Medicine
Director, Meakins Christie Labs
McGill University
Montreal, Canada



**The 16th Annual Meakins-Christie
Laboratories International Symposium**



Saudi Thoracic Society

الجمعية السعودية لطب وجراحة الصدر

Saudi Thoracic Society (STS) is a scientific foundation and a leading resource for improvement of lung health in Saudi Arabia. Its mission is to promote the prevention, diagnosis, and treatment of chest diseases through leadership, education, research, and communication. STS was established in 2002 and it is affiliated with King Saud University in Riyadh.



SUBSIDIARIES



SINA
Saudi Initiative for Asthma
الجمعية السعودية لربو و الحساسية



SAVTE
SAUDI ASSOCIATION FOR VENOUS THROMBOEMBOLISM
الجمعية السعودية لأمراض وعلاج الجلطات الوريدية



STIG
Saudi Thoracic Imaging Group
الجمعية السعودية لاشعة الصدر



Saudi Critical Care Group
الجمعية السعودية للعناية المركزة

SICAD
The Saudi Initiative for Chronic Airway Disease



GENERAL INFORMATION

Badges:

Name badges must be visible and used at all times, anywhere at the conference venue, and off-site social activities.

Colors:	Description:
Green:	Faculty (all access)
Red:	Delegate (all access, except speaker preview room)
Purple:	Exhibitor (no access to scientific sessions)
Orange:	Staff

CME Certification:

This Congress is accredited by The Saudi Commission for Health Specialties (SCHS) for 30 hours for the main congress. Certificates will be released onsite after filing the congress evaluation forms.

Congress Bags:

Congress bags will be distributed to registered participants at the Registration Desk.

Faculty Registration:

There is a dedicated faculty lounge & preview room for faculty's registration and badge collection and is operational at the same time as the registration desks.

Internet:

There will be wireless internet connection available throughout the Grand Hyatt Dubai.

Food & Beverage:

Coffee breaks and lunch will be open to registered delegates. The hotel also offers a variety of all day dining restaurants to choose from.

Automatic Teller Machines (ATM):

There is an ATM located in the Hotel Lobby

Rules:

Smoking Policy in the Hotel: The entire hotel is non smoking. Mobile Phones- Delegates are kindly requested to keep their mobile phones in the off mode in meeting rooms when scientific sessions are in progress.

Parking:

24 hours valet parking is available at the congress venue.

Prayer Room:

Prayer rooms are available in the Event Centre.

Faculty Lounge & Preview Room:

All speakers are requested to report to the Faculty Lounge & Preview Room (Al Majlis) at least one hour before their lecture, for a final check on presentation material. The Faculty Lounge & Preview Room is available for speaker's convenience throughout the congress for final run-throughs of their presentations.

Evacuation Assembly Point:

In case of an emergency evacuation procedure please proceed in an orderly fashion to the open area in front of the Events Centre. Please follow the instructions of the Hotel Staff Wardens at all times.

ABOUT DUBAI

Dubai - the exotic jewel of the United Arab Emirates. Bordered by deserts and beaches, Dubai provides stark contrasts, from intriguing Islamic culture to the ultra-modern, high-tech metropolis of the 21st century. The city is a magnificent expression of an incredible vision and an uncompromising statement of success and opportunity.

Dubai has something for everyone, from vacationers seeking a relaxing break away from the pressures of work, to business travelers looking for a new exciting experience. The emirate is an international conference, exhibition and leisure destination.

Lying on the calm, blue waters of the southern Gulf and flanked by the majestic desert, Dubai offers year-round sunshine and five-star luxury along with the adventure of a unique Arabian experience.

Dubai is a class destination with all the modern amenities of the western world. It is a fascinating emirate with beautiful buildings, excellent restaurants and nightlife as well as white sandy beaches, culture and history that you can feel as you visit the souks, shopping malls, museums and historic buildings and sites.

Climate

Dubai has a sub-tropical, arid climate. Sunny, blue skies can be expected most of the year. Rainfall is infrequent and irregular, falling mainly in winter. Temperatures range from a low of about 10.5°C /50 °F to a high of 48°C/118.4°F. The mean daily maximum is 24 °C/75.2 °F in January rising to 41°C/105.8 °F in July.

Clothing

Lightweight summer clothing is suitable for most of the year, but sweaters or jackets may be needed for the winter months, especially in the evenings. Compared with certain parts of the Middle East, Dubai has a very relaxed dress code. However, care should be taken not to give offence by wearing clothing which may be considered revealing, for example low-cut dresses, very short skirts, or tight shirt or top in public.

At the pool or on the beaches, trunks, swimsuits and bikinis are quite acceptable. Good quality sunglasses are advised, and photo chromatic lenses for those who wear spectacles. Hats, or some protection for the head, are advisable when in direct sunlight.

Culture & Lifestyle

Dubai's culture is firmly rooted in the Islamic traditions of Arabia. Courtesy and hospitality are among the most highly prized of virtues, and the visitor is sure to be charmed by the genuine warmth and friendliness of the people.

Dubai society is marked by a high degree of tolerance for different lifestyles. Foreigners are free to practice their own religion, alcohol is served in hotels and, provided reasonable discretion is shown, the dress code is liberal. Women face no discrimination and may drive and walk around unescorted.

Despite rapid economic development in recent years, Dubai remains close to its heritage. Local citizens dress in traditional robes and headdress. Arab culture and folklore find expression in poetry, dancing, songs and traditional art. Weddings and other celebrations are colorful occasions of feasting and music. Traditional sports such as falconry, camel racing and dhow racing at sea continue to thrive.

Language & Religion

The official language is Arabic but English is widely spoken and understood. Both languages are commonly used in business and commerce.

Islam is the official religion of the UAE and there are a large number of mosques throughout the city. Other religions are respected and Dubai has two Christian churches, St Mary's (Roman Catholic) and Holy Trinity (inter-denominational).

Photography

Normal tourist photography is allowed, however it is considered offensive to photograph Muslim women. It is also courteous to request permission before photographing men.

Currency

The monetary unit is the dirham which is divided into 100 fils. The dirham is linked to the Special Drawing Right of the International Monetary Fund. It has been held constant against the US dollar since the end of 1980 at a mid-rate of approximately US\$1= Dh3.67.

EXECUTIVE COMMITTEE



Chairman, GulfThoracic Congress

Prof. Mohamed S. Al-Hajjaj, MD, FRCP(C)

President, Saudi Thoracic Society
Professor of Pulmonary Medicine & Consultant Pulmonologist
Respiratory Division, Medicine Department
King Saud University & King Khalid University Hospitals
Riyadh, Saudi Arabia



Chairman, Scientific Committee

Prof. Mohamed S. Al Moamary, ABIM, FRCP(Edin), FCCP

Vice President, Development and Quality Management,
King Saud bin Abdulaziz University for Health Sciences (KSAU-HS)
Editor-in-Chief, Annals of Thoracic Medicine
Riyadh, Saudi Arabia



Chairman, 16th Annual Meakins-Christie-McGill University Conference

Prof. Qutayba Hamid, MD, PhD, MRCP (UK), FRCP (Canada), FRC Path, FRS

Director, Meakins-Christie Laboratories
McGill University
Montréal, Canada



Chairman, 2nd Thoracic Oncology Forum (TOF2014)

Prof. Abdul Rahman Jazieh, MD, MPH

Chairperson, Department of Oncology, King Abdulaziz Medical City
Professor, College of Medicine,
King Saud bin Abdulaziz University for Health Sciences
Riyadh, Saudi Arabia



Chairman, Organizing Committee

Bassam Mahboub, MD, FRCPC

Consultant Pulmonary Medicine,
Asst. Prof., University of Sharjah
Head of Allergy and Respiratory Department, Dubai Hospital
Chair, Emirates Allergy & Respiratory Society
Dubai, UAE



Executive Director, GulfThoracic Congress

Hassan S. Alorainy, BsRC, RRT, FAARC

Executive Director, Saudi Thoracic Society
Senior Clinical Respiratory Specialist
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Doha, Qatar

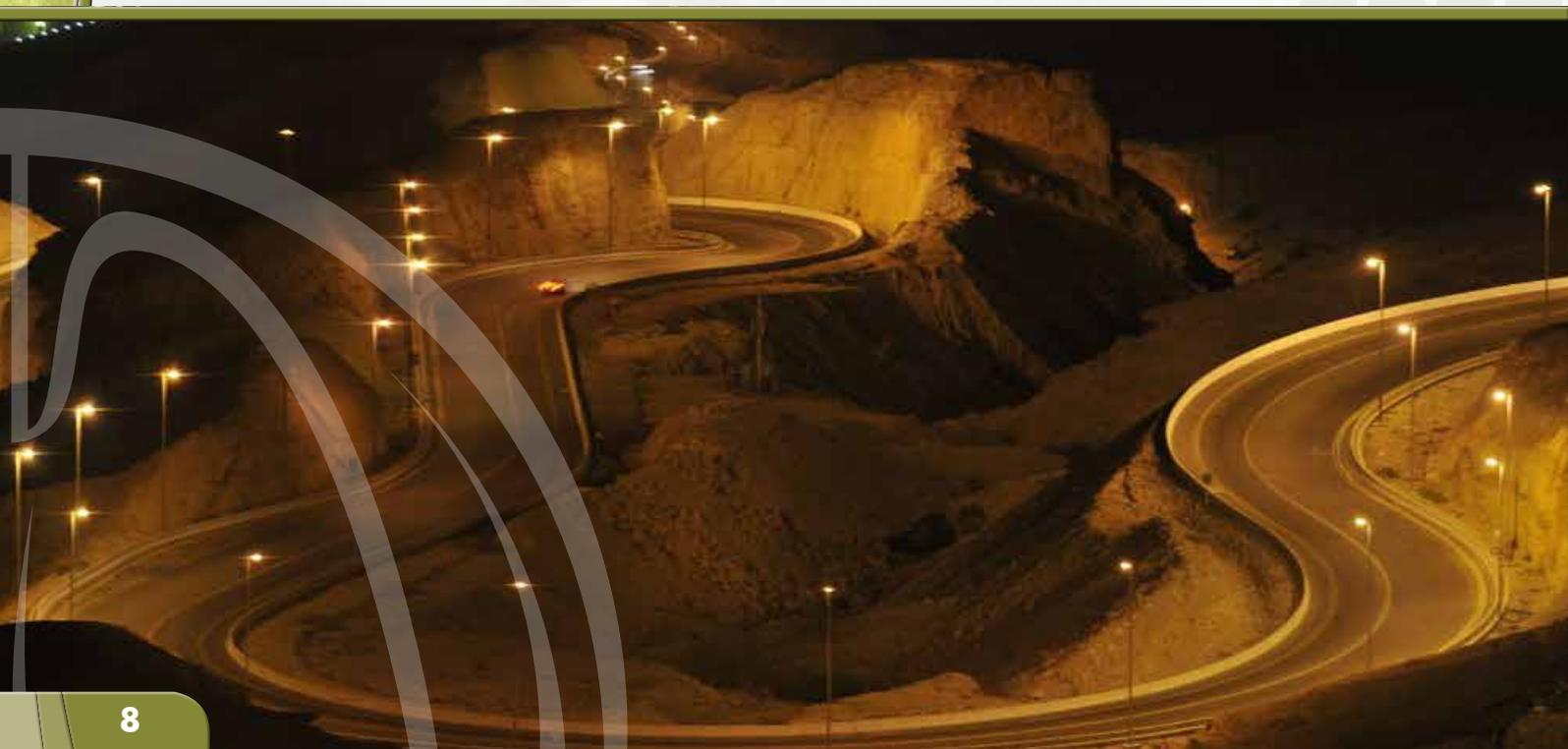


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Saudi Arabia



Member
Waleed Saleh, MD, FRCSI
Saudi Arabia

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SCIENTIFIC COMMITTEE



Chairman, Scientific Committee

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Riyadh, Saudi Arabia



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Qatar



Member

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Member

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Member

Prof. Atul C. Mehta, MBBS, FACP, FCCP
Cleveland, OH, USA



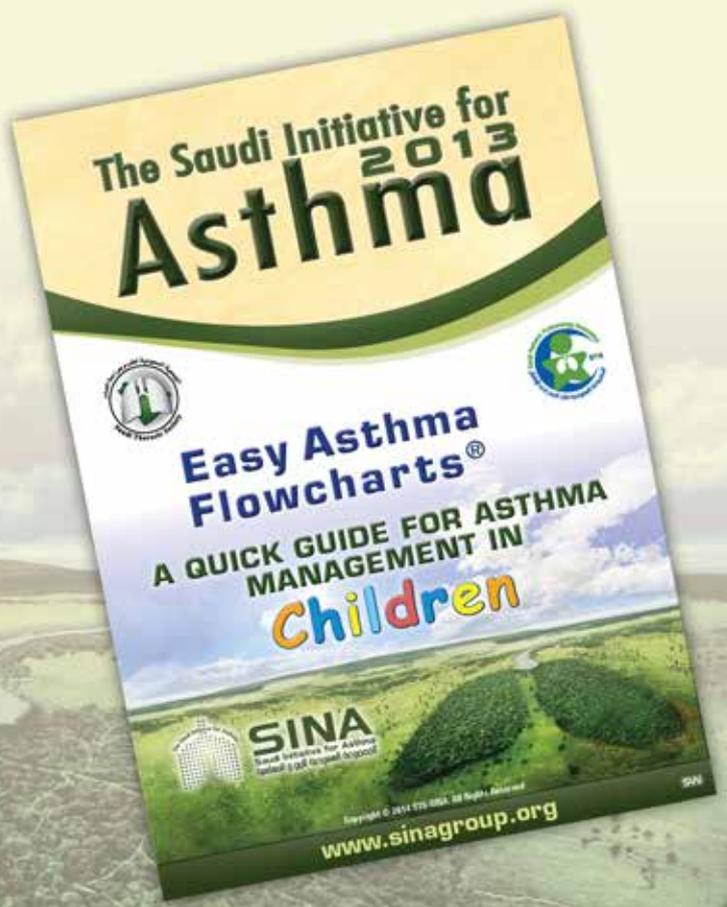
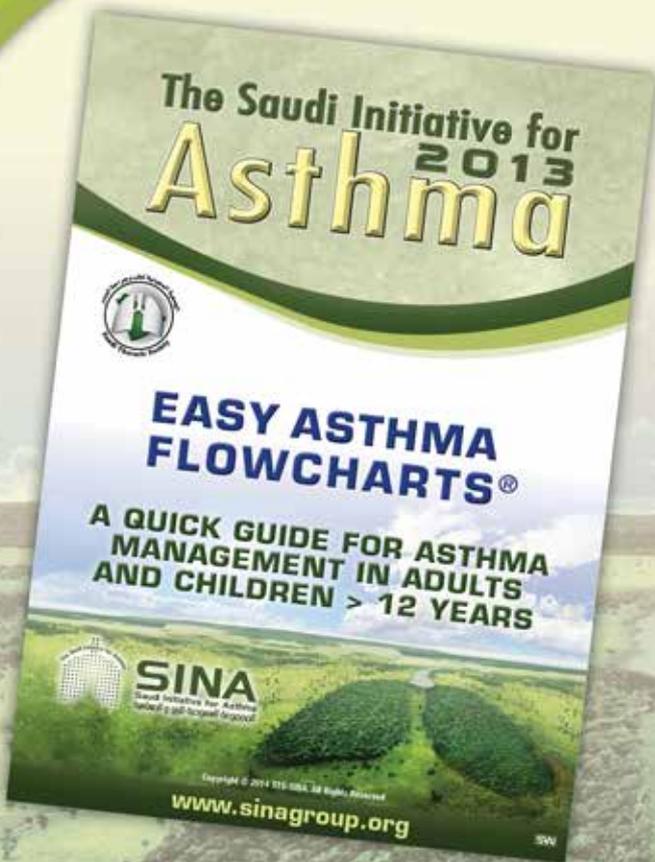
If practicing in Saudi Arabia and would like to acquire **CMEs** from the **SCFHS** you are required to fill the **CME Registration Form** at **STS Booth**.

P.O. Box 109911 Riyadh 11592 Saudi Arabia | Tel: +966-11-4079004 | +966-11-2-888600
Fax: +966-11-4079496 | +966-11-2-887431 | Email: saudi@thoracic.society@yahoo.com

Gulf Thoracic
مؤتمر الخليج لطب وجراحة الصدر
DUBAI 2014
19-20 March 2014 - Grand Hyatt Dubai

Registration Form

First Name: _____
Middle Name: _____
Family Name: _____
Sex/M, FN/Nationality: _____
Present Position: _____
Institution: _____



AVAILABLE FOR DOWNLOAD AT WWW.SINAGROUP.ORG

EASY ACCESS TO SESSIONS

EASY ACCESS BASED ON SESSIONS TYPE

Workshops & Courses

Thursday, 13 March 2014

- W-1** Pediatrics Sleep Medicine
- W-2** How to Get Your Paper Published?
- W-3** Bedside Thoracic Ultrasound
- W-4** Bronchial Hygiene Therapy

Plenary Sessions

Thursday, 13 March 2014

- K-1** The World of Biochips: Past, Present and Future

Friday, 14 March 2014

- M-1** Challenges in the Diagnosis and Management of Asthma

Saturday, 15 March 2014

- M-8** Novel concepts in the diagnosis and management of COPD

Symposia

Thursday, 13 March 2014

- G-2** Pandemic of Respiratory Viral Infections

Friday, 14 March 2014

- T-1** Management of Early Lung Cancer
- M-2** Asthma Co-morbidities - Impact on Management
- G-3** Sleep Disordered Breathing (SDB) in Children
- G-4** Current Update on Respiratory Critical Care
- M-4** Phenotypes and Personalized Medicine in Asthma
- G-5** Mycobacterial diseases and Non-CF Bronchiectasis
- T-3** Advances in Local Management of Thoracic Tumors
- M-6** Asthma and COPD: The Overlap Syndrome
- G-7** Sleep Disorders Medicine: The New Emerging Diseases
- G-8** Advances in Critical Care

Saturday, 15 March 2014

- T-4** Management of Advanced Lung Cancer
- M-10** Exacerbation of COPD and Systemic Manifestation
- G-10** Pulmonary Vascular Diseases: Present and Futures
- G-11** Common Chronic Lung Diseases in Children
- G-13** IPF - Present and Future
- G-14** Advances in Respiratory Care
- M-13** Controversies in Asthma and COPD: Make up Your Mind!

Clinical Sessions

Thursday, 13 March 2014

- G-1** Year in Review

Saturday, 15 March 2014

- T-5** The Multidisciplinary Care of Lung Cancer
- G-12** Challenging Cases in Your Practice
- G-15** Chest imaging in Clinical Practice
- G-16** Board Review

Research Sessions

Friday 14, March 2014

- T-2** Lung Cancer - Regional Experience
- M-3** Basic Research in Asthma
- M-5** Basic Research in Asthma – Remodeling
- G-6** Research Oral Presentations-I
- M-7** Basic Research in Lung Infection

Saturday, 15 March 2014

- G-9** Research Oral Presentations-II
- M-9** Basic Research in COPD
- M-11** Potential Therapies in Asthma and COPD
- M-12** Basic Research in Asthma
- M-14** Basic Mechanisms of Asthma

EASY ACCESS BASED ON ORGANIZING BODIES

GulfThoracic 2014 Sessions

Thursday, 13 March 2014

- W-1** Pediatrics Sleep Medicine
- W-2** How to Get Your Paper Published?
- W-3** Bedside Thoracic Ultrasound
- W-5** Bronchial Hygiene Therapy

Thursday, 13 March 2014

- G-1** Year in Review
- G-2** Pandemic of Respiratory Viral Infections
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- G-9** Research Oral Presentations-II

Saturday, 15 March 2014

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- G-11** Common Chronic Lung Diseases in Children
- G-13** IPF - Present and Future
- G-14** Advances in Respiratory Care
- G-15** Chest Imaging in Clinical Practice
- G-16** Board Review

Thoracic Oncology Forum – STS

Friday, 14 March 2014

- T-1** Management of Early Lung Cancer
- T-2** Lung Cancer - Regional Experience
- T-3** Advances in Local Management of Thoracic Tumors

Saturday, 15 March 2014

- T-4** Management of Advanced Lung Cancer
- T-5** The Multidisciplinary Care of Lung Cancer

The 16th Annual Meakins-Christie-McGill University Conference

Friday, 14 March 2014

- M-1** Challenges in the Diagnosis and Management of Asthma
- M-2** Asthma Co-morbidities - Impact on Management
- M-3** Basic Research in Asthma
- M-4** Phenotypes and Personalized Medicine in Asthma
- M-5** Basic Research in Asthma – Remodeling
- M-6** Asthma and COPD: The Overlap Syndrome
- M-7** Basic Research in Lung Infection

Saturday, 15 March 2014

- M-8** Novel concepts in the diagnosis and management of COPD
- M-9** Basic Research in COPD
- M-10** Exacerbation of COPD and Systemic Manifestation
- M-11** Potential Therapies in Asthma and COPD
- M-13** Controversies in Asthma and COPD: Make up Your Mind!
- M-14** Basic Mechanisms of Asthma

KEYNOTE LECTURE

THE WORLD OF BIOCHIPS: Past, Present and Future

Thursday: 13 March 2014 Time: 19:00- 19:45 Place: Grand Hyatt Dubai



Dr. Hayat S. Sindi, PhD

Founder and CEO, i2 Institute
Member of the Shura Council
Member of the Scientific Advisory Board to the UN Secretary-General
UNESCO Ambassador for Sciences



Dr. Hayat Sindi was born in Makkah, Saudi Arabia. She is one of the world's leading biotechnologists, a member of the Consultative Assembly of Saudi Arabia, a member of the Scientific Advisory Board created by H.E. Mr. Ban Ki-moon, the UN Secretary-General, and the founder and CEO of the i2 Institute for Imagination and Ingenuity, a non-profit organization that seeks to create an ecosystem of entrepreneurship and social innovation for scientists, technologists and engineers in the Middle East.

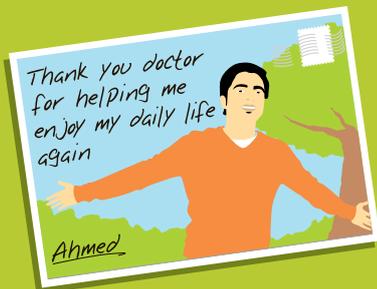
She worked against the odds to become the first female from the Arabian Gulf to earn a PhD in biotechnology, studying at King's College London, Cambridge, MIT and Harvard. Since then, she has been recognized as a National Geographic Emerging Explorer, a Global Ambassador for Vital Voices, and has been listed among the 10 Most Powerful Arab Women by Arabian Business magazine, among the 50 Most Powerful Arabs by Gulf Business Magazine and as one of the world's 150 Fearless Women by Newsweek/The Daily Beast. She was also the first person to be recognized as a Pop!Tech fellow in both Science and Social Innovation. As a global role model in Science, she has been nominated in 2012 and 2013 as a member of the Nifty Fifty program of the prestigious USA Science and Engineering Festival.

In November 2013, Dr. Sindi was awarded the Arabian Business Achievement Award for Medicine. In 2012 H.E. Irina Bokova, Director-General of UNESCO appointed her as the first Goodwill Ambassador for Sciences. Dr. Sindi is also the winner of the Mekkah Al Mukaram prize for Scientific Innovation, given by H.R.H. Prince Khalid bin Faisal Al Saud.

Dr. Sindi is also the co-founder of Diagnostics For All, which offers cost-effective point-of-care diagnostic tools enabling the treatment of 60% of people living beyond the reach of medical infrastructures.



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ABBREVIATED PRESCRIBING INFORMATION:

Symbicort Turbuhaler: 160/4.5 micrograms/inhalation. Inhalation powder. Qualitative and Quantitative Composition: Each delivered dose (the dose that leaves the mouthpiece) contains: budesonide 160 micrograms/inhalation and formoterol fumarate dihydrate 4.5 micrograms/inhalation. Symbicort Turbuhaler 160/4.5 micrograms/inhalation delivers the same amount of budesonide and formoterol as the corresponding Turbuhaler mono-products, i.e. budesonide 200 micrograms/inhalation (metered dose) and formoterol 6 micrograms /inhalation (metered dose) alternatively labelled as 4.5 micrograms /inhalation (delivered dose). Therapeutic Indications: Asthma: Symbicort Turbuhaler is indicated in the regular treatment of asthma, where use of a combination (inhaled corticosteroid and long-acting beta2-agonist) is appropriate; patients not adequately controlled with inhaled corticosteroids and "as needed" inhaled short-acting beta2-agonists or patients already adequately controlled on both inhaled corticosteroids and long-acting beta2 agonists. COPD: Symptomatic treatment of patients with severe COPD (FEV1 < 50% predicted normal) and a history of repeated exacerbations, who have significant symptoms despite regular therapy with long-acting bronchodilators. Posology and method of administration: Asthma: For Symbicort there are two treatment approaches: A. Symbicort maintenance therapy: Symbicort is taken as regular maintenance treatment with a separate rapid-acting bronchodilator as rescue. B. Symbicort maintenance and reliever therapy: Symbicort is taken as regular maintenance treatment and as needed in response to symptoms. Dosage and Administration: A. Symbicort maintenance therapy: Patients should be advised to have their separate rapid-acting bronchodilator available for rescue use at all times. Recommended doses: Adults (18 years and older): 1-2 inhalations twice daily. Some patients may require up to a maximum of 4 inhalations twice daily. Adolescents (12-17 years): 1-2 inhalations twice daily. In usual practice when control of symptoms is achieved with the twice daily regimen, titration to the lowest effective dose could include Symbicort given once daily when in the opinion of the prescriber, a long-acting bronchodilator would be required to maintain control. Increasing use of a separate rapid-acting bronchodilator indicates a worsening of the underlying condition and warrants a reassessment of the asthma therapy. Children (6 years and older): A lower strength is available for children 6-11 years. B. Symbicort maintenance and reliever therapy: Patients take a daily maintenance dose of Symbicort and in addition take Symbicort as needed in response to symptoms. Patients should be advised to always have Symbicort available for rescue use. Symbicort maintenance and reliever therapy should especially be considered for patients with inadequate asthma control and in frequent need of reliever medication; asthma exacerbations in the past requiring medical intervention. Close monitoring for dose-related adverse effects is needed in patients who frequently take high numbers of Symbicort as-needed inhalations. Recommended doses: Adults (18 years and older): The recommended maintenance dose is 2 inhalations per day, given either as one inhalation in the morning and evening or as 2 inhalations in either the morning or evening. For some patients a maintenance dose of 2 inhalations twice daily may be appropriate. Patients should take 1 additional inhalation as needed in response to symptoms. If symptoms persist after a few minutes, an additional inhalation should be taken. Not more than 6 inhalations should be taken on any single occasion. A total daily dose of more than 8 inhalations is not normally needed; however, a total daily dose of up to 12 inhalations could be used for a limited period. Patients using more than 8 inhalations daily should be strongly recommended to seek medical advice. They should be reassessed and their maintenance therapy should be reconsidered. Children and adolescents under 18 years: Symbicort maintenance and reliever therapy is not recommended for children and adolescents. COPD: Adults: 2 inhalations twice daily. Contraindications: Hypersensitivity (allergy) to budesonide, formoterol or inhaled lactose. Undesirable effects: Since Symbicort contains both budesonide and formoterol, the same pattern of undesirable effects as reported for these substances may occur. No increased incidence of adverse reactions has been seen following concurrent administration of the two compounds. Shelf life: 2 years. Special precautions for storage: Do not store above 30°C. Keep the container tightly closed. Further information is available on request from AstraZeneca or local AstraZeneca subsidiaries. Symbicort is a registered trademark owned by the AstraZeneca group of companies. Date of Revision of the Text: 6 October 2006

References:

- GINA Guidelines 2009
- Prescribing information
- P.Kuna et al. International Journal of clinical practice.2007
- Balanag et al.Pulm Pharm Ther 2006;19:139-147
- Van Spiegel & Jenner (1997) Br J Clin Res 8:33-45



1-2 inhalations every morning



extra doses when needed



1-2 inhalations every evening



AstraZeneca Scientific office P.O.Box 17601, Riyadh 11494, Saudi Arabia

Symbicort®
budesonide/formoterol

PRE-CONFERENCE WORKSHOPS & COURSES

Pediatric Sleep Medicine Course

AL DANA
MEETING ROOM

CONDUCTED BY:



PROGRAM DIRECTOR: DR. ADEL S. AL HARBI (KSA)

Rationale: Pediatric Sleep medicine is a rapidly growing specialty in the field of medicine that became an essential specialty service in any clinical or academic institute. Over the past 25 years, this field has expanded and developed in order to diagnose and treat the increasing numbers of different sleep-related disorders. Sleep-disordered breathing in general and more particularly, the Sleep Disordered Breathing is highly prevalent condition in children

Objective

At the end of the course, the attendees are expected to achieve:

- Acquire basic medical knowledge related sleep medicine in children
- Classify Sleep disorders in children
- Elaborate the principles of diagnosis and management of sleep disorders in children
- Elaborate on the use of Non-invasive ventilation in children

Target Audience

- Physicians interested in sleep medicine
- Pulmonologists & Fellows in Training
- Respiratory Therapists & Pulmonary Nurses
- Sleep Technologists

No. Audience: Attendance is limited to **30** participants

Faculty:

David Gozal, MD

Professor and Chairman, Department of Pediatrics, Physician in Chief, Comer Children's Hospital, The University of Chicago, Chicago, IL, USA

Leila Kheirandish-Gozal, MD, MSc,

Associate Professor, Department of Pediatrics, The University of Chicago, Chicago, IL, USA

Anita Simonds, MD

Professor of Respiratory & Sleep Medicine, Royal Brompton Hospital, Imperial College, London, UK

Adel S. Al Harbi, MD

Consultant Pediatric Pulmonary and Sleep Medicine, Director of Pediatric Sleep Disorders Sleep Center, Prince Sultan Military Medical City, Riyadh, Saudi Arabia

Program:

07:30-08:30	Registration
08:30-08:45	Welcome Remarks and course objectives - A. Alharbi
08:45-09:30	Introduction to Pediatric Sleep Medicine A. Alharbi
09:30-10:15	How to set up & score pediatric sleep study - L. Kheirandish-Gozal
10:15-10:45	BREAK
10:45-11:30	Obstructive Sleep Apnea in Children D. Gozal
11:30-12:15	Non Invasive Ventilation in Children A. Simonds
12:15-12:30	Questions and Answers



David Gozal, MD



Anita Simonds, MD



Adel S. Al Harbi, MD



Leila Kheirandish-Gozal,
MD, MSc

PRE-CONFERENCE WORKSHOPS & COURSES

How to Get Your Paper Published?

AL DAR
MEETING ROOM

CONDUCTED BY:

IN COLLABORATION WITH:



PROGRAM DIRECTOR: PROF. ABDUL RAHMAN JAZIEH (KSA)

Rationale: To enhance writing skills and knowledge of participant to improve our regions contribution to the literature.

Objective:

- Learn about the publishing process from inception to print
- Learn about essential components of each manuscript type
- Review practical and useful tips about each manuscript type

Target Audience:

All physicians and healthcare professionals with interest in publishing

No. Audience: Attendance is limited to **20** participants

Faculty:

Prof. Abdul Rahman Jazieh, MD, MPH

King Abdulaziz Medical City, Riyadh, Saudi Arabia

Prof. Semra Bilaceroglu

Dr. Suat Seren Training & Research Hospital for Thoracic Medicine & Surgery, Izmir, Turkey

Prof. Mohamed S. Al-Moamary

King Saud bin Abdulaziz University for Health Sciences, Riyadh, Saudi Arabia

Prof. Atul C. Mehta, MBBS, FACP, FCCP

Staff Physician

Respiratory Institute, Cleveland Clinic

Editor-in-Chief, Journal of Bronchology & Interventional Pulmonology, Cleveland, OH, USA

Program:

07:30-08:30	Registration
08:30-08:35	Welcome Remarks
08:35-09:20	What is the Publishing Process? - A. Jazieh
09:20-10:15	How to Publish an Original Research? S. Bilaceroglu
10:15-10:45	BREAK
10:45-11:15	How to Publish Other Manuscripts? - A. C. Mehta
11:15-12:25	What Editors and Reviewers look for? (Hands on experience) M. Al-Moamary, A. Jazieh, S. Bilaceroglu
	11:15-11:40 – Small groups review of selected manuscripts
	11:40-12:25 – Groups' discussion with the panel
12:25-11:30	Closing Remarks - A. Jazieh



**Abdul Rahman Jazieh,
MD, MPH**



**Semra Bilaceroglu,
MD, FCCP**



**Mohamed S. Al Moamary,
FRCP(Edin), FCCP**



**Atul C. Mehta,
MBBS, FACP, FCCP**

PRE-CONFERENCE WORKSHOPS & COURSES

Bedside Thoracic Ultrasound Course

AL REMAL
MEETING ROOM

CONDUCTED BY:



STIG

Saudi Thoracic Imaging Group
المجموعة السعودية للتصوير الإشعاعي الصدر



PROGRAM DIRECTOR: DR. ALI H. ALTALAG (KSA)

Rationale: To familiarize the Pulmonologists with the use of ultrasound (USS) to diagnose pleura and lung diseases such as pleural effusion and pneumothorax.

Objective:

- Knowledge of basic USS concepts and knobology, image acquisition and interpretation.
- Training using human models and phantom manikins.
- Performance of thoracentesis and small tube drainage placement under USS guidance.

Target Audience:

Pulmonologists, Intensivists, Cardiothoracic Surgeons, Fellows in Training

No. Audience: Attendance is limited to **40** participants

Faculty:

Ali H. Altalag, MD, ABIM

Consultant Pulmonologist, Intensivist & Echocardiographer, Department of Intensive Care Services, Prince Sultan Military Medical City, Riyadh

Mohammed Abdrub Alnabi, MD, SSC-Em, ArBEM, UWO FCCM, ACEP-TF

Emergency & Critical Care Consultant
King Fahad Specialist Hospital- Dammam

Sawsan Alyousef, MD, CABP, FCCP

Consultant, Pediatric Intensivist and Pulmonologist
Children Hospital, King Fahad Medical City, Riyadh

Faiza Al-Talaq, MD

Associate Consultant, Medical Imaging
Dammam, Saudi Arabia

Program:

- 07:30-08:20 Registration
08:20-08:30 Welcome Remarks, A. Altalag
08:30-08:50 Principles of USS and Knobology - F. Al Talaq
08:50-09:10 Focused Thoracic USS and Normal Findings, M. Abdrub Alnabi
09:10-10:15 – First Hands-on session - 20 minutes per station
- **Station 1:** Introduction to USS Machine & Knobology, M. Abdrub Alnabi
 - **Station 2:** USS of the Lower Chest - F. Al Talaq
 - **Station 3:** USS of the Upper Chest - S. Alyousef
- 10:15-10:45 – BREAK**
- 10:45-11:15 Major Thoracic Pathology, USS-Guided Pleural Tap, Pigtail Catheter Insertion, A. Altalag
11:15-12:15 Second Hands-on session - 20 minutes per station
- **Station 1:** Thoracic Pathology on Simulator (VIMEDIX) or Real Patient - S. Alyousef
 - **Station 2:** USS Guided Pleural Tap on Phantom (Sitting Position) - M. Abdrub Alnabi
 - **Station 3:** USS Guided Pigtail Insertion on Phantom (Supine Position) - F. Al Talaq
- 12:15-12:30 Questions and Answers



Ali H. Altalag,
MD, ABIM



Faiza Al-Talaq, MD



Mohammed Abdrub
Alnabi, MD



Sawsan Alyousef,
MD, CABP, FCCP

Air is for everyone



and it's yours to give



Abbreviated Prescribing Information for use in Gulf and Near East Markets based on the Prescribing Information (GDS Version No. 23) and prepared to meet the requirements of the GSK International Pharmaceutical Promotional and Marketing Policy.

SERETIDE™ DISKUS™ Each dose provides: 50 mcg of salmeterol xinafoate and 100, 250 or 500 mcg of fluticasone propionate. **Indications: Asthma:** Regular treatment of asthma where use of a combination product (long-acting beta-2-agonist and inhaled corticosteroid) is appropriate; - patients not adequately controlled with inhaled corticosteroids and 'as needed' inhaled short acting beta-2-agonist or - patients already adequately controlled on both inhaled corticosteroid and long-acting beta-2-agonist. Seretide 50/100 microgram strength is not appropriate in adults and children with severe asthma. **Chronic Obstructive Pulmonary Disease:** Symptomatic treatment of patients with COPD with (FEV1 <60% predicted normal) and a history of repeated exacerbations, who have significant symptoms despite regular bronchodilator therapy. **Posology and Method of Administration:** For inhalation only. Must be used regularly for optimum benefit, even when asymptomatic. Patients should be regularly reassessed by a doctor, so that the strength of Seretide they are receiving remains optimal and is only changed on medical advice. The dose should be titrated to the lowest dose at which effective control of symptoms is maintained, and then the next step could include a test of inhaled corticosteroid alone. Patients requiring a long acting beta-2-agonist could be titrated to Seretide given once daily if it would be adequate to maintain disease control. In the event of once daily dosing when the patient has a history of nocturnal symptoms the dose should be given at night and when the patient has a history of mainly day-time symptoms the dose should be given in the morning. Patients should be given the strength of Seretide containing the appropriate fluticasone propionate dosage for the severity of their disease. Prescribers should be aware that, in patients with asthma, fluticasone propionate is as effective as other inhaled steroids at approximately half the mcg daily dose. If an individual patient requires dosages outside the recommended regimen, appropriate doses of beta-agonist and/or corticosteroid should be prescribed. **Recommended Doses: Asthma:** Adults and adolescents 12 years and older: 1 inhalation of 50 mcg salmeterol and 100, 250 or 500 mcg fluticasone propionate twice daily. A short term trial of Seretide may be considered as initial maintenance therapy in adults or adolescents with moderate persistent asthma for whom rapid control of asthma is essential. In these cases, the recommended initial dose is one inhalation of 50 mcg salmeterol and 100 mcg fluticasone propionate twice daily. Once control of asthma is attained treatment should be reviewed and consideration given as to whether patients should be stepped down to an inhaled corticosteroid alone. Regular review of patients as treatment is stepped down is important. A clear benefit has not been shown as compared to inhaled fluticasone propionate alone used as initial maintenance therapy when one or two of the criteria of severity are missing. Inhaled corticosteroids remain the first line treatment for most patients. Seretide is not intended for the initial management of mild asthma. Seretide 50/100 mcg strength is not appropriate in adults and children with severe asthma; it is recommended to establish the appropriate dosage of inhaled corticosteroid before any fixed combination can be used in patients with severe asthma. Children 4 years and older: 1 inhalation of 50 mcg salmeterol and 100 mcg fluticasone propionate twice daily. The maximum licensed dose of fluticasone propionate in children is 100 mcg twice daily. No data available for use of Seretide in children aged under 4 years. **COPD: Adults:** 1 inhalation of 50 mcg salmeterol and 500 mcg fluticasone propionate twice daily. **Special patient groups:** No need to adjust the dose in elderly patients or in those with renal impairment. No data available for use in patients with hepatic impairment. **Contraindications:** Hypersensitivity to any of the active substances or to the excipient. **Warnings and Precautions:** Management of asthma should follow a stepwise programme and patient response monitored clinically and by lung function tests. Seretide Diskus should not be used to treat acute asthma symptoms for which a fast and short acting bronchodilator is required. Patients should be advised to have their relief medication available at all times. Seretide Diskus is not intended for the initial management of asthma until the need for and approximate dosage of corticosteroids has been established. Patients should not be initiated on Seretide during an exacerbation, or if they have significantly worsening or acutely deteriorating asthma. Sudden and progressive deterioration in control of asthma is potentially life-threatening and the patient should undergo urgent medical assessment. Consideration should be given to increasing corticosteroid therapy. The patient should also be medically reviewed where the current dosage of Seretide has failed to give adequate control of asthma. For patients with asthma or COPD, consideration should be given to additional corticosteroid therapies and administration of antibiotics if an exacerbation is associated with infection. Treatment with Seretide should not be stopped abruptly in patients with asthma due to risk of exacerbation. Therapy should be down-titrated under physician supervision. For patients with COPD cessation of therapy may also be associated with symptomatic decompensation. Seretide should be administered with caution in patients with pulmonary tuberculosis, in patients with severe cardiovascular disorders, heart rhythm abnormalities, diabetes mellitus, thyrotoxicosis, uncorrected hypokalaemia or patients predisposed to low levels of serum potassium. Paradoxical bronchospasm may occur with an immediate increase in wheezing after dosing. Seretide Diskus should be discontinued immediately, the patient assessed and alternative therapy instituted if necessary. Care should be taken when transferring patients to Seretide therapy, particularly if there is any reason to suppose that adrenal function is impaired from previous systemic steroid therapy. The height of children receiving prolonged treatment with inhaled corticosteroid is regularly monitored. Prolonged treatment of patients with high doses of inhaled corticosteroids may result in adrenal suppression and acute adrenal crisis. Children and adolescents <16years taking high doses of fluticasone propionate may be at particular risk. Presenting symptoms are typically vague and may include anorexia, abdominal pain, weight loss, tiredness, headache, nausea, vomiting, hypotension, decreased level of consciousness, hypoglycaemia, and seizures. Additional systemic corticosteroid cover should be considered during periods of stress or elective surgery. The benefits of inhaled fluticasone propionate therapy should minimise the need for oral steroids. Patients who have required high dose emergency corticosteroid therapy in the past may also be at risk. There is also an increased risk of systemic side effects when combining fluticasone propionate with other potent CYP3A inhibitors. Data from a large US study (SMART) suggested that African-American patients may be at greater risk of serious respiratory-related events or deaths when using salmeterol compared to placebo. Caution should be exercised when strong CYP3A4 inhibitors (e.g. ketoconazole) are co-administered with salmeterol. **Interaction with other Medicinal Products and Other forms of Interaction:** Both non-selective and selective beta-blockers should be avoided unless there are compelling reasons for their use. Clinically significant drug interactions mediated by fluticasone propionate are unlikely. Concomitant use of fluticasone propionate and ritonavir should be avoided, unless the potential benefit to the patient outweighs the risk of systemic corticosteroid side-effects. Care is advised when co-administering potent cytochrome P450 3A4 inhibitors as there is potential for increased systemic exposure to fluticasone propionate. **Pregnancy and Lactation:** Only be considered if the expected benefit to the mother is greater than any possible risk to the foetus or child. **Undesirable effects:** Candidiasis of the mouth and throat, Pneumonia, Bronchitis, Cutaneous hypersensitivity reactions, Angioedema, Respiratory symptoms, Anaphylactic reactions, Cushing's syndrome, Cushingoid features, Adrenal suppression, Growth retardation in children and adolescents, Decreased bone mineral density, Cataract, Glaucoma, Hypokalaemia, Hyperglycaemia, Anxiety, sleep disorders and behavioural changes, including hyperactivity and irritability (predominantly in children), Headache, Tremor, Palpitations, Tachycardia, Cardiac arrhythmias (including atrial fibrillation, supraventricular tachycardia and extrasystoles), Nasopharyngitis, Throat irritation, Hoarseness/dysphonia, Sinusitis, Paradoxical bronchospasm, Contusions, Muscle cramps, Traumatic fractures, Arthralgia, Myalgia Overdose: The expected symptoms include tremor, headache, tachycardia, increases in systolic blood pressure and hypokalaemia. The preferred antidotes are cardioselective beta-blocking agents, which should be used with caution in patients with a history of bronchospasm. **Not all presentations are available in every market. Abbreviated Prescribing Information was prepared on 28 April 2008, from GDS version No. 23, Version Date: 04 September 2007.**



GlaxoSmithKline

For full prescribing information please refer to data sheet or contact
GlaxoSmithKline, Gulf and Near East PO Box 50199 Dubai, United Arab Emirates



PRE-CONFERENCE WORKSHOPS & COURSES

Bronchial Hygiene Therapy

AL ITEFAQ
MEETING ROOM

CONDUCTED BY:



PROGRAM DIRECTOR: DR. GHAZI ALOTAIBI (KSA)

Rationale: In patients with pulmonary diseases, mucociliary function and cough mechanism are altered in such a way that compromises patient's ability to expectorate airway secretions. Accumulation of airway and lung secretions leads to chest infection, airway inflammation, and abnormal lung function. Research has shown that early intervention with the proper airway clearance technique can reduce morbidity and mortality in patients with lung diseases.

Objective:

At the end of this workshop, participants are expected to:

- Understand normal airway clearance mechanisms.
- Discuss factors that can impair normal lung expansion and expectoration of pulmonary secretions.
- Identify types of patients in need for bronchial hygiene therapy.
- Understand indications and uses of lung expansion techniques.
- Understand indications and uses of airway clearance techniques.
- Choose the proper bronchial hygiene technique.

Target Audience:

Respiratory Therapists, Nurses, Pulmonologists, and General Practitioners

No. Audience: Attendance is limited to **20** participants

Faculty:

Ghazi Alotaibi, PhD, RRT

Dean, College of Applied Medical Sciences
University of Dammam- Saudi Arabia

Hatem Qutub, MD, FCCP

Prof. and Consultant Intensivist and Pulmonologist
King Fahad University Hospital, University of Dammam

Abdulatif Alhuzaim, MSRC, RRT

College of Applied Medical Sciences, University of
Dammam, Dammam, Saudi Arabia

Ahmed Masehali, BsRC, RRT

King Fahad Medical City, Riyadh, Saudi Arabia

Zahra Zawawi, BsRC

King Fahad University Hospital, University of Dammam

Program:

07:30-08:30	Registration
08:30-08:45	Welcome Remarks, G. Alotaibi
08:45-09:15	Introduction to BHT: Physiological Bases, H. Qutub
09:15-09:45	Lung Expansion Therapy, Z. Zawawi
09:45-10:15	Airway Clearance Therapy, A. Masehali
10:15-10:45	BREAK
10:45-12:15	Hands on Sessions, 30 min each
	Station 1: Chest Physical Therapy, A. Alhuzaim
	Station 2: Lung Expansion Techniques, Z. Zawawi
	Station 3: Airway Clearance Techniques, A. Masehali
12:15-12:30	Questions and Answers



Ghazi Alotaibi,
PhD, RRT



Hatem Qutub,
MD, FCCP



Abdulatif Alhuzaim,
MsRC, RRT



Ahmed Masehali,
BsRC, RRT



Zahra Zawawi,
BsRC

DAY 1 - THURSDAY, 13 MARCH 2014

Registration 07:30-18:00

Opening Remark 14:00-14:30

Location: Baniyas 2 Hall

14:30-16:30 SESSIONS

G-1- Clinical: Year in Review

(GulfThoracic Congress Scientific Program - 2014)

Location: Baniyas 2 Hall

Rationale: A panel of experts will present the most recent updated scientific evidence available in the literature. The session covers four major areas of great interest for health care professionals. These areas are drugs and genes, Interventional bronchoscopy, sleep medicine, and critical care medicine.

Chairpersons: Abdullah Al Dalaan (KSA)
Mirza Al Sayegh (UAE)

Program:

14:30-15:00 **Interventional Bronchoscopy**
Atul C. Mehta, Cleveland Clinic Foundation, Cleveland, OH, USA

15:00-15:30 **Sleep Medicine**
David Gozal, University of Chicago Medical Center, Chicago, IL, USA

15:30-16:00 **Critical Care Medicine**
Herbert Wiedemann, Cleveland Clinic Foundation, Cleveland, OH, USA

16:00-16:30 **Genes and Drugs**
Joanna Pepke Zaba, Cambridge Centre for Lung Infection, Papworth Hospital, Cambridge, UK

16:30-17:00 COFFEE BREAK & EXHIBITION (BANIYAS 1)

17:00-18:30 SESSIONS

G-2- Symposium: Pandemic of Respiratory Viral Infections

(GulfThoracic Congress Scientific Program - 2014)

Location: Baniyas 2 Hall

Rationale: In response to the pandemic respiratory viral infections, this session covers the pandemic of viral infections in the region and their prevention. It also brings the audience to advanced areas in the management of severe cases like non-invasive ventilation and issues related to critical care stay.

Chairpersons: Hamdan Al Jahdali (KSA)
Joudy Bahous (Lebanon)

Program:

17:00-17:30 **MERS Corona Virus Pandemic**
Ali Albarrak, Prince Sultan Medical and Military City, Riyadh, Saudi Arabia

17:30-18:00 **Pulmonary Imaging in Viral Pneumonia**
Abdullah M. Al Jebreen, King Faisal Specialist Hospital & Research Center, Riyadh, KSA

18:00-18:30 **Role of Non-Invasive Ventilation in Pandemic Respiratory Tract Infection**
Anita K Simonds, Royal Brompton & Harefield NHS Foundation Trust, London, UK

Opening Ceremony 18:30-19:00

Location: Baniyas 2 Hall

Keynote Lecture 19:00-19:45



K-1 The World of Biochips: Past, Present and Future

Dr. Hayat Sindi, Founder & CEO, i2 Institute, Member of the Shura Council, Member of the Scientific Advisory Board to the UN Secretary-General. UNESCO Ambassador for Sciences

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ASTHMA & COPD FORUM **ACF2014**

The 12th Annual Conference of the Saudi Thoracic Society

Date: Friday, 19 September 2014

Venue: TBA | Time: 16:00 - 21:00

ORGANIZED BY:



SINA
Saudi Initiative for Asthma
المبادرة السعودية للربو و المساسية



TARGET AUDIENCE:

- Adult Pulmonologists
- Pediatric Pulmonologists
- Allergists & Immunologists
- Internist
- Primary Care Physicians
- Intensivists
- Fellows in Training
- Residents
- Pharmacists
- Researchers in the field
- Respiratory Therapists
- Technologists
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DAY 2 - FRIDAY, 14 MARCH 2014

Registration: 07:30-08:30

08:30-10:10 SESSIONS

M-1 Plenary: Challenges in the Diagnosis and Management of Asthma

(Annual Meakins-Christie-McGill University Conference)

Location: Baniyas 2 Hall

Rationale: Update physicians' knowledge on the latest in asthma pathophysiology, use of biomarkers and current and future therapies

Chairpersons: Patricia Finn (USA)
Mohamed Al-Hajjaj (KSA)

Program:

08:30-08:55 **Changing Concept of Asthma Pathophysiology**

Qutayba Hamid, McGill University, Montreal, QC, Canada

08:55-09:20 **Challenges in Asthma Diagnosis and Role of Biomarkers**

Parameswaran Nair, McMaster University, Hamilton, ON, Canada

09:20-09:45 **Challenges in Current Management of Asthma: Do We Need New Therapies?**

Paul O'Byrne, McMaster University, Hamilton, ON, Canada

09:45-10:10 **Asthma in the Middle East: What are the Challenges?**

Majdy M. Idrees, Prince Sultan Medical and Military City, Riyadh, Saudi Arabia

T-1 Symposium: Management of Early Lung Cancer

(Thoracic Oncology Forum - 2014)

Location: Alameera 2 Hall

Rationale: This session covers the roles of various interventions in the treatment of early lung cancer such as surgery and radiotherapy techniques. It also covers the functional imaging (PET SCAN) as part of

the comprehensive approach of patients with lung cancer. After discussion of these aspects, the new classification of lung cancer pathology will be presented.

Moderators: Sara Al Ghanem (KSA)
Fouad Al Dayel (KSA)

Program:

08:30-08:55 **PET-CT for Lung Cancer – Current Utility**

Simon Padley, Royal Brompton & Harefield NHS Foundation Trust, London, UK

08:55-09:20 **New Frontier for Surgical Interventions in Lung Cancer**

Aman Coonar, Cambridge Centre for Lung Infection, Papworth Hospital, Cambridge, UK

Moderators: Khaled Al Kattan (KSA)
Azzam Khankan (KSA)

09:20-09:45 **Imaging Guided Treatments for Lung Tumors – Current Practice**

Simon Padley, Royal Brompton & Harefield NHS Foundation Trust, London, UK

09:45-10:10 **Value Driven Care in Lung Cancer Management**

Sudish Murthy, Cleveland Clinic Foundation, Cleveland, OH, USA

10:10-10:30 **COFFEE BREAK & EXHIBITION (BANIYAS 1)**

10:30-11:45 SESSIONS

M-2 Symposium: Asthma Co-morbidities- Impact on Management

(Annual Meakins-Christie-McGill University Conference)

Location: Baniyas 2 Hall

Rationale: Discuss the co-morbidity of asthma development and its effect on the course of the disease

Chairpersons: Basil Petrof (Canada)
Bassam Mahboub (UAE)

Program:

10:30-10:55 **Asthma and Obesity**

James Martin, McGill University, Montreal, QC, Canada

10:55-11:20 **Asthma and Sleep Apnea**

Atul Malhotra, University of California in San Diego, La Jolla, CA, USA

DAY 2 - FRIDAY, 14 MARCH 2014

11:20-11:45 **Asthma in the Elderly**
Nizar Jarjour, University of Wisconsin,
Madison, WI, USA

G-3 Symposium: Sleep Disordered Breathing (SDB) in Children

(GulfThoracic Congress Scientific Program - 2014)

Location: Baniyas 3 Hall

Rationale: Pediatric Sleep medicine is a rapidly growing specialty that received a significant attention in clinical institutes. This session covers selected topics in SDB as the management of these disorders has moved beyond the traditional approach.

Chairpersons: Fatma Aljassim (UAE)
Saleh Al Harbi (KSA)

Program:

10:30-10:55 **Pediatric OSA: Time for Personalized Approaches**

David Gozal, University of Chicago Medical Center, Chicago, IL, USA

10:55-11:20 **Anti-inflammatory Therapy in Children with OSA**

Leila Kheirandish-Gozal, University of Chicago Medical Center, Chicago, IL, USA

11:20-11:45 **Obesity and SDB in Children**

Baha AlShawwa, Habib Medical Group, Riyadh, Saudi Arabia

T-2 Research: Lung Cancer - Regional Experience

(Thoracic Oncology Forum - 2014)

Location: Alameera 3 Hall

Rationale: There is a growing interest about lung cancer in the region. This session enriches the participants with the regional experience of lung cancer guidelines development. It will also include selected top abstracts of research generated from the region.

Moderator: Sami Khatib (Jordan)
Adda Bounedjar (Algeria)

Program:

10:30-11:00 **New Classification of Lung Cancer**

Fouad Al Dayel, King Faisal Specialist Hospital & Research Center, Riyadh, KSA

Moderator: Ashwaq Al Olayan (KSA)
Amged Sherif (UAE)

11:00-11:15 **Selected regional research will be announced**

11:15-11:30 **Selected regional research will be announced**

11:30-11:45 **Selected regional research will be announced**

M-3 Research: Basic Research in Asthma

(Annual Meakins-Christie-McGill University Conference)

Location: Alameera 2 Hall

Rationale: To discuss the latest in basic and translational research in asthma

Chairpersons: Qutayba Hamid (Canada)

Program:

10:30-10:50 **Eosinophil activation loci and total serum IgE concentration: An epigenome-wide association study**

Catherine Laprise, University of Quebec in Chicoutimi, QC, Canada

10:50-11:10 **Non-Invasive Assessment of Airway Dynamics in Early Life**

Peter D. Sly, Queensland Children's Medical Research Institute, Brisbane, Australia

11:10-11:30 **Th2 Cells: Key to Severe Asthma**

Lisa Cameron, University of Alberta, Edmonton, AB, Canada

11:30-11:50 **Vertical transmission of respiratory viruses. A new paradigm for childhood asthma**

Giovanni Piedimonte, Cleveland Clinic Children's Hospital, Cleveland, OH, USA

11:50-12:10 **Gut-residing bacteria regulate IL-17A-dependent exacerbation of asthma**

Marsha Wills-Karp, Johns Hopkins University, Baltimore, MD, USA

12:10-12:40 **MicroRNAs and Regulation of Airway Epithelium in Severe Asthma**

Jamila Chakir, Laval University, Québec City, QC, Canada

DAY 2 - FRIDAY, 14 MARCH 2014

G-4 Symposium: Current Update on Respiratory Critical Care

(GulfThoracic Congress Scientific Program - 2014)

Location: Alameera 1 Hall

Rationale: There has been recent significant advancement in mechanical ventilation. This session covers the newer modes of ventilation delivered by highly sophisticated mechanical ventilators that is coupled by patient ventilator synchrony as well. Further, the session also brings to the audience the recent advancement in high-flow oxygen that is considered as an innovative approach that challenged the traditional use low-flow oxygen therapy.

Chairpersons: Ghazi Al Otaibi (KSA)
Soror Al Aithan (KSA)

Program:

10:30-10:55 **Unconventional Modes of Mechanical Ventilation: An Update**

William Andrews, Almafraaq Hospital, Abu Dhabi, UAE

10:55-11:20 **Evidence Based Approaches to Patient Ventilator Synchrony**

Shoug Al Humoud, University of Dammam, Dammam, KSA

11:20-11:45 **High Flow Oxygen Therapy: Breaching the Myths**

Tariq Al Jasser, King Faisal Specialist Hospital and Research Centre, Riyadh, KSA

11:45-13:30 FRIDAY PRAYER, LUNCH, & EXHIBITION (BANIYAS 1)

13:30-15:35 SESSIONS

M-4 Symposium: Phenotypes and Personalized Medicine in Asthma

(Annual Meakins-Christie-McGill University Conference)

Location: Baniyas 2 Hall

Rationale: To update our knowledge with the new concept of asthma phenotypes and discuss the potential of tailoring asthma therapies

Chairpersons: David Eidelman (Canada)
Kheder Al Zahrani (KSA)

Program:

13:30-13:55 **Immunological Phenotypes**

Patricia Finn, University of Illinois at Chicago, Chicago, IL, USA

13:55-14:20 **Clinical Phenotypes**

Richard Leigh, University of Calgary, Calgary, AB, Canada

14:20-14:45 **Severe Asthma: Is it a Distinct Phenotype?**

Kian Fan Chung, Imperial College London, London, UK

14:45-15:10 **Tailoring Asthma Therapy**

Paul O'Byrne, McMaster University, Hamilton, ON, Canada

15:10-15:35 **All that wheezes isn't asthma**

Robert Schellenberg, University of British Columbia, Vancouver, BC, Canada

G-5 Symposium: Mycobacterial Diseases and Non-CF Bronchiectasis

(GulfThoracic Congress Scientific Program - 2014)

Location: Baniyas 3 Hall

Rationale: These two disease entities are interlinked. The session includes controversial topics that face health care professional on a daily basis. Special management issues in managing patients with bronchiectasis and interesting topics related to mycobacterial diseases are covered.

Chairpersons: Abdulaziz Alzeer (KSA)
Emad Kowatli (UAE)

Program:

13:30-13:55 **Update on Bronchiectasis: Assessment and Management**

Michael Loebinger, Royal Brompton Hospital and Imperial College, London, UK

13:55-14:20 **Nebulised Antibiotic Therapy in Non-CF Bronchiectasis**

Charles Haworth, Cambridge Centre for Lung Infection, Papworth Hospital, Cambridge, UK

14:20-14:45 **Surgical Management of Bronchiectasis**

Aman Coonar, Cambridge Centre for Lung Infection, Papworth Hospital, Cambridge, UK

DAY 2 - FRIDAY, 14 MARCH 2014

- 14:45-15:10 **Immunomodulating Effect of Anti-Tuberculous Drugs**
Atef Shibl, King Saud University, Riyadh, KSA
- 15:10-15:35 **Non-Tuberculous Mycobacterial Diseases**
Michael Loebinger, Royal Brompton Hospital and Imperial College, London, UK

T-3 Symposium: Advances in Local Management of Thoracic Tumors *(Satellite symposium conducted by Cleveland Clinic Abu Dhabi in collaboration with the Thoracic Oncology Forum - 2014)*

Location: Alameera 2 Hall 

Rationale: A panel of experts presents various local management approaches to certain tumors such as bronchoscopic management of tracheobronchial tumors, management of early esophageal cancer and thymic tumors. They also cover the role of screening of lung cancer and video assisted thoroscopic surgery as well.

Moderator: Johannes Bonatti (UAE)
Rédha Souilamas (UAE)

Program:
13:30-13:55 **Bronchoscopic Management of Tracheobronchial Tumors**
Atul Mehta, Cleveland Clinic Foundation, Cleveland, OH, USA

13:55-14:20 **Early Esophageal Cancer: Endoscopic and Minimally Invasive Surgery**
Sudish Murthy, Cleveland Clinic Foundation, Cleveland, OH, USA

14:20-14:45 **Lung Cancer: Screening, Staging and Surgical Management**
Rédha Souilamas, Cleveland Clinic Abu Dhabi, Abu Dhabi, UAE

14:45-15:10 **VATS segmentectomy for Lung Cancer: Indications, outcomes and techniques**
Sudish Murthy, Cleveland Clinic Foundation, Cleveland, OH, USA

15:10-15:35 **Management of Thymic Tumors**
Rédha Souilamas, Cleveland Clinic Abu Dhabi, Abu Dhabi, UAE

M-5 Research: Basic Research in Asthma - Remodeling

(Annual Meakins-Christie-McGill University Conference)

Location: Alameera 3 Hall

Rationale: To discuss the latest in basic and translational research in remodeling

Chairpersons: Mara Ludwig (Canada)

Program:
13:30-13:50 **Pericytes: A New Player in Airway Remodeling**
Jill Johnson, National Heart & Lung Institute, London, UK

13:50-14:10 **Smooth Muscle-Myofibroblast Transition in Asthma**
Margaret Kelly, University of Calgary, Calgary, AB, Canada

14:10-14:30 **Modulation of the fast (+)insert SMMHC in the central and peripheral equine asthmatic airways**

Jean-Pierre Lavoie, University of Montreal, Montreal, QC, Canada

14:30-14:50 **Smooth muscle mechanics in airway hyperresponsiveness and asthma**

Anne-Marie Lauzon, McGill University, Montreal, QC, Canada

14:50-15:10 **Rhinovirus infection of airway epithelium facilitates airway smooth muscle migration**

Richard Leigh, University of Calgary, Calgary, AB, Canada

15:10-15:30 **What does innate immunity, differentiation and fibrosis have in common? Clues from the multifunctional protein p300**

Darryl Knight, University of Newcastle, Callaghan, Australia

DAY 2 - FRIDAY, 14 MARCH 2014

G-6 Research: Oral Presentations-I

(*GulfThoracic Congress Scientific Program - 2014*)

Location: Alameera 1 Hall

Rationale: The objective of *GulfThoracic* is not limited to present the most recent evidence. It is also extended to promote research in the region by opening the opportunity for researchers to present their work to experts from all over the world.

Chairpersons: Feisal Al-Kassimi (KSA)
Alaa Gouda (KSA)

Program:

- | | |
|-------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 13:30-14:00 | EXPERT INTRO LECTURE
How Would You Turn an Abstract into a Publication?
Ahmed BaHammam, King Saud University, Riyadh, KSA |
| 14:00 | ICU Admissions: To Refuse Or Not To Refuse. An Evaluation Of Risk Factors Associated With Poor Outcomes. - Abid Butt (USA) |
| 14:10 | Prevalence Of Venous Thrombo-Embolism & Related Morbidity And Mortality Among Hospitalized Patients In Saudi Arabia (SAVTE Study) - Essam Aboelnazar (KSA) |
| 14:20 | Accuracy Of Doppler Echocardiography Estimates Of Pulmonary Artery Pressures At King Faisal Specialist Hospital & Research Center, Riyadh Saudi Arabia. - Imran Nizami (KSA) |
| 14:30 | Early Predictor Of Septic Shock In Patients Admitted To The Medical Floor With Pneumonia- A Quality Project - Maryam Ali Al Nesf (Qatar) |
| 14:40 | Epidemiological And Clinical Presentation Of Middle East Respiratory Syndrome Coronavirus (MERS-CoV)
Ahmed Ibrahim (KSA) |
| 14:50 | 10 Years Experience Of Surgical Management Of Bronchiectasis - 1
Amer Bilal (Pakistan) |
| 15:00 | A Diagnostic Approach To Undiagnosed Pleural Exudates
Enas M Batubara (South Africa) |
| 15:10 | Improving The Quality Of Life For Ambulatory Patients With Advance Lung Cancer Through Phone Triaging - Abdulaziz Aljohani (KSA) |

15:20

Chest Wall Resection And Reconstruction For Primary Malignant Tumors: Indications, Techniques, And Outcome
Hadi Mutairi (KSA)

15:35-16:00

COFFEE BREAK & EXHIBITION (BANIYAS 1)

16:00-18:00 SESSIONS

M-6 Symposium: Asthma and COPD: The Overlap Syndrome

(*Annual Meakins-Christie-McGill University Conference*)

Location: Baniyas 2 Hall

Rationale: Discuss the overlap between Asthma and COPD and the new concept of the overlap syndrome

Chairpersons: Paul O'Byrne (Canada)
Abdullah Al-Mobeireek (KSA)

Program:

- | | |
|-------------|--------------------------------------------------------------------------------------------------------------------|
| 16:00-16:25 | Physiology Overlap
David Eidelman, McGill University, Montreal, QC, Canada |
| 16:25-16:50 | Pathophysiology Overlap
Peter Barnes, Imperial College London, London, UK |
| 16:50-17:15 | COPD: A cardiometabolic disorder?
Leonardo Fabbri, University of Modena and Reggio Emilia, Modena, Italy |
| 17:15-17:40 | Treating Patients with the Overlap Syndrome
Ronald Olivenstein, McGill University, Montreal, QC, Canada |

G-7 Symposium: Sleep Disorders Medicine: The New Emerging Diseases

(*GulfThoracic Congress Scientific Program - 2014*)

Location: Baniyas 3 Hall

Rationale: The management of sleep disorders has moved beyond traditional management. It is not any more treated as a single disease entity; it rather has a new emerging dimension though interaction with other disease entities. This session covers the relationship of sleep disorders with obesity, hyper-reactive airways, and diabetes mellitus.

DAY 2 - FRIDAY, 14 MARCH 2014

Chairpersons: Alaa Ghabashi (KSA)
Abdulaziz Al Hashemi (Qatar)

Program:
16:00-16:25 **Health Consequences of Nocturnal Hypoxia in Obese Patients with OSA**
Mohammed Al Bader, Kuwait

16:25-16:50 **Sleep Apnea and Obstructive Airway Diseases: Interactions and Outcomes**
Irvin Mayers, University of Alberta, Edmonton, AB, Canada

16:50-17:15 **Diabetes and Sleep Apnea, Not So Sweet!**
Leila Kheirandish-Gozal, University of Chicago Medical Center, Chicago, IL, USA

G-8 Symposium: Advances in Critical Care

(GulfThoracic Congress Scientific Program - 2014)

Location: Alameera 2 Hall

Rationale: Critical care is a rapidly changing field. The session covers selected areas that health care workers encounter challenges such as near fatal asthma, ARDS, Sepsis syndrome, and role of bronchoscopy in the ICU interesting.

Chairpersons: Ahmed Al Jabbari (KSA)
Fahad Al Hameed (KSA)

Program:
16:00-16:25 **ARDS: Current Views and Management**
Herbert Wiedemann, Cleveland Clinic Foundation, Cleveland, OH, USA

16:25-16:50 **New Modalities in Treating Near Fatal Asthma**
Abdulaziz Alzeer, King Saud University, Riyadh, KSA

16:50-17:15 **Sepsis Syndrome: 2013**
Herbert Wiedemann, Cleveland Clinic Foundation, Cleveland, OH, USA

M-7 Research: Basic Research in Lung Infection

(Annual Meakins-Christie-McGill University Conference)

Location: Alameera 3 Hall

Rationale: To discuss the latest in basic and translational research in lung infection

Chairperson: David Proud (Canada)

Program:
16:00-16:20 **Eicosanoids and Pulmonary Infectious Diseases**
Maziar Divangahi, McGill University, Montreal, QC, Canada

16:20-16:40 **Influenza-Induced Pulmonary Pathology is Mitigated by STAT6-IP Treatment**
Christine McCusker, McGill University, Montreal, QC, Canada

16:40-17:00 **TBC**

17:00-17:20 **Role of Rhinoviruses in Asthma: An Update**
David Proud, University of Calgary, Calgary, AB, Canada

17:20-17:40 **Regulation of Immune Function at Gut Interface: Identification of Factors Required for Prevention of Allergic and Gastrointestinal Disease in Humans - Meri Tulic**, University of Nice Sophia- Antipolis, Nice, France

17:40-18:00 **CCR2 and TLR4 Reveal the Importance of Innate Immunity in Dystrophic Diaphragm Pathology**
Basil Petrof, McGill University, Montreal, QC, Canada

DAY 2 - FRIDAY, 14 MARCH 2014

G-9 Research: Oral Presentations-II

(GulfThoracic Congress Scientific Program - 2014)

Location: Alameera 3 Hall

Rationale: The objective of GulfThoracic is not limited to present the most recent evidence. It is also extended to promote research in the region by opening the opportunity for researchers to present their work to experts from all over the world.

Chairpersons: Abdullah Alkhenizan (KSA)
Zouhair Harb (UAE)

Program:

16:00-16:25 **EXPERT INTRO LECTURE**
Methodology is the Method for Good Research
Omar Al Rawas, Sultan Qaboos University, Muscat, Oman

16:25 **The Prevalence Of Uncontrolled Asthma Among Children In NGHIA In Riyadh And Their Parents Preference For Seeking Asthma Management Strategies.**
Hessa Alotaibi (KSA)

16:35

Pollen Sensitization Profiles Of Allergic Patients In A Middle European Region
Petr Panzner (Czech Republic)

16:45

Nasal Spirometry: A New Approach For Spirometry To Evaluate Respiratory Functions
Noha Nassef (KSA)

16:55

Derivation and Clinical Validation of A Simple Mathematical Formula to Predict Changes in Blood PaCO₂ and pH Values
Ghazi Alotaibi (KSA)

17:05

Measurement Properties Of An Arabic Version Of The Dyspnea-12 Questionnaire For Saudi Nationals With Chronic Obstructive Pulmonary Disease (COPD)
Mohammed Mahdi Alyami (Australia)

17:15

Precision In Diagnosing And Classifying COPD: Comparison Of Historical Height With Current Height And Arm Span To Predict FEV1. - Khalid Aziz Ansari (KSA)



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DAY 3 - SATURDAY, 15 MARCH 2014

Registration: 07:30-08:30

08:30-10:15 SESSIONS

M-8 Plenary: Novel concepts in the diagnosis and management of COPD

(Annual Meakins-Christie-McGill University Conference)

Location: Baniyas 2 Hall

Rationale: Update our knowledge of the pathogenesis, physiology, and management of COPD

Chairpersons: Gerard Cox (Canada)
Sulaiman Al Majed (KSA)

Program:

08:30-08:55 **New Concepts in Pathophysiology: Role of Autophagy**
Nicola Hanania, Baylor University, Houston, TX, USA

08:55-09:20 **COPD Phenotypes**
Ronald Dandurand, McGill University, Montreal, QC, Canada

09:20-09:45 **Are there any new therapies for COPD in the pipeline?**
Peter Barnes, Imperial College London, London, UK

09:45-10:10 **COPD in the Gulf Region: The Disease of the Future?**
Ashraf H. Alzaabi, Zayed Military Hospital, Abu Dhabi, UAE

T-4 Symposium: Management of Advanced Lung Cancer

(Thoracic Oncology Forum - 2014)

Location: Alameera 2 Hall

Rationale: This session covers various topics that would normally create a dilemma for health care professionals such as the potential curable cases of Stage IV and new endocrine tumors. It also covers updates on systemic therapy and future directions of advanced lung cancer management.

Moderator: Turki Al Fayae (KSA)
Hamad Hussein (KSA)

Program:

08:30-08:55 **Potentially Curable Stage IV Lung Cancer**
Khaled Al Kattan, King Faisal Specialist Hospital & Research Centre, Riyadh, KSA

08:55-09:20 **Update on Systemic Therapy of Lung Cancer - Hassan Jaafar**, Tawam Hospital- John Hopkins Medicine, Al Ain, UAE

Moderator: Mohammad Abdulatief (KSA)
Abdulmohsin Zakari (KSA)

09:20-09:45 **Pathology of Lung Neuroendocrine Tumors**
Walid Khalbuss, King Abdulaziz Medical City, Riyadh, Saudi Arabia

09:45-10:10 **Lung Cancer Guidelines**
Ahmed Saadeddin, King Abdulaziz Medical City, Riyadh, KSA

M-9 Research: Basic Research in COPD

(Annual Meakins-Christie-McGill University Conference)

Location: Alameera 3 Hall

Rationale: To discuss the latest in basic and translational research in COPD

Chairpersons: Richard Leigh (Canada)

Program:

08:30-08:50 **Aryl Hydrocarbon Receptor-Dependent Retention of Nuclear H₂ suppresses Cigarette Smoke-induced Inflammation**
Carolyn Baglole, McGill University, Montreal, QC, Canada

08:50-09:10 **Novel Aspects of Skeletal Muscle Dysfunction in COPD Patients - Sabah Hussain**, McGill University, Montreal, QC, Canada

DAY 3 - SATURDAY, 15 MARCH 2014

09:10-09:30 **Mechanisms of Cigarette Smoke- Induced Immune Subversion and Restitution**
Martin Stämpfli, McMaster University, Hamilton, ON, Canada

09:30-09:50 **Emphysema Progression Assessed by Quantitative CT Analysis in Japanese COPD patients - Shigeo Muro**, Kyoto University, Kyoto, Japan

09:50-10:10 **The Breathe Study**
Marie-Louise Coussa-Koniski, Lebanese American University, Beirut, Lebanon

10:10-10:15

ANNALS OF THORACIC MEDICINE AWARDS FOR BEST RESEARCH

10:15-10:45 COFFEE BREAK & EXHIBITION (BANIYAS 1)

10:45-12:25 SESSIONS

M-10 Symposium: Exacerbation of COPD and Systemic Manifestation

(Annual Meakins-Christie-McGill University Conference)

Location: Baniyas 2 Hall

Rationale: To discuss the recent knowledge in management of COPD exacerbation and the systemic manifestation of COPD

Chairpersons: Parameswaran Nair (Canada)
Ibrahim Janahi (Qatar)

Program:

10:45-11:10 **Can We Predict and Prevent Exacerbations?**
Nicola Hanania, Baylor University, Houston, TX, USA

11:10-11:35 **Exacerbations of respiratory symptoms in patients with COPD may not be exacerbations of COPD**
Leonardo Fabbri, University of Modena and Reggio Emilia, Modena, Italy

11:35-12:00 **Smoking cessation program in the Middle East: A success or a failure story**

Feras Hawari, King Hussein Cancer Foundation, Amman, Jordan

12:00-12:25 **The Bold Study: New Data and New Concepts of COPD in the Gulf Region**

Mohamed Al-Ghobain, King Saud bin Abdulaziz University for Health Sciences, Riyadh, KSA

G-10 Symposium: Pulmonary Vascular Diseases: Present and Future

(GulfThoracic Congress Scientific Program - 2014)

Location: Baniyas 3 Hall

Rationale: The field of pulmonary vascular disease is rapidly progressing and challenging. This session covers an update of the most recent evidence and progress for pulmonary arterial hypertension

Chairpersons: AbdulGhafoor Gari (KSA)
Mohammad Bader (UAE)

Program:

10:45-11:10 **PH Therapy; New Developments**
Abdullah Aldalaan, King Faisal Specialist Hospital and Research Center, Riyadh, KSA

11:10-11:35 **Current Management Approach to Patients with Pulmonary Arterial Hypertension**

Joanna Pepke Zaba, Papworth Hospital, Cambridge, UK

11:35-12:00 **Current and Novel Biomarkers in Pulmonary Arterial Hypertension**

Raed Dweik, Cleveland Clinic, Cleveland, OH, USA

12:00-12:25 **Diagnosis and Management of Chronic Thromboembolic Pulmonary Hypertension**

Joanna Pepke Zaba, Papworth Hospital, Cambridge, UK

DAY 3 - SATURDAY, 15 MARCH 2014

T-5 Clinical: The Multidisciplinary Care of Lung Cancer

(Thoracic Oncology Forum - 2014)

Location: Alameera 2 Hall

Rationale: Team approach is essential in the management of lung cancer; hence, selected cases with high educational values will be presented and discussed to reflect the multidisciplinary care provided to these cases. A panel of experts discusses these cases that include pathologist, radiologist, surgeon, radiation oncologist, medical oncologist, and others.

Panel Members: Khaled Al Kattan (KSA)
Medhat Fares (KSA)
Hanaa Bamefleh (KSA)
Shukri Loutfi (KSA)
Hassan Jafaar (UAE)
Abdulrahman Al Hadab (KSA)
Adnan Hebshi (KSA)
Hamdan Al Jahdali (KSA)

Program:
10:45-12:25 **The forum will be conducted by Prof. Abdulrahman Jazieh, King Abdulaziz Medical City, Riyadh, Saudi Arabia**

M-11 Research: Potential Therapies in Asthma and COPD

(Annual Meakins-Christie-McGill University Conference)

Location: Alameera 3 Hall

Rationale: To discuss the latest in basic and translational research in asthma and COPD

Chairpersons: Meri K. Tulic (France)

Program:
10:45-11:05 **Semaphorin3E as a Novel Therapeutic Target in Allergic Asthma - Soussi Gounni,** University of Manitoba, Winnipeg, MB Canada

11:05-11:25 **Role of PGE2-EP2 axis in allergic airway inflammation and remodeling**
Marc Peters-Golden, University of Michigan, Ann Arbor, MI, USA

11:25-11:45 **Reciprocal Interactions between IL-13 and IL-17 in the Lungs**

Elizabeth Fixman, McGill University, Montreal, QC, Canada

11:45-12:05 **Kca3.1 Channels: A Novel Insight into the Mechanisms Regulating Steroid Insensitivity in Asthma**

Yassine Amrani, University of Leicester School of Medicine, Leicester, UK

12:05-12:25 **Selective antagonists targeting the eosinophil chemoattractant 5- oxo-ETE**

William Powell, McGill University, Montreal, QC, Canada

12:25-12:45 **Immunomodulation of allergic diseases -**

Mark Larché, McMaster University, Hamilton, ON, Canada

G-11 Symposium: Common Chronic Lung Diseases in Children

(GulfThoracic Congress Scientific Program - 2014)

Location: Alameera 1 Hall

Rationale: In this session the panel of experts will explore the most recent updated scientific evidence available in the literature in the fascinating field of pediatric pulmonary medicine. It will also provide practical information on major subjects of great interest for pediatricians in chronic lung diseases in children.

Chairpersons: Hussain Al Kindy (Oman)
Ali Ibrahim (Bahrain)

Program:
10:45-11:10 **Early Origins of Cystic Fibrosis**
Thomas Ferkol, Washington University School of Medicine in St. Louis, St Louis, MO, USA

11:10-11:35 **Bronchopulmonary Dysplasia: An Update**
Ahmed Abushahin, Hamad General Hospital, Doha, Qatar

DAY 3 - SATURDAY, 15 MARCH 2014

11:35-12:00 **Prevention of allergic respiratory disease in infants: current aspects and future perspectives-** **Peter D. Sly**, Queensland Children's Medical Research Institute, Brisbane, Australia

12:00-12:25 **Pediatric Pulmonary Services in Saudi Arabia**
Abdullah Yousef, University of Dammam, Dammam, KSA

12:25-14:00 LUNCH AND EXHIBITION (BANIYAS 1)

14:00-15:40 SESSIONS

G-12 Clinical: Challenging Cases in Your Practice

(GulfThoracic Congress Scientific Program - 2014)

Location: Baniyas 2 Hall

Chairpersons: Mohammed Zeitouni (KSA)

Program:
14:00-14:33

CASE 1 **Acute Pulmonary Hypertension, Rare Cause**

Presenter: Salman Abdulaziz (UAE)

Master Radiologist:
Abdullah Al Jebreen (KSA)

Master Pathologist:
Fouad Al Dayel (KSA)

Master Clinicians:
Herbert Wiedemann (USA)

14:33-15:06

CASE 2 **All That Glitters Is Not Gold**

Presenter: Ahmed Alaini (Qatar)

Master Radiologist:
Abdullah Al Jebreen (KSA)

Master Pathologist:
Walid Khalbuss (USA)

Master Clinicians:
Ahmed Saadeddin

15:06-15:40 **CASE 3**
Medical Therapy For Pulmonary Aneurysm

Presenter: Hussam Sakkijha (KSA)

Master Radiologist:
Abdullah Al Jebreen (KSA)

Master Pathologist:
Fouad Al Dayel (KSA)

Master Clinicians:
Majdy Idrees (KSA)

G-13 Symposium: IPF - Present and Future

(GulfThoracic Congress Scientific Program - 2014)

Location: Baniyas 3 Hall

Rationale: IPF is a progressive and fatal disease with an average life expectancy of 3 years. This session covers a wide spectrum of considerable advances that has provided useful information in determining the best way to assess and treat patients with IPF.

Chairpersons: Battal Al Dosary (KSA)
Sanaa Al Mutairi (Kuwait)

Program:

14:00-14:25 **Pathogenesis of IPF, what's new?**
Marc Peters-Golden, University of Michigan, Ann Arbor, MI, USA

14:25-14:50 **Diagnostic Approach and the Importance of Early Diagnosis of IPF**
Jeffrey T. Chapman, Cleveland Clinic, Abu Dhabi, UAE

14:50-15:15 **Clinical Management Update**
Martin Kolb, McMaster University, Hamilton, ON, Canada

15:15-15:40 **Pirfenidone Treatment in IPF: Saudi Experience**
Esam Alhamad, King Saud University, Riyadh, KSA

M-12 Research: Basic Research in Asthma

(Annual Meakins-Christie-McGill University Conference)

Location: Alameera 3 Hall

Rationale: To discuss the latest in basic and translational research in asthma

DAY 3 - SATURDAY, 15 MARCH 2014

Chairpersons: Dr. Sabah Husain (Canada)

Program:

14:00-14:20 **Regulation of Protease-Activated Receptor-2 expression on the Airway Epithelium: Role in Asthma**
Harissios Vliagoftis, University of Alberta, Edmonton, AB, Canada

14:20-14:40 **CCL17 Production by Dendritic Cells is Required for NOD1-Mediated Exacerbation of Allergic Asthma**
Anne Tsicopoulos, Pasteur de Lille Institute, France

14:40-15:00 **Phosphatase SHP-1 Regulation of Pulmonary Granulomatous Disease**
Zhou Zhu, Yale University, New Haven, CT, USA

15:00-15:20 **Abnormal lung matrix: Cause or consequence of pulmonary fibrosis?**
Martin Kolb, McMaster University, Hamilton, ON, Canada

15:20-15:40 **Microbiome of the Lung**
David Perkins, University of Illinois Chicago, IL, USA

G-14 Symposium: Advances in Respiratory Care

(GulfThoracic Congress Scientific Program - 2014)

Location: Alameera 1 Hall

Rationale: There has been major advancement in the care of patients in the ICU. This session covers various topics of bronchoscopy in the ICU as a diagnostic and therapeutic tool and advancement in airway clearance. It also addresses the new treatment modalities for chronic and acute hypercapnia.

Chairpersons: Abdulaziz Alotaibi (KSA)
Mustafa Itani (Lebanon)

Program:

14:00-14:25 **Pulmonary Rehabilitation – Regional Perspective**
Mohamed S. Al-Moamary, King Saud bin Abdulaziz University for Health Sciences, Riyadh, KSA

14:25-14:50 **Bronchoscopy in the ICU - Efficacy & Safety**
Semra Bilaceroglu, Dr. Suat Seren Training & Research Hospital for Thoracic Medicine & Surgery, Izmir, Turkey

14:50-15:15 **Current Approaches to Airway Clearance**
Bashair Alfozan, University of Dammam, Dammam, KSA

15:15-15:40 **Extracorporeal CO2 Removal: Procedure and Efficacy**
Omar Al Zumaie, King Abdulaziz Medical City, Riyadh, KSA

15:40-16:00 COFFEE BREAK & EXHIBITION (BANIYAS 1)

16:00-17:15 SESSIONS

M-13 Symposium: Controversies in Asthma and COPD: Make up Your Mind! *(Annual Meakins-Christie-McGill University Conference)*

Location: Baniyas 2 Hall

Rationale: Debate controversial issues in the diagnosis and management of asthma and COPD

Chairpersons: Prof. Peter Barnes (UK)
Fatma Al Huraish (Kuwait)

Program:

16:00-16:25 **Nitric Oxide: Measurement in Asthma. Is it a Valid Tool?**
Raed Dweik, Cleveland Clinic, Cleveland, OH, USA

16:25-16:50 **Thermoplasty: Is it Really an Effective Treatment? Do We Need to Do More Research Before We Introduce it to Our Practice?**
Gerard Cox, McMaster University, Hamilton, ON, Canada

16:50-17:15 **Education in Asthma and COPD: Why Did We Fail? How Practical to Introduce?**
Renata Rea, Credit Valley Hospital, Mississauga, ON, Canada

DAY 3 - SATURDAY, 15 MARCH 2014

G-15 Clinical: Chest imaging in Clinical Practice

(GulfThoracic Congress Scientific Program - 2014)

Location: Baniyas 3 Hall

Rationale: This session introduces the audience to a variety of imaging techniques in clinical practice. This will include role of ultrasonography in Pleural disease, utilization of thoracic CT in CAP, and practical aspects of lung biopsy from the point of view of a radiologist.

Chairpersons: Atul Mehta (USA)
Rakesh Chawla (India)

Program:

- 16:00-16:25 **Evaluation of Pleural Space by Ultrasonography**
Ajit Moghekar, Cleveland Clinic Foundation, Cleveland, OH, USA
- 16:25-16:50 **Role of CT Chest in Community Acquired Pneumonia**
Abdullah M. Al Jebreen, King Faisal Specialist Hospital & Research Center, Riyadh, KSA
- 16:50-17:15 **Lung Biopsy – How I Do It?**
Simon Padley, Royal Brompton & Harefield NHS Foundation Trust, London, UK

M-14 Research: Basic Mechanisms of Asthma

(Annual Meakins-Christie-McGill University Conference)

Location: Alameera 3 Hall

Rationale: To discuss the latest in basic and translational research in asthma

Chairpersons: Maziar Divangahi (Canada)

Program:

- 16:25-16:50 **Group 2 Innate Lymphoid (ILC2) Cells Mediate Ozone-Induced Exacerbation of Allergic Airway Inflammation**
Angela Haczku, University of Pennsylvania, Philadelphia, PA, USA

16:50-17:15 **The Atopic March: Progression from Eczema to Asthma**

Tao Zheng, Yale University, New Haven, CT, USA

17:15-17:40 **Dynamic Characteristics of IL-25-Induced Airways Inflammation & Remodeling: Comparison with Classic Murine Model of Asthma**
Sun Ying, King's College London, UK

17:40-17:50 **Closing Remarks of the 16th Annual Meakins-Christie-McGill University Conference**
Qutayba Hamid, McGill University, Montreal, QC, Canada

G-16 Clinical: Board Review

(GulfThoracic Congress Scientific Program - 2014)

Location: Alameera 1 Hall

Rationale: Practicing health-care physicians are faced with controversies in their clinical practice. A panel of experts will address these issues in common conditions to address the concerns raised on day-to-day practice. The update in these topics would also of academic debate especially for those preparing for their board examination.

Chairpersons: Hatem Al Ameri (UAE)
Mohamed Al Marri (Qatar)

Program:

- 16:00-16:25 **Mediastinal Mass**
Ahmed Al-Johany, King Abdulaziz University, Jeddah, KSA
- 16:25-16:50 **Non-resolving Pneumonia**
Walid Mahmood, Rashid Hospital, Dubai, UAE
- 16:50-17:15 **Pulmonary Embolism in Clinically Unstable Patient**
Ibrahim F. Hassan, Hamad Medical City, Doha, Qatar

CLOSING REMARKS 17:15-17:30
BANIYAS 2

INTRODUCING

SAUDI GUIDELINES FOR THE DIAGNOSIS AND MANAGEMENT OF COPD

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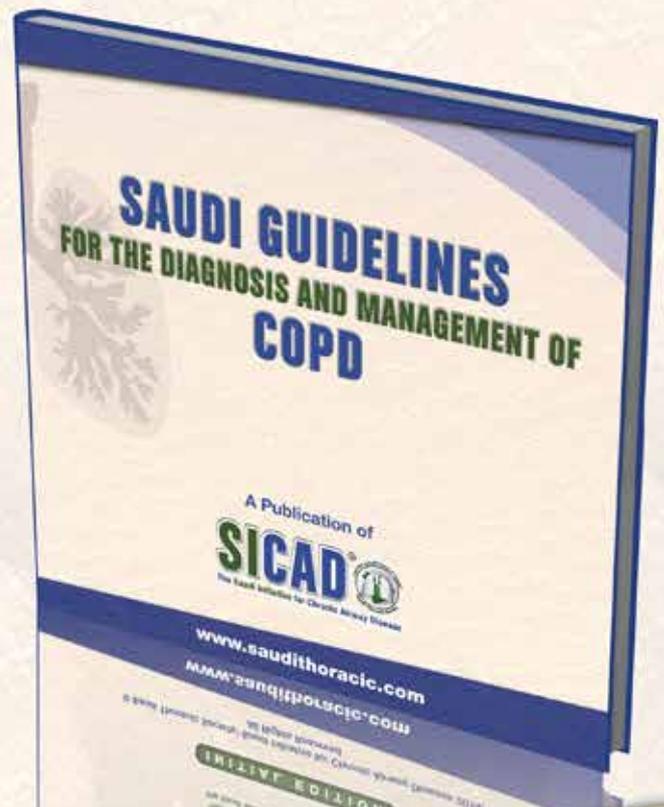
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FACULTY - PROFILE



Yassine Amrani, MD

Associate Professor of Respiratory Immunology
University of Leicester School of Medicine
Leicester, UK

Dr. Yassine Amrani is a trained respiratory pharmacologist who graduated "summa cum laude" from the University of Strasbourg, France. Dr. Amrani started his academic career at the University of Pennsylvania School of Medicine in Philadelphia, one of the top Ivy League Universities in the USA, where he received his first appointment at the Department of Medicine in 2002.

In 2007, he moved to the University of Leicester School of Medicine in the UK where he currently holds a tenured Readership (Associate Professor) in Respiratory Immunology. He is a member of the Institute for Lung Health (Glenfield Hospital).

Throughout his career, Dr Amrani has developed a strong interest in the immunopathogenesis of lung diseases including severe asthma and COPD with a particular emphasis on the role of tumor necrosis factor alpha (TNF). Dr Amrani's main goal is to develop translational "bench-to bedside" approaches that could be used for the development for more effective therapies in the treatment of these diseases. Dr Amrani was the first in the field to have suggested the novel concept that inflammation, by directly altering the function of airway smooth muscle via the action of pro-asthmatic cytokines such as TNF and IL-13, contributes to the impaired lung function in asthma. This hypothesis was later confirmed in different clinical trials showing that anti-TNF (mab infliximab or fusion protein etanercept) or anti-IL-13 (lebrikizumab) therapies lead to improvement of disease condition in severe asthmatics. In more recent years, Dr Amrani's interest shifted at understanding the mechanisms explaining the refractoriness of severe asthmatics to current therapies. His group has uncovered different inflammatory conditions present in severe asthma that dramatically reduce the therapeutic efficacy of corticosteroids and Beta2-agonists (work in progress).



William Andrews MD FRCPC

Chairman, Critical Care Medicine
Mafraq Hospital
Abu Dhabi, UAE

Dr. William (Bill) Andrews was born in Hamilton, Canada, where it is much colder than here, and received all of his undergraduate training in London, Canada, at the University of Western Ontario. His postgraduate medical training occurred at New York University (Anaesthesia) and the University of Western Ontario (Critical Care Medicine). He, and his wife Carmel, called the Middle East home for 10 years (five in Abu Dhabi at Sheikh Khalifa Medical Centre), leaving in 2004 while Bill pursued a Masters degree in Management (Harvard). Recent posts have included Executive Medical Director for Critical Care at Memorial Hermann in Houston and Critical Care Fellowship Program Director at Wake Forest University. Now Bill and Carmel are back in the UAE, with Bill holding the post of Chairman of Critical Care Medicine at Mafraq Hospital in Abu Dhabi. Being an Anaesthetist, Bill has a special interest in airway management, and annually teaches at the ACCP Chest meeting in the Simulation Centre. Other interests include quality improvement, sepsis management and mechanical ventilation (and running and golf).



Prof. Yaseen Arabi, MD, FCCP, FCCM

Chairman, Intensive Care Department
Medical Director, Respiratory Services
Assistant Professor, King Saud Bin Abdulaziz
University for Health Sciences
Riyadh Saudi Arabia

Chairman, Intensive Care Department, Medical Director, Respiratory Services, Associate Professor, College of Medicine, King Saud Bin Abdulaziz University for Health Sciences, King Abdulaziz Medical City Riyadh, Kingdom of Saudi Arabia.

Dr. Arabi obtained his Internal Medicine Training at Wayne State University, Detroit, MI, USA (1992-1994), then he was the Chief Medical Resident at the same institution (1994-1995). He obtained pulmonary and critical care training at the University of Wisconsin, Madison, WI, USA (1995-1998). In 1998, he joined King Abdulaziz Medical City, Riyadh, Saudi Arabia. He is currently the Chairman of the Intensive Care Department and the Medical Director, Respiratory Services. He is also the member of several institutional committees including being the Deputy Chairman of Research Committee as well as a member of several international committees for the Society of Critical Care Medicine (SCCM) and the American College of Chest Physician (ACCP). He is also a member of the administrative board of the Saudi Society of Critical Care.

He received multiple grants and awards and has been an investigator on several multicenter international trials including the Lung Open Ventilation Study (LOVS), The Use of Non-Invasive Ventilation in Post Extubation Failure, DECompressive CRAniectomy trial DECRA (multi-center prospective randomized trial), and Management of Severe Sepsis in Asia's Intensive Care Units — the MOSAIC study, the PROphylaxis of ThromboEmbolism in Critical Care Trial (PROTECT), and OSCILLation for ARDS Treated Early (OSCILLATE) among others. He has more than 80 publications including articles in the New England Journal of Medicine (NEJM), JAMA, Lancet, and Critical Care Medicine. He has been a reviewer for more than 12 international journals as well as granting agencies.



Mohammad Albader, MD

Respiratory Consultant
Head of Respiratory Department in Alrashed
Allergy Center
Head of Sleep Unit
Kuwait

- Graduated from Kuwait school of medicine 1994
- Finished my residency in internal medicine at university of British Columbia 2000 then did my follow ship in respiratory medicine 2002 and respiratory sleep medicine in the same university 2003
- Involved currently in research about sleep apnea prevalence in Kuwait Cpap compliance in Kuwait

FACULTY - PROFILE



Carolyn J. Baglole, MD

Assistant Professor
Departments of Medicine and Pathology
Division of Experimental Medicine
Meakins-Christie Laboratories
Montreal, Canada

- Runs a research laboratory dedicated to understanding the cellular and molecular pathogenesis of cigarette smoke-induced respiratory diseases (COPD, lung cancer)
- Lectures in Environmental Carcinogenesis, Cytokines in Disease, Cellular Methods in Medical Research and Advanced Topics in Respiration
- Member of the Society of Toxicology, Society of Toxicology of Canada and American Thoracic Society
- Invited scientific reviewer for Toxicology and Applied Pharmacology, Journal of Allergy, Respiratory Physiology and Neurobiology, International Journal of Environmental Research and Public Health, Nanotoxicology, Clinical and Experimental Allergy, Pulmonary Pharmacology and Therapeutics, Plos One, Tobacco-Induced Diseases, BMC Research Notes and Toxicology and Industrial Health



Prof. Ahmed S. BaHamam, MD, FRCP, FCCP

Professor of Medicine
Consultant Pulmonary and Sleep Medicine
Director, University Sleep Disorders Center
Chairman, Institutional Review Board
King Saud University
Riyadh, Saudi Arabia

Prof. Ahmed BaHamam graduated from the College of Medicine, King Saud University (KSU) with honor in 1989. He did his residency training in King Faisal Specialist Hospital and Research Center between 1989 and 1993. Then he joined the University of Manitoba, Canada in 1994 for residency and specialty training in Respiratory, Critical Care and Sleep Medicine. He joined King Saud University as an assistant professor in 1998. In 2006, he was appointed as a professor of Medicine in King Saud University. He started the Fundamental Critical Care Support Course in the Middle East in collaboration with the Critical Care Society (USA) in 1998. The first academic sleep disorders center in Saudi Arabia was established by him in 2001 in KSU. Then the first Sleep Medicine Fellowship program in the region was established by him in King Saud University in 2009.

He was a founding member of the Saudi Thoracic Society in 2003 and the Saudi Sleep Medicine Group in 2007. Then he worked with his colleagues to create and establish the Annals of Thoracic Medicine Journal and acted as the associate editor of the journal. In 2009, the University Sleep Disorders Center was recognized as a research center of excellence in King Saud University. Additionally, he served as the Governor of the American College of Chest Physicians in Saudi Arabia for two terms (2000-2006) and currently serves as the National Delegate of the European Respiratory Society in Saudi Arabia. Prof. BaHamam is the Chair of the IRB and a member of the Research Center in the College of Medicine, King Saud University. He published more than 70 articles in peer review journals, 10 chapters in medical books and presented more than 55 scientific abstracts. To educate the public about sleep disorder, he established the

first Arabic website about sleep disorders on the net "Sleep in Health and Disease" on 2002



Prof. Peter John Barnes, MA, DM, DSc, FRCP, FCCP, FMedSci, FRS

Professor of Thoracic Medicine, National Heart & Lung Institute
Head of Respiratory Medicine, Imperial College
Honorary Consultant Physician, Royal Brompton Hospital London,
London, UK

Peter Barnes was born in Birmingham and went to school at Leamington College. He won an Open Scholarship to St Catharine's College University of Cambridge where he graduated with a Bachelor of Arts in Natural Sciences (first-class honours) in 1969. He moved to the Clinical School University of Oxford where he was a Scholar and graduated BM, BCH in 1972.

After qualifying in medicine in 1972, Barnes undertook early clinical training at the Radcliffe Infirmary Oxford, followed by training posts in London at Brompton Hospital, Queen Square and UCH. In 1978 he moved to the Royal Postgraduate Medical School to undertake research in respiratory pharmacology (particularly asthma) and was awarded the degree of Doctor of Medicine(DM) from the University of Oxford.

In 1981 he spent a year continuing this research at the Cardiovascular Research Institute UCSF Medical Center. Returning to London, he worked as a Senior Registrar at Hammersmith Hospital and in 1982 was appointed as Consultant Physician and Clinical Senior Lecturer at RPMS. He then took up the newly created Chair of Clinical Pharmacology at the NHLI in 1985, which was subsequently incorporated as a postgraduate institute into Imperial College and became an Honorary Consultant Physician at Royal Brompton Hospital.

In 1987 he was appointed to the established Chair of Thoracic Medicine at NHLI and became Head of Respiratory Medicine at Imperial College.



Ali M. Al-Barrak MD, FRCP, DTM&H

Consultant Internal Medicine
Head of Infectious Diseases Division
Director of Medical Administration
Prince Sultan Military Medical City
Saudi Medical Journal, Editor in Chief
Riyadh, Saudi Arabia

AlAlBarrak, Graduated from King Saud University in Riyadh 1990, Joined Riyadh Military Hospital same year. Had a Scholarship to Canada where I had my Diploma in Internal Medicine (American Board of Internal Medicine) on 1997, Fellowship from The Royal College of Physicians of Canada in Internal Medicine 1998, and had the Certificate for Special Competence in Infectious Diseases from The Royal College of Physicians of Canada 1999. Also had my Diploma in Tropical Medicine and Hygiene from Georgas Memorial Institute of Tropical and Preventive Medicine and Institute de Medicina Tropical Alexander Von Humboldt 1999.

Retuned back to Riyadh Military Hospital and worked since 1999. Now I am a Consultant Internal Medicine & Head of Infectious

FACULTY - PROFILE

Diseases Division, Director of Medical Administration at Prince Sultan Military Medical City. Also the Editor in chief of the Saudi Medical Journal since 2012.

I am interested in mycobacterium infection, Emerging infections and prevention of infection. Had publications in infection at Hal Tuberculosis, Clostridium difficile, pneumonia.

Work at National Committees related to infection, immunization, and Mass Gathering with Ministry of Health and Saudi Commission for Health specialty.



Semra Bilaçeroğlu, MD, FCCP

Associate Prof. of Pulmonology
Associate Editor, Annals of Thoracic Medicine
Co-director, Department of Pulmonary Medicine
Izmir Training & Research Hospital for Thoracic
Medicine and Surgery, Secretary, EABIP, Regent-Turkey, WABIP
Izmir, Turkey

Semra Bilaçeroğlu, MD, FCCP is, currently, the co-director of a pulmonary department and a faculty member in Izmir Dr. Suat Seren Training and Research Hospital for Thoracic Medicine and Surgery. Dr. Bilaçeroğlu major interests are interventional pulmonology, pleural diseases, granulomatous diseases, lung cancer and pulmonary vascular diseases.

Dr. Bilaçeroğlu had her university education in the Medical School of Edge University (Izmir, Turkey). Following mandatory official service as the director of Bogazliyan Tuberculosis Dispensary, she became a pulmonary specialist in 1987 and an associate professor of pulmonary medicine in 2000 in Izmir Training and Research Hospital for Thoracic Medicine and Surgery. In 2003-2004, her research in pleural diseases prompted a sojourn with Prof. Richard Light at Saint Thomas Hospital and Vanderbilt University (USA). After returning to Turkey, she served as the director of the ICU (2 years) and the emergency department (1 year) in the same hospital.

Dr. Bilaçeroğlu has over 80 publications in national and international peer-reviewed journals and books and is frequently invited to national and international meetings as a speaker. She is the secretary of the European Association for Bronchology and Interventional Pulmonology.

(EABIP), the regent of Turkey in World Association for Bronchology and Interventional Pulmonology (WABIP), the governor of Turkey in ACCP Global Governors Council, and the vice-chair of the Foreign Affairs Committee and chair of the Interventional Pulmonology Group in the Turkish Respiratory Society (TRS). She is an editorial board member and reviewer of Respiration, Respirology, Respirology Case Reports, Annals of Thoracic Medicine, and Journal of Bronchology & Interventional Pulmonology. She is also a member of EABIP, WABIP, AABIP, ACCP and TRS.



Johannes Bonatti, MD

Chairman, Heart and Vascular Institute
Cleveland Clinic Abu Dhabi
Abu Dhabi, UAE

Johannes Bonatti, MD, FETCS, is Chairman of the Department of Cardiothoracic Surgery, Cleveland Clinic Abu Dhabi and consultant staff in the Department of Cardiothoracic Surgery, Sydell and Arnold Miller Family Heart & Vascular Institute. He is board-certified in cardiothoracic surgery by the European Board of Thoracic and Cardiovascular Surgeons. His special interests include minimally invasive cardiac surgery, robotic cardiac surgery and vascular biology of coronary artery bypass grafts.

A native of Austria, Dr. Bonatti earned his medical degree from Innsbruck Medical University, Innsbruck, Austria. After completing multiple medical and surgical internships during three years at the General Public Hospital, Kitzbühel, Austria, he came to the United States for a surgical internship at the Medical College of Virginia, Richmond, Va. He completed his training with a five-year surgical residency at the University Clinic for Surgery in Innsbruck that included specialized training in cardiac and vascular surgery.

Prior to Dr. Bonatti's appointment to the Cleveland Clinic staff in 2012, he was Professor of Surgery at the University of Maryland Medical Center, Baltimore, Md. He previously was an attending surgeon in the Department of Cardiac Surgery and the Bench to Bedside Manager in the Heart Surgery Research Laboratory at Innsbruck University Hospital. Over the past 10 years he has been a visiting surgeon at leading institutions worldwide, including the University of Heidelberg, Heidelberg, Germany; the Medical College of Virginia; General Hospital, Vienna, Austria; San Camillo Hospital, Alberoni, Italy; Charite University Clinic, Berlin, Germany; German Heart Center, Munich, Germany; Lenox Hill Hospital, New York, N.Y. and Emory University Hospital, Atlanta, Ga.

Dr. Bonatti has earned an international reputation for innovation in robotic heart surgery and has developed several procedures in the field. He performed the world's first robotic endoscopic triple and quadruple vessel bypass in the arrested heart and the first simultaneous hybrid coronary intervention using totally endoscopic bypass and drug-eluting stents. He also has organized international workshops on integrated cardiovascular repair and trained teams in robotic surgery in Austria, Czech Republic, Greece, Turkey, India, Australia and the United States. His pioneering achievements have earned Dr. Bonatti a number of prestigious awards, including Intuitive Surgical's "Distinguished Robotic Surgeon and Pioneer in da Vinci Cardiac Surgery" award and the "Best Innovator" award from the European-Asian Bridge Society of Cardiothoracic Surgery. He has published more than 190 articles in peer-reviewed journals and serves as a reviewer for many journals, including Journal of Thoracic and Cardiovascular Surgery, Circulation, Cardiology, Heart, Innovations and Journal of Robotic Surgery.

Dr. Bonatti is a member of the Society of Thoracic Surgeons, the European Association of Cardiothoracic Surgery and the European Society of Cardiology. He is a board member of the International Society of Minimally Invasive Cardiothoracic Surgery, a member of the International Advisory Board of the Japan Robotic Surgery Society and president of the Minimally Invasive Robotic Association.

Chiesi Farmaceutici was founded in 1935, privately owned by Chiesi family. According to 2010 data the number of the employees was 3,737 world wide. Chiesi presence is focused in Europe; the number of the direct affiliates is 24.

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- Cardiovascular & metabolic disorders
- Neonatology & Special Care Diseases

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Prof. Paul O'Byrne, MB, FRCPI, FRCPC, FRCPE, FRCP(Glasg)

Professor, Division of Respiriology, Department of Medicine
Chair, Department of Medicine, McMaster University Medical Centre, St. Joseph's Healthcare Ontario, Canada

Education and Professional Standing

The Firestone Institute is led by Director, Dr. Paul O'Byrne, the E. J. Moran Campbell Professor of Medicine and Chair of the Department of Medicine at McMaster University. Dr. O'Byrne is world renowned for his research on asthma that is the result of allergies.

His current research interests focus on the mechanisms and treatment of asthma, with particular reference to the role of environmental allergens and the mechanisms by which these cause airway inflammation. Dr. O'Byrne is a prolific publisher, as evidenced by his 250-plus peer-reviewed papers in highly regarded journals. He has also edited eight books and has written more than 70 review papers and is a frequent lecturer at international meetings.

Dr. O'Byrne is also the Chair of the Executive Committee for the Global Initiative for Asthma, the WHO and NHLBI sponsored initiative to develop global guidelines for asthma diagnosis and treatment, and a member of the Executive Committee, World Health Organization's Global Alliance against Chronic Respiratory Diseases.

Awards and Distinctions

Medical Research Council of Canada Scholar (1984-89)
Medical Research Council of Canada Scientist (1989-1994)
Medical Research Council of Canada Senior Scientist (1995-2000)
Robert A Cooke Memorial Lecturer, AAAAI Annual Meeting (1998)
EJ Moran Campbell Professor of Medicine (1998-present)



Prof. Lisa Cameron, MD

Associate Professor
AI-HS Scholar
GSK-CIHR Rx&D Chair in Airway Inflammation
Department of Medicine
Faculty of Medicine and Dentistry
Alberta, Canada

Education:

PDF – University of Arizona 2000-2005
PhD – McGill University 1995-2000
BSc – McGill University 1991-1995

Research Interests:

Our laboratory investigates molecular mechanisms of the allergic inflammatory process underlying disorders such as asthma, allergic rhinitis and atopic dermatitis. Currently we are studying the regulation of CRTh2 (chemotactic receptor homologous molecule expressed on Th2 cells), a marker for the Th2 lymphocytes, characteristic of allergic inflammation. CRTh2 is a receptor for prostaglandin D2 (PGD2), a lipid mediator

FACULTY - PROFILE

derived from dietary sources of polyunsaturated fatty acids and released at the site of exposure by allergen activated mast cells. PGD2-CRTh2 signaling perpetuates the allergic cascade through inflammatory cell chemotaxis and by inducing further expression of the Th2 cytokines that mediate allergic inflammation, IL-4, IL-5 and IL-13.



Prof. Jamila Chakir, MD

Assistant Professor, Dept Medicine
Assoc Member, Dept Microbiology and Immunology
McGill University
Montreal, Canada



Prof. Jeffrey T. Chapman, MD, FCCP

Consultant Pulmonologist
Chief, Respiratory & Critical Care Institute
Chief, Quality & Patient Safety Institute
Consultant Pulmonologist
Cleveland Clinic, Abu Dhabi, UAE
Abu Dhabi, UAE

Jeffrey Chapman MD is a graduate of Washington University School of Medicine in St. Louis. He received training in internal medicine at Columbia-Presbyterian Medical Center and in pulmonary and critical care medicine at Yale University. Presently Dr. Chapman is chairman of the department of quality and patient safety at Cleveland Clinic Abu Dhabi where he is building a quality program within the building hospital and clinic that puts patients first and uses technology to support providers. Dr. Chapman was formerly a Cleveland Clinic staff physician from 2000 through 2011 with special interests in quality improvement focusing on technology to improve clinical care and reporting of quality measures. His clinical interests are treatment and investigation of experimental therapies for interstitial lung disease, specializing in idiopathic pulmonary fibrosis, lymphangioleiomyomatosis and connective tissue disease associated with interstitial lung disease as well as lung transplantation.



Prof. Kian Fan Chung, MD

Professor of Respiratory Medicine at Imperial College
Honorary Consultant at the Royal Brompton Hospital NHS Trust

Principal Investigator of its Biomedical Research Unit
London, UK

Fan Chung is Professor of Respiratory Medicine and Head of Experimental Studies Medicine at National Heart & Lung Institute, Imperial College London, and is Consultant Physician at the Royal Brompton & Harefield NHS Trust, London. His current interests are focused on the role of airway smooth muscle and effects of oxidant stress on muscle function, on the energetics of airway smooth muscle function and on the mechanisms underlying corticosteroid resistance. He is also researching on the impact of environmental pollution and nanoparticles on the lungs and in lung disease. The translational aspects of this work relates to the chronic airflow obstruction and inflammation seen in asthma and COPD and finding new treatments, particularly related to antioxidant and anti-inflammatory therapies. He has also an interest in the cough hypersensitivity syndrome and new antitussives.

Professor Chung holds research grants from the Medical Research Council UK, EU Innovative Medicines Initiative, National Environmental Research Council (UK), Asthma UK and the NIH/ National Institute for Environmental and Health Sciences.

Professor Chung is a Senior Investigator of the UK National Institute for Health Research. He is co-leader of the IMI-funded EU/EFPIA UBIOPRED project on Systems Biology of severe asthma. He currently heads the Asthma Consortium of the Biomedical Research Unit of the Royal Brompton Hospital. Professor Chung is an investigator in the MRC/Asthma UK Centre in Allergic Mechanisms of Asthma at Imperial/Kings Colleges, a co-leader of the European consortium UBIOPRED on mechanisms of severe asthma, an investigator of the MRC-EPA Environment & Health Centre at Imperial/Kings Colleges.



Mr. Aman Coonar, BSc.(Hons) MBBS MD MRCP(UK) FRCS(Eng.>h.)

Consultant Surgeon
Thoracic Surgery - Papworth Hospital, Cambridge, UK
London, UK

Research Interests Local principle investigator for the PULMICC Trial - a randomised control trial of resection of bowel cancer metastases versus observation.

Professional Profile

Mr. Coonar qualified as a doctor in London. His general surgery and cardiothoracic surgery training was at Guy's, St Thomas's, King's, Royal Brompton and the London Chest Hospitals.

In 2005-2007, Mr Coonar worked at the Toronto General Hospital in Canada and took fellowships in general thoracic surgery and lung transplant surgery. Mr. Coonar has been a consultant at Papworth since 2007 and his practice is in pure thoracic surgery. He works closely with a large team including other surgeons, specialist nurses, radiologists and physicians.

He handles benign diseases and cancer. His main clinical interests are:

- Minimally invasive surgery (video-assisted, endoscopic and others)
- Lung cancer surgery (including advanced cases and patients with poor lung function)
- Mesothelioma surgery
- Chest wall surgery
- Airway surgery
- Lung volume reduction surgery



Prof. Gerard Cox, MD, MB, FRCPCI, FRCPC

Professor and Head, Division of Respiriology
Department of Medicine
McMaster University
St. Joseph's Healthcare
Hamilton, ON, Canada

Dr. Gerard Cox obtained his MB BAO BCh with Honours in 1981 at University College Dublin, Ireland, completed his Medical and Surgical Internship in 1982, and his Internal Medicine training in Dublin, Ireland. In 1985, he moved to Canada and carried out residency training at McMaster University.

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From 1987-1988, Dr. Cox served as Chief Resident in Respiratory Medicine. Thereafter, he spent 2 years as a Research Fellow under the supervision of Dr. Jack Gauldie at McMaster University. Dr. Cox obtained Royal College certification in Internal Medicine in 1987 and Respiratory Medicine in 1988. In 1991-2, he worked with Dr. Gary Hunninghake as a Research Fellow at the University of Iowa. Dr. Cox was appointed Assistant Professor at McMaster University in 1992. In 1997 he was promoted to the rank of Associate Professor and in 2005 to the rank of Professor. In addition to his clinical and research activities, he has a number of administrative responsibilities.

From 2000-2002, Dr. Cox served as Chair of the Ontario Thoracic Society. He then joined the executive of the Canadian Thoracic Society. Currently, he is Past-President of the Canadian Thoracic Society. He was Director of the Residency Training Program in Respiriology and acting Head of Clinical Services at FIRH. At present he is Director of the Division of Respiriology at McMaster University.



Christine McCusker, MD

Associate Professor, Department of Pediatric
McGill University
Director, Division Allergy & Immunol
Montreal Children's Hospital
Montreal, Canada



Abdullah Aldalaan, MD

Consultant Pulmonologist & Intensivist
Head, Section of Pulmonary Medicine
King Faisal Specialist Hospital & Research Centre
Assistant Professor, Alfaisal University
Director of Respiratory Block, Alfaisal University
Riyadh, Saudi Arabia

Dr. Abdullah M. Aldalaan graduated from King Saud University in Riyadh. He received his residency training at Duke University Medical Center in North Carolina, USA; and completed his fellowship training in Pulmonary and Critical Care at University of Virginia, USA. He obtained American Board of Internal Medicine, Pulmonary Medicine and Critical Care Medicine. Since then, he has been practicing as a Pulmonologist and Intensivist at King Faisal Specialist Hospital and Research Center in Riyadh, Saudi Arabia.

He established the following at King Faisal Specialist Hospital & Research Centre:

- Lung Transplant Program, in 2003 (the first and only one among the Arab countries)
- Pulmonary Hypertension Treatment Program, the only program in the area which provides comprehensive diagnostic and therapeutic protocols for patients with pulmonary hypertension, which includes all available internationally recognized medical interventions in this field.

In addition to his clinical responsibilities, he is currently the Section Head of Pulmonary Medicine, Department of Medicine; and the Director of Ambulatory Care Services.

His areas of interests are Lung Transplantation and Pulmonary Hypertension. However, he runs inpatient and outpatient Pulmonary Services at KFSH&RC which covers a wide range of pulmonary diseases.



Ronald J. Dandurand, MD

Assistant Professor
McGill University
Montreal, Canada

Dr. Dandurand graduated in medicine from McGill University in 1984, and then completed a mixed internship at the Queen Elizabeth Hospital affiliated with McGill University, internal medicine residency at the Danbury Hospital affiliated with the Yale University School of Medicine, clinical respirology fellowship at McGill University and a 5 year research fellowship at the Meakins-Christie Laboratories of McGill University. He has been practicing community respirology for the past 20 years and is Assistant Professor of Medicine, McGill University, attending physician, Montreal Chest Institute and Lakeshore General Hospital, and consulting physician, St. Anne-de-Bellevue Veteran's Hospital. His research interests include alpha-1 antitrypsin deficiency, asthma and COPD phenotypes, COPD exacerbation, difficult to control asthma and forced oscillometry.



Prof. Fouad Al Dayel, MD, FRCPA, FRCPath

Professor and Deputy Chairman
Department of Pathology & Laboratory Medicine
King Faisal Specialist Hospital & Research Centre
Riyadh, Saudi Arabia

Current Positions:

Deputy Chairman
Department of Pathology and Laboratory Medicine
King Faisal Specialist Hospital and Research Centre
Riyadh, Saudi Arabia
Professor of Pathology - College of Medicine, Al Faisal University, Riyadh, Saudi Arabia
President- International Academy of Pathology (IAP) - Arab Division (2010 - 2012)

Other Titles:

Consultant Anatomic Pathologist (1995 to present)

Department of Pathology and Laboratory Medicine
King Faisal Specialist Hospital and Research Centre
Section Head, Molecular Genetics (2007 - 2010)

Department of Pathology and Laboratory Medicine
King Faisal Specialist Hospital and Research Centre
Corresponding Fellow for Saudi Arabia
Royal College of Pathologists of Australasia (2004 - present)

Corresponding Member of the Board of Censors
Royal College of Pathologists of Australasia (2005 - present)
Ex-Chairman, Arab School of Pathology
International Academy of Pathology (IAP) - Arab Division (2003 - 2008)

Subspecialty Interests:

Lung Pathology, Bone Pathology, Molecular Pathology, Stem Cell Therapy

NO. OF PUBLICATIONS: 95

NO. OF ABSTRACTS: 130

FACULTY - PROFILE

**Maziar Divangahi, MD**

Assistant Professor, Dept Medicine
Assoc Member, Dept Microbiology and
Immunology, McGill University
Montreal, Canada

Education & Training:

BSc (Biol), McMaster University, Hamilton, Ontario L8S4L8, -
2000
PhD (Immunol), McGill University, Montreal, Quebec, Canada
H3A 0G4, - 2005
PDF (Int Dis), McMaster University, Hamilton, Ontario L8S4L8,
- 2007
PDF (Innate Immunity) McGill University, Montreal, Quebec,
Canada H3A 0G4, - 2008
PDF (Macrophage Death) Harvard University Cambridge, USA
02138, - 2010

**Raed Dweik, MD**

Director of the Pulmonary Vascular Program
Pulmonary, Allergy and Critical Care Medicine
Cleveland, OH, USA

Raed A. Dweik, M.D. is the Director of the Pulmonary Vascular Program in the Department of Pulmonary and Critical Care Medicine in the Respiratory Institute at Cleveland Clinic. He is board certified in internal medicine, pulmonary disease, and critical care medicine. Dr. Dweik's clinical interests are in

pulmonary hypertension, asthma, critical care, and chronic beryllium disease. He has a joint appointment in the department of Pathobiology in the Lerner Research Institute (LRI) and is Professor of Medicine at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University.

Dr. Dweik's research interests are in exhaled breath analysis and the role of nitric oxide in cardiopulmonary physiology and disease especially pulmonary hypertension and asthma. He served on several related national and international panels and committees including: the American Thoracic Society (ATS) Chronic Beryllium Disease Diagnosis and Management Committee, the ATS taskforce to Standardize measurement of Nitric Oxide (NO) in exhaled breath, and the Joint ATS-ERS taskforce on Exhaled Breath Condensate (EBC). He also chaired the ATS committee writing the guidelines for the use and interpretation of exhaled NO (FENO) in clinical practice and the ATS committee on pulmonary hypertension phenotypes.

Dr. Dweik has been the recipient of many awards including The Best Doctors in America, America's Top Physicians, Who's Who in Medicine and Healthcare, Who's Who in Science and Engineering, Who's Who in America, and Who's Who in the World. Dr. Dweik has been the recipient of the Distinguished Teacher Award from the Internal Medicine Residency Program in 2000-01, 2003-04, 2004-05, 2006-07, 2007-08 and the Pulmonary Fellowship Program in 2006-07. In 2007, he also received the Scholarship in Teaching Award from Case Western Reserve University.



Takeda Pharmaceutical Company is the largest pharmaceutical company in Japan and Asia and a top 15 pharmaceutical company. The company has over 30,000 employees worldwide and achieved \$16.2 billion USD in revenue during the 2012 fiscal year. The company is focused on metabolic disorders, gastroenterology, neurology, inflammation, as well as oncology through its independent subsidiary, Millennium: The Takeda Oncology Company. Its headquarters is located in Chuo-ku, Osaka, and it has an office in Nihonbashi, Chuo, Tokyo. In January 2012, Fortune Magazine ranked the Takeda Oncology Company as one the 100 best companies to work for in the United States.

FACULTY - PROFILE



David Eidelman, MD, CM, FRCPC, FACP
Vice-Principal (Health Affairs)
Dean of the Faculty of Medicine
McGill University
Montreal, Canada

A McGill graduate and native Montrealer, Dr. David Eidelman is Vice-Principal (Health Affairs) and Dean of the Faculty of Medicine at McGill University. He is also President of the Réseau Universitaire Intégré de Santé (RUIS) McGill, a network mandated by the Quebec government to coordinate health care, training and research across 63 per cent of the province's land mass.

Prior to his appointment January 1, 2012, Dr. Eidelman served as Chair of the McGill Department of Medicine and Physician-in-Chief at the McGill University Health Centre (MUHC) for seven years. As Chair, he was responsible for overseeing the largest clinical department of the McGill Faculty of Medicine and its academic network, which includes the MUHC, the Jewish General Hospital, St. Mary's Hospital Center and the Douglas Mental Health University Institute, among other partners.

In addition to his administrative successes as Chair and Physician-in-Chief, Dr. Eidelman has served as Director of McGill's renowned Division of Respiratory Diseases. After receiving his MDCM (Doctor of Medicine and Master of Surgery) degree in 1979, Dr. Eidelman continued training in internal medicine at the University of Toronto, first at St. Michael's Hospital and then at Toronto General Hospital. He returned to Montreal to pursue advanced training in respiratory medicine and research at McGill. He is an accomplished clinician-scientist, whose research in inflammatory disorders of the airways is based at the Meakins-Christie Laboratories in Montreal.

Dr. Eidelman is active in clinical medicine and research in Canada and internationally.



Prof. Leonardo Fabbri, MD
Depart of Medical and Surgical Specialties
Section of Respiratory Diseases
University of Modena and Reggio Emilia
Modena, Italy

Dr. Fabri is the Professor of Respiratory medicine at Modena University and a past president of the ERS, his main interest is the pathogenesis and management of COPD



Prof. Thomas Ferkol, MD
Alexis Hartmann Professor of Pediatrics
Professor of Cell Biology and Physiology
Director, Division of Pediatric Allergy, Immunology
and Pulmonary Medicine,
Washington University in St. Louis,
St. Louis, MO, USA

Dr. Ferkol graduated from Case Western Reserve University (Cleveland, Ohio) in 1981, and he received his M.D. degree from the Ohio State University College of Medicine (Columbus, Ohio) in 1985. He was a pediatric resident at the University of North Carolina at Chapel Hill (1985-1988), where he also served as Chief Resident and Clinical Instructor (1988-1989).

Dr. Ferkol returned to Case Western Reserve University in 1989 for fellowship training in pediatric pulmonology, and subsequently joined the pediatric faculty of Case Western Reserve University and Rainbow Babies and Children's Hospital (Instructor in 1992-1994, and Assistant Professor 1994-2000).

Dr. Ferkol moved to Washington University School of Medicine in 2000, where he currently is Professor of Pediatrics, Cell Biology and Physiology and Director of the Division of Pediatric Allergy, Immunology, and Pulmonary Medicine. In addition, he serves as the Director of the Pediatric Pulmonology Fellowship Training Program at Washington University School of Medicine and St. Louis Children's Hospital, and is past director of the comprehensive, accredited Washington University Cystic Fibrosis Center, which supports premier clinical and research programs in cystic fibrosis. The Center is a member of the Cystic Fibrosis Foundation Therapeutics Development Network.



Prof. Patricia W. Finn, MD
Professor and Head, Department of Medicine
College of Medicine at Chicago
President, American Thoracic Society
Chicago, IL, USA

Patricia W. Finn, MD, was installed as president from 2013 to 2014. Dr. Finn is chairman of the Department of Medicine at the University of Illinois College of Medicine at Chicago. She is an active clinician, researcher and educator whose research has been continuously funded by the National Institutes of Health and the American Lung Association since fellowship. Her research explores immune-mediated pulmonary disorders, including asthma, transplantation and acute lung injury.

Dr. Finn also serves as a non-voting member of the Council of Chapter Representatives and of all committees with the exception of the Nominating Committee. An ATS member since 1994, Dr. Finn has been active in the Assembly on Allergy, Immunology and Inflammation, having served as assembly chair and chair of its Nominating and Program committees. She has also served on the ATS Scientific Advisory, Long Range Planning, Awards and Research Advocacy committees, as well as associate editor of the American Journal of Respiratory and Critical Care Medicine.



Elizabeth D. Fixman, MD
Associate Professor
Department of Medicine
McGill University
Montreal, Canada



Bashair Alfozan, MsRC, RRT
Faculty Member in University of Dammam
Dammam, Saudi Arabia

Ms. Bashair Alfozan graduated with a Bachelor degree from King Faisal University, Respiratory Care department. She got her Masters of Science in Respiratory Care from Rush University, Chicago, IL. she is a Registered Respiratory Therapist at the National Board of Respiratory Care, USA. Ms. Bashair is currently a lecturer and the female lab coordinator for the respiratory care department in the University of Dammam.

FACULTY - PROFILE

**Prof. Marc Peters-Golden, MD**

Professor, Department of Internal Medicine
Division of Pulmonary and Critical Care Medicine
Michigan, USA

Medical School or Training: Duke University, 1978

Residency: Tufts-New England Medical Center, Internal Medicine, MA, 1981

Fellowship: Pulmonary & Critical Care Medicine, Johns Hopkins University, 1984

Board Certification: Internal Medicine & Pulmonary Disease

**Soussi Gounni, MD, MSc, BSc**

Associate Professor, Department of Immunology
University of Manitoba
Manitoba, Canada

Assistant Professor, was recently recruited to the Department of Immunology. Dr. Soussi Gounni has made very significant contributions to the field of inflammation and allergic disease, as exemplified by many authored papers published in highly ranked journals such as Nature, FASEB, Blood and the Journal of Immunology. He has been awarded many prestigious prizes and honours such as the International Fellowship from Pharmacia Foundation, the Merieux Foundation Award, a Swiss National Foundation Fellowship, CIHR and Glaxo Wellcome Fellowships and more recently, the CIHR New Investigator Award. Dr. Soussi Gounni's research interests focus on the role of human neutrophils in allergic asthma. Specific emphasis is given to the molecular regulation and function of Fc and cytokine receptors during the exacerbation of asthma and other neutrophilic related pulmonary disease.

**Mohamed Al Ghobain, MD, MBBS, SBIM, ABIM, HERMES, FACP, PF(C), DEMS, MPH, FCCP**

VicePresident, Saudi Arabian Anti-doping committee (SAADC), Consultant Pulmonologist, King Abdulaziz Medical City, NGH, Assistant professor, College of Medicine, KSAU-HS, ACCP international regent for Saudi Arabia , Associate editor, Annals of Thoracic Medicine
Riyadh, Saudi Arabia

Current Professional Position:**Consultant Pulmonologist**

Department of Medicine, King Abdulaziz Medical City, National Guard Health Affairs. Riyadh, Saudi Arabia
Assistant Professor, college of medicine, King Saud Bin Abdulaziz University for Health sciences
ACCP International Regent for Saudi Arabia
Member of National asthma committee
Members, GINA Assembly

Field of Interest:

Asthma, COPD, Evidence Based Medicine, Medical Education, Medical Research

Education and Qualifications:**University:**

King Saud University, Faculty of Medicine,
Riyadh, Saudi Arabia 1988-1994
MBBS Degree in July 1994

Internship:

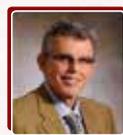
King Khalid University Hospital, July 1994 – July 1995
3 months in General Surgery
3 months in Internal Medicine
3 months in Pediatrics

Residency:

Four years Residency Training Program at the Department of Medicine, King Faisal Specialist Hospital and Research Center, Riyadh, Saudi Arabia
October 1, 1995 to September 30, 1999
Junior Resident: October 1, 1995 to September 30, 1997

Fellowship Training:

Respiratory Clinical Fellowship: July 1, 2001 to June 30, 2003
Firestone Institute for Respiratory Health, St. Joseph Healthcare, Department of Medicine, McMaster University, Hamilton, Ontario, Canada

**Prof. David Gozal, MD**

Chair of Pediatrics at the University of Chicago
Physician-in-chief of Comer Children's Hospital
Sleep Medicine
Chicago, IL, USA

David Gozal, MD, is a leading expert in the treatment of pediatric sleep disorders, the developmental neurobiology of respiratory control, and sleep-disordered breathing. He is known as a pioneer in the study of childhood sleep problems, and the relationships between sleep disorders and neurobehavioral, cardiovascular, and metabolic disease.

Dr. Gozal's research focuses on translational, or "bench to bedside," approaches to pediatric sleep disorders, such as childhood obstructive sleep apnea and sudden infant death syndrome (SIDS). Funded by several National Institutes of Health (NIH) grants, he studies: mechanisms that mediate defense responses; mechanisms that lead to complications from low oxygen levels and disrupted sleep; and long-term health and developmental consequences of chronic sleep and breathing problems during childhood.

Dr. Gozal received his M.D. from the Hebrew University of Jerusalem, completed his pediatric residency at the Haifa Medical Center in Israel, and then spent 2 years in Cameroon, West Africa, developing rural healthcare networks, for which he received the title of "Knight of the Order of Merit". He then completed fellowship training at Childrens Hospital Los Angeles in 1993, and joined the faculty at the University of Southern California and UCLA. In 1994, he moved to Tulane University, where he rose through the ranks and was appointed tenured Professor and Constance Kaufman Endowed Chair in Pediatric Pulmonology Research. In 1999, Dr Gozal moved to the University of Louisville where he built the Kosair Children's Hospital Research Institute, and the Division of Pediatric Sleep Medicine and the Sleep Medicine Fellowship Programs, both of which were recognized

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as programs of distinction by the American Academy of Sleep Medicine. In 2009, Dr Gozal was appointed Chair of Pediatrics at the University of Chicago where he also serves as Physician in Chief for Comer Children's Hospital.



Leila Kheirandish-Gozal, MD
Director of Clinical Sleep Research, Academic Pediatrics
Research Associate (Associate Professor)
Chicago, IL, USA

Leila Kheirandish-Gozal received her Medical Diploma from the University of Damascus. She completed her post-doctoral research and clinical sleep fellowship training in 2005 at the Kosair Children's Hospital Research Institute and the Division of Pediatric Sleep Medicine at the University of Louisville, Kentucky. During her initial training period, she acquired a large array of bench techniques and experience in the laboratory. This highly productive period served to reaffirm her major interest in translational pediatric sleep research. She therefore went on to dedicate the subsequent portion of her training to the application of concepts initially learned in the laboratory to the clinical setting.

Dr. Gozal's current research explores changes in the systemic vasculature that may reflect morbid consequences of sleep disorders in children. She is focused on investigating the role of endothelial progenitor cells on the interaction between sleep apnea and endothelial dysfunction in the presence and absence of obesity. In addition, she is conducting randomized double-blind controlled studies on the potential role of anti-inflammatory agents in pediatric sleep apnea.

Dr. Gozal has extensively published in prestigious peer-reviewed journals and has acquired extramural funds from industry through investigator-initiated projects. She has been an invited speaker at national and international meetings and has multiple collaborations with other investigators around the world.



Esam H. Alhamad, MD, FCCP, FACP
Associate Professor of Medicine
Director, Interstitial Lung Disease Center
Head, Division of Pulmonary Medicine
College of Medicine, King Saud University
King Khalid University Hospital
Riyadh, Saudi Arabia

Dr. Esam Alhamad, is Associate Professor of Medicine and Consultant Pulmonologist in the Department of Medicine, King Saud University, Riyadh, Saudi Arabia. He is also the head division of Pulmonary Medicine at King Khalid University Hospital.

He completed his residency in Internal Medicine at Case Western Reserve University, Cleveland, Ohio, USA, and fellowship in Pulmonary and Critical Care Medicine at the University of Michigan, Ann Arbor, USA. In 2008 he established the Interstitial Lung Disease and Pulmonary Hypertension center at King Khalid university hospital, King Saud University, Riyadh, Saudi Arabia. His main specialty and research interests are related to idiopathic pulmonary fibrosis, CTD-associated ILD, pulmonary hypertension, and COPD.



Angela Haczku, MD, PhD
University of Pennsylvania Medical Center
Pulmonary, Allergy, & Critical Care Division
Translational Research Laboratories (TRL)
Philadelphia, PA, USA

Dr. Angela Haczku completed her MD degree and residency in pulmonary medicine at the University of Debrecen, Hungary and obtained her PhD in immunology at the University of London. Following a basic science post-doctoral fellowship in allergy and immunology at the National Jewish Medical and Research Center in Denver, CO, she joined the faculty of the Pulmonary, Allergy and Critical Care Division at the University of Pennsylvania. She currently holds joint Associate Professor appointments (research track) by the Departments of Medicine and Pharmacology.

Dr. Haczku is an internationally recognized expert in pulmonary immunology, innate immunity and mouse models of airway inflammation. Her laboratory studies the effects of environmental exposures (allergen, ozone, cigarette smoke and social stress) on airway inflammation. Her work on these subjects resulted in critical findings related glucocorticoid responsiveness and pulmonary immune cell biology. Her research group was one of the few that raised the significance of surfactant protein D in allergic asthma and was the first to describe the negative feedback this lung collecting exerts on proinflammatory T cell and dendritic cell function. Her team recently established a unique combined murine model of social stress and asthma and discovered that these conditions synergistically impair glucocorticoid receptor function. Her laboratory has been continuously funded through grants from the NIH, private foundations and the pharmaceutical industry. She is Associate Editor of Allergy as well as Respiratory Research and editorial board member of the Journal of Allergy and Clinical Immunology, American Journal of Respiratory, Cell and Molecular Biology and American Journal of Physiology. She is a standing member of study sections both at the NIH and the Veterans Administration. As chair/vice-chair of several committees she serves in organizing and leadership roles at the American Academy of Asthma, Allergy and Immunology and the American Thoracic Society.



Prof. Qutayba Hamid, MD, PhD, MRCP (UK), FRCP (Canada), FRC Path.
Professor of Medicine
Strauss Chair Respiratory Medicine
Director, Meakins Christie Labs
McGill University
Montreal, Canada

Dr Qutayba Hamid is a Professor of Medicine at McGill University. He is the Director of the Meakins-Christie Laboratories, the Associate Director of McGill University Health Centre Research Institute, He received his MD from Mosul University, Iraq, his PhD from the University of London, UK, and trained at the University of London in the U.K. He has been a professor at McGill University and the Meakins-Christie Laboratories since 1993.

Dr. Hamid is recognized internationally for his work in research on asthma, COPD, and inflammation. Dr. Hamid has published over 450 scientific articles in prestigious international journals and has contributed more than 100 chapters and review articles. He is the

FACULTY - PROFILE

editor of 2 textbooks for Respiratory Cell and Molecular Biology and Respiratory Physiology. He has been a visiting professor worldwide at Universities in Japan , USA, Europe, and Middle East.

He is currently the Co-Editor of the Journal of Clinical and Experimental Allergy. He was the Associate Editor of the Journal of Allergy and Clinical Immunology for 10 years He is a member of many scientific and professional organizations including Royal College of Physicians, London , UK , Royal College of Physicians, Canada, American Thoracic Society, Canadian Society of Allergy and Clinical Immunology, American Academy of Allergy, Asthma and Immunology, and the Royal College of Pathologists.

The main area of research interest of Dr. Hamid includes pathogenesis of asthma and COPD



Prof. Nicola Hanania, M.D., M.S.

M.S. Associate Professor of Medicine
Baylor College of Medicine
Houston, Texas, USA

Dr. Nicolas Hanania is a specialist in Respiratory Diseases and critical care who trained in Canada and currently working at Baylor University in Texas , USA as a Professor of Respiratory Medicine and Critical Care. He is a word expert in COPD and asthma clinical trails and has particular interest in the biology of Bronchial dilators. He has large number of clinical publications and has lectured all over the world. Dr Hanania is a member, of the Academy of Distinguished Educators, and has been a regular speaker at the ATS, ERS and American Chest meetings. As a Chair of the American College of Chest Physicians' Pulmonary Network, Dr. Hanania is also involved in researching drugs for chronic obstructive pulmonary disease, as well as studying new physiologic predictors of clinical response to treatment in patients with asthma and COPD



Adel Al Harbi, MD

Consultant, Pediatric Pulmonary & Sleep Medicine
Head, Pediatric Pulmonary Medicine
Director, Pediatric Sleep Disorders Center
Prince Sultan Military Medical City
Clinical Assistant Professor of Pediatrics, KSU

Chairman, Saudi Pediatric Pulmonology Group
President, Arab Pediatric Pulmonology Association
Associate Editor, Annals of Thoracic Medicine
Riyadh, Saudi Arabia

Academic & Professional Degrees

14 JUL 1994 MBBS- College of Medicine, King Saud University, Riyadh, Saudi Arabia
29 Feb 2001- Arab Board (Paediatrics)
April 2001- Jordanian Board (Paediatrics)
September 2001- The medical council of Canada Evaluating Examination
June 2006- Fellowship in Paediatric Pulmonary Medicine, Alberta Children's Hospital, University of Calgary, Alberta, Canada. 2 years training.
June 2007- Sleep medicine fellowship in Paediatric and Adolescence, University of Calgary, Canada. One year training.

Membership

1. Vice President, Gulf Society of Pediatric Pulmonology "GSPR"
2. Executive Board Member, Saudi Sleep Medicine Group "SSMG"
3. Founder & President, Arab Paediatric Pulmonology Association "APPA"
4. Member of Saudi Paediatric Association.
5. Member of Saudi Thoracic Society, STS.
6. Member of College of Physicians and Surgeons of Alberta (CPSA)
7. Member of American college of chest physicians, ACCP.
8. Member of American Thoracic Society, ATS.
9. Member of European Respiratory Society, ERS.
10. Member of International Congress on Paediatric Pulmonology, ICPP.
11. Member of American Academy of Sleep Medicine, AASM.
12. Member of Sleep Research Society, SRS.
13. Member of the international Paediatric Sleep Association "IPSA"



Ibrahim Mohamed Fawzy Hassan, MD

Director of Medical Intensive Care Unit
Assistant Professor of Medicine
Associate Program Director, Internal Medicine
Hamad Medical Corporation - Weill Cornell
Medical College in Qatar
Doha, Qatar

Dr. Hassan graduated from National Medical University in 2000; he joined New York Presbyterian Hospital of Weill Cornell Medical College for residency and fellowship, He is a scholarly dedicated physician quickly rose to the top of the residency and was acknowledged as a leader in clinical medicine and education by the faculty, his peers and the medical students, he was named Assistant Chief Resident in Medicine, and then the Chief Resident at Memorial Sloan Kettering Cancer Center, he was also selected as the recipient of the Distinguish Alpha Omega Alpha Award given to the "best resident" at NYPH-WCMC in 2007.

On completion of his training in New York, Dr. Hassan joined the MICU staff at Hamad General Hospital and WCMC-Q, and within a year he was named the Medical Director of the MICU. His boundless energy has been evident in the improvements in the organization of the unit, in the delivery of care, and in the training of resident, medical student, nurses and allied health-care professionals. Furthermore Dr. Hassan was elected to be the Chair of Critical Care Board of Directors for HMC, in this role he represents the Critical Care in the corporate level, nationally and internationally, He is working closely with senior national leadership to shape the critical care service and to put strategy for it going forward. Dr. Ibrahim is the clinical lead for the Adult Severe Respiratory Failure Service including the ECMO program in HMC in-collaboration with Guy's and St Thomas' NHS. As the Associate Program Director for medicine residency and Assistant Professor of clinical medicine at WCMC-Q, Ibrahim plays a key role in organizing the clinical curriculum and was a leader in developing and adapting "Objective Structured Clinical Examination tool". He received a Distinguish Leadership award from WCMC-Q in recognition of his work.

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Feras Ibrahim Hawari, MD

Chief, Pulmonary and Critical Care
Director, Respiratory Therapy
Director, Cancer Control Office
Full Member, Department of Medicine
Bethesda, MD, USA



Charles Haworth, MD, FRCP

Consultant Respiratory Physician
Clinical Director, Thoracic Medicine &
Director, Cambridge Centre for Lung Infection
The Adult Cystic Fibrosis Centre | The Lung
Defence Clinic | The Immunology Clinic
London, UK

Charles Haworth is Director of the Cambridge Centre for Lung Infection (incorporating The Adult Cystic Fibrosis Centre, The Lung Defence Clinic and The Immunology Clinic) at Papworth Hospital and was appointed Clinical Director of Thoracic Services in 2013. He is also an Honorary Consultant at Addenbrooke's Hospital in Cambridge.

He trained at the Manchester Adult Cystic Fibrosis Centre, The Royal Brompton Hospital and The Hammersmith Hospital in London, before moving to Cambridge in 2003. He is a co-author of the North American CF Foundation, the UK CF Trust and European CF Society Bone Health Guidelines and has performed a number of external peer review visits of adult Cystic Fibrosis Centres on behalf of the UK CF Trust / British thoracic Society.

He is currently co-chairing the European Cystic Fibrosis Society working group on Non Tuberculous Mycobacterial infection. He collaborates with several research groups at the University of Cambridge and is the chief investigator of multicentre novel therapy clinical trials in CF and non-CF bronchiectasis. He is a member of the North American CF Foundation Data and Safety Monitoring Board.



Shoug Al Humoud, MsRT, RRT

Lecturer and Internship Coordinator
RC Department, CAMS, UD
Dammam, Saudi Arabia

With a BS in Respiratory Care from Dammam University (former King Faisal University) in 2003. She was selected as demonstrator at the same University she graduated from. She got her Masters of Science in Respiratory Therapy from Northeastern University, Boston, MA in 2007 and graduated as top of her class. She is a Registered Respiratory Therapist at the National Board of Respiratory Care, USA. Mrs. Shoug is currently the Internship Coordinator for the respiratory care students both male and female. She is also a lecturer for many core subjects in the department of respiratory care. Her research interest includes mechanical ventilation and pulmonary rehabilitation.



Sabah Hussain, MD, PhD

James McGill Professor of Medicine
Department of Medicine, McGill University
Director of Research,
Department of Critical Care, McGill University
Health Centre
Montreal, Canada

I am currently involved in three main areas of research. First, we currently investigating molecular signaling pathways and mechanisms of action of angiogenesis factors in general and angiopoietins and Tie-2 receptors in particular. Current project include identification of transcription factor networks downstream from Tie-2 receptors both in endothelial cells and in cultured skeletal muscle satellite cells.

In addition, we are exploring the biological functions of both angiopoietin-1 and angiopoietin-2 in regulating cytokine cascade and tissue injury in various models of inflammation including severe sepsis and acute lung injury. To achieve our objective in this area of research we have developed transgenic animal models to over-express angiopoietins selectively in the vasculature.

My second area of research is the biological roles of angiopoietins in skeletal muscle regeneration with particular emphasis on ventilatory muscle function. In this regard, we are investigating the effectiveness of gene therapy in which angiopoietins are delivered in vivo in various models of skeletal muscle injury and regeneration including cardiotoxin necrosis model and mdx model of Duchenne Muscular Dystrophy. My third area of research interest is molecular mechanisms involved in skeletal muscle atrophy in general and regulation of autophagy and proteosomal pathways in particular. Current research project include assessing the contribution of autophagic pathway to skeletal muscle protein degradation in human diaphragm during mechanical ventilation.



Abdulatif Alhuzaim, MSRC, RRT

Lecturer
Department of Respiratory Care
College of Applied Medical Sciences
University of Dammam
Dammam, Saudi Arabia

Mr. Abdulatif Alhuzaim graduated from University of Dammam with a Bachelor Degree in Respiratory Therapy. He got his Master of Science Degree in Health Sciences with Concentration in Respiratory Therapy from Georgia State University in USA. Currently he is appointed as a Lecturer in University of Dammam, College of Applied Medical Sciences.



Carla Irani, MD

Consultant, Allergology
President, Lebanese Society of Allergy and
Immunology' Hotel-Dieu de France University
Hospital,
Beirut, Lebanon

CFTR and the cystic fibrosis disease mechanism: novel therapeutic approaches

(Vertex Symposium – 15th March 2014)

Location: Al Maasa room, Grand Hyatt Dubai

Rationale: In this session the experts will review the data on prevalence of *CFTR* mutations in the Gulf region, scientific evidence of modulation of CFTR protein, and present clinical evidence of the role of potentiators in the treatment of cystic fibrosis.

Chairpersons: [Dr Nizar Kheralla, M.D., F.C.C.P.](#)
Senior Consultant Pediatric Pulmonologist
Head of Division/Section of Pediatric Pulmonology
Sheikh Khalifa Medical City
Abu Dhabi, UAE

Program:

11:00-11:35

CFTR mutations, their prevalence in the Gulf countries, and their relevance to CFTR modulation therapies

[Prof Milan Macek M.D., DSc](#)

CF Centre and Department of Genetics
Charles University Prague
Czech Republic

11:35-12:10

An overview of CFTR potentiators - the trials, real world studies and interesting cases

[Prof Barry Plant M.D.](#)

Director Adult CF Centre,
Department of Medicine
Cork University Hospital,
University College Cork,
Ireland

12:10-12:30

Questions & Answers



FACULTY - PROFILE



Hassan Jaffar, MD

Consultant Medical Oncologist
Tawam Hospital (affiliated with Johns Hopkins)
Al Ain, UAE

Hassan Jaafar, is a medical consultant in Tawam hospital (affiliated with Johns Hopkins) UAE, He is bell in tawam since the year 2000. He received his M.B.Ch.B (MD) in 1992, the internal medicine board in 1997, and he passed the arab board exam in internal medicine, completed a 3 years of fellowship in hematology-oncology and certified as medical hematologist oncologist from American University Hospital of Beirut in the year 2000.

He is the author and co-author of more than 40 peer reviewed papers and abstracts. He is involved in more than 6 ongoing phase II and phase III trials regional and international and he is a member of the GOG (gulf oncology group) which conduct 2 phase II trials in the last 2 years.

He is a lecturer in Al-Ain university faculty of medicine. He is member in many societies (UAE Oncology and radiation therapy association, Lebanese hematology and oncology association, ESMO European society of medical oncology and ASCO American society of clinical oncology) Member of the Scientific and Education Committee of the Arab Collaborative Hematology and Oncology Group (ACHOG).



Prof. Nizar Jarjour, MD

MD, Professor of Medicine, Head,
Section of Allergy, Pulmonary and Critical Care
Medicine,
University of Wisconsin, and Assistant Director,
Research Core (CTRC) University of Wisconsin
Madison, Wisconsin, USA

Clinical and Research Interests:

Dr. Nizar N. Jarjour is a Professor of Medicine, and Head, Division of Allergy, Pulmonary & Critical Care Medicine in the Department of Medicine. He also serves as director of the Clinical and Translational Research Core at the University of Wisconsin Institute for Clinical and Translational Research, Madison, WI. Dr. Jarjour's research program include mechanisms of allergic inflammation, role of eosinophil in airway disease, pathogenesis of viral induced asthma exacerbations, etiology and characteristics of severe asthma, mechanisms of action of anti-asthma medication, airway remodeling and clinical aspects of asthma.

He is Board Certified in Internal Medicine, Pulmonary and Critical Care Medicine. His clinical activities include staffing the University of Wisconsin Hospital Trauma and Life Center, outpatient and inpatient pulmonary consultations and directing the Pulmonary Diagnostics Laboratory.



Tareq Al Jasser, MSc, RRT

King Faisal Specialist hospital and Research Centre
Riyadh, Saudi Arabia

Tareq Aljasser is a Senior Respiratory Therapist at King Faisal Specialist Hospital & Research Center in Riyadh. He had completed his Bachelor Degree Education from the University of Kansas in Kansas, USA. He have been working with KFSHRC

for the past 12 years, accumulating experience in Critical Care and long-term care for patients with pulmonary diseases and/or ventilator dependent. He has been very active in participation with asthma education, airway clearance, noninvasive positive pressure application and overall coping with chronic lung disease for pediatric patients. My interests involve avoidance of invasive ventilation and decrease ICU stay for patients requiring ventilator support. He has earned his master degree in respiratory therapy about a year ago from Georgia State University in USA. I have been closely involved in development and accusation of appropriate equipment needed for providing high-flow oxygen therapy in KFSHRC. He has no conflict of interest to declare.



Prof. Abdul Rahman Jazieh, MD, MPH

Chairman, Oncology Department
Professor, King Saud University for Health Sciences
National Guards health Affairs
Riyadh, Saudi Arabia

Current Positions:

Chairman, Department of Oncology, KAMC, Riyadh, KSA
01/2006- Present Professor, King Saud bin Abdulaziz
University for Health Sciences
06/2011-Present:Member, ASCO International Affairs
Committee

Medical Education:

MD Sept, 1988Damascus University Medical School, Syria
MPH May 1997 Masters Degree in Public Health from
Tulane, University, New Orleans, Major in Health Education/
Communication

Residency:

7/90 – 6/93 Internal Medicine Residency at St. Francis Hospital,
an affiliate of U of Illinois, Evanston, Illinois

Fellowship:

7/93 – 6/ 96 Hematology and Medical Oncology Fellowship,
University of Arkansas for Medical Sciences, Little Rock, Arkansas

Previous Appointments:

- 7/96 - 6/00 - Assistant Professor of Medicine, Division of Hematology/Oncology University of Arkansas for Medical Sciences (UAMS), Little Rock, Arkansas.
- 7/00 – 8/04 - Associate Professor of Medicine, Division of Hematology/Medical Oncology at University of Cincinnati (UC), Cincinnati, Ohio.
- 9/04 – 1/06 - Professor of Medicine, Division of Hematology/Medical Oncology at University of Cincinnati (UC), Cincinnati, Ohio
- 5/02 – 1/06 - Director, Division of Hematology/Medical Oncology University of Cincinnati Medical Center, Cincinnati, Ohio

Board Certifications: Internal Medicine Board, Hematology Board and Medical Oncology Board, USA

Licensure: Licensed to practice Medicine in OHIO, USA and Saudi Arabia

Memberships:

Fellow American College of Physicians (FACP), American Society of Hematology,

FACULTY - PROFILE

American Society of Clinical Oncology, American Medical Association, American Association for Cancer Research, American Association of Cancer Education

Awards and Honors:

1982 Merit Award Recipient from the Syrian Ministry of Education.
1995 Merit Award Recipient from the American Society of Clinical Oncology.
2004 "40 under 40" People to Watch at the UC Medical Center
2005 "Unsung Hero Award" by Cancer Family Care, Cincinnati, OH
2006 Proclamation to the City of Cincinnati naming the day of January 5th 2006 as Dr. Abdul Rahman Jazieh day

Publications:

Dr. Abdulrahman Jazieh has more than 100 publications as manuscripts, book chapters and abstracts.



Abdullah Al Jebreen, MD

Consultant, Cardiac-Thoracic Radiologist
Department of Radiology
King Faisal Specialist Hospital & Research Centre
Riyadh, Saudi Arabia

In 2003, Dr. AlJebreen received his MBBS from King Saud University, Riyadh. In 2003-2004, he did his Internship Training at King Khalid University, Riyadh. In 2004-2008, he did his Radiology Residency Training in the Department of Radiology at King Faisal Specialist Hospital & Research Centre (KFSH&RC), Riyadh. From April – December 2007, he was elected as Chief Resident of the Radiology Residency Training Program in the Department of Radiology at KFSH&RC. From Aug 2007 – Aug 2008, he was elected as Chief Resident of Radiology Residency Training Program for the Central Region (Riyadh, Saudi Arabia).

In 2009-2010, he did his Clinical Thoracic Imaging Fellowship at Ottawa University, Ottawa, Ontario, Canada. From 2010-2011, he did his Clinical Cardiac Imaging Fellowship also at Ottawa University, Ottawa, Ontario, Canada.

After his fellowship training, he joined as Associate Consultant and after almost one year he was promoted to Consultant, Cardiac Thoracic, in the Department of Radiology at King Faisal Specialist Hospital & Research Centre, Riyadh, Saudi Arabia.



Ahmed Abdulaziz Aljohaney, MBBS, DABIM, FRCPC

Assistant Professor of Medicine
College of Medicine, King Abdulaziz University
Consultant in Pulmonary Medicine and
Interventional Pulmonology
King Abdulaziz University Hospital
Jeddah, Saudi Arabia

Dr Ahmed Aljohaney is an Assistant Professor of Medicine and Consultant Interventional Pulmonologist at King Abdulaziz University Hospital and Faculty of Medicine. Dr Aljohaney received his medical degree with honor at King Abdulaziz University. Dr Aljohaney Completed a residency in Internal medicine and fellowship training in Pulmonary and Interventional Pulmonology at University of Ottawa, Ontario, Canada 2005-2011. He is

certified by the Royal College of physicians and surgeons of Canada and the American board of internal medicine in the field of internal medicine and pulmonary medicine. He is proud to be the first Saudi Doctor specialized in Interventional Pulmonology. He has an advanced training in the field of bronchoscopy and pleural diseases. His clinical and research interest involve diagnosis and staging of lung cancer and pleural diseases as well as procedural training, simulation and medical education. He is currently the secretary general for the Saudi society of internal medicine and a fellow of the American college of chest physicians. MD, MS



Jill Johnson, MD

Faculty of Medicine, National Heart & Lung Institute
Research Fellow at Imperial College London
London, UK



Paulanne Jushkevich, MA, CFRE

President at Royal Victoria Hospital Foundation
Montreal, Canada



Prof. Marsha Wills-Karp, MS, PhD

Professor and Chair of the Department of
Environmental Health Sciences
Johns Hopkins Bloomberg School of Public Health
Deputy Editor of Mucosal Immunology
Baltimore, MD, USA

Education and Training

BS / MS: Southwest Texas State University, San Marcos, TX, 1980, 1982.

PhD: University of California, Santa Barbara, CA, 1986.

Postdoctoral Fellowships: Yale University, New Haven, CT, 1986-87; Johns Hopkins University, Baltimore, MD 1987-89.

Marsha Wills-Karp, PhD, a leader in the study of the molecular mechanisms of asthma, has been selected to chair the Department of Environmental Health Sciences at the Johns Hopkins Bloomberg School of Public Health. Wills-Karp will join the Bloomberg School on January 1, 2012, and assume her full duties as Department chair on March 1, 2012.

"Marsha is an outstanding scientist and leader and we are very fortunate to recruit her to this position," said Michael J. Klag, MD, MPH, dean of the Bloomberg School of Public Health.

Wills-Karp is currently professor and the founding director of the Division of Immunobiology in the Department of Pediatrics at Cincinnati Children's Hospital Medical Center. She also directs the Immunobiology Graduate Program at Cincinnati. Wills-Karp previously worked at Johns Hopkins as a postdoctoral fellow from 1987 to 1990 and was a member of the faculty from 1990 to 2000.

FACULTY - PROFILE



Prof. Walid E. Khalbuss, MD, PhD, MPH, FIAC

Professor of Pathology
Director of Cytology at the University of Pittsburgh Medical Center.
Member, Division of Anatomic Pathology
Member, Division of Pathology Informatics
Pittsburgh, Pennsylvania, USA

Dr. Walid E. Khalbuss serves as Professor of Pathology and director of cytopathology at the University of Pittsburgh Medical Center (UPMC), Pittsburgh, Pennsylvania, USA. Dr. Khalbuss did his Anatomic and Clinical Pathology residency at New York Medical College. This was followed by two fellowships; one in Oncologic Surgical Pathology and one in Clinical Cytopathology at The New York Medical College.

Dr. Khalbuss has published extensively and has authored 77 peer-reviewed articles in major scientific journals, over 134 abstracts; 4 textbook and Atlases in Cytopathology (2 additional books are in press/print), and numerous book chapters. He travels widely and is a sought after speaker nationally and internationally. He is a member of the College of American Pathologists (CAP) Cytopathology Resources Committee, and member of the International Academy of Cytology (IAC) Educational and QA Committee. He is on the editorial board of several journals and has major appointments in several professional Pathology organizations. His major areas of interest include pathology informatics; ancillary testing, soft tissue and bone cytopathology, FNA cytology, and EBUS cytology.



Prof. Khaled M. Al Kattan, MD, FRCS

Consultant Thoracic Surgery,
King Faisal Specialist Hospital and Research Centre
Professor of Thoracic Surgery
Dean, College of Medicine
Alfaisal University
Riyadh, Saudi Arabia

Prof. Khaled Manae Al-Kattan, Dean College of Medicine, Acting Vice President for Development at Alfaisal University and Consultant and Head Section of Thoracic Surgery at King Faisal Specialist Hospital & Research Centre. He was a graduate from King Saud University 1983, got his FRCS from Edinburgh with a gold medal in 1988. Appointed as an assistance professor at KSU in 1989, Associate professor in 1995 and then a full professor in 2000. He served as the director of continuous medical education at the college. He was a co-founder of both the Saudi thoracic society and Pan Arab Chest Society. He is the Middle East regent for the European Society of Thoracic Surgery. He is a member of many international societies and sits as a senior editor for the Annals of Thoracic Medicine journal. He is in the editorial board and reviewer of most of the international thoracic surgery journals. Have extensive research and publication in his field, presented many abstracts in international symposiums. Was invited as an international speaker in many medical events. He is the Chairman of the National Lung Cancer Study Group and the national lung transplant program. Have extensive work in medical education and a board member of its Saudi society. Have contributed to public health education and establishment of several charity medical associations.



Margaret M. Kelly, MBChB, PhD, FCPPath(SA), FRCPC

Associate Professor
Department of Pathology and Laboratory Medicine
Department of Physiology & Pharmacology
University of Calgary, Faculty of Medicine
Calgary, Canada

I am a Clinician-Scientist (Pulmonary Pathologist), with an interest in chronic lung diseases, specifically inflammatory and remodeling aspects. My lab focuses on asthma and interstitial lung diseases such as Hypersensitivity Pneumonitis (HP), Idiopathic Pulmonary Fibrosis (IPF), and autoimmune lung disease. We have a mouse model of severe neutrophilic asthma with airway remodeling and a model of chronic pulmonary fibrosis in which the pattern of fibrosis is similar to that seen in chronic HP and IPF. As part of the airway inflammation group, my lab is also involved in sputum and biopsy based studies in asthma and COPD.

Techniques in which my lab specializes include:

Administration of specific volumes of reagents into the mouse lung, using the Penn-Century Micro-sprayer. This technique allows for very accurate reliable administration of reagents by aerosol, which can be repeated as many times as required. The aerosol is evenly distributed throughout the lung fields.

- Laser Capture Micro-Dissection and Real-Time PCR
- Histology, immunohistochemistry, immuno-fluorescence and histochemistry
- Electron Microscopy
- Induced Sputum analysis



Prof. Martin Kolb, MD

Associate Professor, Division of Respiriology,
Department of Medicine
Pathology & Molecular Medicine; St. Joseph's
Healthcare,
Firestone Institute for Respiratory Health

Specialty Clinic for Interstitial Lung Disease and Lung Fibrosis
Inpatient Service for General Internal Medicine
Respirology ICU, Consulting service
Germany

Dr. Kolb's major research area is focused on mechanisms of lung injury, repair and fibrosis, particularly in Idiopathic Pulmonary Fibrosis (IPF). He has a strong interest in growth factor biology (e.g. TGF β and IL-1), extracellular matrix, and mesenchymal cell progenitors (mesenchymal stem cells and fibrocytes). In his lab he uses a variety of animal models to study disease mechanisms and also the efficacy of novel drugs in the preclinical setting. Further, Dr. Kolb leads activities in biomarker development for lung fibrosis and he participates as Principal Investigator and Steering Committee members in numerous clinical trials on interstitial lung disease.

Dr. Kolb has over 70 peer-reviewed publications in journals such as Journal of Clinical Investigation, American Journal of Pathology, American Journal of Respiratory and Critical Care Medicine, Journal of Immunology, European Respiratory Journal and many others. He is/was funded by CIHR, NIH, CFI, OTS and different Pharma companies over the years. He has received career awards from the Parker B. Francis Families Foundation,

FACULTY - PROFILE

the Department of Medicine at McMaster and the New Investigator Award from the Canadian Institute for Health Research.

Dr. Kolb looks after several hundred patients with interstitial lung disease in his specialty clinic and also practices in General Respiriology. He is medical staff at St. Joseph's Healthcare Hamilton for Respiriology and General Internal Medicine. Clinic bookings can be made through extension x35003.

Dr. Kolb is Deputy Editor for Respiriology, the official journal of the Asian Pacific Society of Respiriology, Associate Editor for the European Respiratory Review and Academic Editor for PLoS One. He is on the Editorial Boards of the American Journal of Respiratory and Critical Care Medicine and European Respiratory Journal which are the number 1 and 3 in journals in RC.



Marie-Louise Coussa-Koniski, MD
Assistant Professor
Lebanese American University
Pulmonary Critical Care and Sleep Diseases
Lebanon



Prof. Catherine Laprise, MD
Canada Research Chair on Genetic Determinants of Asthma
Université du Québec à Chicoutimi
Chicoutimi, Canada



Prof. Mark Larché, MD
Professor, Division of Clinical Immunology & Allergy
Canada Research Chair
Allergy & Immune Tolerance
Hamilton, ON, Canada

Education and Professional Standing

Dr. Larché completed his PhD in Immunology at the Royal Postgraduate Medical School, Hammersmith Hospital in 1990, under the supervision of Professor Mary A. Ritter. He spent 3 years in the USA at St. Jude Children's Research Hospital, Memphis, TN as a postdoctoral fellow (Peter C. Doherty, Chairman).

On his return to the UK he joined the Immunology Department at St. Mary's Hospital Medical School (Jonathan R. Lamb, Chairman), prior to joining the faculty of the National Heart and Lung Institute (A. Barry Kay, Chairman) which later became a Division of the Faculty of Medicine of Imperial College.

Research Interests

Mark Larché is Canada Research Chair in Allergy & Immune Tolerance and Professor in the Department of Medicine at McMaster University. Larché is also Honorary Professorial Research Fellow in the Faculty of Medicine at Imperial College, London, UK from where he recently (Sept 2006) made the move to Canada. In 2004 he was a Distinguished Visiting Professor at the University of Manitoba, Canada.

From 2001-2006 he was an Asthma UK Senior Research Fellow. He is a former member of the Medical Research Council New Investigator Awards (NIA) Panel, the MRC College of Experts (Physiological Systems and Clinical Sciences Board) and the

Asthma UK Research Committee. He was Chairman of the Asthma Section of the European Academy of Allergology and Clinical Immunology (EAACI) from 2001-2005, a member of the EAACI Executive Committee (2001-2005) and a member of the BSI Vaccine Affinity Group Board (2003-2006).



Prof. Jean-Pierre Lavoie, DVM
Professor, Department of Clinical Sciences
Faculty of Veterinary Medicine
University of Montreal
St-Hyacinthe, QC, Canada



Anne-Marie Lauzon, MD
Associate Professor, Department of Medicine
Director, Div Exptl Medicine
McGill University,
Montreal, Canada



Richard Leigh, MBChB, MSc, PhD, FCP(SA), FRCP
Division Chief, Respiratory Medicine
GSK-CIHR Professor of Inflammatory Lung Disease
University of Calgary and Alberta Health Services
Calgary, Canada

Richard Leigh is a physician-scientist and the GSK-CIHR Professor of Inflammatory Lung Disease in the Division of Respiratory Medicine at the University of Calgary. Dr. Leigh is the Section Chief of Respiratory Medicine at the University of Calgary, and the Medical Director of the Calgary COPD and Asthma Program.

His areas of interest include understanding the basic mechanisms underlying airway remodeling in asthma, the assessment of airway inflammation and early phase clinical trials in asthma and COPD.

He holds peer-review funding from the Canadian Institutes of Health Research, the National Institute of Allergy and Infectious Diseases and Alberta Innovates-Health Solutions, and he is a Principal Investigator in the AllerGen NCE Clinical Investigator Collaborative. Dr. Leigh currently co-chairs the Canadian Thoracic Society asthma assembly.



Michael Loebinger MD PhD
Consultant in Respiratory Medicine
Royal Brompton Hospital
Honorary Senior Lecturer
Imperial College, London, UK

Michael Loebinger is an Honorary Senior Lecturer at the National Heart and Lung Institute and a Consultant Respiratory Physician at the Royal Brompton Hospital. Dr Loebinger undertook his preclinical studies at Cambridge University gaining a First Class Honours in Medical Sciences followed by study at Oxford University for his clinical studies. He was then awarded a Medical Research Council Clinical Research Training Fellowship in 2006 for studies into the use of adult stem cells in lung disease. This resulted in research published in his PhD, which he was awarded by University College London.

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His current research aims focus around chronic lung infections, in particular idiopathic bronchiectasis and aspergillus, pseudomonas and non-tuberculosis mycobacterial infections. Dr Loebinger is presently investigating host susceptibility to these infections, in addition to the development of biomarkers to assist in the management of these conditions. He is also involved in establishing local and national clinical networks of patients with chronic lung diseases which will help with patient management as well as future research and clinical trials.

Dr Loebinger has won young investigator of the year awards from the Royal Society of Medicine, the European Respiratory Society, the British Thoracic Society and the British Association of Lung Research. He has also received prestigious awards from the American Thoracic Society, the Medical Research Society and the British Lung Foundation.



Prof. Mara Ludwig, MD

Professor of Medicine
Associate Dean of Faculty Affairs
Faculty of Medicine, Meakins-Christie Laboratories
McGill University,
Montreal, QC, Canada



Prof. Atul Malhotra, MD

Professor of Medicine
Division Chief, Pulmonary and Critical Care
Medicine
Director of Sleep Medicine
Kenneth M. Moser Professor, Dept. of Medicine
San Diego, CA, USA

Dr. Atul Malhotra is the Division Chief of Pulmonary and Critical Care Medicine, Director of Sleep Medicine and Kenneth M. Moser Professor of Medicine at UC San Diego. He is very involved in the leadership of the American Thoracic Society, the world's leading professional organization for pulmonary, critical care and sleep medicine. He is the current ATS Vice President and will be ATS President in 2015-2016. Dr. Malhotra is an avid researcher and prolific writer with >190 peer reviewed original articles and >125 reviews/chapters since coming on faculty in 2000. His investigative interests include: The pathogenesis of sleep apnea. The metabolic/cardiovascular complications of sleep disorders. Mechanical ventilation in acute respiratory distress syndrome.

Research Interests

My two major research foci are the pathogenesis of sleep apnea and the metabolic/cardiovascular complications of sleep disorders. The pathogenesis studies include anatomical ones using imaging, upper airway physiology, and control of breathing. These studies are ultimately designed to define the various contributors to apnea in different individuals. We have developed multivariate statistical models, computational finite element computational models, and an intact rat model to assess the various factors that are important in apnea pathogenesis. The ultimate goal is to define specific therapeutic targets for OSA patients of varying phenotypes. The rat studies are exploring the neurochemistry of the various components of upper airway reflexes with an eventual goal of defining potential pharmacological targets for OSA therapy. The metabolic/cardiovascular studies seek to separate obesity

effects from OSA influences by assessing a host of autonomic, microcirculatory, inflammatory, hemostatic, metabolic, and hemodynamic variables. These studies include a cross sectional study comparing OSA patients with weight matched controls, an interventional study to assess the changes in the various biomarkers with OSA therapy, and the impact of weight loss on these biomarkers following gastric bypass surgery.



Prof. James G. Martin, MD

Professor Department of Medicine
Associate Member, Department of Physiology
McGill University,
Montreal, Canada



Ahmed Masehali, BsRC, RRT

Head, Home Respiratory Care Section
King Fahad Medical City
Riyadh, Saudi Arabia

Ahmed Jebreel Masehali is a respiratory therapist graduated from Loma Linda University on June 2001. He started working as ICU therapist in Prince Sultan Cardiac center in both adult and pediatric units. On 2008 Ahmed moved to King Fahad Medical City KFMC as pediatric ICU supervisor where he started the first home health care pilot patient discharge. When KFMC Admin measured the possibility of discharging ventilated patient safely into community they ignite the spark for starting home health care department. Worked in the multidisciplinary team that build the service then he moved as home care respiratory head section and head of operations. On 2011 KFMC home health care department applied for accreditation body CHAP "community health accreditation program" as part of their vision to excellence and to provide patients with international benched mark services. they managed to achieve CHAP accreditation from the first time on 2013 to be the first home health care globally accredited by them outside USA.



Prof. Irvin Mayers, MD, FRCPC

Division of Pulmonary Medicine, Department of
Medicine
Professor of Medicine, University of Alberta
Alberta, Canada

Dr. Mayers (MD, FRCPC) is a Professor of Medicine and Pulmonary Divisional Director, at the University of Alberta. He completed his medical training at the University of Manitoba and then his Pulmonary clinical and research training at University of Manitoba and University of Chicago. He is past president of the Canadian Thoracic Society (CTS). He is formerly the Division Director for Pulmonary Medicine and is currently the site Medicine lead for University of Alberta Hospitals. Dr. Mayers is a member of the Canadian Drug Expert Committee (CDEC) that provides opinions to the provinces regarding drug formulary approvals. Nationally, he is chair of the Health Canada Scientific Advisory Committee on Respiratory & Allergy Therapies and is the co-chair of the Respiratory Division of the Public Health Agency of Canada.

FACULTY - PROFILE



Prof. Atul C. Mehta, MBBS, FACP, FCCP
Staff Physician
Respiratory Institute, Cleveland Clinic
Editor-in-Chief, Journal of Bronchology &
Interventional Pulmonology,
Cleveland, OH, USA

Atul C. Mehta, M.B., B.S., is Vice-Chairman of the Department of Pulmonary and Critical Care Medicine, Head of the Section of Bronchology and acting Medical Director of the Lung Transplant Team at Cleveland Clinic.

Dr. Mehta's specialty interests are the treatment of lung cancer, diagnostic and therapeutic bronchoscopy, lung transplantation, interstitial lung diseases and pulmonary hypertension. He is board-certified in internal medicine, pulmonary disease and critical care medicine. Dr. Mehta's research interests are therapeutic bronchoscopy, lung transplantation and idiopathic pulmonary fibrosis.

He is named in the 2000-2001 Top Doctors in America; 1999-2000 edition of Best Doctors in America; Who's Who in Medicine and Healthcare, 1997; Best Doctors in America- Midwest Region, 1996-1997; and International Who's Who, 1996-1997.

In 1993 he was awarded the Distinguished Physicians of the Year by the Indian Physicians of Northern Ohio and in 1992, the Cleveland Clinic's Bruce Hubbard Steward Award for his ability to combine sensitivity and compassion with knowledge and skill in the practice of medicine.

Dr. Mehta was the founder and president of the American Association for Bronchology. He is a Fellow of the American College of Chest Physicians, the American College of Physicians, and the American Society for Laser Medicine & Surgery. He also is an active member of the American Thoracic Society, International Bronchoesophagological Society, International Society for Heart & Lung Transplantation and World Association for Bronchology.



Walid Moahmood, MD
Rashid Hospital
Dubai, UAE

Currently practicing as a pulmonary consultant in Rashid hospital (Dubai Health Authority-) with a special focus on PFTs and Pulmonary sleep disorders. Graduated From the Royal college of surgeons in Ireland (1999) . Did Internal Medicine residency at McGill University-Montreal- Canada. Adult Pulmonary Fellowship in (McGill University-Completed 2009) Got the American Board of Internal Medicine in 2007 .Then got the American Board of Pulmonary disease in 2010 and the Fellowship of the college of Chest Physicians in 2011 (FCCP).



Prof. Mohamed S. Al Moamary, MBBS, ABIM, FRCP(Edin), FCCP
Chairman, Scientific Committee, *GulfThoracic Congress 2014- Dubai*
Professor & Consultant, Pulmonary Medicine

King Abdulaziz Medical City- Riyadh
Vice President, Planning, Development and Quality

Management, King Saud Bin Abdulaziz University for Health Sciences (KSAU-HS)
Chairman, Saudi Initiative for Asthma
Editor-in-Chief, Annals of Thoracic Medicine
Riyadh, Saudi Arabia

MOHAMED S. AL-MOAMARY is the Assistant Vice President, Educational Affairs, King Saud bin Abdulaziz University for Health Sciences. He is an Associate Professor, Pulmonary Medicine, College of Medicine, KSAU-HS. He is practicing as a consultant in Pulmonary Medicine at King Abdulaziz Medical City-Riyadh, Saudi Arabia. He is the Editor - in —Chief of the Annals of Thoracic Medicine. He chaired many scientific committees and members of counsels. He introduced patient safety in the college of Medicine curriculum. He has contributed in guidelines with the Saudi Thoracic Society and the World Health Organization. Dr. Al-Moamary is the primary author of the Saudi Initiative for Asthma and the framework for medical intern's competencies



Ajit Moghekar, MD, MBBS
Pulmonary, Allergy and Critical Care Medicine -
Associate Staff
Cleveland Clinic Main Campus
Cleveland, OH, USA

Dr Ajit Moghekar is currently Associate Staff in the Respiratory Institute at the Cleveland Clinic, USA. He completed his training in Pulmonary and Critical Care Medicine in 2010 from Albert Einstein College of Medicine in New York and is board certified in Internal medicine, pulmonary diseases and critical care medicine. Dr Moghekar's clinical interests are in intensive care medicine with special focus on the use of point-of- care ultrasonography in the management of critically ill patients.

Dr Moghekar routinely gets invited to teach point of care ultrasonography at the international meetings of the American College of Chest Physician. His research focuses on use of lung ultrasonography in fluid management in patients with severe sepsis and ARDS and also in evaluating utility of lung ultrasonography to detect subclinical rejection in lung transplant patients.



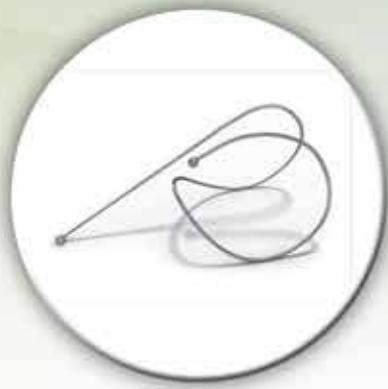
Sudish Murthy, MD, PhD, FACS, FCCP
Thoracic and Cardiovascular Surgery
Cleveland Clinic Main Campus
Cleveland, OH, USA

Sudish Murthy, MD, is the Surgical Director of the Center of Major Airway Disease and a staff thoracic surgeon in the Department of Thoracic and Cardiovascular Surgery, Sydell and Arnold Miller Family Heart & Vascular Institute. He holds joint appointments with the Transplant Center and the Taussig Cancer Institute. He is PhD in protein biochemistry. He is board-certified in general surgery and thoracic surgery.

His specialty interests include esophageal surgery; minimally invasive surgery including Robotics, bronchoscopic, laparoscopic and thorascopic procedures; general thoracic surgery and lung transplantation

Dr. Murthy earned his medical degree from Columbia University College of Physicians and Surgeons and a Ph.D. in pathology

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from the University of British Columbia, Vancouver, BC. At Columbia he received the Janeway Prize for Top Achievement in his graduating class, the Loeb Award for Excellence in Medicine, and the Merck Award for Outstanding Scholarship, among several other awards.

He completed an internship and a residency in surgery at Brigham and Women's Hospital of Harvard University, Boston, continuing there for a residency in cardiothoracic surgery. As a Harvard University Clinical Fellow he was selected as the Whitman Travelling scholar and served as the surgical emissary for Harvard Medical School in the Department of Esophageal Surgery at Queen Mary Hospital Medical Center at the University of Hong Kong.



Shigeo Muro, MD

Kyoto University
Department of Respiratory Medicine
Kyoto, Japan



Mohammed Abdруб Alnabi, MD, SSC-Em, ArBEM, UWO FCCM, ACEP-TF

Emergency & Critical Care Consultant
King Fahad Specialist Hospital- Dammam
Dammam, Saudi Arabia

Profile:

Born on April 22nd, 1976. Saudi male, married with 3 daughters. Certified & double boarded in Emergency Medicine. Also certified in Critical Care Medicine, and finished the ACEP teaching fellowship.

Education:

MBBS College of Medicine, King Faisal University, Dammam, Saudi Arabia - 1993-1999

Internship: King Fahd Hospital of the University, Khobar, Saudi Arabia - 1999-2000

Emergency Medicine Resident: Saudi Commission for Health Specialties, Riyadh Military Hospital, Riyadh, Saudi Arabia - 2001-2005

Emergency Medicine Resident: Arab Board for Medical Specialization, Riyadh Military Hospital, Riyadh, Saudi Arabia - 2001-2005

Critical Care Medicine Fellow:

University of Western Ontario, London Health Sciences Center, London ON, Canada - 2007-2009

Teaching Fellow:

American College of Emergency Physicians, Dallas TX, USA - 2009-2011

Experience:

Service Resident: Department of Urology, Riyadh Military Hospital, Riyadh, Saudi Arabia - 2000-2001

Senior Registrar Emergency Physician: Emergency Department, Riyadh military Hospital, Riyadh, Saudi Arabia - 2005-2006

Associate Consultant Emergency Physician: Emergency Department, King Fahd Medical City, Riyadh, Saudi Arabia



Prof. Parameswaran Nair, MD, FRCP, FRCPC

Canada Research Chair in Airway Inflammometry
Associate Professor, Division of Respiriology,
Department of Medicine

Adjunct Professor of Medicine, McGill University
Staff Respiriologist, Firestone Institute for Respiratory Health
Ontario, Canada

Dr Param Nair is a Professor of Respiratory Medicine and the Canada Research Chair in Airway Inflammation at McMaster University, Hamilton, Canada. He is also an Adjunct Professor of Medicine, McGill University and Staff Respiriologist, Firestone Institute for Respiratory Health. Dr Nair trained in general and respiratory medicine at Kerala Medical College Hospital and Royal Sunderland and Royal Sussex County Hospitals in England. He joined the faculty of Health Sciences of McMaster University in 2004 after obtaining his PhD in clinical research. He was elected a Member of the College of Chest Physicians and the Royal College of Physicians of Canada and the UK. Dr. Nair's research focuses on asthma management and on developing and applying non-invasive measurements of airway inflammation. He has published extensively in the field of management of Respiratory diseases including many clinical trials in prestigious journals including New England Journal of Medicine



Ronald Olivenstein, MD

McGill University · Department of Medicine
Montreal, Canada

Dr. Olivenstein graduated from McGill University with a BSc in biology in 1975 and obtained his medical degree at the Université Libre de Bruxelles in Belgium in 1983. He obtained his specialization in Internal Medicine (1989) and Respiratory Medicine (1992) at McGill University. Dr. Olivenstein is an Associate Professor of Medicine at McGill University where he is currently the Medical Director and Director of the Asthma Clinic at the Montreal Chest Institute of the McGill University Health Center. His research interests include clinical trials in asthma and COPD, investigations into airway inflammation in severe asthma and bronchial thermoplasty.



Prof. Ghazi Alotaibi, PhD, RRT

Assistant Professor of Respiratory Care
Dean, College of Applied Medical Sciences
University of Dammam- Saudi Arabia
President, Saudi Society for Respiratory Care
Dammam, Saudi Arabia

Dr Ghazi got his PhD in Health Sciences majoring in Respiratory Care from University of Medicine and Dentistry of New Jersey in USA, with special interest in mechanical ventilation. He also holds a postgraduate diploma in medical education from University of Dundee in UK in 2009.



Simon Padley, MD

Consultant Radiologist
Specialize in Thoracic and Vascular Imaging and Intervention
London, UK

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Dr. Simon Padley specialises in thoracic and vascular imaging and intervention, and general body imaging. He was the recipient of a 1991-2 thoracic imaging fellowship at Vancouver General Hospital.

Teaching:

He teaches visiting radiologists to the Trust department of radiology and is the organiser of the 2008 Masterclass in Cardiothoracic Imaging.

Dr. Padley has been an invited speaker on thoracic imaging at the European Congress of Radiology Annual Meeting and European Society of Thoracic Imaging Annual Meetings.



Prof. David Perkins, MD, PhD
Professor of Medicine & Surgery
Chicago, IL, USA

David Perkins, MD, PhD is a Professor of Medicine & Surgery at University of Illinois at Chicago. He completed a Nephrology Fellowship at Boston University, a Ph.D. in immunology. Followed by a Postdoctoral Fellowship at Massachusetts Institute of Technology. He developed his research program in the Center for Immunogenetics & Transplantation at Brigham & Women's Hospital, Harvard Medical School where he was an Associate Professor in Medicine. He then transferred to University of California San Diego and in July 2012 moved to University of Illinois at Chicago. He is currently Director of Transplantation Research and his research focus is systems biology and the microbiome.



Prof. Basil John Petrof, MD
Associates Director, Meakins-Christie Labs
Professor Department of Medicine
Assoc Member, Dept Neurol, McGill University,
Montreal, Canada



Giovanni Piedimonte, MD
Pediatric Institute, Institute Chair
Cleveland Clinic Main Campus
Cleveland, OH, USA



Prof. William S. Powell, MD
Assoc Director, Meakins-Christie Labs
Professor, Department of Medicine,
McGill University,
Montreal, Canada



Prof. David Proud, MD
Professor Department of Physiology &
Pharmacology
University of Calgary Medicine
Calgary, Canada



Prof. Hatem Qutub, MD, FCCP
Consultant Intensivist and Pulmonologist
Head of ICU, King Fahad University Hospital
University of Dammam
Dammam, Saudi Arabia

Dr. Hatem Othman Qutub is a Professor for the College of Medicine-University of Dammam, [previously King Faisal University] a Consultant Intensivist , pulmonologist & Internal Medicine for King Fahd Hospital of the University, Al-Khobar-Kingdom of Saudi Arabia. He is currently the Division head for (ICU), pulmonary at KFHU and was formerly appointed as Medical Director for Medical Services for the said hospital. In addition to head of cardiac intensive care unit at Al-Babatin Cardiac center. His diverse experience and expertise in the field of Critical and Respiratory Medicine led him to actively involved in the multiple distinguished organizations such as: Fundamentals Critical Care Support (FCCS) for American College of Critical Care Medicine as a National Course Consultant since 1998, Chairman for Eastern Province Critical Care Committee, Governor on Council for International Regents & Governors, Saudi Arabia for American Colleges of Chest Physicians (ACCP) from 2000- 2006.

In the field of academe, he became a very enthusiastic Chairman of Department of Respiratory Care for the College of Applied Medical Sciences at King Faisal University and later on in November 2007, he was appointed with a vast responsibility as being the Dean of the said college that comprise of seven (7) departments. In his tenure for academic service, he is now the Vice-President for Saudi Society for Respiratory Care, Chapter and fonder for Saudi Critical Care Society He had attained 45 publications of his work and more 450 international and national presentations with publication of 30 per review articles in the field of ICU / education and pulmonary medicine. He also contributed as Associate Editor for Annals Thoracic Medicine Journal for Saudi Thoracic Society Reviewer, Journal of Family & Community Medicine, and referees for many national journals.



Prof. Omar A. Al Rawas, MBChB, FRCP (Glasg.)
Professor and Consultant Pulmonologist
Head, Department of Medicine
College of Medicine and Health Sciences
Sultan Qaboos University
Muscat, Oman

Professor Omar Al-Rawas received his MBChB, postgraduate training in Respiratory Medicine and PhD from University of Glasgow, UK. He is the Dean of College of Medicine & Health Sciences, Sultan Qaboos University, Oman; the Chairman of the Sultan Qaboos University Hospital Board, and is Professor of Medicine and Consultant Pulmonologist at Sultan Qaboos University Hospital. He is a member of the Council of Trustees and Executive Council of Oman Medical Specialty Board, and Chairman of Ministry of Health Committee for improving respiratory services in Oman. Among the positions held in the past are President of Oman Medical Association; Chairman of OMSB Internal Medicine Scientific Committee; Chairman of the Health Sector Open Grant Committee of the Oman Research Council, and member of the Arab Medical Union Supreme Council.

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His experience in medical is focussed on assessment and examinations. He is a regular examiner in MRCP, UK (PACES) and Arab Board (Internal Medicine) in addition to invited examiner to undergraduate and post graduate clinical examinations in the region.

His research interest is lung function in health and disease, epidemiology of respiratory conditions in Oman, especially Asthma; being the Country Coordinator in the International Study of Asthma and Allergies in Children (ISAAC) in addition to respiratory health care delivery in Oman. He contributed to more than 70 publications in peer-reviewed journals in these areas.



Renata Rea, RRT, CRE

Respiratory Therapist & Educator,
Credit Valley Hospital Consultant,
Respiratory Healthcare
Mississauga, ON, Canada

Renata Rea is a Respiratory Therapist and Certified Respiratory Educator. She has 30 years of experience clinically and 20 years of pharmaceutical experience in the Respiratory area. She has a keen interest in improving patient outcomes in asthma and COPD (chronic obstructive pulmonary disease) through education and self-management. She practises at the Credit Valley Hospital as a Staff Respiratory Therapist involved in the care of patients, acute and chronic, with respiratory illness and their families



Ahmed Saadeddin, MD, FRCR (UK)

Consultant Clinical Oncologist
Prince Sultan Military Medical City
Riyadh, Saudi Arabia

Qualifications:

M.D. - King Faisal University / College of Medicine/ KSA
FRCR (UK) - Fellowship of the Royal College of Radiologists /
Clinical Oncology April - 1999, London / UK

Consultant Oncologist & Clinical Tutor

Apr. 2002 - Present Riyadh Military Hospital
Visiting physician / Neuro Oncology Unit
May 12 - July 28, 2008 MGH, Huston, USA
Consultant and Director of Oncology
Oct. 2000 - Apr.2002 Riyadh Military Hospital
Sen. Registrar & Research Fellow
July 1998 - Oct. 2000 Royal Marsden Hospital /UK
Specialist Registrar Dec.1995 - July 1998
Royal Marsden Hospital /UK

Teaching Experience:

- Honorary lecturer at the Institute of Cancer research (UK) 1997-1999
- Teaching supervisor and clinical tutor for clinical oncology since April 2002 /RKH.
- Published more than 30 articles and abstract mostly in Lung and breast cancer
- Speaker/ Chairman in more than 200 National, and International conferences

Research Activities & Current Interest:

- Research in the Treatment of locally advanced breast cancer
- Multimodality Treatment of Lung cancer and research in

personalized treatment in this disease.

- Development of Neuro Oncology National team to optimize treatment and carry on relevant research.
- Radioactive isotopes uses in the treatment of metastatic bone disease
- High dose Rhenium 186, with peripheral blood stem cell transplant.Royal Marsden Hospital (UK)



Prof. Robert Schellenberg, MD

Internist and Allergist / Immunologist
St. Paul's Hospital in Vancouver
Professor in the Faculty of Medicine
University of British Columbia (UBC)

Head of Division of Allergy and Clinical Immunology
Department of Medicine,
Vancouver, Canada

Dr. Robert Schellenberg is an Internist and Allergist / Immunologist at St. Paul's Hospital in Vancouver and a Professor in the Faculty of Medicine at the University of British Columbia (UBC). He is head of the division of Allergy and Clinical Immunology in the Department of Medicine, UBC. He earned his medical degree from the University of Manitoba in 1971 and completed internship and residency at the U. of Manitoba Teaching Hospitals. He did further postdoctoral studies in Allergy and Clinical Immunology at the Johns Hopkins University School of Medicine, Baltimore, MD, concentrating on basic research in mechanisms of allergic mediator release. He was an Assistant Professor in the Dept. Medicine at U. of Manitoba for 2 years prior to taking his first appointment at UBC in 1979.

Hospital and University Commitments:

Dr. Schellenberg is the Head of the Division of Allergy and Clinical Immunology and is responsible for the teaching schedules and elective rotations of medical students and residents. He is involved with Clinical Skills development and teaches in the Med I block as well as gives a lecture on allergic inflammation to Med I. He is involved with subspecialty teaching to other years of medical students as well as does general medicine sessions with Med III students.

Dr. Schellenberg is a member of the Executive Committee of the UBC Department of Medicine and has chaired review committees of various divisions. He has been a member of numerous other committees at both the hospital and university level. He performs consultations for allergy and clinical immunology at St. Paul's Hospital.



Baha Al Shawwa, MD, FCCP, FAAP

Consultant Pediatric Pulmonologist and Sleep
Medicine
Head of Pediatrics Department
Section Chief, Pediatric Pulmonology
Habib Medical Group, Arrayan Hospital
Riyadh, Saudi Arabia

Dr. Al-Shawwa is currently the head of pediatrics department and section chief for pediatric pulmonology at Habib Medical Group/ Arrayan Hospital which one of the largest and leading private tertiary care centers in Saudi Arabia and holds JCI accreditation.

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Before moving to Saudi Arabia, Dr. Al-Shawwa has worked as assistant professor of pediatrics at Indiana University in USA and as instructor of pediatrics at Medical College of Wisconsin. Dr. Al-Shawwa finished his pediatrics training from University of Iowa then got subspecialized in pediatric pulmonology from Medical College of Wisconsin where he also got fellowship training in sleep medicine. Dr. Al-Shawwa is certified by American board in pediatrics, pediatric pulmonology and sleep medicine and a member in many of international medical society. In addition to holding a busy clinical practice, Dr. Al-Shawwa has led many research activities and authored many peer reviewed articles in pediatric pulmonology and sleep medicine. His special interests are pulmonary infections, interventional bronchoscopy, asthma and sleep-disordered breathing.



Ahmed M. Abushahin, MD

Consultant, Pediatric Pulmonology Division
Pediatric Department
Hamad Medical Corporation
Doha-Qatar

Ahmed Abushahin, Graduated from school of medicine Aleppo University in 1998. Joined Hamad Medical Corporation, the largest tertiary care center in Qatar in 1999.

Dr. Abushahin is certified by the Arab Board in pediatrics in 2004 and finished a 3 year fellowship in Pediatric Pulmonology in 2007. Dr. Abushahin is currently consultant in pediatric pulmonology in HMC and assistant professor in clinical pediatric in weill cornell medical college in Qatar since 2011. In addition to clinical practice and education, Dr.

Abushahin has led many research projects in pediatric pulmonology and has special interest in Bronchopulmonary dysplasia.



Prof. Atef M. Shibl, MD

Professor of Microbiology
King Saud University
Riyadh, Saudi Arabia

Professor Shibl obtained his PhD in Medical Microbiology in the United Kingdom in 1980. Later, after two years of post-doctorate work at San Francisco General Hospital, he progressed to Professor of Microbiology in 1985. He is a member of the editorial board for the International Journal of Antimicrobial Agents, Journal of Chemotherapy, International Journal of Infectious Diseases, and Saudi Pharmaceutical Journal.

In addition, he is a council member of the International Society for Infectious Diseases, Mediterranean Society of Chemotherapy and the International Society of Chemotherapy. He is Vice-president of the Arab Society of Chemotherapy, Microbiology and Infectious Diseases (ASCMID). He is a member of the antibiotic committee on policy and infection control, and a member of the national Immunization committee, Ministry of health.

Professor Shibl is an author of more than 120 publications in national and international journals relating to his key interests in antibiotic resistance, policies and infection control. He actively participates in national and international meetings at which he is regularly invited to act as chair and deliver presentations on these topics.



Prof. Anita Simonds

Consultant in Respiratory & Sleep Medicine
Royal Brompton & Harefield NHS Foundation Trust,
London, UK

Anita Simonds is a Consultant in Respiratory Medicine at Royal Brompton Hospital, and Professor of Respiratory and Sleep Medicine at NHLI, with a research and clinical interest in sleep disordered breathing, and acute and chronic respiratory failure in adults and children. She has investigated the physiological basis of breathing difficulties during sleep and carried out trials of ventilatory support in a range of conditions.

Research projects have demonstrated that non-invasive ventilation extends survival in restrictive chest wall and neuromuscular conditions, especially Duchenne muscular dystrophy.

Prof Simonds' team have performed randomised controlled trials of the timing of initiation of non-invasive ventilation, and of a variety of ventilatory modes. This work has contributed to numerous clinical guidelines and standards of care. Having demonstrated that sleep disordered breathing is common in heart failure patients, the sleep research team is now exploring the effects of nocturnal adaptive servo-ventilation on survival and cardiac outcomes as part of a European multicentre trial jointly with Professor Martin Cowie.

The team is also carrying out an NIHR CLAHRC funded trial of telemonitoring in respiratory and heart failure patients, and a trial of an autotitrating non-invasive ventilator. Together with Prof M Morrell, she is examining the impact of obstructive sleep apnoea on cognitive and neuroanatomical function, and the ability of continuous positive airway pressure (CPAP) therapy to reverse any decrements.



Hayat S. Sindi, MD

Saudi Arabian Medical Scientist
Consultative Assembly of Saudi Arabia
Makkah, Saudi Arabia

Is a Saudi Arabian medical scientist and one of the first female members of the Consultative Assembly of Saudi Arabia. She is famous for making major contributions to point-of-care medical testing and biotechnology. She was ranked by Arabian Business as the 19th most influential Arab in the world and the ninth most influential Arab woman

Education:

Hayat Sindi was born in Mecca in 6 November 1967. In 1991, she convinced her family to allow her to travel alone to the United Kingdom in order to pursue her higher education. After a year spent learning English and studying for her A-levels, she was accepted to King's College London, [8] where she graduated with a degree in pharmacology in 1995. While at King's College she was a recipient of Princess Anne's Award for her undergraduate work on allergy.

Sindi, who wears the traditional Muslim headscarf, was pressured to abandon her religious and cultural beliefs while at university; she persisted, holding the view that a person's religion, color or gender has no bearing on scientific contributions. Sindi went on to get a Ph.D. in biotechnology from Cambridge University in 2001;

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she was the first Saudi woman to be accepted at Cambridge University in the field of biotechnology, and the first woman from any of the Arab States of the Persian Gulf to complete a doctoral degree in the field.



Prof. Peter D. Sly MBBS, MD, FRACP, DSc

Pediatric Respiratory Physician
University of Queensland
Deputy Director, Queensland Children's Medical
Research Institute,
Australia

Professor Peter Sly is recognized internationally in the area of Children's Environmental Health. He currently directs the Children's Health and Environment Program at QCMRI, The University of Queensland; is on the Advisory Board for a long standing WHO – National Institute of Environmental Health Sciences Collaborative Agreement; is the Chair of the Board of Directors of the Pacific Basin Consortium for Environment and Health; and is an advisor to the WHO, Public Health and Environment Section. Professor Peter Sly is a NH&MRC Senior Principal Research Fellow and a paediatric respiratory physician with extensive research experience in respiratory physiology.

Faced with the global challenge of the escalating incidence of childhood lung diseases Professor Peter Sly seeks to identify and develop preventative strategies for children at greatest risk. There is an increasing recognition that most chronic adult diseases have their origin in childhood; especially respiratory and cardiovascular diseases. Professor Peter Sly's research aims to understand the mechanisms underlying chronic childhood lung diseases in order to improve clinical management and to delay or prevent their onset, with consequent reductions in adult lung diseases. A combination of basic science, longitudinal cohort studies and translation of research findings into clinical practice, including clinical trials, are included in three main areas: asthma, cystic fibrosis and children's environmental health.

Professor Peter Sly is a frequent speaker at international conferences and widely published in the leading journals in his field.



Prof. Rédha Souilamas, MD

Head of Lung Transplant Program, Department of
Thoracic surgery
European Georges Pompidou Hospital
Abu Dhabi, UAE

In fact, it is Reda who developed the first structure of ambulatory thoracic surgery in France. It is 5 years coordinator of lung transplant program for cystic fibrosis. Meanwhile, he leads a French protocol reconditioning ex vivo lungs used short-term to double the number of lung transplants. Be everywhere and nowhere, without labels or fuss, this is the career of this Cherchellois preppy from a family of 6 children born during the war in Algeria in 1956. He grew up in this provincial town, steeped in history within a family of wealthy background, in which the personality of his father inspired respect and admiration. "At that time, Cherchell was a big family where everyone had his place," he remembers. As for his education, "it was pretty rough. Neither good nor bad student, rather claimant. I spent my tray in Algiers and I started medical studies that were long and boring.

In fact, I hesitated and I took some time to be convinced of the usefulness of these studies.

When I started attending the operating theater as a student, I discovered then surgery, which changed my view of medicine. Operating theaters were the theaters in which to play every day parts with real life actors. I found out 20 years later, during my training transplantation in England, the operating theaters were called "theater". It took, however I validates the non-surgical semesters as cardiology, internal medicine, etc.. to qualify for a surgical specialty, which was not a thin and short case. "His departure for abroad, as we shall see, was not dictated by any ambition. "A combination of circumstances, no more! I went to France just after my military service. There were two reasons (apart from a general malaise that began to settle from the 1980s and was completed as we know). The first is that I followed the woman of my life had gone back to live in France where she had come a few years earlier. The second was related to the fact that I refused to study specialization in surgery. Indeed, the first in my class had chosen positions surgery, then there was breakage. With a letter of recommendation from a distinguished professor, I went to the Dean of the Faculty of Medicine to apply. He refused on the grounds that the unoccupied positions would be attributed to choice the following year. I ventured to ask him if I was his nephew, his answer was the same. He ordered me to leave his office.

I then left the faculty and also Algeria to try my luck in France. I was received in support of surgical specialties for foreigners in Paris where I made my specialty of thoracic surgery in 5 years. After obtaining the equivalence of medical school, I worked as Clinical Director for 2 years at the Laennec Hospital in the service of thoracic surgery, before graduating from the French College of thoracic surgery. "



Prof. Martin R. Stämpfli

Professor
Department of Pathology and Molecular Medicine,
McMaster Immunology Research Centre,
and Department of Medicine, Firestone Institute
for Respiratory Health at St. Joseph's Healthcare
Hamilton, Canada

Dr. Martin Stämpfli is a Professor in the Department of Pathology and Molecular Medicine. His research focus is on the impact of cigarette smoke on the immune system and its implications to smoking-related diseases. Dr. Stämpfli has held several career awards including a Parker B. Francis Scholarship (USA), a CIHR New Investigator Award and received the Respiratory 2000 International Young Investigator Award in recognition of outstanding achievement in basic research.



Ali H. Aitalag, MD, ABIM

Chairman, Saudi Thoracic Imaging Group, Saudi
Thoracic Society
Consultant Pulmonologist, Intensivist and
echocardiographer
Head, Ultrasound Unit, Department of Intensive
Care Services
Head, ICIP Quality Committee, Department of Intensive Care
Services

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Department of Intensive Care Services
Prince Sultan Military Medical City
Riyadh, Saudi Arabia

Current Post:

Consultant Intensivist, department of critical care services,
Riyadh Military Hospital, Riyadh, KSA.

Qualifications:

1. MBBS, King Faisal University, Dammam, KSA, September 1996.
2. Arab Board of Internal Medicine, March 2002.
3. Saudi Board of Internal Medicine, October 2002
4. Jordanian Board of Internal Medicine, March 2002.
5. Fellowship in Respiratory Medicine, University of British Columbia, Vancouver, Canada, July 2005 - June 2007
6. Fellowship in Critical Care Medicine, University of Toronto, Toronto, Canada, July 2007 - June 2009
7. Fellowship in Echocardiography and Clinical Ultrasonography, University of Toronto, Toronto, Canada, July 2009 - June 2010

Publications:

- Published a scientific book in respiratory medicine titled: "Pulmonary Function Tests in Clinical Practice", April 14, 2009; Springer. Full reference: Altalag A, et al. Pulmonary Function Tests in Clinical Practice. Springers, London, UK, 2009.
- Other publications included case reports and review articles.

Ultrasound Course Organization:

- Organized and chaired the First Clinical Ultrasound Course in Riyadh Military Hospital, 18-19 May 2011.
- Currently organizing the second course for May of 2012.
- Participated in organizing several courses in Bedside ultrasound in Riyadh, KSA.



Faiza Al-Talaq, MD
Associate Consultant
Dammam, Saudi Arabia

- King Faisal University, College of Medicine
- Prince Sultan Military Medical City/King Fahad National Guard Hospital-Riyadh, Emergency Medicine Residency
- Saudi/Arab Board of Emergency Medicine
- American College of Emergency Physician member
- Fellowship of American Academy of Emergency Medicine
- Emergency Ultrasound Fellowship, Massachusetts General Hospital, Harvard Medical School of Medicine, Boston.
- Registered Diagnostic Medical Sonographer, USA
- American Institute of Ultrasound in Medicine member.
- Participated in many local and international Ultrasound conferences, courses.



Anne Tsicopoulos, MD
Pasteur de Lille Institute
France

Center for Infection and Immunity of Lille,, Institute Pasteur de Lille, Lille, France F1000 Associate Faculty Member (since 17 September 2013)

Biography: Anne Tsicopoulos was born in 1959 in Strasbourg, France. She did her medical training in Lille and started her scientific carrier at the Center of Immunology and Biological Parasitology headed by Professor Andre Capron. Her post doctoral training was devoted to allergic inflammation at the National Heart and Lung Institute in London, in the department headed by Professor A.B. Kay. Dr Anne Tsicopoulos has dedicated her scientific carrier to the mechanisms regulating allergic inflammation, with particular area of research interest such as immunotherapy, pathogenesis of asthma, role of chemokines in allergic inflammation, and the role of environmental pollutants on allergic inflammation. Dr Tsicopoulos has been Director of Research at the Inserm (National Institute for Health and Medical Research) since 2002 and heads the department of pulmonary immunity at the Institut Pasteur of Lille since 2010. She will be the next President of the scientific council of the French Society for Allergy (SFA).

Current Position:

Dr Tsicopoulos has been Director of Research at the Inserm (National Institute for Health and Medical Research) since 2002 and heads the Department of Pulmonary Immunity at the Institut Pasteur of Lille since 2010.



Prof. Meri Tulic, BSc, W.Aust.
University of Nice Sophia-Antipolis
France

Biography: A/Prof MK Tulic is a Senior Research Fellow working in Professor Susan Prescott's laboratory. She has extensive experience in physiology, cellular and molecular laboratory techniques in both animal and human studies in the field of innate immunology. Her work has been widely recognized by both the local and international scientific community. She has had extensive and sustained research productivity with over 45 published peer-review manuscripts in top-ranked journals and most as first or senior author. These publications are widely cited (collectively more than 650 times) and 2 of these have been referred to as 'citation classics'.

Early interests (PhD project) involved studying the role of bacterial products on modification of allergic inflammation in animal models of asthma primarily studying lung mechanics and inflammatory markers in this model. This work has led to publication of 6 first author peer-reviewed articles in top-rated allergy journals and has been recognized by the ICHR Young Investigator Award (1999) and Thoracic Society of Australia and New Zealand New Investigator Award (2000).

Since then, her postdoctoral work was carried out in Montreal, Canada at the Meakins-Christie Laboratories, McGill University with Prof Hamid's group. Here she independently developed and characterized a novel ex vivo model of bacterial-induced

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inflammation using explanted nasal mucosa from young children. This clinical model has generated much international interest and has resulted in publication of 12 manuscripts in high impact journals. In addition, she has been invited to contribute to 9 book chapters and 7 reviews in her field and has personally been invited to present her work at 22 local and 30 international meetings where she has also chaired sessions. Many of these meetings have been possible due to her success in obtaining travel awards (16).



Herbert Wiedemann, MD, MBA

Pulmonary, Allergy and Critical Care Medicine
Chairman of the Cleveland Clinic Respiratory Institute, Chairman of the Department of Pulmonary, Allergy & Critical Care Medicine
Cleveland, OH, USA

Herbert P. Wiedemann, MD, MBA, is Chairman of the Cleveland Clinic Respiratory Institute as well as Chairman of the Department of Pulmonary, Allergy & Critical Care Medicine, a position he has held since 1991. Dr. Wiedemann also served a five-year term on Cleveland Clinic's Board of Governors (2001-2006).

He is board-certified in internal medicine, pulmonary disease, and critical care medicine. Dr. Wiedemann's clinical interests are intensive care medicine (including acute respiratory distress syndrome and sepsis) and the evaluation of dyspnea (including cardiopulmonary exercise testing). Dr. Wiedemann has been the recipient of many awards including The Best Doctors in America, America's Top Doctors, Who's Who in Medicine and Healthcare, and Who's Who in America. Dr. Wiedemann has participated in several large multicenter trials of new therapies for acute respiratory distress syndrome (ARDS) and sepsis, and he served as principal investigator for three of these trials.

In addition, Dr. Wiedemann is a journal reviewer for many peer-reviewed publications including New England Journal of Medicine, Annals of Internal Medicine, Chest, European Respiratory Journal, and Journal of Intensive Care Medicine. He is a member or fellow of the American College of Chest Physicians, the American College of Critical Care Medicine and the American College of Physicians. Dr. Wiedemann also has taught as a visiting professor at many national and international universities.



Harissios Vliagoftis, MD

Associate Professor and Director
Division of Pulmonary Medicine, Department of Medicine,
Edmonton, AB, Canada

Dr. Harissios Vliagoftis obtained his MD and PhD from the Aristotelian University, School of Medicine, Thessaloniki, Greece. He completed clinical and research training in Allergy and Clinical Immunology at the National Institutes of Health in Bethesda, MD, and obtained further postdoctoral training at Tufts University, Boston, MA and at the University of Alberta. Dr. Vliagoftis is currently Associate Professor and Director of the Division of Pulmonary Medicine, Department of Medicine, University of Alberta. He is an Alberta Innovates — Health Solutions Scholar. Dr. Vliagoftis' research is currently focused on the role of proteinases and their receptors in the development of allergic

sensitization and allergic airway inflammation. He also has interest in the role of psychological stress in allergic airway inflammation.

Dr. Vliagoftis' research has been funded by the Canadian Institutes for Health Research, The Lung Association of Alberta & NWT, Allergen Inc., Hospital for Sick Children Foundation, CFI and Alberta Innovation and Science. In collaboration with colleagues at the University of Alberta, he recently received a highly competitive grant from the National Sanitarium Association (NSA) to study asthma phenotypes using combined genomic and metabolomic approaches. This \$1 million grant is awarded to one site every year and is the first NSA grant awarded to a scientist in Alberta.

Dr. Vliagoftis has shown important leadership for respiratory disease in Alberta over the last 13 years. He has been instrumental in improving the research environment studying allergic respiratory diseases in the province.



Sun Ying, MD

King's College London
London, UK



Abdullah Yousef, MD

Assistant Professor of Pediatrics
Consultant Pediatric Pulmonologist
King Fahad Hospital of the University
University of Dammam
Dammam, Saudi Arabia

Dr Yousef graduated from the King Faisal University in Dammam Saudi Arabia in the year 2000. After completing his internship he joined the residency program at King Fahd Hospital of the University in Al-Khobar, Saudi Arabia. He completed his training in both Saudi and Arab Board of Pediatrics in 2006. In 2009 he completed his fellowship training in Pediatric Pulmonology at Sydney Children's Hospital, Sydney, Australia.

Dr Yousef is currently working as a consultant pediatric pulmonologist and an assistant professor of pediatrics at King Fahd Hospital of the University, University of Dammam, Saudi Arabia. He is also a member of the executive board and Head of research task force of the Saudi Pediatric Pulmonary Association



Sawsan Al Yousef, MD, CABP, FCCP

Consultant, Pediatric Intensivist and Pulmonologist
Assistant professor KSAU-HS
Director PICU Fellowship Program, Children
Hospital, King Fahad Medical City
Riyadh, Saudi Arabia

1. Assistant Professor King Saud Bin Abdulaziz University and Health Science
2. Clinical and Research Pediatric Critical Care, University of Western Ontario, Canada, 2001
3. Clinical Pediatric Respiratory, University of Toronto, Canada, 2003
4. Arab Board of Pediatrics, 1997
5. Saudi Board of Pediatrics, 1997

FACULTY - PROFILE

6. Bachelor of Medicine and Surgery, King Saud University, 1992

Currently Appointed:

- Consultant Pediatric Intensive Care and Pulmonary at King Fahad Medical City .
- Program Director of Saudi Council PICU Fellowship
- Program Director of KFMC PICU Fellowship
- Chairwoman of Health Education and Postgraduate Coordinator of PICU Department at King Fahad Medical City
- Assistant head of skills Lab and simulation centre at KFMC
- Professional Membership
- Society of Critical Care Medicine
- Society of Pediatric Critical Care Medicine
- FCCP, American College of Chest Physician
- Arab and Gulf Pediatric pulmonary society



Zahra Zawawi, BsRC

Senior Respiratory Therapist
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Zahra Zawawi is a senior Respiratory Therapist at King Fahd Hospital of the University in Alkhobar, Damma University, Saudi Arabia. Zahra graduated from king Faisal University in Dammam with a Bachelor's Degree in Respiratory Care Science in 2005, she then went on to study Sleep Medicine at the Michener Institute for Applied Health Sciences in Toronto Canada where she was awarded a Post Graduate Certificate in Sleep Medicine Technology in 2007. Zahra is a Certified Asthma Educator and is currently an Executive Board Member of the Saudi Society for Respiratory Care.



Prof. Joanna Pepke-Zaba, PhD, FRCP

Lead Physician and Director, National Pulmonary Vascular Diseases Unit
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Dr Pepke-Zaba, PhD, FRCP, graduated from Warsaw University School of Medicine in Poland before undertaking a fellowship in respiratory physiology at Papworth Hospital and Addenbrooke's Hospital, Cambridge, which resulted in a PhD. Since 1999 she has been Lead Physician, and since 2004, Director of the national commission group designated National Pulmonary Vascular Diseases Unit.

The Unit is unique in that it deals with the full spectrum of pulmonary vascular diseases and the consequent heart failure. This includes medical and surgical management of patients with all types of pulmonary hypertension. Papworth is the sole referral centre in the UK for patients with chronic thromboembolic disease to be assessed for surgical pulmonary endarterectomy.

Dr Pepke-Zaba's current research interests centre on the translational research programmes; she proposes innovative research with an emphasis on the continual integration of basic science into clinical medicine as a vital part of delivering the best patient care. This encourages young researchers to investigate

basic science questions in terms of clinical applicability as the MD or PhD programmes. She is committed to training in respiratory medicine and was re-appointed as the Recognised Teacher by the Clinical School of the University of Cambridge.

She has been the Honorary Senior Visiting Fellow of University of Cambridge School of Clinical Medicine since 2011. Dr Pepke-Zaba has previously chaired the National Pulmonary Hypertension Service UK and Ireland. She is recognised as the pulmonary hypertension expert, serving on different scientific committees and presenting as invited speaker and chairperson at international and national meetings. She has published over 80 papers and several chapters in the field.



Ashraf H. Alzaabi, MD, FRCPC, FCCP

Clinical Assistant Professor, UAE University
Head, Respiratory Division,
Zayed Military Hospital
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Ashraf Alzaabi, MD FRCPC FCCP. Head, Respirology Division at Zayed Military Hospital in Abu Dhabi, UAE. Clinical Assistant Professor In Internal Medicine, Faculty Of Medicine and Health Sciences. Graduated from The Royal College Of Surgeons In Ireland 1997. Finished the residency program in Internal Medicine and Respirology from the University Of Toronto, Canada 2006.

Held the position of Director of Medical Education at Zayed Military Hospital 2007-2010. Has an interest in COPD research and published the first COPD prevalence study in UAE in January 2011 at the Respiratory Medicine Journal.



Prof. Abdulaziz H. Alzeer, MD, FRCP(C), FCCP

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Dr. Abdulaziz H. Alzeer is a professor of Medicine and a Consultant for Pulmonology and Critical Care Medicine at King Khalid University Hospital, King Saud University, Riyadh, Saudi Arabia. Dr. Alzeer was a graduate of College of Medicine of King Saud University. He is a fellow of the American College of Chest Physician and Royal College of Physicians and Surgeons of Canada. He is a member of the Society of Critical Care Medicine, Saudi Thoracic Society and Saudi Critical Care Society. He was the founding chair of the Department of Critical Care of King Khalid University Hospital. His research, publication and professional involvement focus on pulmonary and critical care medicine. His research interest is in bronchiectasis, COPD and infection in ICU.

FACULTY - PROFILE



Tao Zheng, MD

Associate Professor of Medicine (Immunology) and of Pediatrics (Immunology)
Chief, Section of Allergy and Clinical Immunology
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Zhou Zhu, MD

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Omar Alzumai, BsRT, RRT

Clinical Educator, Respiratory Services
King Abdulaziz Medical City, Riyadh, KSA
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Riyadh, Saudi Arabia

Mr. Omar Al Zumai's humble beginnings started when he worked as a Mechanical Engineering Technician at HADEDD from 1996 - 1998 and as Unit Assistant here at the National Guard Health Affairs from 1999 to 2001. By then, in 2002, he became a scholar and completed both Associate and Bachelor's degrees in Respiratory Care at the prestigious Boise State University in Idaho, United States in 2007. On the same year, these diplomas paved the way for him to work as Respiratory Therapist at the National Guard Health Affairs - King Abdulaziz Medical City in Riyadh. He also worked as a Clinical Polysomnographer at Saint Alphonsus Sleep Disorder Center. He earned the much coveted

designation as Certified and Registered Respiratory Therapist by the National Board of Respiratory Care in 2010. These credentials, not to mention his professionalism, proficiency, knowledge and skills in Respiratory Care enabled him to be promoted as an Educator. Consequently, he shared what he has through conducting workshops and in-services such as FCCS and Mechanical Ventilator Courses both locally and internationally. He also did Special Courses like Functional Analysis, Violence in School, Behavior is a Language, and Dealing with Special Need Students.

Mr. Omar is a member of distinguished and esteemed organizations like the Saudi Society for Respiratory Care and even taught and held lectures and seminars in its various conferences here in the Kingdom.

At present, he is the Clinical Staff Educator of Respiratory Services, King Abdulaziz Medical City - Ministry of National Guard Health Affairs, concurrently a Clinical Instructor at the College of Applied Medical Sciences, King Saud Bin Abdulaziz University for Health Sciences.





SINA

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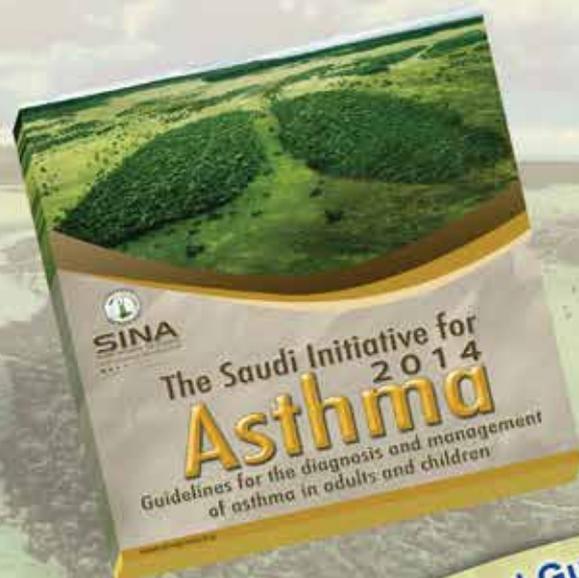
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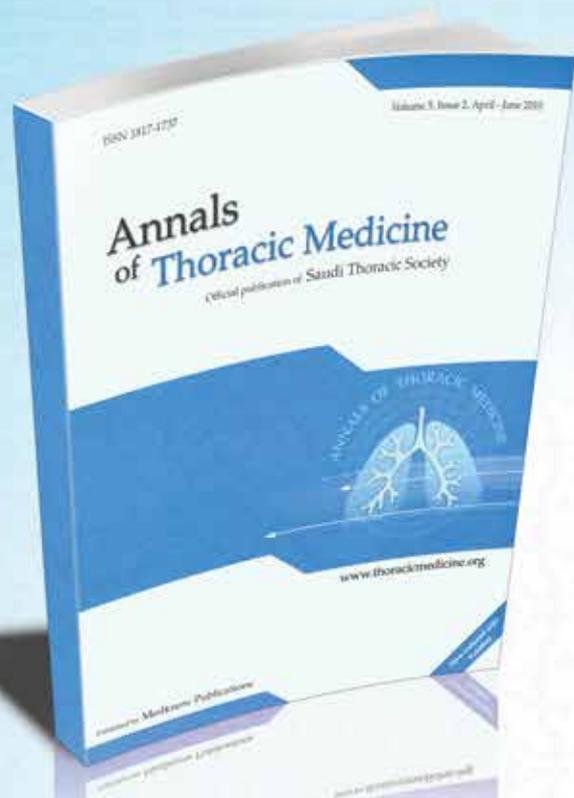
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Efficacy Of Carbamazepine In Treatment Of Bronchial Asthma**Mohamed Shahat Badawy, Ismail Sayed Mobarak, Mohamed Abdalla Abass****Settings:** The real break-through in asthma treatment is still unreachable. In many cases drugs are not effective for reaching the control state.**Objectives:** To investigate the efficacy of Carbamazepine in treatment of bronchial asthma.**Patients and methods:** A Randomized, Parallel 6-month trial. Hundred patients were fulfilled the inclusion criteria and divided into two groups. Group (1) received Carbamazepine (600 – 1600 mg/day) in addition to their usual anti-asthmatic treatment and group (2) received only the usual anti-asthmatic therapy. Baseline Electroencephalography (EEG) studies was done to all patients. Assessment of asthma control according to GINA classification was done before, 3 and 6 months after therapy.**Results:** The mean age of studied patients were (37.9± 9.47 & 28.6±11.06) respectively. Two cases in group 1 showed abnormal EEG and no abnormality in group 2. As regards Level of asthma control, there was statistically significant difference between first visit and third visit in both groups with high value in group 1 (P value 0.001, 0.04). In comparing spirometric data of both groups at each visit revealed statistically significant P value in all parameters (FEV₁ 0.001, FVC 0.003, PEF 0.01, FEF₂₅₋₇₅ 0.001) except FEV₁/FVC (P value was 0.264). The frequency of acute asthma exacerbation in both groups was (0.5 ± 0.57 & 3.2 ± 0.98) in group 1 and 2 respectively (95% CI 2.4 to 3.1) with highly significant p value 0.003. In Carbamazepine group dizziness was recorded in 6 cases 12%, itching in 2 cases 4%, and increasing sleepiness in 2 cases 4%.**Conclusion:** Carbamazepine is effective in treatment and in achievement of better asthma control with minimal side effect.**Asthma Control In Adults In Saudi Arabia: A Single Tertiary Care Center Experience.****Mohamed Banama, Majdy Idrees****Objective:** Asthma control is the target of therapy. Many studies have shown that asthma control is poor in most asthma patients despite the availability of effective treatment. This study was directed to evaluate the level of asthma control among asthma patients followed at Prince Sultan Military Medical City and to study the different cofactors affecting the control.**Methods:** This was a cross-sectional study. The Asthma Control Test

Questionnaire was used to assess asthma control. A score of > 20 indicates controlled asthma, 16-19 as partially controlled asthma, and < 16 as uncontrolled asthma. Medications, adherence to therapy, and history of exacerbation over 1 year was also determined.

Results: A total of 61 patients were interviewed; 45 were female (74%). The median age was 47.8 (range 18-72). The Asthma Control Test revealed controlled asthma in 9 patients (14.8%), partially controlled asthma in 12 patients (19.7%), and uncontrolled asthma in 40 patients (65.5%). Forty one patients (68.3%) had at least one emergency room visit due to asthma exacerbation during the year prior to the interview, and 8 patients (13.3%) had hospital admission because of asthma during the same period. A combination of inhaled corticosteroids and long acting β_2 agonist was the most commonly used drug (88.3%); montelukast was used by 41.7% of the cases; omalizumab by 8.3%, and Tiotropium by 11.7%. Only 2 patients were using inhaled corticosteroids as a monotherapy. Twenty five patients (41%) were on anti-allergic rhinitis treatment. 1 patient (1.5%) was on cyclosporine as steroid sparing agent, and 1 patient (1.5%) was on amitriptyline for the treatment of coexisting vocal cord dysfunction. Only 38 patients (62.3%) had ever received formal education about their disease. Adequate use of inhalers was practiced by 31 patients (50.1%).**Conclusion:** Control of bronchial asthma is still inadequate in the majority of patients. This has led to frequent exacerbations and extensive consumption of health care resources. Patients' education and adherence to therapy are suboptimal, and maybe contributing to the poor asthma control.**Keywords:** Asthma control, ACT, Saudi Arabia**Evaluation of variables which may have an influence over control of asthma in pediatric****Bashayer Alonazi, Nada Sardidi, Aish Hawsawi, Arwa Alghamdi, Sukinah Almwatawah, Khairiah Alshab****Abstract:** More than 2 millions individual is suffering from asthma in Saudi Arabia. Objective of Our study was to evaluate variables that may contribute to asthma control.**Method:** a survey method based on a questionnaire was constructed around these elements : patient profile , education level & income of caregiver , using home nebulizer , MDI and Asthma Control Test (ACT). Out of 200 questionnaires distributed randomly Online (via social media) and manual (hospitals , malls and Dammam university) to patient's caregiver sample aged (2-14) in ALDammam & ALKhuber cities . 152 responses were received.**Results:** The results had showed that (66 patients) 43 % were uncontrolled, (36 patients) 24% were partially controlled and (50 patients) 33% were well controlled.**AOP ORPHAN**
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Conclusion: Majority of Asthmatic patients in ALKhuber & ALDammam was not controlled. Gender, education level, use of MDI or home nebulizer did not show clear association with ACT score. Even though with MDI or home neb use, ACT was not controlled enough, which can be explained by lack of education in using these devices. Income seems to have a contribution on ACT score

Pollen sensitization profiles of allergic patients in a Middle European Region

Panzner P., Vachova M., Vitovcova P., Vlas T.

Objective: The aim of our study was to assess the pollen sensitization patterns by means of molecular diagnosis approach in the region of Pilsen, Czech Republic.

Methods: The microarray system ImmunoCAP ISAC has been used for specific IgE detection to 113 different allergenic molecules. Sera from 789 patients sensitized to at least one pollen-derived molecule were subject of analysis. These patients suffered from at least one of the following diagnoses: chronic rhinitis (62%), bronchial asthma (33%), atopic dermatitis (28%), urticaria or angioedema (28%) and/or anaphylaxis (11%). Patient age ranged from 2 to 68 years, with a mean age of 32,4 years. The sex ratio was 37,0% men to 63,0% women.

Results: The most frequent sensitization rate was observed to grass-derived species specific molecules (82,2% overall), the most frequent being Phl p 1 (66,3%), markedly overwhelming sensitization rates to any non-pollen-derived molecule. The second one were pollen-derived PR-10 molecules (53,2% overall), of which the large majority included Bet v 1 (52,3%). Sensitization to these two types of pollen components (and their co-sensitizations with other components) forms the vast majority of pollen sensitizations. The patterns of co-sensitization is presented by means of Venn diagram approach. Sensitization to Cupressaceae-derived molecules was observed in 16,0% of subjects, to Oleaceae derived-molecules in 12,5% (Ole e 1 and Ole e 9 in 9,0% and 3,8% resp.) and to the plane tree-derived molecules Pla a 2 and Pla a 3 in 15,4% and 4,1% resp; these relatively high rates were surprising as the respective pollens have not been considered as important in the region. The sensitization rates for further molecules were: Art v 1 – 13,4%, Pla l 1 – 11,4%, Che a 1 – 9,9%, Par j 2 – 0,9%, Sal k 1 – 0,6% and Amb a 1 – 0,3%. The sensitization rates to cross-reacting molecules were generally not as high as reported from other regions (profilins 16,2%, polcalcins 5,5%, LTPs 6,7%). Only 1,8% patients reacted to pollen-derived panallergen and not simultaneously to a pollen species-specific component.

Conclusion: Molecular diagnosis of allergy gives a more precise and comprehensive insight into pollen sensitization patterns than extract-based testing, allowing for better understanding of the sensitization process and regional differences. The data presented may help to improve diagnostic and treatment specific procedures in the respective region.

Ten year mortality in a primary care COPD Cohort: multidimensional index BOD more discriminant than GOLD staging.

Khalid A. Ansari, MD, M.Phil, Ph.D,

Objective: Recent COPD guidelines have recognised that the severity with FEV1 alone merely defines impairment which is poorly correlated with symptoms and disability. Multi-dimensional tools have therefore been recommended for the assessment of the clinical impact of COPD e.g. BODE - characterised by: B. Systemic inflammation causing loss of lean body mass and muscle weakness (BMI); O. Impairment due to Airflow Obstruction (FEV1%); D. Disability expressed as perceived breathlessness (MRC Dyspnoea Scale); and E. Exercise capacity (6 minute walk test). Using the BODE index in 625 hospital patients Celli et al (NEJM, 2004) showed that mortality increased with higher BODE scores. However only 7.5% of their subjects were women. We have studied ten year mortality in a cohort of primary care patients with COPD. Since available resources and co-morbidities in the elderly may preclude a meaningful six minute walk test, we have assessed

the prognostic value of BOD (BODE without an exercise test).

Method: In October 2010 we evaluated all-cause mortality from the Registrar-General's reports in 455 patients (51% female) diagnosed with COPD in primary care according to BTS criteria between September 1999 and December 2002. A scoring system was applied to all patients based on their data at entry utilising BMI, FEV1 % predicted, MRC dyspnoea score, age and smoking pack/year history.

Results: The baseline data shows 455 subjects out of which 222 were females. No subject had a BOD score of 7. Mortality increased with BOD score. BOD, BODS, BODAS and GOLD predicted all cause mortality in primary care patients with COPD and a ROC analysis showed that the AUC with BOD was higher than with GOLD. Addition of both age and pack-years improved the predictive power of the model. Cox regression analysis showed that mortality was related to BOD score by quartile ($p < 0.0001$). There was no significant difference in mortality between men and women. Kaplan-Meier analysis of BODS (BOD + pack/years score) shows improved discrimination of quartiles of scores. Health status in 161 survivors (assessed in 2007/8) showed a pattern where those in the worst quartile of BOD scores had higher total SGRQ scores.

Conclusion: BOD is a simple prognostic Read-coded index for the evaluation of the clinical impact of COPD. The study also suggest that Exercise testing is not essential for the multi-dimensional assessment of mortality in COPD. Additionally, BOD is a model that could help identify therapeutic interventions to influence the natural history of COPD. most importantly, adding pack/years improves discrimination.

Precision in diagnosing and classifying COPD: comparison of historical height with current height and arm span to predict FEV1.

Khalid Ansari, Niall Keaney, Andrea D Lawrence, Ian K Taylor, Monica Price, Joan Munby

Objective: Spirometric measurements are markedly affected by age and height. Osteoporosis is a recognized co-morbidity in patients with chronic obstructive pulmonary disease (COPD) and may cause excessive height loss.

The aim of the study was to examine the height variation in COPD patients over 7-8 years period and its impact on overestimation of lung function. We also hypothesized that the classification of severity in an individual could be influenced by underestimation of predicted FEV1 values.

Methods: In 1999-2002 we studied a cohort of primary care patients in Sunderland, UK with COPD and re-examined 104 (56 male) during 2007-2009. We calculated FEV1% predicted for actual and estimated height (armspan/1.03 and armspan/1.01 in males and females respectively).

Results: In 1999-2002 the subjects were aged 62.6 ± 9.4 years, BMI was 26.4 ± 4.7 kg/m², predicted FEV1 was 59.0 ± 16.0 , and mean actual height was 167.3 ± 8.9 cm. The actual height changed significantly ($p < 0.001$) by 2cms over time in both genders.

As a consequence in non-COPD controls, it was found that 5.7% (06/104) in the 1999-2002 and 7.7% (08/104) in the 2007-08 cohort had values for FEV1% predicted of $< 80\%$ when these were calculated using estimated height. The study also suggests that the overestimation of predicted FEV1 influence the classification of severity in 2007-2008.

Conclusions: The study suggests that the current measured height may underestimate predicted FEV1. This study also demonstrates that the use of arm span increased the proportion of patients with FEV1 $< 80\%$ thus help to identify borderline COPD patients who are otherwise considered as normal.

Association of hand grip strength with health related quality of life and copd exacerbation in patients with chronic obstructive pulmonary disease.

Khalid Ansari , Niall Keaney, Andrea D Lawrence, Ian K Taylor, Monica Price, Joan Munby

Objectives: The muscle mass is commonly decreased in patients with chronic obstructive pulmonary disease (COPD), which may alter their health related quality of life (HRQL). Multiple factors contribute to muscle weakness and reduced muscle mass in chronic obstructive pulmonary disease (COPD). One factor implicated in this process is systemic inflammation, an accompaniment of acute exacerbations. Recurrent exacerbations are associated with lower health status and this study examines the relationship between muscle weaknesses, health status and exacerbation frequency in a cohort of COPD patients.

Methods: This was a perspective cohort study. Patients were recruited from outpatient respiratory clinics There were 188 (95 female) patients with COPD were recruited. We measured spirometry, body mass index, health status (St George's Respiratory Questionnaire - SGRQ) and grip strength and recorded MRC dyspnoea scores and the frequency of exacerbations in the previous year.

Results (mean \pm SD): Patients were aged 72.5 \pm 8.3 years with MRC score of 3.6 \pm 0.8, forced expiratory volume in the first second (FEV1) of 49.2 \pm 21.5 percent predicted and a total SGRQ score of 72.2 \pm 15.5 Grip strength, expressed as percent predicted, was 72.0 \pm 21.8 in men and 81.0 \pm 18.2 in women. Exacerbations ranged from zero to five in the previous year and there were associations of reduced grip strength with exacerbation frequency (X2 = 9.634; p = 0.0019) and lower health status (X2 = 34.00; p <0.001).

The dominant hand grip strength is significantly associated with health status in patients with stable COPD. Our data also demonstrate clearly that reduction in grip strength occurs more frequently and to a greater extent in patients with a history of frequent exacerbations and is associated with reduced health status.

Conclusion: Our data demonstrate clearly that reduction in grip strength occurs more frequently and to a greater extent in patients with a history of frequent exacerbation and is associated with reduced health status. Therefore, the present study underscore the importance measuring hand grip strength in order to plan strategies to improve quality of life in patients with COPD. Further studies however needed to further evaluate this pathophysiological phenomenon in patients with COPD which eventually help patients to improve their health status.

The study of asthma among patients with rheumatoid arthritis (RA) diseases

Hossein Ali Khzaei, Nizar Ali Moulaei, Amin Khzaei, Fariba Hejazenia1, and Bahman Khzaei

Objectives: Asthma and rheumatoid arthritis (RA) are two common diseases that are increasing in the world. To investigate whether is there any concerning to develop asthma in RA patients. this cross sectional study was designed to determine the relation between asthma and RA.

Method of study: We undertook a cross sectional study in two hospitals of Zahedan-Iran city from outpatients of immunology and allergy clinics. The study population consisted of 573 patients with asthma diseases during 2005-2010 that their diagnose was based on medical history, clinical and paraclinical examination. Patients completed a questionnaire form about personal data and underwent measuring IgG, IgA, IgM and total IgE serum. Among of these patients 147 of them had joint pain and suffered from some symptoms of rheumatoid arthritis diseases.

Results: From 426 asthma patients aged 27-76 years old with the mean age of 51.5, there were 42% females and 57% males. High level of serum immunoglobins especially total IgE were observed in 83% patients. From 147 RA patients aged 19-78 years old with the mean age of 48.5, there were 64% females and 36% males. High level of serum immunoglobins

especially total IgE were observed in 73% patients.

Conclusion: A significant relation was found between the serum total IgE in patients with both asthma and rheumatoid arthritis.

Keywords: Asthma, rheumatoid arthritis and total IgE

The role of non-infectious factors in the formation of bronchiolitis in infants.

Mustafayev I.A.

Objective: To determine the value of irritative factors in the development of bronchiolitis in infants.

Materials and Methods: The study involved 116 (100%) of children aged from 1 month of age up to 3 years. In order to assess the significance of irritative factors were analyzed medical histories, clinical and radiological features, evaluated the results of laryngoscopy, gastroscopy and cytomorphological study of bronchial washings.

Results: In 67 (58%) of children identified the importance of irritative factors in the formation of bronchiolitis. In 25 (21.5%) patients reported a history of meconium aspiration syndrome and asphyxia direct labor. Clinically determined dyspnea, intercostal retraction, dry and mixed wet rales, radiologically - signs bulge interstitial changes and land hypoventilation. In 15 (13%) of children aged 1 month and older noted choking, coughing during feeding, bubbling breath, abundant regurgitation. Gastroscopy held for children aged 6 months-1 year revealed gastroesophageal reflux. Laryngoscopy revealed in 5 (4.3%) patients plentiful secret throat, various options of laryngomolacia with swelling of the arytenoid cartilage and leaking secret clearance in the trachea. cytomorphological study of lavage in 59 cases revealed lipid inclusions in macrophages, which is a sign of obstructive process in bronchioles. Catamnesis of patients showed that in 39 (34%) children for 8-month-1 year of life formed bronchiolitis obliterans.

Conclusion: bronchiolitis in infants is one of the most frequent pathologies are characterized by heterogeneity causes formation. Clear definition of disease etiology ensures adequacy and success of therapeutic activities, prevents formation of severe chronic forms of diseases of the small bronchi.

R8, A Synthetic Analogue Of Vasicine Attenuates Asthma Phenotypes In A Mouse Model Of Asthma By STAT6 Inhibition

Sheik Rayees, Gurdarshan Singh

Adhatoda vasica is a well-known plant drug in Ayurvedic and Unani medicine. Adhatoda leaves have been used extensively in Ayurvedic Medicine primarily for respiratory disorders. The leaves of the plant contain an alkaloid Vasicine which has been documented as a bronchodilator and anti-asthmatic agent in preclinical studies. We synthesised a series of analogues of Vasicine and evaluated them for their anti-asthmatic activity in a preventive murine model of asthma. The study revealed R8, one of the synthesised analogues, to suppress Th2 cytokine release and eosinophil count significantly. Since R8 showed anti-asthma effect in the preventive model, we wanted to test its efficacy in a therapeutic model also. To determine the therapeutic effect of R8 in asthma, it was administered to the mice after the development of asthma symptoms. Since allergen exposure is likely to continue during asthma therapy of human subjects, OVA challenges were continued during the R8 treatment, until last day OVA challenge. In this therapeutic model, R8 treatment reduced AHR, Th2 cytokine release, IgE levels as well as the infiltration of inflammatory cells in the bronchovascular regions and inflammation score. R8 was found to inhibit the phosphorylation of STAT6 in lung homogenates. It was further evaluated in adenocarcinomic human alveolar basal epithelial cells expressing receptor complex IL-4R α and IL-13R α 1 which is a functional receptor complex for both IL-4 and IL-13. The cells were stimulated with rIL-4 and treated with R8. The results showed that R8 attenuates phosphorylation of STAT6, blocking Jak/STAT pathway. So, R8 attenuates asthmatic phenotypes by inhibiting STAT6 phosphorylation. However, further mechanistic studies are warranted to substantiate the anti-asthmatic potential of R8.

Measurement Properties Of An Arabic Version Of The Dyspnea-12 Questionnaire For Saudi Nationals With Chronic Obstructive Pulmonary Disease (COPD)

Mohammed Alyam

Background: Dyspnea is the most distressing symptom experienced by people with chronic obstructive pulmonary disease (COPD). The Dyspnea-12 (D-12) questionnaire comprises 12 items and assesses the quality of this symptom, its severity and the emotional response. The original (English) version of the D-12 is repeatable and valid for the measurement of dyspnea in pulmonary diseases.

Objective: To translate the D-12 into Arabic and determine whether this version is repeatable and valid in Saudi nationals with COPD. **Methods:** The D-12 was translated into Arabic and reviewed by an expert panel and then back translated into English. The Arabic version administered to five individuals with COPD to test whether it was easily understood. A final Arabic language version was produced. Thereafter, 45 individuals with COPD (aged 63±9 years; 37 (82%) males; forced expiratory volume in one second (FEV1) 48±16 % predicted) completed the D-12, the COPD Assessment Test (CAT) and the Chronic Respiratory Disease Questionnaire (CRDQ). Airflow limitation and 6-minute walk distance were also measured. The D-12 re-administered two weeks later.

Results: The Arabic version of the D-12 demonstrated good repeatability over the two administrations (intra-class correlation coefficient = 0.94, p<0.01). Strong associations were demonstrated between the (i) total score for the D-12 and the CAT, (ii) quality sub-score of the D-12 and the FEV1 and CAT and, (iii) emotional response sub-score of the D-12 and emotional function domain of the CRDQ (r≥0.6, all p<0.01).

Conclusion: The Arabic version of the D-12 is a repeatable and valid instrument in Saudi nationals with COPD.

Exhaled Nitric Oxide Measurement As A Marker Of Inflammatory Activity In Bronchial Asthma Patients

EmanSheblRa, Salah A I Alib

Background: Asthma is a chronic inflammatory disorder involving many kinds of cells and cytokines, in particular the eosinophils. Proper anti-inflammatory treatment requires accurate assessment and monitoring of the underlying inflammatory state of the airways. The aim of our study was therefore to assess if it is possible to monitor airway inflammation and response to treatment in bronchial asthma patients by measuring the fractional concentration of exhaled nitric oxide.

Methods: This study was carried out on 70 non-smoker newly diagnosed stable asthmatic patients and 30 healthy nonsmoking non atopic controls. Patients were recruited from outpatient pulmonary clinic between July 2011 and July 2012. The following were done for all patients, complete medical history, physical examination, laboratory investigations, plain postero-anterior chest X-ray, spirometry (before and after inhalation of 400ug of salbutamol), total and allergen-specific IgE, blood eosinophilic count, Sputum eosinophilic count (EOS), fractional concentration of exhaled nitric oxide (FeNO) and asthma control test score (ACT score).

Results: In this study the FeNO levels in patients with asthma were significantly higher than those of the control group. Asthmatic patients with high FeNO demonstrated several distinct characteristics when compared to asthmatics with low FeNO. Demographically, asthmatics with high FeNO were younger and more likely to be atopic, had higher serum IgE level and higher blood eosinophils, they also had more eosinophils in the sputum. In asthmatic patients there were significant positive correlations between FeNO and blood eosinophilic count and EOS. After 9 months of treatment there was a significant decrease in FeNO, EOS and a significant increase in ACT and FEV1.

Conclusion: FeNO measurement provides a noninvasive measure to reflect the inflammation of airway and could be a useful parameter to monitor the effect of treatment.

Keywords: Nitric oxide, asthma, phenotype, exhaled breath

The Impact Of A School-based Asthma Health Education Programme On Quality Of Life, Knowledge And Attitudes Of Saudi Children With Asthma

Nashi Alreshidi Et Al 2014

Background: In Saudi Arabia, more than 2 million people complain of asthma: 13% being aged 6-10 years. This makes asthma one of the most common illnesses among children in Saudi Arabia (Al Frayh et al 2001, Alamoudi 2006, Ministry of Health 2010). Little has been explored about children's ability to learn more about their own asthma in Saudi Arabia.

Aims: The study was designed to assess the impact of a school-based, nurse-delivered asthma health education programme on asthmatic children's knowledge and attitude towards asthma, quality of life, anxiety level, and school absenteeism.

Methods: A quasi-experimental, non-equivalent group, pretest-posttest design was used. The education programme was developed from existing evidence. The Paediatric Asthma Quality of Life Questionnaire, Spence Anxiety Tool, Asthma Knowledge Questionnaire, and Asthma Attitude Questionnaire were employed for data collection in 2013. Intervention



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Based in Northern Ireland, Armstrong Medical was established in 1984 to manufacture and sell respiratory disposable products for critical care applications. Since then the company has grown considerably to become a worldwide supplier of high quality, innovative respiratory disposables for anaesthesia and critical care. We supply products to over 52 countries worldwide from our 90,000 square foot office, warehouse and manufacturing facility in Northern Ireland.

Our manufacturing resources include state of the art automated and robotic injection moulding and tubing extrusion, class 10,000 and 100,000 - type assembly clean rooms, tool room, and a bespoke research and manufacturing facility. In 2009, we were awarded The Queen's Award for Enterprise for International Trade. The consolidation of our research and development, manufacturing, customer service and distribution facilities on one site increases our ability to react quickly to customer demands and new clinical trends.

This strength has allowed us to create a core group of innovative products while maintaining high manufacturing standards and production throughout for generic catalogue ranges.

(n=130) and control (n=98) groups were drawn from 10 schools in Hail region, Saudi Arabia. Both descriptive and inferential statistics were used to examine differences between groups.

Results: The level of asthma knowledge was increased significantly more in the intervention group than in the control group ($F=26.5746$, df 2, $p<0.001$). Attitude toward asthma was not changed by the intervention ($F=0.0490$, df 2, $p=0.9522$). There was a significantly greater reduction in the intervention group than in the control group in anxiety ($F=3.7599$, df 2, $p=0.0242$), and in absenteeism from school ($F=2.98$, df 2, $p=0.003$). Total quality of life increased significantly more in the intervention group ($F=87.6534$, df 2, $p<0.001$).

Conclusion: The asthma educational program was impacted positively on students' knowledge, anxiety, quality of life, and school attendance. However, asthma education did not change attitudes towards the condition. Asthma education should be integrated into the national child health programme. This presentation will focus on the intervention and results, emphasizing the provision of health education directly to children.

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Meta-Analysis Assessing The Efficacy Of Non-invasive Ventilation (NIV) In Non-COPD Patients With Acute Hypoxemic Respiratory Failure (AHRF)

Marja ALYAMI, MSc, RRT, Mohammed AIAHMARI, PhD, RRT, Mohamed Mubasher, PhD, Hajed AIOTIBI, PhD, RRT, Saad AIRABEEAH, MS, RRT, Ibrahim AIBALAWI, BSRC, RRT

Abstract Content: The objective of this meta-analysis is to determine whether the use of NIV when used as an adjunct therapy to the usual medical care (UMC) can reduce the need for ETI and mortality rate among patients with AHRF excluding those cases with exacerbation of COPD.

Method: Protocol for Search Strategy

A computerized literature search was performed in the current study to identify potentially eligible studies. The PUBMED, MEDLINE, EMBASE databases and Cochrane library were extensively searched for all possible literatures on NIV. In this review, the main focus of the search was limited only to RCTs (Figure 1.), however, other articles were also reviewed to gain insight on the background of the current topic. The search was conducted using the following search keywords and MeSH terms: NIV, NIPPV, BiPAP, and CPAP, RCT

In the current search strategy, formats with higher sensitivity were given the first priority, in order to increase the probability of identifying all relevant articles. All database searches included RCTs that conducted between 1990 and 2010. The full texts of all RCTs were obtained from the Albertson Library, available at the Boise State University website (<http://library.boisestate.edu/>).

Results: As indicated in figure 2. and for the outcome of Endotracheal Intubation, studies by Auriant et al., Squadrone et al Confalonieri et al., Hilbert et al, Antonelli et al and Ferrer et al, all significantly (p -values <0.05) favored NIV as an adjunctive therapy to UMC versus UMC/conventional therapy alone in non-COPD and non-trauma AHRF patients of various etiologies. Figure 3 on the other hand for the outcome of mortality shows that only the study by Hilbert et al, significantly indicating an advantage of NIV/NISPV versus UMC/conventional therapy alone. The study by Auriant et al. showed somewhat of a border-line significant advantage (p -value =0.07).

Conclusion: This Meta-analysis suggests that the rate of Endotracheal intubation and overall mortality rate can potentially decreased by using NIV as an adjunct therapy to UMC as compared to the UMC alone. However, considering the diversity of studied populations, further studies and more

specific trials on less heterogeneous of AHRF patient groups are needed to focus on this aspect.

A Crucial Role of Semaphorin 3E in allergic asthma

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Rationale: Asthma is a chronic inflammation of the airways contributing to bronchial hyperresponsiveness and airflow limitation. Pathophysiological features of asthma include eosinophil-rich inflammatory cell infiltrates and airway wall remodeling. The current therapies fail to overcome pathological events of asthma efficiently. Therefore, development of an effective strategy to control asthma is an urgent health issue. Semaphorins, originally discovered as neuronal guidance cues, are multifaceted proteins expressed in many tissues and regulate cellular processes such as cell growth and migration which are impaired in asthma. Semaphorin 3E (Sema3E) negatively regulates function of some inflammatory and structural cells and it may play an important role in asthma. We have recently shown that Sema3E inhibits human airway smooth muscle proliferation and migration as a cardinal feature of airway remodeling. However, the precise role of this mediator in allergic airways disease has not been studied in vivo.

Methods: We investigated expression of Sema3E in asthmatic and healthy individuals using immunohistochemistry, ELISA and qPCR. Then, we characterized the effect of Sema3E on airway hyperresponsiveness (AHR), inflammation and remodeling using a mouse model of the disease by performing lung mechanics studies, flow cytometry, cell culture and ELISA. We further addressed the role of Sema3E by allergen exposure in Sema3E KO vs WT mice.

Results: Sema3E expression is suppressed in asthmatic patients and experimental animal model. Notably, exogenous Sema3E treatment inhibited allergen-induced airway inflammation, remodeling and AHR. Sema3E KO mice developed an exaggerated form of allergic airway disease compared to WT control group.

Conclusions: Our data suggests a regulatory role for Sema3E in airway inflammation, AHR and remodeling in chronic airway diseases such as asthma.

Gene Expert Resistance Of Rifampicin Inact-2 Patient

Dr Javed Ahmed Shaikh

Abstract Content: This study was carried out at Institute of Chest Diseases kotri w.e.f December 2012 daily more than 8 cultures were applied to gene expert machine by taking sputum of those patients who were on cat -2 treatment likely to be suspected MDR .. a good study as 11 districts of periphery are attached more than 100 cultures performed, results are highly alarming at this third world institute, working at all times, already equipped with full sputum microscopy of sputum a gold standard test for diagnosis of Tuberculosis. This test proves more than 33 cases were detected RIF resistant. Treatment was provided by Institute of Chest Diseases Kotri as mentioned in MDR treatment guided by WHO IUATLD.

Two cc of sputum is required for test, backup of machine is 15 minutes connected with standby generator taken 120 minutes by help of cartridge, at a time 04 cartridges are allowed to continue, within 120 minutes result is ready, can be reused. However if error occurs can be repeated if necessary.

Methods: a gene expert is machine operated by microbiologist of standard university graduate recognized by higher education commission of Pakistan.

Implementation of Anti Tobacco Laws in Pakistan

Javaid. Khan , Muhammad Irfan, Ali.Zubairi , Hashir Majid

Background and/or Objectives: Tobacco is a serious public health issue of Pakistan, being responsible for 100,000 deaths/ year in the country. Pakistan introduced its anti tobacco laws in year 2002 before the introduction of FCTC. Later on some amendments were made in the law in line with FCTC recommendations. It included withdrawal of designated smoking areas from public places and mandatory pictorial health warnings on cigarettes pack. Current laws prohibit smoking at public places and in public transport. It also declare universities as smoke free zones. No Smoking sign has to be displayed within and outside every restaurant according to law. We carried out this study to see how far the law is being implemented in Karachi, the most populous city of Pakistan.

Methods/Description: Final year medical students doing elective rotation in pulmonology were trained on data collection. A performa was prepared in

about the hazards of tobacco use but also about the existing anti tobacco laws. Those who violate the laws must be prosecuted in order to send a strong message to all stake holders who are violating the laws.

Detection Of Hepatopulmonary Syndrome In Patients With Liver Cirrhosis Using 3D Contrast Echocardiography

Rania Gaber, Dina H. Ziada , Nesreen A. Kotb, Gehan H. Abo El-Magd, Manal Hamisa

Background and study aims: Hepatopulmonary syndrome (HPS) is characterised by the triad of advanced liver disease, arterial hypoxaemia and intrapulmonary vascular dilatation (IPVD). The present study aimed to evaluate HPS in patients with liver cirrhosis and the role of three-dimensional (3D) contrast echocardiography in the detection of this syndrome.

Patients and methods: A total of 78 chronic liver disease patients aged 42 ± 11 years fulfilled the criteria for this study and were subjected to clinical examination, laboratory investigations, arterial blood gases measurement,



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order to assess the implementation of various aspects of anti tobacco laws. Study was carried out in the month of May 2012 and data collected was entered in SPSS. Team visited various universities, hotels, restaurants and public offices as well public transport.

Results/Outcomes: Team visited 91 restaurants, 70% did not display "No Smoking sign". People were seen smoking in 58% of the restaurants, 33% of restaurants was found to have designated smoking areas. Of the 99 banks and offices surveyed. No smoking signs were displayed at only 33% of these places. Smoking was witnessed inside 29% of all banks and offices. Smoking was observed in 50% of the 99 public vehicles surveyed. Pakistan introduced mandatory pictorial on cigarette packs from Feb 2010 but of the 37 brands surveyed in May 2011, 62% did not display any pictorial warning on their packs. Our law also prohibits the sale of tobacco to under 18 age group but of the 94 shops surveyed cigarette sale to minors was taking place at 85% of these outlets. Universities are declared smoke free zone in our laws. Of 16 Universities surveyed Smoking was witnessed on the campuses of 77% of the universities cigarettes were being sold near 94% of the universities surveyed inspite of a law which prohibit sale of cigarettes with in 50 meters of educational institutions.

Conclusions: Our study showed poor enforcement of anti tobacco laws in the major city of Pakistan. Our law enforcing agencies should be more active in implementing the current anti tobacco laws. Without the implementations of these laws we will not see any significant reduction in the mortality and morbidity from tobacco use in Pakistan. Public need to be educated not only

pulmonary function tests, upper gastrointestinal endoscopy, 3D contrast echocardiography and computed tomography (CT) pulmonary angiography.

Results: According to 3D contrast echocardiography results, we divided the patients into a positive group ($n = 26$) in which patients showed a delayed appearance of contrast in left heart chambers and a negative group ($n = 52$). Among 26 patients of the positive group, nine had hypoxaemia (partial pressure of oxygen (PaO_2) < 70 mm Hg) and were diagnosed as having hepatopulmonary syndrome (HPS), the other 17 who had shown echocardiographic evidence of IPVDs but without hypoxaemia were diagnosed as having subclinical HPS. This study showed significant correlation between positive contrast echocardiography findings and duration of liver disease, Child score, cyanosis, clubbing, orthodeoxia, portal vein diameter, spleen size and oesophageal varices grades. No significant correlation was found between 3D contrast echocardiography findings and age, sex, spider naevi and pulmonary function tests. Multivariate logistic regression showed that cyanosis, clubbing, orthodeoxia, Child score and portal vein diameter are independent predictors of HPS.

Conclusion: Cyanosis, clubbing and platypnoea-orthodeoxia are suggestive indicators of HPS, which can be easily detected by 3D contrast echocardiography which can replace the trans-oesophageal echocardiogram (TEE) in cirrhotic patients.

The Role Of Allergy Risk Factors And Environmental Factors Against Lymphocyte Th-1 And Th-2 Activity In Relation To Wheezing In Infants Age Up To 1 Year

Mulya Safri, Department Of Child Health Syiah Kuala University-Dr. Zainoel Abidin Hospital, Banda Aceh Indonesia

Backgrounds: Allergic disease is an important issue because it occurs at all levels of society and increasing the number of accident in the last three decades. Risk factors and environmental factors play an important role in the mechanism of allergy. Wheezing is an early symptom of respiratory disorders that often occur as a result of allergic reactions in children.

Objective: This study aims to find the role of allergy risk factors and environmental factors on the activity of Th-1 and Th-2 in association with wheezing in infants up to 1 year of age

Methods: This study is an exploratory of analytic observational with cohort design. Samples were taken with consecutive sampling technique has been obtained as many as 71 infants who had completed observed for 12-months-old.

Results: A total of 64.8% from 71 subjects suffering from wheezing. Allergy risk factors ($p = 0.007$), skin prick test > 3 mm (0.000), IFN- γ levels below 0.53 ($p = 0.033$), IL-5 levels above 0.6 ($p = 0.000$), and the father smoked ($p = 0.003$) appear related to the occurrence of wheezing. Conclusion: Allergy risk factors contribute to the onset of wheezing, through the increased activity of Th-2 lymphocytes generate the levels of IL-5 to be higher in infants suffering from atopic wheeze.

Keywords: infant atopy, allergy risk factors, environmental factors, activity of Th-1 and Th-2

Role Of The Multidimensional Index BOD In Describing The Progression And Predicting Survival In Patients With Chronic Obstructive Pulmonary Disease

Khalid Ansari, Niall Keaney, Andrea D Lawrence, Ian K Taylor, Monica Price, Joan Munby

Background: COPD guidelines classify severity with FEV1 alone, though impairment correlates poorly with symptoms and disability. The clinical impact of COPD should therefore be assessed with a multi-dimensional tool.

COPD is characterised by:

- B. Systemic inflammation causing loss of lean body mass and muscle weakness (BMI);
- O. Impairment due to Airflow Obstruction (FEV1%);
- D. Disability expressed as perceived breathlessness (MRC Dyspnoea Scale).

Using BOD we showed that patients can be re-classified as 57% severe compared to 4% using GOLD criteria (AJRCCM, 2002).

Celli et al (NEJM, 2004) developed the BODE index, showing a 4 year mortality of 26% in 625 hospital patients. Those with lower BODE scores survived longer than the worst quartile. But because only 7.5% of their subjects were women and co-morbidities in the elderly often preclude a meaningful six minutes walk test, we have tested the value of SID in predicting mortality.

Method: We evaluated all-cause mortality in 404 patients (51% female) diagnosed with COPD in primary care between September 1999 and December 2002. The diagnosis was made according to BTS criteria. A scoring system was applied to all patients at entry. Quartiles of the BOD scores (Quartile 1: Score 0-1; Quartile 2: Score 2-3; Quartile 3: Score 4-5 and Quartile 4: Score 6-7).

Results: BOD predicted all cause mortality in primary care patients with COPD. Cox regression analysis showed that mortality was related to BOD score by quartile ($p < 0.0001$) but only showed a trend for greater mortality in men ($p < 0.07$).

Conclusion:

1. BOD is a simple index readily used for the evaluation of the clinical impact of COPD.
2. Exercise testing is not essential for the multi-dimensional assessment of mortality in COPD.
3. BOD is a model that could help identify therapeutic interventions to influence the natural history of COPD.

The Mechanism Of Lipopolysaccharide (LPS)-Induced Lung Inflammation And Effect Of Honey

M. Takeuchi, A. Kawazoe, A. Takiguti, Y. Hirono, K. Sasaki, Y. Tanahashi, M. Sakura

Purpose: Lipopolysaccharide (LPS) that is endotoxin of Gram-negative bacteria has a variety of immune activity and is contained within air and cigarette smoke. LPS inhalation also induces neutrophils into the lung and causes lung inflammation. Although neutrophils are important cells for bacterial killing by phagocytosis, these cells also induce inflammation. Honey is used as a traditional medicine for colds, skin inflammation but not edible. However, the induction mechanism of neutrophils by LPS and the effects of honey on lung inflammation are not fully understood. Therefore, we studied the mechanism of induced neutrophils and the effect of honey.

Materials & Methods: Mice were inhaled 600 μ g of honey and following 1 day later, inhaled 60 μ g of LPS by intranasal administration. After 24 hours of administration, bronchoalveolar lavage (BAL) cell was obtained by BAL. Expression of TLR4 surface antigen in AM was analyzed by FACS. Reactive Oxygen Species (ROS) productions of neutrophils were measured by FACS. Cytokines and NF- κ B mRNA expressions of AM were assayed by RT-PCR.

Results: BAL cells counts were significantly ($p < 0.001$) increased with LPS inhalation. However, BAL cells counts were not increased in TLR4 deficiency mice. The number of neutrophils was significantly ($p < 0.01$) increased by LPS. IL-1 β , TNF- α and CXCL1 mRNA expressions of AM were increased by LPS. NF- κ B mRNA expression of AM was significantly increased by LPS. ROS productions were increased in lung neutrophils. Honey inhibited infiltration of neutrophils to the lung.

Conclusion: These results suggest that the mechanism of lung infiltration by LPS is induced with infiltration of neutrophils via CXCL-1 through NF- κ B activation after LPS recognition of TLR-4 in AM and honey indicates anti-inflammation activity via the suppression of induction of neutrophils.

Attitudes and behaviors of physicians towards the relationship with the pharmaceutical industry in Saudi Arabia.

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Background: Interactions between physicians and the pharmaceutical industry have been increasing over the last several years. However, these relationships have been subjected to major criticism. In our experience and as evident from our observations, it seems that this relationship is increasing in Saudi Arabia.

Objectives: To assess the attitudes and behaviors of physicians towards pharmaceutical representatives (PRs).

Methods: This is a cross sectional survey questionnaire conducted from March to September 2013. The final survey was distributed to all physicians by hand-to-hand distribution in the physicians' offices. The survey's addressed the frequency of meetings and gift receiving with the PRs and the physicians' attitudes and behaviors towards PRs. Our subjects were constituted of all practicing physicians in all specialities.

Results: A total of 300 completed questionnaires were obtained. Among surveyed physicians, 74% used to meet PRs one to three times per month. More than two thirds of physicians received some kind of gift (up to 64%). Approximately two thirds of participants have been invited to activities sponsored by pharmaceutical companies (63%). Among participants, 80% agreed that PRs use promotional techniques in their approach and 84% of them stressed the need of expert physicians attendance during PRs presentations to correct the facts. In addition, 45% and 47.3% agreed that the information supplied by the PRs regarding new drugs and old drugs, respectively, were accurate information. Nevertheless, 61% stated that discussions with PRs and gifts did not have any impact on their prescribing behavior.

Conclusion: The frequent meetings between physicians and PRs and the use of promotional techniques by PRs are concerning. Future studies should assess the impact of this involvement on the medical practice in Saudi Arabia.

Effect Of Humidified Vs. Non-Humidified Continuous Positive Airway Pressure On Inflammatory Response And Nasopharyngeal Symptoms In Human Subjects: A Pilot Study

AIAHMARI, Mohammed PhD, RRT, AI-OTAIBI, Hajed2 PhD, RRT, AIQAHTANI, Abdullah1MSRC, RRT, AL-MAQATI, Thekra1BSCLS, HUSSAIN, Mohi1 BSCLS

Objectives: Continuous positive airway pressure (CPAP) is widely used to treat various pathologies. It has the potential to induce nasal mucosa compression. Subsequently, it would triggers a biological response in the airways (1,2), and induces an inflammatory process (3). The present study aims to examine the impact of heated humidified versus non-humidified CPAP on nasal inflammation and upper airways symptoms of healthy subjects.

Methods: Seventeen, healthy male subjects [mean age \pm SD: 25.7 \pm 5.6 years] with no prior and current histories of nasal symptoms were recruited, Table 1. All subjects received three hours of CPAP with heated humidifier at 12 cmH₂O via nasal mask. Out of the seventeen studied subjects, 7 returned to receive a non-humidified CPAP at 12 cmH₂O via nasal mask. Nasal wash leukocyte count including mononuclear cells (MN; including lymphocytes and monocytes) and polymorphonuclear cells (PMN; including all types of granulocytes) was performed at baseline (before) and after CPAP with and without humidification. Samples were analyzed using XE 500 model analyzer. A six-point nasal score was also assessed before and after the intervention. A one-way repeated measures ANOVA was performed to allocate any significant difference. Paired t-tests were used to examine differences between baseline and post-CPAP therapy measurements. A P value < 0.05 was considered statistically significant.

Results: Non-humidified CPAP resulted in significant rise in nasal inflammatory markers compared to baseline and humidified CPAP. Table 2 presents changes in inflammatory markers in nasal wash fluid and Figure 1 illustrates the changes in WBC count (A) and mononuclear cells (B) at three different conditions. Out of 17 subjects, 12 (70.5%) experienced at least one nasal symptom in response to nasal CPAP at 12 cm H₂O. The most common nasal symptoms were mouth dryness and headache.

Conclusion: The present pilot study showed an inflammatory effect of non-humidified nasal CPAP. Such changes were associated with upper airways symptoms developments. Further studies to understand the mechanisms of CPAP impact on airway inflammation are needed.

References: 1. Almendros I, Acerbi I, Vilaseca I, Montserrat JM, Navajas D, Farre R. Continuous positive airway pressure (CPAP) induces early nasal inflammation. *Sleep* 2008;31:127-31.

The materials presented in this abstract is original and was not published or presented in any conferences.

Perceptions About Exercise And Pulmonary Rehabilitation Programmes In Qatar; A Qualitative Study In Chronic Obstructive Pulmonary Disease (COPD) Patients And Their Respiratory Clinicians.

M. Al-Tamimi, MSc, A. Hussain, MD*, A. Younis, PhD, N. Abdulahad, MBChB, And D.Nikoleitou, PhD. Faculty Of Health, Social Care And Education, Kingston University And St George's University Of London,

Background: Pulmonary rehabilitation (PR) programmes are the cornerstone of rehabilitation for patients with COPD in the UK and other countries worldwide. However, in the Arabic Gulf states, PR is not well established yet. There are currently limited data on the attitudes about participating in a PR programme amongst COPD patients and their health care providers in Qatar.

Objectives: The objective of this study was to explore attitudes toward exercise and perceptions about participating in a PR programme. Similarities and differences between COPD patients and their health care providers were also explored.

Methods: Eight COPD patients (M:F= 5:3; Mean (SD) FEV1: 1.83 (1.8)) and eleven health care providers were recruited from the respiratory medicine department at Hamad Medical Corporation, Doha. We conducted semi-structured interviews and patients also completed the Arabic version of the Activities of Daily Living (ADL) questionnaire, St Georges Respiratory Questionnaire (SGRQ) and COPD assessment test (CAT).

Results: COPD patients had a mean (SD) age 57.62 (8.08) and score for the CAT was 18 (7.27), SGRQ 49.28 (23.22) and ADL 5.37(0.64). The health care providers had mean (SD) years of experience as specialists 13.9 (10.40). Analysis of interview transcripts suggested that a) patients have limited knowledge about their disease and ways of managing it while clinicians perceive that they inform their patients fully, b) communication between health care providers and patients was problematic due to lack of time, language barriers for non-Arabic speakers and differences in terminology c) female patients were more limited in their everyday life than male patients and d) healthcare providers identify more factors that could potentially limit patients' participation to PR than patients themselves. According to health care providers, factors that may limit patients' participation were weather, lack of time, level of education, low value in physical activity, lifestyle and social barriers.

Conclusions: The idea of participation to PR was widely accepted by both clinicians and patients but there are differences in perceptions about possible barriers. COPD patients and healthcare providers in Qatar recognized the need for a more structured education programme about COPD and its management. Further research is required to identify differences on the impact of COPD in female than male patients in Qatar.

PH and CO₂ study_ABSTRACT

Ghazi Alotaibi, PhD, RRT. Ahmed Mansi, BS, RCP. Abdulaziz Matani, PhD

Content:

Agreement between the actual post RR and the calculated RR was assessed by Bland-Altman plot and Passing-Bablok regression analysis. Bland-Altman method assesses agreement between both methods by plotting the difference between the two methods against their mean and by presenting 95% limits of agreement (mean difference \pm 1.96 SD of the difference). Passing-Bablok Regression plots the readings determined by both methods.

At pH of 7.40 :

$$pH = 6.1 + \log \frac{HCO_3}{0.03 \times PaCO_2}$$

$$\log \frac{HCO_3}{0.03 \times PaCO_2} = 1.3$$

$$\frac{HCO_3}{0.03 \times PaCO_2} = \text{anti log } 1.3$$

$$\frac{HCO_3}{0.03 \times PaCO_2} = 19.95$$

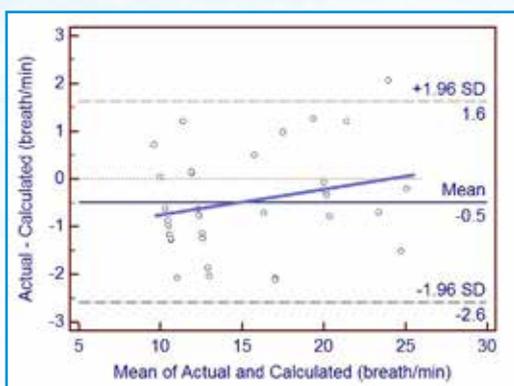
$$PaCO_2 = \frac{HCO_3}{0.03 \times 19.95}$$

$$PaCO_2 = HCO_3 \times 1.66$$

$$PaCO_2 = HCO_3 \times \text{factor} \quad \text{Equation (1)}$$

$$\text{Desired RATE} = \frac{\text{known Rate} \times \text{known PaCO}_2}{\text{desired PaCO}_2}$$

$$\text{Desired RATE} = \frac{\text{known Rate} \times \text{known PaCO}_2}{HCO_3 \times \text{factor}}$$



Background: Clinical Validation of the Formula

Conclusions:

Derivation and Clinical Validation of A Simple Mathematical Formula to Predict Changes in Blood PaCO₂ and pH Values

Derivation of Mathematical Formula:

Ghazi Alotaibi, PhD, RRT. Shoug Alhumoud, MS, RRT. Nawal Alotaibi, BSRT

Henderson-Hasselbalch equation was developed to calculate pH for a buffer solution. For blood gases, this equation portrays the relationship between pH, PaCO₂, and HCO₃. The use of this equation at the bed-side is not practical as the equation contains advanced mathematical expressions. Another common equation used to estimate respiratory rate change to achieve a desired change in PaCO₂ is (New Rate = (known Rate x known PaCO₂)/desired PaCO₂). This formula was criticized for using PaCO₂ as a target parameter, while clinically, pH is a better target for acid base balance. The objective of this study is to propose a simple mathematical derivation of Henderson-Hasselbalch equation to estimate change in respiratory rate necessary to achieve specific pH values. We also present clinical validation of the proposed formula.

Mean Bias was -0.5, 95% LA was 1.6 to -2.6, indicating accuracy and consistency of the formula. No evidence of Fixed Bias as indicated by the closeness of the mean difference (-0.5) to zero. Intercept of the regression line is 0.88 (95% CI -2.18 to 0.95) indicating no significant fixed bias. No evidence of Proportional Bias as indicated by less steeper scatter slope.

Slope of the regression line is 1.01 (95% CI 0.90 to 1.10) indicating no significant proportional bias. Regression line is not significantly different from identity line.

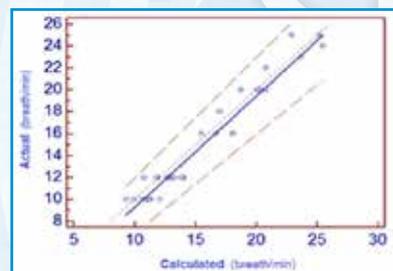
Mechanical ventilation is a commonly used modality in the intensive care units. The main goal of mechanical ventilation is to control two basic physiological functions: ventilation and oxygenation. Monitoring patients on mechanical ventilation and adjusting ventilator settings are essential skills for every respiratory care practitioner. Blood gas analysis is a common test used to monitor oxygenation and ventilation. Ventilation is controlled by adjusting minute ventilation, most commonly via changes in respiratory rate. Several equations have been proposed to estimate changes in blood gas parameters as a result of ventilator setting adjustments. These equations are used as a guide for clinicians to correct deviations in ventilation and oxygenation. They also help to reduce number of blood gas analyses as target parameters are achieved more expeditiously.

Methods: Respiratory Care Department, College of Applied Medical Sciences, University of Dammam
Results: Similarity, for any pH value a factor can be calculated.
Statistical Analysis
Substituting the denominator with equation (1);

The common formula used to predict changes in respiratory rate to achieve desired PaCO₂ is:

The proposed formula showed sufficient accuracy to be used to predict respiratory rate change necessary to achieve specific pH value. It is expected that the use of this formula will reduce number of blood gas sampling, reducing harm to patients and cost of care.
Using Henderson-Hasselbalch Equation

We collected retrospective data of 34 arterial blood gas samples pre and post respiratory rate changes. Duration between rate change and post ABG sample was less than 2 hours. Change in HCO₃ in post ABG sample was within ± 2 mEq/L. The desired rate was calculated using equation (2) targeting pH value of post RR change blood gas sample. Calculated RR values were compared to the actual post RR for agreement level.



COPD In ICU, Non-invasive Versus Invasive Ventilation

Sayed Mohammadreza Hashemian, Hamid Reza Jamaati, Majid Malekmohammad, Pegah Khamechi, Sayed Amir Mohajernai

Background and Aims: There is an inherent belief that the use of invasive ventilation in COPD patients admitted to ICU is safer than of Non-invasive positive-pressure ventilation (NIPPV). In this study, we compared various factors and outcomes of invasive and non-invasive ventilation in COPD patients admitted to respiratory ICU of a tertiary respiratory referral hospital.

Methods: All COPD patients admitted to respiratory ICU requiring ventilation were included in the study. NIPPV was delivered through critical care ventilators using full face mask and related data were compared to invasive ventilation. The duration of stay, death, survival, lab workups, and duration of ventilation were compared in two groups. The disease severity was calculated using APACHE II, SAPS II, and SOFA scores. A multivariate logistic regression model and survival analysis was used to analyze the factors predicting NIPPV versus invasive ventilation survival.

Results: 100 patients (75% men, 25% women) received invasive and NIPPV ventilation. The severity of respiratory insufficiency was not significantly different between two groups based on baseline arterial blood gas, and severity scores. On multivariate logistic regression analysis, baseline APACHE II score, SOFA score, baseline PaO₂/FIO₂, accompanied

pneumonia were associated with survival. The duration of ICU stay was significantly higher in NIPPV (25 d) compare to invasive group (11 d). Survival time was significantly higher in NIPPV (42 d) compare to invasive group (11 d).

Conclusion: NIV was found to be a useful modality in management of COPD patient admitted to ICU. The severity of illness at admission, and baseline PaCO₂ on first day are independent predictors of NIV failure.

ICU Admissions: To Refuse Or Not To Refuse. An Evaluation Of Risk Factors Associated With Poor Outcomes.

Muhammad Rizwan, Zeeshan Ahmad, Zia Rehman, Abid Butt

Background: Many admissions to the Medical Intensive Care Unit (MICU) are guided by absolute indications such as acute respiratory failure. For a large number of patients however, it is the clinical gestalt of the intensivist that determines eligibility. This process of clinical reasoning can vary significantly between practitioners. We reviewed the outcomes of patients declined admission to the MICU in the hopes of being able to identify characteristics of patients who fared poorly after the initial evaluation.

Methods: We conducted a retrospective chart review for a 13 month period where an Emergency Response Team trigger was followed by a formal MICU evaluation. We studied parameters which would be readily available at the bedside for clinician review including patient age, race, BMI, vital signs, co-morbidities, reason for the consult, and reviewed clinical outcomes.

Results: 408 individual encounters were reviewed. A total of 79 patients were declined admission to the MICU. From these, we excluded 8 patients because their advance care directives precluded ICU level interventions. Of the remaining 71, 34 patients were transferred to MICU within the first 24 hours after initial MICU admission was declined (Group A) while 37 patients did not end up needing MICU admission (Group B). No statistically significant differences in the studied baseline features between the cohorts were found.

For Group A versus B, mortality (30 day or same admission) was higher [32% (11/34) vs 24% (9/37)], while discharge of survivors to home was lower [35% (12/34) vs 43% (16/37)]. These differences were not statistically significant however. The length of stay was equivalent between the two cohorts.

Conclusions: Our study indicates that patients initially denied ICU admission who are subsequently admitted to the ICU within 24 hours showed a trend towards increased mortality. Unfortunately, we were not able to demonstrate a statistically significant difference between the two cohorts, which might be a reflection of sample size.

Clinical Implications: This study highlights the absence of an effective and reproducible clinical algorithm for triaging patients being evaluated ICU admission. Clearly ongoing research is needed in this field.

Closed Suction System Versus Open Suction

Ahmed Almansoury, Headia Said

Background: catheter suction are used to remove tracheal secretions

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through the endotracheal tube in mechanically ventilated patients, which may be either closed suction system (css) or open one. In css the catheter is a part of ventilator circuit and there is no need disconnect the ventilator and it seems that the css prevent soiling and spraying of respiratory secretion into the ICU. Objective: to compare css system in comparison with an open tracheal suction system in adult patients receiving mechanical ventilation for more than 24 hours in terms of VAP incidence, length of stay in the intensive care unit and mortality.

Method: We prospectively recruited all mechanically ventilated patient in our general ICU, Darelshafa hospital between January 2012 and January 2013. Group A are those with open tracheal suction system (OTSS) and group B with closed tracheal suction system (CTSS), comparing VAP incidence, length of stay in the intensive care unit and mortality between the two groups.

Results: group A (OTSS) where the incidence of VAP was 30.13/1000 ventilator days not statistically significant in comparison with patients in group B with CTSS with VAP incidence 17.48/1000 ventilator days.

Conclusion: There is no difference in the incidence of ventilator associated pneumonia and mortality rates between the two groups. The average length of stay declined in patients with OTSS group.

Outcome Of Sickle Cell Disease (SCD) Patients Admitted With Acute Chest Syndrome (ACS) To Intensive Care Unit (ICU): A Retrospective Study

Abdullah H Alsaghir MD, Soror A Alaithan MD, Hassan Almustafa MBBS, Hussain Alsadiq MBBS, Ammar Alsaghir MD, Hadi Alawami MD

Background: Acute chest syndrome (ACS) is a frequent pulmonary complication of sickle cell disease (SCD). Aim of this study was to evaluate prognosis of patients with SCD admitted with ACS to Intensive Care Unit (ICU).

Methods: This retrospective study included all adult patients (≥ 18 years) admitted with ACS to Dammam Medical Complex, adult ICU between January 1st, 2011 and December 31st, 2012. Data were collected from hospital medical records. Demographic data, clinical, risk factors for illness severity and ICU and hospital LOS were evaluated. Odd Ratio (OR) was used for analysis.

Results: 22 patients with ACS were evaluated, among them 82% male and 18% female, with a mean age at admission 27 years (range 18-49). All patients had Hemoglobin SS (table 1). Their presentation were mainly with fever (82%), chest pain (82%), dyspnea (82%), and cough (59%) (table 2). 20 patients (90%) received blood transfusion, and 10 patients (45%) received

dexamethasone. Among 22 patients, 16 patients (72%) required simple oxygen supply, 3 patients (14%) required non-invasive ventilation (NIV) where one of them eventually required intubation, and 3 patients (14%) required invasive mechanical ventilation (MV) (table 3). Among those 3 patients with MV, 2 patients had a past history of ACS (odd ratio [OR] 1.38, 95% confidence intervals [CI] 0.12 – 16.23). During the hospital stay, ICU length of stay (LOS) and hospital LOS for patients who received dexamethasone were 6 days and 12 days, respectively, compared with patients who did not receive dexamethasone were 5 days and 10 days, respectively.

Discussion: Acute chest syndrome (ACS) is a common complication and reason for hospital admission in patients with sickle cell disease (SCD). Moreover, ACS causes approximately 25% of deaths in patients with SCD. In this study, all patients survived ICU and hospital admission, but it was shorter in those patients whom did not receive dexamethasone. Additionally, a previous history of ACS could be a risk for repeated admission requiring MV.

Impact: Although, ACS has a good prognosis, but treatment with dexamethasone may have a negative impact on LOS, as well past history of ACS on the severity of readmission. This need further studies to validate these.

Keywords: Intensive care unit, sickle cell disease, acute chest syndrome, dexamethasone

Extubation Failure Rate And Its Impact On The Management Of Critical Care Patients In Saudi Hospital

Alaithan AM, El Sawi MM, Almeer L, Obaid O

Background: Extubation failure has bad consequences to the patient and health care institute. Our aim is to measure our ICU extubation failure rate and its impact on patient outcomes.

Material and Methods: This is an observational prospective cohort study which include Inclusion patient with acute respiratory failure patient, either medical or surgical who required invasive mechanical ventilation for more than 48 hours for the first time only and had planned or unplanned extubation. The patients are followed up until death or discharged from the hospital.

Results: Out of 550 patient admitted over the study period 165 (%) were intubated. 82 (%) Patents were female and 26(%) were surgical patient. Of 165 Patients 111 (%) were successfully extubated in ICU and 91 (%) patient were extubated after > 48h of mechanical ventilation. 20 (%) were re-intubated within 48 hours. 8 (%) of patients who failed extubation required tracheostomy in the same ICU admission. Compared with those successfully extubated patients who failed extubation has significantly higher mortality, length of stay and higher fluid balance on extubation day.



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Conclusion: Re-Intubation rate is within acceptable limit and it increases ICU mortality and ICU length of stay after extubation.

Relation Between Pulmonary Rehabilitation Program And Hospitalization Period In Critically Ill Patients

Abaas Fadaee And Mohammad Amin Abbasi

Generally ICU patients are in critical status and need long stay in ICU. Pulmonary rehabilitation program (PRP) is considered as an important tool to improve outcome and shorten the length of stay in ICU. The aim of this study was to investigate whether PRP can affect outcome and duration of hospitalization in ICU patients.

Materials and methods: This study was performed in medical ICU during 2010 and 2011. All of patients who had more than one day stay in ICU were included in the study. In 2010, PRP was performed only by physicians order but since Jan, 2011 it was done for all of ICU patients. We compared length of stay; mortality rate and number of hospitalized patients within 2 years. Statistical analyses were performed with SPSS software. P values less than 0.05 were considered statistically significant.

Results: In 2010, 155 patients and in 2011, 173 patients were hospitalized in ICU. Data are presented in mean \pm SD. Hospitalization period was 15 ± 2.7 and 11 ± 2.1 days, respectively ($p < 0.001$). Pulmonary physiotherapy showed no affect on patents outcome in which during 2010, 94 patients were discharged and 61 patients were dead and in 2011, 98 patients were discharged and 64 patients were dead ($p=0.9$).

Conclusion: In summary it seems that PRP can cause hospitalization period which can indirectly decrease hospitalization costs and may improve patients' quality of life but further studies are recommended to explore PRP effect on mortality rate especially in more categorized and selective patient groups for better evaluation.

Using Proportional Assist Ventilation To Wean Difficult-to-Wean Prolonged Mechanically Ventilated Patients

Hassan Al Gazwi BsRC, Malak Al-Basha BsRC, Leila Al-Jarodi MD

Background: Weaning is the process of liberating patients from mechanical ventilation support. Weaning comprises 40% of mechanical ventilation duration. Studies have shown that 20% to 30% of ventilated patients are difficult-to-wean. Studies also showed that respiratory muscle function is an important determinant of success or failure of the weaning process. Proportional assist ventilation (PAV+) is a novel mode of ventilation that is designed to keep up the changing patient's demand and lung mechanics, and unload respiratory muscles. These study reports six patients tried on PAV+ after several unsuccessful attempts to wean by PSV.

Objectives: This study was designed to determine the effect of PAV+ on adult Difficult-to-Wean patients.

Methods: After multiple weaning attempts of PSV had failed for six adults, prolonged mechanically ventilated patients who spent more than three weeks but less than three months on ventilator support and were difficult to wean /failed SBT trials with PSV more than five times. We switched them to PAV+ mode using predetermined PAV+ protocol starting with 70% of support. Negative Inspiratory Force (NIF), which reflects respiratory muscle strength, was measured throughout PAV+ trails.

Results: Six adult patients were included in this study. All patients were on tracheostomy tube. Mean duration of ventilation was 53.2 days prior to PAV+ trial. On PAV+, NIF measurements improved by 87% from the baseline (average baseline NIF was -22.2 cmH₂O increased to -41.5 cmH₂O at the lowest PAV+ support). All patients were successfully weaned off mechanical ventilation with an average weaning time of 5.8 days. Few days later, patients were transferred to General Care wards.

Conclusion: PAV+ can be used safely and efficiently to wean prolonged mechanically ventilated patients who failed multiple trails of conventional weaning. PAV+ provides opportunity for a respiratory muscle to recover and strengthen, increasing the likelihood of weaning success.

Performance Assessment Of Automatic Vs. Fixed Expiratory Trigger In An ICU Ventilator Under Simulated Clinical Conditions

Ghazi Alotaibi, PhD, RRT. Ahmed Mansi, BS, RCP. Abdulaziz Matani, PhD

Background: Spontaneous breathing during mechanical ventilation requires a big deal of synchronization between patient and ventilator. Literature indicates that the degree of synchronization in majority of ventilated patients is not optimal. Mismatch between the patient and the ventilator can lead to many deleterious effects, such as increased patient's work of breathing, prolongation of ventilation time, and ICU length of stay. Studies have shown that expiratory dys-synchrony is the rule not the exception. Expiratory synchrony refers to the degree of matching between patient's breath ending and cease of flow from the ventilator. Most commercially available ventilators use expiratory flow as a signal to start expiratory phase. In such design, a user-selected flow level is set so that expiration ends once that set level is reached. User-selected expiratory trigger level may not adapt to the ever-changing patient's ventilatory demand. The Newport E360 ventilator has introduced a patented feature (FlexCycleT) by which the expiratory threshold is automatically selected based on a built-in mathematical model. The purpose of this study is to compare the performance of Fixed vs. Automatic expiratory trigger the Newport E360 ventilator under different simulated clinical conditions using variations of PS Levels, patient's demands, airway resistance, and lung compliance.

Methods: We used Active Servo Lung simulator (ASL5000) to simulate breathing conditions. ASL5000 is capable of initiating spontaneous breaths, and allows different settings of breathing profile. Lung Simulator was connected to Newport E360 ventilator. Twenty breaths were recorded for each settings and 5 consecutive breaths were analyzed for expiratory delay time (EDT). Experimental setup for study 1: PEEP 4 cmH₂O, FIO₂ 21%, Flow Trig 1.5 L/min, ET 23% or Auto. Simulator settings: RR 15 b/min, Ti 1 sec, R 5, C 60. Experimental setup for study 2: PS 6 cmH₂O, PEEP 4, FIO₂ 21%, Flow Trig 1.5 L/min, ET 23% or Auto. Simulator settings: RR 15 b/min, Ti 1 sec. Expiratory Delay Time (EDT) was defined as the time between the beginning of the drop of the flow to the cease of patient's effort as Pmus returns back to zero. Data was analyzed using SPSS version 15.0. The variables were described using means and standard deviations. All comparisons were tested for statistical significance using independent t-test. Significance level was considered as p value < 0.01 .

Results: As PS increases late breath termination becomes evident, while increases in patients effort (Pmus) induced early breath termination. Higher Resistance induced late breath termination, whereas low lung compliance induced early breath termination. This study shows that Fixed ETS performed slightly better than Auto ETS at low Pmus. At medium and high Pmus, Fixed and Auto ETS performances were comparable. Performance of Fixed and Auto ETS as a response to changes in lung mechanics were comparable.

Conclusions: Expiratory synchrony is affected by the delicate balance between patient's effort and set PS level. Auto ETS performed at least as good as Fixed ETS but was not superior to Fixed ETS. Auto ETS may not be suitable for patients with low breathing efforts. Interplay of PS level, degree of patients' effort, compliance, and resistance should be taken into consideration when evaluating patient-ventilator synchrony.

Ultrasound-Guided Percutaneous Tracheostomy, A Case Series

Dr. Ali H Altalag

The use of ultrasound in the critical care field is not limited to the usual procedures, like vascular access and other related procedures, but extends

to those that are unthought-of. One of these is the use of ultrasound to guide the insertion of the percutaneous tracheostomy needle. Most of the time, using bronchoscopy to assure the correct placement of the needle in trachea is successful and uneventful. However, there are three situations where unwanted events may take place. First, the trachea may not be palpable especially following the withdrawal of the endotracheal tube to the level of the vocal cords, which may result in repeated attempts of needle insertion. Several complications may take place as a result. Second, superficial vessels may pass in front of the trachea and may be injured and cause significant bleeding during or hours after the procedure. Third, the bronchoscope may get damaged by the needle if it accidentally punctures it.

Using ultrasound guidance is likely to prevent such complications/difficulties to a great extent.

We tested this method on 37 of our regular patients scheduled for percutaneous tracheostomy (so far). Any patient who is eligible for apercutaneous tracheostomy is eligible to be entered into the study. The same consent used for percutaneous tracheostomy is used to perform the procedure. The operator must at least be capable of using ultrasound guidance in central venous cannulation. The trachea is initially examined using the linear array transducer in long plane to identify the cricoid cartilage and the tracheal rings. A mark is then made at the level of second or third rings depending on the patient's neck anatomy. On transverse plane, the trachea and surrounding structures are examined for superficial vessels using both plain ultrasound and color Doppler. If that is excluded and under sterile technique, the tracheostomy needle/cannula is introduced using ultrasound guidance in transverse plane at the center of the second or third tracheal ring that was marked previously. The needle & cannula are introduced under direct guidance until air is aspirated, then the cannula is advanced and the needle is removed. The bronchoscope is then used to ensure the correct position of the cannula from the inside of the trachea. The percutaneous tracheostomy is then completed in the standard way.

We noted that ultrasonography helps identify any superficial or deeper vessels adjacent to the trachea prior to needle insertion. In addition, it shows the tracheal rings on transverse plane, which helps guiding the needle to the middle of the ring preventing repeated needle insertion attempts especially if the trachea is impalpable. On long plane, the cricoid cartilage and tracheal rings can be easily identified which allows accurate needle insertion site in relation to the tracheal rings. Furthermore, we only used the bronchoscope after the needle cannula has been inserted to ensure its correct placement in order to validate this method, which prevents the scope from being damaged.

The major disadvantage of such procedure is the fact that it is somehow more time consuming than the standard procedure, which in, my opinion, is

justified to prevent potentially serious complications.

Prevalence Of Diabetes-Type-2 & Pulmonary Tuberculosis In Filipinos And Treatment Out Comes: A Surveillance Study In Eastern Saudi Arabia.

Liaqat Ali Chaudhry, Ebtesam Ba Essa, Shehab Al-Solaiman, Kamellia Al-Sindi

Objective: To study prevalence of diabetes type-2 and pulmonary tuberculosis among Filipino patients and treatment out comes. Tuberculosis centre of Dammam medical complex (MOH) is a referral centre for the Eastern Saudi Arabia where patients from all government and private hospitals having open pulmonary tuberculosis are admitted for isolation till they are rendered noninfectious. All patients are treated for 6 months under DOTS strategy with 4 drugs (2HRZE) for 2 months as initial intensive phase and 2 drugs (HR) for 4 months as continuation phase.

Methods and materials: We retrospectively reviewed clinical records of 1388 patients admitted with open pulmonary tuberculosis between Jan-2003 and June-2010.

Results: Among 1388 patients, 39% (n=542) were Saudis and 61% (n=846) were non-Saudis. Among these 12.39% (n=172) were Filipinos, 153 males and 19 females respectively. Out of 1388 patients, 114 (7.17%) were found to have diabetes type-2. Among these diabetics, majority n=91 (79.82%) were Filipinos. Sputum conversion was late in diabetic patients resulting in relatively longer hospital stay compared to fellow patients having only tuberculosis.

Conclusion: Our study has shown that one possible risk factor for tuberculosis is diabetes. Majority of TB patients having diabetes type-2, n=91 (79.82%) were Filipinos. Their sputum conversion was relatively late and their hospital stay was longer than their fellow patients having only tuberculosis. Our findings are in agreement with the current literature on the correlation of diabetes and tuberculosis.

Keywords: Diabetes mellitus, FBS-fasting blood sugar, HbA1c-glycated haemoglobin, Tuberculosis, Direct smear AFB sputum conversion, DOTS-directly observed treatment short course..

Prevalence, Patterns And Predictors: Cigarette And Waterpipe Smoking In Male Adolescents In Jordan

Nihaya Al-sheyab, Mahmoud Alomari, Smita Shah, Patrick Gallagher, Robyn Gallagher

Introduction: Cigarette and waterpipe smoking usually begin in adolescence. The prevalence amongst males in Jordan is one of the highest in the world. Our study investigates the prevalence, patterns and predictors of tobacco smoking among early adolescent males in Northern Jordan.

Methods: A descriptive cross sectional design was used. Males in grades 7 and 8 from 4 randomly selected high schools in Irbid city of Northern Jordan were enrolled. Data on water pipe use and cigarette smoking frequency, intensity, age of initiation, family smoking, exposure to household smoking and asthma diagnosis were obtained (n=815; participation rate = 92.4%) using a survey in Arabic language adopted from the Youth Risk Behavior Survey.

Results: The overall prevalence of ever having smoked a cigarette was 35.6% with 86.2% of this group smoking currently. Almost half of the sample reported waterpipe use (48.6%). The most common age of smoking initiation was 11-12 years old (49.1%), although 10 years was also common (25.3%). Significant predictors of male cigarette smoking were waterpipe use (OR=4.15, 95% CI=2.99-5.76), asthma diagnosis (OR= 2.35, 95% CI=1.46-3.78), grade 8 (OR= 1.52, 95% CI=1.10-2.11), and having a sibling who smokes (OR=2.23, 95% CI=1.53-3.24).

Conclusions: Cigarette smoking and waterpipe use rates in early adolescent males in Jordan are alarmingly high. Public health programs and school-based anti-tobacco smoking interventions that target children in primary and early years in high schools and their families are warranted to prevent the uptake of tobacco use among this vulnerable age. Students with asthma should also be targeted in such programs.

Prevalence Of Venous Thrombo-Embolism & Related Morbidity And Mortality Among Hospitalized Patients In Saudi Arabia (SAVTE Study)

Essam Aboelnazar - Fahad Alhameed

Background: Venous Thrombo Embolism (VTE) is a serious and potentially fatal condition. Despite of its cost-effectiveness and favorable outcome evidence-based prophylaxis is underutilized in many countries including Saudi Arabia. VTE prevalence and incidence has not been clearly defined on a large scale bases in Saudi Arabia.

Objectives: This study is a retrospective observational study that was conducted in 7 major hospitals in Kingdom of Saudi Arabia. The primary objectives were to estimate the percentage of patients who received prophylactic thrombolytic treatment according to ACCP guidelines among VTE-patients in addition to, assess the mortality rate in them. The Secondary objectives were: to assess the percentage of VTE confirmed patients in each ward type (surgical and medical), to estimate the percentage of patients prescribed anti-coagulant therapy and adhering to it and to determine percentage of VTE mortality among all cause hospital mortality.

Patients/Methods: Seven major tertiary hospitals in the Kingdom of Saudi Arabia have participated in this study. During the period from 1 July 2009 till 30 June 2010, all cases of VTE recorded in the hospitals were collected using patients' medical records and computerized databases of the hospitals. Only confirmed cases of VTE were included in the analysis.

Results: 1241 of confirmed VTE were included in the study analysis. 58.3% of them were DVT only, 21.7% were PE and 20% were both DVT and PE. 21.4% were related to surgery and 78.6% were related to medical conditions. Only 40.9% of them received appropriate prophylaxis. About 63.2% of surgical patients and 34.8% of medical patients received this prophylaxis (P < 0.001). Mortality rate was 14.3% of all patients representing 1.6% of total hospital mortality. Mortality was 13.5% for surgical patients Vs 14.5% for medical patients (P > 0.05). 89.4% of survived patients received anti-coagulation therapy at discharge, 71.7% of them were adherent to it on follow-up.

Conclusions: VTE is a significant cause of morbidity and mortality in hospitalized patients. Prophylactic thrombolytic therapy is underutilized denoting a gap between guideline and practice for patients at-risk of developing VTE. This gap is markedly more in medical patients compared to surgical patients. Efforts must be devised to improve prophylaxis utilization and to reduce the gap between guidelines and practices in implementing appropriate VTE prophylaxis.

Keywords: Venous thromboembolism, Deep venous thrombosis, Pulmonary Embolism, Thromboprophylaxis

The Prevalence Of Uncontrolled Asthma Among Children In NGHIA In Riyadh And Their Parents Preference For Seeking Asthma Management Strategies.

Ms. Hessa Alotaibi, Dr. Hoda Jaradi, Dr. Ashraf Elmetwally

Background: The evaluation of asthma severity, management and control are important in improving the response to treatment and better management of asthma episodes. Asthma is a disease that is considered a major public health problem and its prevalence is increasing worldwide. Since children are the most vulnerable group that may develop the symptoms and exacerbation that may affect their daily activity and even their lives the role that the parents play is very important to be monitored and evaluated.

Methods: Data of uncontrolled asthma among children was collected from demographical data and Asthma Control Questionnaire for interviewer-administered (ACQ-IA) for children that containing asthma symptoms evaluation and spirometer test. Asthmatic children and their parents were interviewed by respiratory therapists and technicians. 15

Result: A sample of asthmatic children (N=170) aged between 6- 12 years were identified for this study. Response rate was 78.8 % and the study sample was 134 children in the specified age group. The overall prevalence of uncontrolled asthma patients was 88.8% among them. There was no association between asthma control and preferred method of information seeking. However, there was no association between type of asthma control, care-givers level of education and type of information that the parents needed.

Conclusion: Studies about uncontrolled asthma are limited. However, this study tried to highlight the importance of controlling and managing asthma among children. Parents preferred source and type of information needed for managing asthma is crucial and should be considered to contain asthma as a public health burden in Saudi Arabia.

Epidemiological And Clinical Presentation Of Middle East Respiratory Syndrome Coronavirus (MERS-CoV)

Ibrahim A.

Introduction: Middle East Respiratory Syndrome Coronavirus (MERS-CoV) is severe respiratory infection characterized by high great fever cough and a typical pneumonia.

Patients and methods: Sixty-eight suspected patients with MERS-CoV, were admitted to isolation unit. Demographic, clinical and laboratory data were collected prospectively and patients received optimal medical care and they were meticulously followed-up for outcome.

Results: Four cases (6%) were confirmed positive for novel corona virus. All positive cases were exclusively males. There was statistically significant difference in age of positive cases compared to negative cases (32.2 vs. 52.0, P=0.005). TBC was significantly lower among positive cases compared to negative cases (4.8 x10⁹/l vs. 8.2 x10⁹/l, P = 0.02) respectively. Serum creatinine was significant high among positive cases compared to negative cases (587.0 vs. 152.3, P= 0.0003). Chest radiography showed that all positive cases (100%) have parenchyma infiltration compared to 87% of

negative cases. (P=0.0003). Patients with renal failure on hemodialysis and diabetes are at high risk of developing complications and death with estimated 50% case fatality rate.

Conclusion: Majority of suspected cases with MERS-CoV were negative while the confirmed cases have chronic renal failure on hemodialysis and diabetes. There is crucial need to establish case definition based on clinical, epidemiological and microbiological data on field practice, rather than desk practice to minimize the negative consequence of over diagnosis of MERS- CoV.

A National Survey For Noninvasive Ventilation Utilization In The Kingdom Of Saudi Arabia

AIAHMARI, Mohammed^{1*} PhD, RRT, AIOTIB, Hajed PhD, RRT, QUTUB, Hatem MD, ALMOUSODI, Bander MSRC, RRT, AIBALAWI, Ibrahim BSRC, RRT, AIQAHTANI, Abdullah MSRC, RRT

have NIV protocol for specific indications; 42% for weaning; and 47.2% for monitoring. The perceived efficiency of NIV practice was low on the medical wards, with <49% success rate in 39% of the hospitals. Shortage of staff and lack of formal training were the most common reasons for NIV underutilization.

Conclusion: NIV practice seems to be available in all clinical sites. However, the efficiency of NIV appears to be low. Lack of appropriate exposure and formal training could have negative impact on NIV practice. Well developed protocols and structured training have the potential to improve the success rate of NIV.

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Objectives: Noninvasive ventilation (NIV) has been shown to be utilized widely in the last two decades [1]. However, there is currently no available data on the uses of NIV in the Kingdom of Saudi Arabia (KSA). Therefore, the present study is aimed to assess and quantify the utilization of NIV in clinical practices nationwide.

Methods: A web-based survey composed of 31-item, self-administered questionnaire was developed and validated. The questionnaire was designed to address general information for each hospital, availability of NIV practice, utilization of NIV, and obstacles that may render NIV utilization at the clinical site. A participation request was sent by e-mail with a link to questionnaire to senior respiratory therapists (RTs) in 50 hospitals in KSA.

Results: A total of 36 hospitals (72%) responded to the survey; 29 were governmental hospitals and 7 were private. Respondents' characteristics are shown in Table 1. NIV practice was available in all hospitals, Figure 1. NIV is utilized in all intensive care units, 78% of medical wards, 61% of surgical wards, 58% of emergency department, and 25% in other areas. Majority of RTs (85%) have a good experience with NIV, with a confident rate of 81% but only 21.2% had formal training. NIV set up is solely the responsibility of RTs in all hospitals, but only 69.4% of RTs play a role in NIV management. NIV was identified as a first-line option for patients' with COPD exacerbation & acute cardiogenic pulmonary edema, 91.7% and 88.9% respectively. Data shows that 28% of the hospitals do not have a protocol for NIV. Other hospitals have protocol for NIV set up but 50% of them have no protocol for NIV failure. However, 64% of the hospitals

Recurrence Of Tuberculosis In Patients With Interrupted Antituberculous Therapy.

Dr Javed Iqbal

Abstract: Recurrence of tuberculosis in interrupted antituberculous therapy Javed Iqbal, Ayesha Iqbal, Abdul Sattar, Mirza Imran Mughal Presenter- Dr Javed Iqbal- Assistant Professor Chest and TB- jiqb@hotmail.com Prior Honours of this Abstract - 1- Accepted for presentation at European Respiratory Society Meeting at Spain Barcelona-2013. 2- Presented at Quaid E Azam medical college Annual Alummuni Meeting 2012. **ABSTRACT Objective** To know risk of tuberculosis recurrence in patients who completed the total therapy but interrupted course as compared to those who completed it without any interruptions. **Design Cohort study** Place of study: Outpatient and Inpatient units of Chest and TB ward Bahawal Victoria Hospital Bahawalpur from February 2012 to September 2012.

Method: Patients diagnosed recurrent (second time) tuberculosis were interviewed about their prior antituberculous therapy and its compliance and any modified treatment taken.

Results: There were total 67 patients enrolled in the study and among them 34 (50.7%) males and 33 (49.3%) females. Age ranged from 13-75

years (mean 43.35 years). Time since last ATT taken ranged from 2 months to 30 years (mean 9.42 years). Previously 63 (94%) patients took ATT for pulmonary tuberculosis and 4 (6%) were treated for extra pulmonary tuberculosis. The site for which the recurrent tuberculosis was being treated was pulmonary 37 (55.2%), meninges 17 (25.4%), abdominal 12 (17.9%) and pericardial 1 (1.5%). Among these relapse cases 6 (9%, P-Value < .05, significance range) of patients ATT was interrupted during their first therapy for a period ranged 2-90 days (Mean-48.33 days) (P-value 0.001). Among these 5 (83%) were females and 1 was male. Age of these patients whose ATT was interrupted were 2 were young, 3 were middle aged and 1 was old. Reason for this interruption of ATT was 3 (50%) patients were none affording. Among other 1 thought him completely cured, 2 other stopped as they were out of town for personal reasons and forgot to take medicine along.

Conclusion: Interrupted ATT carries statistically significant risk for future recurrence of tuberculosis. Patient must be educated for the compliance at any cost.

Evaluation Of Pulmonary Fungal Diseases In Patients With Fungal Rhino-Sinusitis

Mohamed Shahat Badawy (MD), Badawy Shahat Badawy (MD), Laila Mohamed Yousef (MD), Noha El Sherief

Setting: Little is known on the concomitant occurrence of pulmonary fungal diseases in patients with fungal rhino-sinusitis.

Objective: To evaluate presence of pulmonary fungal diseases in patients with fungal rhino-sinusitis.

Patients and Methods: A prospective study was done for 44 patients who fulfilled inclusion criteria (sinus CT, and histopathological examination). All patients were assessed for pulmonary symptoms, chest X-ray, CT scan, routine lab study, and Broncho-alveolar lavage. Microscopic examination of fungal hyphae, fungal culture, skin prick tests, total and specific IgE were done to all cases.

Results: The mean age of patients were 32.5 ± 13.2 . Fungal Sinusitis were categorized

Diagnosis of tuberculosis suspects at a district tb public health facility under dots

Dr Taj Muhammad , District Tb Control Officer Peshawar Kpk Pakistan.

Introduction: Tuberculosis is a contagious disease, not only in the developing countries due to many aggravating factors, but also in the developed countries due to dual infection of the Tuberculosis and AIDS, that is why it was declared as a Global Emergency in 1993, by the WHO, and as a National Emergency in Pakistan in 2001. Pakistan ranks 6th among the countries with highest disease burden.

Objectives: The aim of the study was to screen the patient coming to the district health clinic for their chest symptoms, selecting TB suspects and advising sputum examination for their cough, and also showing the importance of the sputum examination, and after starting treatment the follow up examination at the end of 2nd / 3rd, 5th and 6th month.

Method: Patients visiting the health facility were advised for 2 sputum specimens, if positive started with anti TB medicine, if negative, chest X ray was advised and decision was made on personal history, family history, response to antibiotic. Extra pulmonary TB cases were received from the other specialties with their diagnoses and clinical evidences.

Results: [1st April to 30th June 2013] (2nd Quarter 2013)

Male	Female	Total
New Smear Positive,	253	278
Previously Treated,	40	35
Treatment After default,	01	01
Sputum Smear Negative,	171	194
New Extra Pulmonary,	395	415
	810	

Others, 00 03 03
Total All Cases, 860 926 1786

Conclusion: DOTS method of Treatment cure rate is 90%. Diagnosis by Microscopy and prescription writing is most important. The priority is given to the Diagnosis and treatment of infectious cases i.e Sputum Smear Positive responsible for the spread of the disease in the society. The quarterly data as TB 08 shows the patients in a district with their sputum conversion and at the end of 2nd, 3rd month and treatment outcome at the end of 12th- 15th month as a TB 09.

Discussion: TB control Program shares the Work and responsibilities of Health workers, because TB is not a Medical, but a Social Problem, aggravated by poverty, malnutrition, congested living, houses with improper ventilation, poor living style, and illiteracy. Cough for more than 2 weeks, not responding to antibiotic should be given due importance and sputum examination should be stressed. TB is completely curable Diseases with the available drugs and standard regimen and no more a social stigma.

Surgical Intervention In Treatment Failure Multidrug Resistant Tuberculosis

Amer Bilal

Objective: To assess the results of surgery for treatment failure Multidrug-Resistant Tuberculosis.

Methodology: Retrospective analysis was done in 114 cases of multidrug-resistant tuberculosis in whom surgical cure was attempted after being declared treatment failure were carried out at Department of Thoracic surgery, Lady Reading Hospital, Peshawar, Pakistan between the years 2002 to 2013.

Results: There were 70 male and 44 female patients in the age group of 14-54 years. All were sputum positive at the time of surgery. Majority of patients were treated with pulmonary resections (pneumonectomy [n=25], bilobectomy [n=32] and lobectomy [n=50]), while primary thoracoplasty with apicolysis was done in 7 patients. Post operatively 2nd line anti tubercular chemotherapy was prescribed for 24 months.

There were four early deaths which included respiratory failure in three and myocardial infarction in one and two late death due to bronchopleural fistula with empyema. Postoperative complications were seen in nine cases; four patients developed bronchopleural fistula with empyema, apical space in three patients and wound infection in two patients. At a mean follow-up of one year bacteriological cure was achieved in 101 patients.

Conclusion: Judiciously performed adjuvant surgery can yield excellent long term bacteriological cure with acceptable mortality and morbidity in multidrug-resistant tuberculosis.

Association of mycoplasma pneumoniae with respiratory tract infections in children

Ali Mohammed Ali Asseri

Mycoplasma pneumoniae is one of four most common species of organisms that are responsible for most clinically significant infections in humans. It is a frequent cause of acute respiratory infections in both children and adults. The organism can cause pharyngitis, otitis, tracheobronchitis, or community-acquired pneumonia, but patients may also remain totally asymptomatic. The aim of this retrospective study on children was to investigate the association of M. pneumoniae with respiratory tract infections in a Saudi population. This work was designed as a case-control study in which 90 patients (mean age of the patients in case group was 5.94 ± 2.73 and in control group was 6.51 ± 2.26) of either sexes were included.

These patients were classified into two groups: first group (case group), included 45 patients who had been admitted in hospital with diagnosis of respiratory tract infections and the second group (control group), included 45 healthy patients who had no history of respiratory tract infections. Both groups were age and sex matched. Presence of IgM antibodies to Mycoplasma

pneumoniae was assessed by ELISA technique in both groups. In the case group, 4 (9%) cases out of 45 children were positive for anti-mycoplasma antibody whereas in the control group, all children were negative.

All positive case group patients had symptoms of acute bronchopneumonia. 18 (40%) of the patients were diagnosed with bronchial asthma (40%) inclusive of all the four cases diagnosed with Mycoplasma pneumoniae infection. The relative risk for the occurrence of mycoplasma infection was estimated to be 9 (95% CI=0.49-162.43). However, on comparing the case and control groups, the result was not found to be statistically significant. (Fischer Exact Test $p=0.0583$). Children in Saudi Arabia are at a relatively higher risk of developing Mycoplasma pneumoniae infection especially those predisposed with underlying chronic respiratory illnesses such as asthma. This is a first study of its kind from the region reporting such a disease in children using a serological assay as ELISA.

Further studies are required to evaluate the risk of co infection by Mycoplasma pneumoniae, Streptococcus pneumoniae and Chlamydia pneumoniae. Evaluating and establishing a correlation between Mycoplasma pneumoniae and the onset of asthma among infected children can be a retrospective field of study

Early Predictor Of Septic Shock In Patients Admitted To The Medical Floor With Pneumonia- A Quality Project

Maryam Al-Nisf, Shaima Arroub, Lubna Ebnomer, Ibrahim Fawzi, Tasleem Raza, Noor Sulieman

Background/ Introduction: Unrecognizing of early signs of septic shock in patient admitted to medical floor with acute pneumonia is a leading cause to transfer them to critical care late with grave complications (Figure 1). Severe sepsis and septic shock can be prevented by applying the "Early Predictors" checklist to patients admitted with pneumonia to the medical floor. The checklist is an excellent screening tool for all patients potential for deteriorations while in hospital and is a good practical application of the international guidelines leading to better physician awareness, faster recognition of early signs and initiation of basic and intensive care therapy.

Aim/Objectives: To decrease percentage of medical transfer to critical care for patients admitted with pneumonia complicated into sepsis from 24.7% to $\leq 15\%$ from 25-April to 15- May 2013. This can directly provide

a significant reduction in hospital cost as well as improving the care of patients with infection and increase chance of survival.

Method:

- a) Formulating a checklist with two arms:
 - I. Identifying all predictors associated with infection complications based on international sepsis guidelines.
 - II. Applying early goal directed therapy for sepsis management.
- b) Implementing the checklist to all adult patients with pneumonia admitted to the medical wards that focuses on the first 6 hours of care after recognition of infection.
- c) Root Cause analysis with cause effect methodology was utilized.
- d) Educational sessions have been conducted to medical and ICU residents about the use of checklist.

Results/Outcomes: Applying the sepsis checklist decreased the percentage of transfers to less than 15% as shown in figure 2. It helped to identified all pneumonia cases in which their illness may deteriorate into more complications early in their disease course and facilitate earlier and more efficient transfer process to ICU.

Discussion/Conclusion: Applying the early predictors checklist help in early identification of patients with sepsis and early intervention that prevent multi-organ failure and increase chances of survival. This leads to reducing the transfer to ICU beds by 10%. Moreover, it helps in improving the quality of transfer from medical floor to ICU and facilitates the transfer of sick patient to ICU early and safely. We expect that this step will affect the total hospital stay in the medical as well as in ICU care. This will need further studies in the future as this was not measured in this project.

Sustainability/Replication potential:

- Coordinate with the Medicine Quality Committee for project sustainability through applying the check list.
- Continue data collection for the coming one year to ensure success and eliminate seasonal variation bias.
- To implement for all pneumonias as well as other types of infections e.g. UTI.
- To make the checklist part of the pneumonia guideline in the Department of Medicine.
- Though the checklist was designed for Medical Department, it can be applied to any area where care is given to Patients with sepsis e.g. Emergency Department, Recovery Rooms and ICU.



Lessons learned/Critical success factors:

Success came from collaborative work between the General Medicine and MICU Teams. The early predictor of sepsis checklist is an excellent tool in areas where the guidelines need to be applied based on each institution environment.

Acknowledgment:

- This work was sponsored by Department of Medicine as part of CCIT workshop in partnership with Partners Health.
- Presented at Qatar Patient Safety Week, 2014

References: Surviving sepsis campaign: international guidelines for management of severe sepsis and septic shock: 2012. Crit Care Med. 2013;41(2):580.

Community Vs. Hospital Based Multi-drug Resistant Tuberculosis Management In Adults: Systematic Review

The Role Of Serum Procalcitonin In Diagnosing Bacterial Infection Of The Lower Respiratory Tract In Patients With Acute Exacerbation Of COPD

Khaloudon Tabbah. Consultant And Associate Professor In Respiratory Medicine, Faculty Of Medicine, Aleppo University, Aleppo, Syria

Acute exacerbation of chronic obstructive pulmonary disease is a main cause of morbidity and mortality, and a frequent indication for antibiotic prescription. The aim of this study was to identify the bacterial-infection triggered cases of acute exacerbation of COPD, so to reduce the burden of antibiotic use that has been increased in recent years. Procalcitonin (PCT) appears to be a useful inflammatory marker in differentiation between bacterial and non-bacterial causes to guide antibiotic therapy thus, it can reduce unnecessary antibiotic use and subsequent bacterial resistance.

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Shirin Anil, Quratulain Humayun

Objectives: To determine the success rate of MDR TB treatment in adults receiving care under community-based model compared to the hospital-based model.

Methods: Extensive electronic search was done for studies published till 2011 looking at the success rate of MDR TB treatment, exclusively mentioning the type of care delivery model (community-based or hospital-based). Those reporting only the initial outcomes like culture conversion rate as well as reviews and case reports were excluded. Weighted average for success rate (SR) was calculated.

Results: Of 206 studies extracted, 33 met the inclusion criteria: 11 studies looked at the SR of community-based model and 21 at the hospital-based model. In one study community-based model was followed by hospital-based model. All were observational descriptive studies. Weighted average SR in patients in community-based model was 55 (range 32.3-89.2) % and in hospital-based model was 56.7 (range 37-91.3) %. This was affected by the income status, presence of DOTS, individualized or standardized treatment and decentralization of care delivery.

Conclusion: Though both models seem equally effective but this is based on low grade studies and this research gap needs to be addressed by conducting good quality comparator study.

Method: the study was carried out over 18 months period (March 2011-August 2012) at the Department of Respiratory Medicine at Aleppo University Hospital, Aleppo, Syria. PCT was measured using a sensitive immunoassay for all patients and sputum culture was done for 43 patients.

Results: Of the 102 patients (91 male, 11 female) included in the study, 80 patients were undergoing a COPD exacerbation (13 with pneumonia, 33 with a bacterial infection but without pneumonia, 34 with viral infection) and 22 patients were in a stable phase without clinical signs of infection. PCT was significantly elevated in pneumonia patients (11.15 ng/ml), and moderately increased in patients with bacterial infection (1.61 ng/ml) ($P < 0.05$). No increase in PCT level was seen in patients with viral infection (0.29 ng/ml) nor without infection (0.22 ng/ml). Furthermore, serum PCT levels were higher in Gram-negative infections compared with Gram-positive infections. In contrast, CRP levels were elevated in all COPD patients during exacerbation even in the absence of infection.

Conclusion: Bacterial cause of acute exacerbation of COPD was found in nearly 50% of cases, and serum PCT level was elevated in patients with manifestations of bacterial infection that helped guidance antibiotic use. However, further studies are necessary to assess the safety of procalcitonin-based therapeutic strategy in critically ill COPD patients.

Antibiotic Consumption In The First Year Of Life And The Risk Of Respiratory Conditions In Children.

Kamal Eldeirawi, PhD

Rationale: Little is known about risk factors of asthma and other respiratory conditions in Mexican American children; an immigrant population in transition. Although frequent use of antibiotics early in life has been linked with the risk of asthma in children, the unique effect of antibiotic use in infancy on the risk of asthma and other respiratory conditions has not been well delineated in children of Mexican origin. The purpose of this study was to determine the associations of antibiotic use in infancy with lifetime doctor-diagnosed asthma, wheezing in the year prior to the survey, and other respiratory symptoms after controlling for covariates.

Methods: This study is a population based cross-sectional investigation with parents of 2,023 school children. In this study, parents completed a questionnaire or telephone interview which collected data on asthma, respiratory conditions, antibiotic use, early childhood infections, and other potential confounding variables.

Results: Children's any use of antibiotics in the first year of life was significantly associated with a lifetime doctor-diagnosis of asthma (Odds Ratio =2.34, 95% confidence interval (CI): 1.54, 3.55) after adjusting for age, gender, having a regular place for health care, parental history of asthma or allergies, and ear infections as well as Tylenol use in infancy. There was a statistically significant dose-response relationship between the frequency of antibiotic utilization in infancy and the risk of asthma ($p < 0.0001$). Compared with children who did not use antibiotics in infancy, the adjusted odds ratios for asthma were 1.84 (95% CI: 1.15, 2.93) and 3.41 (95% CI: 2.07, 5.61) for receiving antibiotics for 1-2 and ≥ 3 times in the first year of life, respectively.

In multiple logistic regression analyses, antibiotics use in infancy was also associated with history of wheezing in the 12 months prior to the survey but the relationship was not statistically significant. However, when we excluded children who had a history of infection (ear infection as well as viral and bacterial infections) in infancy, those who consumed antibiotics in their first year of life were over twice as likely to wheeze in the past year than their counterparts who did not use antibiotics in infancy ($p < 0.01$). In addition, we found significant associations of antibiotics use in infancy with an increased risk of other respiratory conditions including ever wheezing, wheezing due to exercise in the past year, and dry cough at night not associated with cold in the past year.

Conclusions: Our findings suggest a significant and a dose-dependent association of antibiotic use in infancy and the risk of asthma in school aged children of Mexican origin. This study adds to the evidence linking antibiotic consumption early in life with an increased risk of asthma and

other respiratory conditions but additional prospective studies are needed to further determine the effect of early life exposure to antibiotics on the development of asthma.

Supported by the University of Illinois at Chicago's Provost's Award for Graduate Research. Time for data analysis and presentation development was supported by the Robert Wood Johnson Foundation Nurse Faculty Scholar Program (Grant # 71249)

Pleural Fluid Triglyceride Cholesterol Ratio In Chylothorax

Sameh I Sersar MD

Introduction: Very little, if any, is discussed in the recent cardiothoracic surgery publications about Triglyceride Cholesterol Ratio value either in the diagnosis or the prognosis of Chylothorax.

Patients and Methods: A retrospective analysis of 60 patients of chylothorax with a mean age of 21 months (range, 1 month-65 years) who developed chylothorax after heart surgery (January 2007 through December 2010). Data were collected regarding demographics, method of diagnosis, surgical procedures, characteristics of chylous drainage and its management. The patients were divided into 3 groups; Group 1 (ratio < 1); Group 2 (ratio between 1-2) and Group 3 (ratio > 2).

Results: Eighteen cases had a ratio < 1 , 14 had a ratio between 1-2 and 28 had a ratio > 2 . There were 2 hospital mortalities; Both had a triglyceride/cholesterol ratio > 2 . All patients responded to the conservative treatment except two cases who required further thoracic duct ligation.

Conclusions: Pleural Fluid Triglyceride Cholesterol Ratio in Chylothorax can be used in the diagnosis of chylothorax and more importantly as a prognostic detector in cases of post cardiac surgery chylothorax.

5-Aminolevulinic Acid-induced Fluorescence Diagnosis Of Pleural Malignant Tumor

Abdellah Hamed Khalil Ali, Takizawa H, Kondo K, Matsuoka H, Toba H, Nakagawa Y, Kenzaki K, Sakiyama S, Kakiuchi S, Sekido Y, Sone S, Tangoku A

Background: It is known that endogenously synthesized protoporphyrin IX (PpIX) following the administration of 5-aminolevulinic acid (5-ALA) is an effective photosensitizer for photodynamic diagnosis (PDD). We tested in vivo and in vitro susceptibility of human lung cancer and mesothelioma cells to photodynamic diagnosis (PDD) using 5-aminolevulinic acid (5-ALA) as a photosensitizer.



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LUNG INFECTIONS

Methods: Human lung cancer cell lines A549, Ma44-3, FT821 and human mesothelioma cell lines MSTO-211H, NCI-H290, Y-MESO-14 were incubated with 0.03% 5-ALA for 4 h. After incubation, protoporphyrin IX (PpIX) fluorescence was detected using a fluorescence microscope. Pleural carcinosis was induced in severe combined immunodeficiency disease mice using the previous cell lines to test the efficacy of PDD in vivo. The mice were sacrificed 4 h after oral administration of 400 mg/kg of 5-ALA. We counted the visible tumors under white light then fluorescence light.

Results: In vitro, clear red fluorescence was observed in all cell lines. The mean fluorescence intensity was stronger in A549 and FT821 cells than Ma44-3 cells (165.59 ± 26.49 , 157.62 ± 18.93 vs. 104.01 ± 17.58). Also, MSTO-211H and NCI-H290 cells had stronger fluorescence intensity than Y-MESO-14 cells (142.51 ± 26.85 , 165.16 ± 12.91 vs. 92.31 ± 8.69). In vivo, the tumor detection rate of fluorescence diagnosis was 1.1-4.5 times higher than that of white light. The mean number of metastases detected by the PDD was significantly higher than that of white light for FT821 ($p=0.004$), Ma44-3 ($p=0.006$) and Y-MESO-14 cell lines ($p=0.005$), but not for A549, NCI-H290 and MSTO-211H cell lines. Small lesions were detected by fluorescence diagnosis even though the lesions were invisible macroscopically under white light.

Conclusion: Our results suggest the possibility of clinical application of fluorescence diagnosis with intrapleural malignant tumors.

A Diagnostic Approach To Undiagnosed Pleural Exudates

Enas Batubara, Florian Von Groote-Bidlingmaier, Johannes Bruwer, Prof. Chris Bolliger (deceased), Prof. Elvis Iruen, Prof. Andreas Diacon, Prof. Coenraad Koegelenberg

Background: We assessed the efficiency and safety of an image-guided diagnostic pathway with ultrasound (US)-assisted closed pleural biopsy as an alternative to thoracoscopy as first-line investigation in undiagnosed pleural exudates.

Methods: Patients with non-diagnostic thoracentesis were prospectively stratified on imaging as having (A) an associated mass lesion ($>10\text{mm}$) abutting the chest wall; (B) diffuse pleural thickening ($>10\text{mm}$) and/or nodularity or (C) insignificant/no pleural thickening. US-assisted repeat thoracentesis and transthoracic fine-needle aspiration were performed on patients stratified to (A), and if non-diagnostic on on-site analysis, a Tru-Cut biopsy was performed in the same session. US-assisted thoracentesis and Abrams needle biopsies were performed on all others aiming at the region(s) of interest (B) or low supra-diaphragmatic pleura (C). Thoracoscopy was reserved for cases not diagnosed by repeat thoracentesis and biopsy.

Results: Final diagnoses in 78 consecutive patients included malignancy ($n=42$), TB ($n=30$), and other causes ($n=6$). Accurate diagnoses were obtained in 69 (88.5%) with US-assisted thoracentesis and biopsy. The yield was high for TB (93.3%) and malignancy (88.1%). Complications included mild haemoptysis ($n=1$) and pneumothorax ($n=1$, no intervention required). Thoracoscopy was performed in 13 cases (16.7%), including all 4 cases correctly diagnosed on closed biopsy as non-specific pleuritis, and yielded diagnoses in 12.

Conclusion: A diagnostic algorithm based on pleural morphology, US-assisted thoracentesis and biopsy has a high diagnostic yield and offers an efficient and safe alternative to thoracoscopy as a first-line investigation in undiagnosed exudates.

Diagnostic Utility Of Mesothelin And Thoracoscopy In Malignant Mesothelioma

Rana Elhelbawy, Nessrean Elhelbawy, Safaa Tayel, Ehab Shaltoot

Malignant pleural mesothelioma (MPM) is an aggressive malignant tumor of mesothelial origin. In this study exudative pleural fluid was collected from 44 patients presented to respiratory clinics. Definite histological diagnosis was

reached using one or more of the three investigative tools that were used in this study. Diagnosis was confirmed by analysis of pleural fluid in 10 out of 44 patients (22.7%), by needle biopsy in 12 out of 34 patients (35.3%), while thoracoscopy had a diagnostic yield of 90.3%. There were 16 cases of MPM, 13 cases of pleural metastases of carcinomas and 15 patients with non malignant pleural effusion. Mesothelin was measured in both serum & pleural fluid by enzyme-linked immunosorbent assay (ELISA). Patients with MPM had significantly higher pleural effusion mesothelin level (107.01 ± 44.16 ng/ml) than those with metastatic effusion of carcinoma (34.88 ± 30.88 ng/ml) or non malignant pleural effusion (38.08 ± 18.99 ng/ml). Serum mesothelin showed similar trends. Pleural fluid & serum mesothelin levels positively correlate in patients with MPM: significantly higher levels of mesothelin were found in effusion and serum of patient with mesothelioma with a sensitivity 94% and specificity of 100% compared with those with effusion of non-neoplastic origin. Mesothelin had an accuracy of 97% in distinguishing between MPM and effusion of non-neoplastic origin. Using a pleural mesothelin cut-off of 50.45 ng/ml, 15 out of 16 patients (93.8%) were positive in MPM group versus 3 out of 13 patients (23.1%) in the metastatic effusion from carcinoma.

Conclusions: The pleural or serum mesothelin concentrations are useful ad junction to thoracoscopy in the diagnosis of MPM. Mesothelin can distinguish between MPM and benign pleural effusion.

Keywords: Pleural effusion, MPM, Mesothelin, SMRP, thoracoscope, pleuroscopy.

The value of use of amino-terminal brain natriuretic peptide as marker in cases of pleural effusion of different etiologies

Laila A Banawan, Yehia M Khalil, Abeer H Kassem* & Nermin Hossam Zakaria, Eriny M Tawedrous

Background: The criteria of Light et al. have been used to make the differentiation between transudate and exudate effusion for the past 25 years. The main problem with those criteria is that although they identify nearly all exudates correctly, they misidentify about 20-25% of transudates as exudates.

The plasma NT-proBNP level is a sensitive marker of cardiac dysfunction and has proved to be a useful tool for the identification and management of systolic and diastolic cardiac dysfunction.

Objective: The aim of this work was to study the value of pleural NT-pro brain natriuretic peptide in the diagnosis of pleural effusion of different causes in comparison to the conventional diagnostic procedures in cases of pleural effusion.

Subjects and methods: The present study was conducted on 32 patients who suffered from pleural effusion, they were classified according to Light's criteria into two groups namely transudate, exudate, and the third group of 10 normal healthy subjects as control group.

Results: The levels of both serum and pleural fluid pro-BNP in group I patients with transudate effusion were significantly higher than group II patients with exudate effusion ($P > 0.001$, 0.003) respectively.

Conclusion: The results support the feasibility of using the pleural fluid amino terminal proBNP measurement in thoracentesis that would enhance discrimination among the different causes of pleural effusion especially for heart failure patients. Serum and pleural fluid levels of NT-proBNP were closely correlated and measurement of NT-pro BNP in serum showed equally good diagnostic properties.

Six-Minute Walk Test Performance In Healthy Adult Pakistani Volunteers

Nisar Ahmed Rao*, Muhammad Irfan, Ahmed Suleman Haque, Ali Bin Sarwar Zubairi And Safia Awan

Objective: To determine the six-minute walking distance (6MWD) for healthy Pakistanis, identify factors affecting 6MWD, compare published equations with the local data and derive an equation.

Study Design: Cross-sectional study.

Place and Duration of Study: Two medical institutes of Karachi, from January to May 2011.

Methodology: Subjects between 15 and 65 years were prospectively enrolled after screening. A standardized 6MWT was administered. SpO₂, HR, BP and dyspnoea scores were determined pre- and post-test.

Results: Two hundred and eleven (71%) men and 85 (29%) women participated. Mean 6MWD was 469.88 ± 101.24 m: men walked 502.35 ± 92.21 m and women walked 389.28 ± 74.29 m. On univariate analysis, gender, height, weight and age showed a significant relationship with the 6MWD. Gender and age were identified as independent factors in multiple regression analysis, and together explained 33% of the variance. The gender-specific prediction equations were: 6MWD (m) for men = $164.08 + (78.06 \times 1) - (1.90 \times \text{age in years}) + (1.95 \times \text{height in cms})$ 6MWD (m) for women = $164.08 - (1.90 \times \text{age in years}) + (1.95 \times \text{height in cms})$.

Conclusion: 6MWDs among the volunteer subjects were shorter than predicted by reference equations in literature. Height, gender and weight combined explained 33% of the variance. The moderate over-estimation of the 6MWD in Pakistani subject. The proposed equation gives predicted (mean) 6MWDs for adult Pakistani naïve to the test when employing standardized protocol.

Keywords: Healthy subjects. Pakistani. Six-minute walking distance.

Tobacco smoking and pulmonary function indices among undergraduates: report from a nigerian population

Adegoke Boa, Akinremi AA, Adekemi EA

Background: Tobacco smoking is known as a risk factor for developing several chronic disorders and its current epidemic is driven by adolescents and young adults. Most life-time smokers become regular smokers during young adulthood. While tobacco-related morbidity rises with increasing years of smoking, increase in the number of young smokers may have considerable public health implications; hence examining the impact of smoking on lung function of this population may be of great importance.

Objective: The effect of tobacco smoking on lung function indices among young adults was assessed in this study.

Method: The cross-sectional study involved 104 male undergraduates, aged between 18 and 30 years. They were recruited by snowball sampling and grouped based on their smoking status (current smoker 52: never-smoker 52). Participants with signs of respiratory disease or thoracic spine deformity or contraindication to spirometry were excluded from the study. Participants' forced vital capacity (FVC), forced expiratory volume in first second (FEV1) and forced expiratory ratio (FER) were assessed using standard protocols. Data were analyzed using mean, standard deviation, independent t-test and chi-square test with alpha level set at 0.05.

Result: The two groups were not significantly different in age, height and body mass index. Smokers, had significantly reduced FVC (3.42 ± 0.42 vs 3.87 ± 0.4), FEV1 (2.39 ± 0.37 vs 3.22 ± 0.38) and FER (70.7 ± 7.58 vs 82.3 ± 4.05). Among the smokers a dose-response relationship was observed between years and numbers of cigarette smoked and spirometric indices. Proportion of participants with FER below the age-matched reference was significantly higher among smokers than never-smokers (40.4% vs 6.7%).

Conclusion: Smoking reduced pulmonary function among undergraduates. This may have important public health implication as continued smoking may further deteriorate lung function and consequently increase future disease burden due to tobacco use. Longitudinal studies with large sample size are needed to investigate risk factors associated with smoking among this population.

Students' Perceptions Of The

Effectiveness Of Respiratory Skills Lab In Preparing Them For Clinical Training

Mohammed A Yadak, MHPE, RRT, Omar M Al-Omar, Ahmed A Mansi

Introduction: In the past, emphasis has been placed on the importance of Early Clinical Exposure training in the AHP curriculum. Clinical skills were performed at bedside in which patients were used as teaching aids. Change in professional education and health care systems had made this teaching method less effective. Clinical Simulation Labs are widely adopted as a strategy to support student development of clinical skills. CSL have been established not to replace clinical experience, but to allow the early practice of skills in a safe, supervised and ethical environment. (Godson, 2007)

Study Context: The Respiratory Skill laboratories (RSL) at UD was established in 1999, as part of the curriculum of RC program at CAMS which aimed to provide hands on learning experience for the practice of clinical skills to ensure that all students have the necessary learning opportunity and appropriate assessment before approaching real patients. The RSL take place starting from the 2nd semester of the 2nd year. Skills are taught and trained with all students using manikins, computer-based simulations, models, demonstration, and role-players.

Research Methodology: An internally developed questionnaire was used to collect Student perception of RSL. Focus group discussion with discussion guide was used to identify the key factors in the RSL and to assess face validity. The reliability of the questionnaire was assessed using Cronbach's alpha which was 0.94. Questionnaire comprised of 4 main themes. Data analyzed using SPSS v.17.0).

Results: Students' written comments pointed to some of the strong areas in the program, while at the same time indicating areas for improvement.

Nasal Spirometry: A New Approach For Spirometry To Evaluate Respiratory Functions

Nasr A. Belacy, MD, Tawfik M. Ghabrah, MD, Mustafa H. Abdelsalam, MD, Magdi A. El-Damarawi, MD, Basem M. Elsayy, MD, Noha A. Nasif, MD and Eman A. El-Bassuoni, MD

Conventional oral spirometry is a commonly used test for respiratory functions. However, the nasal passages are the primary pathway for regulating ventilation and modulating ventilated air. Here, we tested the validity of using the nasal route (nasal spirometry) for the evaluation of respiratory functions. 250 healthy young adults (150 males and 100 females; 17 to 23 years of age) were subjected to two spirometry tests: oral spirometry by using the mouth piece and the nasal spirometry by using a face mask. Measurement parameters included: Vital capacity (VC), forced vital capacity (FVC), forced expiratory volume first second (FEV1), FEV1/FVC%, peak expiratory flow (PEF25/75%), and maximum voluntary ventilation (MVV). In both males and females, only VC was significantly higher in nasal than oral spirometry, while FVC, FEV1, FEV1/FVC%, PEF25/75% and MVV were significantly higher in oral than nasal spirometry. Prediction equations for different measurements of nasal spirometry were derived by multiple regression analysis using sex, height, and weight as independent variables. We conclude that nasal spirometry is an easy and valid procedure that can be used as a reliable alternative to oral spirometry in testing for respiratory function.

Results: Students' written comments pointed to some of the strong areas in the program, while at the same time indicating areas for improvement.

Abdominal Pathology In The Chest. Experience Of 112 Cases

Amer Bilal

Objective: Experience with traumatic diaphragmatic hernias was reviewed to identify pitfalls in the diagnosis and treatment of this injury.

Material and Methods: A Computerized chart review of all patients admitted to the Cardiothoracic Unit with traumatic diaphragmatic ruptures was undertaken for the period of January 2003 to October 2013. The diagnosis was made by chest X-ray, thorax and upper abdominal computed tomography, and upper Gastrointestinal contrast study.

Results: We retrospectively analyzed 112 patients who presented between January 2003 and October 2013 with traumatic diaphragmatic rupture, caused by blunt injuries in 94 (83.92%) and by penetrating injuries in 18 (16.07%). There were 99 (88.39%) cases of acute diaphragmatic rupture and 13 (11.60%) cases of post traumatic hernia. Average age of the patients was 30 years ranging from 12-70 years. Chest pain, abdominal pain, Or dyspnea were the predominant symptoms. Traumatic diaphragmatic hernia was right-sided in 14 (12.5%) patients and left-sided in 98 (87.5%). Repair of diaphragmatic hernia was performed through a thoracotomy in 96 (85.71%) cases and in 16 (14.24%) cases through thoracoplasty. The mortality rate was 2.67% (n=3) all three died due to multiple concomitant injuries. Morbidity was 5 (4.46%) including wound infection 4, collection 1.

Conclusions: Early diagnosis and treatment reduce intra-and post-operative morbidity and mortality

sarcoma and one case a clear cell carcinoma. the right lung cancer is based in 53% of patients have metastases were cas.29 whose metastatic site is bone in 37%, 34% in adrenal, liver in 17%, 14% in brain and contralateral in 17%. Several chemotherapy regimens were used category platinum salt + docetaxel (+/- bevacizumab +/- bisphosphonate), platinum-gemcitabine (+/- bisphosphonate), platinum-pemetrexed (+/- bisphosphonate) salt platinum + doxorubicin, CAV and carboplatin + etoposide. Evolution: 60% of patients are undergoing chemotherapy (one or more lines) 13% are sent to either surgery or radiation therapy, 17% of patients with impaired general condition and 10% of cases are lost view.

Conclusion: The lung cancer because of its frequency and its severity is a real public health problem. Diagnosis is often delayed and treatment is palliative despite advances in treatment. Lung cancer is accessible prevention (since its main risk factor is smoking) by national anti-tobacco programs.



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LUNG CANCER AND TOBACCO: About 47 Cases

Dr Athamnia Houda

Introduction: Lung cancer is the 1st human cancer and the leading cause of cancer death in the world. The main causative agent is tobacco and occupational exposure Surgery is curative action in NSCLC and chemotherapy in SCLC

Materials And Methods: This is a study of 47 cases of patients treated in 2012 at the medical oncology unit hematology Annaba whose objective was: to establish the epidemiological profile and evaluation of the relationship between smoking and the occurrence of lung cancer and determine its severity

Results: The average age of patients was 59 years (18-83 years) with 91% of cases are men. 87% of patients are active smoking with an average of 45 percent / year, the rest 13% (04 women and 02 men) are smoking passifs. 17% of patients are alcohol-tobacco 4 of 47 patients are tabachiques. 80% of patients have a family history of one or more other cancer (03 cases of colon cancer , 03 cases of breast cancer , 02 cases of the thyroid cancer, a one case ovarian cancer and NHL cases) 26 patients have bronchial adenocarcinoma, 12 patients epidermoid carcinoma, 04 patients a SCLC, 02 patients adeno-squamous cell carcinoma, 02 cases

TMEM158 And FBLP1 As Novel Marker Genes Of Cisplatin Sensitivity In Non-small Cell Lung Cancer Cells

Ahmed El Sayed Mohammed, Hidetaka Eguchi, Satoru Wada, Nobuyuki Koyama, Michio Shimizu, Keiko Otani, Megu Ohtaki, Keiji Tanimoto, Keiko Hiyama, Mohammed Soliman Gaber, And Mas

Even after development of molecular targeting therapies, platinum-based chemotherapy is still a standard care for treatment of locally advanced non-small cell lung cancer (NSCLC). So far, critical molecular markers capable to predict the therapeutic response in NSCLC patients remain undetermined. We here attempted to identify novel biomarker genes for cisplatin (CDDP) for a tailored therapy.

Initial screening to explorer association of IC50 values of CDDP obtained by MTT assay and gene expression levels measured with oligonucleotide microarray and real-time RT-PCR provided 6 candidate genes, namely, NUBPL, C9orf30, ZNF12, TMEM158, GSK3B, and FBLP1 using 9 lung cancer cells consisting of 3 small and 6 NSCLC cells. These 6 genes together with 5 reported biomarkers, i.e., GSTP1, ERCC1, BRCA1, FRAP1, and RRM1, were subjected to a linear regression analysis using 12 NSCLC cell lines including 6 additional NSCLC cells: only FBLP1 and TMEM158 genes showed positive associations with statistical significances (P = .016 and .026, respectively).

The biological significance of these genes was explored by in vitro experiments: Knockdown experiments in PC-9/CDDP cells revealed that the reduced expression of TMEM158 significantly decreased the chemoresistance against CDDP ($P < .0001$), while 2 transformants of PC-6 cells stably over-expressing FBLP1 resulted in an enhanced resistance to CDDP ($P = .004$ and $P = .001$). Furthermore, a stepwise multiple regression analysis demonstrated the best prediction formula could be fixed when we used expression data of TMEM158 and FBLP1 ($R^2 = 0.755$, $P = .0018$). TMEM158 and FBLP1 may be powerful predictive biomarkers for CDDP therapy in NSCLC.

Time Trend And Pattern Of Cancers Among Men In Population-based Cancer Registry In Setif, Algeria.

Zoubida Zaidi, Abbas Mahnane, Manal Rekab, Dahbia Charka, Slimane Laouamri, Mokhtar Hamdi Cherif.

Objectives: An attempt has been made to better understand the burden of cancer in Setif man by analyzing the database contributed by population-based cancer registry of Setif over the last two decades. 45% of the total cancer in men constitutes the cancers of lung, colon-rectum, stomach and bladder. The present study examines the pattern of cancers and their trends among the male population of Setif.

Methods: Evaluation of trends in age-standardized rate (ASR) was done using the Joinpoint method on incidence data collected over the years 1986-2010 by population based cancer registry of Setif.

Results: The most common cancers among men reported during the period 2005-2010, were lung ASR (24.7 per 100 000), colon-rectum (13.8 per 100 000), stomach (12.4 per 100 000), bladder (12.1 per 100 000) and non-hodgkin lymphoma (11.6 per 100 000). Lung cancer accounted for 16.1 % of all cancers reported in this area, colon-rectum was 9.0%, stomach 7.9%, bladder 7.8% and non- hodgkin lymphoma 7.6%. Between the years 1986 and 2010, significant rising trends were observed in cancers of the lung, colon-rectum, bladder, prostate and larynx. Significant decreasing trends were observed in cancers of the stomach, nasopharyngeal carcinoma.

Conclusions: It has been observed that cancer is becoming a severe disease which requires serious efforts to better understand the etiology of these cancers. Systematic epidemiological studies should be planned in the near future on a priority basis.

These trends have resulted in a significant change in the pattern and load of cancer in the population of Setif. The changes in the trend and pattern of cancer will help the health care system in reformulating the cancer care and cancer control activities in the region.

Esophageal cancer complicated by Esophago-Pulmonary fistula and lung abscess formation: A Surgical Approach

F. Al-Shahrabani, A. Rehders, B. Baseras, S. Angenendt, L. Telan, M. Ghadimi, W. Knoefel

Objectives: Esophago-pulmonary fistula is a devastating complication of advanced esophageal cancer, usually treated by endoscopic stent placement. Despite of successful endoscopy maintaining esophageal patency and sealing of the fistula, stent placement does not adequately address intrapulmonary abscess formations triggering rapid septic deterioration occurring in the vast majority of these patients. Possibly surgical treatment with removal of the underlying esophageal malignancy and the pulmonary abscess might be a more promising approach.

The incidence of esophageal cancer is not only constantly rising, but neoadjuvant radio-chemotherapy protocols are also being used more frequently, which have been associated with formation of esophageal fistulae previously. Consequently the number of patients presenting with intractable esophago-pulmonary fistula is likely to increase in the near future, challenging the treatment modalities available.

Methods: We report our experience with surgical treatment of two consecutive patients presenting with malignant esophago-pulmonary fistula, who underwent simultaneous esophageal and pulmonary resection (Lobectomy). In both cases gastrointestinal passage was reconstructed using a retrosternal isoperistaltic colonic interposition.

Results: Even though both patients had considerably reduced general health and pre-existing pulmonary co-morbidity, they survived various surgical interventions and finally could be discharged free of tumor and with restored swallowing function.

Conclusions: Esophago-pulmonary fistula is a dreadful complication of the underlying malignancy and the two cases presented impressively demonstrate the difficulties associated with major surgery when performed in such patients. Still the therapeutic option of surgical resection should at least be considered, particularly in patients, who are free of distant metastasis.

Comparative study between vinorelbine based versus taxanes based chemotherapy in treatment of parenchymal metastatic breast cancer.

Mohamed Omara Ibrahim Hussein

Background: Vinorelbine based and taxanes based chemotherapy are the most commonly used regimens given for parenchymal metastatic breast cancer. This study was held to compare the response of those regimens according to Response Evaluation Criteria In Solid Tumors (RECIST) in patients with parenchymal metastatic breast cancer in Suez Canal University Hospital, Clinical Oncology and Nuclear Medicine Department (SCUCON). Aim: We performed this study to identify the best management to be given for patients with parenchymal metastatic breast cancer in (SCUCON).

Patients and Methods: This was a retrospective descriptive study that included all the patients with parenchymal (lung and/or liver) metastatic breast cancer (166 patients) treated in SCUCON between Jan.1995 and Jan. 2011. The collected data included the medical history, clinical, laboratory, radiological and pathological data, the treatment received and follow-up for each patient, from files which are coded. Data was recorded without identifiable information, so the researchers asked for waiving of informed consent because it is a retrospective study.

Results: The study included 166 representing 12.6% of breast cancer patients. Over all comparison showed mild superiority of Navalbine based chemotherapy over Taxanes based chemotherapy. In metastatic breast cancer to liver, complete response was 25% with Navalbine compared to 54.5% with Taxanes. While in metastatic breast cancer to lung, complete response was 40.9% with Navalbine compared to only about 9% with Taxanes.

Conclusion: Navalbine based chemotherapy is more superior in patients with metastatic breast cancer to lung, while Taxanes based chemotherapy is more superior in patients with metastatic breast cancer to liver.

Improving The Quality Of Life For Ambulatory Patients With Advance Lung Cancer Through Phone Triaging

Aljohani Abdulaziz, Alshamari Sami, Anber Mahmud, Pachev George, Marry Beth

Problem: Palliative care strives to improve the quality of life for patients and their families by impeccable assessment and management using an interdisciplinary approach. However, patients with lung cancer-related pain and other symptoms tend to be undertreated because of limited follow-up visits due to late referrals and logistics. Thus, Patients have to deal with the complex and time consuming logistics of ambulatory cancer care. At the same time, members of staff often waste considerable time and energy in organizational aspects of care that could be better used in direct interaction with patients.

Design: Quality improvement study using the Edmonton Symptom

Assessment Scale (ESAS) is a formalized symptom assessment tool used to capture patients' subjective measurement of symptoms and focus group meetings with patients and families regarding how to complete the ESAS and rate their symptoms by using the numerical 0 to 10 rating scale.

Setting: Outpatient palliative care clinic at Supportive Care Center, Security Forces Hospital, Medina where lung cancer patients receive chemotherapy and complementary palliative care.

Methods: At each clinic visit, a nurse trained in palliative care explains the ESAS to the patient and caregivers to ensure the scale is understood and properly filled out. Symptoms included on the ESAS are pain, fatigue, depression, nausea, anxiety, drowsiness, best appetite (with a score of zero signifying no subjective report of appetite issues), best feeling of well-being, no shortness of breath (SOB), and best sleep. While the ESAS is systematically used with each phone call, the numerical 0 to 10 rating scale is also used to assess current patient distress. The phone triage nurse has access to previous ESAS scores through the patient's medical record to determine the patient's goals for pain control, recent symptom scores, and recent changes in medication regimen. ESAS scores are included in this study for the 24 lung cancer patients to illustrate the effects of continued patient contact between as well as after clinic visits in abetting an overall decrease in symptom distress.

Result: The first ESAS consultation revealed a high symptom burden. Initial management of symptoms focused on pain, nausea, appetite, anxiety, and sleep. Time from the first consultation to the final clinic visit was 2 months, at which time symptom burden had decreased overall. Phone conversations between the palliative care nurses and the patients took place between visits and continued after their final visit and until their ultimate decision to transition to hospice care. Because the patient's subjective feeling of SOB increased with disease progression, home oxygen and short-acting opioid therapy were introduced to lessen their distress; subsequent follow-up phone calls with palliative care nurses noted a decrease in symptom burden and an increased sense of comfort and control with self-managing care at home.

Conclusion: The information from the cases included in this study, as well as our experience with other palliative patients regarding the importance and effectiveness of an outpatient palliative care phone triaging staffed by designated nurses, is limited. Nevertheless, the results suggest that patients, as well as their family members and at-home caregivers, benefit from having this resource available to discuss questions and concerns regarding symptom management and emotional support throughout their cancer journey. Further studies of the effectiveness of such a program are warranted.

Non-small cell lung cancer in non smokers

H. Jamous Md, T. Filali PhD

Introduction: Although smoking is known as the main lung cancer risk factor, lung cancer in people who never smoked is still the seventh leading cause of cancer deaths worldwide.

Objective: To illustrate the presentation, management and outcome of patients with non-small cell lung cancer (NSCLC) among never smokers in our population.

Patients And Methodes: A retrospective study of all non-smoker lung cancer patients, managed at the Medical Oncology Service- Constantine, Algeria, between Jan 2005 and Dec 2012, with a feed back of 1 year.

Results: During the 8 years, we identified 581 patient with NSCLC, 102(17.6%) have never smoked.

Male: Female ratio is 1.76, (females represent a big proportion in this population). Median age was 60 years (21-81), 8 patients were exposed to alcohol. Median time to diagnosis was 6 months (1 months-2 years)

The most common presenting symptoms were cough (43%), chest pain (36%), dyspnea (25%), hemoptysis (15%), and extra-thoracic symptoms (11.8%). Chest X-Rays were obtained in 99 patients, 65% had abnormal findings and 35% were negative. Chest scanner performed and positive in 98% of our patients. 30% of specimens were obtained by bronchoscopy, 58% by CT scan guided biopsy, 7% were surgical biopsies.

Adenocarcinoma represented 51% (40% were females), squamous carcinoma 42% (22.5% were females), large cell carcinoma 4% (25% were females) and 3% unknown subtype. 58.8% of the patients had stage IV disease, 8.8% stage IIIB, 14.7% stage IIIA, 6.8% stage IIB, 1% stage IIA, 2% stage IB. 10 patients underwent surgical therapy, 4 lobectomy, 5 pneumonectomy, and 1 tumorectomy. 11 were irradiated.

First line chemotherapy (CT) was administered to 88.2% of the patients, with an appropriate PS, and no medical contra-indication. 2nd line was used in 13.7% and 3rd line in 4.9%. During 2005, 2006 chemotherapy in lung cancer was limited to the EP regimen (etoposid, cisplatin) in our center. In 2007 occurred Gemcitabine, in 2008 Taxanes, in 2009 Carboplatin. These 3rd generation molecules with Navelbine became the most used in 1st, 2nd, and 3rd line. Pemetrexed and Bevacizumab became standard of care in adenocarcinoma subtype in 2012. Median time to follow up was 6.8 months: 3.5 years in stage I, 2 years in stage II, 10.5 months in stage III, and 6 months in stage IV. One year survival was 15.7%, to 2 years is 5%, and to 5 years is 2%.

Conclusions: Non smokers with lung cancer are no more a minority, while in fact many of them are second hand smokers. Other causes, like genetic mutations, environmental and occupational exposures (to radon gas, asbestos, fumes...) might be accused.

In this category adenocarcinoma is the most frequent histological subtype, and young females are especially affected. Lung cancer in non-smokers

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is diagnosed after a long delay and at a late stage, because symptoms are often attributed to a respiratory infection or allergy. NSCLC is treated similarly in smokers and non-smokers, and the outcome is similar.

Keywords: non-smokers, Non small cell lung cancer, chemotherapy.

References: <http://www.nih.gov/researchmatters/december2012/12102012lungcancer.htm>

Lung Cancer Stem Cells Isolation From Primary Lung Carcinomas: Forming A Cell Model To Predict The Response On Chemotherapy

Maher Salamoon, Nizar Abbas

Background: lung cancer is the most common cause of cancer death with its two subtypes: non-small cell lung cancer (NSCLC) and small cell lung cancer (SCLC). Studies showed that cancer stem cells (CSCs) may

line for every patient could be a future trend towards manipulating lung cancer patients in a realistic way, further; targeting those cells may form a new focus for researchers to deplete the main root of the tree of cancer.

Preliminary Validity And Reliability Of A Thai Berlin Questionnaire For Screening Obstructive Sleep Apnea In Stroke Patients

Niramon Ungtrakul, Jittima Saengsuwan, Jiamjit Saengsuwan, Kittisak Sawanyawisuth

Objectives:

(1) To develop a Thai-language Berlin Questionnaire (Thai BQ) and (2) to preliminary assess construct validity, test-retest reliability and the agreement of the Thai BQ with the Thai Epworth Sleepiness Scale (Thai ESS).



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stand behind recurrence after therapy due to its special characteristics: self renewal, promoting metastasis and resistance to both radio and chemotherapy.

Objective: the study aims at establishing a CSCs model which enables us to test (in vitro and in vivo) different chemotherapeutic protocols in both neoadjuvant and metastatic setting.

Material and method: we have cultured cancer cells obtained from 50 patients known to have primary (NSCLC). Lung cancer stem cells were isolated by means of dilution and passage in flowcytometer showing a high expression of CD133+/high. After incubation in liquid nitrogen, 95% cells were still viable. Cells and their corresponding patients were subjected to treatment with the same protocol (Cisplatin+Docetaxel / Cisplatin+Gemcitabine).

Result and discussion: we were able to isolate lung cancer stem cells with high viability showing their special characteristics: - high CD133 expression – ability to form spheres in adherent and non adherent conditions – and their ability to resist treatment. Resistant cells were also proved to be stem cells through another passage in the flowcytometer. In the 50 patients (radiologically responders showed a similar response in vitro with rare CSCs while non responders showed high population of CSCs in vitro (p 0.0001).

Conclusion: isolating cancer stem cells and forming a cell model or a cell

Methods: 100 patients after stroke and caregivers enrolled in the study. The Thai BQ was developed using the forward-backward translation method. Evaluation of construct validity was done by factor analysis. Internal consistency of the Thai BQ and the Thai ESS were evaluated using Cronbach's alpha coefficient. Test-retest reliability and the agreement of the Thai BQ and the Thai ESS were evaluated using Cohen's kappa coefficient.

Results: Factor analysis identified 4 main factors. Cronbach's alpha coefficient was 0.74 and Cohen's kappa coefficient was 0.86 in the Thai BQ. Cronbach's Alpha coefficient was 0.59 and the Cohen's kappa coefficient was 0.81 in the Thai ESS. The agreement of the Thai ESS and the Thai BQ was fair.

Conclusions: The Thai BQ was developed and preliminary results were shown to be a valid and reliable tool in stroke patients. However, as factor analysis revealed 4 factors in contrast to the 3 factors in the original BQ, further modification of the Thai BQ may be required.

Keywords: stroke, Obstructive sleep apnea, Berlin Questionnaire, Epworth Sleepiness scale, Validity

Relationship Between Road Accidents With OSA And Sleep Quality Among Truck Drivers In Iran



Abolfazl Mozafari - Nahid Zand - Seid Ali Abyar Hossieni - Siamak Mohebi - Reza Gholabchi Fard-Ali Rasouli- Mohammad Gharib Beiglo – Sam Hatami

Background: Drivers with obstructive sleep apnea (OSA) are at 2 to 3 times increased risk of being involved in motor vehicle crashes. Also sleepiness and low sleep quality is a major contributing factor in the frequency of highway vehicle crashes and has serious consequences as it leads to a far higher fatality rate than other factors. This study is aimed to assess the correlation among traffic accident with risk of OSA and sleep quality.

Method: this article was studied among truck driver in Transportation Company in Iran (Qom province). The drivers filled out demographic questionnaire, Berlin and Pittsburg questionnaire about risk of OSA and sleep quality and questions about history of car accident and its frequency in previous 5 years. Pearson correlation coefficient was used to measure the strength of association between continuous variables. For analysis of qualitative parameters, we use from chi-square and if it was required, checked by fisher's exact test. Data analysis was done in SPSS and P value below than 0.05 was significant.

Results: out of 250 drivers, 214 persons filled out questionnaires. Of these, mean age was 42.15 years, 19.6% had poor sleep quality and 23.8% had risk of OSA. This article showed significant difference among driver accident with sleep quality and risk of OSA ($P= 0.034$ and $p=0.004$ respectively). Also there were prominent correlation between sleep quality with sleep duration and night driving ($p<0.001$).

Conclusion: according to this data, risk of OSA and poor sleep quality in drivers in high and attention to this items help to decrease frequency of traffic accidents.

Keywords: obstructive sleep apnea, sleep quality, traffic accident

Validation Of The Epworth Sleepiness Scale, Berlin, STOPBANG Questionnaires And American Society Of Anesthesiologists Checklist As Screening Tools For Obstructive Sleep Apnea In Patients With Chronic

Hamdy A. Mohammadien-Suzan S.Salama- Azazza M. Ahmad

Purpose: Obstructive sleep apnea (OSA) is a common medical condition and may lead to life threatening problems if it is left undiagnosed. Polysomnography is the gold standard™ for OSA diagnosis; however, it is expensive and not widely available. This study was conducted to evaluate the Epworth Sleepiness Scale (ESS), Berlin, STOP-Bang questionnaires and the American Society of Anesthesiologists (ASA) checklist for screening OSA in patients with COPD, asthma and CVD.

Methods: The study was performed on 180 patients, 60 COPD, 60 asthmatics and 60 patients with CVD without previously diagnosed OSA were recruited. Subjects completed the Questionnaires. The scores from the ESS, Berlin, STOPBANG questionnaires, and ASA checklist were evaluated.

Results: In the COPD, asthma & CVD groups, the mean ages were 61.5 ± 4.8 (80% male), 45.6 ± 7.1 (47% male) and 58.8 ± 8.5 (78.3% male) respectively. Of 180 screened patients, (30, 70, 20 and 15% of COPD), (32, 55, 37, & 35% of asthmatic) and (70, 35, 60 & 49% of CVD) were respectively classified as being at high risk of OSA by the ESS, STOP BANG, Berlin questionnaires, and ASA checklist. The risk of OSA increased up to age 65 years. A significant number of obese individuals (58%) were at high risk for OSA. Those whose questionnaire scores indicated a high risk for OSA were more likely to report subjective sleep problems, a negative impact of sleep on quality of life, and a chronic medical condition than those who were at lower risk. The ESS score was highly significant in the cardiac patients in comparison to the COPD and asthmatic patients. The Berlin questionnaire shows very high risk among the cardiac patients followed by the COPD

patients and lastly the asthmatic patients. In STOP BANG questionnaire demonstrate significant difference between the cardiac patients with the COPD and asthmatic patients existed. ASA checklists how high risk among the cardiac,asthmatic and COPD.

Conclusions: Berlin&STOP-Bang Questionnaires are quite reliable to determine which patient need further evaluation of OSA followed by ASA checklist then ESS,STOP and STOP-Bang questionnaires for screening of OSA in the surgical population are suggested due to their higher methodological quality and easy to-use features.

Thymectomy By Video-assisted Thoracoscopy Versus Open Surgical Techniques

Magdi Ibrahim, Abdulla Allam

Objective: Thymectomy is well established in the treatment of myasthenia gravis. We conducted this study to compare operative variables and postoperative outcomes in adult patients with myasthenia gravis undergoing thymectomy through three different operative techniques which are total median sternotomy, partial median sternotomy and video-assisted thoracoscopy.

Methods: Between January 2008 and December 2010, Thirty patients (9 male and 21 female) aged 20-65 years were included in this study. Patients were subdivided into three groups: group (A) 8 patients underwent thymectomy through total median sternotomy, group (B) 9 patients underwent thymectomy through partial median sternotomy and group (C) 13 patients underwent thymectomy through video-assisted thoracoscopy. Preoperative, intra-operative, postoperative variables and mortality are compared in all groups.

Results: In all groups, preoperative variables were well matched for age, sex and preoperative clinical staging according to the Myasthenia Gravis Foundation of America (MGFA) clinical classification. Operative time was statistically highly significant; it was longer in Group [C]. There was no intra-operative complication in all groups. Also, postoperative length of hospital stay was statistically highly significant; it was shorter in Group [C]. Postoperative complications occurred in three patients (10%) mostly in group [A] and group [B]. There was no perioperative mortality in all groups.

Conclusions: We conclude that video-assisted thymectomy is effective as the traditional open surgical approaches for performance of thymectomy in the management of patients with myasthenia gravis. In addition, the improved cosmesis of the video-assisted approach ideally will lead to earlier thymectomy in patients with myasthenia gravis.

Keywords: Myasthenia gravis, Thymectomy, sternotomy, thoracoscopy.

Bronchial Stump Aspergillosis In Patient With Resected Non-Small-Cell Lung Cancer

Funda Seçik¹, Engin Aynacı¹, Celalettin İbrahim Kocatürk², Neslihan Fener Akanıl³, Pınar Yıldız¹

Bronchial stump aspergillosis (BSA), Aspergillus infection of bronchial granulation tissue surrounding endobronchial suture threads, is a very rare variant of localized suppurative bronchial Aspergillus infection. The majority of reported cases have occurred within one year after lung surgery. We report the case of a patient who developed BSA five years after pulmonary resection for lung cancer.

A left upper lobectomy for bronchogenic squamous cell carcinoma was performed in 2007 in a 61 year old man (satage T2N0M0).No postoperative radiotherapy or chemotherapy were given. Follow-up was uneventful. In October 2011, the patient suffered from cough and sputum.A fiberoptic bronchoscopy was performed to exclude tumour recurrence.Fiberoptic bronchoscopy showed necrotic granulation on the stump, around the visible suture wire.Biopsies revealed an ulcerated bronchial mucosa, extensively invaded by hyphae and fungal spores, without evidence of tumour recurrence.Cultures of the bronchial aspirate yielded Aspergillus fumigatus.Follow-up bronchoscopy after one month showed a normal aspect of the stump.

10 Years Experience Of Surgical Management Of Bronchiectasis

Amer Bilal

Objective: To observe the various clinical presentations of bronchiectasis and evaluate its surgical management and outcome.

Materials and methods: Computerized clinical data of 900 patients surgically managed were retrospectively analyzed. Detailed scrutiny of the record was carried out to determine the clinical presentation, various surgical procedures done and analyze the clinical outcome.

Results: A total of 900 patients underwent various surgical procedures. Male to female ratio was 3:1. Age range was 13-62 years with a mean age of 28.7 years. The predominant clinical presentation was productive cough with copious sputum in 785 (87.2%) patients. Recurrent chest infection in 765 (85%), and hemoptysis in 280 (31.1%) patients. Bilateral localized bronchiectasis was present in 72 (8%). Etiology wise post tuberculous bronchiectasis present in 788 (87.55%) cases, congenital in 44 (4.88%) cases, FB inhalation in 38 (4.22%) cases and post measles bronchiectasis in 30 (3.33%) cases. The mean operative time was 68 (40) minutes. 630 (70%) patients underwent lobectomy, 140 (15.55%) patients underwent pneumonectomy, bilobectomy in 60 (6.66%) cases, 38 (4.22%) patients required wedge resection and lingulectomy in 32 (3.55%) cases. Morbidity was 38 (6.26%); four patients required ventilatory support, air leak was noted in 18 patients, wound infection in 14 patients and post resection empyema in 02 patients. Mortality was 08 (1.3%) including respiratory failure in 05 patients, myocardial infarction in 02 patients and pulmonary embolism in 01 patient. 711 (79.00%) patients were asymptomatic in the follow up. 162 (18%) experienced improvements in symptoms and in 19 (2.11%) symptoms were unchanged.

Conclusion: Surgical resection for bronchiectasis can be performed with acceptable morbidity and mortality at any age.

10 Years Experience Of Surgical Management Of Bronchiectasis

Amer Bilal

Objective: To analyze the results of surgery in the management of Pulmonary Aspergilloma.

Methodology: Computerized records of 306 cases of diagnosed Pulmonary Aspergilloma were retrospectively analyzed from Jan 2003 to October 2013. Patients of all ages, both sexes, medically fit and unilateral Pulmonary Aspergilloma were included in the study. Routine investigations, serology for aspergillus, sputum culture, Computed Tomography, Pulmonary Function Tests and Bronchoscopy were performed in all cases. Specimen sent for histopathology in all cases.

Results: Out of 306 patients, 185 patients were male and 121 were female, age ranges from 16 years to 70 years, mean age was 35.6 years. The most common symptom was hemoptysis (92%) followed by persistent chest pain (30.7%) and recurrent cough with sputum (23%). The most common underlying lung disease was tuberculosis in 289 (94.75%), whereas lung abscess was present in 16 (4.91%) and lung cancer in 1 (0.32%) case. The procedures performed were Lobectomy in 249 (81.63%) cases, Bilobectomy 27 (8.85%), wedge resection 18 (5.9%), Pneumonectomy 12 (3.93%). Postoperative complications occurred in 22 (7.21%) patients, of which 9 (2.95%) had prolonged air leak, 4 (1.31%) had significant postop bleeding out of which two required re-exploration, 2 (0.65%) patients developed Empyema and wound infection occurred in 3 (0.98%) patient. 30 days Mortality was 6 (1.96%) of which 05 patients died due to respiratory failure and one patient due to pulmonary embolism.

Conclusion: We recommend early surgical resection of symptomatic and asymptomatic cases of Pulmonary Aspergilloma, both, with the use of one lung ventilation.

Retrosternal Goiters And Surgical Approaches- Experience With 131 Cases

Amer Bilal

Objective: To observe the various clinical presentations of retrosternal goiter and evaluate their management and outcome.

Methodology: Clinical record of 131 surgically treated patients over a period of 11 years (2002 – 2013) was retrospectively analyzed. Detailed scrutiny of records were carried out to analyze the clinical presentation; Surgical procedures, histopathology of specimens and surgical outcome.

Results: Cervical collar incision was used in all patients and in 116 cases was adequate. In 1 patients it had to be combined with a full median sternotomy while 2 patients had a partial sternal split along with the cervical collar incision. In 12 cases anterior mediastinotomy was done to push the goiter from below to aid delivery through cervical collar incision. The mean operative time was 68 minutes. Post-operatively 05 patients required ventilatory support, 3 patients had hoarseness while 2 each had transient hypocalcaemia and wound hematoma. There were 2 mortalities,

flap were not used included in group I. We employed intercostal muscle flap in last 450 patients which were included in Group II. Detailed scrutiny of the record was carried out to determine the surgical outcome.

Result: In group I male to female ratio was 2:1. Age range was 9-61 years. Lung resection included left lower lobectomy 92, Left upper lobectomy 102, right lower lobectomy 92, right upper lobectomy 106 and 68 pneumonectomies. In group II, Male to female ratio was 3:1. Age range was 13-62 years with a mean age of 28.7 years. Lung resection included left lower Lobectomy 101, left upper Lobectomy 96, right lower Lobectomy 81, right upper lobectomies 98, and 74 pneumonectomies. We observed decreased rate of bronchopleural fistula in intercostal muscle flap group 8/450 (1.77%) then in non-intercostal muscle flap group 16/450(3.55%).

Conclusion: Use of Intercostal Muscle flap reduces incidence of post resectional fistulas in bronchiectasis.

SHARP

About SHARP Middle East

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due to tracheomalacia despite tracheostomy and ventilatory support; one of these was a redo case. 88/131 (67.17%) cases were multinodular goiter, follicular adenoma in 25/131(19.08%); and papillary carcinoma in 17/131 (12.77%) cases.

Conclusion: Retrosternal goiters can be delivered through the cervical approach, but where delivery is difficult it can be aided by a mediastinotomy thereby avoiding splitting the sternum.

To Compare The Out Come Of Surgical Resection For Bronchiectasis With And With Out Intercostal Muscle Flap

Amer Bilal

Objective: To compare the outcome of surgical resection for bronchiectasis with and without intercostal muscle flap.

Materials and methods: Computerized clinical data of 900 patients surgically managed for bronchiectasis from Jan 2003 to October 2013 were retrospectively analyzed. After necessary preoperative workup the patients were subjected to the surgical procedure. Patients were divided into two groups comprising 450 cases each. In initial 450 cases intercostal muscle

The Pedicled Latissimus Dorsi Muscle For Treatment Of Wounds Related To Bronchopleural Fistula

Dr Harinder Singh BEDI

Aim: Transposition of extrathoracic muscle flaps has been the cornerstone of treatment of a number of complex intrathoracic chronic wounds related to bronchopleural fistulas (BPF) and residual infected pleural spaces. We used the Lattismus Dorsi (LD) flap for treating BPF related empyemas.

Material and Methods: 4 patients with BPF and chronic empyema underwent a LD flap based repair. All had in situ chest tubes and continuous air leak with pus discharge. 3 had received a full course of ATT. All were on appropriate antibiotics . All were referred after failure of the conventional treatment strategy at the primary hospital . Intrathoracic transposition of an extrathoracic muscle to buttress repair of the BPF was performed. The standard posterolateral thoracotomy incision was used. Superior and inferior subcutaneous flaps were raised superficial to the muscle fascia extending to its anterior and posterior borders. the muscle was then detached from its points of origin . We routinely divide the thoracodorsal nerve in order to prevent any muscle stimulation that may disrupt the inset of the muscle. A large mass of muscle is now available. The muscle is then wrapped in a moist laparotomy pad to be used for transposition later. The decortication is then done followed by closure of the BPF with the LD flap.

Results: The average time for harvesting the entire LD flap was approximately 20–30 min. All 4 patients were successfully healed. The overall length of hospitalization reached 8.4 days (range 6 to 15). One patient developed a sterile seroma which needed to be drained. There was no functional disability of shoulder movement.

Conclusion: The extrathoracic muscle LD flap transposition is an effective technique to obliterate potential pleural space problems, especially in the presence of chronic infectious disease, and to reinforce closure of postoperative BPF. The LD flap should be part of the armamentarium of any surgeon dealing with challenging chronic infected wounds.

Preoperative Echocardiography In Thoracic Surgery; A Single Institution Study

Yasser Aljehani, Safi Qutub, Suha Kaaki, Waleed Saleh

Aim & Background: Cardiac death in non-cardiac surgeries is estimated to ranges between 0.5-1.5% and major cardiac events take place in 2-3.5% of cases. Cardiac complications are the leading cause of perioperative mortality in thoracic surgery. Therefore, the importance of preoperative screening cannot be overemphasized. The nature of surgery and the comorbidities play a major role in determining the risk. Preoperative echocardiography is one of the non-invasive modalities to assess and evaluate the cardiac stability before surgery. Such evaluation would predict the risk and help implementing measure to reduce risk. There are no standard protocols to follow in the workup of these patients. The cost of preoperative testing is a factor to consider as well the utilization of resources. The aim of the observational study is to audit our practice and to analyze the indications for preoperative echocardiography testing according to our population setup.

Material & Methods: We performed a retrospective observation study in a single institution over the period from Jan 2007 till Jan 2011 (3 years period) for all cases undergoing thoracic surgery intervention (n=236), mainly thoracotomies. Variables and data were collected from the patient charts.

Results: The number of subjects was 236 patients. Males were 144 (61%) and females 93 (39%). The age ranges between 13-81 years with mean age 41 years. Addressing the comorbidities; patients with comorbidities were 108 (46%) and patients without comorbidities were 128 (54%). Analysis of the preoperative echocardiography demonstrated the following; normal results in 48 (20%), abnormal results in 61 (26%), and the study was not done in 127 (54%). Among the abnormal echocardiography group; 26 (43%) were females and 35 (57%) were males. Moreover, 14 (23%) were below 40 years of age and 46 (77%) were above 40 years of age. The data demonstrated that echo findings in patients with comorbidities were positive in 40%, normal in 34% and not done in 26%. In patients without comorbidities; 14% abnormal, 70% not done, 16% were normal. The most common comorbidities were Hypertension and Diabetes. The data showed that the most common echo findings were sclerotic valves, pulmonary hypertension, atrial wall dyskinesia, pericardial effusion and dilated ventricles in order of frequency.

Conclusion: Selective preoperative testing is our recommendation based on less costly measures such as history and physical examination. This is overemphasized in the current lack of standard protocols for preoperative testing. Clear indications for testing, namely cardiac diseases, remain a mainstay for stratifying the risk of such patient to implement perioperative measure to reduce the adverse outcomes. Adopting such selective approach would be cost effective and improve utilization of hospital resources.

A Clinical Trial On Post-thoracotomy Pain Management, Transdermal Fentanyl Patch Compared To Intravenous Morphine

Ali Jabbari, Parvize Amri Maleh, Novin Nikbakhsh, Ebrahim Alijanpour

Introduction: Post thoracotomy analgesia has evolved with increasing knowledge about the impact of pain in recovery and new methods for

treating it. Intravenous morphine commonly used to control moderate-to-severe postoperative pain. A transdermal system of Fentanyl delivery as an alternative treatment is recently approved. Transdermal Fentanyl patch is used to manage postoperative pain.

Material and methods: We compared the effect of Transdermal Fentanyl patch versus Intravenous morphine for patient's postoperative pain management under thoracotomy surgery. We conducted a randomized, prospective, multi center, clinical trial on fifty ASA class I-III patients scheduled for thoracic surgery. Patients were divided into two equal groups after the operation as follows: intra venous morphine (4 mg) was prescribed every 6 hours in the Morphine group, whereas in Fentanyl group a Transdermal Fentanyl patch (50µg/h) was placed one hour prior to anaesthesia. The anaesthetic method was the same in both groups. Pain score of patients was recorded based on visual analogue scale, facial expression type. An additional morphine dose was administered to the patients if needed. Analysis was done with T-test, Chi square test or Fisher's exact test.

Results: The efficacy of transdermal Fentanyl patch in 12, 18, 30, 48 hours post operation was better than the morphine group. The mean prescribed morphine dosage for the patients in Morphine group was 64±3.82 mg and in Fentanyl group 26±5.63 mg (p<0.05).

Conclusions: In this study transdermal Fentanyl patch showed to be an appropriate method instead of intermittent intra venous Morphine for analgesia and it is more effective in acute post thoracotomy pain controlling.

The Efficacy Of Fiberoptic Bronchoscopy Via Laryngeal Mask Airway In Pediatric Foreign Bodies Extraction

Ashraf Madkour, Ahmed Almansoury, Samar Sharkawy

Background: The use of fiberoptic bronchoscopy (FOB) via laryngeal mask airway (LMA) in children allows the use of adult size bronchoscope with its grasping tools, thus it may aid in foreign body (FB) extraction.

Objective: To evaluate the efficacy of FOB via LMA in FB extraction in pediatrics. Methods: We prospectively recruited all children (≤ 16 years) presented or referred to Pulmonary Medicine Department, Ain Shams University Hospital with clinical suspicion of FB inhalation between June 2012 and June 2013. All the patients were subjected to FOB via LMA under general anesthesia. Rigid bronchoscopy (RB) was available to extract any FB failed to be removed.

Results: Of the 49 children suspected of having FBs, 41 FBs were identified in 28 boys and 13 girls with a mean age 5.9 years (9 months to 16 years). FBs were more often lodged in the right side than in the left one (48% vs. 38%) and with predominance of organic FBs (75.6%) mainly seeds (60.9%). Successful extraction by current technique was in 34 out of 41 (82.9%) FBs identified. RB succeeded in extraction of 6 out of 7 FBs that failed to be removed and open thoracotomy was required in 1 case. Non-critical complications related to FOB via LMA included laryngeal edema, transient hypoxia, gastric distension, mild hemoptysis and fever occurred in 5,5,4,3 and 2 patients respectively. One critical complication (stridor) related to RB.

Conclusion: FOB via LMA is safe and effective in pediatric FB retrieval under general anesthesia with RB backup.

The Effect Of Low Body Mass Index (BMI) And Obesity On Post-lung Transplant Outcome Of The Patients In Saudi Arabia.

I.Y.Nizami, B.J.Khan, S Akram, W.Saleh, M. Hussein, B.J.Khan

Purpose: To analyze the effect of low BMI defined as BMI <18 and obesity defined as BMI >27 on the post-operative outcome of the lung transplant patients in Saudi Arabia.

Methods: Retrospective chart review of all patients between Jan 2010 and

January 2013. Patients were defined as normal BMI if their BMI was 18-27, Obese if BMI was >27 and underweight if BMI was <18.

Summary of results: A total of 34 patients underwent lung transplant during the study period. 17 male and 17 female. 12 patients had normal BMI, 15 were underweight and 7 were obese. There was no statistically significant difference between the 30 days mortality, length of mechanical ventilation (MV), and ICU or hospital stay between the underweight vs. non-underweight group and the obese vs. non obese group.

	Underweight	Not underweight	P value
30 days mortality	1	6	0.103
Days on MV (mean)	9.9	23.2	0.165
ICU days (mean)	13	27	0.135
Hospital days (mean)	29	45	0.222
Age (mean)	19.9	38.4	<0.0001
	Obese	Non-Obese	P value
30 days mortality	2	5	0.103
Days on MV (mean)	18	17	0.927
ICU days (mean)	20.8	20.9	0.993
Hospital days (mean)	36.1	38.5	0.834
Age (mean)	45	25	<0.0001

Conclusion: Being underweight or obese did not have any statistically significant effect on the post-operative outcome of the lung transplant patients in Saudi Arabia.

Chest Wall Resection And Reconstruction For Primary Malignant Tumors: Indications, Techniques, And Outcome

Hadi Mutairi, Ikram Chaudhry

Background: Primary malignant chest wall tumors (PMCWT) are uncommon and data concerning treatment and results are sparse. Reconstruction after resection represents a challenge for thoracic surgeons. We aim to report our experience in treating these rare tumors and report on 5-year survival.

Methods: A retrospective review of consecutive patients with PMCWT from 2007 through 2012. The clinicopathological features, methods of reconstruction, and recurrence rate were reviewed.

Results: A total of 32 patients were treated for PMCWT. The majority are men (28 Vs 4) with a mean age of 45 years (range 23 - 62). Most patients has American Society of Anesthesiology (ASA) score of 2. Only 3 patients has ASA score of 4 and 7 patients with ASA score of 3. Of the 32 lesions, 30 were found in the ribs (13 in the lateral part, 7 in the anterior part, and 10 in the posterior part of the rib), and the remaining two in the sternum. Diagnosis was made by core needle biopsy in 7 cases while the remaining 25 cases the radiological and clinical features were sufficient to decide for surgical resection without a prior biopsy. None of these patients received any neoadjuvant or adjuvant therapy. Pathology included chondrosarcoma (16 cases), malignant fibrous histiocytoma (10 cases), fibrosarcoma (2 cases), desmoid tumors (2 cases), osteosarcoma (1 case), and malignant peripheral nerve sheath tumor (1 case). Average ribs resected was 4 (range 2 - 7). The two cases where the tumor involves the sternum, total sternectomy was done for both cases. The chest wall resected en bloc with a wedge from the ipsilateral lung because of its involvement in 4 cases. Skeletal reconstruction was performed in 28 cases using a prolene mesh (7 cases), methyl methacrylate (20 cases), and one case required two different type of meshes. 4 cases did not require any reconstruction because the defect was small (less than 4 cm) or the defect was protected by the scapula. None of the cases required soft tissue coverage by means of local or free flaps. Hospital stay ranges from 3 to 7 days with an average of 4.8 days. Morbidity included atelectasis (3 cases), seroma formation (2 cases), air leak (1 case). No patients required reoperation or ventilatory support. No mortality during hospitalization or 90 days after discharge. At 5 year follow up, there was no local or distant recurrence based on computer tomography (CT) scan imaging.

Conclusion: Wide resection with tumor-free margins is required in order to provide the best chance for cure in treating PCWT. The surgical risk associated with tumor resection and reconstruction is acceptable. Longer follow up period is needed to study the natural history of this disease and define the role of chemotherapy and radiotherapy in treating these tumors.

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From behind-the-scenes experimental work for the U.S. Department of Defense to today's highly advanced ultrasound systems used around the globe, SonoSite has been defining and redefining next-generation point-of-care (POC) ultrasound as its recognized market leader. Since the company's early pioneering days in the 1980s, SonoSite has continued to enjoy remarkable growth while earning worldwide recognition for its progressive product line, educational programs, and advocacy for a broader understanding of ultrasound's multiple benefits.

SonoSite began originally when the D.O.D awarded a DARPA (Defense Advanced Research Projects Agency) grant to SonoSite's parent company ATL Ultrasound, Inc., to create a portable ultrasound system that weighed less than 10 pounds and was durable enough to withstand the severe, unpredictable conditions of the battlefield. It took the leveraging of over a decade of expertise in digital ultrasound and customized ASIC (application-specific integrated circuit design) technology to meet the project goals, but the result was SonoSite's first point-of-care (POC) ultrasound machine—the SonoSite 180™ system. The 180 represented both a major step forward in technology and a revolutionary approach to bringing ultrasound to the patient, wherever the patient's point of care might be.

Evaluation Of Pulmonary Hypertension In Bilharzial Patients

Mohamed. Shahat. Badawy, Mohamed. Abd El Razeq. El-Senbesy, Hasan. Sedeek. Mahmoud

Setting: Most of the observational studies suggested that pulmonary hypertension occurs in as low as 5% to as high as 21 % of patients infected with Schistosomiasis. No reports of the real incidence in our locality.

Objective: To evaluate presence of pulmonary hypertension in Bilharzial patients. Material and Methods: A case control study was done; fifty bilharzial patients were fulfilled inclusion criteria and matched with forty control subject. All patients and control were subjected to full clinical assessment. Patients group was subdivided according to abdominal sonography into fine and thick hepatic peri-portal fibrosis (PPF). Complete Liver function tests and Echocardiography were done for all patients.

Results: The mean age were 34.24+ 9.68 and 33.9 +9.23 years for patients & control groups. Patients with thick PPF showed significant decrease in prothrombin concentration (P value =0.000) and increase in total bilirubin than those with fine PPF (P value= 0.014). Eight Bilharzial patients had PASP >30 mmHg (range 30–38 mmHg) representing 16% of this group. There was statistically significant decrease in ejection fraction (EF) (P value=0.016) and increase in pulmonary artery pressure (P value= 0.001) in patients versus control. Patients with thick PPF showed significant decrease in the values of ejection fraction (P value 0.02) and increase in the values of pulmonary artery pressure (P value= 0.001) comparing with those with fine PPF.

Conclusions: Evaluation of Bilharzial patients with thick periportal fibrosis for pulmonary hypertension is essential for detection and monitoring. Bilharziasis considered an important cause of mild pulmonary hypertension in developing countries.

Pulmonary Hypertension In Saudi Arabia: Physicians Behavior And Compliance With Guidelines Recommendations.

Majdy Idrees, Mohamed Banama, Tarek Kashour

Aims: The purpose of this study is to evaluate the management behavior of the pulmonary hypertension treating physicians and their adherence to the international guidelines recommendations in Saudi Arabia.

Methods: This was a cross-sectional survey. Eligible physicians were asked to answer a questionnaire describing their behavior towards certain aspects of pulmonary hypertension management and evaluating their compliance towards major guidelines recommendations concerning diagnostic (echocardiography and right heart catheterization) and therapeutic interventions. The questionnaire also evaluated the resources available for the treating physicians and the appropriateness of some centers to treat this very complex disease.

Results: Fifty two pulmonary hypertension treating physicians agreed to participate in the study. Twenty four (46.2%) were adult pulmonologists, 13 (25%) we pediatric cardiologists, 6 (11.6%) were adult cardiologists, 5 (9.6%) were pediatric pulmonologists; while 4 (7.6%) belonged to other specialties. The majority of the physicians (79%) were practicing at tertiary care teaching hospitals, while 17% were practicing in second care or private hospitals. As a diagnostic tool, echocardiography was available for all physicians (100%), whereas right heart cath (RHC) was only available to 82% of treating physicians; of those, 45% had to refer their patients to another center for RHC study. Interestingly, only 35% of treating physicians had RHC data available to all of their patients before starting modern therapy, and 30% of the treating physicians were happy to start and continue treatment based on echocardiography only. Furthermore, 15% of treating physicians have started calcium channel blockers as the first-line therapy based on echocardiographic evidence. Finally, 10% of the physicians used modern therapy in all 5 pulmonary hypertension groups, including group 2.

Conclusion: Despite the significant improvement in the management of PH in Saudi Arabia, still evidence-based management guidelines are not fully followed. Better distribution and implementation of guidelines recommendation are clearly needed.

Pulmonary Arterial Hypertension In Saudi Arabia: Single Center Experience.

Idrees MM, Al-Najashi K, Khan A, Al-Dammas S, Al-Awwad H, Batubara E, Al Otai A, Abdulhameed J, And Kashour T; On Behalf Of The SAPH Registry Taskforce.

Aims: The purpose of this study is to present our center experience in managing patients with pulmonary arterial hypertension. The main objectives are to assess patients' characteristics, physiological and hemodynamics behavior, and to evaluate the consequences of treatment.

Methods: The Registry of Pulmonary Arterial Hypertension in Saudi Arabia (PATENTS) has been designed by the Saudi Association of Pulmonary Hypertension (SAPH) to meet the need for available information about patients with pulmonary arterial hypertension in Saudi Arabia. Until the complete data from PATENTS registry becomes available, we are presenting our center experience in managing this disease. This study reports the early results from one PH specialized centers in Riyadh, Saudi Arabia, namely Prince Sultan Medical Military City and Cardiac Center (PSMMC & CC). Both newly diagnosed cases (incidence cases) and referred cases (prevalence cases) are included. All outcomes, including modified New York Heart Association functional class, clinical behavior, 6-minute walk distance, hemodynamic parameters, and survival, are evaluated prospectively.

Results: A total of 107 patients were identified as having pulmonary arterial hypertension as diagnosed by right heart catheterization. The mean age at diagnosis was 37.1 years, and there was a female preponderance of 62.6%. The mean duration between symptom onset and diagnosis was 27.8 months. At the time of enrollment 56.1% of patients were in functional class III and 16.8% were in functional class IV. Fifty five patients (51.4%) were diagnosed as idiopathic pulmonary arterial hypertension, 29 patients (27.1%) as congenital heart disease associated with pulmonary arterial hypertension, 16 patients (14.9%) as connective tissue diseases associated with pulmonary arterial hypertension, 4 patients (3.7%) as heritable pulmonary arterial hypertension, and 3 patients (2.9%) as portopulmonary hypertension. Seventy nine patients (73.8 %) received a combination target therapy, and 31 patients (28.9%) died during the 3-year follow up period.

Conclusion: This early data from the PATENTS registry highlights the current situation of pulmonary arterial hypertension and offer the first report of this disease status in Saudi Arabia. The patients in our center are much younger than patients described in other international registries, but still detected as late in the course of the disease. The majority of patients display severe functional and hemodynamic compromise. The patients' outcome in is comparable to that reported in other international registries.

Keywords: Pulmonary arterial hypertension, registry, Saudi Arabia, SAPH.

Acute Pulmonary Embolism In Young: A Prospective Observational Study On The Clinical Implication Of Age On The Presentation And Management Of Patients With Acute Pulmonary Embolism.

Soumya Patra, Navin Agrawal, Manjunath C.N

Background and rationale: Prevalence of acute pulmonary embolism is on an increase owing to early detection but the effect of age on the prevalence, therapy and prognosis is unknown. The objective of this study was to assess the prevalence of embolism in young (<40 years) population and to compare the clinical presentation and the effect of age on therapy.

Methods: In this study, an arbitrary cut off level of 40 years was decided as is usually described to categorize myocardial infarction and stroke in the young. Among 202 patients enrolled, 97 & 105 patients were categorized as young & old, respectively. The clinical presentation and course after therapy among them were observed and compared.

Results: Forty-eight % of our study population belonged to the age group <40 years. There were no significant differences seen in the mode of presentation in terms of functional class, hypotension, electrocardiographic & echocardiographic features. Clinical improvement

after treatment (68% vs. 78%, $p=0.42$) and in hospital death (10% vs. 16%, $p=0.36$) and the incidence of minor bleeding (14% vs. 11%, $p=0.68$) showed a trend towards statistical significance for higher incidence in older age group. Two patients in the older age group had intra-cerebral bleed following thrombolytic therapy.

Conclusion: As there were no significant differences in the clinical presentation, therapeutic benefit, course after therapy and complications, age should not influence the decision and strategy to treat acute pulmonary embolism especially with thrombolytic agents though caution regarding increased bleeding risk in the elderly should be taken into consideration.

Postsplenectomy left lower lobe bronchiectasis

Sameh I Sersar MD

Background: bronchiectasis has decreased significantly. We describe a new underestimated clinicopathological entity of postsplenectomy left lower

Accuracy Of Doppler Echocardiography Estimates Of Pulmonary Artery Pressures At King Faisal Specialist Hospital & Research Center, Riyadh Saudi Arabia. Imran Nizami, Talal Otaibi, Basha Khan, Saeed Akram

Purpose: To study the correlation of pulmonary artery systolic pressure (PASP) measured by Doppler echocardiography and right heart catheterization.

Methods: Retrospective analysis of 100 consecutive patients was done who have undergone the echocardiogram and right heart catheterization within 3 months of each other during the last five years at our hospital. The estimation of Pulmonary artery systolic pressure by echocardiogram was compared with the pulmonary artery systolic pressure measured directly by the right heart catheterization. A difference of > 10 mm Hg was considered as poor correlation while a difference of ≤ 10 mm Hg was considered as good correlation between the two measurements and was considered accurate for statistical considerations. Bland-Altman analysis was used to evaluate the agreement between the Doppler Echocardiographic estimates



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lobe bronchiectasis.

Methods: this was a retrospective study on 24 patients who had a left lower lobectomy for left lower lobe bronchiectasis after splenectomy. The mean age was 34.6 years (range 18 to 63 years); there were 19 men and 5 women. The available data included history, radiological investigations (ultrasonography and computed tomography of the chest and abdomen), operative data, postoperative complications, and follow-up data.

Results: all patients had a history of splenectomy and 10 had undergone subphrenic collection drainage either percutaneously or through open drainage a few years prior to the left lower lobectomy. Fourteen patients were lost to follow-up. The mean follow-up in 10 patients was 5.8 years (range 2 to 13 years).

Conclusions: postsplenectomy left lower lobe bronchiectasis is an underestimated clinicopathological entity of bronchiectasis. It can be managed by a left lower lobectomy, with acceptable results.

of PASP and right heart catheterization measurement of PASP

Summary of results: The majority of patients were male and having diagnosis of World Health Organization group II PAH, although patients with other causes of Pulmonary hypertension were also included in the study. Among 100 patients the mean age was 41 ± 13 SD, 81 were male and 19 were female. Wide ranges of pulmonary artery systolic pressure (PASP) were noted during Doppler Echocardiographic (32 mm Hg to 105 mm Hg) and right heart catheterization (25 mm Hg to 106 mm Hg) measurement. There was a moderate correlation between PASP determined during RHC and estimated PASP using Doppler Echocardiography ($r = 0.51$, $P < .0001$). Using the predefined definition of an inaccurate Doppler Echocardiographic estimation of PASP as ± 10 mm Hg different from PASP measured during RHC, we found that Doppler Echocardiography was inaccurate 49% (49/100) of the time. When inaccurate, Doppler Echocardiography overestimated PASP by 38 mm Hg and underestimated PASP by 37 mm Hg.

Conclusion: The Doppler Echocardiographic estimates of PASP in patients with PH were found inaccurate at our center. Echocardiography is a useful screening tool for suspected PH, but for the definite diagnosis and management RHC should be performed.

Role Of Signaling Pathways That Regulate Cytoskeletal Dynamics In Pulmonary Vascular Diseases

Usamah S. Kayyali, PhD, Ali Aldawood, MD, Rod Warburton, BSc, Deniz Toksoz, PhD, Nicholas S. Hill, MD, Geraldine Finlay, MD, Tiegang Liu, PhD

Objective: Cytoskeletal proteins are believed to play an important role in vascular cell structural integrity and function. Because of their ability to alter vascular smooth muscle contractility and stiffness, as well as, alter endothelial permeability barrier function, they are implicated in vascular diseases ranging from Pulmonary Hypertension to Acute Lung Injury/Acute Respiratory Distress Syndrome (ARDS). The goal of our research is to identify signaling pathways that alter cytoskeletal dynamics in relation to pulmonary vascular physiology.

Methods: We have investigated signaling involving p38 MAP kinase and its downstream kinase MK2 and their interaction with Tsc1 signaling leading to modulation of two major cytoskeletal components: actin microfilaments and vimentin intermediate filaments. Experiments have been conducted in animal models and cultured pulmonary microvascular endothelial cells.

Results: Our results implicate a substrate of MK2, HSP27, as a key regulator of endothelial barrier properties through its ability to interact with and stabilize actin and vimentin filaments. In particular we show data on the role of vimentin intermediate filament dynamics in opening the pulmonary vascular endothelial barrier to allow blood components access to site of injury to fight infections, while consequently augmenting the barrier to limit vascular leak and edema that can disrupt gas exchange. Our studies with various permeability-inducers and pharmacological agents suggest a correlation between vimentin filament collapse and perinuclear redistribution and barrier weakening. They also suggest that extensive filamentous vimentin network formation correlates with barrier augmentation. Our data indicate that vimentin redistribution and altered endothelial function are mediated both by changes in vimentin phosphorylation, as well as, by its interaction with HSP27.

Moreover we show that the ability of Withaferin A, a compound that targets vimentin, to aggregate vimentin! correlates with its barrier-disrupting action. The effects of this compound as well as of physiologically relevant permeability-inducers, such as LPS, on the barrier can be overcome by overexpressing a non-phosphorylatable vimentin mutant. These findings demonstrate the importance of key phosphorylation events in vimentin

distribution and barrier function. Finally, our results also show that we can ameliorate the effects of permeability-inducers by activating the kinase that phosphorylates HSP27, MK2.

Conclusion: Our experiments highlight the role of HSP27 and vimentin and suggest ways to target these proteins in management of conditions that involve compromise of the vascular endothelial permeability barrier. A major condition in which the latter occurs is ARDS, which is a complication of a variety of diseases including MERS and influenza.

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Infliximab For Pulmonary Aneurysm

Hussam Sakkijha, M.D, Saleh Abu Daff, M.D Khalid Qushmaq, M.D

18 years old male with Behcet syndrome who presented with cough, one episode of hemoptysis and abnormal Chest X ray, CT scan of the chest confirmed the presence of 2 pulmonary artery aneurysms in the rt upper lobe of the lung patient was treated with Infliximab 5mg/kg at 0, 2, 6 weeks then every 8 weeks. follow up CT scan in 6 months showed complete resolution of the aneurysms. we will show radiographs before and after therapy.

DYSPHAGIA LUSORIA: Case Report Of Young Lady Present With A typical Chest Pain And A Review Of The Literature

Brigd Dr Mohammed Almarri, Dr Ahmed Emad Mahfouz, Dr. Hamad Saadon Al-Adba, Dr. Rafid S. Hamid Al Ani , Dr Nood D AlMarri

Abstract: The term Dysphagia lusoria refers to extra ordinary disposition of the subclavian artery (Lusorian artery) as a cause of oesophageal obstruction. Although most individuals are asymptomatic however they might present with unspecific thoracic pain, dysphagia, dyspnea, arterioesophageal or arteriotracheal fistulae with hematemesis or hemoptysis. This paper present the first case report in Qatar of young lady presented with atypical chest pain resulting from dysphagia lusoria caused by a right aortic arch with a diverticulum (of Kommerell) at the origin of an aberrant left subclavian artery and a review the literature.

Keywords: Dysphagia, Lusoria, atypical chest pain and aortic anomalies.



Asthma Lusoria: Right Aortic Arch With Aberrant Left Subclavian Artery Masking As Severe Asthma: Case Report And A Review Of The Literature

Brigd Dr Mohammed Almarri And Dr. Hassan Moyad

The term Asthma lusoria refers to extra ordinary disposition of the subclavian artery (Lusorian artery) as a cause of intrathoracic variable obstruction. Although most individuals are asymptomatic however they might present with unspecific thoracic pain, dysphagia, dyspnea, arterioesophageal or arteriotracheal fistulae with hematemesis or hemoptysis. This paper present the first case report in Qatar of young lady missed diagnosed as severe asthma resulting from arteria lusoria caused by a right aortic arch with a diverticulum (of Kommerell) at the origin of an aberrant left subclavian artery and a review the literature.

Intralobar Pulmonary Sequestration In 22 Year-old Male: Case Report And Review Of Literature

Mohammed R Al-Marri, Ahmed Mahufouz, Ahmed Derwish, And Nood Al-Marri

Pulmonary sequestration is a rare congenital malformation of the lower respiratory tract characterized by a non-functioning mass of lung tissue that is not communicating with the normal tracheo-bronchial tree and receives its vascular supply from a systemic artery. We report the first case of intrapulmonary sequestration in Qatar, of a 22 year-old Qatari male who presented with recurrent chest infection. This case study includes a literature review. Keywords: pulmonary sequestration, congenital, malformation, Qatar

Primary Tracheal Schwannoma (neurilemoma) Presenting As Asthma: First Case Report In Qatar And Review Of Literature

Brig. Dr. Mohammed RHA AlMarri, Zaina S. Rohani, Abdelhaleem A. Elheday And Tasleem Raza.

We report a case of primary tracheal schwannoma presenting with symptoms of upper airway obstruction in a 37-year old woman. She was misdiagnosed as severe persistent asthma that did not respond to repeated courses of systemic steroids and bronchodilators with normal lung volume on Chest radiology that has been consistently reported as normal. Spirometry and flow volume loop were suggestive of upper airway obstruction. Computerized tomography (CT) scan demonstrated a polypoid mass in the cervical trachea obstructing 90% of the lumen. Urgent tracheostomy was performed followed by bronchoscopic excision of the mass. Histopathological diagnosis of schwannoma was confirmed with markers. This is the first reported case of tracheal schwannoma from the Middle East, and the 27th case worldwide. Keywords: Airway obstruction, Tracheal mass, Schwannoma, Neurilemoma, Bronchial tumor, Tracheal tumor.

Muriatic Acid Ingestion Complicated By Penetrating Head Injury, A Case Report And Literature Review

Nani Gelvezon DO, Andrew McCague DO, Joseph Vivian Davis DO, David T. Wong MD

Caustic ingestion is a serious medical problem associated with widespread tissue injury. Most commonly a result of suicide attempts, these injuries are often fatal. Here we present a rare case of a 44 year- old male who ingested muriatic acid and thirty minutes later fired two nails into his head with an automatic nail gun. After arriving to the emergency room with a Glasgow Coma Scale of 15, he was admitted for resuscitation. Esophagoscopy showed full thickness necrosis of the oropharynx and epiglottis and was aborted. He developed an acute abdomen with pneumoperitoneum

requiring exploratory laparotomy and partial gastrectomy with multiple drains placed. His abdomen was left open and he underwent multiple re-explorations. A completion gastrectomy was performed with duodenostomy tube and jejunostomy feeding tube placement. His abdomen remained open and was later grafted. Neurosurgery removed both of the nails in his head due to concerns for abscess formation and he remained neurologically intact. He had a prolonged hospital course complicated by enterocutaneous fistulas and total parenteral nutrition dependence. He was subsequently discharged home with tube feeding, tracheostomy and wound care requirements. At one year follow up he is awaiting reconstruction. Suicidal ingestion of caustic substances is a life threatening injury. Here we present a rare case of muriatic acid ingestion complicated by intracranial nail gun injury. After a prolonged hospital course he has survived his injuries and is awaiting reconstruction.

Unusual Cause Of Surgical Emphysema

Yasser Aljehani, , Shadi Alshammary, Mohammad Mesfer, Yasser El-Ghoneimy

Background and Aim: Pharyngeal perforation is considered rare these days. It is considered serious with dreadful outcomes if not diagnosed and managed promptly. The most common cause is iatrogenic due to instrumentation. Neck pain and swelling are the most common presentation. Surgical emphysema and pneumomediastinum have been reported in such entity especially in the context of difficult intubation. We report a predisposing factor for such entity which is pharyngeal candidiasis in a diabetic patient.

Material & Method: This is a single case report. The Case: A 52 years old gentleman who underwent open suprapubic radical prostatectomy for prostate cancer. It was reported that it was a difficult intubation setting. He is a type 2 diabetic on oral hypoglycemic agents. On the 2nd postoperative day, he developed left sided chest & neck pain associate with dyspnea and cough. He was hemodynamically stable & local exam revealed surgical emphysema on the neck and anterior chest wall. Chest X-ray demonstrated surgical emphysema as well as pneumomediastinum. CT scan confirmed the findings. The patient underwent bronchoscopy which showed normal tracheobronchial tree. A small perforation in the posterior pharynx with evidence of pharyngeal candidiasis was seen. The patient was managed conservatively. Repeat contrast swallow testing showed no evidence of leak. He was discharged 6 days later with no residual complaints.

Discussion: Surgical emphysema and pneumomediastinum are not uncommonly seen in the critical setting but rarely seen in the operative setting. They are mainly due to disruption of cutaneous barriers, mucosal barriers, barotraumas or bacterial infection. Several factors have been addressed as contributing factors; older age group, female gender, infection and difficult intubation setting. Diagnosis is essential since late complications carry high morbidity and mortality. Such complications include; mediastinitis, retropharyngeal abscess, pneumonia, pericarditis and death. The management depends on the extent of injury, location and the general condition of the patient. Conservative measures, NPO and parenteral nutrition with antibiotics are the mainstay management in stable patients with small perforations. Surgical intervention is reserved for larger perforations and more septic patients who need drainage.

Conclusion: Surgical emphysema and pneumomediastinum in the post-operative setting is essential to be recognized early and managed promptly to prevent acute and late serious complications. Addressing the risk factors minimize the occurrence of such complications. Pharyngeal candidiasis is a risk factor in diabetics especially with difficult intubation setting.

Migration Of Two Metallic Coils Placed For Treatment Of Erectile Dysfunction To The Pulmonary Artery: A Very Rare But Potentially Fatal Complication.

F. Al-Shahrabani, S. Angenendt, C. Vay, W. Knoefel

Case Report We report about a 37 year old man who was treated for his erectile dysfunction with an embolization of the penile veins. Three days after having the embolization done our patient was admitted to our Hospital

suffering from dyspnoea and right sided chest pain. Chest X ray and CT scan showed a migration of the coils to the right pulmonary artery. A trail to recover the coils with a catheter failed. After obtaining informed consent from the patient we did an anterolateral thoracotomy, explored the right pulmonary artery in the fissure. The coils could be palpated in the pulmonary artery just distal the middle lobe artery. The right pulmonary artery and the upper, middle and lower veins were precautionary looped. Then all outgoing arteries proximal and distal the impacted coils were looped and temporarily pinched off. The artery was opened through a transverse incision.

The coils and the thrombus were removed with a dissector. Prior to closing the artery a local injection with heparin solution was performed. In the postoperative period an intensive physiotherapy was done and the dyspnoea disappeared gradually over 3 days. The percutaneous oxygen saturation at day 3 postoperatively was 97% in room air. Because of the big thrombus and the presumably accrued small / micro pulmonary embolism we recommended an systemic anticoagulation for 6 month postoperatively. Impotence can be caused by leakage of venous blood from the penis during erection. An embolization of the penile veins by coils has been reported as a possible effective form of treatment of this venogenic erectile dysfunction. Migration of coils to the pulmonary artery is very rare but potentially fatal complication

Metastatic Lung Cancer Presenting As Thoracic Empyema In An Old Patient

Yuan-Ming Tsai, Yu-Chieh Lin, Hsu-Kai Huang, Tsai-Wang Huang, Chih-Ming Hsieh, Jian-Bo Cheng, Ching Tzao, Shih-Chun Lee, Hung Chang

An 83-year-old male presented to the emergency department with productive cough and acute shortness of breath. Imaging and biochemical and microbiological studies of the pleural fluid indicated empyema. After antibiotic treatment and tube drainage, symptoms of the patient persisted and he received thoracoscopic decortication. His condition improved gradually, but histopathological examination showed metastatic adenocarcinoma of lung. We must pay attention to the possible association of malignant tumors and empyema in older patients.

The Long Waiting Times In Hamad Medical Corporation (HMC) Out Patient Department (OPD) Clinics: The Causes Using Lean Approach

Brig. Dr Mohammed AlMarri MD, FRCPC, FCCP. MSC Healthcare Management, PhD Quality Management

Background: Is to identify the causes of the long waiting times in the OPD clinic using the Lean approaches.

Methods: analyze the flow of patients, objective waiting, focus group discussion with the clinic's stakeholders including patients, doctors, nurses, clerks and administration to identify the causes of the long waiting times using lean.

Results: There were 768 clinics per week in the 96 rooms that service 2700 patients with an overall patient to doctor ratio is 22.5 to 1 and an average doctor to nurse ratio of 1 to 1.33. The subjects were 224 patients who attending the pulmonary clinic over two weeks' period in additional to 4 nurses and 4 chest physicians in the chest clinic. The average wait time for the patient to see the physicians for the morning and afternoon clinic was 80 minutes +/- 42.2 (STD= Standard deviation) and 97 minutes +/- 42.4 STD respectively. Sixty six of the morning clinic Attendances arrived in the first hour and half of the appointment hours compared to 85% of PM clinics attendances that were there before the appointed clinic time. The Overall Equipment (SERVICE) Efficiency (OEE) was 172 % and the quality of care was 72%. The takt time is 143 minutes of which 29 minutes were valuable time

Conclusion: The lean is an approach targets waste elimination and improves the value stream flow. Although the OPD overall Service Efficiency (OEE) was higher than the best practice however the quality of care was lower than best practice due to number of wastes that were identified by

lean approaches including OPD attendances come big batch in the first hour of appointment, tardiness of the physicians, increased demand with low capacity of the HMC OPD clinics and inappropriate appointments.

Keywords: Waiting, Times, Clinic, Causes, solutions, HMC, OPD and Lean approach.

No association between A(H1N1)pdm09 vaccine and narcolepsy in Saudi patients: A preliminary report

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Introduction: Recently, there has been a concern about a possible association between the pandemic strain of influenza [A(H1N1)pdm09] vaccine introduced on 2009 and narcolepsy.¹ Most of the reported cases received vaccines containing a lipid containing adjuvant called AS03.1 While some studies reported an increase in the diagnosis rate of narcolepsy after the introduction of the A(H1N1)pdm09 vaccine, other studies reported no association.

In Saudi Arabia, the A(H1N1)pdm09 vaccine campaign was launched in November 2009. No study has assessed the association between A(H1N1)pdm09 vaccine and narcolepsy in Saudi Arabia. Therefore, we designed this preliminary study to assess the diagnosis rate of narcolepsy among Saudi patients referred to the University Sleep Disorders Center (USDC) and the pediatrics sleep disorders center in the Military hospital, Riyadh before and after the introduction of A(H1N1)pdm09 vaccine and to explore any association between the vaccine and narcolepsy.

Methods: The two sleep disorders centers accept any patient referred with excessive daytime sleepiness from all over the Kingdom. We used the databases of both centers during the period from January 2002 to End of June 2013 to retrieve all the data of patients diagnosed with narcolepsy. Narcolepsy was diagnosed following the International Classifications of Sleep Disorders Diagnostic and Coding Manual diagnostic criteria.² The diagnosis of narcolepsy for each included patient was reviewed and verified a sleep medicine specialist. Patients who were diagnosed after September 2009 were contacted and asked whether they received the H1N1 vaccine. When feasible, the patient's record was checked for vaccination.

Results: During the period from January 2002 until June 2013, 108 patients (males = 84.8%) fulfilled the diagnostic criteria of narcolepsy with a mean age at diagnosis of 29.6 ± 11.7 years (range 5-68 years). The number of cases diagnosed on 2010 and 2011 increased to 28 cases. However, when we assessed the date of onset of symptoms, we found that only eight cases had symptoms onset after September 2009. None of the patients who had symptoms onset after September 2009 received A(H1N1)pdm09 vaccine. Among patients who were diagnosed after November 2009, one patient received the A(H1N1)pdm09 vaccine. However, symptoms of narcolepsy appeared on 1994.

Conclusion: No clear association between the A(H1N1)pdm09 vaccine and narcolepsy among Saudis. However, data need to be interpreted with caution as we do not have a national registry. Hence, data cannot be generalized. In addition, there could be a delay in referring patients with narcolepsy to sleep medicine specialists due to the under-recognition of narcolepsy among practitioners.³ Therefore, sleep medicine specialists should keep this association in mind when evaluating patients with narcolepsy in the future. This preliminary report should encourage sleep medicine specialists and infectious diseases specialists in the country to conduct a national study to explore any association between A(H1N1)pdm09 and narcolepsy in Saudi Arabia.

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Conclusion: The lean is an approach targets waste elimination and improves the value stream flow. Although the OPD overall Service Efficiency (OEE) was higher than the best practice however the quality of care was lower than best practice due to number of wastes that were identified by lean approaches including OPD attendances come big batch in the first hour of appointment, tardiness of the physicians, increased demand with low capacity of the HMC OPD clinics and inappropriate appointments.

Keywords: Waiting, Times, Clinic, Causes, solutions, HMC, OPD and Lean approach.

Islamic Intermittent fasting has No Effect on Oxidative Stress in Health Subjects

Mohammad Alzohaibi, Munir SharifAhmed BaHammam
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Background: Islamic intermittent fasting is distinct from regular voluntary or experimental fasting with impact on several biomarkers. In addition, several lifestyle changes accompany Ramadan fasting like changes in meals frequency and composition, and changes in sleep, time, duration and pattern, which may influence the oxidant/antioxidant system in the body. Two previous studies that assessed the effect of Ramadan fasting on oxidative stress have reported conflicting data.

However, both studies did not monitor sleep objectively to document sleep duration and sleep quality, did not account for the possibility that attendant lifestyle changes that occur during Ramadan, may affect the measure oxidative stress regardless of fasting. Malondialdehyde (MDA) is one of

the final products of polyunsaturated fatty acids peroxidation in the cells. An increase in free radicals causes overproduction of MDA.

MDA level is commonly known as a marker of oxidative stress and the antioxidant status. We designed this study to assess the effect of Islamic intermittent fasting outside Ramadan period on the circadian changes in MDA as a lipid peroxidation marker. By controlling for potential confounders, we aim to assess the pure effect of Islamic intermittent fasting on oxidative stress.

Methods: Serum MDA levels were measured in eight healthy volunteers during baseline (BL) and after fasting for 1 week outside Ramadan (BL Fasting) to control for the associated lifestyle changes and eating habits during Ramadan. Blood samples were collected 5 times at 2200, 0200, 0400, 0600 and 1100.

During the measurement day, participants were admitted to the sleep disorders center (SDC) for 24 hr. When in the SDC for sleep studies, each participant received meals with fixed caloric intake and fixed proportions of carbohydrate, fat and protein based on their ideal body weight. Light exposure and total sleep time were maintained the same during the participants' stay in the SDC. MDA was extracted by the addition of n-butanol (500 µl). Absorption was measured by a 96-well plate reader at 530 nm and 570 nm. The range of the standard curve was 0.1 µM to 5 µM per milliliter blood serum.

Results: The participants had a mean age of 26.6 ± 4.9 years and BMI of 23.7 ± 3.5 . There were no significant changes in MDA during BL, BL Fasting and Ramadan (Table 1).

Conclusion: Under conditions of fixed sleep-wake schedule and caloric intake, Islamic intermittent fasting does not alter oxidative stress parameters in healthy subjects.

	BL	BL Fasting	Ramadan	p-value
MDA @ 22:00	63 ± 76.4	84.9 ± 67.9	48.4 ± 49	0.135
MDA @ 02:00	75.4 ± 92.5	81.9 ± 91.2	76.6 ± 80.6	0.687
MDA @ 04:00	81.6 ± 78	78.2 ± 86.2	70.6 ± 70.7	0.417
MDA @ 06:00	67.7 ± 63.9	66.1 ± 75.7	75.5 ± 97.7	0.687
MDA @ 11:00	82.1 ± 99.2	75.5 ± 88.3	70.1 ± 67.9	0.607

Table 1: Measured MDA values during BL, BL Fasting and Ramadan





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