



Gulf Thoracic
مؤتمر الخليج لطب وجراحة الصدر

DUBAI 2015

4 - 7 MARCH

Grand Hyatt Hotel, Dubai, UAE

One Gulf...

One Air...

One Breathe...

**The 6th Annual Congress of The Saudi Thoracic Society
& The Emirates Allergy and Respiratory Society**

Final Program



ORGANIZED BY:



IN COLLABORATION WITH:



ERS EUROPEAN
RESPIRATORY
SOCIETY
every breath counts

WITH PARTICIPATION FROM:

Cleveland Clinic

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CHAIRMAN'S MESSAGE



Dear Colleagues and Friends,

On behalf of the Executive Committee of the *GulfThoracic* Congress 2015, I would like to extend my warmest welcome to you all, to participate in this international event, which will be held in Dubai, UAE on 4-7 March 2015.

The *GulfThoracic* Congress 2015 is the sixth 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) and European Respiratory Society (ERS), with special participation from The Cleveland Clinic Foundation, USA, The Royal Brompton and Harefield Hospitals, UK. Alfaisal University, Riyadh, Saudi Arabia.

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

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

Chairman, *GulfThoracic* Congress 2015

President, Saudi Thoracic Society

Professor of Pulmonary Medicine & Consultant Pulmonologist

Respiratory Division, Medicine Department

King Saud University & King Khalid University Hospital

Riyadh, Saudi Arabia



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.

The specific aims of the Society are:

- Promoting and coordinating activities in the field of respiratory medicine
- Fostering research activities in the field of respiratory medicine
- Organizing and coordinating regular national and regional meetings
- Publishing a newsletter and a journal of international repute
- Publishing and updating clinical practice guidelines in the field of respiratory medicine

You are invited to become a member of the Joint STS-ERS Membership. You will be a valuable member of our mailing list and it is important to keep you informed on relevant updates, articles, news and announcements.

Therefore, kindly spare a minute to register.

Register Now:

http://www.saudithoracic.org/sts_ers/

SUBSIDIARIES



SINA
Saudi Initiative for Asthma
المبادرة السعودية لمرض الربو



SAVTE
SAUDI ASSOCIATION FOR VASCULAR THROMBOEMBOLISM
الجمعية السعودية للتصاقات الوعائية



SGTS
Saudi Group for Thoracic Surgery
الجمعية السعودية لجراحة الصدر



STIG
Saudi Thoracic Imaging Group
الجمعية السعودية لتصوير الصدر



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 (SCFHS) 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.

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. Anybody with Congress badge are eligible to go the designated restaurants within the hotel.

Automated 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 pegged to 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



Honorary Chairman, Organizing Committee
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Consultant, Pulmonary Medicine
Dubai, UAE



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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
King Faisal Specialist Hospital and Research Centre
Riyadh, Saudi Arabia





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Honorary Chairman, Organizing Committee
Mirza A. Al Sayegh, MD
Dubai, UAE



Local Chairman, Organizing Committee
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Dubai, UAE



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Salman Abdulaziz, MD
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Riyadh, Saudi Arabia

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Chairman, Scientific Committee
Prof. Mohamed S. Al-Hajjaj MD, FRCP(C)
Riyadh, Saudi Arabia



Co-Chairman, Scientific Committee
Hassan S. Alorainy BsRC, RRT, FAARC
Riyadh, Saudi Arabia



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Cleveland, OH, USA



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MD, FRCPC
Riyadh, Saudi Arabia

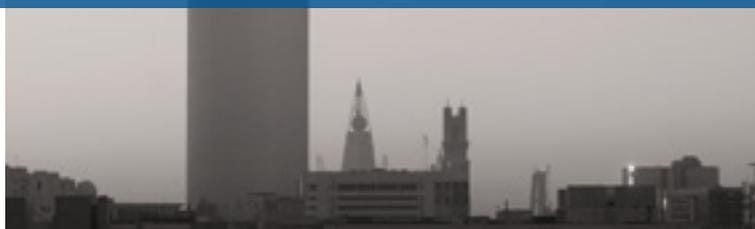


Member
Prof. Mohamed S.
Al Moamary, MBBS,
ABIM, FRCP(Edin),
FCCP
Riyadh, Saudi Arabia



ERS & STS JOINT *membership*

Join the *Saudi Thoracic Society* (STS) today and become a member of the *European Respiratory Society* (ERS) for free. ERS is a leading medical organisation in the world working to promote lung health and combat lung diseases. In addition to the benefits you receive from the STS, your ERS membership entitles you to a range of benefits across core areas of ERS activity: science, education and advocacy.



ERS BENEFITS

SCIENCE

- Discounted access to the European Respiratory Society International Congress
- Online access to a range of publications and books
- Funding opportunities for research and conferences
- Opportunity to apply for the Fellowship of ERS (FERS)

EDUCATION

- Free online educational material
- Reduced rates for training courses
- Access to harmonised qualifications through the HERMES initiative

ADVOCACY

- Opportunities to shape EU policy
- Access to a patient network

STS BENEFITS

- Opportunity to chair sessions at meetings and participate in committees
- Free or discounted admission to scientific activities
- Free subscription to Annals of Thoracic Medicine and Al Tanafus
- Receiving the monthly 'Pulmonary Medicine updates & abstracts'
- Free admission to the monthly "Chest Club" meetings with credit hours
- Receiving all STS Scientific materials

Find out more:
ERSNET.ORG/MEMBERSHIP
SAUDITHORACIC.COM

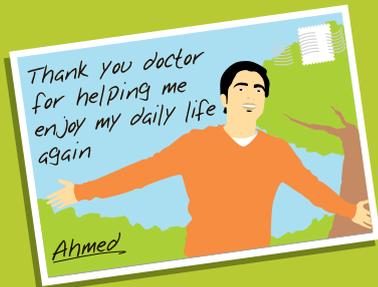


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every breath counts





Symbicort® .. The only single inhaler therapy for maintenance and relief^{1,2}



• EFFECTIVE..

Superior control with lower steroid load³



• RAPID..

The only ICS/LABA combination proven to act as rapidly and effectively as Salbutamol⁴



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Just one inhaler for better compliance, easy to operate device⁵

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/or 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. Food 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



1-2 inhalations every morning



extra doses when needed



1-2 inhalations every evening

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

AstraZeneca

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

Symbicort®
budesonide/formoterol



Bring more to life



RIGHT FROM THE START...

Mundipharma has been about people to improve the quality of life of patients through innovative therapeutic treatments.

Mundipharma and its Independent Associated Companies (IACs), Purdue & NAPP, are privately owned companies. Having started in 1957, we now support 105 countries with our international research and development.

We support this growth with an innovative spirit, as well as product development that challenges orthodoxies, all of these fuelled by a singular aim to improve quality of life for people across the globe.

Research & Development: State-of-the-art research centers in the US, UK, and Germany provide solutions with quality and safety. Since 2006, approximately 11,000 patients have been enrolled in 74 studies across 34 countries.

Therapeutic & Business Area Focus: We are now the leading company in pain management. Apart from this, our repertoire includes a broad range of products, areas to improve patient outcomes and quality of life, from clinical disinfectants to treatment for hematological malignancies.

To complement these areas, we specialize in drug delivery systems, particularly applied to our range of analgesics and respiratory treatments.



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START SPIRIVA® when COPD symptoms impact everyday life

LIFE CAN'T WAIT.

SPIRIVA®: the only once-daily, long-acting anticholinergic maintenance treatment for COPD patients



Prescribing Information

Indications: SPIRIVA® is indicated for the maintenance treatment of patients with COPD (including chronic bronchitis and emphysema), the maintenance treatment of associated dyspnoea and for reduction of exacerbations. Contraindications: SPIRIVA® inhalation powder is contraindicated in patients with hypersensitivity to tiotropium bromide, atropine or its derivatives, e.g. ipratropium or oxitropium or to the excipient lactose monohydrate. Special Warnings and Precautions: SPIRIVA®, as a once daily maintenance bronchodilator, should not be used for the initial treatment of acute episodes of bronchospasm. Immediate hypersensitivity reactions may occur after administration of SPIRIVA® inhalation powder. As with other anticholinergic drugs, tiotropium bromide should be used with caution in patients with narrow-angle glaucoma, prostatic hyperplasia or bladder-neck obstruction. Inhaled medicines may cause inhalation-induced bronchospasm. Interactions: although no formal drug interaction studies have been performed, tiotropium bromide has been used concomitantly with other drugs, commonly used in the treatment of COPD, including sympathomimetic bronchodilators, methylxanthines, oral and inhaled steroids without clinical evidence of drug interactions. Pregnancy and lactation: for SPIRIVA®, no clinical data on exposed pregnancies are available. Therefore, SPIRIVA® should not be used in pregnant or nursing women unless the expected benefit outweighs any possible risk to the unborn child or the infant. Effects on ability to drive and use machines: No studies on the effects on the ability to drive and use machines have been performed. Side effects many of the side effects can be assigned to the anticholinergic properties of SPIRIVA®. In controlled clinical studies, the most commonly observed side effect was dry mouth which occurred in approximately 3% of patients. Dosage and administration: the recommended dosage of SPIRIVA® is inhalation of the contents of one capsule once daily with the HandiHaler device at the same time of day. SPIRIVA® should only be inhaled with the HandiHaler device. The recommended dose should not be exceeded. SPIRIVA® capsules must not be swallowed. For full prescribing information, please read the package insert.



PRE-CONFERENCE WORKSHOPS & COURSES

Pulmonary Function Testing: Techniques and Interpretation

CONDUCTED BY:



PROGRAM DIRECTOR: GHAZI ALOTAIBI (KSA)

Rationale: Pulmonary function test (PFT) has been the mainstay diagnostic and monitoring tool of airway and parenchymal diseases. Pulmonary function studies help to establish diagnosis and guide decisions for further treatments or interventions. There are array of PFT methods ranging from simple measurements of volume and flow to advanced measurement of gas diffusion capacity. Treatment guidelines and protocols for many pulmonary diseases emphasize the importance of PFT as a diagnostic tool. Therefore, Knowledge of PFT techniques and interpretation are essential for clinicians working with pulmonary patients.

Objective:

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

- Understand basic physiology underpinning pulmonary function tests.
- Perform basic spirometry, and assess acceptability and repeatability of the test.
- Perform lung volume measurement tests.
- Perform lung diffusion capacity (DLco) test.
- In clinical contexts, assess and interpret PFT results

Target Audience:

- Pulmonologists
- PFT Technologists
- Respiratory Therapists
- General Practitioners

No. Audience: Attendance is limited to 20 participants.

PRE-CONFERENCE WORKSHOPS & COURSES

Pulmonary Function Testing: Techniques and Interpretation

15:00 – 19:00		WEDNESDAY, 4 MARCH 2015	MEETING ROOM: AL MAASA
TIME	TOPIC		FACULTY
14:00 - 15:00	Registration		
15:00 - 15:15	Welcoming Remarks		Dr. Ghazi Alotaibi - KSA
15:15 - 15:40	Pulmonary Physiology for PFT		Dr. Khalid Ansari - KSA
15:40 - 16:05	Spirometry: Techniques and acceptability of the test		Dr. Hajed Alotaibi - KSA
16:05 - 16:30	TLC and Diffusion Capacity		Mr. Abdullah AlQarni - KSA
16:30 - 17:00	COFFEE BREAK		
17:00 - 17:30	Practice 1: FVC and Basic Spirometry		Mr. Jose Rex - KSA
17:30 - 18:00	Practice 2: TLC/RV & Diffusing Capacity		Ms. Marwa A. Wakkas - KSA
18:00 - 19:00	Case Studies & Interpretation		Prof. Omar A. Al Rawas - Oman
	Closing Remarks		Dr. Ghazi Alotaibi - KSA



Ghazi Alotaibi, PhD, RRT

Assistant Professor of Respiratory Care
University of Dammam
President, Saudi Society for Respiratory Care
Dammam, Saudi Arabia



Khalid Aziz Ansari, MD, M.Phil., PhD

Assistant Professor, Respiratory Care
Department
University of Dammam
Dammam, Saudi Arabia



Hajed Alotaibi, PhD, RRT

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



Abdullah S. AL Qarni, MS, RRT-NPS, CPFT

Clinical Instructor, Respiratory Care
Department
University of Dammam
Dammam, Saudi Arabia



Prof. Omar A. Al Rawas, MBChB, FRCP (Glasg.)

Professor of Medicine and Consultant
Pulmonologist, Department of Medicine
Dean, College of Medicine and Health
Sciences
(CoMHS), Sultan Qaboos University (SQU)
Muscat, Oman



Jose Rex Navarrosa, BSRT

Clinical Instructor, Respiratory Care
Department
University of Dammam
Dammam, Saudi Arabia



Marwa A. Wakkas, RRT

Laboratory/Clinical Instructor
Respiratory Care Department
College of Applied Medical Sciences
University of Dammam
Dammam, Saudi Arabia

PRE-CONFERENCE WORKSHOPS & COURSES

How to Get Your Paper Published?

CONDUCTED BY:



IN COLLABORATION WITH:



PROGRAM DIRECTOR: PROF. MOHAMED S. AL MOAMARY (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
- Healthcare professionals with interest in publishing

No. Audience: Attendance is limited to 20 participants.



PRE-CONFERENCE WORKSHOPS & COURSES

How to Get Your Paper Published?

15:00 – 19:00		WEDNESDAY, 4 MARCH 2015	MEETING ROOM: AL DAR
TIME	TOPIC	FACULTY	
14:00 - 15:00	Registration		
15:00 - 15:05	Welcome and Course Objectives	Prof. Mohamed S. Al Moamary - KSA	
15:05 - 15:30	What Editors are Looking For?	Prof. Atul C. Mehta - USA	
15:30 - 16:10	Methodology and Results Section	Prof. Peter Cahusac - KSA	
16:10 - 16:30	Publishing Your Research	Prof. Mohamed S. Al Moamary - KSA	
16:30 - 17:00	COFFEE BREAK		
17:00 - 17:35	Review Articles and Meta-Analysis	Prof. Robert Kotloff - USA	
17:35 - 18:00	Copyrights and Ethical Issues	Prof. R. Duncan Hite- USA	
18:00 - 18:55	Case Studies	Panel Discussion	
18:55 - 19:00	Conclusion	Prof. Mohamed S. Al Moamary - KSA	



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

Professor & Consultant, Pulmonary Medicine, King Abdulaziz Medical City- Riyadh, VP, 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



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

Staff Physician, Cleveland Clinic Foundation Respiratory Institute, Cleveland Clinic Editor-in-Chief, Journal of Bronchology & Interventional Pulmonology Cleveland, OH, USA



Prof. Peter Cahusac, PhD

Associate Professor, Pharmacology & Biostatistics Riyadh, Saudi Arabia



Prof. R. Duncan Hite, MD

Chairman, Department of Critical Care Medicine, Respiratory Institute Chief Pulmonary Critical Care Cleveland Clinic, Department of Critical Care/Respiratory Institute Cleveland, OH, USA



Prof. Robert Kotloff, MD

Chief Pulmonary Critical Care Chairman, Department of Pulmonary Medicine, Respiratory Institute Cleveland, OH, USA

PRE-CONFERENCE WORKSHOPS & COURSES

Endobronchial Ultrasound (EBUS) Workshop

SPONSORED BY:



OLYMPUS

PROGRAM DIRECTOR: DR. AHMED ALJOHANEY (KSA)
PROGRAM DIRECTOR: PROF. ATUL C. MEHTA (USA)

Objective:

- To inform delegates about the exact role of EBUS and briefly review the literature.
- To provide a clear understanding of the tools and techniques involved.
- To demonstrate the practice of EBUS-TBNA and provide an opportunity for delegates to perform the procedure on a phantom.
- At the conclusion of the workshop the participant will have a good understanding of basic principles of skills required to safely begin performing EBUS in a clinical setting.

Target Audience:

This workshop is designed for the practicing Pulmonologist, Chest Surgeon and Interventional Bronchoscopy Assistants. The course is intentionally limited in the number of participants, in order to allow for maximum benefit of small group instruction and interaction with faculty in the hands-on sessions.

Summary: In the last years endobronchial ultrasound (EBUS) has revolutionized the world of bronchoscopy. EBUS is a minimally invasive technique that allows visualization of tracheobronchial wall structures and other structures adjacent the airway such as blood vessels or lymphadenopathy. There are two types of EBUS: linear and radial. The linear EBUS consists of several transducers forming a curve in the distal extreme of the flexible bronchoscope that generate an image of 50 degrees in relation to the major axis of the bronchoscope, which allows for a puncture to be directly observed in real time. The radial EBUS consists of a rotatory transducer in the distal extreme of a miniprobe that generates an image of 360 degrees around the major axis of the bronchoscope, but does not allow for real-time samples. The main indication of the radial EBUS is the diagnosis of peripheral lung opacities. EBUS should be considered as a primary method of evaluation of lymph nodes seen to be positive in PET scan and may replace the majority of surgical mediastinal staging/diagnostic procedures. Linear EBUS has become the heart of N lung cancer staging, avoiding the comorbidity and comorbidity of mediastinoscopy.

No. Audience: Attendance is limited to 20 participants.





PRE-CONFERENCE WORKSHOPS & COURSES

Endobronchial Ultrasound (EBUS) Workshop

15:00 – 19:00		WEDNESDAY, 4 MARCH 2015	MEETING ROOM: AL DANA
TIME	TOPIC	FACULTY	
15:00 - 15:05	Welcome Notes		
15:00 - 15:30	EBUS-TBNA: Theory and Evidence	Dr. Ahmed A. Aljohaney - KSA	
15:30 - 16:00	EBUS: Step by Step	Dr. Amr Albanna - KSA	
16:00 - 16:30	Dare to do EBUS-TBNA?	Prof. Atul C. Mehta - USA	
16:30 - 17:00	COFFEE BREAK		
17:00 - 17:30	C-TBNA: How to improve the yield?	Prof. Atul C. Mehta - USA	
17:30 - 19:00	Station - 1: Hands-On Session: Step by Step Demonstration of Technique in EBUS TBNA Models	Dr. Ahmed A. Aljohaney - KSA	
	Station - 2: Hands-On Session: Step by Step Demonstration of Technique in EBUS TBNA Models	Dr. Amr Albanna - KSA	
	Station - 3: Hands-On Session: Step by Step Demonstration of Technique in C-TBNA Models	Prof. Atul C. Mehta - USA Dr. Ayse E. Küpeli - Turkey	
	Closing Remarks	Dr. Ahmed A. Aljohaney - KSA	



Ahmed A. Aljohaney, MBBS, DABIM, FRCPC

Assistant Professor of Medicine College of Medicine, King Abdulaziz University Hospital
Jeddah, Saudi Arabia



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

Staff Physician, Cleveland Clinic Foundation Respiratory Institute, Cleveland Clinic
Editor-in-Chief, Journal of Bronchology & Interventional Pulmonology
Cleveland, OH, USA



Amr Albanna, MD, MSc

Assistant Professor, Consultant Pulmonologist and Pulmonary Intervention, King Saud bin Abdulaziz University for Health Sciences
Jeddah, Saudi Arabia



Ayse E. Küpeli, MD

Assoc. Prof Pulmonary Medicine Department
Baskent University School of Medicine
Ankara, Turkey

PRE-CONFERENCE WORKSHOPS & COURSES

Percutaneous Dilational Tracheostomy (PDT) Course

CONDUCTED BY:



PROGRAM DIRECTOR: DR. ALAWI ALSAEEDI (KSA)

Objectives:

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

- Airway anatomy and difficult airway evaluation.
- The indications, contra-indications and complications of percutaneous Tracheostomy.
- Surgical vs. percutaneous technique differences.
- Bronchoscopy guided percutaneous tracheostomy.
- Post tracheostomy care.

Target Audience:

- Intensivists
- Critical Care Medicine Fellows
- Anesthesiologists
- Emergency Physicians
- Respiratory Therapists
- Critical Care Nurses

Rationale: Critically ill patients with respiratory failure may require invasive mechanical ventilation. Some of these patients will need prolonged ventilation, which usually provided thorough tracheostomy. Percutaneous procedures are a new option for patients to have minimally invasive procedures. Bronchoscopically guided percutaneous tracheostomy offers a bedside procedure for critically ill patients and eliminates the need for transport to an operating room, and is associated with a higher morbidity and mortality. In addition, there is a cost saving and more accurate technique to reduce complications such as stoma infections when compared to current open techniques for tracheostomy.

No. Audience: Attendance is limited to 20 participants.

PRE-CONFERENCE WORKSHOPS & COURSES

Percutaneous Dilational Tracheostomy (PDT) Course

15:00 – 19:00		WEDNESDAY, 4 MARCH 2015	MEETING ROOM: AL ITEFAQ
TIME	TOPIC	FACULTY	
14:00 - 15:00	Registration		
15:00 - 15:05	Course Outlines and Introduction	Dr. Alawi Alsaeedi - KSA	
15:05 - 15:30	Anatomy of the Airway, Evaluation of the Difficult Airway	Dr. Alawi Alsaeedi - KSA	
15:30 - 15:55	Indications and Timing of Tracheostomy in the ICU	Dr. Haytham Tlayjeh - KSA	
15:55 - 16:05	COFFEE BREAK		
16:05 - 16:30	Contraindications and Complications of Tracheostomy	Prof. Atul C. Mehta - USA	
16:30 - 17:00	COFFEE BREAK		
17:00 - 17:25	Techniques: Surgical Vs. Percutaneous	Dr. Haytham Tlayjeh - KSA	
17:25 - 17:50	Post Tracheostomy Care	Mr. Yasser Ajina - UAE	
17:50 - 18:55	Station 1: Percutaneous Tracheostomy	Dr. Haytham Tlayjeh - KSA	
	Station 2: Percutaneous Tracheostomy	Dr. Alawi Alsaeedi - KSA	
18:55 - 19:00	Closing Remarks		



Alawi S. Alsaeedi, MBBS, SB-Anaes, FCCM-UFT

Consultant, Anesthesiology and Critical Care Medicine
King Abdulaziz Medical City
Riyadh, Saudi Arabia



Yasser Mahmoud Ajina, RRT

Senior Respiratory Therapist
Rashed Hospital
Dubai, UAE



Haytham Tlayjeh, MD

Assistant Professor, King Saud Bin Abdulaziz University
Consultant, Pulmonary & Critical Care Medicine Section
Head, Oncology ICU King Abdulaziz Medical City
Riyadh, Saudi Arabia

PRE-CONFERENCE WORKSHOPS & COURSES

Bedside Thoracic Ultrasound Course

CONDUCTED BY:



STIG
Saudi Thoracic Imaging Group
الجمعية السعودية لاشعة 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:

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

- 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 20 participants.



PRE-CONFERENCE WORKSHOPS & COURSES

Bedside Thoracic Ultrasound Course

15:00 – 19:00		WEDNESDAY, 4 MARCH 2015	AL REMAL MEETING ROOM
TIME	TOPIC		FACULTY
14:00 - 14:55	Registration		
14:55 - 15:00	Opening Remarks		Armin Meyer - UAE
First Lecture Session			
15:00 - 15:20	Principles of Ultrasound and Knobology		Mohammed Alabdrab Alnabi - KSA
15:20 - 15:40	Focused Thoracic Ultrasound and Normal Findings		
15:40 - 15:45	COFFEE BREAK		
1st Hands-on Session (15:45 -16:30) - 15 minutes per station			
15:45 - 16:30	Station 1	Introduction to Ultrasound Machine & Knobology	Mohammed Alabdrab Alnabi - KSA
	Station 2	Ultrasound of the Lower Chest on a Normal Subject, Imaging Costophernic Angles (liver or spleen, diaphragm, curtain sign, A & B lines, rib shadows)	Armin Meyer - UAE
	Station 3	Ultrasound of the Upper Chest on a Normal Subject, Imaging for Pneumothorax Using Linear Array Transducer (sliding pleura, lung pulse, A & B lines, M-mode for seashore sign)	Ali Altalag - KSA
16:30 - 17:00	COFFEE BREAK		
17:00 - 17:30	Major Thoracic Pathology & Ultrasound-Guided Pleural Tap & Pigtail Catheter Insertion		Ali Altalag - KSA
17:30 - 17:40	COFFEE BREAK		
2nd Hands-on Session (17:40 - 18:55) - 25 minutes per station			
17:40 -18:55	Station 1	Thoracic Pathology on Simulator (VIMEDIX) or Real Patient	Ali Altalag - KSA
	Station 2	Ultrasound-Guided Pleural Tap on Phantom (Sitting Position)	Mohammed Alabdrab Alnabi - KSA
	Station 3	Ultrasound-Guided Pigtail Insertion on Phantom (Supine Position)	Armin Meyer - UAE



Ali H. Altalag, MD, ABIM

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



Armin Meyer, MD, FCCP

Consultant, Pulmonologist and Intensivist
Respiratory & Critical Care Institute
Cleveland Clinic Abu Dhabi
Abu Dhabi, UAE

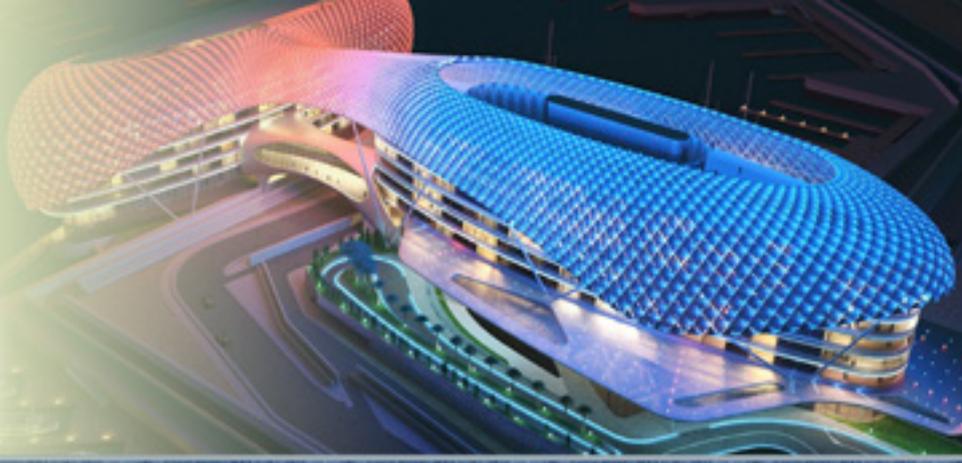


Mohammed Alabdrab Alnabi, MD

Emergency & Critical Care Consultant
Assistant Professor of Emergency Medicine
Residency & Fellowship Program Director
King Fahd Specialist Hospital
Dammam, Saudi Arabia

SAUDI ASSOCIATION FOR PULMONARY HYPERTENSION

SAPH 2015 Abu Dhabi



The 8th Annual Joint Pulmonary Hypertension Conference & The 4th Pulmonary Hypertension in the Young

Saudi Association for Pulmonary Hypertension (SAPH) The Easter Meditternean Region (PVRI)

09-11 April 2015 • Yas Viceroy Hotel, Abu Dhabi, UAE

ORGANIZED BY:

COLLABORATION WITH:



TOPICS INCLUDE:

- PH and Pregnancy
- Congenital Heart Diseases and PH
- Pulmonary Hypertension in Children
- High Risk Pulmonary Hypertension
- CTEPH
- PH and Rheumatic Diseases
- PH in Developing Countries

SAPH OBJECTIVES

- To investigate the local incidence, prevalence, and pathobiology of PVD in Saudi Arabia.
- To identify local characteristics of the illness including its morbidity and mortality.
- To develop national guidelines for the diagnosis and treatment of PVD.
- To provide expertise that will address issues related to the education and training of healthcare professionals in the field of PVD
- To focus on improving the treatment of PVD, by promoting basic and clinical research
- To promote public awareness through different means including print and electronic media, and public seminars

FACULTY RENOWNED INTERNATIONAL AND REGIONAL SPEAKERS

To be Updated



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... MORE TO COME

Thoracic Oncology Forum TOF2015

The 3rd Annual Scientific Conference of
The Saudi Lung Cancer Association (SLCA)

9-11 April 2015 | Jeddah, Saudi Arabia



CO-ORGANISERS:



LOCAL CO-ORGANISERS:



TOPICS TO BE COVERED:

- Management of Early Lung Cancer
- Tumor Board: Case Presentations and Expert Discussion
- Management of Advanced Lung Cancer
- Advances in the Management of other Thoracic Cancers
- Regional Experience (Abstract Session)

TARGET AUDIENCE:

- Oncologists
- Pulmonologists
- Thoracic Surgeons
- Radiologists
- Pathologists
- Physicians in Training
- Researchers
- All Physicians with interest in Thoracic Oncology

KEY-NOTE PRESENTATIONS:

- Guideline Adaptation Training Workshop
- ALK Testing in Lung Cancer Adenocarcinoma Workshop

MAIN SPONSOR:



SAUDI SOCIETY OF
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TO March 2015 - Deadline for:
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Registration Fee :
Residents **SAR 1,500**
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Care Professionals **SAR 1,000**

Symposium Organization :
Telephone: +966 (11) 462 3676
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For Registration Please Visit:
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DAY 1 - THURSDAY 05 MARCH 2015

MORNING SESSION

BANIYAS II HALL | DAY 1 - THURSDAY 05 MARCH 2015 | 08:30 - 10:30

	Plenary: American Thoracic Society (ATS) - Update in Pulmonary Medicine
	Chairing: Mohamed S. Al Hajjaj (KSA) – Thomas Ferkol (USA)
08:30 - 09:00	Asthma- COPD Overlap Syndrome - Qutayba Hamid (Canada)
09:00 - 09:30	Cystic Fibrosis: State of the Art - Thomas Ferkol (USA)
09:30 - 10:00	Treatment of IPF: The Start of a New Era - Luca Richeldi (UK)
10:00 - 10:30	Thrombotic Lung Diseases: What is New? - Majdy Idrees (KSA)
10:30 - 11:00	Coffee Break

BANIYAS II HALL | DAY 1 - THURSDAY 05 MARCH 2015 | 11:00 - 12:15

	Severe Asthma - I
	Chairing: Mirza Al Sayegh (UAE) - Hatem Qutub (KSA)
11:00 - 11:25	Definition and Diagnosis of Severe Asthma - Elisabeth Bel (Netherlands)
11:25 - 11:50	Role of T-Cell in Asthma - Saba AlHeialy (KSA)
11:50 - 12:15	Phenotype-Guided Treatment of Severe Asthma - Elisabeth Bel (Netherlands)

AL-AMEERA II HALL | DAY 1 - THURSDAY 05 MARCH 2015 | 11:00 - 12:15

	Pulmonary Hypertension
	Chairing: Muhammad Badr (UAE) - Manal Al Hazmi (KSA)
11:00 - 11:25	The Right Ventricle in Lung Disease - Anton Vonk Noordegraaf (Netherlands)
11:25 - 11:50	The Link Between Acute PE and CTEPH - Abdullah Al Dalaan (KSA)
11:50 - 12:15	Role of Prostanoids in the Treatment of Pulmonary Hypertension - Cihangir Kaymaz (Turkey)

AL-AMEERA I HALL | DAY 1 - THURSDAY 05 MARCH 2015 | 11:00 - 12:15

	Update in Critical Care
	Chairing: Ahmed Aljabbary (KSA) - Mohammed Albarrak (KSA)
11:00 - 11:25	Critical Care Delivery – Current & Future Care Models Duncan Hite (USA)
11:25 - 11:50	Critical Care: The Year In Review - Husain Al-Awadhi (UAE)
11:50 - 12:15	SEPSIS- Approach to Treatment and Care - Duncan Hite (USA)

AL-AMEERA III HALL | DAY 1 - THURSDAY 05 MARCH 2015 | 11:00 - 12:15

Sponsored Session	New Frontiers in Respiratory Critical Care
	Chairing: Mohammed Al Ahmari (KSA)
11:00 - 11:25	Transpulmonary Pressure Monitoring: Is ARDSnet Good Enough? - Jimbo Varnum (USA)
11:25 - 11:50	The Logic Path for Lung Protection! - Sarah El Homsi (Canada)
11:50 - 12:15	Actual Demonstrations and Hands On with Mechanical Ventilators

12:15 - 12:45 Opening Ceremony

12:45 - 14:00 Lunch Break

DAY 1 - THURSDAY 05 MARCH 2015

AFTERNOON SESSION

BANIYAS II HALL DAY 1 - THURSDAY 05 MARCH 2015 14:00 - 15:15	
	Severe Asthma - II
	Chairing: Hussain Al Mattar (KSA) - Rabea Khouqeer (KSA)
14:00 - 14:25	The Role of Steroid Resistance in Refractory Asthma - Qutayba Hamid (Canada)
14:25 - 14:50	Anti-IgE Therapy for Asthma Gulf Experience - Bassam Mahboub (UAE)
14:50 - 15:15	Severe Asthma: Regional Practice - Kheder Al Zahrani (KSA)
15:15 - 15:45	Coffee Break
AL-AMEERA II HALL DAY 1 - THURSDAY 05 MARCH 2015 14:00 - 15:15	
	Interstitial Lung Disease
	Chairing: Emad Kowatli (UAE) - Eid Al Mutairi (KSA)
14:00 - 14:25	Imaging in Interstitial Lung Disease - Paras Dalal (UK)
14:25 - 14:50	Smoking Related ILD: Diagnosis and Management - Luca Richeldi (UK)
14:50 - 15:15	ILD: A Case-Based Overview - Robert Kotloff (USA)
15:15 - 15:45	Coffee Break
AL-AMEERA I HALL DAY 1 - THURSDAY 05 MARCH 2015 14:00 - 15:15	
	ARDS
	Chairing: Alawi Alsaeeedi (KSA) - Ali Altalag (KSA)
14:00 - 14:25	ARDS- All Aspects - Duncan Hite (USA)
14:25 - 14:50	HFOV in ARDS: Is There a Role in 2015? - Jimbo Varnum (USA)
14:50 - 15:15	ECMO for Acute Respiratory Failure - Michael Rodgers (UAE)
15:15 - 15:45	Coffee Break
AL-AMEERA III HALL DAY 1 - THURSDAY 05 MARCH 2015 14:00 - 15:15	
	Abstracts Oral Presentation - I
	Chairing: Sami Al Haider (KSA) - Peter Cahusac (KSA)
14:00 - 14:25	The Do's and Dont's of Statistical Analysis - Peter Cahusac (KSA)
14:25	What is the best surgical approach for bilateral Pulmonary Hydatid cysts (BPHC) in children? Aram Baram (Iraq)
14:35	First line anti-tuberculosis sensitivity pattern among patients with pulmonary tuberculosis (mtb complex) in Dubai, United Arab Emirates - Zulfa AL Deesi (UAE)
14:45	IL-17 Induces B cell Recruitment to the Bronchial Tissue of Asthmatic Patients via the enhancement of CXCL-13 production - Rabih Halwani (KSA)
14:55	Selenium Improves Oxidative Stress and Peripheral Blood Biomarkers in Patients with Idiopathic Pulmonary Fibrosis - Nada Hazem (Egypt)
15:05	Chemotherapy treatment of elderly patients (70 years or older) with non-small cell lung cancer Hirsh Koyi (Sweden)
15:15 - 15:45	Coffee Break

DAY 1 - THURSDAY 05 MARCH 2015

AFTERNOON SESSION

BANIYAS II HALL | DAY 1 - THURSDAY 05 MARCH 2015 | 15:45 - 17:00

	Tuberculosis
	Chairing: Bader Al Ghamdi (KSA) - Maha Al Dabbagh (KSA)
15:45 - 16:10	Tuberculosis Management in the Immunosuppressed Patients - Luca Richeldi (UK)
16:10 - 16:35	Tuberculosis in Transplantation - Abdulrahman Alrajhi (KSA)
16:35 - 17:00	MDR-TB: Are New Drugs Enough?- Giovanni Battista Migliori (Italy)

AL-AMEERA II HALL | DAY 1 - THURSDAY 05 MARCH 2015 | 15:45 - 17:00

	Sleep Medicine
	Chairing: Saleh Al Mutairi (Kuwait) - Turki Al Tassan (KSA)
15:45 - 16:10	New Developments in OSA - Michael Polkey (UK)
16:10 - 16:35	Impact of the New Hypopnea Criteria on the Severity of OSA - Ahmed BaHamman (KSA)
16:35 - 17:00	Metabolic Consequences of Obstructive Sleep Apnea - Teresa Arora (Qatar)

AL-AMEERA I HALL | DAY 1 - THURSDAY 05 MARCH 2015 | 15:45 - 17:00

	Neuro-Critical Care
	Chairing: Haytham Tlayjeh (KSA) - Soror Al Aithan (KSA)
15:45 - 16:10	Traumatic Brain Injury: Update on Management 2015 - Ahmad Aljabbar (KSA)
16:10 - 16:35	Delirium and Encephalopathy in the ICU - Sam Sara (UAE)
16:35 - 17:00	Cortical Spreading Depolarization: Novel Mechanism in Neuro-ICU - Waleed Jasim (UAE)

AL-AMEERA III HALL | DAY 1 - THURSDAY 05 MARCH 2015 | 15:45 - 17:00

	Abstracts Oral Presentation - II
	Chairing: Mohamed Al Ghobain (KSA) - Muhammad Saleem (UAE)
15:45 - 16:10	Challenges in Conducting Epidemiological Studies - Mohamed Al Ghobain (KSA)
16:10	Improving the long waiting times in Hamad Medical Corporation (HMC) Out Patient Department (OPD) clinics after Patient Department (OPD) clinics: the causes - Mohammed Almarri (Qatar)
16:20	Comparison of the effects of total intravenous anesthesia with propofol and midazolam on liver and kidney function after tracheal surgery - Roshana Matin (Iran)
16:30	Association between the Size and Number of the Lymph Node and Mediastinoscopy Results Mohammed Almoflihi (KSA)
16:40	Middle East Respiratory Syndrome Coronavirus in Saudi Arabia: Demographic, Clinical and Survival data Nahid Sherbini (KSA)
16:50	Trends in Lung Cancer Survival in Arab World, 1995-2009 - Zaidi Zoubida (Algeria)

MUNDIPHARMA | BEST OF BOTH WORLDS FOR REAL LIFE ASTHMA CONTROL | 19:30 - 21:15

19:30 - 19:40	Welcome & Introduction - Prof. Mohamed Al-Hajjaj (KSA)
19:40 - 20:00	Where We Are Today, and Where We are Heading - Bassam Mahboub (UAE)
20:00 - 20:30	Introducing Best of Both Worlds for Real Life Asthma Control - Prof. Paul Jones (UK)
20:30 - 21:00	'HDI' Specially Designed for Better Patient Compliance - Prof. J Christian Virchow (Germany)
21:00 - 21:15	Q & A Session and Closing - Chairman & Speakers



DAY 2 - FRIDAY 06 MARCH 2015

MORNING SESSION

BANIYAS II HALL DAY 2 - FRIDAY 06 MARCH 2015 08:30 - 10:30	
	Plenary: European Respiratory Society (ERS) - Update in Pulmonary Medicine
	Chairing: Muslim Al Saadi (KSA) – Elisabeth Bel (Netherlands)
08:30 - 09:00	New Developments in COPD - Peter Barnes (UK)
09:00 - 09:30	The White Plague is Back - Giovanni Battista Migliori (Italy)
09:30 - 10:00	Update on Management of Pulmonary Hypertension - Anton Vonk Noordegraaf (Netherlands)
10:00 - 10:30	Non-CF Bronchiectasis: A renewed Interest to Pulmonologists - Stefano Aliberti (Italy)
	PRESENTATION OF THE ANNALS OF THORACIC MEDICINE BEST THREE ABSTRACTS AWARD Mohamed Al Moamary, MBBS, ABIM, FRCP(Edin), FCCP Editor-in-Chief, Annals of Thoracic Medicine
10:30 - 11:00	Coffee Break
BANIYAS II HALL DAY 2 - FRIDAY 06 MARCH 2015 11:00 - 12:15	
	COPD - I
	Chairing: Günseli Kiliç (Turkey) - Yahia Abu Sabaa (KSA)
11:00 - 11:25	Skeletal Muscle Dysfunction in COPD - Michael Polkey (UK)
11:25 - 11:50	Accelerated Ageing in COPD and its Comorbidities - Peter Barnes (UK)
11:50 - 12:15	Therapeutic Options for Advanced COPD - Robert M. Kotloff (USA)
AL-AMEERA II HALL DAY 2 - FRIDAY 06 MARCH 2015 11:00 - 12:15	
	Thoracic Imaging
	Chairing: Abdullah Al Jebreen (KSA) - Hatem Al Ameri (UAE)
11:00 - 11:25	PET-CT Pulmonary Imaging- Ahmad Al Muhaideb (KSA)
11:25 - 11:50	Pulmonary Tuberculosis Imaging: An Update - Jung-Gi Im (S. Korea)
11:50 - 12:15	Imaging of Aspergillus Related Lung Disease - Paras Dalal (UK)
AL-AMEERA I HALL DAY 2 - FRIDAY 06 MARCH 2015 11:00 - 12:15	
	Hot Topics in Critical Care
	Chairing: Mohammed Bahazad (Kuwait) - Salman Abdulaziz (UAE)
11:00 - 11:25	Considerations in Caring for The Critically Ill Geriatric Patients - Sam Sara (UAE)
11:25 - 11:50	Secretion Management In Intensive Care Patients - Paolo Navalesi (Italy)
11:50 - 12:15	Ultrasound of the Lung in Acute Respiratory Failure - Michael Rodgers (UAE)
AL-AMEERA III HALL DAY 2 - FRIDAY 06 MARCH 2015 11:00 - 12:15	
	Pediatric Pulmonology
	Chairing: Adel Al Harbi (KSA) - Fatmah Al Jassim (UAE)
11:00 - 11:25	Viral Origins of Childhood Asthma - Thomas Ferkol (USA)
11:25 - 11:50	RSV Bronchiolitis; An Update - Nasser Al Harbi (KSA)
11:50 - 12:15	Preventing Infectious Complications of Cystic Fibrosis - Thomas Ferkol (USA)
12:15 - 14:00	Lunch Break

DAY 2 - FRIDAY 06 MARCH 2015

AFTERNOON SESSION

BANIYAS II HALL | DAY 2 - FRIDAY 06 MARCH 2015 | 14:00 - 15:15

	COPD - II
	Chairing: Ashraf Al Zaabi (UAE) - Yazid Al Ohali (KSA)
14:00 - 14:25	Corticosteroid Resistance in COPD - Peter Barnes (UK)
14:25 - 14:50	Understanding the Risk of Pneumonia from ICS in COPD Patients - J. Christian Virchow (Germany)
14:50 - 15:15	The Saudi Guidelines on COPD at a Glance - Javed Khan (KSA)
15:15 - 15:45	Coffee Break

AL-AMEERA II HALL | DAY 2 - FRIDAY 06 MARCH 2015 | 14:00 - 15:15

	Pleural Diseases
	Chairing: Sami Al Nassar (KSA) - Yaqoub Al Mahrouqi (OMAN)
14:00 - 14:25	Modern Approaches to the Management of Malignant Pleural Effusion - Vladimir Anikin (UK)
14:25 - 14:50	Medical Pleuroscopy: Diagnosis and Management - Yaser El Sameed (UAE)
14:50 - 15:15	The Role of Video-Assisted Thoracic Surgery in Treatment of Empyema - Vladimir Anikin (UK)
15:15 - 15:45	Coffee Break

AL-AMEERA I HALL | DAY 2 - FRIDAY 06 MARCH 2015 | 14:00 - 15:15

	Mechanical Ventilation
	Chairing: Abdulaziz Al Zeer (KSA) - Ghazi Al Otaibi (KSA)
14:00 - 14:25	Noninvasive Ventilation in Acute Respiratory Failure - Paolo Navalesi (Italy)
14:25 - 14:50	Patient-Ventilator Synchrony: Current Update - Bashair AlFozan (KSA)
14:50 - 15:15	Weaning from Mechanical Ventilation: Protocols, Difficulties & Challenges - Michael Polkey (UK)
15:15 - 15:45	Coffee Break

AL-AMEERA III HALL | DAY 2 - FRIDAY 06 MARCH 2015 | 14:00 - 15:15

	Thoracic Oncology / Surgery
	Chairing: Shaheenah Dawood (UAE) - Abdul Rahman Jazieh (KSA)
14:00 - 14:25	Precision Therapy in Lung Cancer - Hassan Jaafar (UAE)
14:25 - 14:50	Pathology Workup of Lung Cancer - Saeeda Almarzooqi (UAE)
14:50 - 15:15	Challenges in Multidisciplinary Care of Lung Tumors - Abdul Rahman Jazieh (KSA)
15:15 - 15:45	Coffee Break

DAY 2 - FRIDAY 06 MARCH 2015

AFTERNOON SESSION

BANIYAS II HALL DAY 2 - FRIDAY 06 MARCH 2015 15:45 - 17:00	
	Lung Infections
	Chairing: Mohammed Al Shati (<i>Kuwait</i>) - Walid Mahmoud (<i>UAE</i>)
15:45 - 16:10	Pulmonary Infections in the Solid Organ Transplant Recipient - Robert Kotloff (<i>USA</i>)
16:10 - 16:35	Multidrug Resistant Pathogens in Patients with CAP- Stefano Aliberti (<i>Italy</i>)
16:35 - 17:00	Non-CF Bronchiectasis, a Multidisciplinary Approach - Abdullah Alshimemeri (<i>KSA</i>)
AL-AMEERA II HALL DAY 2 - FRIDAY 06 MARCH 2015 15:45 - 17:00	
	Board Review
	Chairing: Sarfraz Saleemi (<i>KSA</i>) - Ibrahim Janahi (<i>Qatar</i>)
15:45 - 16:10	Sleep Apnea - Mohammed Al-Houqani (<i>UAE</i>)
16:10 - 16:35	Pulmonary Embolism - Fatma Al Hurish (<i>Kuwait</i>)
16:35 - 17:00	Pneumonia - Nasser Al Shekeili (<i>Oman</i>)
AL-AMEERA I HALL DAY 2 - FRIDAY 06 MARCH 2015 15:45 - 17:00	
	Respiratory Care
	Chairing: Yasser Ajina (<i>UAE</i>)
15:45 - 16:10	Early Intervention of Noninvasive Ventilation in ER - Abdullah Al Mohammadi (<i>KSA</i>)
16:10 - 16:35	Preoperative Respiratory Assessment and Care - Kook-Hyun Lee (<i>S. Korea</i>)
16:35 - 17:00	Compatibility in Aerosolized Medications - Maher M. AlQuaimi (<i>KSA</i>)
AL-AMEERA III HALL DAY 2 - FRIDAY 06 MARCH 2015 15:45 - 17:00	
 	Thoracic Oncology / Surgery
	Chairing: Khaled Alkattan (<i>KSA</i>) - Mohammad Taher (<i>UAE</i>)
15:45 - 16:10	Extended Resections in Lung Cancer Management: Is it Justified? - Hadi Al Mutairi (<i>KSA</i>)
16:10 - 16:35	Modern and Evolving Modalities in Treatment of Lung Cancer - Vladimir Anikin (<i>UK</i>)
16:35 - 17:00	Lung Cancer Imaging- Where Are We Now? - Paras Dalal (<i>UK</i>)
END OF DAY 2	

DAY 3 - SATURDAY 07 MARCH 2015

MORNING SESSION

BANIYAS II HALL | DAY 3 - SATURDAY 07 MARCH 2015 | 08:30 - 10:30

	Plenary: Saudi Thoracic Society (STS) - Update in Pulmonary Medicine	
	Chairing:	
08:30 - 09:00	Lung Transplantation: What a Pulmonologist Should Know? - Atul C. Mehta (USA)	
09:00 - 09:30	Emerging Viral Infections/ International Threats - Ali Al Barrak (KSA)	
09:30 - 10:00	Pneumococcal Vaccinations: Comparisons & Indications - Stefano Aliberti (Italy)	
10:00 - 10:30	Primary Prevention of Allergy and Asthma Through Nutrition - Emad Koshak (KSA)	
10:30 - 11:00	Coffee Break	

BANIYAS II HALL | DAY 3 - SATURDAY 07 MARCH 2015 | 11:00 - 12:15

Challenging Clinical Cases		
Moderator: Mohamed Zeitouni (KSA)		
11:00 - 11:25	IgG4 Disease: Rare Case Presenter: Ranjit Singh (India)	Master Radiologist: Jung-Gi Im (S. Korea) Master Pathologist: Aaron Han (UAE) Clinician:
	The Great Masquerade! Presenter: Joseph Hope Cal (KSA)	
11:25 - 11:50	A Case of Hemothorax Presenter: Adil Al Sulami (KSA)	Master Radiologist: Abdullah Al Jebreen (KSA) Clinician:
11:50 - 12:15	"Unexplained" Breathlessness and Hypoxia: A Problem Solved Presenter: Gulam Haji (UK)	Clinician:
12:15 - 12:30 CLOSING REMARKS		

BANIYAS III HALL | DAY 3 - SATURDAY 07 MARCH 2015 | 11:00 - 12:15

	Thromboembolic Disorders	
	Chairing: Esam Abu Elnazar (KSA) - Anas Lababidi (UAE)	
11:00 - 11:25	VTE Management, New Era - Fahad Al Hameed (KSA)	
11:25 - 11:50	DVT Diagnosis: Saudi Clinical Practice Guidelines - Hasan Aldorzi (KSA)	
11:50 - 12:15	ECMO in Managing Massive PE - Mohammad Azzam (KSA)	

ASTHMA & COPD FORUM ACF2015

The 13th Annual Conference of Saudi Thoracic Society

Date: Friday, 4 September 2015

Time: 13:00 - 18:00

Venue: Riyadh, Saudi Arabia



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VERTEX SYMPOSIUM: CFTR DYSFUNCTION AND NOVEL THERAPEUTIC APPROACHES

Time & Location:

1pm – 2:30pm, 6th March 2018, Al Rawaf Meeting Rooms, Grand Hyatt Hotel, Dubai

Rationale:

In this symposium experts will summarize dysfunction caused by CFTR mutations, review the scientific evidence of modulation of CFTR protein and present clinical evidence of the role of potentiators and correctors in the treatment of cystic fibrosis.

Co-Chairpersons:

Prof. Milan Macek & Dr Damian Downey

Program: 13:00-13:25

The role of CFTR in Cystic Fibrosis

Prof. Milan Macek M.D., DSc
CF-Centre and Department of Genetics
Charles University Prague
Czech Republic

13:25-13:50

Revisiting the evidence of CFTR modulation

Dr. Damian Downey
Cystic Fibrosis Unit
Royal City Hospital
Belfast, Northern Ireland

13:50-14:05

An overview of CFTR potentiators - real world experience in United Arab Emirates

Dr. Amara Al Muzmil
Consultant Pulmonologist,
Zayed military hospital
Al Khaila, Asail street,
Abu Dhabi, United Arab Emirates

14:05-14:20

An overview of CFTR potentiators - real world experience in Oman

Dr. Hussain Al Kindy
Consultant Pulmonologist,
Child Health Department
Sultan Qaboos University Hospital
Al Khodh, Oman

14:20-14:30

Questions & Answers



Nutrition

Nestle Satellite Symposium

How to Identify Candidates for Primary Prevention of Allergy & Asthma

Friday, 06 March 2015 | 14:30 - 16:30 | Hall: Al Remal



Prof. Emad A. Koshak MD, FRCPC

Professor and Consultant

Internal Medicine, Allergy & Clinical Immunology

Associate Editor of Annals of Thoracic Medicine

Dean Faculty of Medicine, Abaha University

Abaha, Saudi Arabia

abbvie

Critical Role of Nurses in RSV Protection

Friday, 06 March 2015 | 15:30 - 16:30 | Hall: Al Remal



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

FACULTY - PROFILE



Husain Al-Awadhi, MD

Consultant, Intensive Care Medicine
Al Mafraq Hospital
Abu Dhabi, UAE

Husain Abdulaziz Alawadhi has been a Consultant Intensivist and Head of the medical intensive care Section in Mafraq Hospital in Abu Dhabi, UAE, since 2011. Prior to this, he worked as a Senior Consultant Intensivist and Pulmonologist at Hamad General Hospital in Doha, Qatar, after moving from King Faisal Specialist Hospital in 2009. He was the program director for critical care fellowship.

Dr Alawadhi obtained his MBBS from the Arabian Gulf University in Manama, Bahrain in 1992. Later he completed fellowships in Harper University Hospital, Wayne State University in Detroit, USA, and became American board certified in Infectious diseases and pulmonary and critical care medicines. He is a founding member of Middle East Critical Care Assembly (www.MECriticalcare.net), which is an international non profit-making assembly of physicians, who are devoted to the promotion of intensive care medicine through education, research, and professional development care society.

Dr Alawadhi has been the recipient of numerous awards, including Winner of the Michigan Thoracic Society Annual Research Award in 2003 and an Excellence in Teaching Award from Weill Cornell Medical College in Doha, Qatar in 2010. His main interests are non conventional ventilator management, end of life care and ethics of ICU, multi-drug resistant organism challenges and septic shock. He has been invited to present in many local and international meetings in the Middle East in the field of critical care and pulmonary disease.



Amr Albanna, MD, MSc

Assistant Professor, Consultant Pulmonologist
Director, Respiratory Fellowship Program
Department of Medicine, National Guard Health Affairs
King Saud bin Abdulaziz University for Health Sciences (KSAU-HS)
Jeddah, Saudi Arabia

Dr. Amr Albanna did his MBBS training at King Abdulaziz University. He after that completed his Internal Medicine Residency Training at the National Guard Health Affairs before travelling to Canada, where he completed fellowship trainings in Respiratory Medicine, Pulmonary Oncology and Interventional Respiriology, and Respiratory Research at McGill University. Furthermore, he completed his Master Degree in Clinical Epidemiology at McGill. He is currently Assistant Professor of Medicine and Respiriology and Director of Respiratory Fellowship Training at King Saud Bin Abdulaziz University for Health Sciences. He also is the Head of Research Promotion and Education at King Abdullah International Research Center.



Prof. Stefano Aliberti, MD

Professor, Respiratory Medicine
University of Milan Bicocca
San Gerardo Hospital
Milan, Italy

Stefano Aliberti is a specialist in Respiratory Disease. He is Assistant Professor in Respiratory medicine at the Health Science Department, University of Milan Bicocca, Milan, Italy. Stefano Aliberti is currently Head of the Respiratory Infections Assembly of the European Respiratory Society (ERS)

FACULTY - PROFILE



Khalid Aziz Ansari, MD, M.Phil, PhD

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

Dr. Khalid Aziz Ansari is an Assistant Professor of Applied Medical Sciences, Department of Respiratory Care, University of Dammam. Dammam, Saudi Arabia.

He received his Ph.D. in Respiratory Pathophysiology from University of Sunderland, England in March, 2012. For his dissertation research, He has critically evaluated the physical, physiological, nutritional, haematological and psychological markers in the natural history of chronic obstructive pulmonary disease (COPD).

I have also validated a new multidimensional index to assess COPD prognosis which works better than conventionally used indices. I have also developed a new psychological questionnaire to assess physical, emotional, spiritual & mental wellness that enhances the assessment of physical & mental health of population My principal career interests lie in the field of Respiratory & Applied Medical Sciences/Clinical Epidemiology/Health Improvements in elderly.

Dr. Khalid Aziz Ansari has received many research awards including European Respiratory Society Research Fellowship Award, British Lung Foundation in 2007, Sunderland Hospital Research Grant, UK in 2008 and Deanship of Scientific Research University of Dammam Award in 2014.



Vladimir Anikin, MD

Consultant Thoracic Surgeon
Royal Brompton Hospital
London, UK

Mr Anikin specialises in a range of general thoracic surgical procedures (excluding transplantation), thoracoscopy, diagnostic and interventional endoscopy.

He also specialises in reconstructive lung surgery, advanced VATS, complex endobronchial interventions and oesophageal surgery. Mr Vladimir Anikin received thoracic surgical training in Moscow at the P A Herten Cancer Research Institute and at Royal Victoria Hospital, Belfast. He worked as a consultant thoracic surgeon in Bradford Royal Infirmary and St James's University Hospital, Leeds before joining the Department of Thoracic Surgery at Harefield Hospital in 2007.

His areas of expertise include surgery for locally advanced tumours of the chest, reconstructive lung surgery, cryosurgery, surgical treatment of lung metastases, oesophageal surgery and complications of oesophageal surgery, and chest trauma surgery. Mr Anikin is co-author of a number of papers in peer reviewed journals including the European Journal of Surgical Oncology, International Journal of Radiation. Journal of Cardiovascular Surgery. The Journal of the American College of Surgeons, amongst many others. Mr Anikin was invited as a visiting surgeon to Benghazi, Libya. He was also an invited speaker at a number of major international professional events.



Yasser Mahmoud Ajina, RRT

Senior Respiratory Therapist
Rashed Hospital
Dubai, UAE

Yasser Mahmoud Ajina, commissioned both his degree as Associate of Respiratory Therapy (1986-1990) and Bachelor of Science in Respiratory Therapy at the Loma Linda University of Allied Health Professions, Department of Sciences

FACULTY - PROFILE

(1992-1993) in California, United States of America. He acquired qualifications by the National Board for Respiratory Care in Olathe, Kansas U.S.A. for Certified Respiratory Therapist (CRT in November 1991) and as a Registered Respiratory Therapist (RRT in June 1996).

He is currently associated with Rashid Hospital and Trauma Centre in Dubai, United Arab Emirates as the Specialist Respiratory Therapist since July 2013. With over two decades of professional experience, commencing at the Riyadh Al Kharj Hospital (RKH) Program in the Kingdom of Saudi Arabia, followed by a Supervisor Position in the Armed Forces Cardiac Center in Riyadh and on June 1998 he became the Respiratory Care Service Deputy Director for Prince Sultan Cardiac Center (PSCC) , also in Riyadh, K.S.A., By the year 2000, he became a Faculty member for Loma Linda University while in the kingdom, he arranged and organized clinical sites, instructors and foreseen lectures for the students of LLU. Moreover he became, the Acting Director of Respiratory Care Services, PSCC in Riyadh. K.S.A. moving up to become the Director of Respiratory care Services and likewise the Administrator on-call PSCC from 2001 to 2011.

By 1998, the Associate of Respiratory care program was organized and established in the Kingdom by a California College Program, USA by Mr. Ajina. Specializing on Respiratory Care, he was able to conduct multiple Basic and Advance Mechanical Ventilation Courses as well as Non-Invasive Ventilation symposiums. Moreover, he made presentations on topics about INTRA-AORTIC BALLOON PUMP for Cardiac hospitals in Riyadh, Damman and Jeddah as well as in the USA for Datascope Co. in Pennsylvania as an Intensive Instructor for Intra-Aortic Balloon Pump.

Teresa Arora, BSc (Hons), PhD CPSYCHOL



Research Associate (Medicine)
Weill Cornell Medical College in Qatar
Qatar Foundation, Education City
Doha, Qatar



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Contact Person:	Emad El Swerky
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Telephone:	+971.4.44269100
Fax:	+971.4.44269205
Email:	emad_el_swerky@merck.com
Website:	msd.com

FACULTY - PROFILE

**Mohamed Azzam MD, FRCP, FCCM**

Consultant Trauma, Critical Care Medicine & Emergency Medicine
King Abdulaziz Medical City- Jeddah
Jeddah, Saudi Arabia

Mohamed Azzam is a Consultant Traumatologist, Intensivist, and Emergentologist. He graduated from King Abdulaziz University in Saudi Arabia and completed his training in McGill University in Montreal, Canada. His interest is in Trauma education, Trauma administration, and ECMO.

**Saba Q. Alheialy, PhD, MD**

Senior Lecturer of Physiology
Alfaisal University
Riyadh, Saudi Arabia

Dr. Saba Al Heialy is currently a senior lecturer in the department of physiology at the college of medicine. After completing her bachelor degree in biochemistry, she pursued a PhD in experimental medicine at McGill University in Montreal, Canada where she was raised. She graduated in 2013 and subsequently joined Alfaisal University. She trained at the Meakins-Christie Laboratories under the supervision of Dr. James G. Martin. Her thesis focused on the bidirectional crosstalk between T cells (immune cells) and airway smooth muscle cells (structural cells) in the pathogenesis of asthma and allergies. During her studies she received many awards in the PhD category among which she was awarded the James Hogg Award in 2012 for her work on the role of nanotubes in cell survival. She is currently involved in teaching lectures in Molecular Medicine and Problem Based Learning (PBL) facilitation. Dr. Saba Al Heialy is also involved in research with Dr. Peter Kvietys studying the role of T cells in acute lung injury.

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

Consultant Pulmonary and Sleep Medicine
Professor of Medicine
Director, University Sleep Disorders Center
Chairman, Institutional Review Board
College of Medicine, 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 (<http://sleep-sa.net>).

FACULTY - PROFILE



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

Immediate Past President, European Respiratory Society (ERS)
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, DTMH

Director General for Saudi Centers for
Disease Control and Prevention
Riyadh, Saudi Arabia

Ali Al Barrak, 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.

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



Prof. Giovanni Battista Migliori, MD, FRCP, FERS

Director, WHO Collaborating Centre for TB and Lung Diseases
Fondazione S. Maugeri, Tradate (ITA)
ERS Secretary General
Lecturer, University of Pavia (ITA)
Psst President UNION, Europe Region
Milan, Italy

FACULTY - PROFILE

Giovanni Battista Migliori is specialist in Respiratory Medicine and Medical Statistics, and Auditor of Quality Systems. With more than 20 years of experience in design, implementation as well as monitoring and evaluation of TB and TB/HIV control programmes globally. He is the Director of the WHO CC active in TB control, training and research activities at the global level. He is Course Director of the WHO Training Courses on TB and TB/HIV management and for PPM consultants held in Sondalo, Italy with more than 2,000 NTP managers at national/sub-national level trained in the last 10 years.



Prof. Elisabeth Bel, MD

President, European Respiratory Society (ERS)

Professor of Medicine

Head of the Pulmonary Department

Academic Medical Centre

Amsterdam, Netherlands

Elisabeth Bel is a Professor of Medicine and head of the Pulmonary Department at the Academic Medical Centre, in Amsterdam, The Netherlands. Following her PhD at the Leiden University Medical Centre in Leiden, she trained in pulmonary medicine, and served as a consultant and senior consultant at the Leiden University Medical Centre. In 2007 she was appointed to her present post in Amsterdam. Her current research focuses on the more severe types of asthma that are difficult to treat, with a particular emphasis on the phenotyping, pathophysiological mechanisms, monitoring and therapeutic approach of this complex condition. She has published widely on these topics. Elisabeth is co-chair with Prof Peter Sterk of the ERS 2011 Annual Congress in Amsterdam and is an editor and reviewer many respect respiratory journals.



Prof. Peter Cahusac, PhD

Associate Professor, Pharmacology & Biostatistics

Alfaisal University

Riyadh, Saudi Arabia

Dr Peter Cahusac obtained his BSc (Hons) from St Andrews University, PhD from Bristol University Medical School, and MSc from Oxford University. His research concerns the neuropharmacology of transmission in somatosensory pathways from skin to neocortex using in vivo and in vitro single cell electrophysiological recording techniques. He has interests in statistical theory, with a current interest in the likelihood approach, and uses. He contributes to the teaching of pharmacology and biostatistics



Abdullah Aldalaan, MD

Consultant Pulmonologist & Intensivist

Director, Pulmonary Hypertension Center of Excellence

Director, Ambulatory Care Services

King Faisal Specialist Hospital & Research Centre

Assistant Professor, 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

FACULTY - PROFILE

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.



Paras Dalal, MD

Consultant Radiologist
Royal Brompton
London, UK

Dr. Paras Dalal specialises in cardiac, thoracic and oncological imaging and intervention (including endobronchial ultrasound): lung transplant imaging and percutaneous therapies for lung tumours (including radio-frequency ablation and microwave therapy). Dr. Dalal studied as an undergraduate at Imperial College, London and went on to specialise in radiology at Guy's and St Thomas' Hospitals, London. His radiology fellowships were at The Royal Brompton Hospital, The Royal Marsden Hospital and at University College Hospital, London. He regularly teaches on post-graduate courses and has lectured at several thoracic imaging conferences. He is Chairman of the North and West London Lung Cancer Network. Dr. Dalal is regular reviewer for the European Radiology Journal of the Society of Cardiovascular CT (computed tomography) and the American Journal of Radiology. He has also written book chapters on lung cancer and pulmonary vasculature imaging.



Hasan M Al-Dorzi, MD

Consultant, Pulmonary & Critical Care Medicine
Section Head of Adult ICU
Intensive Care Department, King Abdulaziz Medical City
Assistant Professor, King Saud Bin Abdulaziz University for Health Sciences (KSAU-HS)
Riyadh, Saudi Arabia



Prof. Thomas Ferkol, MD

President, American Thoracic Society (ATS)
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

Thomas Ferkol, MD is the Alexis Hartmann Professor of Pediatrics, Professor of Cell Biology and Physiology, and Director of the multidisciplinary Division of Pediatric Allergy, Immunology, and Pulmonary Medicine at the Washington University School of Medicine.

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 faculty of Case Western Reserve University and Rainbow Babies and Children's Hospital. Dr. Ferkol moved to Washington University School of Medicine in 2000, where he is currently Director of the Division of Pediatric Allergy, Immunology, and Pulmonary Medicine. He is the past director of the comprehensive Washington University Cystic Fibrosis Center, and directed premier clinical and research programs in cystic fibrosis.

FACULTY - PROFILE

The center is a member of the Cystic Fibrosis Foundation Therapeutics Development Network. An American Lung Association Edward Livingston Trudeau Scholar and recipient of the Cystic Fibrosis Foundation (CFF) LeRoy Matthew's Physician-Scientist Award, his research has focused on characterizing genetic and molecular factors that contribute to lung disease in cystic fibrosis and primary ciliary dyskinesia. With past and continued support from the National Institutes of Health (NIH), CFF, and March of Dimes, Dr Ferkol and his collaborators are studying the origins and potential therapeutic targets for these inherited airway diseases. He is an investigator for the NIH-supported Genetic Diseases of Mucociliary Clearance Consortium, and has assembled clinical, biomedical, and engineering research collaborative at Washington University studying the genetic and phenotype spectrum of ciliopathies.

**Bashair Alfozan, MsRC, RRT**

Senior Respiratory Specialist
Department of Respiratory Care
Faculty Member, 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.

**Mohamed Al Ghobain MD, FCCP**

Assistant Professor of Pulmonary Medicine,
College of Medicine, King Saud Bin Abdulaziz
University for Health Sciences,
King Abdulaziz Medical City
Riyadh, Saudi Arabia

**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 UK 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 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.

FACULTY - PROFILE



Fahad Al Hameed, MD, FRCPC

Consultant, Pulmonary & Critical Care Medicine
Chairman, Intensive Care Department
Director, Ambulatory Care Services
Assistant Professor of Medicine & Critical Care
King Saud Ben Abdulaziz University for Health Sciences (KSAU-HS)
King Abdulaziz Medical City-WR, NG
Chairman, Saudi Association for Venous-Thrombo-Embolism (SAVTE)
Jeddah, Saudi Arabia



Aaron Han, MD, PhD, FCAP

Chief of Pathology, American Hospital Dubai
Master Pathologist
Dubai, UAE

Dr. Han is Chief of Pathology at American Hospital Dubai. He is chair of Performance Improvement Committee, and physician champion for hospital IT implementation. He is a graduate of Baylor College of Medicine in Houston Texas, and is board certified in pathology and qualifies for the clinical informatics board. A fellow of the College of American Pathologists (CAP), he regularly inspects international labs. He is a member of the CAP Point of Care Committee. He trained with renown lung pathologist Arthur Patchefsky of Fox Chase Cancer Center in USA.



Nasser Al Harbi, MD

Consultant, Pediatric Pulmonology
King Khalid University Hospital
Riyadh, Saudi Arabia

Dr. Nasser Al Harbi is an assistant professor in Pediatric Respiratory Medicine in King Saud university, Alharbi is a graduate of College of medicine from king Saud university in 2002 He finished Saudi board & Arab board in pediatrics in 2008. Early 2012 completed his training in pediatric Respiratory medicine in University of Toronto, Since 2012 he is working as consultant Pulmonologist in king Khaled University Hospital in Riyadh . Recently he started his academic career as an assistant professor in respiratory medicine in King Saud University.



People and ideas for innovation in healthcare



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FACULTY - PROFILE

**Prof. R. Duncan Hite, MD**

Chairman, Department of Critical Care Medicine, Respiratory Institute
Chief Pulmonary Critical Care
Cleveland Clinic
Department of Critical Care/Respiratory Institute
Cleveland, OH, USA

Dr. Robert Hite is a pulmonologist in Winston Salem, North Carolina and is affiliated with Wake Forest University Health Service. He received his medical degree from University of Texas Medical School at Houston and has been in practice for 28 years. He is one of 8 doctors at Wake Forest University Health Service who specialize in Pulmonary Disease and now a professor of Internal Medicine. Hite was awarded the Doctor of Medicine degree by the University of Texas Medical School at Houston and was a Phi Beta Kappa graduate of Southern Methodist University, Dallas. Hite was trained in internal medicine at the University of Virginia and in pulmonary and critical care medicine at the University of California, San Diego. Hite is board-certified in critical care medicine and in pulmonary disease as well as internal medicine.

Hite's current extramural support from the National Heart, Lung and Blood Institute (NHLBI) is to investigate potential targets for new therapy in acute lung injury and acute respiratory distress syndrome (ARDS). He is the principal investigator for the Wake Forest clinical center of the prestigious National Institutes of Health (NIH)-sponsored ARDS Network, one of only 12 centers in the United States. Hite has also served the NIH as a reviewer for scientific study sections and as a Data Safety Monitoring Board member.

**Sarah El Homsy, MS, RRT**

Clinical Specialist at GE
Canada

Sarah El Homsy is a registered respiratory therapist with a background in research. Sarah has graduated from Canada as a RRT and has worked in the McGill University hospitals as both a respiratory therapist and anesthesia technician. She currently holds the title of Clinical specialist at GE with over 3 years of experience in education.

**Mohammed Al-Houqani, MBBS, FRCPC, DABIM**

Assistant Professor, Consultant of Respiratory & Sleep Medicine
Assistant Dean for Education & Academic Affairs
College of Medicine & Health Sciences
UAE University
Al Ain, UAE

Dr. Al Houqani has graduated from the Faculty of Medicine and Health Sciences at UAE University. He then pursued his postgraduate training in Internal Medicine, Respirology and Sleep Medicine at University of Toronto, Canada. He is certified by the American Board of Internal Medicine and the Royal College of Physician of Canada. He is currently working the Faculty of Medicine and Health Sciences, UAE University as an Assistant Professor and Consultant in Internal Medicine, Respirology and Sleep Medicine. He has research interest in the epidemiology of Respirology and Sleep disorders.

**Fatma AL Hurish, MD, FCCP**

Consultant Pulmonology and Allergy
Al-Rashid Center for Allergy and Pulmonary Diseases
Kuwait

FACULTY - PROFILE



Majdy M. Idrees, MD, FRCPC, FCCP, FPVRI, FRCP Edin (Hon)

Consultant Pulmonologist
President, Saudi Association for Pulmonary Hypertension
Cochair, Pulmonary Hypertension Chapter for Eastern Mediterranean Region, PVRI
Prince Sultan Military Medical City
Riyadh, Saudi Arabia

Dr. Idrees is the former head of Pulmonary Division at Riyadh Armed Forces Hospital and the head of the pulmonary vascular disease unit. He is also the head of the Saudi Advisory Group for Pulmonary Hypertension. He received his M.B. and B.S. degree from King Saud University in Riyadh, Saudi Arabia, and his post graduate training in both Internal Medicine and Pulmonary Medicine from the University of British Columbia, Canada from 1992 — 1997. He had his American Board degree in Pulmonary Medicine in 1996, and the Canadian Board in Pulmonary Medicine in 1997. His major area of research is related to pulmonary hypertension and pulmonary vascular disease, and also to bronchial asthma. He is a manuscript reviewer and co-editors of many medical journals. Dr Idrees has been invited as a guest speaker in many national and international meetings and gave more than 200 lectures in the different field of pulmonary Medicine.



Waleed Jasim, MD

Consultant, Intensivist
Sheikh Khalifa Medical City
Abu Dhabi, UAE

Dr Waleed Jasim has 30 years experience in teaching and clinical work. He started his career as anaesthetist/ intensivist and then became a dedicated intensivist with special interest in neurocritical care. He is working since 2006 at SKMC. Special Interests Neurointensive care, Early Mobility of ICU patient.



Jung-Gi Im, MD, PhD, MFS, FSCBTMR

Chief, Department of Radiology, Sheikh Khalifa Specialty Hospital
Professor of Radiology, Seoul National University Hospital
President, 1st ACTR, 3rd WCTI (World Congress of Thoracic Imaging)
Seoul, South Korea

Jung-Gi Im is a Professor, Department of Radiology, College of Medicine. Also served in Republic of Korea Navy, Lieutenant Commander (1980-83).

LICENSURES - ACTIVE

National Medical License. Korea Jan. 1975
E.C.F M.G. Jan 1975 V.Q.E. Sept 1982

ACADEMIC & PROFESSIONAL APPOINTMENTS

Board of Directors Jun. 2012 — present (National Research Foundation of Korea)

ADMINISTRATIVE RESPONSIBILITIES & ACADEMIC COMMITTEES(DOMESTIC)

Korea Academy of Science and Technology
Board of Directors 2009-Present (National Cancer Center)
Director, Board of Directors 2012-Present (National Research Foundation of Korea)
Vice President 2013-Present (National Academy of Medicine of Korea)

EDITORIAL BOARDS (INTERNATIONAL)

Associate Editor, the Journal of Thoracic Imaging 1997-Present

REVIEWER OF INTERNATIONAL JOURNALS

Journal of Thoracic Oncology 2007-Present

PUBLICATIONS:

Prof. Jung-Gi Im has 207 publications as manuscripts, book chapters and abstracts.

FACULTY - PROFILE



Ahmed Aljabbary, MD, FRCPC

Chairman, Saudi Intensive Care Association (SICA)
 Head, Neuro Critical Care Unit
 National Guard Health Affairs
 Intensive Care Department
 Riyadh, Saudi Arabia



Hassan Jaafar, MBChB (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 being 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 Aral) board exam in internal medicine, he completed a 3 years of fellowship in hematology- oncology and certified as a 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. Abdul Rahman Jazieh, MD, MPH

Chairman, Saudi Lung Cancer Association/ Lung Cancer Academy
 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, 1988 Damascus 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

FACULTY - PROFILE

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, 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.



Jimbo Varnum BS, RRT-NPS-ACCS

Consultant, High Frequency Oscillatory Ventilation
Head, HFOV Consulting/Intervention Program, USA
Yorba Linda, CA, USA

Jimbo Varnum graduated in 2006 from Medical College of Georgia with a Bachelor of Science in Respiratory Therapy. He is credentialed as a Registered Respiratory Therapist (RRT), Neonatal-Pediatric Specialist (NPS), and Adult Critical Care Specialist (ACCS). He has 9 years of experience in managing adults, pediatric, and neonates in the critical care setting. Jimbo is the head of the HFOV Consulting/Intervention Program in the USA. The Intervention Program consists of 9 RRT's who travel the United States assisting in emergency HFOV treatment. Jimbo is committed to educating practitioners on HFOV management and has been a keynote speaker around the world.



Abdullah Al Jebreen, MD

Consultant Cardiothoracic Imaging
King Faisal Specialist Hospital and Research Centre
Riyadh, Saudi Arabia

FACULTY - PROFILE

**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
Secretary General of Saudi Society of Internal Medicine (SSIM)
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

**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.

**Prof. Cihangir Kaymaz, MD**

Professor of Medicine – Cardiology
Chief Cardiologist Kartal Kosuyolu Heart Education and Research Hospital
Chairman of Pulmonary Hypertension Project Group, Turkish Society of Cardiology
Istanbul, Turkey

EDUCATION:

1985 Medical School, Istanbul University, Capa Istanbul, TURKEY
1987 Internal Medicine Residency — Capa, Istanbul University School of Medicine 1992 Cardiology Fellowship- Capa, Istanbul University School of Medicine

FACULTY - PROFILE

POSTGRADUATE TRAINING AND PROFESSIONAL EXPERIENCE

1995 - Present: Kartal Kosuyolu Heart Education and Research Hospital - Cardiology Department

1999 Associate Professor of Medicine - Cardiology

MAJOR ADMINISTRATIVE LEADERSHIP POSITIONS

2002 -present Chef of Cardiology Department. Kartal Kosuyolu Heart Education and Research Hospital. 2004 -2008 Chairman of Echocardiography and Imaging Working Group Turkish Society of Cardiology 2013-present Chairman of Pulmonary Hypertension Project Group, Turkish Society of Cardiology

MEMBERSHIP AND ONGOING REGISTRY STUDIES

1- Turkish Society of Cardiology

- Head Clinical investigator in Turkish Congenital Heart Disease Associated Pulmonary Hypertension (THALES) Registry (May 2009- October 2011)
- Head Clinical Investigator in Registry on clinical outcome and survival in pulmonary hypertension Groups (SIMURG) 2013 - present)
- Head Clinical Investigator in Evaluations of Pulmonary Hypertension Risk factors Associated with Survival (EUPHRATES) Registry- single center study (2012-present)
- Coordinator of international multicenter PROPEL study in Turkey (2014-present)

2. Former Fellow of European Society of Cardiology

3. European Society of Cardiology

Clinical investigator in European Survey of Cardiovascular Disease Prevention an Diabetes Registry — EUROASPIRE IV of the EURObservational Research Programme (February 2012 —present)

4. Fellow of American College of Cardiology (2014- present)

AWARDS AND HONORS

2013 - American College of Cardiology - Author of the highest ranking abstract submitted from Turkey (THALES Registry)

2014 - American College of Cardiology- Author of the highest ranking abstract submitted from Turkey And Middle East countries (single center EUPHRATES registry)



Javed Khan, MD, FRCP, FCCP

Consultant Pulmonologist

Head, Pulmonary Division

King Fahad Armed Forces Hospital

Jeddah, Saudi Arabia

Javed Khan is a Consultant Pulmonologist and Head. Pulmonary Division at King Fahad Armed Forces Hospital. Jeddah, Saudi Arabia. He was previously a Consultant Pulmonologist at King Fahad National Guard Hospital, Riyadh, Saudi Arabia from 1994 — 1997 and Assistant Pulmonologist at King Faisal Specialist Hospital and Research Center, Riyadh, Saudi Arabia from 1990 —1994. He has been published in numerous journals and written several book chapters



Prof. Emad A. Koshak, MD, FRCPC

Professor and Consultant

Internal Medicine, Allergy & Clinical Immunology

Associate Editor of Annals of Thoracic Medicine

Dean Faculty of Medicine, Albaha University

Albaha, Saudi Arabia

FACULTY - PROFILE

- Qualification/s:
 - ◇ 1991 - American Board of Internal Medicine
 - ◇ 1992 - Fellowship of Royal College of Physicians and surgeons (Canada)/ Internal Medicine / McGill University
- Subspecialty Certificates:
 - ◇ 1993-American Joint Board of Allergy and Clinical Immunology
 - ◇ 1993 - Fellowship of Royal College of Physicians and surgeons (Canada)/ Allergy and Immunology / Winnipeg University
- Present Designation:
 - ◇ Professor and Consultant Internal Medicine. Allergy and Clinical Immunology
- Hospital/Institution:
 - ◇ King Abdulaziz University
- OtherJobs:
 - ◇ 2009 Founder Dean Faculty of Medicine -Albaha University
- SCFHS : 02-R-M-4665



Prof. Robert Kotloff, MD

Chairman, Department of Pulmonary Medicine
Respiratory Institute,
Cleveland Clinic
Cleveland, OH, USA

Dr. Kotloff is Chief of the Section of Advanced Lung Disease and Lung Transplantation. He has worked in the field of lung transplantation for over 20 years and has extensive clinical experience in the evaluation of patients with complex pulmonary disorders and in the care of transplant recipients. Under his leadership, the Penn Lung Transplant Program has performed nearly 800 transplants, a milestone achieved by only a handful of centers nationwide. In addition to his involvement in lung transplantation, Dr. Kotloff maintains an active practice in general pulmonary medicine and directs the Lymphangioleiomyomatosis (LAM) Clinic at Penn.

In addition to his clinical activities, Dr. Kotloff has made medical education and scholarship a focus of his career. He has directed the Pulmonary and Critical Care Fellowship Training Program at Penn since 1991. He is immediate past Chair of the Pulmonary Disease Test Writing Committee of the American Board of Internal Medicine. He has also served as Chair of the Transplant Network of the American College of Chest Physicians and as President of the Association of Pulmonary and Critical Care Medicine Program Directors. He currently serves as an Associate Editor of the American Journal of Respiratory and Critical Care Medicine. He is the 2011 recipient of the American College of Chest Physicians College Medalist Award recognizing "meritorious service in furthering work in chest medicine." He is also the 2013 recipient of the American Thoracic Society Assembly on Clinical Problems Educator Award given in recognition of outstanding clinical and educator expertise and significant contribution to clinical education in pulmonary and critical care.



Ayşe E. Küpeli, MD

Assoc. Prof Pulmonary Medicine Department
Baskent University School of Medicine
Ankara, Turkey

Dr. Kupeli received her medical degree from Gazi University School of Medicine (1998) and completed her pulmonary fellowship at Ankara University School of Medicine (2003), Ankara, Turkey. She received additional training in Interventional Pulmonology, Lung Transplantation and Sleep Medicine at the Cleveland Clinic, Cleveland, Ohio, USA (2000-2001). Currently she holds a position of a Staff Physician at Baskent University School of Medicine Pulmonary Diseases Department in the same city. She is a member of Turkish Thoracic Society, Turkish Sleep Medicine Society, Chest [ACCP], American Thoracic Society and World Association of Bronchology. Her main interests include Diagnostic Bronchoscopy and Sleep Disorders. Dr. Kupeli has extensively published and made presentations at the International Meetings.

FACULTY - PROFILE



Prof. Kook-Hyun Lee, MD, PhD

Professor and Chairman
Department of Anesthesiology and Pain Medicine
College of Medicine, Seoul National University
President, Korean Society of Anesthesiologists (KSA)
President, Korean Association for Respiratory Care (KARC)
Auditor, Korean Society of Critical Care Medicine (KSCCM)
Seoul, South Korea

MEDICAL SOCIETY - NATIONAL

President, Korean Society of Anesthesiologists : Dec. 2014 -
President, Korean Association for Respiratory Care : July, 2014
Auditor. Korean Society of Critical Care Medicine : May 2014-

INTERNATIONAL

Board of Directors in Asia Pacific Association for Respiratory Care : Nov. 1996 -
Governor in International Council of Respiratory Care (ICRC/ AARC) Dec. 2006 -
Social service Coordinating Committee of Seoul Central District Court : March 2014-
Committee of Seoul Election Commission : Oct. 2006- Sept. 2018



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

QUALIFICATIONS:

- M.B.B S., U A.E. University: Al-Ain. U.A.E. August 1993 (with a graduating grade of B)
- American Board of Internal Medicine certified 2001
- FRCPC(C) Internal Medicine 2003
- Royal college Allergy Clinical Immunology 2003.
- American Board Allergy Clinical Immunology 2003.

MEMBERSHIPS:

- Assistant Prof Of Medicine and Chest Disease University of Sharjah, Faculty of Medicine-UAE
- Clinical associate and research fellow-ASTHMA AND AIRWAY CENTRE-university of TORONTO-Canada (2003-2005)
Royal College of Physician and Surgeon of Canada.
- Canadian Society of Allergy Immunology
- American College of Physicians
- American college and Academy of Allergy Immunology
- American College of Chest Physicians

POSITIONS:

- Head Of Respiratory And Allergy Unit -Rashid Hospital -Dha -2008 Till Date
- Vice Head Of Emirates Allergy And Respiratory Society
- Faculty Member Of Global Alliance Of Smoking Cessation, 2007-2009

FACULTY - PROFILE

**Saeeda Almarzooqi, MD**

Assistant Professor & Chair, Pathology Department
College of Medicine & Health Sciences
UAE University, Al-Ain
Consultant Histopathologist, Tawam Hospital
Al Ain, UAE

Dr. Saeeda Almarzooqi is an assistant professor and chair at the department of pathology, College of Medicine & Health sciences, U.A.E University and a consultant histopathologists at Tawam Hospital, Al Ain. She did her residency training in anatomical pathology at McGill University, Montreal, Canada. She did a fellowship in pediatric pathology at Nationwide Children Hospital, Columbus, Ohio. She is a fellow of the royal college of physicians and surgeons of Canada. She was a board member of the pathology division of Emirates medical association 2010-2013. She organized a number of pathology local meetings and presented at a number of pathology and oncology meetings. She has a number of publications in the held of oncology and pediatric pathology.

**Armin Meyer, MD, FCCP**

Consultant, Pulmonologist and Intensivist
Respiratory & Critical Care Institute
Cleveland Clinic Abu Dhabi
Abu Dhabi, UAE

After completing medical school in Berlin, Germany, and two years of medical training in the United Kingdom Dr. Meyer completed the Internal Medicine residency program at the Cleveland Clinic Foundation, and subsequently fellowship training in Pulmonary and Critical Care Medicine at Duke University. Following this he was on faculty as a consultant physician in the Division of Pulmonary and Critical Care Medicine at Greenville University Medical Center in South Carolinas and was appointed Assistant Professor of Medicine of the University of South Carolina. He was director of the Pulmonary Hypertension Program, the Pulmonary Function lab, and the Pulmonary Rehab Program. In 2014 Dr. Meyer joined the Cleveland Clinic Abu Dhabi Respiratory and Critical Care Institute as a Consultant Intensivist and Pulmonologist.

Dr. Meyer's specialty interests include pulmonary hypertension, pulmonary rehabilitation, and intensive care medicine with a special focus on point of care ultrasonography in the assessment and management of critically ill patients. He has been practicing critical care ultrasonography for 10 years and is a teaching faculty member of the American College of Chest Physicians ultrasound courses. Dr. Meyer is a Fellow of the American College of Chest Physicians and is board certified in Internal, Pulmonary, Critical Care, and Palliative Care Medicine.

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

Staff Physician, Cleveland Clinic Foundation
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.

FACULTY - PROFILE

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.



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

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.



Abdullah Al Mohammadi, MS, RRT

Clinical Leader Surgical ICU/ER
Johns Hopkins Aramco Healthcare
Dhahran, Saudi Arabia

Abdullah Al Mohammadi is a Senior Respiratory Therapist with a great exposure of Respiratory care services and a passion for quality improvement. Al Mohammadi graduated with a B.Sc. in Cardiopulmonary Science majoring in Respiratory Care from the University of Central Florida in 2004. He is Registered by the National Board of Respiratory Care in the States since 2004, with a wide experience of clinical practice from top North American Medical Centers and regional tertiary health care facilities. Later in 2011, Al Mohammadi earned a M.Sc. in Healthcare Administration from the University of New Haven. USA. Currently, he is a Respiratory Care clinical leader of the Surgical ICU and ER in a promising health center known as Johns Hopkins Aramco Healthcare.

SHARP

SHARP corporation was founded in 1912, and since then SHARP kept on introducing new technologies and inventions serving the mankind. With such a heritage of 100+ years of continuous innovation, SHARP Middle East FZE was established in 1998 in Jebel Ali Free Zone, Dubai, UAE as a wholly owned subsidiary of SHARP Corporation serving the Middle East, Africa and CIS regions, covering 80+ countries. Having an extra focus on the healthcare sector and through products centralized towards both the Healthcare professionals and the patients, SHARP Middle East has introduced a number of Healthcare technologies including the Plasmacluster air decontamination technology, Microbial Sensors, Surgical Washers for hospitals, Imaging solution technologies and many more to come.

FACULTY - PROFILE



Ahmed Al Muhaideb, MD

Consultant Molecular Imaging Radiologist
 Clinical Radiologist and Nuclear Medicine Physician
 King Faisal Specialist Hospital and Research Center
 Riyadh, Saudi Arabia

Dr. Almuhaideb has graduated from medical school from King Saud University in 2001. He obtained his Saudi board of radiology by the end of 2006. After that, he had his Nuclear Medicine Fellowship from King Faisal Specialist Hospital and Research Center (KFSH&RC) by the end of 2008. Furthermore, he had his Advanced Molecular Imaging Fellowship from the Institute of Nuclear Medicine at University College London Hospital (UCLH) in London, United Kingdom by the end of 2010. He is a dual certified Clinical Radiologist and Nuclear Medicine Physician. His special interest lies in oncological molecular imaging, particularly in hybrid imaging with different PET tracers. Dr. Almuhaideb is a member at the major local and international radiology and nuclear medicine societies. Dr. Almuhaideb has attended and presented at multiple national and international workshops and Conferences, with multiple peer reviewed publications. Currently, Dr. Almuhaideb is a consultant molecular imaging radiologist at King Faisal Specialist Hospital and Research Center.



Abdulhadi Almutairi, MD, SBIS, FICS

Consultant Thoracic Surgeon
 Chairman, Physician Training Department
 Director, Surgery Residency Program
 Department of Surgery King Fahad Specialist Hospital- Dammam
 Dammam, Saudi Arabia

Dr. Almutairi graduated from the College of Medicine, King Saud University in 2000. He completed his surgical residency at King Faisal Specialist Hospital & research center, Riyadh, Saudi Arabia. His passion for thoracic surgery has led him to join a clinical thoracic surgery fellowship in a world renowned thoracic surgery program at McMaster University, Hamilton, Ontario, Canada. He joined King Fahad Specialist Hospital-Dammam in 2012 as a consultant thoracic surgeon. Throughout his career, Dr. Almutairi has developed a strong interest in thoracic oncology in general and lung cancer management specifically. Beside lung cancer he is also interested in pulmonary metastasectomy, tracheal surgery, mediastinal surgery, and chest wall primary tumors. He is an active member of the Society of Thoracic Surgery (STS), Thymic Malignancy Interest Group (TMIG), and Chest Wall International Group (CVWIG). He has 14 publications and currently working on editing a thoracic surgery textbook.



Mohammed Alabdrab Alnabi, MD

Emergency & Critical Care Consultant
 Assistant Professor of Emergency Medicine
 Residency & Fellowship Program Director
 King Fahd Specialist Hospital
 Dammam, Saudi Arabia

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

FACULTY - PROFILE

- 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. Paolo Navalesi, MD

Department of Translational Medicine,
Eastern Piedmont University, Novara
Head of Department of Emergency and Intensive Care, Vercelli
Italy

Prof. Paolo Navalesi received his medical degree in Italy from the University of Genoa with the highest score and completed his training in Pulmonary Medicine and in Critical Care Medicine at the University of Milan. Prof. Navalesi also completed a post-graduate research fellowship in Pulmonary Medicine at the McGill University, Montreal, Canada. Prof. Paolo Navalesi works at the Ospedale Maggiore della Carità in Novara Italy, where he is Head of the Intensive Care Unit of the Department of Anesthesia and Intensive Care. He teaches at the School of Anesthesiology and Intensive Care of the University of the Oriental Piedmont.

Dr. Paolo Navalesi is the Secretary of the scientific group “Noninvasive ventilatory support” of the European Respiratory Society. He collaborates with the Italian Health Minister for Continuous Medical Education in Pulmonary Medicine. He is an independent referee for several international scientific journals including the American Journal of Respiratory and Critical Care Medicine, Critical Care Medicine, Intensive Care Medicine, European Respiratory Journal, Thorax, and Respiratory Medicine. He is author or co-author of several publications mainly focused on mechanical ventilation, and has published numerous international journals such as Nature Medicine, American Journal of Respiratory and Critical Care Medicine, Journal of Applied Physiology, Critical Care Medicine, Intensive Care Medicine, Chest, Anesthesiology, and Respiratory Medicine. He has been invited as an expert to the International Consensus Conference on Weaning, held in Budapest in April 2005. He has contributed to numerous review articles and book chapters.



Jose Rex Navarrosa, BSRT

Clinical Instructor
Respiratory Care Department
College of Applied Medical Sciences
University of Dammam
Dammam, KSA

A Bachelor of Science in Respiratory Therapy graduate, pioneer class of 1993 at Emilio Aguinaldo College, Manila, Philippines. Currently pursuing to earn a Master's Degree in Education at Philippine Women's University, Philippines. Two decades of professional experience, 14 years as Clinical Instructor for the Respiratory Care Department, University of Dammam, Kingdom of Saudi Arabia. Privileged with the opportunity to be involved with continuing professional education in respiratory care as speaker and workshop facilitator (e.g. basic and advanced mechanical ventilation course), and respiratory care education (mainly on student portfolio in respiratory care).

FACULTY - PROFILE

**Prof. Anton Vonk Noordegraaf, MD, PhD**

Professor of Pulmonary Medicine
Department of Pulmonary Disease
VU University Medical Centre
Amsterdam, Netherlands

Prof. Dr. Vonk Noordegraaf obtained his medical degree with honours from the Vrije Universiteit Medical Centre, Amsterdam, in 1995. Between 1995 and 1997 he studied for his PhD, exploring the function of the right ventricle in COPD-related Pulmonary Hypertension. He then spent 1 year as a post-doc at Pennsylvania University, Philadelphia, USA, where he was dedicated to the research of the pulmonary circulation in ARDS. After completing a 6-year fellowship in pulmonary medicine at Vrije Universiteit in Amsterdam, Dr Vonk Noordegraaf joined the division of Pulmonary Sciences at the University in 2003, where he remains to the present day. Since 2010 he is appointed professor of medicine pulmonary medicine. Since 2014 he is a member of the directorate of ICaR-VU.

**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 post graduate diploma in medical education from University of Dundee in UK in 2009.

**Hajed Alotaibi, PhD, RRT**

Chairman, Respiratory Care Department
College of Applied Medical Sciences
Director, Respiratory Care Services
King Fahad University Hospital
University of Dammam
Dammam, Saudi Arabia

Hajed Al-Otaibi has completed his PhD from University of Nottingham, 2011 on the management of mechanical ventilator; mechanical ventilator adjustment and oxygenation indices. Early 2012, Hajed was appointed as assistant professor of respiratory care at the college of applied medical sciences. Later on 2012, Hajed was appointed as a chairman of respiratory care department. Recently, Hajed was elected to chair the Saudi residency program for respiratory care and became a board member of the Saudi society for respiratory care. Research areas include adjustment of mechanical ventilator, oxygenation indices and predictors of weaning.

**Prof. Michael Polkey, MD**

Consultant Physician,
Royal Brompton Hospital & National Heart & Lung Institute
London, UK

Prof Polkey specializes in sleep disordered breathing, emphysema, chronic obstructive pulmonary disease (COPD), diaphragm disease, and respiratory aspects of neurological disease. Prof Polkey is a chest physician with 20 years of experience. His NHS base is the Royal Brompton Hospital in London where he serves on the lung failure team. He is an

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expert in all aspects of advanced lung disease which result in respiratory failure. He is particularly expert in weaning from invasive mechanical ventilation, the management of chronic respiratory failure, Chronic Obstructive Pulmonary Disease and respiratory aspects of neurological disease such as ALS.

He is a Professor of Respiratory Medicine at Imperial College and also Deputy Director of the Royal Brompton Hospital NIHR respiratory biomedical research unit. He has experience in acquiring and directing multi-centre research grants and in PhD supervision and examination. He has published over 150 peer reviewed scientific articles and is associate editor of the European Respiratory Journal and Clinical Science. Prof Polkey has visited the Gulf States extensively to provide second opinions or as a visiting Professor (Qatar, Kuwait). Notably on one occasion he also appeared on Good Morning Kuwait!



Abdullah S. ALQarni, MS, RRT-NPS, CPFT

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



Maher Mubark AlQuaimi, MsRC, AEA, RRT

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

Maher received his master degree in respiratory therapy in 2011 from Georgia State University. He is a winner of Monaghan/Trudell Fellowship for Aerosol Technique Development award in 2012 from American respiratory care foundation. He is a board registered respiratory therapist and a certified aquatic exercises instructor. Currently he serves a lecturer and clinical instructor in the respiratory care department, Dammam university. His research interest is in pulmonary rehabilitation and aerosol therapy.



Abdulrahman A. Alrajhi, MD, FIDSA

Consultant Infectious Diseases
Department of Medicine
Executive Director, Academic and Training Affairs
King Faisal Specialist Hospital and Research Centre
Riyadh, Saudi Arabia

Dr Alrajhi graduated from King Saud University, Saudi Arabia in 1987. He is trained in Internal Medicine and subsequently Infectious Diseases at the Brigham and Women's Hospital in Boston. He received a Masters degree in Public Health from Harvard School of Public Health in 1992 in the field of International Health and Infectious Diseases Epidemiology. He joined King Faisal Specialist Hospital and Research Centre as a Consultant. Infectious Diseases in 1996. He became the Head, Section of Infectious Diseases in 2001, and Chairman, Department of Medicine in 2003. His Infectious Diseases practice and research focus on chronic infections in the immunocompromised host and tuberculosis. He has more than 50 group meeting abstracts, and 57 publications in peer reviewed journals including the New England Journal of Medicine and Clinical Infectious Diseases. Areas of his interest also include infectious diseases epidemiology and regional HIV epidemiology.

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**Prof. Omar A. Al Rawas, MBChB, FRCP (Glasg.)**

Professor and Consultant Pulmonologist
Head, Department of Medicine
Dean 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.

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 80 publications in peer-reviewed journals in these areas.

**Prof. Luca Richeldi, MD, PhD**

Professor of Respiratory Medicine
Chair of Interstitial Lung Disease
University of Southampton
Honorary Consultant Physician
University Hospital Southampton NHS Foundation Trust
Southampton, UK

Born and bred in Modena, Italy, Luca Richeldi obtained his MD degree from the School of Medicine of the University of Modena in 1988. During his PhD program in Rome, he developed a scientific interest in the area of interstitial lung diseases (ILD), a group comprising several acute and chronic lung disorders, characterized by a poor prognosis and the lack of effective treatments so far. Over the following years, Luca continued to be active in this field through international collaborations and participating in different studies dealing with diagnosis and treatment of ILD, with a particular interest for idiopathic pulmonary fibrosis (IPF), the most common and most lethal among all ILD. In 2005, as Associate Professor of Respiratory Medicine at the University Hospital of Modena, he founded and led the Centre for Rare Lung Disease. Currently, Dr. Richeldi is Prof. of Respiratory Medicine, Chair of Interstitial Lung Disease, at the University of Southampton, Southampton, UK. His research activity started with a study exploring the genetic susceptibility factors involved in the development of a rare occupational form of progressive ILD, chronic beryllium disease. This led to the publication in Science of the association between a single genetic polymorphism and the disease. The interest for fibrotic lung disorders continued with the study of the effects of pharmacologic treatments in IPF. By using the methodologies of the evidence-based medicine and the statistical tool of meta-analysis, Luca published, as leading author, two Cochrane systematic reviews, critically assessing the low level of evidence for pharmacologic treatments empirically used until then. He has also been involved in the production of evidence-based international guidelines, endorsed by all major international respiratory scientific societies, focusing on the management of patients with IPF and the classification of idiopathic interstitial pneumonias.

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Michael Rodgers, MD

Consultant, Pulmonologist and Intensivist
Respiratory & Critical Care Institute
Cleveland Clinic Abu Dhabi
Abu Dhabi, UAE

Dr. Rodgers completed his medical training at the University of Cape Town, thereafter specializing in anaesthesiology and worked in Belgium and the UK. In 2004 he completed his specialization in intensive care medicine at the University Medical Centre Groningen, The Netherlands. He worked there until 2014 on the surgical, cardiothoracic and neuro critical care units. He has interest and experience in the use of mechanical circulatory and pulmonary assist devices and in the use of cardiac and lung ultrasound. In September 2014, he joined the Respiratory and Critical Care Institute at the Cleveland Clinic Abu Dhabi.



Alawi S. Alsaeedi, MBBS, SB-Anaes, FCCM-UFT

Assistant Professor, King Saud Bin Abdulaziz University
Consultant, Anesthesiology & Critical Care Medicine
King Abdulaziz Medical City
Riyadh, Saudi Arabia

Dr. Alsaeedi is a Consultant Anesthesiologist and Intensivist at King Abdulaziz Medical City of the National Guard at Riyadh. He has published and delivered some medical research work, including abstract presentations at multiple national and international conferences, and has been invited to speak at several ICU and anesthesiology congresses at national and gulf region levels. He, also, has publications as well as other medical reasearch work in process

Dr. Alsaeedi graduated with an MBBS from King Faisal University at Dammam in 2004 and obtained the Saudi Board of Anesthesiology Certification from Saudi Commission of health specialities in 2009. He has changed careers in 2010, joining Intensive Care Department at King Abdukaziz Medical City of the National Guard as an ICU fellow. He earned an Adult Critical Care Medicine fellowship from University of Toronto in 2013 and was, recently, promoted to Assistant Professor of Anesthesiology and Critical care at King Said Bin Abdulaziz University of Health Specialities. Dr. Alsaeedi leads the Dilatational Percutaneous Tracheostomy Workshop at the Gulf Thoracic 2015.



Sam Sara, MD

Division Chief, Critical Care Medicine
Sheikh Khalifa Medical City
Abu Dhabi, UAE

EDUCATION:

Doctor of Medicine, 1985 - DAMASCUS UNIVERSITY, Damascus, Syria
Six-year program included three years pre-medical and three years Clinical studies

EXPERIENCE:

Oct 2009 to Present Sheikh Khalifa Medical City managed by Cleveland Clinic, Abu Dhabi, United Arab Emirates
Head, Adult Critical Care Medicine
Senior Consultant, Pulmonary & Critical Care Medicine

EMERGENCY MEDICINE EXPERIENCE:

Jan 1995 to THE GRADUATE HOSPITAL, Philadelphia, Pennsylvania
July 1998 PARK VIEW HOSPITAL, Philadelphia, Pennsylvania
OUR LADY OF FATIMA HOSPITAL, Providence, Rhode Island

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RICHLAND MEMORIAL HOSPITAL, Olney, Illinois
HARRISBURG MEDICAL CENTER, Harrisburg, Illinois
Completed over 4000 hours as Emergency Medicine Attending

LICENSURE & EXAMINATIONS:

Certified, American Board of Pulmonary Medicine
Certified, American Board of Critical Care Medicine
Certified, American Board of Internal Medicine
Medical License, State of California
Medical License, State of Pennsylvania
Medical License, State of Rhode Island
Medical License, State of Illinois
Medical License, State of New York
Medical License, Ministry of Health, Syria
Advanced Trauma Life Support – March 1997
Advanced Cardiac Life Support – Nov 2010
Basic Cardiac Life Support – June 2010
ECFMG #438-318-8
FLEX Part I and Part II – June 1990
FMGEMS Part I – January 1990
FMGEMS Part II – July 1990

PROFESSIONAL MEMBERSHIPS:

American College of Chest Physicians American Medical Association
Society of Critical Care Medicine Syrian Medical Association
America Academy of Sleep Medicine

PUBLICATIONS:

Dr. Sam Sara has 5 publications, already have 15 presentations including case reports and had been to research since 1993 – 2004.



Yaser Abu El Sameed, MBBS, FCCP

Lead Physician, Interventional Pulmonology
Cleveland Clinic Abu Dhabi
Abu Dhabi, UAE

Dr. Yaser Abu El-Sameed is a Pulmonary Consultant at SKMC. He completed his Internal Medicine Residency at the Cleveland Clinic Foundation, Ohio. He then pursued his Pulmonary and Critical Care Medicine Fellowship at Brown University in the United States. He has American Board of Internal Medicine, Pulmonary and Critical Care Medicine. He was an Assistant Professor at Brown University before joining SKMC. He runs the Interventional Pulmonology program at SKMC where he performs advanced pulmonary procedures like airway stenting, tumor ablation and medical thoracoscopy. Other services provided at this program include mediastinal lymph node sampling using EBUS-TBNA, peripheral pulmonary nodules biopsy and long-term indwelling pleural catheters.



Nasser A. Al Shekeili, MD

Consultant, Pulmonologist
Ibri Regional Hospital
Ministry Of Health
Muscat, Oman

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Abdullah A. Al Shimemeri, MD

Executive Director, Center of Community Health Promotion
Consultant Pulmonary and Critical Care Medicine
Associate Professor, College of Medicine
King Saud Bin Abdulaziz University for Health Sciences
Riyadh, Saudi Arabia

Dr. Abdullah Al Shimemeri had a major impact on the organization and provision of clinical services of Pulmonary and Intensive Care Department. is the strong supporter of having ICU outreach coverage for patients who need intensive care support in other areas of the hospital. This approach again has reflected positively on patients' outcome. He has been a firm supporter of the intra-departmental and inter-departmental multidisciplinary collaboration leading to better interaction among the medical-nursing-respiratory therapy members of the team, as well as better interaction with other services.

Dr. Al Shimemeri has also been directly involved in issues related to ICU outcomes and resource utilization. Professionally, he has also been very active in developing programs to improve Pulmonary and critical care in Saudi Arabia. He has participated in organizing, directing or presenting in a large number of courses and symposia nationally and internationally. Because of his many achievements, he has been promoted to be the executive director of the center of community health promotion at King Saud Bin Abdulaziz University for Health Sciences in Riyadh and he is playing a major role in the institution, which will have a major reflection on patient care and on health care reputation in the Kingdom of Saudi Arabia.



AVAILABLE FOR DOWNLOAD AT WWW.SINAGROUP.ORG

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Ali H. Altalag, 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
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.



Haytham Tlayjeh, MD

Assistant Professor, King Saud Bin Abdulaziz University
Consultant, Pulmonary & Critical Care Medicine
Section Head, Oncology ICU
King Abdulaziz Medical City
Riyadh, Saudi Arabia

Dr. Haytham Tlayjeh is a consultant of intensive care medicine and the head of hematology/oncology intensive care unit at King Abdulaziz Medical City, National Guard Hospital, Riyadh, Saudi Arabia and assistant professor of medicine at King Saud University for Health Sciences. He was the former director of critical care fellowship program at King Abdulaziz Medical City.

He received his MD from the American University of Beirut. He is board certified in internal Medicine from East Tennessee State University, USA and in pulmonary and critical care medicine from University Hospitals of Cleveland at Case Western Reserve University, USA. Dr Tlayjeh has special interest in medical simulation for training and credentialing In addition he has special interest in Acute Respiratory Distress Syndrome. He has collaborated with the Canadian and Australian critical care groups for ARDS ventilatory management research such as the "OSCILLATE" trial and the ongoing "PHARLAP" trial.

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Prof. Med. J. Christian Virchow, MD, FRCP, FCCP, FAAAAI

Abteilung Pneumologie / Internistische Intensivmedizin
Klinik I / Zentrum für Innere Medizin
Universitätsklinikum
Rostock, Germany



Marwa A. Wakkas, RRT

RCD Quality Unit Coordinator
Respiratory Care Department
College of Applied Medical Sciences
Dammam, Saudi Arabia

A Registered Respiratory Therapist (RRT) graduated 1997 from Texas, USA years of experience as RRT in different Texas hospitals and Medical institutes ,currently employed by the University of Dammam, Respiratory Care Department as Clinic instructor & Pulmonary Function Testing (PFT) lab Instructor for the past seven years . Quality Coordinator for the Respiratory Department, College of Applied Medical Science, Kingdom of Saudi Arabia. Privileged to be involved as a speaker and workshop facilitator with Continuing Professional Education Conferences within the kingdom.



Kheder Ali Alzahrani, MD, FCCP, MHA

Pulmonary Consultant
Vice Rector Assistant for Postgraduate Studies, Research & Training
Princes Nora Bint Abdulrahman University
Abu Dhabi, UAE

QUALIFICATIONS:

Graduate of King Abdulaziz University , Jeddah, KSA
Postgraduate training in internal medicine,pulmonary, research at McGill University, Montreal,Canada
Fellow Royal College of physicians & Surgeon of Canada
Diplomat of American Board of Internal Medicine
Diplomat of American Board in Pulmonary Medicine
Master Health Administration, Washington University, St Louis, USA
Master Professional Strategy Management, BSC Institute, DC Washington, USA

LEADERSHIP POSTS:

Associate Dean , KFMC, Medical School
Corporate Planning & Development Director, KFMC
Medical Director MH, KFMC



Mohamed Zeitouni, MD, FCCP

Consultant Pulmonary/Critical Care
Department of Medicine
King Faisal Specialist Hospital and Research Centre
Riyadh, Saudi Arabia



SINA

Saudi Initiative for Asthma
المبادرة السعودية للربو و الحساسية

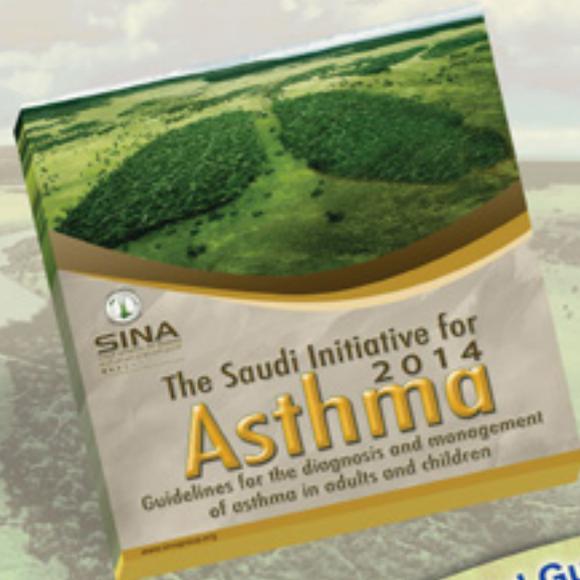
The Saudi Initiative for Asthma (SINA) aims toward a comprehensive approach for Asthma. Such approach should increase the awareness and knowledge in many aspects of the disease including research, education for patients, healthcare workers and public, and creation of links between different parties interested in asthma.

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INTRODUCING

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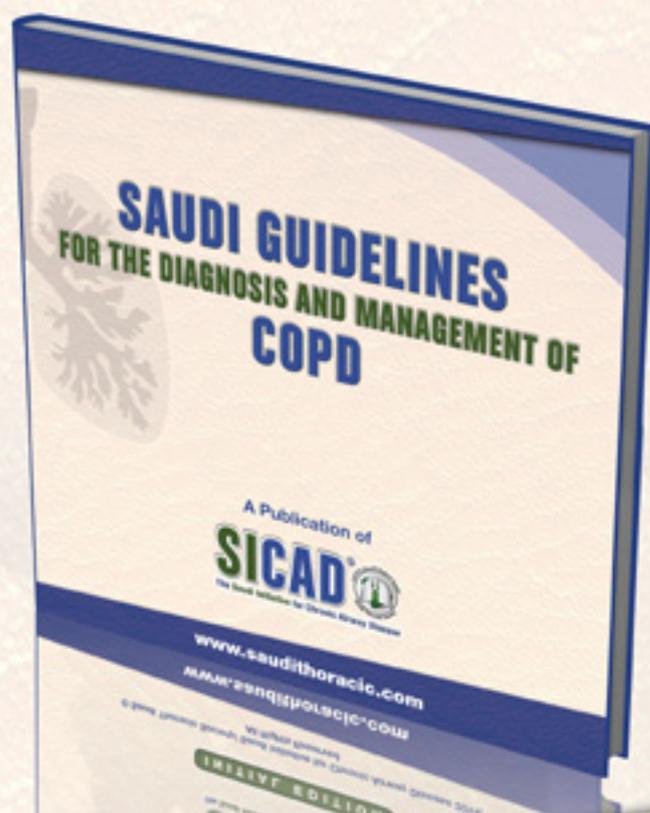
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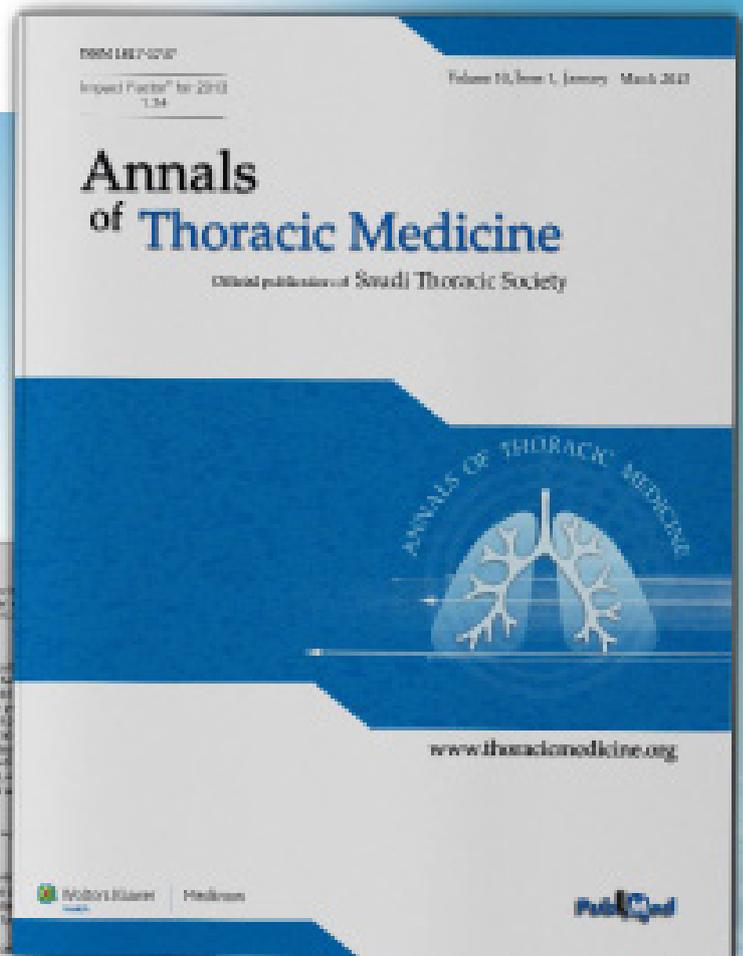
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Adaptive Support Ventilation (ASV) Mode, a Review of Its Clinical Implementation

Saja A. Al-Marshad

Mechanical ventilation is a corner stone in critical care. There are many modes of mechanical ventilation which are currently available. Understanding their concept, initial settings, management, and weaning is vitally important before initiating on a critical care patient. There are many newer mode of ventilation and the clinicians might be susceptible of their value to critical care patient's survival and well-being. And due to the unavailability of well robust research supporting their value; their use is not maximize. It could be argued that the development of Evidenced Based Guidelines over such a specific aspect of critical care will take significant time which should not delay the use of the sophisticated modes of mechanical ventilation such as ASV. On the other hand, the concrete understanding of these mode operations and limitation is vital in order to maintain a safe practice. This article not only will aim to review ASV mode and its management, but also will provide clinicians with a summary of its clinical implications and limitations.

Prospects for the Development of Interventional Surgery in Kazakhstan

Ten I., Shakeyeva A

Interventional surgery - a young and rapidly developing branch of medicine in the Republic of Kazakhstan, to extend the capabilities of modern medicine and replace traditional surgery. All major hospitals equipped with the latest technologies endovascular actively use them for diagnosis and treatment of vascular surgery, hepatology, gynecology, urology, oncology, traumatology, neurosurgery, cardiology, surgery and other branches of medicine, where, until recently, assumed a serious surgery.

Materials and Methods:

Hardware: Angiography Axiom - Artis Siemens..

During the period from 2010 to 2013 in one of the largest and most advanced clinics RK Science Center ambulance "NC NSR" Submitted endovascular interventions under local anesthesia in 1330 patients including:

1. With acute coronary syndrome "ACS" - 373 patients

Stenting: -337 Of the selective coronary thrombolysis -2

Selective endovascular thrombolysis for TELA- 4

Balloon dilatation of the coronary arteries - 30

2. Embolization of vascular complications with portal hypertension - 180 patients.

3. Balloon dilatation and stenting of the bile ducts, cholangiostomy and cholecystostomy - 197 patients.

4. Embolization of blood vessels in cancer pathology of various localization -275 patients.

5. Stenting and balloon dilatation of the peripheral vessels in the atherosclerotic lesions of arteries of large and medium caliber - 282 patients.

6. Others- 23 patients

Results: In all six intervention groups were conducted under the local infiltrative anesthesia.

Perenosimost Intervention is good - at 89.1% (1185 patients);

udovletvoritel'naya- 10.75% (143 patients); oslozhneniya: observed in 2 cases, which accounted for 0.1%.

The latter speaks of highly skilled surgeons and endovascular strictly differentiated approach in the treatment of patients.

This gives the prerequisites for increasing the volume of medical services for each coming year.

Conclusions: The minimally invasive and minimal risk of interference, as well as reduce the time of finding a hospital bed to 3 days; a significant reduction in terms of post-operative rehabilitation of patients: allows you to expand the indications for interventional surgery.



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AOP Orphan Pharmaceuticals is a multinational Austrian company with a strong focus on the development, manufacturing & distribution of medicines for rare and or complex diseases.

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AOP Orphan Pharmaceuticals specialises in orphan and complex diseases in Cardiology, Pulmonology, Hematology / Oncology, Intensive Care Medicine, Neurology and Psychiatry.

Predictors of Successful & Difficult Endotracheal Intubation of Infants in NICU-KAMC, Riyadh, KSA

Khalil Al Tawil, Ibrahim Ali, Aly Farouk, Denise Gittens, Amir Omair, Saif Alsaif

Purpose: To study the effect of different factors that may contribute to the success & difficulty of elective and semi elective endotracheal intubation of sick infants managed at NICU of KAMC-Riyadh

Methods: A retrospective review of prospectively collected data of infants that had semi elective endotracheal intubation from 1/1/2010 till 1/7/2011. The studied factors that may affect success of intubation were: experience of intubating physician, body weight and post conceptional age (PCA) of the infants, premedication. The success-difficulty of intubation was assessed by the number of trials, pain score, and occurrence of bradycardia and or desaturation

Results: During the study period: 180 infants had semi elective intubation. Birth weight (490 - 4995gms), PCA (25 to 53 weeks). Premedication was used in 108 infants, 66 infants received Fentanyl. Midazolam was used in 33 infants, while both medications were used in 9 infants. Univariate Analysis showed that success of intubation was positively correlate with seniority of physician performing the intubation.

Factors Associated with Anxiety and Depression among adults with Bronchial asthma in a Malaysian public hospital: a cross-sectional study

Sami Abdo Radman Al-Dubai, Kurubaran Ganasegeran, Pukunan Renganathan, Snigdha Misra, and Mohd Rizal Abdul Manaf

Background: Patients with Bronchial asthma are at risk of mental disorders particularly anxiety and depression. Purpose: This study aimed to explore the factors associated with anxiety and depression among asthmatic patients.

Methods: A cross-sectional study was conducted among 202 confirmed asthmatic patients from the chest clinic at the Medical Outpatient Department of a public hospital in Malaysia. A self-administered questionnaire was used to collect information on the socio-demographic factors and clinical health information. The validated Hospital Anxiety and Depression Scale (HADS) were used to assess anxiety and depression. Descriptive statistics, t-test, ANOVA and multiple logistic regressions were conducted using SPSS software version 18.

Results: Moderate anxiety and depression were found in 24.3% and 21.3% of the patients respectively. Severe anxiety and depression were found in 4.4% and 3.5% of the patients respectively. Factors associated significantly with anxiety were patient's age and newly referred cases. Factors associated significantly with depression were patient's age, race, monthly household income, and employment status.

Conclusion: Socio-demographic factors are important correlates of anxiety and depression among asthmatic patients. Early recognition of anxiety and depression symptoms is necessary to promote patients adherence and compliance to asthma control.

What is the Best Surgical approach for Bilateral Pulmonary Hydatid Cysts (BPHC) in children?

Aram Baram

Introduction: The most common site for hydatid cysts in children is the lungs while in adult hepatic cysts are predominant. Bilateral pulmonary involvement is relatively rare and its surgical management is poorly described in the current literature (1-7). Until now no definite consensus described in the literature for the ideal surgical approach in pediatric bilateral pulmonary hydatid cysts (BPHC) (6-9). The aim of this prospective cohort study was to describe the problems encountered in treating pediatric BPHC by two different surgical techniques.

Patients and Methods: Between June 2007 and June 2014, 60 children (group one =31, group two = 29) with BPHC, were operated on in our center. Group one included all children with BPHC operated by single session bilateral anterolateral mini-thoracotomy. Group two included all cases operated by two stage standard posterolateral thoracotomy at 21 days interval.

Results: In group one (19 males and 12 females), the mean age was 8.9 years (3.5-17). In group two there were 29 cases (18 males and 11 females), the mean age was 9.6 years (2-17). There was no significant statistical difference in terms of the presentations and age distribution. The duration of surgery in group one was significantly shorter and the duration of hospital stay was significantly shorter as well (group one 3.6 days versus 4.6 days in the second group). Pain scale was not more in the first group as it was believed to be.

Conclusion: We believe that single session bilateral anterolateral thoracotomy is a better approach than either one stage successive thoracotomies, median sternotomy or clamshell thoracotomy as it involves less postoperative pain and does not precipitate a decrease in respiratory Capacity.

Keywords: Bilateral pulmonary hydatid cyst (BPHC), bilateral anterolateral thoracotomy.

Improving the long waiting times in Hamad Medical Corporation (HMC) Out Patient Department (OPD) clinics after Patient Department (OPD) clinics: the causes

Mohammed R Al-Marri, Fatih Mutlu, Avril O'Donoghue, Noora Al-Marri

Background: Is to identify the out-come of implementation of Fixed Appointment Time system (FATS).

Methods: Prospective data collection during the period 7th April 2012 till the 14th April 2012 about the quantitative metrics which measure four indicators, waiting time in the clinic, time spend with the physicians, rate of customers arrived on time and no show (quantitative) and qualitative metrics which measures the stalk holders' satisfaction (customers and staff).

Results: The average waiting time in the clinic improved from 80 minutes to 32 minutes for the morning (am) clinic and from 97 minutes to 45 minutes for the evening clinics. Thus, the overall time waiting time improved from 83 minutes before to 38 minutes after the implementation of FATS. The rate of no show dropped from 34% to 15%. The post change survey did identify transportation and job commitment issues as the recent causes for missing appointments. There was no statistically significant difference (p value= 0.15) between pre and post FATS implementation on time of physicians' arrival. Eighty percent of physicians arrived at least 30 minutes late especially in the am. This continues to cause a backlog in the waiting list. The average customers' time spent with the physicians remains 12 minutes which was not significantly different from the time before implementation of FATS. The pulmonary OPD clinic operates at higher sigma after implementation of FATS (1.2 vs 0.6 both sides limitation and 0.9 vs 0.3 sigma using one side limitation).

Conclusion: The HMC pulmonary OPD department operates better than the best practice after the implementation of FATS as 78% of the customers were seen within 30 minutes compared to 50% seen in best practice.



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The long waiting times in Hamad Medical Corporation (HMC) Out Patient Department (OPD) clinics: the causes using Lean approach

Mohammed R Al-Marri, Fatih Mutlu, Avril O'Donoghue, Noora Al-Marri

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 addition 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 take 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.

Intralobar pulmonary sequestration in 22 year-old male: Case report and review of literature

Mohammed RHA AIMarri, Ahmed Mahufouz, Ahmed Derwish, Nood D AIMarri

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 trachea-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.

DYSPHAGIA LUSORIA: Case report of young lady present with Atypical Chest Pain and a review of the literature

Mohammed R Al-Marri, Ahmed Mahufouz, Hamad Al-Adba, Rafid AlAni, Nood D Al-Marri

The term Dysphagia lusoria refers to extra ordinary disposition of the subclavian artery (Lusorian artery) as a cause of esophageal 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 of the literature.

Innominate vein compression syndrome in Patients with Aberrant Right Subclavian Arteries Case Reports and review of the literature

Mohammed R Al-Marri, Nood D Al-Marri

The term "innominate vein compression syndrome" was first recognized by Wurtz et al. In 1989. Here in this paper we present a case of left innominate vein compression associated with an aberrant right subclavian artery in asymptomatic individual with no history of trauma or surgical intervention. Review of the literature and management is discussed in this article.

ASTHMA LUSORIA: right aortic arch with aberrant left subclavian artery (Lusorian artery) masquerading as severe asthma; case report and a review of the literature

Mohammed R Al-Marri, Hassan Mobayed, Nood Al-Marri

Asthma is chronic inflammatory disease of the airways which is considered the most common chronic diseases that present as dyspnea and wheezing. However not every wheezing is asthmatic as other health conditions may have symptoms that may mimic asthma symptoms. This paper present the first case report in Qatar of young lady presented with asthma since childhood resulting

from Asthma lusoria caused by a right aortic arch with a diverticulum (of Kommerell) at the origin of an aberrant left subclavian artery (Lusorian artery) and persistence of ligamentum arteriosum (LA) followed by a review of the literature.

Rule of Conservative Management in Occult Pneumothorax

Faisal M Almulhim, FRCS, Alaa M Gaafar, MD, Gamil K Mohamed, MD, Ibrahim Z, MSC And Tareq A Khalifa, MBCh

Aim of the work: The aim of this study is to revise retrospectively all patients with occult pneumothoraces regarding diagnosis and management to outline the criteria for management of occult pneumothorax whether conservative or thoracotomy tube placement especially in those patients whom were mechanically ventilated.

Patients and Methods: This retrospective study was done in King Fahad Hospital Hufuf (KFHH), KSA. In this study, all the data including clinical, radiological (CXR & CT) and measures of management were retrospectively reviewed for all patients with blunt chest trauma during the period of Jan 2006 till Dec 2012, regarding the occult pneumothoraces which were not discovered by the conventional CXR but were detected only by CT. The number of patients with blunt chest trauma during this period was 3765 patients, 334 patients of them were discovered to have occult pneumothoraces which detected only by CT not by the conventional CXR. All the data of those 334 patients including clinical, radiological (CXR & CT) and measures of management were collected, compared and statistically analyzed.

Results: Of these 334 patients, 261(80%) patients were managed conservatively in the form of close observation, analgesics, chest physiotherapy and daily CXR for follow up, the other 73 patients (20%) were managed by tube thoracotomy. Of the 261 of the conservatively managed patients, 74 patients (28%) were mechanically ventilated, while, 52 patients (71%) of the tube thoracotomy patients were mechanically ventilated. Of the 261 of the conservatively managed patients, 145 patients (55.5%) had less than 4 rib fractures and the other 116 patients (44.5%) had 4 rib fractures or more, while, in the group of tube thoracotomy patients, 16 patients (22%) had less 4 rib fractures and the other 57 patients (78%) had 4 rib fractures or more. In sixty five patients (25%) of the conservatively managed patients, the size of occult pneumothorax by CT was 6*100 mm or more, while, 57 patients (78%) of the tube thoracotomy managed patients, the size of occult pneumothorax by CT was 6*100 mm or more. Subcutaneous surgical emphysema was detected in 64 patients (25%) of the conservatively managed patients, and was detected in 49 patients (67%) of the tube thoracotomy managed patients.

Conclusion: Conservative management with close observation is an accepted and safe type of management in those patients with occult pneumothorax even with mechanically ventilated patients. Tube thoracotomy placement may be indicated in patients had higher number of rib fractures (4 ribs or more), increasing subcutaneous emphysema, bilaterally and larger size of occult pneumothorax (6*100 mm or more) especially in mechanically ventilated patients.

Low cost biological lung volume reduction therapy for advanced Emphysema

M. Bakeer, T. Abd El-Gawad, R. El-Metwaly Ali, A. El-Morsi, M. El-Badrawy, S. El-Sharawy

Background: A bronchoscopic lung volume reduction (BLVR) using biological agent is one of the new alternatives to lung volume reduction surgery.

Objectives: To evaluate efficacy and safety of biological BLVR using low cost agents including autologous blood and fibrin glue.

Methods: 8 male patients were enrolled and divided into two groups: group A in which autologous blood was used and group B fibrin glue was used. The agents were injected through a triple lumen balloon catheter via fiberoptic bronchoscope. Changes in high resolution CT (HRCT) volumetry, pulmonary function tests, symptoms, and exercise capacity were evaluated at 12-week post procedure as well as for complications.

Results: The mean ($\bar{A} \pm SD$) age was $57.75 \bar{A} \pm 10.62$ years. In group A at 12-week post procedure there was significant improvement in the mean value of modified medical research council (mMRC) score, 6-min walk distance (6MWD), residual volume / total lung capacity (RV/TLC) ratio, forced expiratory volume in one second /forced vital capacity (FEV1/FVC) ratio, HRCT volumetry (p-value: 0.014, 0.014, 0.008, 0.008, 0.003 respectively). In group B at 12-week post procedure there was significant improvement in the mean value of FEV1/FVC ratio (p-value: 0.012). However, the improvement in the mean value of mMRC score, 6MWD, RV/TLC ratio, HRCT volumetry was not significant (p-value: 0.058, 0.075, 0.164, 0.402 respectively). All patients tolerated the procedure and were discharged 1 day later, except one in group B who developed exacerbation that was controlled by medical therapy.

Conclusion: This preliminary results indicate that BLVR using low cost biological agents was safe, less invasive, less costly and effective in treating advanced emphysema.

Occurrence and Genetics of Asthma

Dr. Saira Baloch, Prof. Dr. Bikha Ram Devrajani

Background & Objectives: Asthma is the chronic childhood disease and its occurrence has risen in the world over the last few years. Family history is a significant risk factor for the progression of asthma, depending upon genetic and environment interaction. The present study was to identify the inheritance patterns of asthma and the effect of family history on asthma inheritance.

Methods: One hundred (100) families, 50 children and 50 adults with clinically diagnosed asthma, along with 100 non-asthmatic children and adults as control subjects were selected for the this study. Data and family history of patients and control subjects was collected and analyzed.

Results: A history of asthma was observed in 40% of cases. Risk of progression asthma was observed in family history of asthma of children and adult patients. The most common type of asthma was recessive inheritance.

Conclusions: It is concluded that family history of asthma is a leading risk factor for progression asthma in the offspring and a variance risk of asthma was also observed in family history. These aspects increase significant form of inheritance and genetic transmission of asthma which requires being further studied.

Keywords: Asthma, Family history, Children, Occurrence



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Chewing Tobacco and Non Small Cell Lung Cancer in Algerian Population

H. Jamous, MD, T. Filali, PhD

Background: Chewing tobacco, locally called "chemma" or "nufha" is practiced by 11.6% of Algerian men and 4% of country women. Users put a wad of it between their cheek and gum and hold it there, sometimes for hours at a time, unwanted juices are then expectorated (spat), but addicted users may tend to swallow some of it. Chewing tobacco is known to increase the risk of oral, esophageal and pancreatic cancers. Our study describes the effect of chewing tobacco on patients with non small cell lung cancer (NSCLC)

Methods: A retrospective study of all NSCLC patients managed between January 2012 and December 2013, in an Algerian cancer care center.

Results: We identified 152 patients with NSCLC, 126 (83%) were tobacco users; 43 (34%) were chewers, 21 (16.6%) chewers only, 22 (17.4%) chewers and smokers, and 83 (66%) were smokers only. Chewer Patients were 3 categories: patients who had no idea it was a kind of tobacco, patients who started chewing in order to help them in weaning cigarettes, and patients who were very addicted to tobacco to use it in both forms of the 43 chewers, only 5 patients have weaned from chewing tobacco at cancer diagnosis, the others didn't even after diagnosis, and 8 patients converted from smokers to chewers.

Median age among patients who used chewing tobacco was 57 years (36-73), 1 female and 42 males. The most common

presenting symptoms were cough (29.4%), chest pain (23.5%), hemoptysis (20.6%). Adenocarcinoma represented 67.6%, squamous cell carcinoma 23.5%, adenosquamous carcinoma 6%, large cell carcinoma 2.9%. Most of the patients had an advanced stage disease; 74% stage IV, 6% stage IIIB, 15.6% stage IIIA. Three patients underwent surgical therapy, 1 lobectomy, 2 pneumonectomy, and 3 needed palliative radiotherapy. First line platinum based chemotherapy was administered to 61.8% of the patients, with an appropriate PS and no medical contra-indication. Overall Response rate was 14.7% and overall disease control was 20.6%, median time to follow up was 6 months, in chewers only it was 4 months, in both cigarettes and spit tobacco users it didn't exceed 2.5 months, while it reached 13 months in smokers only (who were 75% stage IV), 1 year survival was 23.5%, 2 years survival was 5.9%, in patients both smokers and chewers 1 year survival was 5.9%.

Conclusion: Chewer patients with NSCLC presented common symptoms, at advanced stages, and majority had an adenocarcinoma subtype. Unfortunately, most of the chewer do not quit this deadly habit, by ignorance or by addiction and dependence. However, they had response rates to the conventional chemotherapy comparable with other NSCLC categories; they had a poorer chance of a long survival.

A public campaign to increase the awareness about the risk of all tobacco products including smokeless tobacco is needed.

Keywords: chewers, tobacco, NSCLC

Young female with carcinoid tumor of lung requiring Pneumonectomy

Sidra Kiran, Saulat Fatimi

Introduction: Lung carcinoid are the slow type of tumors that starts in the lungs and are formed by neuroendocrine cells. About 1% to 2% of all lung cancers are carcinoids. Only about 3 out of 10 carcinoid tumors start in the lungs. Most of the tumors are centrally located. We present case of a young lady with hemoptysis treated with pneumonectomy.

Case: 23 year old lady, student, resident of Hyderabad. She was in her usual state of health 5 year back then she started having cough, productive of yellow coloured sputum, weight loss was positive, no history of fever. No family history of tuberculosis. Being treated as pneumonia with antibiotics, cough persisted and later started having hemoptysis. Treated for 8 months with antituberculous drugs, hemoptysis settled but dry cough persisted. CT Chest done which showed a mass in right main bronchus. Bronchoscopy showed large right sided endobronchial mass occluding right main bronchus, Biopsy and lavage taken. Histopathology was inconclusive. Thoracotomy done which showed large mass in right main bronchus with bronchiectatic lung, underwent right pneumonectomy. Histopathology Revealed well differentiated neuroendocrine tumour (carcinoid tumour). Patient remained symptomatically well and later discharged home.

Discussion: Bronchial carcinoid tumors are an uncommon group of pulmonary neoplasms formed by neuroendocrine cell that have migrated from the embryologic neural crest. Bronchial carcinoids typically presents in late adolescence. Surgery is the mainstay of treatment.

Conclusion: Carcinoid tumors are potentially curable. The Management requires multidisciplinary care. 5-year survival is excellent and the prognosis of operated patients is very good.

Keywords: carcinoid tumor, neuroendocrine cells, bronchiectasis.

Effect of Khat (catha Edulis) on Bronchial Asthma in Jimma University Specialized Hospital, Adult Chest Clinic, Jimma, Ethiopia

Eden Yitna, Andualem Mossie, Alemshet Yami

Introduction: Asthma is a chronic inflammatory disorder of the airways. About 300 million people worldwide were affected by asthma leading to approximately 250,000 deaths per year. The active chemical present in Khat could have a bronchodilator effect like that of catecholamine. The present study aims at determining the effect of khat chewing on bronchial asthma.

Methods: A comparative cross sectional study was conducted in JUSH Adult Chest Clinic on 170 asthmatic patients with a 1.4 to 1 ratio of non-chewer to chewer between November 2010 and January 2010. Interviewer Administered questionnaire, patient history and pulmonary function test using Spirometer was used to collect the data.

Results: 170 asthmatic patients, 72 were khat chewers and 98 were non chewers. Frequent asthmatic symptoms was seen on 23(31.9%) of chewers and 43(43.9%) of non chewer ($\chi^2=2.488$, $p=0.11$). A less frequent use of β_2 agonist was observed on 42(58.3%) of chewers and 53(54.1%) of non chewer patients ($\chi^2=12.678$, $p=0.12$). Less frequent night time awake and chewing status was found to be positively associated [AOR=2.633, CI(1.778, 3.059)]. The mean predicted personal best of forced expiratory volume in one second (FEV1%) for chewers and non chewer was 62% and 46% respectively while their PEF% was 40% and 26% respectively. Based on Pharmacologic profile of cathinone particularly its half life time, percent predicted FEV1 and PEF% were calculated among chewers themselves and there was significant difference in these parameters parallel to the time of chewing before spirometry.

Table 1- FEV1 and PEFr among khat chewer asthmatic patients within a specified period of time before spirometry in JUSH 2010/2011

Conclusion: In apart from psycho stimulating prosperities, khat has moderate potential benefit for the improvement of episodes of asthma attack. This study showed that chewer asthmatic patients had relatively better PEFr and also relatively lesser recurrent night time awake due to asthmatic attack.

Clinical features and treatment outcome of nocardia

Ehafiz Abdul Wase

Background: Nocardiosis is an uncommon bacterial infection that is caused by aerobic actinomycetes of the genus *Nocardia*. This pathogen has emerged as an important cause of mortality and morbidity among both immunocompetent and (more commonly) immunocompromised hosts. The prevalence of nocardiosis is unknown in Pakistan. In this study, we performed a 10-year retrospective review of all cases of nocardiosis identified at the Aga Khan University Hospital in Karachi. Clinical presentation, risk factors, site of disease involvement, radiological features, and outcomes of 55 patients with pulmonary nocardiosis are presented. The present study identifies the risk factors for Pulmonary Nocardiosis, clinical symptoms and radiographic features and the factors that affect its prognosis.

Materials and Methods: A retrospective review of all cases of nocardiosis over the last ten years.

Results: Fifty Five cases of nocardiosis were identified. The disease was more common in males. Fever, cough and dyspnea were the most common presentation. Most of the patients had chronic steroid administration and an underlying malignancy. The most frequent abnormality in the chest X-ray was pleural effusion followed by consolidation. Cure was possible in thirty six cases, while nineteen patients died. Co-trimazole was most commonly used for the treatment. Duration of therapy ranged from 12 days to 95 days. Chest tube placement was indicated in 13 patients. Most common complication observed was respiratory failure and septicemia.

Conclusion: Pulmonary nocardiosis is difficult to diagnose as diagnosis is frequently delayed and a high level of suspicion is, thus, required in patients with underlying diseases or chronic corticosteroid therapy. Also, there is frequent dissemination and high mortality associated with *Nocardia*. Prevalence is not known in Pakistan. A database is urgently needed to better evaluate the prevalence of the illness among the Pakistani population.

Keywords: *Nocardia*, Nocardiosis, Pneumonia

Hematological Changes in Oral Cancer Patients with Smoke-able and Chew-able Tobacco

Mohsin Ali Baloch, Saira Baloch

Objective: To analyze hematological changes in patients of oral cancer with history of smoke able and chewable tobacco use, and to compare them with healthy controls.

Study Design: Descriptive type of study survey.

Setting: This study was conducted at department of Oral and Maxillofacial Surgery, LUMHS, Jamshoro.

Study Period: One year July, 2013 to July, 2014

Subject & Methods: Histo-pathologically confirmed hundred cases of oral cancer with history of smoke able and non-smoke able tobacco were selected to analyze the hematological variation.

Inclusion Criteria: Histopathologically diagnosed patients of oral squamous cell carcinoma, with history of smoke able and non smoke able tobacco.

Exclusion Criteria: Patient with any systemic medically compromising problem, terminally ill patients, radio or chemotherapeutically treated patients, Patients with metastasis to lungs or any distant metastasis, patients with history of more than one well defined etiological factor involved.

Results: There were 73% patients of oral cancer reported with anemic. Significantly lower values of Hb, Platelet and higher mean values of ESR, TLC and were observed in both groups of oral cancer patients; tobacco smokers and tobacco chewers as compared to non-smokers healthy controls. There was more decline in the level of haemoglobin and incline in the level of ESR observed in tobacco chewer oral cancer patients as compared to tobacco smokers patients, while TLC was more observed in smokers.

Conclusion: Oral cancer patients with history of chewable/smoke able tobacco have likely worse hematological profile, which increases the anesthetic and surgical challenges for maxillofacial surgeons, which have significant impact on treatment planning as well.

The pattern of chest injuries; Analysis of 275 Cases

Mohammed Nasser Aldahmashi

Aim: To investigate the impact of the patterns of chest trauma on the management modalities.

Methods: A retrospective descriptive analysis was conducted among 275 cases of chest trauma managed at our hospital over the period 2010-2013.

Results: We present our experience in the management and clinical outcome of 275 consecutive patients with chest trauma associated with 51% (n.140) blunt injuries which mostly related to traffic accidents and 49% (n.135) penetrating injuries. There were 255 male (72.7 %) and 20 female (7.27 %), with average age of 33.0 years. Among the penetrating injuries, 77(57%) had left -sided, 43 (31.8%) had right-sided, and 15 (11%) had bilateral penetrating injury, three patients (1.09%) were sustained direct cardiac injuries. Males were 130 (96.3 %) and the remaining 5 (3.7%) were female, the average age was 32.4. The blunt chest trauma group consist of 89.3 % (n.125) of male patients and 10.7 % (n.15) were female patients. Seventy five (53.6%) had left-sided, 54 (38.6%) had right-sided, and 11 (7.8%) had bilateral blunt injury. The commonest presenting features were pain (100%), dyspnoea (78.57%), haemorrhagic shock 17% and others had associated injuries. The concomitant injuries were 22.18% (n=61); spinal cord 9 (3.27 %), brain injuries 17(6.18%), intraperitoneal injuries 12 (4.36%) were mostly due to penetrating injuries which necessitate thoraco-abdominal approach or CTD and laparotomy, bone fractures 20 (7.27%). The CT, CXR, US, and Echo were the main diagnostic tools used, 95.27 %, 96.72 %, 9.73 %, and 9.33 % respectively. Intercostal tube thoracostomy was required in 130 patients of penetrating trauma (96.29 %), and 35 (25.92 %) patients underwent thoracotomy and bleeding control and late thoracotomy for retained FB removal and empyema was done for 22 patients (16.29%). CTD was inserted in 107 (76.42%) patient of blunt injuries whereas 33 patients (23.57%) had conservative management and only 4 patients (2.85%) underwent thoracotomy for tracheobronchial repair and bleeding control. Respiratory care was provided for all patient. Mean hospitalization period was 6 days in penetrating trauma group and 7.33 in blunt trauma group.

Out of all cases, 94.54% (n. 260) were cured, and the overall mortality was 5.4% (n. 15). Among the dead cases, three died of hemorrhagic shock, three of acute respiratory distress syndrome, nine of severe multiple trauma patients due to brain death and multiple organ failure.

Conclusion: CTD is the most appropriate methods of treating complicated chest injuries, however the penetrating trauma has higher rate of internal damage that require early intervention to save life, specially for severe or progressive intrathoracic bleeding and cardiac injury.

Pulmonary contusion and rib fracture are the most common complications in chest trauma, for which the strong painkiller, anti-infection therapy, respiratory care measures and mechanical ventilation are the component of an effective treatment strategy.

The associated extra thoracic injuries constitute a major prognostic factor in the chest trauma, which is higher rate in blunt trauma.

Keywords: Chest Trauma, Chest Tube Drainage, Thoracotomy.



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Prevalence of habitual snoring in a Saudi Population

Adil Alsulami, Abdelfattah Touman, Bahaa Abalkhail, Ayman Krayem, Siraj Wali

Background: Several studies suggest that snoring might be related to various disorders including hypertension, ischemic heart disease, and stroke. Epidemiological studies on prevalence of snoring in Middle East is scanty and lacking in the Arab Peninsula.

Objective: This study was conducted to estimate the size of the problem and its predictive risk factors. Design, Setting, and Participants: A cross-sectional study was conducted from March 2013 until June 2013 in Jeddah, Saudi Arabia. The enrolled subjects were 2682 school employees (aged 30-60 years, 52.1% females) who were randomly selected and interviewed. Information on snoring was collected using a modified Wisconsin Sleep Questionnaire. Anthropometric measurements and blood pressure readings were recorded using standard methods.

Results: Forty percent of the 2682 enrolled subjects were snorers, of which 23.5%, 16.6%, and 59.9% were habitual snorers, moderate snorers, and non-snorers, respectively. A multivariate analysis revealed that independent predictors of snoring were ageing, male gender, daytime sleepiness, hypertension, family history of both snoring and obstructive sleep apnea, water-pipe smoking, and consanguinity.

Conclusions and Relevance: This study shows that snoring is a common condition among the Saudi population. Previously reported risk factors were re-emphasized but consanguinity was identified as a new independent predictive risk factor of snoring. Exploring snoring history should be part of the clinical evaluation.

Keywords: Sleep breathing disorder, snorers, consanguinity and risk factors

Assessment of the role of high resolution computed Tomography in the diagnosis of suspected Sputum Smear Negative Active Pulmonary TB

H Shaarawy, MH Zeidan, A.Sabry, M. Nouh

Is to study the utility of multi-detector CT chest in diagnosis of sputum smear negative pulmonary TB and correlation between the CT features and sputum culture results.

Patients and Methods: One hundred patients suspected to have smear-negative active pulmonary TB were subjected to HRCT chest and sputum culture. At HRCT the combination of tree-in-bud, larger nodules, lobular consolidation and presence of main lesion in S1, S2 and S6 segments was ranked as rank 3 if at least three of them were present and as rank 2 if at least two of them were present. Patients with these findings mainly in the middle lobe and lingual were ranked as rank 1. The sensitivity, specificity and positive likelihood ratio for each rank was calculated.

Results: Sputum culture for AFB was positive in 60 patients. At HRCT only six out of the 28 patients ranked as I and 24 out of the 40 ranked as II and 30 out of the 32 patients ranked as III had final diagnosis of active pulmonary TB. The sensitivity, specificity and positive likelihood ratio of rank I HRCT criteria for diagnosing active pulmonary TB was 90%, 50% and 1.5%, respectively, while in rank II it was 70%, 60%, 3.2%, respectively, and in rank III it was 50%, 95%, 12.5%, respectively.

Conclusion: HRCT chest findings can help to segregate higher risk patients among those suspected of having active pulmonary TB whose smears were negative. In addition HRCT can be used to select candidate patients for further laboratory tests or bronchoscopy.

Risk factors for Atypical Mycobacterial disease in patients with smear Positive Pulmonary TB

H. Shaarawy, A. Alhawary

Non Tuberculous Mycobacteria (NTM) can cause severe infection in selected groups of patients and is very difficult to be differentiated from TB infection clinically or radiologically leading to miss diagnosis and wrong treatment in these cases, the aim of the present study is to study risk factors associated with NTM disease in patients with Acid Fast Bacilli (AFB) smear positive patient

Subjects and Methods: 1402 patient with AFB smear positive were included in the study, only 47 patients from the study group proved to have NTM disease (diagnosis was done according to ATS/IDSA criteria).

Results: The mean age of the NTM patients was 61.8 \pm 23.2 years, NTM was more common in older age groups and more common in white race patients, on using logistic regression analysis NTM disease was more commonly associated with old TB infection (42.6%) and with bed ridden patients on tracheostomy (31.9%). the most common organisms isolated were the MAC complex (55.3%) followed by M. Kansassi (34.04%).

Conclusion: NTM disease should be put into consideration in patients with AFB smear positive and suffering from old TB infection or in bed ridden patients who are on tracheostomy, also if smear is positive for AFB and PCR is negative NTM should be suspected.

Pleural Effusion And Empyema In Children: A Philippine Experience

Amelia G. Cunanan, MD, FPPS, FPAPP

Abstract Content: Pleural effusion is a condition where there is an excessive accumulation of fluid in the pleural cavity and classified as either exudate or transudate based on Light's Criteria; empyema, on the other hand, is defined as purulent fluid collection in the pleural space.

Objective: To present an overview of the updated census report on Pleural effusion and Empyema in children in the Philippine setting.

Specific Objectives:

1. To present the demographic characteristics as to the frequency of distribution according to gender.
2. To review the causes and etiology of pleural effusion and empyema.
3. To discuss the types of medical and surgical management of childhood pleural effusion and empyema.
4. To present the burden of disease as to Philhealth reimbursement and PPS data.

Methods: This is a cross-sectional descriptive study. Patients aged 0-18 years with a diagnosis of Pleural effusion or Empyema from January 2007 to December 2013 were included. A registry of Philippine Pediatric Society (PPS), Philippine Academy of Pediatric Pulmonologists (PAPP) and Philippine Health Insurance Corporation (Philhealth) were reviewed. PPS data came from accredited hospitals from 10 chapters all over the Philippines. PAPP is composed of six accredited training institutions and general hospitals. Philhealth data came from accredited private and government hospitals with corresponding reimbursements.

Results: PPS data showed a total of 2001 patients with Pleural effusion, whereas 457 presented with Empyema thoracis, with the same male-to-female ratio of 1.4:1. PAPP data showed a total of 1317 patients with Pleural effusion and Empyema, with the same male-to-female ratio. According to PPS statistics, majority of patients came from Chapter 6 or National Capital Region (889), followed by Chapter 5 or Northern/Central Mindanao (199). As per PAPP data, majority of patients presented with exudative type of effusion, which can be classified into infectious and non-infectious causes. Based on pleural fluid analysis, 458 presented with infectious causes (Parapneumonic, Tuberculous), while 313 presented with non-infectious causes (Malignancy, Trauma, Others). Among culture-positive isolates, majority (28) were found to be caused by Methicillin-resistant Staphylococcus aureus. On the other hand, PPS data showed 271 cases of Empyema, non-tuberculous type, 136 cases of tuberculous with no bacterial confirmation, and 50 cases of confirmed tuberculous type. As to the management, majority of patients were treated with Medical + Thoracentesis (475), followed by Medical management alone (392) and Medical + Closed tube thoracostomy (289). Video assisted thoracoscopic surgery or VATS is an emerging surgical procedure that can also be used for treatment (41). Outcomes of disease were improved clinical parameters (609), improved diagnostic modalities like chest xray, ultrasound and CT scan (615), while complications include pleural thickening, bronchopleural fistula and others (73). Mortality was only 34 out of 1317 cases. Burden of disease shows pleural effusion and empyema in children are still significant causes of morbidity, with a total amount of >Php 55,000,000 claims from January 2007 to December 2013 from the Philippine Health Insurance Corporation. Pleural effusion ranked 101 from Philhealth reimbursements, whereas it ranked 83rd according to PPS statistics.

Conclusion:

1. There remains to be an increasing trend of pleural effusion and empyema in the Philippines despite advances in medical and surgical management.
2. There was M:F ratio of 1.4:1, with almost equal distribution, among patients 1-18 years of age.
3. MRSA is the most frequently isolated organism.
4. Medical management with thoracentesis and CTT was the most commonly used mode of management.
5. Burden of the disease: Pleural effusion and empyema in children are significant cause of morbidity.



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An Unusual Case of Granulocytic Sarcoma Presented with Pleural Effusion and Mediastinal Mass: A Case Report

Abdelhameed Yousif MD, Mohammed Munir MD, Sherbini Nahid MD

Introduction: Granulocytic sarcoma (GS), also known as chloroma is a rare tumor that may arise during or precede acute myeloid leukemia. We report this unusual initial presentation of GS with bilateral pleural effusion, mediastinal mass, testicular enlargement and to identify the relations between serosal involvement in GS and high CA 125.

Method/Case Report: The patient is a 33- year- old male presented with cough, breathlessness, weight loss and fever for three months. On clinical examination features of right side pleural effusion, generalized lymphadenopathy, signs of superior vena cava obstruction and testicular enlargement were detected. Complete blood count and peripheral smear were normal. Chest radiography and the computed tomography of the chest show large anterior mediastinal mass with bilateral pleural effusion more on the right side, pericardial infiltration and left internal jugular vein thrombosis. Testicular ultrasonography confirmed a homogenous bilateral enlargement. Tumor markers showed high CA 125 and the histological examination of the axillary lymph node biopsy showed hematopoietic malignancy with strongly positive myeloperoxidase and for CD45, CD43, bcl-2 which consistent with granulocytic sarcoma.

Conclusion: GS is a rare diagnosis and the initial presentation may involve Pleura, mediastinal masses, lymph nodes or testis as in our patient. Diagnostic confirmation requires an appropriate immune histochemical staining.

Keywords: Granulocytic sarcoma, chloroma, CA 125, Myeloperoxidase

Middle East Respiratory Syndrome Coronavirus in Saudi Arabia: Demographic, Clinical and Survival data

Nahid Sherbini MD, Ayman Kharaba MD , Mohammed Abduljawad MD , Ayman Iskandrani MD

Background: In Saudi Arabia, a new coronavirus was isolated for the first time at the end of 2012 from a patient with a chronic renal failure who presented with acute community acquired pneumonia. After that, many laboratory-confirmed cases have been reported with this virus which named 'Middle East respiratory syndrome coronavirus' (MERS-CoV). It has high mortality rates and wide ranges of clinical features. Epidemiological data are minimal and those from Saudi Arabia showed that patients from Medina have one of the highest numbers of cases and deaths.

Objectives: This study describes the clinical characteristics and outcome of Middle East respiratory syndrome coronavirus (MERS-CoV) in Saudi Arabia (Medina).

Methods: This was a retrospective study that looked at all the patients confirmed to have positive MERS-CoV from March 2014 to May 2014 at two tertiary care hospitals in Medina region (Saudi Arabia). We collected the demographical, clinical, laboratory and radiological data from the patients' medical records. Medications administered and survival was also assessed.

Results: A total of 29 cases were recorded over the study period with laboratory-confirmed MERS-CoV disease. Their baseline characteristics included: age (Mean $\bar{A} \pm$ SD) $45 \bar{A} \pm 12$ years, Male were more affected (n: 20 (69%)) than females (n: 9 (31%)), the case fatality rate was higher for men (52%) than for women (23%). Smoking history was significant in (65%). Most of cases was originally presented from areas around Medina especially from Al Henakiah (n: 11 (37%)) where they are rising camels, while those from inside Medina were (n: 6 (20%)). Initial presentation with fever were recorded in (n: 22 (75%)), Cough (n: 20 (69%)), shortness of breath (n: 20(69%)), while vomiting and diarrhea presented in (n: 8 (27%)). Associated comorbidities were Diabetes in (n: 9 (31%)) and Chronic Kidney Disease (n: 8 (27%)) . Mean duration of symptoms before hospitalization was 2.9-5 days. On Examination they were tachycardia with mean pulse $111 \bar{A} \pm 2$, normotensive & feverish $38 \bar{A} \pm 0.6$. Laboratory findings reveals white blood cells $7.1 \bar{A} \pm 4.3$, Hemoglobin $12.7 \bar{A} \pm 1.8$, platelet $293.1 \bar{A} \pm 83$, raised concentrations of alanine aminotransferase and aspartate aminotransferase (14 (50%)) and all of them show an element of impaired renal profile. Arterial blood gases at presentation show a respiratory acidosis with mean pH ($7.3 \bar{A} \pm 0.1$), pCO₂ ($57.1 \bar{A} \pm 8.2$) & sPO₂ ($88.9 \bar{A} \pm 5.4$). All patients had abnormal initial chest radiographs. The predominant finding was a patchy consolidation with a ground-glass opacities ranging from minimal changes to extensive abnormalities which may be suggestive of an organizing pneumonia pattern. In addition, all of the patients admitted to intensive care unit with mean duration of stay $13 \bar{A} \pm 4$ but use of mechanical ventilation needed for nine patients only (n:9 (31%)). They all received a broad antibiotics coverage, steroids (n: 29 100%) interferon and ribavirin (n:19 (65%)) used in some cases.

Conclusion: In Saudi Arabia, MERS-CoV is considered an epidemic. The frequency of cases and deaths is higher among men than women, and those around 45 years of age are most affected patients and the disease reported higher mortality in older men with diabetes and chronic kidney diseases used mechanical ventilation and stay longer in intensive care units matching data of other cohorts. Acute respiratory infection caused by MERS-CoV presents with respiratory and gastrointestinal manifestations. There are gaps in our knowledge of the epidemiology, prevalence, clinical spectrum and course of the disease. The influence of geographical distribution and comorbidities on the incidence and outcome of MERS should be explored further.

Keywords: Epidemiology, Characteristics, MERS, Coronavirus, Survival, Saudi Arabia

Allergic Bronchopulmonary Aspergillosis with Pneumothorax, Lung Collapse and Pleural Effusion

Sherbini Nahid, Abdulhamid Yosef

Introduction & Objectives: Allergic bronchopulmonary aspergillosis (ABPA) is seen in patients with asthma characterized by hypersensitivity reaction affecting the airways after exposure to aspergillus species. Secondary pneumothorax, pleural effusion and lobar collapse are very rare radiological findings in patients with ABPA. Pneumothorax usually is due to rupture of the peripheral cystic bronchiectasis or fibrocystic changes and the lobar collapse is a result of mucoid impaction in the bronchi. Early diagnosis and treatment may prevent the development of end stage pulmonary disease.

Case Report: We report a rare presentation of a 23 year old man admitted to intensive care unit with a life threatening exacerbation of bronchial asthma and pneumothorax required chest tube insertion. He is smoker with a history of poorly controlled asthma and recurrent admissions with asthma exacerbations and pleural effusion mandated drainage. Investigations revealed peripheral eosinophilia, strongly positive tests for aspergillus specific antibodies and elevated serum immunoglobulin E. Chest radiograph and computed tomography of the chest showed the left upper lobe cystic bronchiectasis, pneumothorax and left lower lobe collapse. The patient is improved on mechanical ventilator support, high doses of steroid and antifungal therapy.

Conclusion: ABPA in a rare cases present by secondary pneumothorax, recurrent pleural effusion and lobar collapse. Early consideration of this diagnosis may help to manage those patients and prevent chronic complications.

First line anti-tuberculosis sensitivity pattern among patients with Pulmonary Tuberculosis (mtb complex) in Dubai, United Arab Emirates

Zaid AL Tawil, Layla AL Dabal, Zulfa AL Deesi, Salman Abdulaziz

Background: Pulmonary Tuberculosis (TB) remains a serious medical problem due to prolonged treatment course, drug-induced side effects and the emergence of drug resistant TB. It has important implications regarding proper infection control measures in the community as well as in the healthcare settings. The United Arab Emirates is in close geographical proximity to a number of highly endemic countries for Mycobacterium Tuberculosis in general and multi-drug resistant TB in particular implying that local Anti-tuberculosis treatment guidelines should consider sensitivity patterns in immigrants with tuberculosis from these endemic areas.

Aims: This study reviews first line anti-tuberculosis sensitivity and resistance pattern among patients with pulmonary tuberculosis in Rashid Hospital, Dubai, UAE.

Methods: A single-center retrospective review of all culture positive respiratory samples from patients with pulmonary tuberculosis from 01/01/2013 till 30/09/2014 were included in the analysis. Respiratory specimens were processed following conventional methods for mycobacterial isolation; digestion and decontamination by the N-acetyl-L-cysteine-NaOH procedure using the MycoPrep Specimen Digestion/Decontamination Kit (Becton Dickinson (BD). Microscopic detection was done using Auramine fluorescent stain and was confirmed by Ziel-Neelsen Stain. All samples were cultured on both L-J Egg base solid media; and BBL Middlebrook 7H9 MGIT liquid media in MGIT 960 (BD). Identification of the isolates was confirmed by both the Rapid Identification method - TBc ID (immunochromatography) and by their susceptibility to Para Nitrobenzoic acid (PNBA). MGIT 960 was also used for the susceptibility testing to the first line drugs: Streptomycin (low-dose) 1.0 mcg/ml and (high-dose) 4.0 mcg/ml, Isoniazid (low-dose) 0.1 mcg/ml and (high-dose) 0.4 mcg/ml, Rifampicin 1.0 mcg/ml, Ethambutol 5.0 mcg/ml and 7.5 mcg/ml and Pyrazinamide 100 mcg/ml. Multidrug resistant tuberculosis (MDR) was defined as resistance to at least Rifampicin and Isoniazid.

Results: Between January 2013 and September 2014, 346 non-repetitive sputum-culture positive cases were identified by our TB lab. 265 isolates were pan-sensitive and 81 isolates showed variables sensitivity and resistance patterns. The distribution of mono-resistance rates of Mycobacterium tuberculosis to first line anti-tuberculosis drugs was reported as: Isoniazid low-dose 3.47%/ high-dose 3.18%; Streptomycin low-dose 1.45%/ high-dose 2.31%; Rifampicin 0.29%; Pyrazinamide 2.89% and no Ethambutol mono-resistant strains were isolated. The resistance rate to at least Rifampicin and Isoniazid, MDR TB, was 7.82% and one strain showed resistance to all first line drugs. All the MDR strains except one were isolated from Asian patients and one strain was isolated in a UAE national patient.

Conclusion: This study reported high levels of resistance to first line anti-tuberculosis drugs and mainly to low-dose Isoniazid and Pyrazinamide which are both bactericidal agents used to achieve early control of infection. In addition, it revealed a high prevalence of MDR-TB among isolates from patients coming from endemic countries. This pattern of resistance to backbone first line agents can have serious consequences regarding optimal control of diseases activity and chances of cure and should be taken into consideration upon choosing optimal regimen particularly in non-UAE national patients.

Spectrum of Respiratory system involvement among HIV/AIDS adult patients admitted to a tertiary care hospital, Dubai, United Arab Emirates, 2009-2014

Salma O. AL Shamsi, Zaid M. Al Tawil, Laila M. Al Dabal, Zulfa Al Deesi

Background: UAE has a low prevalence of HIV and is estimated to be 0.2% among national adults. Respiratory system is an important target of HIV virus and a significant proportion of HIV infected patients present with one form or another of pulmonary involvement. This association is important and knowing the pattern of respiratory involvement is important for early diagnosis and appropriate management. We lack data on the prevalence of pulmonary complications among HIV infected patients in UAE. The aim of this study was to evaluate the prevalence and pattern of pulmonary complications among HIV/AIDS infected adult patients over 6 years period.

Methods: Data was collected longitudinally and analyzed retrospectively in patients admitted to Infectious Diseases Unit in Rashid Hospital, Dubai, and included patient's demographics, nationality, CD4 upon first admission, chest X-ray, sputum microscopy/culture, AFB staining/culture. CT chest and FOB were performed in few selected cases.

Results: Between January 2009 and December 2014. 214 adult patients with HIV/AIDS were admitted to our unit 54 patients being UAE nationals (45%). 120 patients had abnormal chest X-ray and non-specific respiratory symptoms (56.1%), mostly presenting with cough and fever (93%). We identified 77/120 (64.2%) patients with active pulmonary TB, 20/120 (16.7 %) patients with CAP and 10/120 patients with PJP (8.3%) and 2 patients had Kaposi Sarcoma with pulmonary involvement (1.7%). No confirmed diagnosis was made in 11/120 (9.2 %), out of whom 7 patients died within 48-72 hours of admission. 28 patients (23.3 %) with pulmonary involvement were on ART and 15 patients (12.5%) were on PJP prophylaxis at the time of admission. 81/120 patients had CD4 200/ μ L (32.5 %, range 204-1047). 22/77 (46.8%) patients with pulmonary tuberculosis had CD4 /culture positivity was 82.5% and 94.8% respectively.

Conclusions: Pulmonary TB was the most frequently diagnosed respiratory illness followed by CAP and less frequently PJP. In patients with AIDS and TB, chest x ray showed a pattern of primary infection in most of the cases and sputum positivity rates were comparable to HIV infected and immunocompetent subjects.

The influence of low birth weight on the development of asthma in children: observations from a meta-analysis

Nadia Hussain

Background: Low birth weight has strongly correlated with an increased risk of developing several adult diseases. Low birth weight is also an additional factor in the risk of developing asthma in the later years.

Methods: A literature search of the PubMed database from 1966 to 2013 was conducted. The criteria to include papers were: case-control or cohort studies; the odds ratio (OR) or risk ratio (RR) estimates with the corresponding 95% confidence intervals (CIs) were presented, or sufficient data available for calculation. Random-effect and fixed-effect meta-analyses, meta-regression, and cumulative meta-analysis were conducted.

Results: Sixteen cohort studies that included 1,105,00 subjects were included. The overall pooled RRs (95% CIs) of asthma risk for low birth weight were 1.162 (fixed-effects model, 95% CI, 1.128-1.197) and 1.152 (random-effects model, 95% CI, 1.082-1.222). In stratified analyses, the effect of low birth weight on childhood asthma was strong.

Conclusions: This meta-analysis shows that low birth weight significantly increases the risk of childhood asthma.



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Bronchial aspirates glucose level as indicator for MRSA in Intubated mechanically ventilated patients

Sherif Alsayed, Samar Marzouk , Essam Mousa, and Ashraf Ragab

Objectives: To detect the Association between increased level of glucose in bronchial aspirate and the risk of MRSA in mechanically ventilated ICU patients.

Methods: 50 critically ill patients was enrolled and were under tight glycemc control to abolish the effect of hyperglycemia on bronchial secretion, if they were expected to require ventilation for more than 48 hours. Bronchial aspirates were detected for glucose and sent twice weekly for microbiological analysis and whenever an MRSA was expected.

Results: 28 patients were positive for glucose in their bronchial secretion. Patients with glucose were much more likely to have methicillin resistant Staphylococcus aureus (MRSA) than those without glucose in bronchial aspirates (p value 0.001)

Conclusion: In mechanically ventilated ICU patients, early detection of glucose in their bronchial aspirate improves the ability of the physician to recognize early detection of MRSA this is simple, rapid, inexpensive technique serve as marker for nosocomial infection.

Malignant Pleural Effusion Biomarkers as Predictor for Chemical Pleurodesis

Sherif Alsayed, Samar Marzouk, Sherif Abelhalim And, Essam Mousa

Background: 42-77 % of exudative pleural effusions are due to malignant diseases (1) this study aimed to evaluate the value of biochemical parameters of the pleural aspirate in predicting success of chemical pleurodesis in adult patients with malignant pleural effusion.

Patients and Methods: This prospective study included 30 adult patients with malignant pleural effusion diagnosed by clinical examination, Chest CT scanning and closed pleurocentesis. Patient ages mean of 60.4 ± 7.8 years, multiple sessions of closed pleurocentesis were carried out followed by insertion of an intercostal tube. The pleural aspirate was then sent for chemical analysis to detect Glucose, PH, and LDH. Pleurodesis was then done either by using Tetracycline (group A, or Bleomycin (group B). All patients were then followed up for success of the pleurodesis process within one month.

Results: Within one month of follow-up, rates of clinical response to treatment in group A (Tetracycline) were successful in (40 %); versus group B (73.3 %). Complete response (CR) occurred in group A cases (20 %); versus (33.3 %) in group B; whereas partial response (PR) occurred in 3 cases of group A; versus 6 cases of group B; and treatment failure (TF) occurred in 9 of group A cases versus 4 of group B case. None of our patients died. Morbidity occurred in the form of mild-to-moderate The success of the pleurodesis was closely-associated to a higher glucose and PH levels together with a low LDH level in the pleural fluid.

Conclusion: The success of pleurodesis is usually higher when the pleural fluid PH and glucose levels are high & the LDH level is low in MPE

Keywords: MPEs: Malignant Pleural Effusions

Acute asthma in emergency department, prevalence of respiratory and non-respiratory symptoms

Sherif Refaat, Hassan Aref

Background: Although asthma is a well identified presentation to the emergency department, little is known about the frequency and percentage of respiratory and non-respiratory symptoms in patients with acute asthma in the emergency department (ED).

Objective: The aim of this study is to identify the relationship between acute asthma exacerbation and different respiratory and non-respiratory symptoms including chest pain encountered by patients visiting the emergency department.

Subjects and Methods: Prospective study included 169 (97 females and 72 males) asthmatic patients who were admitted to emergency department of two tertiary care facility hospitals for asthma exacerbation from the period of September 2010 to August 2013, an anonymous questionnaire was used to collect symptoms and analysis of symptoms.

Results: Females were 97 (57%) of the patients, mean age was 35.6 years; dyspnea on exertion was the commonest symptom accounting for 161 (95.2%) of patients, followed by dyspnea at rest 155 (91.7%), wheezing in 152 (89.9%), chest pain was present in 82 patients (48.5%), the pain was burning in 36 (43.9%) of the total patients with chest pain. Non-respiratory symptoms were seen frequently in acute asthma in ED.

Conclusion: Dyspnea was the commonest chest symptoms encountered in patients with acute asthma followed by wheezing. Chest pain in acute asthma is a common symptom and should be fully studied to exclude misdiagnosis as of cardiac origin; there

is a need for a better dissemination of knowledge about this disease association with chest pain. It was also noted that other non-respiratory symptoms are frequently encountered with acute asthma in emergency department.

Influence of 7 weeks self management education on the BAI and 6MWD of COPD stable patients

Sherif Alsayed, Khalid Elnagar, Essam Mousa

Content: This study examines the effect of self education on, exercise tolerance, and dyspnoea. 20 patients with stable COPD (mean forced expiratory volume in one second FEV1 =1.29±0.28, 6MWD 333.15±70, BAI43.15±3.47 had seven 90 min sessions of self education at weekly intervals. Patients Completed the Beck Anxiety Inventory (BAI), 1 day before and 7 weeks after therapy. FEV1, forced vital capacity (FVC), blood gas tensions and 6 min walking distance (6MWD) were measured. 20 control patients attended weekly for spirometer and 6MWD for 7 weeks. There were no differences in mean baseline (BAI) score, lung function, blood gas tensions or 6MWD between groups. After Treatment, the BAI score had decreased significantly to 40.8±3.11, in association; the mean 6MWD had also improved in the treated group only, from 333.15±70 to 376.9±64.9m, an increase of statistical significance 0.042.

Conclusion: 7 weeks self management education to the COPD patients produced a good improvement in exercise tolerance and BAI.



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Recurrent Pneumothorax with a Relapse-free Interval of 7 Years as a First Manifestation of a Lymphangiomyomatosis (LAM)

Dr. Feras Al-Shahrabani, Dr. Marcus Albert

Content: Lymphangiomyomatosis (LAM) is a rare slowly progressive multisystem disorder which occurs predominantly in young women. It occurs in about 3.4–7.8 per million women. LAM is characterized by the proliferation of abnormal smooth muscle-like

cells, leading to progressive cystic destruction of the lung. In patients with LAM the lung function declines at rates that vary between 3% and 15% per year. Recurrent pneumothorax is often the first manifestation of the disease.

Case Description: This case description concerns a 40 year old woman who was referred to us for treatment of a recurrent and persistent pneumothorax. The current CT of the chest showed bilateral multiple bullae/cystic formation and a left sided pneumothorax. In comparison with the previous CT 7 years ago the actual CT showed obvious progress in number and in size of the bilateral bulla. These CT findings were most suggestive of LAM. To treat the current left sided pneumothorax and to insure the Diagnosis of the LAM, we performed a VATS with resection of the ruptured bulla and a subtotal pleurectomy of the parietal pleura. The histopathological examination of resected specimen using immunohistochemical staining of HMB-45 confirmed the LAM diagnosis.

Conclusion: LAM is a rare disease which often presents with features of pulmonary involvement. Its clinical pulmonary manifestations vary from simple cough to development of recurrent pneumothorax, hemoptysis, and even complicated pleural effusions. Progressive dyspnea develops as the disease progresses. This wide range of manifestation, the rarity of the disease and the unknown etiology may result in a delayed diagnosis. The physician should be familiar with this disease to achieve the correct diagnosis. The CT image is characteristic and sometimes diagnostic of LAM. The most specific method for diagnosing LAM is lung biopsy to demonstrate the presence of LAM cells, either by their characteristic histological appearance or by specific immunostaining with HMB-45 antibody. The European Respiratory Society guidelines for the diagnosis and management of LAM show that although progesterone is widely used in the treatment of LAM there is not enough scientific evidence to recommend its routine use. Sirolimus, an inhibitor of the mammalian target of rapamycin (mTOR), has been reported to decrease the size of angiomyolipomas and stabilize the pulmonary function in patients with LAM. However, the optimal dose for the treatment of LAM remains unclear.

Flail Chest, To Ventilate or Not to Ventilate

Banjar AH, Alshareef SM, Reza A

Background: Flail chest injuries are associated with severe pulmonary contusion, a requirement for intubation and mechanical ventilation, and high rates of morbidity and mortality. Our goals were to review our experience in managing flail chest following road traffic accidents admitted in a tertiary referral Hospital in Holly Makkah.

Methods: A retrospective analysis of the demographic data, various methods of pain control, hospital stay and complications, and clinical outcomes associated with flail chest injuries. Outcomes included the number of days on mechanical ventilation, days in the intensive care unit (ICU), days in the hospital.

Results: 46 patients were recruited with Flail chest injury over 2 years period; the mean age was 52.2 years, and 83% of the patients were male. Significant head injury was present in 26%, while 30% had lung contusions. Treatment practices included pain control by opioids and non-steroidal anti-inflammatory (NSAID), neither epidural catheters nor patient control analgesia were used. Mechanical ventilation (MV, as a mode of internal fixation of flail segment, was required in 36% (N=11), for a mean of 17.1 days. MV was required due to respiratory failure in 10%, Head injuries in 10% other injuries in 8% and electively in 6% of total cases. Significant factors predicting requirement of mechanical ventilation were number of fracture ribs, bilateralism, lung contusion and association of lung injuries. Neither age nor associated abdominal nor musculoskeletal injuries were significant factors. 89% were improved and discharged home. 11% died due to ARDS (N=1), Septicemia (N=2), Massive bleeding (N=1) and sudden cardiac arrest (N=1).

Conclusion: Patients who have sustained a flail chest have significant morbidity and mortality. In our series these patients were treated non-operatively, and only 17% were required MV. Aggressive pain management with opioids and NSAID can prevent patients from deterioration and requirement of MV. Review of current literatures and current increasing trend of external fixation will be discussed and whether a change of practice to operative intervention is mandatory or not.

Manubrioclavicular and Manubriosternal Reconstruction after Radical Resection for Chondrosarcoma of Manubriosterni: A New Surgical Technique

Hadi Mutairi, Ikram Chaudhry

Content: Primary tumours of the chest wall are uncommon, comprising only 0.5% - 1% of all neoplasms, However 20% of all chest wall neoplasms are chondrosarcoma, among that 80% arise from the ribs and 20% from sternum(1). Although sternum is unusual site, the annual incidence is less than 0.5/million/year(2). Early diagnosis and radical resection with wider margin and optimal reconstruction is the gold standard of treatment. Reconstructive procedure should be aimed to provide rigid thoracic cage, for chest wall stability, good pulmonary function and protection of internal thoracic organs(3).

Case Report: A 42-year old male presented with slowly growing painful manubriosternal mass of six months duration. There was no history of cough, dyspnea, hemoptysis, night sweats, pyrexia or itching. On physical examination, revealed a hard, fixed,

non tender mass with no palpable axillary and cervical lymphadenopathy. His routine laboratory investigations including complete blood count (CBC,) liver and renal panel and pulmonary function test they were all within normal limits. CT scan of thorax revealed a manubrial mass extending to the sternum and both clavicular heads. Patient was discussed at the tumor board and it was decided to proceed for radical resection and reconstruction with an idea to achieve complete resection.

Midline incision was given and skin flap were raised on each side. Radical enblock resection of both clavicular heads, manubrium and full sternum including all bilateral costal cartilages was carried out.(Fig 2). Both sternocleidomastoid muscles clavicular attachments were detached from its origin. A mralex methyl methalacrylate sandwich plate was made and molded according to the shape of defect. Holes were drilled in ribs and both clavicals and mralex methyl methalacrylate plate and it was anchored by interrupted 2/0 prolins sutures (Fig 3). Sternocleidomastoid muscles were reimplemented on mesh which was deliberately made loose so it can accommodate the sternocleidomastoid muscle and upper arms movements without any compromise. The margins of sandwiched marlex mesh was stitched with continuous 2-0 Prolene suture to the surrounding tissues. Anterior chest wall wound was closed by approximating the soft tissues and pectoralis major muscles . Skin was closed without the use of myocutaneous flap. Patient was extubated on table and sent to ICU for overnight observation. Histology report showed low grade well differentiated chondrosarcoma of manubriosterni with all resection margins free of tumour. The patient was discharged home for further follow up in outpatient and his follow up CT thorax showed no recurrence at 2 years follow up.

Pulmonary Metastasectomy for Metastatic Sarcoma: Prognostic Factors Associated with improved Outcomes

Hadi Mutairi, Ikram Chaudhry

Content: Pulmonary metastasectomy (PM) for sarcoma metastases has been shown to be associated with long-term survival. Several prognostic factors, including tumor histologic subtypes, number of metastasis, disease-free interval (DFI) and tumor doubling time, have been evaluated in order to predict the benefit of pulmonary metastasectomy and their impact on long-term survival. Carefully selected patients may achieve 5-year survival of 45%. However, there are no clinical guidelines to optimize patient selection for PM. The aim of this study is to evaluate a cohort of patients in order to identify prognostic factors associated with improved survival.

Methods: Retrospective chart review of patients who underwent pulmonary metastasectomy for bone or soft-tissue sarcoma between January 2007 and December 2013 was conducted. Our Institutional Review Board (IRB) approved this study. Inclusion criteria included adults patients; age 18 years or older, complete local control of the primary sarcoma, and had metastatic disease limited to the lungs. Patients with primary pulmonary sarcoma were excluded from the study. All patients underwent chest computed tomography (CT) scan as part of metastatic surveillance at 3-month and 6-months interval. Fitness for lung resection was evaluated by clinical performance status, spirometry, and pulmonary function tests in all patients.

Patients who had synchronous pulmonary metastases or other extrathoracic metastases at first presentation of the primary sarcoma were treated with chemotherapy first, followed by surgical resection of the primary disease. If a patient's metastatic survey confirmed local control of the primary tumor and no other extrathoracic metastases, pulmonary metastasectomy was offered based on their ability to tolerate lung resection. Patients with metaschrous pulmonary metastases were either treated with chemotherapy first or offered lung resection, depending on tumor histologic features, aggressiveness of recurrence, and their overall performance status.

Operative approaches that were implemented for pulmonary metastasectomy included open posterolateral thoracotomy, video-assisted thoracoscopy, and median sternotomy. All patients had intraoperative bronchoscopy. The operative approach was chosen based on the surgeon's judgment and the ability to achieve a complete resection. Demographics and outcome data such as age, sex, histologic type, grade, operative approach, number of operations, laterality, tumor size, surgical margins, and history of chemotherapy were reviewed. Pulmonary metastases were confirmed pathologically and the histologic features were compared and matched with primary sarcoma.

Estimated overall survival was calculated from the time of first metastasectomy to the last day of follow up. Disease free interval (DFI) was defined as the time of detection of primary tumor until diagnosis of pulmonary metastases. Disease-free survival (DFS) was defined as the time from pulmonary resection to radiographic evidence of pulmonary recurrence or other distant metastasis. Local recurrence in the primary sarcoma site was not included as DFI. Survival curves were constructed using the Kaplan-Meier method and compared using the log-rank test. The variables that were found to be significant on univariate analysis.

Assessing the role of Mitochondrial Dysfunction in COPD and its association to clinical phenotype: Do Mitochondrial targeted agents hold the key to future treatment?

G Haji, C Wiegman, C Michaeloudes, J Hull, P Kemp, I Adcock, K F Chung, M Polkey

Introduction and Rationale: COPD is the third leading cause of death worldwide. Limited medical therapies are available to improve outcomes and course of disease. Oxidative stress may underlie both pulmonary and non-pulmonary manifestations of the disease and may result from mitochondrial dysfunction. We hypothesised that if oxidative stress arose from the airways and lungs and spilled over to cause non pulmonary manifestations (specifically skeletal muscle dysfunction) then greater evidence of mitochondrial dysfunction would be present in the airways; and that the degree of mitochondrial dysfunction would be associated with the severity of the clinical phenotype. We also hypothesised that mitochondrial dysfunction could be induced in murine models using Ozone as an oxidative stressor and that a novel targeted mitochondrial agent, MitoQ10, could potentially reverse this process and hold the key to future trials and treatment in patients with COPD.

Objectives: To measure mitochondrial function in endobronchial and skeletal muscle biopsies in a group of phenotypically well characterised age- and smoking- matched ex-smokers stratified according to FEV1. We also examined the effect of a novel mitochondrial-targeted agent in ozone-exposed mice.

Methods and Measurements: Subjects were recruited and stratified according to FEV1 into 3 groups (Table). Groups A and B underwent endobronchial biopsy and vastus lateralis muscle biopsy on the same day. Patients with more severe disease underwent vastus lateralis biopsy only in accordance with ethics committee safety criteria. Mitochondria were isolated from fresh tissue on the day and membrane potential as a recognized marker of function was measured using the carbocyanine dye JC-1. Concurrently we tested the effects of MitoQ10 in acute ozone exposure murine models.

Results: Mitochondrial membrane potential was higher in the airway compartment than muscle ($p < 0.0001$), and there was a difference between mitochondrial function in the airways between the groups ($p = 0.0012$). There was no such difference in muscle ($p = 0.49$). Airway mitochondrial function correlated with lung function parameters FEV1 and TLCoc ($r = 0.77$, $p = 0.0007$ and $r = 0.59$, $p = 0.019$, respectively). Mitochondrial function in the airways correlates with six minute walk distance ($r = 0.57$, $p = 0.027$) and peak oxygen uptake during an incremental exercise test to exhaustion ($r = 0.74$, $p = 0.0015$). No such correlations were noted with muscle mitochondrial function. Acute ozone exposure (3 ppm, 3 hrs) induced mitochondrial dysfunction in the lungs of mice ($p < 0.01$) and this was reversed by MitoQ10 ($p < 0.05$).

Conclusion: Mitochondrial dysfunction is present in the airway compartment of ex-smokers with COPD and there is an association between airway mitochondrial function and exercise ability which has not been demonstrated previously. Mitochondrial dysfunction can be induced in mice using ozone as an oxidative stressor and the mitochondrial targeted agent that we have tested demonstrates a beneficial effect. Human clinical trials and drug development in this area could improve outcomes for patients with a condition that has limited treatments.

Against bacteria commonly implicated in surgical site infection and their cost effectiveness

Ahmad Faraz, Abdul Hameed, Hamzullah Khan, Fazal Bari, Irum Sabir Ali*, Fazl-e-Rahim, Amjad Naeem, Mumtaz Khan, Abid Hussain

Objective: To know the in-vitro activity of various brands of ceftriaxone against bacteria most commonly grown from surgical site infection (SSI). A comparison of five days cost of these brands will also be done.

Material & Methods: It was experimental study conducted by a team of surgical "C" unit LADY READING HOSPITAL (LRH) in collaboration with departments of pharmacology KHYBER GIRLS MEDICAL COLLEGE (KGMC) and microbiology department of Lady Reading Hospital Peshawar. Isolates of five bacteria i.e. Staphylococcus aureus, Proteus mirabilis, Escherichia coli, Enterobacter Spp, and Klebsiella pneumoniae, found sensitive to ceftriaxone were grown on 50 slopes each and the zone of inhibition was checked for each of the ten brands of ceftriaxone. Ceftriaxones were coded as C1, C2, C3,.....C10. The international CLSI guide lines was used for reference. All the authors except one were kept blinded. Cost was also analyzed for an average of five days therapy.

Results: The zones of inhibitions of different brands of ceftriaxone against the above mentioned bacteria were not significantly different. The cost of therapy was significantly different for ten brands.

Conclusion: Various brands of ceftriaxone of variable cost had no influence on their activity against bacteria involved in SSI.

Keywords: Brands of Ceftriaxone, in-vitro antimicrobial activity, SSI, Cost.

Types of Treatment of Acute Mediastinitis

Aiya Bimurzayeva, Kulsara Rustemova, Batyr Aitmoldin, Zhazira Seydagalieva

Actuality: Rapidly progressive increase in the development of modern medicine, development and implementation in the diagnosis and treatment of robotic technology, the discovery of new drugs do not solve the problem of early diagnosis and treatment of acute

mediastinitis. It is still relevant for practical public health at the present time.

Purpose: The selection of the optimal treatment of acute mediastinitis, achieving a favorable outcome.

Materials and Methods: During the period from 2012 to 2014 in our hospital were treated 7 patients with suppurative necrotizing mediastinitis. The patients' age: from 35 to 73 years. Men – 5, women – 2 CT, MRI, endoscopic equipment «Karl Stors», microbiological methods of research, clinical and laboratory research.

Results: Over the past three years in the “City Hospital 2” of Astana treated 7 patients with severe acute clinic pyonecrotic mediastinitis.

Causes of Mediastinitis Were: Trauma (perforation foreign body, chemical burns acids) of the esophagus - 3; polytrauma -1; odontogenic osteomyelitis of the mandible -1; complication of tonsillitis -2. In 5 cases against the background of complex treatment recovered. In These cases, the patients were hospitalized during the first 3 days; relatively young age (35 to 50 years).

2 cases have been fatal: Patients sought medical help after 7 days. Patient 73 years old, suffered from decompensated type 2 diabetes. The second patient, 45 years old, festering mediastinitis developed against the backdrop of odontogenic osteomyelitis of the mandible. Cause of death in both cases, acute cardiovascular failure on the background of endogenous intoxication.

In all cases, patients made mediastinotomy, drainage of the mediastinum; software flow washing; ozone; antibiotic therapy for the type of microflora; correction of water and electrolyte balance and protein; symptomatic therapy.

In 1 patient, the diagnosis of anterior-posterior upper mediastinitis was made opening the posterior mediastinum using endoscopic equipment. In 2 cases additionally imposed gastrostomy; 1 in enterostomies Maida method to preserve the stomach for subsequent operations esophagoplasty shunt.

All patients were discharged in satisfactory condition.

Conclusion: Favourable outcome of treatment depends on the quality and timely delivery of health services.

Tracheal Bronchus as an Incidental Finding in Trauma Patient: A Case Report

Kharaba Ayman, Sherbini Nahid, Al beihany Amal

Content: Congenital conditions of the major airways are very uncommon. Tracheal bronchus is the commonest, it affects 0.1-2% of the population. Usually asymptomatic but especially in childhood they may present with cough, recurrent infections, or hemoptysis. We describe a 25-years-old male trauma patient with a right -sided tracheal bronchus arising from the lateral wall of the trachea (Conacher's carinal trifurcation TYPEIII) found incidentally on routine chest radiography upon admission to intensive care unit which confirmed by chest computed tomography and bronchoscopy. In adults with tracheal bronchus, the main concerns are complications during endotracheal intubation, risk of obstructive pneumonia, prolong hypoxia, lung neoplasms and the association with cardiovascular, renal and other congenital anomalies.



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Evaluation of Thoracomyoplasty in Chronic Empyema Thoracis- An Institutional Experience

Anurag Rai, Dr. Suresh Kumar

Background: Open pleural drainage is an uncommon modality in the current arena of appropriate antibiotic coverage and multiple means of closed pleural drainage. Open drainage is usually reserved for very ill patients for whom a thoracoscopy or thoracotomy would be too morbid. In its extreme form, open pleural drainage results in a thoracotomy. The present paper is an institutional experience that deals with the staged management of chronic ET with destroyed lung, and use of thoracomyoplasty to improve the outcome of this morbid condition in resource limited condition.

Material & Methods: A retrospective review of all adult patients admitted to KING GEORGE'S MEDICAL UNIVERSITY between January, 2009 and 2013, with the diagnosis of chronic Empyema thoracis. Data included patient demographics, presentation, chest computed tomography (CT) findings, treatment, and outcome. The diagnosis was made by clinico-radiological assessment. All very ill patients for whom a thoracoscopy or thoracotomy would be too morbid included in study and underwent two-stage surgical treatment- Open Window Thoracostomy(OWT)/Modified Open Drainage (MOD), followed by thoracomyoplasty. The Quality of life scoring was done on a 1 to 20 scale, and included various aspects viz. functional, social, psychological, and financial.

Results: The total number of patients (n) was 42 patients. The mean age of the patient was 37 years. The male to female ratio was 1.44:1. In majority, the etiology was tuberculosis. In 28 (66.6 %) patients, the etiology was tuberculosis. It was pyogenic in 13 (30.9 %) and traumatic in one (2.3 %). The per-operative findings revealed pleural thickening in all patients. Thickened pus was observed in 30 (71.4 %) patients, while bronchopleural fistula was observed in 22 (52.3 %) patients. After the stage I, no mortality or revision of surgery was observed and the patients had improvement in clinical signs and symptoms. After stage I, the quality of life scores were very poor for all the parameters. After stage II, for all the aspects of quality of life, excellent scores were achieved. The patient satisfaction was 97.75 %. The Latissimus dorsi was the most commonly used muscle, either alone (32, 76.1 %) or in combination (6, 14.2 %). Serratus anterior in combination with Latissimus dorsi was used in 2 (4.7 %) patients, while Latissimus dorsi in combination with erector spinae was used in 1 (2.3 %). In one (2.3 %) patient, Pectoralis major muscle was used. The mean duration between first and second stage of surgery was 4.77±0.75 months (range 2–7 months). The mean duration of hospital stay was 5.27±1.28 days (2–7 days). The pulmonary functions were restored to normal in 26 (61.9 %) patients. The clinical symptoms were relieved in all the patients. In all the patients, BPF was corrected. Normal BMI (>18.5 kg/m²) was achieved in 36 (85.7 %) patients.

Conclusion: Open window thoracotomy is the obvious choice for severe grades of Empyema Thoracis, however, Thoracomyoplasty not only improves the function but also provides greater relief to the patient in terms of physical, social, psychological, and financial dimensions. It is important in any setup where patients are from low socioeconomic groups.

Keywords: Thoracomyoplasty, modified open drainage, Chronic Empyema Thoracis

Video-Assisted Thoracic Surgery (VATS): A Promising Role In Pulmonary Aspergilloma

Anurag Rai, Suresh Kumar

Introduction: Pulmonary Aspergilloma has been treated surgically for many years but the mortality rates of larger surgical series, varying from 7% to 23%, is not considered acceptable by today's standards. We report our experience in the surgical treatment of pulmonary aspergilloma through VATS and present a review of the literature.

Materials & Methods: We operated upon 12 patients with pulmonary Aspergilloma through VATS in 2 years. Among them, 09 were male with a median age of 42yrs and 3 were female with median age of 38yrs. 11 were afflicted with simple aspergiolloma and the one with complex aspergiolloma.

Results: The most common clinical presentation of pulmonary aspergilloma was haemoptysis which occurred in 10 patients (93.0%) Diagnostic tools were Chest X-ray and CECT Thorax scan. Tuberculosis and Bronchectasis were the most common underlying lung diseases. Systemic antifungal therapy neither palliated the clinical symptoms nor eradicated the Aspergilloma. Surgery offered the only chance of cure. The most common surgical procedures was VATS guided lung wedge resection (n=9), segmentectomy (n=2) and lobectomy (n=1). The postoperative complications in the complex type were bronchopleural fistula. No Intraoperative and Postoperative mortality occurred in our cases. Postoperatively, Most of the patients were symptom-free. Recovered better in terms of pain and forced expiratory volume. Only one patient develop Empyema.

Conclusion: With appropriate preoperative evaluation and judicious surgical technique, surgery is the preferred treatment for pulmonary aspergilloma, for curing the underlying disease. In particular, Simple Aspergilloma is considered to be a good indication for VATS

Keywords: Aspergilloma, VATS, Fungi, Lobectomy

Early results of excision of 207 cases of Primary Chest Wall Tumors in 12 year period

Amer Bilal

Objective: To assess the surgical outcomes in primary chest wall tumor.

Methodology: 207 patients from June 2002 to May 2014 were retrospectively analyzed. Patients of all ages, both sexes and operable primary chest wall tumor were included. Clinical evaluation, routine investigations, chest radiographs, computed tomography and biopsy were done. Incisional biopsy was done for >5cm mass while excisional biopsy was done in smaller tumors. Complete excision of the chest wall tumor with 5cm free margin and one normal rib above and one normal rib below was done. Specimen was sent for histopathology. In skeletal reconstruction plastic surgeon was involved. Patients sent to oncologist for adjuvant therapy accordingly. One Year follow-up were done.

Results: Out of 207 patients, 143 were male and 64 were female, age ranges from 9-80 years with a mean of 27.8 years. 143 patients experienced painless mass and 64 patients painful mass. 103 chest wall masses presented on right side, 67 left sided and 37 on sternum. Sizes were 10 cm 08. Chest wall resection and primary closure was done in 65 cases while in 113 cases resection and reconstruction done using marlex mesh alone in 24 cases and reinforced with methyl methacrylate in 05 cases. Histologically Chondrosarcoma was reported in 61.5%, Fibrosarcoma in 25%, Ewing sarcoma in 11.5% while 2% specimens were reported as chondroma. Postoperative flail observed in 8 cases, 5 patients died despite prolonged ventilation. 89 patients referred to oncologist. 135 patients were followed for one year with no recurrence, 72 patients were lost to follow up.

Conclusion: Primary chest wall tumor can be safely managed by resection and primary closure or chest wall reconstruction and are associated with long term survival.



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Experience Of Decortication for Empyema Thoracis

Amer Bilal

Objective: To assess the outcome of surgical management of empyema thoracis in cases treated by open decortication.

Methodology: Computerized clinical record of 3006 patients who underwent decortication for empyema thoracis from Jan 2003 to May 2014 was retrospectively analyzed. Patient of all ages, both sexes and diagnosed empyema thoracis were included. Medically unfit, empyemas due to malignant pleural effusion, empyema due to clotted hemothorax were excluded from the study. All patients were admitted through outpatient department. All patients underwent decortication by conventional posterolateral thoracotomy. Follow up done in all cases.

Methodology: Computerized clinical record of 3006 patients who underwent decortication for empyema thoracis from Jan 2003 to May 2014 was retrospectively analyzed. Patient of all ages, both sexes and diagnosed empyema thoracis were included. Medically unfit, empyemas due to malignant pleural effusion, empyema due to clotted hemothorax were excluded from the study. All patients were admitted through outpatient department. All Patients underwent decortication by conventional posterolateral thoracotomy. Follow up done in all cases.

Results: Out of 3006 patients, 1923 (63.97%) patients were male and 1083 (36.02%) were female, age ranges from 2 to 71 years with a mean age of 33.12 years. 1910 (63.53%) underwent right thoracotomy and 1096 (36.46%) left thoracotomy. Bronchopleural fistula was present in 610 (20.29%) patients and empyema necessitans in 245 (8.15%). Pneumonia and tuberculosis were seen in 1161 (38.62%) and 1845 (61.37%) cases respectively. Mean duration of postoperative chest drain was 14 days. Follow-up ranged from 15 days to 6 months. Morbidity was 245 (8.15%) including wound infection 140, air leak 55, bleeding 21, failed decortication 29. Mortality was 66 (2.19%) including respiratory failure 46, pulmonary embolism 14 and myocardial infarction in 06 patients.

Conclusion: Delayed referral causes irreversible changes in the lung prolonging recovery and increasing complication rate. Meticulous decortication gives gratifying results.

Surgical Resection Of Pulmonary Hydatid: An Experience Of 532 Cases

Amer Bilal

Objective: To assess outcome of surgical resection of pulmonary Hydatid disease

Methodology: All patients admitted to cardiothoracic unit from June 2002 to May 2014 with pulmonary hydatid cysts were evaluated retrospectively as to age, sex, symptoms, diagnostic procedures, anatomic location of cysts, surgical procedures, complications, and outcomes.

Results: Total of 532 patients was operated for hydatid cystectomy. 380 were men and 152 women. Mean age was 39.14 ± 16.8 years (range, 16–69 yr). 339 of these were symptomatic, most commonly with hemoptysis and chest pain. 82 Patients presented with ruptured hydatids. 111 patients were asymptomatic, found to have Hydatid cyst incidently. There Were 296 Hydatid cysts on the right side while 236 on the left side. Hydatid cystectomy and wedge resection of pulmonary parenchyma were the chief operative procedures. Lobectomy was done in 35 patients, Bilobectomy in 6 patients and Pneumonectomy in 2 patients. Albendazole was prescribed to all patients postoperatively. Patients were followed up for a period of 13 ± 15.4 months (range, 2–36 months). 31(5.82%) patients had postoperative complications including wound infection in 22 patients, bronchopleural fistula in 5 patients and recurrence in 4 patients. Mortality was 2% including respiratory failure 08 and septicemia in 03 patients.

Conclusion: The principal involved in surgical resection of pulmonary Hydatid included; in all resection, individual closure of bronchial communication, obliteration of pleural space and assessment of residual lobe, whether viable or required resection and anthelmintic medical regimen post operatively.

Outcome of Surgical Management of Pulmonary Aspergilloma

Amer Bilal

Objective: To analyze the results of surgery in the management of Pulmonary Aspergilloma.

Methodology: Computerized records of 450 cases of diagnosed Pulmonary Aspergilloma were retrospectively analyzed from June 2002 to May 2014. 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 450 patients, 255 patients were male and 195 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 407 (90.44%), whereas lung abscess was present in 36 (8%) and lung cancer in 7(1.55%) case. The procedures performed were Lobectomy in 372 (82.66%) cases, Bilobectomy 36 (8%),wedge resection 24 (5.33%), Pneumonectomy 18 (4%).Postoperative complications occurred in 32 (7.11%) patients, of which 15 (3.33%) had prolonged air leak, 8 (1.77%) had significant postop bleeding out of which two required re-exploration, 4 (0.88%) patients developed Empyema and wound infection occurred in 3 (0.66%) patient. 30 days Mortality was 6 (1.33%) of which 05 patients died due to 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.

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 135 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 2014.

Results: There were 81 male and 54 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=31], bilobectomy [n=32] and lobectomy [n=60]), while primary thoracoplasty with apicolysis was done in 12 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 fourteen cases; seven patients developed bronchopleural fistula with empyema, apical space in three patients and wound infection in four patients. At a mean follow-up of one year bacteriological cure was achieved in 120 patients.

Conclusion: Judiciously performed adjuvant surgery can yield excellent long term bacteriological cure with acceptable mortality and morbidity in multidrug-resistant tuberculosis.

Utilization Of Sweat Chloride Testing To Affirm The Diagnosis Of Cystic Fibrosis

Dr. Iqbal Bano

Aim and Objective: To determine The Relevance and utilization of Sweat Testing to affirm the diagnosis of Cystic Fibrosis.

Patients and Methodology: It is a prospective descriptive cross sectional study done at the Pulmonology OPD of the Children's Hospital Lahore from Nov 2012 to Oct 2013.

Total 126 patients from 2 months to 16 years of age with the suspected diagnosis of cystic fibrosis were enrolled. Sweat chloride test was performed in all the enrolled patients. Supportive investigations for our suspected diagnosis were done including CXR, HRCT, Serum Amylase level, Stool fat. We used the SM-01 Sweat Analyzer which shows total ion concentration so the result which showed conductivity equivalent to 90mmol/L will be considered equal to chloride value of 60mmol/L.

The data obtained was analyzed by the help of statistical software SPSS version 16 and Chi- square test was applied. Descriptive statistics were obtained by frequencies and percentages.

Results: Total 126 patients were enrolled as suspected cases of cystic fibrosis. The test was performed twice in all the suspected patients. Those patients were declared as definite cases of cystic fibrosis in whom the results were more than 90 mmol/L. Out of 126, 12 patients had score more than 90 mmol/L. The commonest age group was between 1-10 year i.e. above 66% lie in this age group, and male exceeded the females. Consanguinity was present in 10 (83.3%) patients. The mean age of presentation was 12 months and the mean age of diagnosis was 68 months. The commonest clinical features were repeated respiratory tract infections, failure to thrive, diarrhea, abdominal pain and constipation in order of frequency.

Conclusion: Sweat chloride can be considered as a gold standard for definite diagnosis specifically in developing country like ours where neither CFTR gene mutation analysis nor new born screening is easily accessible.



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Evaluation of psychological status in patients with chronic obstructive pulmonary disease and its relationship with disease outcomes Evaluation of psychological status "Wellness" in COPD patients

Khalid Aziz Ansari

Background: It is believed that the level beneath current state of health (HRQL) is the lifestyle status of the patient. However there other more important levels that play a vital role such as psychological, mental, motivational levels and the spiritual being are understudied. This research attempted to validate a new wellness assessment questionnaire and investigate the role of different wellness domains in patients with COPD clinical status and health status.

Method: This is a longitudinal prospective / observational study. Both qualitative and quantitative methods are used. The study consists of two phases. First, is the development of the new Wellness Questionnaire with the help of a focus group followed by an examination of the wellness questionnaire and its relationship with other COPD outcomes.

Results: Thematic analysis of focus group and original cohort respondents highlighted some factors that influence wellness status and that may lead to un-wellness state of the body. Five domains are explored as a marker of wellness in patients with COPD.

Some of these factors are considered as markers of high wellness status and others as markers of low wellness status. (Table 1 and Figure 1). The quantitative analysis of the wellness questionnaire with Spearman correlation demonstrate a significant correlation between Physical/Personal Wellness and other markers of COPD progression such as GOLD (0.006), FEV1% (0.01), health related quality of life (0.009), multidimensional BOD score and quartile (0.003 and 0.02) (Table 2).

Conclusion: This study needs to be considered as a unique addition to the literature with respect to the identification of new markers of wellness status for the improvement in overall health and well-being in these patients. Assessment of Wellness suggesting the possible role of wellness assessment in these patients and its impact on disease progression.

Aeroallergenic Profile of Indoor Allergens and their Clinical Relevance in Allergy and Asthma Patients in Saudi Arabia

Syed M. Hasnain, PhD, FACAAl, FAAAAI; Abdulrahman S. Al-Frayh, MD, FACAAl, FAAAAI

Objective: Bronchial asthma and other respiratory allergic diseases are not only prevalent in Saudi Arabia and the Middle-East but the published data indicate that such diseases are on the rise. Investigations of extrinsic and intrinsic factors causing such diseases have been undertaken at different places in the Kingdom of Saudi Arabia. However, studies on the presence of indoor allergens and their clinical relevance still lack a clear understanding in the region.

Methods: House dust samples were collected in sterile ALK filters (ALK Laboratory, Denmark) and analyzed for various indoor allergenic factors including Der p 1, Der f 1, Bla g 1, Per a 1 and Fel d 1 using antibodies and ELISA technique. Indoor allergenic fungal flora was also examined by collection of samples and culture using dilution plate technique. The samples were collected through the individual's own vacuum cleaner after the operation on their respective home carpets and mattresses. These samples were extracted individually and allergens were quantitated using specific antibodies from Indoor Biotechnologies (U.S.A) and ALK Laboratories (Denmark) by ELISA procedure.

At Some selected locations, Skin Prick Tests were conducted on allergic patients with various indoor allergens using both commercial and indigenous species.

Results: The data for the two house dust mites *Dermatophagoides pteronyssinus* (Der p) and *Dermatophagoides farinae* (Der f) showed a higher concentration in the humid areas of the country particularly in Jeddah with concentration exceeding threshold levels for both sensitization and exacerbation of acute attack asthma. The central region with very low humidity showed negligible presence of both mite species. The data from Jeddah and Abha showed variation in qualitative nature, one species being prevalent in Jeddah while the other being prevalent in Abha. The variation was also noted in the Skin Prick Testing in Taif. Data for *Blattella germanica* (Bla g 1 and Bla g 2), *Periplaneta americana* (Per a 1) and *Felis domesticus* (Fel d 1) showed quantitative regional variation as well.

Conclusion: The results obtained for both the prevalent indoor aeroallergens and their IgE Mediated Skin Prick Test re-activities indicate: (1). There are regional qualitative and quantitative variations in the appearance of these allergens, and (2). the prevalence of these allergens in the region are significantly relevant in the IgE sensitization of many patients and probably cause of the symptoms. Data from other countries in the Middle-East are either limited or none for any comparison. It is therefore recommended that a regional aeroallergenic profile should be prepared by conducting joint studies with standardized protocol for better clinical diagnosis and treatment in the region.

Efficacy and safety of low-dose colistin in the treatment for infections caused by multidrug-resistant gram-negative bacteria

S. T. R. Zaidi, Al Omran, Al Aithan AM , Al Sultan

Introduction: Infections due to multidrug-resistant gram-negative bacteria (MDR-GNB) are a significant burden to the healthcare system globally. Colistin is the drug of choice for MDR-GNB and recent studies recommend high doses. This study investigated the safety of low-dose colistin and the relationship of minimum inhibitory concentration (MIC) of colistin with bacterial cure in the treatment for MDR-GNB infections.

Methods: Computerized dispensing records identified all patients who received colistin during January 2010 and December 2011. Patients who were aged hieved and failed to achieve bacterial cure with regards to age, gender, site of infection, mg/kg dose or duration of colistin use. The average MIC in the bacterial cure group was significantly lower than the MIC in the bacterial failure group (P = 0 002). Similarly, 30-day mortality from the last dose of colistin was significantly lower in the bacterial cure group (P = 0 002). Nephrotoxicity occurred in 12 8% of patients and was not associated with the dose of colistin or concomitant use of nephrotoxic medications. MIC of ievie it. Colistin dose should be based on the MIC data of a given patient or local antimicrobial sensitivity data to maximize its efficacy.

The body mass index, airflow obstruction, dyspnoea and exercise capacity (BODE) index in chronic obstructive pulmonary disease for Saudi population

Ms. Nawal AlOtaibi, Dr. Khaile Ansari

Objective: To determine whether the BODE (body mass index, airflow obstruction, dyspnea and exercise capacity) index correlates with frequency of exacerbation in patients with COPD and smoking (pack/year) in Saudi Arabia.

Methods: The study recruited 40 patients with COPD and two sets of outcome were measured: the BODE Index result and the correlation between BODE index with the frequency of exacerbation events as well as the number of packs of cigarettes that a patient consumes in a year. All the statistical analyses done in the study were carried out using Statistical Package for the Social Sciences (SPSS) software, version 21.

Results: There was a positive and significant correlation between the BODE Index and exacerbation events ($r = 0.389$, $N = 23$, $p < 0.05$). However, for smoking frequency, the result of the correlation analysis showed that its correlation with the BODE Index was not statistically significant ($r = 0.021$, $N = 23$, $p = 0.461$). Those involved in the study were 23 participants after the application of the inclusion and exclusion criteria, all are male with a mean age of 67.70 years.

Conclusions: The results of the study showed that while a significant correlation was observed for exacerbation, the correlation with smoking frequency was not significant. The analysis also identified BMI and age, only age proved to have a significant correlation with the BODE Index due to the lack of control and uniformity in the age range of the participants. It is recommended that these variable controls be emphasised and better gender representation be achieved in future study.

A Case with Pulmonary Involvement of Sjogren's syndrome

Tahir Taha BEKCI, Mustafa CALIK, Hilal KOCABAS, Yavuz Sultan Selim AKGUL.

We presented as case with pulmonary manifestation of primary Sjogren's syndrome (pSS). A 35-year-old female patient presented with shortness of breath and backache, which progressed in couple of years. Patient had not any history of chronic diseases. Physical examination is unremarkable except for crackles in the lower lobes. There were interstitial changes in both lower zones in the thorax x-ray. High Resolution CT showed interstitial fibrotic changes prominent in the lower lobes. Because of these findings patient was questioned for connective tissue diseases. She has mouth dryness and eye dryness for a long time, and infertility that the reason was unexplained. WBC: 8.500 /mm³, Sedimentation 9 mm/hour, CRP 5 mg/l, ANA (-), ENA (-), anti-Ro and (-), anti-La (-) RF (15). Schirmer's test was positive. Lip biopsy was reported as Sjogren's syndrome.

SS is a chronic autoimmune disease that involves primarily the exocrine glands with a typical focal lymphocytic infiltration leads to dry mouth and eyes. SS which may involve any tissue or epithelial surface is affecting 0.1% of the general population, more common in women. Lung involvement occurs, ranging from 9% to 90% of SS patients but is clinically significant in approximately 20%. Lung involvement in particular is a very important determinant of the patient's clinical status, quality of life, and outcome. Sometimes, pulmonary manifestations are detected before diagnosis of SS as in our case. In this case, the reasons of pulmonary symptoms and infertility were clarified with SS diagnosis. SS should kept in mind in the patient with interstitial lung diseases.

Assessment of Hematological Parameters in Patients with Obstructive Sleep Apnea

Dr. Ilker Buyuktorun, Assoc. Prof. Dr. Taha T Bekci, Dr. Aysenur Oglakkaya, Prof. Dr. Samil Ecirli, Assoc. Prof. Dr. Mehmet Kayrak

Objective: Some recent studies showed increased significance of neutrophil: lymphocyte ratio (NLR) and platelet: lymphocyte ratio (PLR) as markers of systemic inflammation. In this study, it was aimed to measure hematological parameters, mainly NLR and PLR, in patients with OSA; to assess relationship between disease severity and these parameters; and to discuss availability of NLR and PLR markers for OSA follow-up.

Material and Method: We retrospectively reviewed records of 667 patients, who admitted to Sleep Laboratory of Pulmonary Division, Konya Education and Research Hospital with sleep complaints between January 2012 and April 2014. After exclusion criteria, overall 235 cases were included to the study. According to the results of PSG, OSA patients was divided to four group. Correlation between results of the PSG with hematological parameters were analysed among these groups.

Results: RDW was found to be significantly higher in patients with severe OSA when compared to those with mild or moderate OSA. NLR was found to be significantly higher in patients with OSA when compared to controls,

What Changed in Asthma Management at Pediatric Intensive Care After 10 Years: Observational Study

Ayman A Al-Eyadhy MD, Mohamed-Hani A Temsah MD, Ali AN Alhaboob MD, Abdulmalik K Aldubayan, Nasser A Almousa, Abdulrahman M Alsharidah, Mohammed I Alangari, Abdulrahman M Alshaya

Keywords: Asthma, Children, Critical Care, Intensive Care, Pediatric, Saudi, Status Asthmaticus

Objectives: The purpose of this study is to describe the clinical course and outcome of children with status asthmaticus (SA) admitted to PICU, and to describe change of practice in their management at our institute, as compared to previously published report in 2003.

Methods: This is a retrospective observational study. All consecutive patients less than 14 year of age with status asthmatics who were admitted to PICU during the period from November 2011 to October 2013 were included. The data were extracted from PICU database and medical records, using pre-designed case form. The cohort in this study (2013 cohort) was compared to the cohort of SA which was published in 2003 from our institution (2003 cohort).

Results: Out of 330 patients admitted to pediatric floor with the diagnosis of acute asthma, 67(20.3%) children were admitted to PICU. Out of these 67 patients, 29(43.3%) were on maintenance inhaled steroids, and 34(50.7%) were on inhaled salbutamol. Poor compliance to medication was documented in 36(53.7%). 16 (23.9%) had a history of previous PICU admission. Comorbidities were present in 19 (28.4%). One third of patients 19(28.8%) received antibiotics. Hyperinflation was the most common finding in chest x-ray (CXR) in 45(67.2%), followed by collapse in 16 (23.9%). Spontaneous air leak syndromes were observed upon presentation in 3 cases. The number of patients who required non-invasive ventilation was 24(35.8%). Multivariate Logistic regression Analysis revealed that older age, higher respiratory rate, and presence of collapse in CXR were significantly associated with NIV requirement. None of our patients required intubation, and there was no mortality. More cases were admitted during fall and winter compared to summer and spring. In comparison to our previous 2003 cohort, current cohort (2013) revealed higher mean age (5.5 vs. 3.6 years; p-value 0.001), higher rate of PICU admission (20.3% vs. 3.6%; p-value 0.007), less patients who received maintenance inhaled steroids (43.3% vs. 62.4%; p-value 0.03), less patients with pH < 7.3 (17.9% vs. 42.9% , p-value.

Conclusion: We observed slight shift towards older age for children with SA who required admission to PICU, with peak admission at fall and winter. Although the rate of ward admission due to acute asthma has decreased, the rate of PICU admission has considerably increased. This study demonstrates an increase in utilization of magnesium sulfate and non-invasive ventilation as important modalities of treatment. Also, there is no more use of Aminophylline in severe asthmatics at our PICU. This study also reports low rate of complications, as well as no mortality among asthmatics in our institute.



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Frequency of Glaucoma in patients with Obstructive Sleep Apnea at King Abdul Aziz University Hospital

Nahlah A. Bagabas, Wafaa Y. Ghazali , Mariam Mukhtar, Siraj O. Wali , Ashfaque Minyar, Osama Badeeb

Introduction and Research Problem: Obstructive sleep apnea (OSA) is a common disorder that has been coincided with several

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eye diseases including glaucoma. However, the association between OSA and Glaucoma is not clear yet in the literature. Such link may be due to the direct effect of hypoxia or impaired auto regulation of optic nerve perfusion. The aim of our study is to determine the frequency of glaucoma in OSA patients and find out the correlation, if any, between severity of OSA and glaucoma.

Materials and Methods: This is a cross sectional study. 330 patients diagnosed from 2012 to 2014 to have OSA with Apnea Hypopnea Index (AHI ≥ 10), based on over night polysomnography, at the Sleep Medicine and Research Center, King Abdulaziz University Hospital, Jeddah, were reviewed. After excluding patients on corticosteroid, only 100 patients remained. However, only 48 patients agreed to participate in the study. Informed consents were obtained from all participants. All 48 patients were examined by an expert glaucoma specialist and underwent the first visit examination. The first visit included: Testing visual acuity, measuring intra ocular pressure (I.O.P) by applanation tonometry, slit-lamp visualization of the anterior eye segment, and fundus examination in mydriasis to assess the optic disc and cup: disc ratio. Patient with optic nerve changes suggestive of glaucoma and/or increase (I.O.P >20 mmHg) were labeled as glaucoma suspects. Those glaucoma suspects underwent the second visit examination. The second visit examination included: Visual field test performed by experienced perimeters to assess glaucomatous visual field changes, assessment of retinal nerve fiber layer thickness, optical coherence tomography (OCT) to confirm optic nerve changes, and finally central corneal thickness (CCT).

Results: Ten patients found to be glaucoma suspects (Three with high I.O.P, and seven with glaucomatous optic nerve changes). However, only five of these confirmed in the second visit to have glaucoma in at least one eye. This lead to an estimated prevalence of glaucoma of 10.4% among sleep apnea patients. Diabetes, hypertension, and AHI were not significant as risk factors of glaucoma (p-value >0.05).

Conclusion and Recommendations: Glaucoma is common among sleep apnea patients; however, this is similar to its prevalence in the general population.

Impact of asthma on the quality of life of adolescent patients with different severity symptoms

Reham S. Alhenaki, Badra'a A. Muharib, Sarah I. Bin Hussain, Fatima M. Alkhashram, Rowaa Al Qufaidi, Saleh Al Muhsen, Rabih Halwani

Background: Bronchial asthma is a chronic inflammatory disease of the lungs afflicting people worldwide without distinction of age, gender or ethnicity. The health-related quality of life of asthmatic patients, characterized in terms of physical, emotional and social aspects, can be disrupted considerably and may reflect the effectiveness of symptoms management, therapy and health services provided.

Objectives: To assess the quality of life (QOL) in a population of asthmatic adolescents comparatively to healthy subjects of equivalent age.

Methods: In this cross-sectional survey, an adapted questionnaire of 27 questions, based on both the Mini Asthma Quality of Life Questionnaire (Mini AQLQ) and the Pediatric Quality of Life Questionnaire (PAQLQ), was applied to 135 asthmatic adolescents and 146 healthy subjects (11 to 19 years old) randomly selected. Demographic and clinical data were also collected.

Results: Our data revealed lower QOL scores for asthmatics than healthy subjects, for most of the questions pertaining to Physical, Emotional and Environmental categories. When the asthmatic patients are classified by severity of symptoms, significant differences between the healthy group and the asthma groups were observed, in 15 out of 27 variables that included physical, emotional and social activities. Lower QOL scores were not always associated to the severe asthma group; Intermittent and mild asthma groups also indicated lower QOL scores than healthy control. Asthmatic patients felt more anger, worry and were more anxious than healthy adolescents. The most consistent finding was related to the influence of environmental triggers; dust, cigarette smoke and air pollution affected all asthma groups than the healthy subjects. Symptoms were bothersome for severe asthmatics, compared to Intermittent asthmatics.

Conclusion: Our data indicated that asthma lower the quality of life of Saudi asthmatic adolescents, in terms of physical, social and emotional aspects. This effect was not restricted to severe asthmatics, since patients with milder symptoms also had lower QOL scores than healthy adolescents.

IL-17 Induces B cell Recruitment to the Bronchial Tissue of Asthmatic Patients via the enhancement of CXCL-13 production

Rabih Halwani, Roaa al Kufaid, Qutayba Hamid, Saleh Al Muhsen

Background: Asthma is a chronic inflammatory disorder of the lung airways that is associated with airway remodelling and hyperresponsiveness (AHR). IgE plays an important role in triggering inflammatory responses responsible for asthma symptoms and pathogenesis. IgE levels increases in asthmatic patients both systematically and in lung tissues. However, the source behind

this increase in IgE is still debatable. B cells play an important role in asthma development mostly via the production of IgE. In this proposal, we hypothesized that IgE is increased in lung tissue of asthmatic patients due to increased infiltration of B cells to this tissue. We have recently reported elevated expression of IL-17 in severe asthma. So we suggested that IL-17 is involved in the migration of B cells to the mucosal surface of the airways.

Methods: We determined the number and pattern of infiltrated B cells into lung tissues of asthmatic compared to healthy subjects. Bronchial biopsies from asthmatic versus healthy subjects were stained for B cells marker (CD20) using Immunohistochemistry. Structural cells such as endothelial cells, fibroblasts, and ASM cells were stimulated with IL-17 and levels of CXCL-13 were determined using RT-PCR and flowcytometry. Migration of B cells towards supernatant of IL-17 stimulated structural cells was determined using Boyden Chamber migration assay in the presence or absence of anti-CXCL-13. Mechanism of IL-17 induced B cell migration were tested using MAP kinase inhibitors to determine pathways involved in IL-17 induced CXCL-13 production.

Results: The number of CD20 positive cells in asthmatic biopsies was significantly higher than those in healthy subjects. Interestingly, we have also observed an increase in lymph follicle numbers in asthmatic airways compared to healthy subjects although this increase did not reach significance. Most of the lymph follicles were B cells follicles (CD20 positive cells) and were formed close to the epithelial layer.

IL-17 as well as CXCL-13 were upregulated in these bronchial tissues as shown using immunohistochemistry. Stimulation of endothelial, fibroblasts, but not ASM cells with IL-17 enhanced their production of CXCL-13. B cells were shown to migrate towards supernatants of structural cells stimulated with IL-17 cytokines containing CXCL-13. This migration was inhibited upon neutralizing of CXCL-13. Blocking IL-17 signaling using MAP kinase inhibitors prevented CXCL-13 production and in vitro migration of B cell.

Conclusion: These results indicated that IL-17 might drive the migration of B cells in the lung tissues of asthmatic patients by enhancing the production of CXCL-13 in local structural and/or inflammatory cells.

Unsuspected Diagnosis of Mucoepidermoid Carcinoma of Lung

Dr Bassil Al Zamkan, Dr Niravkumar Sangani, Dr Michael Jansen, Dr Obaid Al Jassim

A 40 year old male presented with dry cough since 5 years. His chest x-ray showed an opacity in the right lung. He underwent a CT guided core needle biopsy of the lung mass. The initial histopathological diagnosis of the biopsy was adenocarcinoma of lung. A right upper and middle lobectomy was performed. The final pathology of the lobectomy specimen revealed mucoepidermoid carcinoma of lung. The initial core needle biopsies only sampled a mucinous component of this tumour leading to an initial interpretation of adenocarcinoma. This case report demonstrates the possibility of a different diagnosis when analysing small tissue samples and the need to correlate the clinical and radiologic features. We present a case of mucoepidermoid carcinoma, a rare salivary gland type of tumour presenting in the right main bronchus and lung. We highlight the potential for initial missteps in tumour management when utilizing core needle biopsy to obtain material for pathologic analysis without the proper context of radiologic and clinical status being taken into account. This unusual case highlights the continuing importance of adequate multidisciplinary review of patients who are increasingly receiving pathologic diagnoses critical to future clinical decision making on ever smaller tissue samples especially with rare or unusual tumours.

Eastern Mediterranean region tuberculosis economic burden in 2014

Aliyeh Sargazi, Zahra Sepehri, Atefe Sargazi, Mansooreh Farsi, Zohre Kiani

Introduction: Tuberculosis (TB) is known one of reasons of human mortality to this date cause by Mycobacterium tuberculosis with the infectious dose less than 100 bacteria. It particularly infects lungs but other organ infection also observed. Tuberculosis incidence was 280, 29, 121, 39, 183 and 87 per 100,000 with the mortality of 42, 1.5, 23, 4.1, 23 and 5.8 per 100,000 in African, American, Eastern Mediterranean, European, south East Asian and western pacific region respectively. In this study we tried to evaluate Eastern Mediterranean region tuberculosis direct economic burden in 2014 and determine its economic effect in gulf region.

Methods: In this descriptive analytical study, data gathered from world health organization global report and World Bank data sheet. We considered decrease of disability-adjusted life year (DALY index) related to tuberculosis and its influence on gross domestic production (GDP) as TB economic burden. TB economic burden obtained from multiplying GDP by DALY. DALY itself is equal summation of two components called years of life lost (YLL) and years lived with disability (YLD). YLL is calculated from multiplying lost years of life expectancy by number of death in a period of time. YLD is calculated from multiplying TB incidence by TB duration by disability weight.

Results: GDP per capita was 665USD, 24689USD, 1668USD, 3314USD, 4763USD, 6862USD, 5214USD, 52197USD, 9928USD, 11965USD, 3093USD, 21929USD, 1275USD, 93714USD, 25962USD, 1753USD, 4317USD, 43049USD and 1773USD for Afghanistan, Bahrain, Djibouti, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Tunisia, United Arab Emirates, Yemen respectively in 2013. No GDP per capita reported by World Bank for

Somalia and Syria in 2013. Eastern Mediterranean Mean GDP per capita was about 16744USD in 2013. GDP gross was 3% in Middle East in 2014 therefore Mean Eastern Mediterranean GDP per capita is calculated as 17246USD for 2014.

Mean years of life expectancy at birth is reported as 68 years in Eastern Mediterranean region for the period of years from 2010 till 2014. Tuberculosis weight is estimated about 0.271 and TB incidence is considered in one year period. Approximately about 10% of patients were children below 15 years old. Mean age for infected children is considered as 7 years old and mean age for infected adults is considered as 34 years old. Therefore years of life lost were 61 and 34 years for a child and an adult respectively. Number of TB infected cases was 750,000 in Eastern Mediterranean region. YLL is calculated as 5,138,000 years, YLD is calculated as 203,250 years and DALY is calculated as 5,341,250 years in Eastern Mediterranean region. Economic burden related to Tuberculosis mortality and morbidity is calculated more than 92 billion dollars in Eastern Mediterranean region in 2014.

Conclusion and Discussion: The total money spent in tuberculosis care system was less than 250 millions USD in Eastern Mediterranean region in 2014. According to TB high economic burden, We suggest to specialize sufficient budget for TB control in this region. Middle East countries place in one of the most strategic regions of the world. It cause powerful business and trade, Therefore TB transmission to the world and from the world is easier there. We strongly advise to plan new strategies for TB transmission control in this area. In this project we evaluated tuberculosis direct economic burden while indirect burden sometimes has more cost. Indirect burden contain emotional effect of TB on patient and family, funeral cost of expired patients, hospitalization, health care and etc, Therefore Tuberculosis real economic burden is more than just 9.2 billion USD.

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Public Awareness and Attitude toward MERS-CoV Outbreak in Saudi Arabia

Omar A. Al-Mohrej, Sarah D. Al-Shirian, Salman K. Al-Otaibi, Hani M. Tamim, Emad M. Masuadi, Hana M. Fakhoury

Background: Middle East respiratory syndrome (MERS) is a disease that affects the respiratory system and is caused by a coronavirus (MERS-CoV). The infection has swept the Arabian Peninsula, especially, Saudi Arabia. To limit the spread of the disease, the Ministry of Health in Saudi Arabia tried to raise public awareness using different media.

Objectives: We aimed to measure public awareness and attitude toward MERS-CoV outbreak in Saudi Arabia.

Methods: This cross-sectional study was conducted between May and June 2014. A newly designed Arabic questionnaire was completed online by Saudi and non-Saudi residents of Saudi Arabia. Descriptive statistics was used for baseline demographic and socioeconomic characteristics of the respondents. A total score of awareness/knowledge was calculated as the percentage of correct answers. One-way ANOVA and two-independent sample t-test were used to examine the differences in total score between different categories of baseline characteristics.

Results: We analyzed the response of 1149 respondents across the Kingdom, with a wide range of education and income. We found that 97% of the participants were aware of Corona virus, and 89% were familiar with its symptoms. However, only 54% recognized that MERS and Corona refers to the same condition. Moreover, 49% knew that camels and bats are the main cause of Corona. In addition, 72% realized that coughing and sneezing could spread the disease, and 74 % were aware that close contact is one way to transmit the infection. As a protection measure, 74% used hand sanitizers, 41% avoided going to hospital or clinics, and 43% avoided crowded places. Only 11% were wearing masks in public places. In addition, 83% thought that the disease is treatable. In this respect, 62% thought that a vaccine can prevent the disease, and 64% assumed that taking antibiotics could combat the virus. About 59% thought that new medication have been manufactured to treat Corona.

As anticipated, this level of awareness varied between the different categories of the studied population. Female participants were

significantly more aware of the protective measure against virus ($p=0.004$). Interestingly, married individuals had a better overall knowledge of the disease ($p=0.003$). As expected, public awareness was significantly raised in individuals with better education ($p<0.005$) and with higher income ($p<0.005$).

Conclusion: The information gathered in this study from a wide range of people across the Kingdom confirms that public awareness about MERS-CoV is generally sufficient. However, some false hopes about vaccine and medication were fairly common among the population. The research conducted hereby, should have also helped in deepening this awareness, by stimulating the public to explore their knowledge gap.

Factors associated with quitting among smokers from a Saudi population

Omar A. Al-Mohrej, Sara I. AlTraif, Sarah D. Al-Shirian, Hani M. Tamim, Hana M. Fakhoury

Objectives: Despite the noticeable increase in public awareness among Saudis, Saudi Arabia remains the fourth in tobacco import globally. A very limited number of studies have studied ex-smokers in the Saudi population. In this study, we aimed to analyze the socio-demographic characteristics of ex-smokers in an attempt to determine who is most likely to quit smoking among Saudis.

Methods: This work is part of a cross-sectional study, which was conducted in Saudi Arabia in the period between April and May 2013. A new questionnaire was developed and distributed, manually in public places in Riyadh, and electronically through different popular twitter accounts. The self-administered questionnaire was written in Arabic and included information on socioeconomic factors and smoking history.

Results: The results of 2057 questionnaires showed that 808 (39 %) were current smokers, 460 (22%) were ex-smokers, while another 808 (39%) never smoked. The majority of ex-smokers (57%) had decided to quit because of religious and social reasons. In addition, health reasons were the drive for 40% of the quitters, while only 2.7% of quitters made the decision because of financial reasons. In the multivariate analysis for reasons to stop smoking, we found that quitting was not influenced by gender, income, or age at onset of smoking.

Conclusion: We have looked at quitting from a broader perspective analyzing different categories of the Saudi population. Social, religious, and health reasons must be emphasized by counselors assisting Saudi smokers to quit.



Today, Pfizer is helping to usher in a new era of vaccine innovation - both to prevent and treat disease. As the global leader in pneumococcal disease prevention, Pfizer will continue to push the boundaries of innovation to pursue the next scientific breakthrough for the prevention of pneumococcal disease. In addition, Pfizer is developing vaccines that target meningococcal serogroup B disease - which is an important cause of meningitis and bloodstream infections for which no vaccine is currently available, and a vaccine for Staphylococcus aureus - the leading cause of hospital-acquired infections.

In Tuberculosis Endemic Area, How Pulmonologists Treat Their Patients With Pathological Diagnosis Of Pulmonary Granuloma And Is Empirical Anti Tuberculosis Justified?

Salman K. Al-Otaibi, Omar A. Al-Mohrej, Al-Jahdali H

Background: Granuloma is a chronic inflammatory disease secondary to antigen exposure and is considered a defense mechanism against antigens, which stays in the organs inactive. One of the major causes of pulmonary granulomatous disease is tuberculosis. It is common practice for many physicians in the region where tuberculosis is prevalent to start empirical treatment for tuberculosis based on the finding of granuloma even if not caseating waiting for either clinical response or culture results.

Methods: Retrospective chart review study conducted at King Abdulaziz medical city over 7 years. The chart reviewed for demographic data, initial physician diagnosis, pathologist diagnosis, and the final diagnosis based on the response to therapy or due to bacteriological or serological results. Also we examined the agreement between the clinicians and pathologists diagnosis based on final diagnoses which are the response to treatment or serological or bacteriological diagnosis.

Objectives: Is the common practice of physicians of starting empirical anti-tuberculosis based on pathological diagnosis of granuloma justified ?

What is the level of agreement on the final diagnosis among clinicians and pathologists ?

What are the causes of granulomatous diseases among our patients?

Any clinical/radiological/pathological predictors that can differentiate between different causes of granulomatous pulmonary diseases?

Results: The numbers of cases with final pulmonary granuloma were 158, all Saudis, males 78 (49%) and females were 80 (51%). The most common symptoms at presentation were cough (69.9%) , fever (52.7%), and dyspnea (47.9%). The final diagnoses were TB in 74.4 % of the pulmonary granuloma followed by Sarcoidosis in 19.2% of the patients.

Based on clinical data the first physician impression was tuberculosis in (81.6%) of the total number of the patients. And the second most common impression was Sarcoidosis in (8.9%) of the patients. The pathologists' report was Tuberculosis in 27.2% and Sarcoidosis 2.5% of the patients. The agreement between clinicians' impression and the final TB diagnosis was moderate (kappa = 0.51). The agreement between pathologists' impression and the final TB diagnosis was poor (kappa = 0.12). The agreement between initial pathologist impression and the clinician's impression was poor (kappa = 0.01). The agreement between clinicians' impression and final of Sarcoidosis diagnosis was good (kappa = 0.67). The agreement between pathologists' impression and the final Sarcoidosis diagnosis was fair (kappa = 0.33). Compared to final diagnosis the clinician impression agreement with the final diagnosis of TB was moderate (Kappa 0.51) whereas the pathologist's was poor.

Conclusion: Based on clinical information available to physicians they are better in suspecting pulmonary tuberculosis among patients with granulomatous disease than pathologist. The suspicion of tuberculosis and empirical treatment of tuberculosis based on clinical imprecision in most of the cases was justified.

Obstructive Sleep Apnea, Obesity and High Mallampati Score: Triple insult to lung function?

Nazia Uzma, Ashfaq Hasan, V. Devender Reddy, R. Basalingappa

Background: Obstructive sleep apnea (OSA) is a common medical condition with significant adverse effects but it remains undiagnosed in many individuals. Few Data are available for Indian patients and public health hazard of the condition continues to be seriously underestimated in this country. The objective of this study was to evaluate the prevalence of obesity, and Metabolic syndrome in a South Indian population with proven OSA and to assesses the combined effect of high Mallampati score, obesity and obstructive sleep apnea (OSA) on lung function.

Methods: A retrospective analysis of data accrued in patients undergoing polysomnography (PSG) was undertaken. Lung function test was assessed by spirometry. Three hundred and twenty-four (324) patients of either sex in the age of 54±11 years who tested positive for OSA were compared with control group. An apnea-hypopnea index (AHI) of >5 in the presence of snoring and daytime somnolence was taken to define sleep apnea.. The OSA patients were divided into three subgroups: mild (22%), moderate (21%) and severe (57%).

Results: The mean AHI among the study group with OSA was 34.3±18.6 as compared with 1.2±0.5 in the control group. The BMI among patients with OSA was 42±6 as compared with 24±4 in comparison group (p80%) patients. The apnoea index, hypopnea index and microarousals were much higher in the OSA groups than in controls. Higher Mallampati score was observed in patients with severe OSA than in moderate and mild OSA patients. Our results showed that the combination of obstructive sleep apnea, obesity and high Mallampati score resulted in a degree of restriction that was significantly greater than that produced by each factor alone.

Conclusion: A perceptible relation between the severity of the Mallampati score and a restrictive type of defect on spirometry was observed in our study. In view of this finding,assessment of Mallampati scoring during routine clinical examination of the obese patient who has a presumptive diagnosis of sleep apnea, can actually be predictive of impaired pulmonary function, and this may help prioritization for subsequent testing of such patients.

The management of thoracic surgical patients after inter hospital transfer to a tertiary specialist hospital

Alison Smith, Julia Beeson, Vladimir Anikin

Objectives: Inter-hospital transfer of patients to a tertiary referral centre for specialist intervention is an integral part of routine healthcare delivery. A more efficient referral system could reduce the delay in the transfer of patients for specialist care, increase patient numbers, reduce lost theatre time, decrease staff time and increase patient satisfaction.

The objectives of this project are to establish the incidence of inter-hospital transfers of thoracic surgical patients, to assess the time frame from referral to transfer, to identify the diagnosis and clinical condition of referred patients, assess the time from arrival to surgery and the results of surgical treatment.

Methods: Between February - April 2012 275 thoracic surgical patients were admitted to the Department of Thoracic Surgery

at Harefield Hospital, 48 (17%) of these patients were inter-hospital transfers from ten affiliated hospitals. Clinical notes of all 48 thoracic surgical referrals to four Thoracic Surgical Consultants from twenty-one referring Physicians during this three month period were retrospectively reviewed. There were 27 (56%) males, 21 (44%) females aged from 17 to 84 (mean 55.7) with a suspected diagnosis of pneumothorax 13 (27%); empyema 13 (27%); pleural effusion 12 (26%); tracheal tumour 3 (6%); haemothorax 3 (6%); inhaled foreign body 2 (4%); airway obstruction 1 (2%); small cell lung cancer 1 (2%).

Results: All 48 patients were transferred within 0-22 (mean 4.2) days with 24 (50%) of referrals arriving at the specialist centre within 48 hours of referral. No referral letter was received in 7 (14%), 2 (4%) patients were referred twice and the date of going onto the waiting list documented in only 16 (33%) cases. Surgery was performed on 41 (85%) of patients. Drainage of empyema was performed in 7 (15%), pleurodesis in 7 (15%), bullectomy in 7 (15%), drainage of effusion in 6 (13%), decortication in 5 (10%), bronchoscopy and cryotherapy in 3(6%), bronchoscopy in 2 (4%), pericardial window in 2 (4%), lobectomy in 1 (2%), laparotomy and insertion of PEG in 1(2%) patient. In 31 (65%) of patients VATS technique was employed. Seven (15%) patients did not proceed to surgery. Four (8%) patients were considered not fit for surgery due to advanced malignant disease. Palliative care for advanced disease was required for 2 (4%) patients who died from disease progression. Chest drains were inserted in the remaining 2 (4%) for conservative management. Three (6%) patients did not require surgery, 2 (4%) patients required only conservative management of an empyema with intravenous antibiotics and CT drainage with 1 (2%) having resolution of the pleural effusion identified on the imaging on arrival and discharged on the same day. The time from admission to surgery ranged from 0-5 days (mean 1.5 days).

Hospital length of stay for transferred patients ranged from 1-46 (mean 10.7) days. There were no mortalities in the surgical group. Thirty five (73%) of patients were discharged home, 11 (23%) were transferred back to their original centres for on-going management.

Conclusion: Inter-hospital transfers represent a substantial proportion of the workload in thoracic surgery. The majority of transferred patients required urgent surgical intervention or palliative treatment. Improvement in the communication and documentation process could expedite the appropriate transfer and reduce the length of stay and bed occupancy in both centres. This abstract has not been submitted for consideration to any organisation before.

The influence of the inhalation flow on the performance of the Symbicort® Turbuhaler

Col Mohammed Almeziny, BPharm, RPh, Msc, PhD

Introduction: In the oral inhalers, it is commonly recognised that particle size plays an important role in defining where the particles will deposit in the lung [1]. In this experiment Anderson Cascade Impactor (ACI) has been used to assess the performance of Symbicort®. The ACI is an eight-stage cascade system intended for measuring the particle size distribution [2]. Symbicort® Turbuhaler is an inhaled drug. It is a combination of budesonide and formoterol [3]. Budesonide is a glucocorticoid. It is provided as a mixture of two epimers, 22R and 22S. The budesonide epimer R is known to be 2 to 3 times more potent than the budesonide epimer S [4]. In addition, formoterol is a long-acting selective beta-2 adrenoceptor agonist [3]. The Symbicort® Turbuhaler® shows flow-dependency for aerodynamic characteristics [5]. Also, the rate flow of each component may be different and therefore the pharmacological ratio may vary in delivery to the patient. As a result, it is essential to keep the combination ratio constant.

Methodology: The aim of the study was to examine the effect of the flow rate on this combination. High-performance liquid chromatography (HPLC) analysis The amount of drug deposited in each stage was measured using the HPLC method of analysis which was developed and published [6].

Result: There are statistically significant differences for formoterol, budesonide R and budesonide S between 28.3L/min and 60 L/min in total emitted dose, particle dose (FPD) and the mass median aerodynamic diameter (MMAD).

Conclusion: The effect of this was more obvious for the FPD and the throat deposition. From the data obtained it can be expected that at a lower flow rate the drug particles might be deposited on the oropharyngeal. In addition the low FPD indicated that lung deposition would be low. However, the ratio between the Symbicort combinations was constant at all flow rates.

Keywords: Symbicort, Turbuhaler, Inhalation flows

Metering Performance Of A Breath-operated (QVAR®) PMDIs With Different Type Spacers

Mohammed Almeziny

Introduction: Pressurised Metered Dose inhalers (pMDIs) are a convenient way of administering medication. They emit an aerosol at high velocity and to be used properly they require co-ordination of inhalation and pMDI actuation. But, even with an optimum technique, only pellant, so decreasing oropharyngeal deposition of therapy [1]. In addition, particle size is obviously a crucial factor

in inhaled drugs, affecting both the lung dose and delivery location and therefore clinical efficacy. It has been proposed that the primary factor of drug deposition in the lung is its aerodynamic size. In many formulations, the fraction of the cloud in sizes of 1 to 5 μm is usually expressed as the fine particle dose (FPD), i.e. the fraction of the label claim measure the dose emitted from Qvar alone and attached to spacers. To compare the in-vitro aerosol deposition characteristics from Qvar® with three common spacers using Mass Median Aerodynamic Diameter (MMAD), FPD and Fine Particle Fraction (FPF) as parameters.

Results: It show that there are different effects on aerodynamic characterization and the amount of drug available for inhalation when different spacers are used as inhalational aids.

Conclusion: The study results show that experiments with one spacer cannot be extrapolated directly to other spacers or drugs, therefore it is necessary to test specific drugs and device combinations. In addition, the spacer leaflet should include the brand names of acceptable pMDIs with which it has been tested.



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The Application of Vacuum-Assisted Closure Device in the Management of Empyema thoracis:case report

Yasser Aljehani, Zahra AlMatar, Samah Nawar, Zahra Abuzaid

Content: Empyema thoracis is a collection of purulent fluid in the pleural space, commonly as a sequel of untreated pneumonia. The management of late stages of empyema usually requires invasive techniques such as thoracotomy and decortication. Open window thoracostomy is implemented for resistant cases. Although it is considered to be an efficient technique ,it requires daily changes of the intracavitary wound and prolonged hospital stay. A novel adjunct, Vaccum-assisted closure, which is a modality used in treating wounds in different sites of the body, is being implemented in the management of Intrathoracic Infections. We report a case of a patient who presented with empyema developed as a consequence of poorly managed parpneumonic effusion. VAC therapy was used to assist in wound closure . The patient had complete healing of the wound with no subsequent complications. VAC therapy as modality in the treatment of such conditions is clinically proven to be an efficient and safe adjunct that alleviates morbidity decreases treatment cost and shorten the hospital stay. Moreover it can provide an outpatient based management and therefore increases the overall patient satisfaction.

Work-up of patients suspected of having a pulmonary embolus; are we doing the right thing?

Noura Al-Foraih, Fatemah Behbehani, Mohammad Faraj, Saeed Etiyani, Naser Behbehani

Background: Pulmonary Embolism (PE) is a common, potentially lethal condition, and is one of the most significant causes of sudden death. CT Pulmonary Angiography (CTPA) is currently considered as 'gold standard' for the diagnosis of PE. Guidelines have recommended the use of clinical pretest probability (PTP) tools such as 'Wells score', to guide the evaluation of a patient with a suspected PE. We aim to assess the frequency of PE in patients who had CTPAs in our hospital, and what their pretest probability is according to Wells score.

Methods: We retrospectively reviewed clinical information of 138 patients suspected to have a PE, and underwent imaging with CTPA over a 12 month period (January 1st 2013 through December 31st 2013) at Mubarak Al-Kabeer Hospital in Kuwait. The Wells score for each of the patients was calculated by two physicians, without knowledge of CTPA results.

Results: Within the 12 month period, 192 patients had CTPA, 35 (18.2%) of which had a confirmed PE. The detailed medical records were available for 138 patients only. The mean age of patients with confirmed PE was 42.3 years, compared with 52.4 years for patients without PE ($p=0.004$).

In our study subjects, the percentage of patients with high wells score > 4 (High probability of P.E.) was only 23%. This percentage was much higher in patients with confirmed PE 69% versus 12.5% in patients without PE ($p < 0.001$).

The most important predictors for the presence of PE in our study were; history of old DVT ($p 0.019$), presence of malignancy within the last 6 months ($p 0.05$), and clinical signs of DVT ($p 0.001$). D dimer was done in 101 patients and the mean (SE) of D dimer was 3336 (658 ng/mL) for patients with confirmed PE versus 1650 (200 ng/mL) for patients without PE, $p < 0.01$. However the majority of our patients 84% had high D dimer > 500 ng/ml.

Conclusion: Our positive rate for PE is very low in patients who had CTPA for suspected PE. The majority of our patients who had CTPA had low wells score. This suggests that CTPA is over utilized in our hospital. The D dimer level was not a good discriminator in our acute care hospital setting.

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Association between the Size and Number of the Lymph Node and Mediastinoscopy Results

Mohammed Almoflihi, Anmar Fatani, Turki Alhazmi, Amr S Albanna, Ayman Alsulaimani

Objective: Mediastinoscopy is the reference standard procedure for diagnosis of mediastinal pathologies. Nevertheless, with the introduction of less invasive technologies, such as endobronchial ultrasound, the use of mediastinoscopy has been limited to selected cases. However, these new technologies are not widely available. Therefore, other modest diagnostic tools are used to determine patients who will benefit mostly from mediastinoscopy. Our objective is to assess the characteristic features of mediastinal CT scan (size and number of involved lymph node [LN]) that are associated with positive mediastinoscopy results.

Methods: A retrospective cohort study was designed to include all patients underwent mediastinoscopy between Jan 2002 and Dec 2014 at the National Guard Health Affairs, Western Region (NGHA-WR) of Saudi Arabia. Descriptive analysis was performed to determine patients' demographics and disease characteristics. Association between variables was analyzed using chi-square, t test, and regression analysis as appropriate. Statistical significance was determined using two-tailed p-value of 0.05.

Results: 60 patients were included; of which, 63% were males and the mean age of the patients was 53.5 years. The most common presenting symptoms were cough (56%), dyspnea (37%), fever and weight loss (36%). The diagnosis was lymphoma in 22%, cancer metastasis in 22%, non-specific inflammation in 19%, sarcoidosis in 19%, tuberculosis (TB) in 19%, and amyloidosis in 2% of patients. Mediastinoscopy was diagnostic in 82% (95% CI: 70 – 91%) of cases. The probability of positive mediastinoscopy result increased by two-folds as the size of LN increased by one centimeter (OR: 2, 95% CI: 1.1 – 3.8) and per each additional LN station involvement (OR: 2.5, 95% CI: 1.2 – 4.9). Most of positive mediastinoscopy results were encountered among patients with mediastinal LN size of three or more centimeters and those with two or more LN station involvement. Procedure complications occurred in 4 (6.7%) of the patients, which include vocal cord paralysis in 2 (3.4%) patients, significant bleeding in 1 (1.6%) patients, and transient ischemic attack in 1 (1.6%) patients.

Conclusion: Characteristic features of mediastinal LN determined by CT scan (size and number of involved lymph node) can be utilized to select patients who are likely to benefit from mediastinoscopy.

Cannabis Smoking in donors of Lung Transplantation

Prashant N Mohite, Diana García Sáez, Anton Sabashnikov, Bartłomiej Zych, Nikhil P Patil, Aron-Frederik Popov, Andre Simon

Objectives: Cannabis smokers are at risk of lung infections, bullous emphysema and lung cancer. Limited data is available about lung transplantation (LTx) from donors with history of cannabis smoking. This study evaluates the outcomes of LTx utilizing organs from this group.

Methods: We retrospectively analyzed lung 'organ offers' and LTx at our center between years 2007 and 2013. The outcomes of LTx utilizing lungs from donors with history of cannabis smoking were compared to those with no such history using unadjusted model as well as propensity score matching.

Results: Incidence of history of cannabis smoking was 5.6% in the donors that were offered to our institute. 302 LTx were performed during this period and were grouped depending on the history of cannabis smoking in donors – 'cannabis' group (n=19) and control group (n=283). The donors from 'cannabis' were significantly younger, taller, of male gender compared to control group. All the donors in 'cannabis' group were tobacco smokers compared to 43% in control group. Preoperative characteristics in recipients in both groups were comparable. Intra-operative and post-LTx variables including PaO₂/FiO₂ ratios, duration of mechanical ventilation, and ICU and hospital stays were comparable. 1- and 3- year survivals were also comparable in both groups.

Conclusion: The history of donor cannabis smoking does not affect early and mid-term outcomes after LTx and potentially improve the donor pool. As it does not seem to negatively affect outcomes after LTx, it should not be per se considered a contraindication for lung donation. However, it's essential to assess the donor lungs for the signs of infection, emphysema and carcinoma.

Secondary infection and clinical aspects after pandemic swine-origin influenza A (H1N1) admission in an Iranian critical care unite

Seyed Mohammadreza Hashemian, Payam Tabarsi, Reza Saghebi, Hamidreza Jammati, Navid Noorae.

Objectives: A new flu virus (H1N1) swine origin and cause of human infection with acute lung disease was published in the world and led to many patients were admitted in ICU

Methodology: In a prospective descriptive study, all ICU patients in a pulmonary disease specialist hospital between April 2010 until July 2011 with confirmed infection (H1N1), were evaluated. Information including demographic, clinical and microbiology using statistical software SPSS version 16 was studied and classified.

Results: Of 46 patients hospitalized with confirmed diagnosis of swine flu pneumonia (H1N1), 20 cases (7 / 43%) admitted in intensive care unit that 10 cases were male (50%), the mean age 36/9 and the range was 21 to 66 years. 9 patients (45%) had underlying diseases. Most underlying disease was respiratory disease that 4 cases (20%) were asthma, and one patient had chronic obstructive pulmonary disease (COPD). No admission of pregnant patient with swine flu was reported in the ICU. Cough and sputum were the most frequent symptoms (19 patients equal 95%). 4 patients (20%) were admitted with decreased level of consciousness. 5 cases (25%) died during hospitalization.

Conclusion: It seems, swine flu with high mortality and transfer rates is a worldwide health problem. Because of limited treatments regiment, the risk of secondary infection and high need to intensive care in H1N1 pneumonia, environmental control, including vaccination of high risk people and public announcement, make determining role in controlling of this disease.

Carinal Surgery

Rajan Santosham, Rajiv Santosham, Harikumar, Anjith Prakash R

Objectives: Carina is a cartilaginous ridge within the trachea that runs between the two primary bronchi at the site of tracheal bifurcation. Carinal surgery is challenging because of challenges in exposure, limits in mobilization, resection as well as anesthetic and surgical management.

Methods: From 1990 to 2015 we have had 35 cases which needed Carinal exposure and mobilization.

Results: To obtain good results, proper preoperative evaluation with plain and contrast CT scan with 3D reconstruction is required to determine the extent of disease as well as to determine operability. Care should be taken to prevent excising too much of carina to avoid anastomosis under tension. Carinal mobilization was done for 33 cases with right thoracotomy, one with midline sternotomy and in 2 cases with concomitant left thoracotomy. Carinal release measures include cutting the inferior pulmonary ligament, making a U shaped incision in the pericardium just below the inferior pulmonary vein and mobilizing all hilar vessels, lower end of trachea, carina and main bronchi. In the lower trachea and carina, we limit the extent of resection to 3.5 centimeters. Careful anesthetic management has to be planned as well. Sterile cross field ventilation during surgery is very useful. We prefer interrupted

absorbable sutures 3-0 or 4-0 PDS with knots outside the trachea. Anastomosis has to be tension free. Carinal mobilization was done for Carinal left pneumonectomy - 2, Carinal right pneumonectomy - 2, Carinal tumors -6, low tracheal tumors - 8, low tracheal stenosis - 2, right sided sleeve resection - 9, traumatic bronchial rupture - 6.

Conclusion: Carinal surgery is challenging and needs careful preoperative preparation, anesthetic support, and preoperative care. Better results are obtained as the experience of the surgical team increases.

Foreign Body in the Lung

Syed A Asghar

Content: Retained Foreign bodies in the lungs are not so common these days. This case is a 26 years old female who had an accidental aspiration of a dental drill bit four years ago, Now has a chronic foreign body in the left lingular segment, Foreign bodies are a good source for recurrent infection in the lung, leading to a development of a chronic cough and eventually causing Bronchiectasis or chronic atelectasis. All attempts should be made to retrieve a foreign body from the lungs using a rigid or a flexible bronchoscope. Surgical options need to be considered in patients with chronically retained foreign bodies in the lung.

A Rare and Massive Primitive Neuroectodermal Tumour

Mohd. Shahbaaz Khan, Poornima Sivakumar, Bishwajeet Mohapatra

Introduction: Primitive neuroectodermal tumour was originally described by Askin et al. It is commonly found in children and young females. It frequently appears as a chest wall mass and grows rapidly to involve the neighboring pleura. It exclusively arises from one hemi thorax and progresses rapidly to involve the chest wall.

Case Report: A 63-year-old female presented with dry cough and progressive shortness of breath and left-sided severe chest pain for 2 months. Respiratory System examination revealed grossly shifted mediastinum to right side, dull percussion note over left side of chest and tubular breath sounds on auscultation. Imaging studies showed left hemithorax space occupying lesion. CT-guided Fine Needle Aspiration Cytology (FNAC) suggested it to be a small round cell tumour (PNET). Surgery was done through left thoracotomy incision and a large 25Å—15 cm sized mass occupying the whole of the left hemithorax removed. It weighed 9.2 kilograms, the heaviest PNET tumour reported so far.

Conclusion: PNET arising from mediastinum is extremely rare. Here we presented a very huge PNET measuring 25Å—15 cm and weighing 9.2 kilograms, the heaviest and the largest reported so far.

Keyword: PNET, left hemithorax occupying huge mass.

Bridging Bronchus, Type Six as a Rare Bronchial Anomaly Associated With Congenital Tracheal Stenosis

Ashraf El Molla, MD, Hussain Al Qudaihy, MD, Rashed Al Otaibi, MD, Samir Bawazir, MD

Case Report & Review of Literature Bridging Bronchus, Type Six as a Rare Bronchial Anomaly Associated With Congenital Tracheal Stenosis

Introduction: Bridging bronchus is a rare bronchial branching anomaly that was introduced by Gonzales-Crussi et al in 1976, since then till 2012, approximately, only 14 cases had been described worldwide that were grouped into 5 types, we present the first international description of type six as well as a thorough discussion of the tracheobronchial anomalies and its clinical implications will be clarified.

Case Report: We present an infant, 4 month old who underwent a major laparoscopic surgery; he had a double outlet right ventricle, congenital tracheal stenosis, as well as imperforate anus and duodenal atresia. Intraoperative course was complicated by severe respiratory acidosis from which he was completely recovered. 3 D reconstruction CT was carefully examined and bridging bronchus was identified.

Conclusion: Bridging bronchus is a rare congenital anomaly, and not only we present the case, approximately, number 15 but we also describe the first case of type six of this bronchial anomaly. The surgical, medical, radiological, and anesthetic implications are of great considerations especially the association of congenital tracheal stenosis and double outlet right ventricle, as well as gastrointestinal anomalies.

Congenital Laryngo-tracheal Atresia/Agenesis as an Indication of Esophageal Intubation for Oxygenation and Ventilation

Ashraf El Molla, MD, Hussain Al Qudaihy, MD, Rashed Al Otaibi, MD, Samir Bawazir, MD

Introduction: Laryngo-Tracheal Atresia/Agenesis (LTAA) is a rare congenital anomaly that neonatologist, anesthesiologist, as well as obstetricians may confront in an obstetric ward or an operating room as a challenging unexpected emergency both for diagnosis and for providing secured, patent, and protected airway.

Case Report: We present an infant with a severe respiratory distress, non-audible cry, and inability to pass an endotracheal tube via vocal cords in whom bag mask ventilation and insertion of endotracheal tube in the esophagus enabled oxygenation and ventilation until complete diagnosis was done.

Conclusion: Laryngo-Tracheal Atresia/Agenesis (LTAA) is a rare congenital anomaly, but it may be encountered more frequently. Awareness of this condition facilitates diagnosis as well as management, initially by esophageal intubation, followed by microlaryngobronchoscopy, and computerized tomography for proper diagnosis. The possibility of surgical correction rests on early diagnosis, associated congenital anomalies as many cases have been corrected surgically and we should not generalize that LTAA cases are incompatible with life but we should categorize operable cases.

Comparison of the effects of total intravenous anesthesia with propofol and midazolam on liver and kidney function after tracheal surgery

Shideh Dabir, Tahereh Parsa, Zohreh Mohammad-Taheri, Roshana Matin (presenter), Mohammad Abbasnazari, Ali Jafarian, Golnar Radmand.

Objective: Intravenous anesthetics are widely used for induction and maintenance of anesthesia. However, when compared with volatile anesthetics, less information is available about their impact on postoperative liver and renal function. The present prospective, double-blind, randomized clinical study was conducted to compare the effect of total intravenous anesthesia (TIVA) with midazolam or propofol on hepatic and renal functions after elective tracheal surgery, a type of surgery that has no direct influence on the liver and kidney blood flow and function.

Methods: 58 patients, American Society of Anesthesiologists physical status I and II (13 women and 45 men, aged 16-44 years.), Scheduled for an elective tracheal resection and reconstruction surgery for postintubation tracheal stenosis were randomly divided into two groups of 29 to receive either continuous infusions of propofol and remifentanyl or midazolam and remifentanyl for maintenance of anesthesia. Induction of anesthesia was similar in both groups. To evaluate the hepatic and kidney function, preoperative serum levels of aspartate aminotransferase (AST), alanine aminotransferase (ALT), alkaline phosphatase (ALP), lactate dehydrogenase (LDH), total bilirubin (TBil), g-glutamyltransferase (GGT), blood urea nitrogen (BUN), and creatinine were compared with those on postoperative days 1 and 3 in two groups.

Results: Patients' characteristics and operative data were similar in both groups. Hemodynamic parameters were in the acceptable ranges. The level of AST was significantly higher and TBil was significantly lower on postoperative day 1 in the midazolam group. ALT was significantly higher on postoperative day 3 in the midazolam group. However, the all values were not exceeded the normal limit. The remaining test results were not significantly different between the two groups. A significant changes in serum levels of ALT, GTT, LDH, TBil and BUN were also detected in each group but these changes were within normal range. No statistically significant difference in sedation scores was found between the groups. Time to tracheal extubation was shorter in midazolam (13.48 \pm 7.44 min) than in propofol group (18.34 \pm 13.93 min), but the difference was not statistically significant. There were no intra or postoperative serious complications throughout the study period.

Conclusion: TIVA with propofol and midazolam had a little effect on liver and kidney function. All changes in the test results were small and without clinical significance.

Keywords: midazolam, propofol, intravenous anesthesia, liver function tests, kidney function tests



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The Evaluation of Lung Function Tests of 120 Non Smoker Tailor Working in Workshop For Sewing Clothes Considering Working Time

Yakup Arslan, Muhammed Erdal, Ahmet Ertuğrul

Aim: In order to search the effect of textile items and working environments on non-smoker tailors who work in the workshop for sewing clothes by using the lung function tests and considering working time and respiratory symptoms.

Material Methods: The lung function test results and anamnesis which had been taken during the 2012 regular checkup of the tailors were evaluated retrospectively. According to the working time, the female tailors were nominated into two groups, which of first belongs to 1 to 20 year working experienced and the second belongs to 21 years and over. Tailors lung function tests results and the presence of at least one respiratory symptoms were evaluated.

Results: The number of the tailors at first group were 57 of which 18 woman and 39 man, at second group were 73 of which 5 woman and 68 man. According to the lung function test results, any significant restrictive and obstructive pattern wasn't present. The FVC percentage of 8 tailors of which 4 from 1st. and 4 from 2nd. group were <80%. Total Lung Capacity couldn't be measured. The FEV₁/FVC of 25 tailors of which 14 from 1st. and 11 from 2nd. group were <80%. The numbers of tailor suffering from at least one respiratory symptoms were respectively 14 and 8, and totally 22.

Discussion: We didn't find neither restrictive nor obstructive pattern which was considered to be significant. And we couldn't measure the TLC. The limitation of study was absence of tailor's previous spirometric results and smoking. We plan to control them this year again.

Conclusion: We must remember that the tailors working in workshop for sewing clothes may have either restrictive or obstructive pulmonary pathology. We couldn't detect neither restrictive nor obstructive respiratory pathology with lung function tests at the tailors who were non-smoker. We must remind tailors bad effect of textile items, working environments and smoking to the pulmonary system.

Keywords: Non-smoker Tailors Working in Workshop for Sewing Clothes and lung functions

Status Asthmaticus presenting with Pneumomediastinum

Y. Arslan-S, Ince-O, Karatas-Bozkara

Case: A 21-Year-old female patient referred to emergency service with dyspnea, chest pain and cough. She has been using salbutamol diagnosed as asthma for 1 year. Her sO₂ was %93 monophonic rhonchuses were auscultated on her thorax. Bronchovascular lines were apparent on her chest x-ray (Picture-1). At her blood count, the number of wbc was 15,5 (consist of neutrophile %93,4, eosinophile %0,1) and ESR was 27. We hospitalized her as status asthmaticus and then started to therapy with bronchodilators (1 mg/kg methylprednisolone, LABA-budesonide), nasal oxygen and antibiotics. At the second day, crepitations were palpated on her neck, and then chest x-ray and thoracic CT were applied; wide pneumomediastinum through the neck was seen (Picture-2). The patient was checked by chest surgeon and advised to continue the same therapies. Lung function test results were as FEV₁/FVC:70-76-FEV₁:2,03(%61)-Postb:2,3(%76)-FVC:2,9(%76)-Postb:3,04(%81). At the fifth day the patient signs like rhonchus and crepitations were reduced. Radiological (Picture-3), biochemical (wbc was 12,4-consist of neutrophile %85,5, eosinophilia %0,1-ESR-11) and lung functions controls (FEV₁/FVC:86,3-FEV₁:3,1-%94-FVC:3,6-%96) were done, all were approximately normal. After then, we ordered oral asthma treatment to the patient and discharged her.

Conclusion: We must remind that uncontrolled asthma may present with pneumomediastinum.

Keyword: Pneumomediastinum, status asthmaticus.

Small Left Hilum Cases Diagnosed as Swyer James Macleod Syndrome in Adulthood

Y. Arslan, S. Ince

Case: We retrospectively reviewed 4 male adult cases, who were diagnosed as Swyer-James-MacLeod syndrome in our service while acceptance to the military at 2014. The clinical and radiological features of these 4 cases are presented in the light of the literature. CASE PRESENTATIONS-All four patient presented with dyspnea, cough and sputum since childhood. Severe obstruction and moderate restriction were determined of all four patient on spirometric examinations. On chest x-ray, all four patient has small left hilum. Upon detecting hypoplasia beginning from the proximal of the left main pulmonary artery on thoracic BT, all the patients were diagnosed as SJMS.

Case 1: A 23-year-old male patient, axial chest computed tomography scan demonstrates hyperinflation in the left pulmonary parenchyma.

Case 2: A 29-year-old male patient, axial chest computed tomography scan reveals hyperlucency of left lower lobe with bronchiectasis.

Case 3: A 20-year-old male patient, axial chest computed tomography scan shows reduced left lung volume with air trapping.

Case 4: A 23-year-old male patient, axial chest computed tomography scan demonstrates small left hemithorax with cylindrical bronchiectasis.

Keyword: Small left hilum, Swyer James Macleod Syndrom

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Bronchiectasis Associated With Celiac Disease

Yakup Arslan, Mustafa Kaplan, Selami Ince, Hakan Cermäk

Case: A-25 Year old male patient referred to the polyclinic of pulmonary medicine with the symptoms of cough, sputum, dyspnea, being fatigue and loss of weight. He Was non-smoker and these complaints had been present since his childhood. Coarse Crackles were auscultated on his thorax. Biochemical Test results were wbc:5,8 Hgb:12,8-Hct:40,5-Serum iron:61-Ferritin:4,14-unsature iron binding capacity:377-ESR:16. Lung Function test results were FEV1/FVC:85,9-FVC:5,1(%93)-FEV1:4,4(%95). Bronchovascular signs were apparent on inferior-left zone of his chest x-ray.HRCT scan was performed:Bronchiectasis on inferior-lingular lobe and left lower-lobe posterior basal segments were seen. We diagnosed him as bronchiectasis, and then started to give therapeutic agents to him. The patient was consulted with gastroenterologist.Endoscopy was performed to him and specimens from stomach and intestines were taken. A duodenal biopsy specimen showed features of total villous atrophy and increased crypt hyperplasia consistent with a diagnosis of celiac disease.Gluten-free diet and specific nutritional supplementation were performed to him.

Discussion: Previous reports have suggested an association of coeliac disease with fibrosing alveolitis, bird fancier's lung, farmer's lung, sarcoidosis, idiopathic pulmonary haemosiderosis, lung abscess, and asthma, but this is the very rare case ,association with bronchiectasis. The cause of the association of pulmonary disorders with coeliac disease remains poorly defined. Absorption of an extrinsic allergen or immune complexes through an abnormal gastrointestinal mucosa may lead to the pulmonary disease. Alternatively, the association of coeliac disease with HLA status and various autoimmune diseases suggests that a common disturbance in immunity may underlie both coeliac disease and pulmonary disorders

Exhaled Nitric Oxide Measurement As A Marker Of Inflammatory Activity In Bronchial Asthma Patients

Eman SheblRa, 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



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Bi-level Positive Airway Pressure Ventilation for Patients with Stable Hypercapnic Chronic Obstructive Pulmonary Disease

Eman Shebl R., Magid M. Abderaboh

Background: The role of noninvasive positive pressure ventilation (NPPV) has been well established in the treatment of acute hypercapnic respiratory failure due to chronic obstructive pulmonary disease (COPD), however, its benefits in clinically stable hypercapnic COPD patients still not well known, so this trial aimed to assess the efficacy of NPPV in patients with stable hypercapnic COPD.

Patients and Methods: This study included 30 stable hypercapnic COPD patients hospitalized for long term stay in Hyat National Hospital in Saudi Arabia from June 2012 to May 2014. The 30 patients who met the study criteria were randomized into the control group (15 patients: 13 males and 2 females with mean age 66 ± 6.2) maintained on standard treatment and the second group (15 patients: 12 males and 3 females with mean age 65 ± 7.3) received bi-level positive pressure ventilation added to their standard treatment after giving a written consent. The patients were evaluated and followed up after initiating this therapy.

Results: After 6 months of NPPV, daytime PaCO₂ (mmHg) during spontaneous breathing decreased from 55.2 ± 6.7 to 47.1 ± 3.1 mmHg and daytime PaO₂ (mmHg) on room air increased from 48 ± 6.1 to 55.1 ± 8.3 with improvement of dyspnea scale and quality of life parameters. This was achieved with mean inspiratory pressures of 19.7 ± 2.41 cm H₂O and mean expiratory pressures of 6.8 ± 1.7 cm H₂O. CONCLUSIONS: NPPV is well tolerated and can improve blood gas levels, dyspnea and quality of life parameters in patients with stable hypercapnic COPD.

Keywords: COPD, bi-level positive airway pressure, respiratory failure

Selenium Improves Oxidative Stress and Peripheral Blood Biomarkers in Patients with Idiopathic Pulmonary Fibrosis

Nada Hazem, Ahmed Mahmoud Abd El Hafiz, Lamia Mohamed El Wakeel, Mona F Schalaan, Samah Selim

Objectives: Idiopathic Pulmonary Fibrosis (IPF) is a common chronic progressive fibrotic lung disease with poor prognosis. This study aims to evaluate the effect of selenium supplementation, an essential trace element with potential antioxidant effect, on glutathione peroxidase, one of the major enzymatic antioxidants of the lungs which is depleted in IPF patients and Matrix Metalloproteinase 7 (MMP-7) the known peripheral blood protein signature in IPF.

Methods: The current study is a prospective, randomized comparative study. Eligible patients were randomly assigned to either group A; 20 patients with IPF receiving oral Selenium 200 µg once daily for 6 month or group B; 20 patients receiving oral N-acetyl cysteine (NAC) 600 mg 3 times daily for 6 month. Prednisone tabs (0.5 mg/kg/d) were given to both groups. Serum levels of glutathione peroxidase and MMP-7 levels were estimated once every 2 month in both groups. Arterial blood gases sample was withdrawn at room air and at rest once every two month to determine the gas exchange levels in the blood related to respiratory functions. Informed consents were obtained from all patients.

Results: The comparison of Selenium group with NAC one revealed a significant increase of serum GPx level (227.17 %, 168.82, respectively), and significant decrease of MMP 7 (83.88 %, 35.4 %, respectively). In addition to a notable improvement in partial oxygen pressure (PO₂) (61.39 %, 8.66%, respectively) together with oxygen saturation (S_O2C) (35.08 %, 2.6 % respectively). All values are relative to their baseline levels. MMP 7 showed significant negative correlations with partial oxygen pressure (PO₂) and oxygen saturation (S_O2C). There were no remarkable adverse drug reactions observed in both groups, other than gastric upset in NAC group.

Conclusion: This study showed that selenium supplementation in IPF patients significantly improved GPx and MMP-7 levels, activities that reflect its potent antioxidant capacity. In addition patients' clinical presentation are shown as significant improvement in arterial blood gases and decrease of coughing and dyspnea on exertion.

Keywords: Idiopathic Pulmonary fibrosis; Selenium; antioxidant; Matrix Metalloproteinase 7

Surgery in Lung Cancer – To Cure or Not To Cure?

Brandén E, Micke P, Botling J, Mattsson J, Ekman S, Landelius P, Koyi H.

Background: Early detection in lung cancer improves survival. Patients with less tumour burden have better prognosis. Adjuvant chemotherapy has in studies shown to prolong survival and is recommended to patients with non small cell lung cancer stage IB- IIIA and 80 year. In the material of 330 patients, where medical journals were available: 161 male and 169 female; 45-84 years of age; median 67 years. 9 patients > 80 year. 163 were current smokers (73 male), 124 were ex-smokers (quitted for > 1 year ago; 74 male) and 39 never smokers (13 male). Missing smoking data in 4.

Results: There was a dominans of adenocarcinoma followed by squamous cell carcinoma. The stages IB and higher were together more frequent than stage IA. Concerning the surgical procedure lobectomy/bilobectomy was the dominating. Pulmectomy was performed in all stages but more frequently in IIB and IIIA. In stage IV there were lobectomies, in two after neoadjuvant chemotherapy. Adjuvant chemotherapy was given according to guidelines in stage IB and higher but also to patients in stage IA. Some patients in stage IB and higher refused chemotherapy, had bad PS, postoperative complications, comorbidities eg and didn't receive adjuvant therapy – will be shown. There were patients with stage IIIA (pTNM) where chemoradiotherapy should have been preferred instead of operation if N status had been known preoperatively. Preoperative PET was not mandatory during this period. Concerning survival 154 patients are still alive, 2 are lost for follow up. Death date is available so survival time according to stage, sex, smoking habits and postoperative treatment will be presented in detail.

Conclusion: Although patients for surgery were well selected and adjuvant therapy was given as recommended cure is not the rule in a real life setting in lung cancer but is the best we can offer our patients. Lung cancer is still a life-threatening disease where smoking is the main cause and never smokers survive longest.

Serum protein electrophoresis as a laboratory diagnosis tool for alpha 1 antitrypsin deficiency in COPD

Isac Sree Renjini, Hawsawi, Najat Al Jameil Noura; Al buhairan, Ahlam Hassan Amina.

Objective: To identify a simple, quick laboratory diagnostic test for identification of Alpha1 antitrypsin deficiency in COPD patients and at-risk smokers

Methods: Sampling and Patient cohorts: We conducted a case control study in collaboration with University hospitals and

pulmonary specialized hospitals in Riyadh, Saudi Arabia. Ethical approval was obtained from the Institutional review board of the respective hospitals and informed patient consent was taken. We collected blood samples and medical history of people belonging to 3 groups. Group 1 comprised of patients who were clinically diagnosed as having emphysema, COPD or liver cirrhosis. Group 2 consisted of normal control population belonging to both sexes. Group 3 comprised of smokers/ ex-smokers to study the effect of smoking on the enzyme deficiency. The whole blood sample was collected and was used for serum preparation. The sample was left at room temperature for 30 minutes, allowed to form clot and was centrifuged at 2,000 rpm for 15 minutes. The serum that separated was separated and stored at -20C. Serum protein Electrophoresis: Serum samples stored at -20C were thawed, diluted 1: 1 with 2x sample buffer (Novagen, USA), and denatured at 80C in water bath for 3 minutes and loaded into the Precasted ready gel (Mini- ProteanTGX stain free, BIORAD Inc, CA, USA) with an unstained molecular weight marker (Invitrogen, USA) to the first well. Sodium dodecyl sulphate Polyacrylamide gel electrophoresis (SDS PAGE) was done in Mini Protean gel assembly (BIORAD Inc, CA, USA) using 1x Tris Glycine running buffer at a voltage of 170 for 1 hour. The gel was taken out of frame and image was captured using Gel Doc EZ image lab software (Biorad, CA,USA).

Results and Discussion: Alpha1Antitrypsin (AAT) enzyme is an inhibitor of the lung alveoli damaging protein elastase leading to emphysema, chronic obstructive pulmonary disease (COPD) and infantile liver cirrhosis. The only established risk factor causing this deficiency is genetic variation in the gene coding for the enzyme, viz, SERPINA1. AAT gene and protein are highly polymorphic causing varying genotypes and thus varying levels of deficiency.

Protein profile of Serum samples were analysed and interpreted as per O' Connell et al 2005. There were five prominent protein bands- Albumin, alpha1 zone, alpha 2, beta1, beta 2 and gamma globulin region. Alpha 1 region included alpha1 antitrypsin which showed up on the gel as a 52 kDa protein band. SDS PAGE showed that the enzyme deficient samples had a heterozygous genotype as compared to the normal. This was seen clearly as two separate protein bands in the SDS PAGE gel. Smoker samples also showed marked variation in band intensity as compared to normal indicating deficiency.

Serum protein profiling can be used as a valuable diagnostic tool for early lab diagnosis of at-risk people who are smokers. This technique is quicker compared to the laborious procedures for identification of deficiency at the phenotypic level using Isoelectric focusing and molecular identification of genotype using polymerase chain reaction and sequencing. Serum electrophoresis thus holds a valuable key to preliminary diagnosis of the deficiency at both phenotypic and genotypic levels.

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Chemotherapy treatment of elderly patients (70 years or older) with non-small cell lung cancer. A five-year material in clinical practice from Karolinska University Hospital – Sweden

Hirsh Koyi, Gunnar Hillerdal, Olov Andersson, Karl Gustav Kölbeck, Per Liv, Eva Brandén

Introduction: Worldwide, more persons survive to older age, and as a consequence an increasing proportion of patients with cancer are older than 65 years and many older than 70 years. Treatment of the elderly with lung cancer (LC) has therefore become an important issue, and we decided to make a retrospective study of our patient to illustrate our experience.

Methods: All patients 70 years or older with non-small cell lung cancer (NSCLC) at the Department of Respiratory Medicine and Allergy, Karolinska Hospital from 2003 to 2007 were retrospectively reviewed.

Results: In all, 767 patients (50.4% of all NSCLC patients) were 70 years of age or older, 37 (18.9%) were 80 years or older. Chemotherapy was given to 186 of them (24%), thereof 140 (75%) a platinum doublet using carboplatin. 96 patients (57%) received all courses. In 23% toxicity necessitated to stop the therapy. Second and third line chemotherapy was given in 10.6% and 4.7%, respectively. Median overall survival was 289 days. Patients with performance status (PS) 0 had significant better survival than patients with PS1 or PS 2: 423, 298, and 222 days, respectively (80 years old).

Conclusion: Treatment of elderly patients with LC is feasible if they have a good PS and seems to result in prolonged survival. These results also suggest that elderly patients in good PS could be offered salvage chemotherapy regardless of age.

Lobar emphysema with pneumothorax in an infant : report of a case

Khalid zahraldin, Amjad Tuffaha

Content: Congenital lobar emphysema and tension pneumothorax are rarely reported. A 40-day-old male infant, weighing four kg, presented in an emergency room with progressively increasing respiratory distress since birth. The mother gave a history of fatigability, excessive cough. Inter-costal and sub-costal recession was evident. Based on X-Ray chest findings hyperlucency on the left side, mediastinal shift a diagnosis of left-sided tension pneumothorax was done and an inter-costal chest drainage (ICD)

tube was inserted. A repeated X-ray chest showed resolution of pneumothorax with large cystic area involving the left upper and mid lung. Chest computed tomography (CT) scan done showed large multiloculated cystic lesion in the left upper lung, a diagnosis of congenital lobar emphysema / cystic adenomatoid malformation Type1 was made and the child was scheduled for left upper lobectomy. Left upper lobectomy was performed uneventfully; the patient had an uneventful postoperative course and was discharged from hospital 5 days after surgery. Histopathology result came back and confirms the diagnosis of congenital lobar emphysema.



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Trends in Lung Cancer Survival in Arab World, 1995-2009

Z. ZAIDI, M. Hamd iCherif, A. Djemaa Djazia, D. Abdellouche, S. Laouamri, A. Mahnane

Background: Lung cancer is the most common cancer in men and the third most common in women. Tobacco smoking, including second-hand smoke, is the predominant cause of lung cancer worldwide. Screening for lung cancer is under development. It is one of the most aggressive human cancers, with a 5-year overall survival of 10-20%. We use the results of the World Cancer Survival, CONCORD study2, 2014, for lung cancer in six Arab countries.

Materials and Methods: Individual lung tumour records were submitted by 07 population-based cancer registries in 06 Arab countries (Algeria, Libya, Tunisia, Jordan, Saudi Arabia and Qatar) for 60,208 adults (15-99 years) diagnosed during 1995-2009 and followed up to 31 December 2009. Estimated five-year net survival, adjusted for background mortality by single year of age, sex, calendar year in each country.

Results: Age standardised five year net survival was generally low in the range 10-20% for most geographical areas both in the developed and developing world. Survival was very low less than 10% (only 02% in Libya).

Conclusion: Cancer survival research is being used to formulate cancer control strategies to prioritise cancer control measures and to evaluate both the effectiveness and cost-effectiveness of those strategies.

Prevalence and Attitudes of Waterpipe Smoking among Saudi Physicians

Al Ghobain M, Anwar E. Ahmed, Abdrabalnabi Z, Mutairi W, Al Khathaami A

Objectives: To estimate the prevalence and the attitude of waterpipe smoking among Saudi physicians and to identify the factors associated with its use.

Method: A cross sectional study conducted among 454 Saudi physicians in 4 major hospitals in Riyadh, Saudi Arabia. We used self-administered modified questionnaire to achieve our objectives.

Results: The prevalence of waterpipe smoking was 44.9%. Higher prevalence of waterpipe smoking was found among males than females (57.8% vs. 18.2% p-value = 0.001) and among physicians with surgical specialty compared to physicians with medical specialty (58.1%, 38.1%, respectively; p-value = 0.001). The Majority of the non-smokers reported that physicians should serve as "role models" in society compared to waterpipe smokers (79%, 60.3%, respectively; p-value = 0.001). Non-waterpipe smokers received more formal training on cessation approaches during their medical school or residency training programs compared to waterpipe smokers (49.8%, 35.8%, respectively; p-value = 0.001).

Conclusion: Waterpipe smoking among Saudi physicians is high and it is associated with low exposure to education of waterpipe hazards and cessation during medical education. Such alarming prevalence reflects a negative image on physicians as the patients looking to them as a model for health education and diseases prevention.



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Contact Person: Emad El Swerky
Address: Dhcc, Al Faris Building #39
 Dubai | United Arab Emirates
Postcode: PO Box 2096 | Dubai | United Arab Emirates

Telephone: +971.4.44269100
Fax: +971.4.44269205
Email: emad_el_swerky@merck.com
Website: msd.com

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CHIESI FARMACEUTICI S.p.A.
 Via Palermo 26/A
 (Ingresso: Via Giacomo Chiesi 1)
 Telefono +39 0521 2791 (20 linee)

Telefax +39 0521 774468
 e-mail: info@chiesigroup.com
 Codice Fiscale e Partita IVA IT 01513360345
 Cap. Soc. Euro 75.000.000

Registro delle Imprese di Parma N. 15739
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 43122 Parma (Italy)



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