Annual Congress of Saudi Thoracic Society
in Collaboration with Emirates Allergy and Respiratory Society

8th
DUBAI 2017
15-18 March | Grand Hyatt Hotel

Final Program

Easy Breathing @ The Gulf!!
Gulf Thoracic
15-18 March | Grand Hyatt Hotel
DUBAI 2017
Easy Breathing @ The Gulf !!!
Dear Colleagues and Friends,

On behalf of the Executive Committee of the Gulf Thoracic Congress 2017, I would like to extend my warmest welcome to you all, to participate in this international congress, which will be held in Grand Hyatt Hotel, Dubai, UAE on 15-18 March 2017.

The Gulf Thoracic Congress 2017 is the eighth joint meeting of the Saudi Thoracic Society (STS) and the Emirates Allergy and Respiratory Society (EARS), in collaboration 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, and Saudi Society for Respiratory Care (SSRC).

Once again, 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.

This year, GT2017 will be featuring two special programs: Pulmonology for Family Medicine & Primary Care Physicians covering all respiratory problems commonly seen first by the Family Medicine/Primary Care physicians. For the first time in our region a dedicated conference catering for Thoracic Surgeons, Thoracic Surgery Forum (TSF 2017) is in collaboration with the European Society of Thoracic Surgeons (ESTS) and will cover all current issues on Thoracic Surgery.

Also, due to the great success of the 1st Medical Students Forum, GT2017 will once again include the MSF2017 with yet another very innovative program and workshops catering for medical students.

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, Gulf Thoracic Congress 2017
President, Saudi Thoracic Society (STS)
Riyadh, Saudi Arabia
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)
Golden Fizz: Medical Students Delegate
Fuel Yellow: Staff
Blue: Volunteer

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 Murjan) 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.
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.

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. 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.

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 horse racing at sea continue to thrive.

Language & Religion 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. The dirham is divided into 100 fils. The dirham has been held constant against the US dollar since the end of 1980 at a mid-rate of approximately US$1 = Dh3.67.

A separate regular inhaler is not required†

About 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.

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At the pool or on the beaches, trunks, swimsuits and bikinis are quite acceptable. Good quality sunglasses are advised, and photochromatic 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.

Language & Religion

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).

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ORGANIZING COMMITTEE

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Riyadh, KSA

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Riyadh, KSA

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Nahid Ali Sherbini, MD
Riyadh, KSA

Member
Ayman Al Sulaimani, MBBS, FRCS, MHSc
Jeddah, KSA
ERS-STS JOINT MEMBERSHIP form

### Membership Fee:
- **SAR200**
- **EUR50**
- **USD50**

### Eligible Countries:
- GCC Countries: Saudi Arabia, Bahrain, Kuwait, Oman, Qatar, and United Arab Emirates.
- Middle East Countries: Egypt, Sudan, Lebanon, Syria, Jordan, Iraq, Yemen, and Iran.
- Any other Nationality residing and/or practicing in any of the above countries.

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**ERS-STS JOINT MEMBERSHIP Benefits**

1. The ERS will provide full electronic access to the European Respiratory Journal (ERJ) to all members of STS, except ERS Congress Abstracts and Proceedings supplements of the ERJ, which will be distributed to Congress attendees only. ERS reserves the right to change the format of the ERJ to “open access”, if needed.
2. The ERS will provide full electronic access to the European Respiratory Review (ERR), Breathe (both currently open access) and the Monograph to all members of STS.
3. The ERS will offer all its publications in printed form to all interested members of STS at a special discounted price.
4. The ERS will distribute the ERS Weekly Newsletter to STS members.
5. ERS and STS will proactively co-operate to offer STS members preferred access to ERS Educational Services online and Events, as well as to endorse STS Educational Services by ERS, where applicable.
6. Ordinary, distinguished and honorary members of STS may participate in the constitutional meetings of the ERS and may vote. They are eligible for election to office up to Assembly Head without any residence restrictions and eligible for any office position up to ERS Presidency, provided they have their main residence in Europe, according to ERS Constitution and Bylaws in its last approved version. Members of STS are accorded all rights and privileges as detailed in the ERS Constitution and Bylaws in its last approved version.
7. Distinguished Officers of the Executive Committee, members of Governance bodies and members of STS, provided they qualify and they apply for it, duly endorsed by STS, will be considered for election in the prestigious Fellow of ERS program (FERS).

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**Additional ERS Membership Entitlements**

1. Discount on ERS international Congress. Special rates available for: Scientists (PhD, non-MD), Allied Health Professionals, Under 35s
2. Special rates on ERS Events
3. Affiliation to up to three groups of your choice in any of our eleven Scientific assemblies
4. Exclusive access to all research proposals
5. Eligible to stand for office and vote for Assembly and Group Officers and to vote at the General Assembly
6. Eligible to propose Symposia for the ERS International Congress
7. Eligible to apply for grants
8. Eligible to apply for financial support when setting up seminars and task forces – enables members to produce position papers statements or guidelines that subsequently become the official ERS documents on issues related to respiratory medicine

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**STS Membership Benefits**

1. The opportunity to chair sessions in Society’s meetings and active participation in scientific committees related to the member’s experience and academic interest.
2. Free or discounted admission to all STS scientific activities (Symposiums, Conferences, medical meetings with credit hours… etc…).
3. Free subscription to Annals of Thoracic Medicine “ATM; www.thoracicmedicine.org”, the scientific journal of STS.
4. Obtaining all brochures, handouts, and booklets of STS for FREE.
5. Getting the monthly “Pulmonary Medicine updates & abstracts”.
6. Free subscription to the STS Arabic Magazine “Al.Tanafus”.
7. Free admission to the monthly “Chest Club” meetings with credit hours.
8. Receiving all STS scientific materials including local guidelines and medical books in the field of chest diseases.
9. Email Alerts to all scientific events in the Kingdom and the world.

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**Title:**
- Prof.
- Dr.
- Mr.
- Ms.

**Gender:**
- Male
- Female

**First Name:**

**Middle Name:**

**Last Name:**

**Date of Birth:**
- Day / Month / Year

**Specialty:**

**Area of Interest:**

**Current Post:**

**Degrees:**
- MD, MBBS, PhD, etc.

**Institution:**
- Name of your Hospital, Med. Center...

**City:**

**Region:**

**Country of Residence:**

**Nationality:**

**Telephone No.:**

**Fax No.:**

**Mobile No.:**
- Include Country Code

**Email Address:**

**Alternate Email Address:**

**SCFHS:**
- (if any)

**Signature:**

**Date:**
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Prevenar 13 is indicated for active immunization for the prevention of invasive disease, pneumonia, and acute otitis media caused by S. pneumoniae in infants and children from 6 weeks to 5 years of age.

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The Saudi Thoracic Society
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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 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.

**Target Audience:**
- Pulmonologists
- Respiratory Therapists
- Residents
- PFT Technologists
- General Practitioners

**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 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.

**Audience:** Attendance is limited to 30 participants.
To familiarize the Pulmonologists with the use of ultrasound (USS) to diagnose pleura and lung diseases such as pleural effusion and pneumothorax.

**OBJECTIVES:**

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

- 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

**AUDIENCE:** Attendance is limited to 30 participants.

**FACULTY:**

Mohammed Alabdrab-Alnabi, MD, ABIM
Consultant Pulmonologist, Intensivist & Echocardiographer
Department of Intensive Care Services
Prince Sultan Military Medical City
Riyadh, Saudi Arabia

Nasir Siddique, MB, MRCP, FCCP, CCT(UK)
Consultant in Respiratory Medicine
Lead in Respiratory Education
Member Standards of Care Committee BTS
Kettering General Hospital
Kettering, UK
PRE-CONFERENCE WORKSHOPS & COURSES

Thoracic Imaging: From Basic to Advanced

**PROGRAM DIRECTOR:** Dr. Abdullah Al Jebreen

**Date:** Wednesday, 15 March 2017 | **Time:** 14:30-19:00 | **Meeting Room:** AL DANA

**OBJECTIVES:**

- Identify important diagnoses not to be missed on chest CXR.
- Identify various presentations of Tuberculosis in the thorax.
- Learn the diagnostic approach of pulmonary fibrosis.
- Identify various types of lung nodules and the diagnostic workup.
- Identify various presentations of smoking and smoking related lung.
- Identify various roles of imaging in lung cancer.

**TARGET AUDIENCE:**

- Radiologists
- Pulmonologists
- Thoracic Surgeons
- Anesthesiologist
- General Practitioners

**RATIONALE:**

Chest imaging using chest radiograph (X-ray) and Computed Tomography (CT) have been the mainstay of diagnosis in various infectious, inflammatory and neoplastic diseases. While, chest X-ray is the primary imaging modality for patients with various clinical presentations. Chest CT on the other hand is preserved for more detailed assessment of abnormalities seen on chest X-ray or when the chest X-ray fails to explain the clinical presentation. Radiologists, clinicians and surgeons need to be familiar with imaging features of important diseases of the chest and further workup.

**AUDIENCE:** Attendance is limited to 30 participants.

**FACULTY:**

- Abdullah Al Jebreen, MD
  Consultant Cardiothoracic Imaging
  King Faisal Specialist Hospital and Research Centre
  Riyadh, Saudi Arabia

- Abdulmunhem Obaidineen, MD
  Associate Professor of Radiology,
  University of Sharjah
  Head of Medical Diagnostic Imaging
  Sharjah University Hospital
  Sharjah, UAE

- Prof. Suhail Raoof, MD, FCCP, FACP, FCCM
  Chief, Division of Pulmonary Medicine
  Lenox Hill Hospital - Manhattan, NYC
  Professor of Medicine,
  Hofstra-Northwell School of Medicine
  New York, USA

- Yasir Alshaikh, MD
  Cardiothoracic Radiology Consultant
  King Khalid University Hospital
  Riyadh, Saudi Arabia

- Cecilia Wassberg, MD, PhD
  Consultant Radiologist and Nuclear Medicine,
  Karolinska University Hospital, Solna,
  Stockholm
  Uppsala, Sweden

**PROGRAM:**

<table>
<thead>
<tr>
<th>TIME</th>
<th>TOPIC</th>
<th>FACULTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>14:00 - 15:00</td>
<td>Registration</td>
<td>Abdullah Al Jebreen - KSA</td>
</tr>
<tr>
<td>15:00 - 15:05</td>
<td>Introduction:</td>
<td>Abdullah Al Jebreen - KSA</td>
</tr>
<tr>
<td>15:00 - 15:30</td>
<td>Acute Chest Imaging</td>
<td>Abdulmunhem Obaidineen - UAE</td>
</tr>
<tr>
<td>15:30 - 16:00</td>
<td>Imaging Fact of Thoracic Tuberculosis</td>
<td>Yasir Alshaikh - KSA</td>
</tr>
<tr>
<td>16:00 - 16:30</td>
<td>Top 10 Diagnosis Not to Miss on Chest X-Ray</td>
<td>Abdullah Al Jebreen - KSA</td>
</tr>
<tr>
<td>16:30 - 17:00</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>17:00 - 17:30</td>
<td>Approach to Lung Fibrosis</td>
<td>Yasir Alshaikh - KSA</td>
</tr>
<tr>
<td>17:30 - 18:00</td>
<td>Incidental Lung Nodules, What to do with Them?</td>
<td>Suhail Raoof - KSA</td>
</tr>
<tr>
<td>18:00 - 18:30</td>
<td>The Role of PET-CT in Lung Cancer Staging</td>
<td>Cecilia Wassberg - Sweden</td>
</tr>
<tr>
<td>18:30 - 19:00</td>
<td>Rare Chest Imaging Presentations</td>
<td>All Speakers</td>
</tr>
<tr>
<td>19:00</td>
<td>Closing Remarks</td>
<td></td>
</tr>
</tbody>
</table>

**WORKSHOPS & COURSES**
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.

**OBJECTIVES:**
- 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 and other conventional bronchoscopic procedures in a clinical setting.
- To demonstrate the practice of ENB (Medtronic) in collaboration with Fujifilm.
- 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 and other conventional bronchoscopic procedures in a clinical setting.
- To demonstrate the practice of ENB (Medtronic) in collaboration with Fujifilm.

**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 lung cancer staging, avoiding the comorbidity and comorbidity of mediastinoscopy. Nevertheless, pulmonologists should remain competent in performing conventional TBNA as a supplementary skill that is needed especially in the absence of newer technology at local hospitals.

**AUDIENCE:**
Attendance is limited to 25 participants.
PRE-CONFERENCE WORKSHOPS & COURSES

Research Methodology and Medical Writing: From Idea to Publication Workshop

PROGRAM DIRECTOR: Dr. Abdullah Alkhenizan
Date: Wednesday, 15 March 2017 | Time: 14:30-19:00 | Meeting Room: AL MANARA

SPONSORED BY:

Annals of Thoracic Medicine

RATIONALE:
To provide attendees with the skills necessary to undertake high quality research projects.

OBJECTIVES:
- Understanding key concepts of research design and analysis.
- Formulating research question and appropriate study design.
- Understand the application and interpretation of key statistical analysis.
- Awareness of research ethics, publication and plagiarism.

TARGET AUDIENCE:
- Physicians
- Microbiologists
- Laboratory Specialists
- Nurses

AUDIENCE: Attendance is limited to 30 participants.

FACULTY:

Prof. Abdullah Alkhenizan, CCFP, FCFP, ABHPM, MSc, DCEpid
Professor, College of Medicine, Al Faisal University
Chairman, Department of Family Medicine and Polyclinic KFSH&RC
Riyadh, Saudi Arabia

Prof. Qutayba Hamid, MD, PhD
Professor of Medicine
University of Sharjah
Sharjah, UAE

Prof. Mohamed S. Al Moamary, ABIM, FRCP(Edin), MBA-LS, FCCP
Executive Director, Medical Services, KAMC-Riyadh, Saudi Arabia
Vice President, Development and Quality Management, KSAU-HS, Saudi Arabia
Professor & Consultant, Pulmonary Medicine, KAMC-Riyadh
Chairman, Saudi Initiative for Asthma
Editor-in-Chief, Annals of Thoracic Medicine
Riyadh, Saudi Arabia

Abderrahim Oulhaj, PhD, MSc & Cstat
Associate Professor in Biostatistics
Institute of Public Health
College of Medicine and Health Sciences
United Arab Emirates University
Al Ain, UAE

PROGRAM:

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<tr>
<th>TIME</th>
<th>TOPIC</th>
<th>FACULTY</th>
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<tbody>
<tr>
<td>14:30 - 14:55</td>
<td>Registration</td>
<td>Abdullah Alkhenizan - KSA</td>
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<tr>
<td>14:55 - 15:00</td>
<td>Introduction</td>
<td>Abdullah Alkhenizan - KSA</td>
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<tr>
<td>15:00 - 15:25</td>
<td>Selecting Your Research Project</td>
<td>Marc Moss - USA</td>
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<tr>
<td>15:25 - 15:50</td>
<td>Study Design</td>
<td>Abdullah Alkhenizan - KSA</td>
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<tr>
<td>15:50 - 16:15</td>
<td>Writing the Proposal</td>
<td>Mohamed Almoamary - KSA</td>
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<tr>
<td>16:15 - 16:45</td>
<td>Break</td>
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<tr>
<td>16:45 - 17:10</td>
<td>Statistical Analysis Made Easy...</td>
<td>Abderrahim Oulhaj - UAE</td>
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<tr>
<td>17:30 - 17:35</td>
<td>Writing the Manuscript</td>
<td>Abdullah Alkhenizan - KSA</td>
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<td>17:35 - 18:10</td>
<td>Increase your Chance of Getting your Paper Accepted at High Impact Journal</td>
<td>Qutayba Hamid - KAIA</td>
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<tr>
<td>18:30 - 19:00</td>
<td>Open Discussion</td>
<td>All Faculty Members</td>
</tr>
<tr>
<td>19:00</td>
<td>Closing Remarks</td>
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</tbody>
</table>

www.gulfthoracic.com
Now you can get the best of both worlds, in one.¹⁻⁶

Introducing flutiform®
For rapid and sustained control of asthma³⁻⁵,⁷,⁸

flutiform® can transform asthma control with a fast onset and sustained efficacy in a consistent high fine particle fraction inhaler.³⁻⁵,⁷,⁸

Combining fluticasone and formoterol, flutiform® offers effective, rapid and sustained control of asthma symptoms.³⁻⁵,⁷ What's more, the flutiform® aerosol inhaler delivers a consistently high fine particle fraction (~40%) across a wide range of flow rates.³⁻⁵,⁷

For detailed information, please refer to full prescribing information.

References:
3. Approved Prescribing Information/Data Sheet.

Flutiform® (fluticasone propionate and formoterol fumarate) - Indications: Regular treatment of asthma where the use of a combination product (inhaled corticosteroid & long-acting β₂-agonist) is appropriate: For patients not adequately controlled with inhaled corticosteroids & ‘as required’ inhaled short-acting β₂-agonist (SABA), or for patients already adequately controlled on both an inhaled corticosteroid & a long-acting β₂-agonist (LABA).

Flutiform® 50/uniBCg/5/uniBCg & 125/uniBCg/5/uniBCg per actuation are indicated for use in adults & adolescents 12 years & above. Flutiform® 250/uniBCg/10/uniBCg per actuation is only indicated for use in adults.

Dosage & administration: The appropriate strength should be taken as two inhalations, twice-daily & used every day, even when asymptomatic.

Contraindications: Hypersensitivity to any of the active substances or excipients.

Precautions & warnings: Use with caution in patients with: pulmonary tuberculosis; quiescent tuberculosis; fungal, viral or bacterial infections; diabetes; uncorrected hypokalaemia; predisposition to low levels of serum potassium; impaired adrenal function; hypertrophic obstructive cardiomyopathy; idiopathic subvalvular aortic stenosis; severe hypertension; aneurysm or other severe cardiovascular disease; diabetes; severe dyspnoea; asthma or chronic obstructive pulmonary disease in unstable or acute severe asthma & other conditions when the likelihood for hypokalemia adverse effects is increased.

Flutiform® should be discontinued immediately if there is evidence of paradoxical bronchospasm.

Pregnancy and lactation: Flutiform® is excreted in breast milk; a risk to the breast feeding infant cannot be excluded. A decision should be made on whether to discontinue breastfeeding or discontinue/abstain from Flutiform®.

Side-effects: Potentially serious side-effects: hyperglycaemia; depression; aggression; behavioural changes (predominantly in children); paradoxical bronchospasm; agitation; vertigo; palpitations; ventricular extrasystoles; angina pectoris; nausea; weight gain; muscle weakness; bone loss; hypocalcaemia; adrenal suppression; growth retardation; cataract and glaucoma; hypersensitivity reactions and QTc interval prolongation.
DAY 1 - THURSDAY, 16 MARCH 2017

SCIENTIFIC PROGRAM

Baniyas II

Update in Pulmonary Medicine I

Chairs: Mohamed Al Hajjaj (KSA) | Marc Moss (USA)

08:30 - 09:00
Asthma 2017: Beyond the Guidelines - Monica Kraft (USA)

09:00 - 09:30
Targeting Small Airways in Asthma - Qutayba Hamid (UAE)

09:30 - 10:00
Personalized Medicine in COPD: How Close are We? - Frank C. Sciurba (USA)

10:00 - 10:45
Opening Ceremony

COFFEE BREAK

Hall
Session
Severe Asthma | Sleep Medicine | Esophagus | ILD
Chairs: Bassem Mahboub (UAE) | Fatima Al Huthn (KSA)
11:15 - 11:40
Current Update on the Management of Acute Severe Asthma - Chairs: Caims (UAE)

11:40 - 12:05
Asthma and the Microbiome: 2017 Update - Monica Kraft (UAE)

12:05 - 12:30
Bronchial Thermoplasty Revisited - Vivek Iyer (USA)

13:00 - 14:00
LUNCH BREAK

Abstracts

Bibliography for Family Pulmonology and Primary Care Physician | Lung Cancer
Chairs: Nabil Kurashi (KSA) | Wadieb Al Shehief (UAE)
14:00 - 14:25
Asthma and COPD: Differences and Similarities in Inflammatory Answer - Guy Joos (Belgium)

14:25 - 14:50
TB Screening - Farida I. Al Hosani (KSA)

14:50 - 15:15
Upper Respiratory Tract Infections: Viral Vs. Bacteria - Mohammed Alswes (KSA)

15:15 - 15:45
COFFEE BREAK

Hall
Session
Pulmonology for Family Medicine and Primary Care Physician | Surgical Medical Interface | Abstracts Presentation B | Pharmaceutical Sponsored Symposium
Chairs: Abdullah Al Mutairi (KSA) | Anwar Alwadi (KSA)
15:45 - 16:10
COPD: Diagnosis, Treat, and When to Refer - William Main (UK)

EBUS vs Mediastinoscopy in Lung Cancer Pro and Con - Abbas M. Mohiai (KSA) | M. Rehda Soullamas (UAE)

Common Reasons for Manuscript Rejection - Adil Al Hatt (KSA)

16:10: Noninvasive Self Regulation MTS: In Lung Surgery - Zaid Alzahrani (KSA)
DAY 1 - THURSDAY, 16 MARCH 2017

16:20: A Study on Etiology of Mediastinal Lymph Node Enlargement and Role of Volume Reduction in...Saheer Sainalabdeen

16:30: Early Results of Excision of 261 Vaccination in AdultsStefano Aliberti (Italy)

16:40: Chest X-Ray Changes in Cystic Fibrosis Patients at KFSH&RC. - Abdulaziz Tackling Refractory Pleural Effusions - Mohammed Alhajji (KSA)

16:50: Prognostic Value of CYFRA 21-1 and Carcinoembryonic Antigen in NSCLC. Azza El-Toney (Egypt)

20:30 | Faculty Dinner | Place: Garden 1, Grand Hyatt Dubai Hotel

DAY 2 - FRIDAY, 17 MARCH 2017

08:30 - 09:00 Air Pollution: General and Respiratory Effects - Guy Joos (Belgium)

09:00 - 09:30 Latest GOLD Guidelines: An Overview - Wisia Wedzicha (UK)

09:30 - 10:00 Steroids for Community-Acquired Pneumonia - Stefano Aliberti (Italy)

10:00 - 10:30 IPF: The Importance of Early Diagnosis and Current Therapies - Neal Chaisson (USA)

10:50 - 11:15 Lung Infection - I

COFFEE BREAK
### DAY 2 - FRIDAY, 17 MARCH 2017

#### SCIENTIFIC PROGRAM

**Al Ameera**

### LUNCH BREAK

13:00 - 14:00

#### Pulmonology for Family Medicine and Primary Care Physician

**Baniyas II**

### Day 2 - Friday, 17 March 2017

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<tr>
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<tr>
<td>08:30</td>
<td><strong>Update in Pulmonary Medicine III</strong></td>
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<tr>
<td>09:00</td>
<td><strong>Respiratory Care</strong></td>
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<tr>
<td>09:30</td>
<td><strong>Approach to Unexplained Chronic Cough</strong></td>
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<tr>
<td>10:00</td>
<td><strong>COFFEE BREAK</strong></td>
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<td>10:50</td>
<td><strong>COPD: More than Meets the Eye</strong></td>
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<td>11:15</td>
<td><strong>Pulmonary Hypertension Experience in the UAE</strong></td>
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<tr>
<td>11:40</td>
<td><strong>Approach to Unexplained Chronic Cough - Week Var (UAE)</strong></td>
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<td>12:00</td>
<td><strong>Shocks and its Management</strong></td>
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### Day 3 - Saturday, 18 March 2017

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<tr>
<td>10:00</td>
<td><strong>Approach to Unexplained Chronic Cough</strong></td>
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<td><strong>COFFEE BREAK</strong></td>
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<tr>
<td>11:15</td>
<td><strong>Pulmonary Hypertension Experience in the UAE</strong></td>
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<td>11:40</td>
<td><strong>An Unusual Presentation of Common Pulmonary Disorder</strong></td>
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### Medical Students Forum - MSF2017

**Hall Baniyas II Baniyas I**

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<td><strong>Mini Symposia III</strong></td>
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<td><strong>Mini Symposia IV</strong></td>
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<td><strong>Update in Malignant Pleural Mesothelioma</strong></td>
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<td><strong>Approach to a Wheezy Child</strong></td>
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<td><strong>COPD</strong></td>
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<td><strong>Lung Infection - II</strong></td>
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<td><strong>Challenging Clinical Cases</strong></td>
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<td><strong>MSF2017 Medical Students Forum</strong></td>
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<td><strong>Challenging Clinical Cases</strong></td>
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**Baniyas I**

**Hall**

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<td><strong>Challenging Clinical Cases</strong></td>
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The Saudi Initiative for
Asthma 2016
Guidelines for the Diagnosis and Management of Asthma in Adults and Children

TO VIEW OR DOWNLOAD
VISIT THE WEBSITE

www.sinagroup.org

SAUDI GUIDELINES
ON THE DIAGNOSIS AND MANAGEMENT OF LUNG CANCER
2017 Update

TO VIEW OR DOWNLOAD
VISIT THE WEBSITE

www.slca-sts.com

Life around the tree
Remind her of what she’s been missing

Despite current treatment, almost 9 out of 10 asthma patients still adjust their lives and miss out because of their condition. You can help these patients get back moments they’ve been missing, with 24 hours of continuous efficacy from just one daily dose.13

Asthma

Conclusions

GSK0530168Fustin data

Asthma is an chronic inflammatory disorder that affects the airways. It is characterized by airway hyperresponsiveness, bronchial inflammation, and mucus production. The symptoms of asthma include wheezing, chest tightness, coughing, and shortness of breath. The cause of asthma is not entirely understood, but it is thought to be related to a combination of genetic and environmental factors. Treatment for asthma typically involves the use of inhaled corticosteroids, long-acting beta-agonists, and anticholinergics. In some cases, oral corticosteroids may be necessary. It is important to identify and avoid triggers that can exacerbate asthma symptoms. Regular follow-up with a healthcare provider is essential to manage asthma effectively. 

References:


### Session: 1 Medical Student Forum (MSF2017)

**Chairpersons:** Sami Al Nassar - KSA | Ihab El Jizi - Lebanon

<table>
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<tr>
<th>Time</th>
<th>Topic</th>
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<tbody>
<tr>
<td>08:00 - 08:25</td>
<td>How to Approach a Patient with Respiratory Disease</td>
<td>Carlos R. Cordeiro - Portugal</td>
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<td>08:25 - 08:50</td>
<td>How to Read Chest X-Ray</td>
<td>Mashael Al Rujaib - KSA</td>
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<tr>
<td>08:50 - 09:15</td>
<td>Respiratory Emergencies</td>
<td>Nasir Siddique - UK</td>
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<td>09:15 - 09:40</td>
<td>Smoking Cessation</td>
<td>Javeid Khan - Pakistan</td>
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<td>09:40 - 10:00</td>
<td><strong>COFFEE BREAK</strong></td>
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### Session: 2 Medical Student Forum (MSF2017)

**Chairpersons:** Suhaila Al Jawder - Bahrain | Mahmoud Al Bakshi - KSA

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<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>10:00 - 10:25</td>
<td>How to Read ABG’s</td>
<td>Asma O. Alamoudi - KSA</td>
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<tr>
<td>10:25 - 10:50</td>
<td>Interpretation of Pulmonary Function Test</td>
<td>Sultan Ayoub Memo - KSA</td>
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<tr>
<td>10:50 - 11:15</td>
<td>How to Control Asthma / Management of Sick Asthmatic Patient</td>
<td>Guy Joos - Belgium</td>
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<tr>
<td>11:15 - 11:40</td>
<td>Patient Safety Competencies for Future Doctors</td>
<td>Mohamed Al Moamary - KSA</td>
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<td>11:40 - 13:05</td>
<td><strong>LUNCH BREAK / ABSTRACTS TOUR</strong></td>
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### Session: 3 Medical Student Forum (MSF2017)

**Chairpersons:** Waseem Hajjar - KSA | Mohammed Al Lawati - Oman

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<th>Topic</th>
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<tr>
<td>13:05 - 13:30</td>
<td>Use of Social Media in Medicine</td>
<td>Mohamad Alswes - KSA</td>
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<td>13:30 - 13:55</td>
<td>Career Development After Graduation</td>
<td>Charles Cairns - USA</td>
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### MSF2017 - SCIENTIFIC PROGRAM

**Friday, 17 March 2017 | Al Ameera II-III Hall**

#### Session: Selected Students Abstracts

**Chairpersons:** Sami Al Nassar - KSA | Emad Koshak - KSA

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>13:55 - 14:15</td>
<td>How to Get Your Abstract Accepted in an International Medical Congress: Some Tips &amp; Tricks to Improve an Abstract to be Presented at an International Congress.</td>
<td>Enrico Ruffini - Italy</td>
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<tr>
<td>14:15</td>
<td>Assessing the measurement of preoperative B-Type Natriuretic Peptide…</td>
<td>Nadia Hussain</td>
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<tr>
<td>14:23</td>
<td>The Prevalence and Predictors of Poor Sleep Quality Among Medical Students…</td>
<td>Yasmine Mansouri</td>
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<tr>
<td>14:31</td>
<td>The Association Between Caffeine Consumption and Sleeping Habits Among Medical Students…</td>
<td>Basil Alsoumaire</td>
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<tr>
<td>14:39</td>
<td>A Comparison Between Two Types of Resistive Inspiratory Muscle Training Devices…</td>
<td>Mashail Alrayes</td>
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<tr>
<td>14:47</td>
<td>Impact of Knowledge and Attitude on Intention To Breastfeed…</td>
<td>Noof Almasoud</td>
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<tr>
<td>14:55</td>
<td>Pre-Ramadan Education Among Patients with Diabetes Mellitus…</td>
<td>Afnan Elahi</td>
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<td>15:03 - 15:23</td>
<td><strong>COFFEE BREAK</strong></td>
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<td>15:23</td>
<td>Child Maltreatment between Knowledge, Attitude and Beliefs among Saudi…</td>
<td>Dana Alatabeeb</td>
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<tr>
<td>15:31</td>
<td>The Association between BMI and Frequency of Emergency Department Visits for Asthma Exacerbation…</td>
<td>Ghadah Alhekail</td>
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<tr>
<td>15:39</td>
<td>Awareness, Acceptance and Perspective of Women for Reconstruction Post Mastectomy</td>
<td>Rawan AlTaleeb</td>
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<tr>
<td>15:47</td>
<td>Restless Legs Syndrome and Vitamin D is there a Link?</td>
<td>Samah Alsafadi</td>
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<tr>
<td>15:55</td>
<td>Prognosis and Treatment Outcomes of Small Cell Lung Cancer Patients…</td>
<td>Ghidhaa Babeer</td>
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<tr>
<td>16:03</td>
<td>Predictors of Outcome in Blunt Chest Trauma: A Single Center Experience.</td>
<td>Ahmed Alrahim</td>
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<tr>
<td>16:11</td>
<td>Primary Spontaneous Pneumothorax: a Clinical Profile and Recurrence of 112 Adult Patients…</td>
<td>Najia Alotaibi</td>
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<tr>
<td>16:19</td>
<td>Prevalence of Self-Diagnosis and Self-Management of Pain Among Residents of Riyadh…</td>
<td>Moneera Bin Saleem</td>
</tr>
</tbody>
</table>
Nabil Abouchala, MD, FACP, FCCP  
Department of Adult Critical Care Medicine  
Medical Director, MS ICU-C  
King Faisal Hospital & Research Centre  
Riyadh, Saudi Arabia

Dr. Abouchala is a Consultant Intensivist/Pulmonologist previously held several titles at King Faisal Hospital and Research Center, Riyadh, Saudi Arabia, including the Medical Director of the Medical and Surgical ICU, Program Director of the Critical Care Fellowship, Section Head of Intensive Care Medicine, and currently the Deputy Chairman of the Department of Adult Critical Care Medicine. He is currently the President of the Middle East Critical Care Assembly (MCCA).

Between April 2006 and August 2007, Dr. Abouchala was the section head of Critical Care Medicine at the Department of Medicine in the King Faisal hospital. Since 2014, Dr. Abouchala is the Deputy Chairman of the Adult Critical Care Department at King Faisal Hospital and research Center in Riyadh, Saudi Arabia. Dr. Abouchala has authored many book chapters, meeting abstracts and publications in peer-reviewed journals and is a Fellow of the American College of Physicians and the American College of Chest Physicians and a Member of the American Thoracic Society and the American Association of Respiratory Care.

Prof. Nasser Behbahani, MBChb, FRCPC  
Professor of Medicine, Department of Medicine  
Kuwait University  
Consultant, Respiratory Medicine  
Kuwait

Dr. Nasser Behbahani is a consultant in Pulmonology. He earned his bachelor of Medicine and Surgery from Royal College of Surgeons in Ireland. He completed his postgraduate training in Internal Medicine and respiratory diseases at the University of British Columbia, Vancouver, Canada. Dr. Behbahani is American Board certified in Internal Medicine and Respiratory Diseases. He is also a fellow of the Royal College of Physicians, Canada. He is a member of the American Thoracic Society, the European Respiratory Society, and Kuwait Medical Association.

Prof. Stefano Aliberti, MD  
Head, ERS Respiratory Infections Assembly  
Professor, Respiratory Medicine  
Department of Pathophysiology and Transplantation, University of Milan  
Consultant, Respiratory Medicine, Policlinico 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 Bocca, Milan, Italy. Stefano Aliberti is currently Head of the Respiratory Infections Assembly of the European Respiratory Society (ERS).

Abdulmohsen M. Alahmad, RRT, PhD  
Senior Respiratory Care & Critical Care Specialist  
King Fahd Medical City  
Riyadh, Saudi Arabia

Abdulmohsen M. Alahmad is a Senior Clinical Respiratory Care & Critical Care Specialist, previously held several titles and positions at King Fahd Medical City, Riyadh, Saudi Arabia, including the Head of Respiratory Critical Care Department (Medical, Surgical, and Cardiac ICUs). Abdulmohsen has graduated from several universities with several degrees and specialties including; Loma Linda University, Boise State University, Immam Mohammad Bin Saud University, and the University of Nottingham.

His PhD researches were in advanced mechanical ventilation modalities in the management of ARDS from the School of Medicine in the University of Nottingham, the department of Anaesthesia & Critical Care. The focus of his most recent clinical researches has been on the Airway Pressure Release Ventilation (APRV) mode of mechanical ventilation.

Abdulmohsen has presented several research projects in national and international conferences such as the American Thoracic Society and the American Association of Respiratory Care. Abdulmohsen has led the project of reducing the incidence rate of unplanned extubation and establishing an international benchmark for unplanned extubation (started from 2009-present).

Amr Albanna, MD, MSc  
Assistant Professor, Consultant Pulmonologist  
King Saud bin Abdulaziz University for Health Sciences  
Head of Research Office, KAIMRC-WR  
Deputy Chairman, Quality and Patient Safety, Department of Medicine  
National Guard Health Affairs- Jeddah  
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 Respirology, 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 is also Adjunct professor at McGill University, Canada. He has been recently appointed as Head of Research Office at KAIMRC and Deputy Chairman of Quality and Patient Safety in the Department of Medicine, King Abdulaziz Medical City, Western Region of Saudi Arabia. Secondary School: 1996, Manarat Jeddah High School, Jeddah, Saudi Arabia.
In 2006, he won in the Kuwait Foundation of the Advancement of Sciences Annual Award for Best Research Publications in Medical Sciences. He has published more than 40 original articles in peer reviewed indexed journals and more than eight full-length review articles and book chapters. Dr. Nasser Behbahani is currently a professor in the faculty of medicine in Kuwait University.

Education
- American board certification in Internal Medicine and Respiratory diseases, Canada
- Fellowship in Internal Medicine as well as Special Certificate in Respiratory Medicine, Royal college of Physician, Canada Bachelor of Medicine and Surgery, Royal College of Surgeons of Dublin, Ireland

Charles B. Cairns, MD, FACEP, FAHA, is the assistant vice president for clinical research and clinical trials at the University of Arizona Health Sciences, interim dean of the University of Arizona College of Medicine – Tucson, and a professor in the Department of Emergency Medicine at the UA College of Medicine – Tucson. Dr. Cairns previously served as professor and chair of the Department of Emergency Medicine at the University of North Carolina at Chapel Hill (UNC-CH), where he also served as consulting faculty for the Duke Clinical Research Institute at Duke University Medical Center. At UNC-CH, he served in leadership roles in medical education and curriculum reform, health information technology strategy, university system campus security and health-care system strategic planning.

He was elected by the medical students as an alumnus faculty member of the Alpha Omega Alpha honor society and served in leadership roles in medical education and curriculum reform, health information technology strategy, university system campus security and health-care system strategic planning.

He is also a member of the Society of Critical Care Medicine, the American College of Chest Physicians and the American Thoracic Society.

Edward Black, MD
Consultant Thoracic Surgeon
Al Ain Hospital
Al Ain, UAE

Prof. Charles B. Cairns, MD, FACEP, FAHA
Dean, College of Medicine
Assistant Vice President, Clinical Research and Clinical Trials
Professor, Emergency Medicine
University of Arizona College of Medicine - Tucson
Tucson, AZ, USA

Dr. Cairns' research interests include the host response to acute infections, acute asthma, trauma and cardiac resuscitation and regionalization of emergency and critical care.

Neal Chaisson, MD
Pulmonologist, Cleveland Ohio
Assistant Program Director,
Pulmonary and Critical Care Medicine Fellowship
Pulmonary Medicine Department
Cleveland Clinic, Cleveland, Ohio, USA

Dr. Chaisson joined the Cleveland Clinic in 2013 after completing his fellowship in Pulmonary/Critical Care medicine at Johns Hopkins University. His primary area of expertise is in the evaluation and treatment of patients with pulmonary arterial hypertension (PAH). Dr Chaisson has active clinical and research interests in the utilization of bedside ultrasound for evaluating critically ill patients and in developing improved methods of treating PAH patients with right heart failure. He also maintains a strong interest in general pulmonary medicine and, in particular, in evaluating patients with complex pulmonary disorders.

In addition to his clinical activities, Dr. Chaisson serves as the associate program director of the Pulmonary/Critical Care fellowship, as the medical liaison to visiting scholars of the Cleveland Clinic and is active in creating new methods of teaching trainees through simulation and advanced educational techniques.

Jeffrey Chapman, MD
Chief, Respiratory & Critical Care Institute
Cleveland Clinic Abu Dhabi
Abu Dhabi, UAE

Jeffrey Chapman, MD, is Chief of the Respiratory & Critical Care Institute, one of the five Centers of Excellence at Cleveland Clinic Abu Dhabi, and Chief of the Quality & Patient Safety Institute. In his dual role, Dr. Chapman oversees a team focused on implementing a high quality, Patients First philosophy which uses the latest technology to enhance quality, drive patient safety, and address critical care needs in the fields of respiratory and critical care medicine. Before moving to Abu Dhabi, he served as a Staff Physician at US-based Cleveland Clinic from 2000 to 2011.

Dr. Chapman specializes in the treatment of interstitial lung disease, idiopathic pulmonary fibrosis, lymphangioleiomyomatosis, and connective tissue disease, as well as lung transplantation. Dr. Chapman received his undergraduate degree at Northwestern University in Biomedical Engineering and obtained his medical degree from Washington University School of Medicine in St. Louis, Missouri, US. He received training in internal medicine at Columbia-Presbyterian Medical Center in New York City and in pulmonary and critical care medicine at Yale University.

He is also a member of the Society of Critical Care Medicine, the American College of Chest Physicians and the American Thoracic Society.
Carlos Robalo Cordeiro was born in Coimbra, Portugal, in 1958. He is a specialist in Pulmonology - Coimbra University Hospital, since 1992. He received his MD in Medicine from the University of Coimbra in 1988. He is president of Pulmonology Portuguese National Board, since October 2006 and the coordinator of the Research Unit “Center of Pulmonology” from the Ministry of Science and Technology, since July 2006.

He was elected Chairman of European Respiratory Society Group “Diffuse Parenchymal Lung Disease”, in January 2008 (former Secretary 2005/2008). Furthermore, he was elected Member of the ERS Council, in January 2008. He was chairman of the “10th International Conference on Bronchoalveolar Lavage”, held in Portugal, June 2006. He is a peer reviewer of: “Revista Portuguesa de Pneumologia”, “European Respiratory Journal”, “Respiration”, “Respiratory Medicine”, “Journal of Internal Medicine”, “Breath” and “Pneumon”.

He was first author of 104 publications as and 148 as co-author. Since 2003 he is the coordinator of “Diagnostic and Therapeutic Techniques Unit” from the Department of Pulmonology and Allergology – Coimbra University Hospital. He was the Portuguese delegate in the UEMS (2000-2006) and he is a member of the Portuguese Academy of Medicine, since 2006.

Richard Costello graduated from the Royal College of Surgeons in Ireland in 1988 and is currently Consultant Physician in Respiratory Medicine at Beaumont Hospital Dublin and Associate Professor of Medicine at the Royal College of Surgeons in Ireland. He runs specialist clinics in COPD, sleep and ventilation and severe asthma. Professionally, he has served as National Specialist Director of Training in Respiratory medicine.

He is the clinical lead for the national severe asthma program, is President of the Irish Sleep Society and Director of Research at the Royal College of Physicians. He is a board member of the ERS HERMES respiratory exam group, the ERS Education Council and President of the European Board of Assessment. Academically, he is a HRB Clinician Scientist and leads program projects that address the role of adherence and healthcare outcomes and clinical communication. He has published over 120 papers, has developed patented and copyrighted technology. His work is supported by grants from the EU, industry and the HRB.

Dr. Ali is Certified in Surgery, thoracic Oncology and Thoracic Surgery. He received his advanced thoracic surgical education in Harvard Medical School, Boston USA at Brigham and Women’s Hospital. Following that he completed an Advanced fellowship in minimally invasive Thoracic and Foregut surgery at Harvard Medical School. He was mentored by US leaders in their field of Thoracic surgery who followed the tradition of pioneers in their fields, including Dr. Pearson in Toronto, Lutetchi in Pittsburgh, Orniger. He has closely worked with Dr. Sugarbaker the late President of the American Association of Thoracic Surgery, Dr. Scott Swanion a world leader in VATS surgery and Dr. Steve Menzer, an expert in Lung surgery and Esophagectomy in North America.

Research Interest
His main interest include lung cancer, esophageal surgery, video-assisted thoracic surgery (VATS), GERD, hiatal hernia, lung transplantation, minimally invasive visceral cancer surgery and thoracic oncology. Dr Ali is a Fellow member of the Royal Australasian & American College of Surgeons, Society of Thoracic Surgery, Member of the Society of Surgical Oncology, Member of The American Gastrointestinal and Endoscopic Surgeons and Member of the Society for the Surgery of the Alimentary tract. His principal professional goal is the welfare of patients with thoracic , lung cancer and upper GI disease and malignancies. His main interest is in minimally invasive surgery and robotics to provide faster and smoother recovery for his patients.

Saleh Abu-Daff graduated from King Saud University in 2001 and after completing his General Surgery Residency training program at the Riyadh Military Hospital he discovered his interest in Thoracic Surgery that led him to join the Thoracic Surgery fellowship Program at Ottawa University. Currently he is a consultant General & Thoracic Surgeon and Department Chief of Thoracic Surgery at King Fahad Medical City. His main clinical interests are in applying minimal invasive techniques for lung, foregut and mediastinal operations and implementing quality assurance programs for surgical pathways and outcomes.

Aerogen is the world’s leading medical device company specialising in the design, manufacture and commercialisation of aerosol drug delivery systems. Aerogen’s patented vibrating mesh technology turns liquid medication into a fine particle mist, gently and effectively delivering drugs to the lungs of critically ill patients of all ages. Aerogen’s innovative products, such as the Aerogen® Solo and Aerogen® Ultra, significantly improve aerosol drug delivery resulting in better patient care throughout the Hospital. Founded in Galway, Ireland in 1992, Aerogen has grown to become the global leader in high performance aerosol drug delivery and has partnered its technology with the leading mechanical ventilation companies. Aerogen technology is used by millions of patients and caregivers in over 75 countries worldwide.
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 intensivists at King Faisal Specialist Hospital and Research Center in Riyadh, Saudi Arabia.

He established the following at King Faisal Specialist Hospital & Research Centre:
- Lung Transplant Program, in 2003 (the first and only one among the Arab countries)
- Pulmonary Hypertension Treatment Program, the only program in the area which provides comprehensive diagnostic and therapeutic protocols for patients with pulmonary hypertension, which includes all available internationally recognized medical interventions in this field.

In addition to his clinical responsibilities, he is currently the Section Head of Pulmonary Medicine, Department of Medicine, and the Director of Ambulatory Care Services. His areas of interests are, Lung Transplantation and Pulmonary Hypertension. However, he runs inpatient and outpatient Pulmonary Services at KFSH&RC which covers a wide range of pulmonary diseases.

Sulaiman Al Gazlan, MD, MRCP(UK), ABIM
Consultant, Allergy/Immunology
Department of Medicine
King Faisal Specialist Hospital and Research Centre
Riyadh, Saudi Arabia

Sulaiman Al Gazlan is currently a Consultant, Allergy/Immunology, Department of Medicine at King Faisal Specialist Hospital and Research Centre Riyadh, Saudi Arabia. He has Graduate and Postgraduate Education Degrees: MD, King Saud University, Riyadh, Saudi Arabia - July 1988, MRCP, United Kingdom- February 1994 and Arab Board in Internal Medicine (ABIM) & Saudi Board in Internal Medicine (SBIM) Saudi Arabia- April 1994.

Additionally, he also has several Peer-Reviewed Publications and Research.

Ahmed Bamousa, MD, CABS
Consultant, Thoracic Surgery
Prince Sultan Military Medical City
Riyadh, Saudi Arabia

Fahad Al-Ghimlas, MD, MSc, FACP, FCCP, FRCPC
Consultant Respirologist,
Department of Medicine- Amiri Hospital
Ministry of Health- State of Kuwait
Kuwait

Clinical Post
- Consultant Respirologist in the Department of Medicine, Amiri Hospital, Kuwait
- Director of the Continuing Education and Professional Development (CEPD) Center – at The Kuwait Institute for Medical Specialization (KIMS)
- President of The Kuwait Evidence-Based Healthcare Society under Kuwait Medical Association

Qualifications
- The Degree of Bachelor of Medical Sciences, Kuwait University (1999)
- The Degree of Bachelor of Medicine and Surgery, Kuwait University (2001)
- The American Board of Internal Medicine – Internal Medicine (2006)
- Fellow of The Royal College of Physicians of Canada (2007)
- Specialty Certificate from The Royal College of Physicians of Canada – Internal Medicine (2007)
- Subspecialty Certificate from The Royal College of Physicians of Canada – Adult Respiratory Medicine (2009)
- The American Board of Internal Medicine – Pulmonary Medicine (2009)
- Master in Science (MSc) Degree in Clinical Epidemiology and Health Research Methodology – McMaster University (2009)

Professional Affiliations
- Member of the Kuwait Medical Association (KMA)
- Member of the Kuwait Thoracic Society under KMA
- President of The Kuwait Evidence-Based Healthcare Society under KMA
- Fellow of the Royal College of Physicians and Surgeons of Canada (RCPSC) – FRCP C
- Fellow of the American College of Chest Physicians (ACCP) – FCCP
- Fellow of the American College of Physicians (ACP) – FCP
- Associate Member of the American Thoracic Society
- Member of the Alliance for Continuing Education in the Health Professions
FACULTY - PROFILE

Waseem M. Hajjar, MD, MS, FRCS Ed, FCCP
Associate Professor and Consultant Thoracic Surgeon,
College of Medicine, King Saud University,
King Khalid University Hospital, Riyadh
Riyadh, Saudi Arabia

QUALIFICATIONS
» M.D. Aleppo University Faculty of Medicine Registered 12.08.1984
» M.S. General Surgery Certificate of Specialization in General Surgery Ministry of Health Damascus Syria 02.07.1988
» FRCS Edinburgh - Nov. 1992
» ATLS Certificate - May 1993
» ACLS Certificate - March 1996
» ATLS Certificate - April 2013
» FCCP Certificate - Nov. 2014
» GMC Certificate of Full Registration, U.K. Registration No: 4040545
» MDU Member of the Medical Defense Union No. 300195E
» Member of the Society of Cardio thoracic Surgeons of Great Britain and Ireland
» Member, Riyadh Chest club
» Member of Arab Thoracic Associations
» Member of Saudi Thoracic Society
» Saudi Council for Health Specialties (SCFHS)

PRIZES AND AWARDS:
FIRST PRIZE for the “best paper”
Intra-operative Heparin Release during Lung Surgery

EXCELLENCE AWARD IN TEACHING
The Dean of College of Medicine From Deanship of Quality 1431-1432

EMPLOYMENT:
Present Position:
09 September 2006 until February 2016.
Assistant Professor & Consultant Thoracic Surgeon.
01 March 2016 until now.
Associate Professor & Consultant Thoracic Surgeon.
Division of Thoracic Surgery, Department of Surgery
King Khalid University Hospital,
College of Medicine, King Saud University,
Riyadh, Saudi Arabia.


FACULTY - PROFILE

Mohammed Alhajji, MD, MSc, MRCP (GIM), MRCP (Resp.), CCT
Consultant, Interventional Pulmonologist
King Faisal Specialist Hospital & Research Center
Riyadh, Saudi Arabia

Dr. Alhajji graduated from Faculty of medicine, Aleppo University after that he moved to UK, Yorkshire and Humberside Deanery where he completed his general medical rotation and respiratory medicine training Dr. ALHAJJI is a Member of the Royal College of Physicians of London (MRCP) for General and Respiratory Medicine with CCT certificate Dr. ALHAJJI worked as a consultant Pulmonologist in George Eliot Hospital NHS Trust and Heart Of England NHS Trust, UK before he moved to Saudi Arabia Dr. ALHAJJI is an active member in several scientific societies like BTS, ERS, and GTS Dr. ALHAJJI is currently a consultant pulmonologist at King Faisal Specialist Hospital & Research Centre in Riyadh where he established the pulmonary interventions service Dr. ALHAJJI main field of interest is lung cancer, interventional bronchoscopy and pleural disease

Prof. Qutayba Hamid, MD, PhD
Professor of Medicine
University of Sharjah
Sharjah, UAE

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 UK. He has been a Professor at McGill University and the Meakins-Christie Laboratories since 1995.

Prof. Hamid is recognized internationally for his work in research on Asthma, COPD and Inflammation. Prof. 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.

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SWITCH TO THE BEST!
Umur Hatipoğlu, MD, is a staff member in the Respiratory Institute at Cleveland Clinic’s main campus since September 2008. Prior to that appointment, he served as the Chief of Pulmonary and Critical Care Medicine at Mercy Hospital and Medical Center in Chicago, and was appointed Clinical Associate Professor of Medicine at the University of Illinois at Chicago. Dr. Hatipoğlu serves as the Quality Improvement Officer of the Respiratory Institute. His clinical interests include asthma, COPD, acute respiratory distress syndrome, general (diagnostic) pulmonary medicine and critical care medicine. Dr. Hatipoğlu received his medical degree from Istanbul University Istanbul Faculty of Medicine in 1992. He completed an internal medicine residency at the University of Illinois at Chicago and pulmonary and critical care fellowship at Loyola University and Medical Center.

He has current board certifications in internal medicine, pulmonary medicine, sleep medicine and critical care medicine. Dr. Hatipoğlu is a member of the American Thoracic Society and Society of Critical Care Medicine.

Manal S. Al Hazmi, MD

Consultant, Pulmonary and Critical Care Medicine
King Fahad Specialist Hospital, Dammam
Dammam, Saudi Arabia

Dr. Al-Hazmi has 14 years’ experience as pulmonary and critical care consultant and pulmonary hypertension specialist, 10 years was at King Fahad Medical City (KFMC), Riyadh, K.S.A, appointed a Section Head of Critical Care Medicine (2007-2010), she established the pulmonary hypertension program at KFMC and was the director of pulmonary hypertension program at King Fahad Medical City 2007-2014.

Then she moved to the Eastern province of Saudi Arabia where she joined King Faisal Specialist Hospital-Dammam, appointed a section head of pulmonary division and deputy chairperson of department of Medicine. Through 2014, present she is a member of Pulmonary Vascular Institute (PVRI), where she is actively involved in Women’s Health & Pregnancy Task Force.

She contributed to the Pulmonary Hypertension Guidelines of the Saudi Association for Pulmonary Hypertension and Statement on pregnancy in pulmonary hypertension from the Pulmonary Vascular Research Institute.

Her mission is to help patients with Orphan diseases to get the best medical care they need.

Dr. Hamdan Hemeed Al-Jahdali is a Professor at King Saud University for Health Sciences and Adjunct Professor at McGill University. He is a Consultant in Internal medicine, Pulmonary and Sleep Disorders. Also, He is the Deputy Chairman of department of medicine, Head of Pulmonary Division/ Director of Sleep Disorders Center and Chairman of corporate pharmacology and therapeutic National Guard affairs.

Dr. Hamdan Hemeed Al-Jahdali’s research interest are centered in Internal medicine, pulmonary medicine, Sleep Disorders, pharmacology and therapeutics & Traum.

In recognition of his work, Dr. Al-Jahdali has received many awards and honors, including Best of ACCP Award, conferred by the American College of Chest Physicians Annual Meeting, Best New Investigator Award for Epidemiological Studies, conferred by the Society of Critical Care Medicine.

Vivek N. Iyer, M.D., is a consultant in the Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine at Mayo Clinic in Rochester. Dr. Iyer holds the academic rank of assistant professor of medicine, Mayo Clinic College of Medicine. He joined the staff of Mayo Clinic in 2010. Dr. Iyer earned his M.B.B.S and M.D. degree with a specialization in internal medicine at B.J. Medical College in Ahmedabad, India. He earned his M.P.H. degree at Columbia University and a residency in internal medicine at State University of New York at Buffalo, New York. He further completed a fellowship in critical care medicine and a fellowship in pulmonary medicine at Mayo Clinic. He is certified in clinical research through Mayo School of Graduate Medical Education and is certified as a Mayo Clinic Quality Fellow: Silver Level through Mayo Clinic Quality Academy. Dr. Iyer’s clinical interests focus on pulmonary vascular diseases such as HHT, HPS and POPH and upper airway disorders (chronic cough, asthma, vocal cord dysfunction). He also practices critical care medicine.

Vivek Iyer, MD
Pulmonologist, Pulmonary and Critical Care Medicine Department
Mayo Clinic, Rochester
Rochester, Minnesota, USA
Mouhamad Ghyath Jamil, MD
Consultant Pulmonary/Critical Care
Director, Sleep Medicine
King Faisal Specialist Hospital and Research Center - Riyadh
Society of Critical Care Medicine
Riyadh, Saudi Arabia

Dr. Mouhamad Ghyath Jamil graduated from Aleppo University, Syria. After finishing his residency in Internal Medicine at University of North Dakota, he joined the university as an Associate Professor. Dr. Jamil finished his fellowship in Pulmonary, Critical Care and Sleep Medicine at George Washington University. He is Board Certified in Internal Medicine, Pulmonary, Critical Care and Sleep Medicine. He is currently a Consultant in Pulmonary, Critical Care and Sleep Medicine at King Faisal Hospital and Research Center. He is Director of Medical ICU. He is an active member of many societies including American Colleague of Chest Physician, Society of Critical Care Medicine, American Society of Sleep Medicine, Saudi Society of Critical Care, Saudi Thoracic Society, and Middle East Critical Care Assembly. He has a major interest in E-health; he established the first Tele ICU program in Middle East.

Tariq Al Jasser, MsC, RRT
Senior Respiratory Care Specialist
King Faisal Specialist Hospital and Research Centre
Riyadh, Saudi Arabia

Completed my bachelor degree education form the University of Kansas in Kansas, USA and earned my master degree in respiratory therapy in 2012 from Georgia State University in USA. Currently, Senior Respiratory Therapist at King Faisal Specialist Hospital & Research Center in Riyadh with more than 15 years of experience in critical care and long-term care for patients with pulmonary diseases and/or ventilator dependent, asthma education, airway clearance, noninvasive positive pressure application and overall coping with chronic lung disease for pediatric patients. Current, interests involve avoidance of invasive ventilation and decrease ICU stay for patients requiring ventilatory support and involved in development and accuation of appropriate equipment needed for providing high-flow oxygen therapy and NIV in KFSHRC.

Yasser Aljehani, MD, SCC-Surg
Assistant Professor & Consultant Thoracic Surgeon
Chairman, Department of Surgery
King Fahad Hospital of the University
University of Dammam
Dammam, Saudi Arabia

Dr. Yasser Aljehani is an assistant professor and consultant thoracic surgeon. He is currently the chairman of surgery department at King Fahad Hospital of the University – Imam Abdulrahman Bin Faisal University (Formerly University of Dammam). Dr. Aljehani graduated in 2002 from medical college - Arabian Gulf University in the Kingdom of Bahrain.

He did his general surgery training in Saudi Arabia followed by Saudi thoracic surgery fellowship from King Faisal Specialist hospital and research center in 2012. In 2013, he joined a thoracic surgery fellowship at Dalhousie University in Halifax – Canada for a year. Dr. Aljehani has published several articles and co-authored a book in the field of thoracic surgery. He is co-founder of eastern province thoracic surgery club.

Nawal Al Kaabi, MD, MBBS
Pediatric Infectious Disease Consultant
Chief, Division of Pediatric Infectious Disease
Chair of Education, DIO
Shaikh Khalifa Medical City Managed by Cleveland Clinic Abu Dhabi, UAE

Dr. Nawal obtained MBBS from United Arab Emirates University in Al Ain, UAE. She is certified as a Fellow in Pediatrics (2002) and Pediatric Infectious Disease (2004), Royal College of Physicians, Canada. She completed Infection Control Fellowship, Children's Hospital of Eastern Ontario, University of Ottawa, Canada. Dr Nawal is American Board Certified (2001). She is Division Head of Pediatric Infectious Disease at SKMC since 2007. Prior she was consultant at Zayed Military Hospital, Abu Dhabi, UAE. She has been pediatric residency Program Director since April 2010 and DIO, Chair of Education since June 2014. She is also SEHA Infection Control Committee Chair since September 2012 and National Immunization Technical Advisory Group Chair Since Nov 2012. Dr Nawal is also member of the Scientific Advisory Committee, Shaikh Zayed Institute, Children’s National Medical Center, Washington DC, USA. Her main interests are Immunization, Multidrug Resistance Organisms, Infection Control and Medical Education.

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**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 M. 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 Assistant 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.

He has 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.

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**Prof. Javaid A. Khan, FRCP (Edin)**
Dean Pulmonology College of Physician & Surgeon Pakistan  
Professor of Medicine and Consultant Chest Physician  
Department of Medicine  
The Aga Khan University  
Chair National Alliance for Tobacco Control  
Karachi, Pakistan

Prof. Javaid A. Khan is the Dean of Pulmonology College of Physicians and Surgeon Pakistan. He is also professor and Consultant Pulmonologist at the Aga Khan University Karachi, Pakistan. Prof. Khan received his postgraduate training in U.K and is Fellow of the Royal College of Physician Edinburgh. Prof. Khan is a strong anti-tobacco advocates and was awarded WHO medal for his anti-tobacco efforts in 2009. He has over 100 publications to his credit in various peer reviewed Journals.

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**Prof. Abdullah Alkhenizan, CCFP, FCFP, ABHPM, MSc, DCEpid**
Professor, College of Medicine, Al Faisal University  
Chairman, Department of Family Medicine and Polyclinic KFSH&RC  
Riyadh, Saudi Arabia

Dr. Abdullah Alkhenizan presently works as the Chairman of Department of Family Medicine and Polyclinics, King Faisal Specialist Hospital & Research Centre (General Organization) –Riyadh. He has concurrent assignments in this Institution as Chairman, Evidence Based Practice Committee. Dr. Alkhenizan career focused in the fields of Family Medicine with a special interest in the field of research and the dissemination and implementation of evidence-based medicine. Dr. Alkhenizan holds the academic title of Professor, College of Medicine, Alfaisal University in Riyadh. For his postgraduate training, Dr. Alkhenizan completed the Family and Community Medicine Program, Geriatric Fellowship, Palliative Medicine Fellowship and the Clinical Epidemiology Program at the University of Toronto, Toronto, Ontario, Canada.

He also holds a Master’s Degree in Health Systems and Quality Management. Dr. Alkhenizan is a co-author of two books and published several publications in several peer-reviewed journals.

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**Prof. Samuel Kemp, MD**
Consultant Chest Physician  
Department of Respiratory Medicine  
Royal Brompton Hospital & Harefield Hospital  
London, UK

Dr. Samuel Kemp is a Consultant Respiratory Physician with a special interest in Lung Cancer and Interventional Bronchoscopy. He completed an MD on Bronchoscopic Lung Volume Reduction in Severe Emphysema, before taking up a Consultant post in the East Midlands. Having set up an interventional bronchoscopy service at his previous hospital, he moved to the Royal Brompton Hospital in 2015.

**Clinical Practice**
Dr. Kemp’s main clinical interests are in COPD, Severe Emphysema, Cancer and Lung Nodules, Pleural Disease, and Interventional Pulmonology, but he also sees undifferentiated first presentations of Respiratory Disease.

**Research Interests**
Dr. Kemp’s research focus is on developing new advanced Bronchoscopic Techniques for the diagnosis and Treatment of Lung Cancer, and Interventions for Severe Emphysema (including lung volume reduction therapies) and Airways Disease. He also has an interest in Respiratory Physiology, including Diving Medicine.
Prior to joining the University of Arizona in 2014, Dr. Monica Kraft, MD, was at Duke University, where she served as chief of the Division of Pulmonary, Allergy and Critical Care, as the Charles C. Johnson, MD, Distinguished Professor of Medicine, and as Director of the Duke Asthma, Allergy and Airway Center, which she founded. As Vice Chair for research in the Duke University Department of Medicine from 2009-13, Dr. Kraft implemented several important initiatives to support the department’s research endeavors and was instrumental in the re-submission and renewal of Duke’s National Institutes of Health-funded Clinical Translational Science Award (CTSA). Prior to joining Duke in 2004, Dr. Kraft served as director of the Carl and Hazel Felt Laboratory in Adult Asthma Research and as Medical Director of the pulmonology Physiology Unit at the National Jewish Medical and Research Center in Denver, Colo. Dr. Kraft has received the Presidential Early Career Award for Scientists and Engineers, awarded by President Bill Clinton at the White House in 2000. She also served as president of the American Thoracic Society in 2012-13.

Research Interests
Dr. Kraft has more than 150 publications in the areas of adult asthma, the role of infection in asthma and the role of the distal lung in asthma and airway remodeling. Her work has appeared in such prestigious publications as the Journal of the American Medical Association, The Lancet, the American Journal of Respiratory and Critical Care Medicine, the Journal of Allergy and Clinical Immunology, and Chest. Her research has been funded by the National Institutes of Health and the American Lung Association for more than 20 years.

Residency
Harbor-UCLA Medical Center, Chief Resident

Fellowship
University of Colorado Health Sciences Center, Pulmonary and Critical Care Medicine

Board Certifications
American Board of Internal Medicine
ABIM Certification in Internal Medicine, Pulmonary Medicine and Critical Care Medicine

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Prof. Arvind Kumar, MBBS, MNAMS, FACS, FICS, FUICC
Senior Consultant, General Thoracic Thoracoscopic and Robotic Surgery
Chairman, Center for Chest Surgery and Director, Institute of Robotic Surgery
Sir Ganga Ram Hospital (SGRH), New Delhi
Founder & Managing Trustee, Lung Care Foundation
New Delhi, India

Prof. Arvind Kumar Chairman, Center for Chest Surgery[1] and Director, Institute of Robotic Surgery[2][3][4] at Sir Ganga Ram Hospital (SGRH) New Delhi and Founder & Managing Trustee, Lung Care Foundation. He is Former Professor of Surgery & Head of Thoracic & Robotic Surgery Unit, All India Institute of Medical Sciences (AIIMS), New Delhi (1988-2012). Dr. Arvind Kumar has performed over 10,000 Thoracic Surgeries including over 5000 surgeries using Minimally Invasive[5] (Key-hole i.e. VATS)[6]and Robotic method. He has also performed 2000 complex (high-risk) chest surgeries and over 500 surgeries for thymoma. Dr. Kumar is considered as the safest Thoracic Surgeon in Asia. He is also recognized world over for his pioneering contribution to development of Thoracic Surgery in India exceptional success rate for Mesthena Gravis & Thymoma surgeries.

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

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

AOP Orphan Pharmaceuticals provides its services across East Europe, Middle East, Asia & Africa.
Ms. Asma Alamoudi, is a Respiratory Care Lecturer at the Respiratory Care Department of Prince Sultan Military College of Health Sciences, Dhahran, Saudi Arabia. In 2011 she graduated with a second-degree honor from the Respiratory Care department at Dammam University. In 2012 she worked as a Respiratory Therapist at Saad’s Specialist Hospital, Al Khobar. Ms. Asma has graduated from Rush University, College of Health Sciences, at Chicago IL with a Master’s degree of Health Sciences in Respiratory Care.

She received the Dean’s Outstanding Academic Achievement award, Academic Excellence in Respiratory Care award, and Clinical Excellency in Respiratory Care award from Rush University in 2015. She was the recipient of the prestigious Lambda Beta Scholarship from the Lambda Beta Society, a National Honor Society for the Profession of Respiratory Care in 2015. She is a Registered Respiratory Therapist, Registered Pulmonary Function Technologist, Credentialed Neonatal/Pediatric Specialist, Adult Critical Care Specialist and a Certified American Heart Association BLS Instructor.

Dr. Muna Maarafyia is a Pediatric Pulmonology and Sleep Medicine Senior Consultant at Hamad Medical Corporation, Doha – State of Qatar. She obtained her medical degree from King Saud University in Riyadh, Kingdom of Saudi Arabia. She finished her residency and fellowship trainings in Pediatric Pulmonology at Hamad Medical Corporation (HMC). She then pursued her training specialization in Pediatrics Sleep Medicine and Cystic Fibrosis at Kosair Children’s Hospital Research Institute, Louisville – USA. She established and pioneered the Pediatric Sleep Medicine services in the State of Qatar. Recently, Dr. Muna completed another training in Pediatric Pulmonology and Sleep Medicine at Cincinnati Children’s Hospital Medical Center, Cincinnati – USA. Her professional career has been focused on being a Pediatric Pulmonologist, educator, and administrator. She is very much involved in the education of medical students, interns, residents, and fellows. She is the Associate Program Director and chairs the Clinical Competency Committee of the Pediatric Residency Program. She holds a faculty position of Assistant Professor in Clinical Pediatrics at Weill Cornell Medical College-Qatar and Assistant Professor at the College of Medicine, Qatar University. Moreover, she is the Deputy Chairman of the Pediatric Department. Dr. Muna is also a member of several local, regional, and international professional associations. She organized many local and regional specialized conferences and a frequent guest speaker in many local and regional scientific meetings.

Ms. Suhaila Alameeri is a Consultant Anatomic Pathologist with 10 years experience in Surgical and Cytopathology (Gynecological and Non-Gynecological sample). Leading Anatomic Pathology team to ensure patient safety and comply with local and international accreditation. Through locum or part-time Anatomic Pathology Consultant. Provide consultation/education to Anatomic Pathology laboratory to improve the quality and minimize errors in reports. Working as Chief of Anatomic Pathology in accredited laboratory at tertiary governmental hospital for the past 5 years and Consultant Anatomic Pathology for 10 years. In addition to earning master degree in quality management advanced my skills and expertise in laboratory quality management to ensure patient safety and minimize errors. She have special interest in breast and gynecologic pathology.
Dr. Man is a General Chest Physician with specialist training in Chronic Obstructive Pulmonary Disease (COPD), pulmonary rehabilitation, sleep medicine, acute and chronic non-invasive ventilation, respiratory muscle weakness and interstitial lung diseases. Dr. William Man is a lung and sleep specialist at the Royal Brompton & Harefield NHS Foundation Trust. He is the lead Respiratory Clinician at Harefield Hospital and Chair of the Lung Assessment Care Group. Dr. Man qualified from Imperial College with a 1st class Honours BSc and Distinction Honours in MBBS, and obtained his PhD in 2007. He has trained in Respiratory, General Internal and Sleep Medicine in London, and has received specialist training from some of the UK’s leading teaching hospitals including the Royal Brompton Hospital, Hammersmith Hospital, St. Mary’s Hospital and King’s College Hospital. Although Dr. Man is a specialist in all aspects of respiratory medicine, he has a particular clinical interest in the diagnosis and management of sleep disorders (such as obstructive sleep apnoea) and respiratory failure. Dr. Man also has an international clinical and research reputation for excellence in Chronic Obstructive Pulmonary Disease (COPD), pulmonary rehabilitation, and respiratory muscle disorders. In 2006, he received the prestigious European Respiratory Society COPD award for “Outstanding Contribution to COPD Research in Europe”. In 2008, 2010 and 2013, Dr. Man received prestigious fellowships from the National Institute for Health Research and the Medical Research Council.

Atul C. Mehta, is a Vice Chairman of the Department of Pulmonary and Critical Care Medicine. He is the Head of the Section of Bronchoscopy and acting Medical Director of the Lung Transplant Team at Cleveland Clinic. Prof. 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 Medicine. Prof. Mehta’s research interests are Therapeutic Bronchoscopy, Lung Transplantation and Idiopathic Pulmonary Fibrosis.


Prof. Mehta was the founder and president of the American Association for Bronchoscopy. 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 Bronchoscopological Society, International Society for Heart & Lung Transplantation and World Association for Bronchoscopy.
Prof. Sultan Ayoub Moe is currently a Consultant Thoracic Surgery at King Hussein Cancer Centre. Also, he is a Director of Physician Education Office and Head of the Thoracic Malignancy Multi-Disciplinary Tumour Board. He finished his medical School 1992 from Jordan University, then had residency in General Surgery at Jordan University hospital and fellowship in Thoracic Surgery at University of Toronto, Toronto General Hospital followed by Fellowship in Lung Transplant at the same hospital, joined Jordan University as a Consultant Thoracic Surgeon in 2010 then moved to King Hussein Cancer Centre in January 2012 were he is currently working.

Dr. Ehab Massad is currently a Consultant Thoracic Surgery at King Hussein Cancer Centre. Also, he is a Director of Physician Education Office and Head of the Thoracic Malignancy Multi-Disciplinary Tumour Board. He finished his Medical School 1992 from Jordan University, then had residency in General Surgery at Jordan University hospital and fellowship in Thoracic Surgery at University of Dundee, Scotland UK. Prof Moe is credited with 10 books and 130 scientific papers in peer reviewed national / International, pub med and ISI indexed bio-medical Journals. He has published papers in leading science journals including Science, PLOS ONE, BMC-Medical Education, BMC Complement Altern Med, Medical Teacher, Marine Pollution Bulletin, Lupus, Rheumatology International, International Journal of Occupational Medicine and Environmental Health, Saudi Medical Journal, JCPSP, JPMA etc. Prof Moe has been invited as a speaker / key note speaker to deliver talk in about 85 National / International conferences in different countries including Pakistan, Kingdom of Saudi Arabia, Kingdom of Bahrain, United Arab Emirates, China, Turkey, United Kingdom and USA.

Prof. Marc Moss is the Roger S. Mitchell Professor of Medicine and Vice Chair of Clinical Research for the Department of Medicine at the University of Colorado School of Medicine. For more than 16 years, Dr. Moss has received continuous NIH funding as a principal investigator, and his research has been published in high impact journals. Dr. Moss’s research interests include: examining the effects of alcohol abuse on the increased susceptibility to the development of acute lung injury; exploring the diagnosis and treatment of neuromuscular dysfunction in critically ill patients who require mechanical ventilation; and studying burnout syndrome, posttraumatic stress disorder, and wellness in critical care healthcare professionals. In addition, he is the principal investigator for the Colorado component of the NHLBI PETAL network, and is the Co-chair of one of their protocol committees. Dr. Moss is currently the President Elect of the American Thoracic Society. He will be their President from 2017-2018. An ATS member since 1993, Dr. Moss has previously served on multiple ATS committees including the International Conference, Communications and Marketing, Clinicians Advisory, Program and Budget, Awards, Nominating, and Education. He has also been a member of several Critical Care Assembly committees, ATS task forces, and the Board of Directors for four terms as a presidential appointee. During his term as chair of the Communications and Marketing Committee, he helped to develop the ATS tagline “We help the world breathe”. As chair of the International Conference Committee, he helped to implement the acceptance of case reports, pairing of junior and senior investigators to serve as co-facilitators for thematic poster sessions, enhancement of poster discussion sessions, and the institution of late-breaking abstract submissions.

Dr. Ali Al Omrani is Head of Adult Infectious Diseases Physician, Deputy Chairman of the Department of Medicine and Chairman of the Antimicrobial Utilization and Evaluation Committee at King Faisal Specialist Hospital and Research Centre, Riyadh. He completed his specialist training in Adult Infectious Diseases and Medical Microbiology at the University Hospital of Wales, Cardiff. His clinical and research interests focus on the management of infections caused by extensively resistant pathogens, infections in immune compromised hosts and infections in critically care patients. Dr Omrani is a fellow of the Royal College of Physicians of London and the Royal College of Pathologists. He is an Editorial Board Member of the Saudi Medical Journal and Annals of Saudi Medicine, a frequent speaker at national and international medical events and is lead author on numerous of original research articles, reviews and editorials.

Dr. Suhail Raoof is Chief of Pulmonary Medicine at Lenox Hill Hospital, New York, NY and Professor of Medicine at Hofstra-Northwell School of Medicine. Dr. Raoof’s medical career spans over 25 years. He is a full time hospital based clinician and teacher who devotes his time to both in-patient and out-patient care. His clinical interests include chest radiology for the pulmonologist and advanced modes of mechanical ventilation. He is well published and has over 100 publications,
book chapters, and abstracts. He was the co-editor of the ACP Manual on Mechanical Ventilation and Editor of the ACP Manual of Critical Care. He has participated in numerous physician and executive leadership programs to further enhance his leadership skills through organizations such as the American Association for Physician Leadership and the American College of Chest Physicians. Professionally, he is a Member of the Fleischner Society, Fellow of the American College of Chest Physicians (FCCP), Fellow in the Society for Critical Care Medicine (FCCM), Master in the American College of Physicians (MACP), and Past President of the American College of Chest Physicians (2011-2012).

Prof. Enrico Ruffini, MD
Director of Annual Meeting,
European Society of Thoracic Surgeons
Professor, University of Turin,
Department of Thoracic Surgery
Turin, Italy

Enrico Ruffini is Associate Professor of Thoracic Surgery at the University of Turino, Italy. He is involved in the European Society of Thoracic Surgeons, formerly as Councillor and presently as officer in the role of Director of the ESTS annual meeting for the years 2014-2017. In the ESTS, he is also the chair of the ESTS thymic working group. He served the ITMIG as secretary for the years 2012-2014 and as member of several ITMIG committees.

He is a member of the Staging and Prognostic Factors Committee – Thymic domain (SPFC-TD) of the International Association for the Study of Lung Cancer (IASLC) for the years 2012-2015.

He is a reviewer for the following journals: European Journal of Cardio-Thoracic Surgery, Journal of Thoracic Oncology, Lung Cancer, Journal of Thoracic Disease. He contributed to several textbooks on thoracic surgery and he is author or Co-author of 130 indexed journal articles.

Mashael K. Al Rujaib, MBBS, FRCR, DABR, FRCPC
Consultant Radiologist and Associate Professor Alfaisal University
Radiology Department, King Faisal Specialist Hospital & Research Centre
Riyadh, Saudi Arabia

Dr. Mashael AlRujaib is a graduate of Dammam University Medical School. She is also the graduate of McGill University Radiology Residency program in 2010. Dr. AlRujaib completed her fellowship training in Ottawa University and Toronto University end of 2013. Dr. AlRujaib is currently a Cardiothoracic Consultant Radiologist at King Faisal Specialist Hospital (KFSH&RC) – Riyadh.

She is the director of quality in the Department of Radiology and Director of Cardiothoracic fellowship at KFSH&RC.

Dr. AlRujaib has special interests including:
- Lung Cancer
- Chronic Thromboembolic Pulmonary Hypertension
- Congenital Heart Disease
- Quality Assurance in Cardiothoracic Imaging

Prof. Muslim M. AlSaadi, MD
Professor & Consultant Pediatric Respirologist and Sleep Medicine
Head, Pediatric Respiratory Division
Pediatric Department College of Medicine
King Saud University
Riyadh, Saudi Arabia

Muslim Mohammed Salamah Al Saadi was born on November 6, 1964. He received his MBBS from College of Medicine, King Saud University, Riyadh, Saudi Arabia in 1988 - 1989. In March 1996, he qualified under the Canadian Evaluation Examination and Certified Arab Board in Pediatrics. He did his internship rotation at King Khalid University Hospital, Riyadh in 1990, the arab board training program in pediatrics at King Saud University, Riyadh from 1991 - 1995. He completed a clinical fellow in the pulmonology and allergy unit, department of pediatrics, King Saud University, Riyadh from 1995 - 1998. He also did a fellow in pediatrics respiratory medicine and pediatrics sleep, University of Toronto and the hospital for sick children from 1996 - 2000. He is a member of the Saudi Pediatric Association, the European Respiratory Society, the American College of Chest Physicians and the Canadian Sleep Society. He has participated in various conferences/symposia/seminars in the KSA, North America, Asia and Europe.

Waleed Saleh, MD, FRCSI
Consultant Thoracic Surgery
Surgical Director of Lung Transplant Program
Department of Surgery
King Faisal Specialist Hospital and Research Centre-Riyadh
Assistant Professor, College of Medicine, Alfaisal University
Riyadh, Saudi Arabia

Waleed Saleh is currently a Consultant Thoracic Surgery, Surgical Director of Lung Transplant Program Department of Surgery at King Faisal Specialist Hospital and Research Centre-Riyadh. He is also an Assistant Professor, College of Medicine, Alfaisal University. He received his MBBS from Faculty of Medicine, King Saud University, Riyadh, Saudi Arabia in 1996.

Accomplishments:
- October 2001- Re-appointed Academic Activities Representative for the Academic Year 2001/2002
- Department of Surgery- Riyadh Military Hospital, Saudi Arabia
- Appointed Resident’s Representative for Riyadh City in the Saudi Council for Health Specialties
- October 2000- Elected General Surgery Best Resident for the Academic Year 2000/2001
- Department of Surgery- Riyadh Military Hospital, Saudi Arabia
- October 1999- Appointed Academic Activities Representative for the Academic Year 1999/2000
- Department of Surgery- Riyadh Military Hospital, Saudi Arabia

Waleed Saleh presented & has been invited as a speaker to a National & International conferences in different countries. He also has several peer-reviewed publications & research.
Dr. Hani Sabbour, MD, FACC, FHRS, FASE graduated with a Bachelor’s Degree in Basic Medical Sciences and Bachelor’s Degree in Medicine and Surgery from Kuwait University Faculty of Medicine in 1994 with first-class honors and was twice awarded His Highness the Emirs Gold Medal for academic excellence in both degrees. He subsequently went on to train in Internal Medicine and Cardiovascular Disease at SUNY Stony Brook in New York and was elected resident and fellow of the year several times.

He then completed his training in Clinical Cardiac Electrophysiology at Massachusetts General Hospital and was appointed Clinical Instructor in Cardiology at Harvard Medical School in 2001 as well as SUNY Stony Brook. He is currently American Board if Internal Medicine Certified in Internal Medicine, Cardiology, Electrophysiology, and Board Certified in Echocardiography and Nuclear Cardiology. He has always been heavily involved in teaching and been on the teaching faculty at Brown University since 2006. He was recently promoted to Clinical Assistant Professor of Medicine and Cardiology at Brown University Warren Alpert School of Medicine. Dr. Sabbour has been active in research and is currently an active PI in two international multicenter trials in the field of pacing and ICDs and has had several publications in the field.

He was also appointed the Internal Medicine Residency Program Director at Al Ain Hospital as well as Arab Board Cardiology Fellowship Site Director. He has been in practice in Rhode Island for 11 years and recently moved to the UAE to be on staff as Consultant Cardiologist at SKMC, Al Ain Hospital and Tawam Hospitals. His main clinical interests are the management of Arrhythmias and Advanced CHF and Pulmonary HTN as well as Cardiac Imaging.

Dr. Frank Sciurba received his undergraduate degree in biochemistry from the University of Illinois and attended medical school at the University of Chicago Pritzker School of Medicine. He has been an American Thoracic Society (ATS) member and a member of the Clinical Problems Assembly since 1988 and has served on the Drug Device Discovery & Development Committee, Council of Chapter Representatives and 10 years on the Clinical Problems Program Committee.

He has further contributed to and co-authored several ATS statements related to field and laboratory exercise testing and chronic obstructive pulmonary disease (COPD) issues, and he has organized and chaired many well-attended ATS symposia and post-graduate courses over the years. Dr. Sciurba’s research has been inspired by real clinical problems facing his patients. He has co-authored over 200 manuscripts and has had continuous National Institutes of Health funding for 20 years including a Specialized Clinical Center of Research Excellence in COPD P50 award.

He has demonstrated clinical and translational research leadership in phenotyping and sub-classification of COPD and interstitial lung disease, surgical and bronchoscopic volume reduction, biomarker identification and development, lab based cardiopulmonary and field walk exercise testing and has facilitated tissue biology, genetic and blood mechanistic and translational projects with basic science collaborators.

Dr. Sciurba’s current leadership positions include his role as a Principle Investigator of the Network Management Core of the new National Heart, Lung, and Blood Institute-sponsored Pulmonary Trials Consortium which manages the execution of pragmatic, “real world” studies in a variety of chronic pulmonary conditions; and his role as academic chair of the COPD Biomarker Qualification Committee, a group of academic, foundation and industry partners that work with U.S. Food and Drug Administration leadership to address the need for new biomarkers to facilitate development of drugs and devices for chronic pulmonary conditions.

Dr. Hani Sabbour, MD, FACC, FHRS, FASE
Consultant Cardiologist
Cleveland Clinic Abu Dhabi
Abu Dhabi, UAE

Prof. Frank C. Sciurba, MD, FCCP
Professor of Medicine
Director, Emphysema Research Center
Director, Pulmonary Function Exercise Physiology Laboratory
University of Pittsburgh School of Medicine
Pittsburgh, Pennsylvania, USA

Dr. Farida Al Hosani, M
Consultant, Infectious Diseases
Health Authority Abu Dhabi (HAD)
Abu Dhabi, UAE

Dr. Nasir Siddique, MB, MRCP, FCCP, CCT(UK)
Consultant in Respiratory Medicine
Kettering General Hospital
Kettering, UK

He is a Consultant Physician in Kettering General Hospital United Kingdom. He has a special interest in pleural disease, medical thoracoscopy and pleural ultrasound.

He is heavily involved in medical education with students from Leicester University and won the award of best medical tutor of the year for Leicester University. He has developed very popular national level courses in chest drain insertion and pleural ultrasound in UK.

He has conducted several workshops on pleural US and medical thoracoscopy in the UK and other countries.

Dr. Farida worked and participated in formulating the policies and standards related to infectious diseases in the Emirate of Abu Dhabi. She is a member of national committees for strategic planning and regulation of different programs in the national level.

Prior to joining HAAD, she spent five years in Preventive Medicine Department practicing medicine and dealing with infectious diseases mainly. Dr. Farida is a physician graduated from Faculty of Medicine and Health Sciences (FMHS) in Al Ain University and she had MPH degree from in John Hopkins Bloomberg School of Public Health.

She is currently enrolled in DrPH program in the same University Dr. Farida is currently Manager of Communicable Diseases Department in Public Health in HAAD and adjunct Associate Professor in the College of Medicine and Health Sciences in UAEU. She won excellence in teaching award from UAEU in 2014.

Dr. Farida joined HAAD in 2008. She was the lead person in the establishment and implementation of the Visa Screening electronic system in addition to Infectious Diseases e-notification system. The two programs are the source of the infectious diseases surveillance data. She lead communicable diseases programs in the Emirate of Abu Dhabi including: Vaccination Program, Tuberculosis Control Program, Visa Screening Program, Infectious Diseases E-notification, HIV Control Program, and Malaria Control Program.

He is a Consultant Physician in Kettering General Hospital United Kingdom. He has a special interest in pleural disease, medical thoracoscopy and pleural ultrasound.

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Dr. Farida Al Hosani, M
Consultant, Infectious Diseases
Associate Professor UAE University College of Medicine
Manager of Communicable Diseases Department
Health Authority Abu Dhabi (HAD)
Abu Dhabi, UAE

Dr. Nasir Siddique, MB, MRCP, FCCP, CCT(UK)
Consultant in Respiratory Medicine
Lead in Respiratory Education
Member Standards of Care Committee BTS
Kettering General Hospital
Kettering, UK

He is a Consultant Physician in Kettering General Hospital United Kingdom. He has a special interest in pleural disease, medical thoracoscopy and pleural ultrasound.

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He has conducted several workshops on pleural US and medical thoracoscopy in the UK and other countries.
Dr. Redha Souilamas, MD, PhD
Staff Physician, Thoracic Surgery
Heart & Vascular Institute
Cleveland Clinic Abu Dhabi
Abu Dhabi, UAE

Redha Souilamas, MD, is a Staff Physician in the Heart & Vascular Institute at Cleveland Clinic Abu Dhabi. Prior to joining Cleveland Clinic Abu Dhabi, Dr. Souilamas held several roles in European-based hospitals. Most recently, Dr. Souilamas practiced as an Attending Physician in the Thoracic Surgery Department at Erasme Hospital in Brussels, Belgium. Prior, he served as the Director of the Lung Transplant Program for Cystic Fibrosis at Georges-Pompidou European Hospital in Paris, France. Additionally, Dr. Souilamas has held several other roles, including Program Committee Member & Local Organizer for the International Society for Heart and Lung Transplantation 2009 Meeting in Paris, and has been a Founding Member and Teacher in the French Multi-Organ Donation and Retrieval School (Ecole Francophone du Prélèvement Multi-organe, EFPMO) since 2010. Further, he served as Director of the Student Program Exchange between Paris Descartes University Faculty of Medicine and Columbia University Medical School between 2007 and 2013. In 2009, he travelled to the US as a Visiting Professor to the Thoracic Surgery and Lung Transplant Department at Columbia University Hospital in New York City.

Dr. Souilamas earned his medical degree in 1986 from the University of Algiers Medical School in Algiers, Algeria. He went on to complete his residency at the Pierre & Marie Curie University Faculty of Medicine and a fellowship in Thoracic Surgery at Laennec Hospital, Paris Descartes University Faculty of Medicine, both in Paris, France. He later went on to receive a PhD in Medical Ethics & Lung Transplantation, due to his interest and studies of ethical aspects in organ donation and transplantation fields.

Dr. Elnazir has presented and published extensively his research both nationally and internationally, and has given a number of invited presentations. He is also a member of several societies including the British Pediatric Respiratory Society, the European Respiratory Society, and the American Thoracic Society.

Basil Elnazir, MD, PhD, FRCPI, FRCPCH, DCH
Consultant, Pediatric Pulmonary Medicine
Medical Director Al Jaillia Children’s Specialty Hospital
Dubai, UAE

» Consultant Pediatric Pulmonologist & Medical Director at Al Jaillia Children’s Specialty Hospital, Dubai, UAE.
» Consultant Pediatric Pulmonologist, Dublin, Ireland.
» Senior Clinical Lecturer, Trinity College Dublin, Ireland.
» Previous Chairman of the Asthma Society of Ireland.
» In 2004, he was appointed to the National Children’s Hospital, Dublin, Ireland as a Consultant Respiratory Pediatrician with clinical and research interests in Asthma and Cystic Fibrosis.
» In 2011, he was appointed as a National Specialty Director and Board Member in Paediatrics at the Faculty of Paediatrics, Royal College of Physicians in Ireland.
» Vice President of the Arab pediatric Pulmonology Association.
» Member of the Executive Board of MECFA (Middle East Cystic Fibrosis Association).
» Dr. Elnazir has presented and published extensively his research both nationally and internationally, and has given a number of invited presentations. He is also a member of several societies including the British Pediatric Respiratory Society, the European Respiratory Society, and the American Thoracic Society.

William Hans Steup, PhD, MD
Surgical Oncologist, Thoracic Lung Surgeon
HagaZiekenhuis, Department of Surgery
The Hague, Netherlands

Dr. Steup is a surgical oncologist and Thoracic Surgeon at the HagaHospital, The Hague, The Netherlands since 1995. It is one of the largest non-academic teaching Hospitals in The Netherlands, where he is responsible for the training programs for Surgical Oncology and Thoracic Surgery and Co-President of the Committee on Oncology. He is also a certified Thoracic Surgeon and Teaching Surgeon Thoracic Surgery. He spent part of this childhood in the Gulf Area, primary school at The English Speaking School, Doha, Qatar. He studied medicine at Leiden University and graduated 1984. Surgical training followed at University Hospital Leiden, Red Cross Hospital The Hague, Dr. Daniel den Hoed Cancer Center Rotterdam, National Cancer Center Hospital Tokyo, Japan and University Hospital Gasthuisberg Leuven, Belgium.

He is Secretary of the Dutch National Lung Surgery Society, Board Member of the Dutch Lung Cancer Audit, member of the Council of the ESTS and active in several other national committees and foundations. His fields of interest are minimal invasive thoracic surgery (VATS), training in thoracic surgery, Audits in Surgery, Quality Assurance in Surgery.
### Prof. Wisia Wedzicha, MA, MD, FRCP, FMedSci
Professor, Respiratory Medicine
National Heart and Lung Institute, Imperial College, UK

Wisia Wedzicha is Professor of Respiratory Medicine at the National Heart and Lung Institute, Imperial College, UK. She qualified from Somerville College, Oxford University and St Bartholomew’s Hospital Medical College, University of London. She was elected as Fellow of the Academy of Medical Sciences (FMedSci) in 2013 and is an National Institute of Health Research (NIHR) Senior Investigator. She received the Helmholtz International Fellow Award in 2014. Professor Wedzicha has a major interest in the causes, mechanisms, impact and prevention of Chronic Obstructive Pulmonary Disease (COPD) exacerbations, and in the role of bacterial and viral infection in COPD exacerbations.

She directs an active research group specializing in COPD exacerbations, and has published extensively on this topic. Professor Wedzicha chaired the English Department of the Health Home Oxygen Clinical User Group, and was a member of the Guideline Development Group for the revision of the National Institute for Healthcare and Clinical Excellence COPD Guidelines. In 2016, she has been appointed as an Expert Adviser to the NICE Centre for Clinical Practice. Professor Wedzicha was Editor-in-Chief of Thorax from 2002 to 2010, and is a member of the BioMed Central advisory board. She is currently Editor in Chief for the American Journal of Respiratory and Critical Care Medicine. In addition, she is on the editorial boards of a number of international journals. She was the Lancet Ombudsman till 2014, Publications Director for the European Respiratory Society (ERS) and has also previously been ERS Guidelines Director.

### Mohammed Alabdrab Alnabi, MD
Consultant, Emergency & Critical Care
Head of Adult Intensive Care Unit
Maternity & Children Hospital, Dammam
Dammam, Saudi Arabia

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

Education:
- **MBBS College of Medicine**, King Faisal University, Dammam, Saudi Arabia - 1993-1999
- **INTERNSHIP** King Fahd Hospital of the University, Khobar, Saudi Arabia - 1999-2000
- **EMERGENCY MEDICINE RESIDENT**
- **SAUDI COMMISSION FOR HEALTH SPECIALITIES**
- **RESEARCH & 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:
- **EXPERIENCE 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 - 2006-2007
  - **CONSULTANT EMERGENCY & CRITICAL CARE PHYSICIAN**
  - Emergency Department & Critical Care Department, King Fahd Medical City, Riyadh, Saudi Arabia - 2010-2011
  - **CONSULTANT EMERGENCY PHYSICIAN**
  - King Fahd Specialist Hospital, Dammam, Saudi Arabia - 2012-Present

### Mohamed Zeitouni, MD, FCCP
Consultant Pulmonary/Critical Care
King Faisal Specialist Hospital and Research Centre
Riyadh, Saudi Arabia

Mohammed Zeitouni is currently a Consultant, Intensivist/ Pulmonologist of Pulmonary Medicine section, Department of Medicine at King Faisal Specialist Hospital and Research Centre Riyadh, Saudi Arabia. He has Graduate and Postgraduate Education Degrees: Biology with Distinction- American University of Beirut, 9/1983 and Medicine with Distinction-American University of Beirut, 6/1987.

He is a member of Saudi Initiative for Asthma, The Saudi Guidelines for the Diagnosis and Management of COPD, The Saudi Thoracic Society Pneumococcal Vaccination Guidelines, and the first author for the Saudi Thoracic Society Guidelines for Influenza Vaccinations. Additionally, he has several Peer-Reviewed Publications and Research.

### Mohamed Alswes, MD, ABCFP
Consultant, Family Medicine
King Faisal Specialist Hospital and Research Centre
Assistant Professor, Alfaisal University
Riyadh, Saudi Arabia

### Ashraf H. Alzaabi, MD, FRCPC, FCCP
Clinical Assistant Professor, UAE University
Head, Respiratory Division, Zayed Military Hospital
Abu Dhabi, UAE
Ahmed Aljohaney, MBBS, DABIM, FRCP
Associate Professor of Medicine
College of Medicine, King Abdulaziz University-Jeddah
Consultant in Pulmonary Medicine and Interventional Pulmonology
King Abdulaziz University Hospital
Jeddah, Saudi Arabia

Dr. Ahmed Aljohaney is an Assistant Professor of Medicine and Consultant Interventional Pulmonologist at King Abdulaziz University Hospital and Faculty of Medicine. Dr. Aljohaney received his medical degree with honor at King Abdulaziz University. Dr. Aljohaney completed a residency in Internal medicine and fellowship training in Pulmonary and Interventional Pulmonology at University of Ottawa, Ontario, Canada 2005-2011. He is certified by the Royal College of physicians and surgeons of Canada and the American board of internal medicine in the field of internal medicine and pulmonary medicine. He is proud to be the first Saudi Doctor specialized in Interventional Pulmonology. He has an advanced training in the field of bronchoscopy and pleural diseases. His clinical and research interest involve diagnosis and staging of lung cancer and pleural diseases as well as procedural training, simulation and medical education. He is currently the secretary general for the Saudi society of internal medicine and a fellow of the American college of chest physicians. MD, MS

Enas Batubara, MD, SBIM, SF-AP, FCCP
Pulmonary Consultant
Head, Bronchoscopy and Pleural Disease Unit
Prince Sultan Military Medical City, Riyadh
Riyadh, Saudi Arabia

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which works better than conventionally used indices. He has 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. Ahmed 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.

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A Bachelor of Science in Respiratory Therapy graduate, pioneer class of 1993 at Emilio Aguinaldo College, Manila, Philippines. Currently pursuing to earn a Masters 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).

Founding President of the Philippine Society for the Advancement of Respiratory Therapy-Saudi Arabia, an organization composed of Filipino Respiratory Therapy professionals working in the Kingdom of Saudi Arabia.

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Dr. Abderrahim Oulhaj is an Assistant Professor in Biostatistics at the College of Medicine and Health Sciences, UAE University. He holds a PhD in statistics from the UCL University in Belgium. Before joining the UAE, he worked as a Senior Medical Statistician at the University of Oxford for almost 10 years.

He was the lead Medical Statistician for the Oxford Project to Investigate Memory and Ageing cohort study (OPTIMA) and for the EXCEL study at the Diabetes trial Unit, University of Oxford. Dr. Abderrahim Oulhaj divides his time in teaching undergraduate and post-graduate programs at the UAEU, supervising PhDs and Master students and working on many research activities as well as consulting with clinicians.

He received an award from the UAE University for two consecutive years in 2015 and 2016 for excellence in research by publishing in top 1% peer-reviewed journals and bringing recognition to the United Arab Emirates University.

His research field is the statistical modelling in medical field especially Diabetes, Cardio-Vascular and Alzheimer’s diseases. He established very strong collaborations with many international universities including the University of Oxford (UK), the UCL University (Belgium), Graz Medical School (Austria) and University of Oslo (Norway).

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Yasir Alshaikh, MD, is consultant at the Cardiothoracic Radiology at the King Khalid University Hospital. He has been a radiology consultant for more than 12 years. He has published several articles in peer-reviewed journals, including case reports and review articles.

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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 (SSRC). Research areas includes adjustment of mechanical ventilator, oxygenation indices and predictors of weaning.

**Ali H. Altalag, MD, ABIM**
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5. Fellowship in Respiratory Medicine, University of British Columbia, Vancouver, Canada, July 2007 - June 2009.
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Published a scientific book in respiratory medicine titled. “Pulmonary Function Tests in Clinical Practice”, April 14, 2008;

Full Reference:

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» Currently organizing the second course for May of 2012.
» Participated in organizing several courses in Bedside Ultrasound in Riyadh, KSA.
» Saudi Council for Health Specialties- PICU Scientific Committee.
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Assessment Of EpCAM Intensity Of Expression And Outcome In Breast Carcinoma Neoadjuvant Chemotherapy Treated Patients

Ahmad Mohammad Ragab Shalaby

Content: Background:
The wide use of Neoadjuvant chemotherapy nowadays became so wide to the degree that it is more or less established as a standard regimen in management of breast neoplasia, in spite of different outcome results. Expression of epithelial cell adhesion molecule (EpCAM) is deregulated in epithelial malignancies. It is found that it acts as signaling molecule with tumor-promoting functions in addition to its role in cell adhesion.

Aim of Work:
It is aimed to assess the expression intensity of malignant mammary cells of EpCAM and its relation to the patient outcome and their response to neoadjuvant chemotherapy.

Patients & Methods:
140 patients with breast carcinoma and undergone treatment with neoadjuvant chemotherapy were included in the study. Both Tru-cut tissue biopsy and radically-excised breast tissues, before and after neoadjuvant chemotherapy, were examined for intensity of staining by EpCAM.

Results:
High intensity of EpCAM expression pattern is found correlated with lympho-vascular invasion status and higher nuclear grade (P = 0.01 and 0.008, respectively). It was also found that patients with high EpCAM expression before and after neoadjuvant chemotherapy showed worse pathological and clinical outcome (P=0.008 and <0.001, respectively) than the patients with high intensity before and low intensity after neoadjuvant chemotherapy. The overall survival rate of the first group is less than the second one (P = 0.048).

Conclusion:
Strong EpCAM intensity in carcinoma of breast is correlated with bad response to neoadjuvant chemotherapy and subsequently with worse prognosis than in patients with negative or low staining intensity.

Key words:
Chemo-resistant breast carcinoma, epithelial cell adhesion molecule.
A Case of Primary Pulmonary Angiosarcoma with Pleural Metastasis

Muhammad Hawari, Shamayel Mohammed

Content:
Angiosarcomas are a subtype of soft tissue sarcomas which are aggressive, malignant endothelial-cell tumors of vascular or lymphatic origin. Even though the lung is a vascular organ, it is usually not the primary site for vascular neoplasms. The lungs are more often the site of metastasis from extrapulmonary tumors. We report a 26-year-old previously healthy gentleman who presented with chest pain. His chest images showed multiple bilateral nodules and nodularity of the left pleura. He underwent video assisted thoracoscopy (VATS) and nodule biopsy which showed Angiosarcoma.

Introduction:
Angiosarcomas are a subtype of soft tissue sarcomas which are aggressive, malignant endothelial-cell tumors of vascular or lymphatic origin. Even though the lung is a vascular organ, it is usually not the primary site for vascular neoplasms. The lungs are more often the site of metastasis from extrapulmonary tumors. We report a 26-year-old previously healthy gentleman who presented with chest pain. His chest images showed multiple bilateral nodules and nodularity of the left pleura. He underwent video assisted thoracoscopy (VATS) and nodule biopsy which showed Angiosarcoma.

Method:
A total of 124 patients (83 men and 41 women), with mean age of 46±18 years and mean duration of drainage 5.3±2 days, were included in the study. The trocar technique was attempted in 201 (86.5%) cases, and the modified Seldinger technique was used in 38 (16.5%) cases.

Results:
A total of 124 patients (83 men and 41 women), with mean age of 46±18 years and mean duration of drainage 5.3±2 days, were included in the study. The trocar technique was attempted in 201 (86.5%) cases, and the modified Seldinger technique was used in 38 (16.5%) cases.

Discussion:
Primary Pulmonary angiosarcoma is a rare disease with a very poor prognosis and no definite treatment so far. More cases have been reported in recent years with different therapeutic modalities, none of which proving to be effective. Pleural involvement is not an uncommon feature in such patients.

Conclusion:
Primary Pulmonary angiosarcoma is a rare disease with a very poor prognosis and no definite treatment so far. More cases have been reported in recent years with different therapeutic modalities, none of which proving to be effective. Pleural involvement is not an uncommon feature in such patients.

Disclosure Statement:
The Authors have indicated no conflicts of interest.

Ultrasound-Guided Pleural Effusion Drainage With A Small Catheter Using The Single-Step Trocar Or Modified Seldinger Technique

Ola Alkady, MD, Mohammad Abusedera, MD

Content:
Ultrasound-Guided Pleural Effusion Drainage With A Small Catheter Using The Single-Step Trocar Or Modified Seldinger Technique

Objective:
Studies have shown that small-caliber pleural effusion drainage is safe and has a lower complication rate. Our objective was to evaluate the outcomes and the safety of the single-step trocar or the modified Seldinger technique.

Methods:
A total of 124 patients (83 men and 41 women), with mean age of 46.8±18 years and mean duration of drainage 5.3±2 days, were included in the study. The trocar technique was attempted in 201 (86.5%) cases, and the modified Seldinger technique was used in 38 (16.5%) cases.
Results: Technical success was obtained in 96% for the trocar technique and in 100% for the modified Seldinger technique. The procedure time for the trocar and the modified Seldinger techniques was approximately 7 and 12 minutes, respectively (P-value=0.02). The overall success rate was 72.9%. The success rate was highest for massive transudative effusions (98%) followed by malignant effusions (87%), and it was least for parapneumonic effusions (72%). Pneumothorax occurred in 10.5% (n=4) for modified Seldinger versus 0.5% (n=1) (P=0.12) for trocar, whereas bleeding occurred in 0% for modified Seldinger and in 1% (n=2) for trocar (P=0.04). The single-step trocar technique was technically unsuccessful in 8 cases (7 had empyema with narrow intercostals spaces and one had kyphoscoliosis), technical success was achieved by using the modified Seldinger.

Conclusion: Ultrasound-guided pleural effusion drainage by catheter insertion is a safe and effective procedure. The success rate is low when the effusion is loculated and septated. Both the trocar and the modified Seldinger techniques can be used. The trocar technique is faster and easier.

Trans-Thoracic Ultrasound-Guided Biopsy of Selected Central Lung Masses Cases
Ola Alkady, MD, Mohammad Abuseder, MD

Content: Purpose:
To Evaluate Feasibility, Safety And Outcome Of The Percutaneous Ultrasound Guided Biopsy Of The Central Lung Masses.

Methods and Materials:
True cut needle biopsy of central lung lesion perihilar and hilar was carried out guided by CT scan or Ultrasound exam when bronchoscopy either was not available or not feasible. Ultrasound guided biopsy with color Doppler was performed when feasible, otherwise CT guided technique was performed.

Single shaft needle technique was conducted by 18 Gauge true cut spring loaded needle. Chest radiological exams were offered at some time after the procedure. Levine's test, t test, Fischer exact tests were used for statistical analysis.

Results:
87 patients had had central lesion. Ultrasound group was 48 patients (n=37 M, n=11 F) mean age of 54.6 years. CT group was 39 patients (n=27 M, 12 F) mean age 55.6 years. The ultrasound window was the mass abutting the chest wall (n=21), pleural effusion (n=13) and lung collapse (n=14). The mean lesion size 6.7 cm and 4 cm for US and CT group respectively (P =0.004).

The mean number of passes and time and the cost were lower for the US group compared to CT group 2.3 vs. 3.0 times (p value<0.001) and 15 vs. 32 minutes and 192 vs. 242 LE (P value =0.001). Diagnostic yield was 88% and 85% for US and CT group respectively. No mortality was encountered. Hemothysis occurred in 8% and 10% of US and CT group respectively. Pneumothorax occurred in 7% of CT group only (p value =0.12).

Conclusion: Percutaneous Ultrasound guided biopsy for the central lung lesion is feasible, safe and effective.

Asthma Prevalence Among Adults In Saudi Arabia
Al Ghobain M, Algazlan S, Oreibi T

Content: Background:
To investigate asthma prevalence and to measure asthma symptoms among Saudi adults in Riyadh, Saudi Arabia.

Methods:
A cross-sectional survey using the ECRHS questionnaire among male and female Saudi nationals aged 20 to 44 years living in Riyadh. Disproportionate cluster sampling method was used. Asthma was defined based on answering ‘yes’ to any of the followings: Have you had wheezing when did not have a cold in the last 12 months? Have you been told by a physician to have asthma? Are you taking medicine for asthma?

A total of 2405 participants completing the survey. The prevalence of wheezing in the last 12 months when not have a cold was 16.2% with no significant difference between males and females (p-value = 0.107). The prevalence of physician-diagnosed asthma was 11.3% with no significant difference between males and females (p-value = 0.238). The prevalence of taking medicine for asthma was 10.6%. There were no significant differences between asthmatic vs. non-asthmatic in terms of residency area, education level and smoking tobacco (p-values 0.07, 0.11 and 0.06 respectively) but not for nasal allergies.

Conclusion: Asthma prevalence is high and much higher than the prevalence reported in most countries using the ECRHS questionnaire.

Prevalence And Attitudes Of Waterpipe Smoking Among Saudi Physicians
Al Ghobain M, Anwar E. Ahmed, Abdrahalban Z, Mutairi W, Al Khathaami A

Content: Background:
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% vs. 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%, 63%, 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.

Psychological Impact of the Middle East Respiratory Syndrome Outbreak on Emergency Room Resident Physicians
Al Ghobain M, Idriss T.

Content: Background:
Middle East respiratory syndrome (MERS) outbreaks have had a considerable negative impact on health systems in Saudi Arabia. We aimed to study the psychological impact of MERS-CoV outbreak on emergency room resident physicians (ERRPs).

Methods:
We assessed the MERS-related psychological impact and concerns of ERRPs using a self-report questionnaire that asked about the perceived impact and preparedness for a MERS outbreak, and work- and non-work-related concerns in four tertiary care hospitals in Riyadh.

Results:
The majority (91%) of the ERRPs agreed that their work put them at risk of infection, but most (65%) did not agree that they should not be looking after patients infected with MERS. Despite that, 54% of ERRPs reported being afraid of contracting the infection from infected patients and only 4.2% of them were willing to change their current job. The majority of the ERRPs felt that their job would expose their families (85%), parents (83%), and close friends (77%) to risk of infection.
A Successful Lower Lobe Lung Transplantation In A Patient With High Panel Reactive Antibody And Positive Cross Matching

Samar Shadly, MD, Imran Nizami, MD, Waleed Saleh, MD, Mohamed Hussein, MD

Content: Introduction
Lung transplantation has become the standard treatment for patients with end-stage lung disease. Survival after lung transplantation is inferior to other solid organs. Sensitization to HLA adversely affects the success of lung transplantation. High pre-transplant panel reactive antibody levels (PRA) decrease the chance of finding a suitable donor. However, delaying the transplant in these patients increases their mortality on the waiting list. We are reporting a successful case of lung transplant recipient with positive donor-specific antibodies (DSA) and cross-match positive, who underwent lower lobes lung transplantation.

Case Presentation
A 37-year-old lady with diagnosis of pulmonary fibrosis. She progressed to respiratory failure and was placed on the active lung transplantation waiting list. However, her chance to find a suitable donor was low because of high PRA and multiple HLA antibodies and small chest cavity. Because of her worsening condition lung transplantation was performed despite positive cross matching result using perioperative desensitization protocol. She underwent plasma exchange prior to and 4 sessions after the transplant followed by intravenous immunoglobulin (2mg/kg). Thymoglobulin was part of the protocol. However, it was not given because of positive respiratory culture for multidrug resistant (MDR) Pseudomonas aeruginosa.

To compensate for size discrepancy, lobar transplant was performed using only the lower lobes from the donor. Ischemia time was 6 hours for left lung and 5 hours for right lung. Post-operatively, patient developed severe primary graft dysfunction (PGD). She was managed with lung protective strategies along with inhaled nitric oxide. Her maintenance immunosuppression regimen includes; Tacrolimus and mycofenolate mofetil and prednisone. At third post-operative day, she started to show signs of graft recovery. Patient was successfully intubated after 1 week of transplantation.

Her DSA;
Anti A2 and anti B38 were above 13000 MFI prior to transplant and they reached around 2000 MFI after the plasmapheresis sessions and they remained stable during weekly follow up post-operatively. Patient completed 18 months post-transplant at the time of writing this report, with no sign of graft dysfunction. She underwent multiple surveillance bronchoscopies and biopsies, which indicated negative result for acute rejection, C4d was repeatedly negative.

Conclusion
Positive cross-match lung transplantation is a feasible option using peri operative desensitization protocol. We were able to transplant a first successful cross-match positive recipient in our program with no evidence of rejection during 18 months of her follow up. However, the long-term results of positive cross-match lung transplantation are needed. Size mismatch between donors and receptions is a challenge in our program. Lobar transplant using the donor’s lower lobes, can be one of solution in selected patients.

Pulmonary Allograft Kaposis Sarcoma After Lung Transplantation

Samar Shadly, I. Nizami, W. Saleh, M. Ahmed, K. Kattan

Content: Introduction
Recipient of solid organ transplants are at an increased risk of developing malignancies. Kaposis sarcoma (KS) accounts for 5-7% of these malignancies. It is most commonly seen in renal transplant recipients, however, it has been reported in recipients of other solid organ transplants and bone marrow transplants. It is very rare after lung transplantation. Here we are reporting a case of lung transplant recipient with KS affecting the lung allograft.

Case Report
A 21-year old man underwent bilateral lung transplantation in November 2014 for pulmonary fibrosis secondary to chemotherapy for Burkitt’s lymphoma. His immunosuppression regimen includes; Tacrolimus, mycofenolate mofetil (MMF) and prednisone. The post-operative course was uneventful. Six months following transplantation, patient presented with dry cough and dyspnea. Physical examination revealed scattered crackles bilaterally. Skin examination was unremarkable. A routine chest x-ray showed new pulmonary nodules and CT chest confirmed multiple bilateral small pulmonary nodules. Transbronchial biopsy from left lower lobe was remarkable with the presence of numerous spindle-shaped cells with irregular cell-like spaces consistent with diagnosis of Kaposis’s sarcoma. The tumor cells stained positive for human herpesvirus 8 (HHV8). EBV negative. A whole-body PET CT showed no evidence of metastasis.

The patient’s immunosuppression therapy was changed to Sirolimus and prednisone. Both tacrolimus and mycofenolate mofetil (MMF) were discontinued. The patient was given liposomal doxorubicin. Two months after the diagnosis of KS, the patient presented with dry cough and dyspnea, he was found to have a A2 allograft rejection, that was treated with methylprednisolone pulse therapy (4-6). Sirolimus was continued with target levels of 6-8 with low tacrolimus trough levels of 1-4. She received intravenous immunoglobulin (2mg/kg) on an ongoing basis for KS. She was anti-retroviral naïve and was started on atazanavir/ritonavir. She had no history of opportunistic infections. KS was extensively ruled out. She was discharged on oral doxorubicin. After a few months she developed recurrent infection and the skin lesions resolved. She was started on intravenous cyclosporine therapy and was discharged on oral doxorubicin. However, she was readmitted three times with recurrent KS disease. She was started on intravenous doxorubicin and had significant improvement. At the last follow up, she has been maintained on oral doxorubicin.

Conclusions
Our study demonstrated the considerable psychological impact of MERS outbreaks on ERRPs. The ERRPs’ concerns and the psychological impact of MERS outbreaks should be considered in greater detail by hospital policymakers.
An Interesting Case Of Surgical Translocation Of ALCAPA In An Infant

Mohammed Abiduddin Arif, Ramesh Chandra Mishra, Amareesh Rao Malempati

Content:
Left pulmonary artery (PA) sling is a rare vascular anomaly. PA sling is associated with congenital tracheal stenosis, more than half of the cases are due to presence of complete tracheal ring, called ringed-ring complex. Definitive diagnosis is must before surgical translocation of PA to its usual site. Contemporarily 3D reconstruction with VISIBLE PATIENT software is useful technique for pre surgical evaluation of anatomy and to make the patient visible during surgery through virtual transparency in order to increase accuracy and safety of procedure.

We describe an interesting case wherein a 3.5 years-old male presented with stridor. On evaluation contrast computed tomography (CT) thorax confirmed the diagnosis of PA sling with narrowing of the trachea above carina due to extrinsic compression by the left pulmonary artery. We have done a corrective surgery for the vascular abnormality after diagnosis. Pulmonary arterioplasty was successfully performed.

The left pulmonary artery arising from the proximal part of right pulmonary and ligamentous arteriosus were divided to relieve tracheal compression. On follow up the collapsed upper and middle lobe of right lung became normal and destroyed heart returned to usual position. Postoperatively he had no respiratory distress.

Tuberculosis Presenting As Bronchoesophageal Fistula In Young Healthy Man

Eid Humaid Al-Gurashi, MD, Ahmed Sayeed, MD, Adnan B. Alzanbagi, MD, Nabil Abdulwadod Badr Ghaieb

Content:
Background: The most common causes of Esophagorespiratory fistula are malignancy and trauma in adults. Tracheo-esophageal fistula is more common, especially in immune-compromised patients. Esophageobronchial fistula due to tuberculosis is rare and even rarer in young healthy immune-competent individuals. Hence we present this as the case report.

Case Presentation:
21-year Saudi male presented with the history of dysphagia and choking. The CT chest showed clear evidence of chronic recurrent aspiration pneumonia in the left lung. Endoscopy showed clear opening on the esophageal side. Bronchoscope also confirmed the presence of the fistula opening on the left bronchial side. Bronchoalveolar lavage was done and sent for mycobacterial analysis. However, recent technical advances in echodcontrast imaging enabled better visualization of the anomalous origin of coronary artery and associated findings. Surgical translocation of origin of left main coronary artery from left sinus of pulmonary artery to aorta was done.

3D Printing Model Of A Case Of Left Pulmonary Artery Sling With Tracheal Stenosis

Mohammed Abiduddin Arif, Ramesh Chandra Mishra, Amareesh Rao Malempati

Content:
3D Printing Model Of A Case Of Left Pulmonary Artery Sling With Tracheal Stenosis

Surgical translocation of origin of left main coronary artery from left sinus of pulmonary artery to aorta was done.
Prognostic Value of CYFRA 21-1 and Carcinoembryonic Antigen in Non-Small Cell Lung Cancer

Azza Farag Said, Emad A Abd-Elnaeem, Bahaa Ibrahim Mohamed, Ashraf A Ewis and Hager Yehia Mohammed

Content: Background:
The diagnostic value of serum tumor markers, such as cytokeratin 19 fragment (CYFRA 21-1) and carcino embryonic antigen (CEA) in non-small cell lung cancer (NSCLC) has been established. Only few studies have focused on the prognostic values of these two markers.

Objective:
The study was designed to verify the prognostic significance of serum CYFRA 21-1 and CEA assay in patients with NSCLC.

Methods:
The study population comprised of 40 patients of NSCLC (30 males and 10 females) with a mean age of 62 3 yrs. Out of forty, twenty two had an adenocarcinoma and 18 had squamous cell carcinoma. Seven patients were at stage II, 24 were at stage III and 9 were at stage IV. None of the patients received any previous treatment. Chest computed tomography (CT) scan was done on baseline and every 2 months frequency to assess the objective radiological responses. Twice serum samples were collected, initial collection was done before the beginning of treatment and the other collection was done after the second cycle of first line chemotherapy. Analysis was performed for CYFRA 21-1 and CEA using an enzyme immunoassay (EIA). Fifteen healthy volunteers with similar age and sex as the study population were selected and were used as a control group.

Results:
The study revealed that 80.8% sensitivity was observed both for CYFRA 21-1 and CEA as a predictor of favourable radiological response. The cut-off values used for the patients were 10.40 ng/ml for CYFRA-21 and 9.30 ng/ml for CEA respectively. Univariate regression analysis identified 3 fold improved survival for the patients with post treatment CYFRA 21-1.

Cryo Transbronchial Lung Biopsy Versus Thoracoscopic Lung Biopsy In Diagnosis Of Interstitial Lung Diseases

Ayman Farghaly, Yaser ElSayed, Khaled Zamzam, Marwa A. Radi, Mohammed Nagati and Niveen A. Fattah

Content: Introduction:
The issue of determining exact histopathology for ILD especially IPF is mandatory for treatment options and for prognostic parameters determination. Open lung biopsy is usually the resort, as conventional TBLB is not enough to provide biopsy expressing the diseases. Thoracoscopy and cryo-TBLB represent non invasive procedures competing to get enough tissue to start proper treatment with local anesthesia in endoscopy suite.

Methods:
30 cases of ILD picked from the military respiratory center outpatient clinic are divided randomly between thoracoscopic and cryo-TBLB rand, and results are compared.

Results:
Thoracoscopic lung biopsy Cryo TBLB
Mortality 0 0
Hospital stay 10 1
Bleeding 2 5
Residual pneumothorax 4 0
Pain 11 0
Definite Diagnosis 12 13

Conclusion:
Both procedures are carried out in the endoscopy suite under conscious sedation, however Cryo TBLB carries the advantages of better diagnostic accuracy, less hospital stay, postprocedure pain, and no residual pneumothorax after the procedure.
Minimally Invasive Esophagectomy Shows Comparable Surgical Outcome To Open Esophagectomy In Esophageal Cancer Patients


Content: Background:
For esophageal cancer without metastasis, the standard treatment strategy is surgical resection despite the risk of morbidities and mortality after surgery. In the hope to minimize postoperative complications, minimally invasive esophagectomy (MIE) has been tried in many institutions. But it is still uncertain if MIE has significant benefits to reducing complications and is enough to remove mediastinal lymph nodes. Thus, we were willing to compare MIE with TE performed by experienced surgeons in high-volume centers excluding a possibility of weakness following unfamiliar new procedure.

Methods:
We retrospectively analyzed clinical data of 374 patients who received esophagectomy and reconstruction and 2-field lymph node dissection for esophageal cancer from 2013 to 2015 in Samsung Medical Center, Seoul, South Korea. Patients with neoadjuvant treatment, palliative surgery, and joint operation for other co-morbid diseases were excluded in this analysis.

Results:
228 patients (61%) received TE and 146 patients (39%) received MIE. Among the study population, male was 91% and squamous cell carcinoma were 94%. There was no difference in pulmonary complications but anastomosis leakage and recurrent laryngeal nerve paralysis occurred more often in MIE due to the cervical anastomosis. There was a tendency of less bleeding and shorter hospital stay in MIE, patient comparing to TE. For lymph nodes dissection, the total number of LNs removed in TE was higher than in MIE (36.9±13.0 vs. 33.2±10.5, p=0.004). Operative time including docking time in MIE is longer than TE. However, the difference decreases as years go by, mean operative time for MIE was 88 minutes longer in 2013, 41 minutes longer in 2014, and 31 minutes longer in 2015.

Conclusion:
In conclusion, MIE showed similar surgical outcome comparing with TE in high-volume center. Despite the significant differences in LNs dissection, both groups met the minimal requirement for LNs dissection. In regard to the operative time difference, which was longer in the MIE, it became to be comparable to TE after the learning period.

The Effect of Arabic Coffee on Pulmonary Function Test among Adults with Asthma

Rawan Al-Herz, Amjad Al-Homaidan, Duaa Al-Dar, Walaa Agil, Nawal Al-Otaibi

Content: Introduction:
Caffeine has a weak bronchodilator effect; it helps to reduce airflow limitation and it is chemically similar to theophylline which can be used to treat asthma. Several studies evaluated the effect of caffeine in general on lung functions, but this paper will primarily focus on the effects of Arabic coffee on lung functions among adults with asthma. The aim of this study is to find out if Arabic coffee works as a weak bronchodilator among asthmatic patients and to determine if there is a need to avoid Arabic coffee consumption prior to lung function test.

Methods:
Thirty patients between the age of 14 to 65 years old who have been diagnosed with asthma were included in the study to perform pulmonary function test (PFT). The patients were instructed to perform PFT three times and the best value was reported then drink one cup of Arabic coffee and repeat the test after 15 minutes. Wilcoxon’s sign rank test was used to find out if there is an effect of Arabic coffee on lung function parameters with the help of IPM SPSS 20.

Results:
The result of pre-test and post-test of FEV1 and FEF25-75% showed a significant difference (P= 0.05); (P=0.01) respectively. However, the effect may not be statistically significant when it comes to PEF (P>0.25) and FVC (P>0.13). Those included in the study were 30 participants after applying the inclusion and exclusion criteria. Twenty-one subjects (70%) of the study had an improvement in FEV1, 17 subjects (56%) in PEF, 20 subjects (66%) in FEF 25-75% and 19 subjects (63%) in FVC.

Conclusion:
The study concluded that Arabic coffee can work as a weak bronchodilator in adult asthmatic patients. Based on this finding, patients should be instructed to avoid consumption of Arabic coffee on the day of the pulmonary function test.

Key Words:
Asthma, Arabic coffee, Caffeine, Pulmonary Function Test, Bronchodilator.
Asthma Control With Omalizumab Therapy KFH, AlMadina Experience

Mohammed Salem, Aysed Rashad, MD, Aymen Iskendarani, MD, Abeer Alharbi, MD

Content:
The most common asthma phenotype in children is allergic asthma, making up 80-90% of cases, (1) and in adults it may exceed 50%. (2) Despite long-term treatment with inhaled corticosteroids (ICS) and long-acting β-agonists (LABA), asthma remains poorly controlled in a significant proportion of patients. (3) Omalizumab, a humanized monoclonal antibody against human immunoglobulin E (hIgE), was registered for the treatment of severe allergic asthma which is insufficiently controlled by conventional treatment. Several studies have demonstrated the therapeutic efficacy and safety of omalizumab in asthmatic patients and have found a reduced annual rate of clinically significant asthma exacerbations, systemic requirements of corticosteroids, emergency department (ED) visits and overall symptoms. (4,5) The aim of this study was to evaluate the effect of omalizumab on asthma control, and lung function test.

Condition:
In KFH, ALMADINA .KSA

Methods:
Prospective and open-label study in 12 adult patients with uncontrolled severe persistent allergic asthma on omalizumab treatment more than 24 weeks.

Results:
We studied 12 patients 75 % male, aged 38.33±15.96 y (mean ±SD), Mean IgE at baseline was high and ranged widely (mean of 483.5±473.4 kU/L), while mean body weight was 66.8±10.6 kg. Seven patients have finished 24weeks follow-up. Regarding asthma control test, we verified a significant improvement over time in the total score (9.86±4.49 to 18.14±3.39 points at 16 weeks, p = 0.003). Concerning lung function, there was a significant rise in FEV1 (66.0±32.1 to 69.86±19.94% at 16 weeks, p=0.5). The 20 SCD group had a mean 6M distance of 498.20 ± 51.27 m compared to 475.20 ± 57.49 m in 20 controlled group which was not significantly different (p=0.934).

Conclusion:
Sickle cell disease is a common serious genetic blood disorder in Saudi Arabia, significant changes in vital signs and the Borg scale.

Prevalence and Factors Associated With Smoking among Female Students in College of Applied Medical Science, University of Dammam.

Maryam Al-Khamis, Sajidah Sulays, Zahra Al Salat, Zainab Al-Baher, Khalid Ansari

Content: Introduction
Smoking is the main cause of premature deaths in the world. Prevalence of smoking in developed countries has been decreased steadily, whereas in Saudi Arabia, it is found that the percentage of smoking has been increased on a daily basis. The aim of this study is to estimate the prevalence of smoking (cigarettes/shisha) and factors associated with smoking habits among female medical students in all departments in College of Applied Medical Science (CAMS) at Dammam University.

Methods:
A cross-sectional study was conducted in College of Applied Medical Sciences. A modified structured Global Youth Tobacco Survey (GYTS) questionnaire developed by World Health Organization (WHO) was used to collect detailed information about smoking habits and factors associated with smoking.

Results:
A total of 332 out of 408 female students responded to the questionnaire, showing a response rate of 81%. The mean age of the sample was 21±1.2. The prevalence of those who tried smoking was 13.3%, of those 0.5% were active smokers. Results also indicate that smoking water-pipe 54.5% was higher than common cigarettes 20.4%. Most of the smokers have high GPA (p<0.01). Also, 61.3% of the sample got their first smoking trail from someone they know (p<0.01). Marital status, year level, religious beliefs and parental educational level have no role in starting to smoke. The exposure to passive smoking was high in public area 50%.

Conclusion:
The study results suggest that the prevalence of the current smoking is not significantly high. However, the data of this study suggests that some students tried to smoke in the past which may be considered as a risk factor of becoming regular smoker in future. This study highlighted the need of organizing more smoking awareness programs in educational settings.
Osseous Metaplasia Presenting As Congenital Lobar Emphysema

Saleh Abu Daff

Content: Introduction:
A 25 y.o. lady with no previous history of smoking or previous chest symptoms presented to her community hospital with sudden left sided chest pain and shortness of breath. She was found to have a left sided pneumothorax on CXR and a chest tube was inserted demonstrating a continuous air leak with failure of lung expansion on CXR. After failing conservative therapy for 2 weeks, she was referred to our center where a CT scan of the chest demonstrated a lobar emphysematous bulla encompassing her left upper lobe and lingual with focal areas of hyper densities on the scan. The patient underwent video assisted resection of her left upper lobe bulla and a pleurectomy. The specimen conforms to the size and shape of the left upper lobe. Her final pathology revealed osseous metaplasia leading to congenital lobar emphysema. Osseous metaplasia of the lung is a rare but benign disorder that can occur focally or diffusely and can present as a lung nodule, bulla or rarely as respiratory failure in the diffuse type. The case includes radiological as well as pathological images. And can be presented as a poster or video presentation.

A Newly Identified Novel Variant In CSF2RA Gene In Child With Pulmonary Alveolar Proteinosis, A Case Report

Adel Al-Haidary, Wadha Alotaibi, Sami A. Alhaider, Suhail Al-Saleh

Content: Introduction:
Pulmonary alveolar proteinosis (PAP) is a very rare disease with prevalence of 0.1 per 100000. Congenital PAP caused by CSF2RA gene mutation with only a few cases reported. We report her a new pediatric case of PAP with the typical presentation of congenital PAP due to CSF2RA gene defect with a novel variant in this gene.

Modified Ravitch Operation For Correction Of Pectus Excavatum

Reda Abdulmaasty, MD, Nabil El-Sadek, MD, Yasser Farag, MD, Ayman Jabal, MD, Nahed Abd Al-Latif, MD, Mohamed Abd El-Sadek, MD

Content: Background:
Classic Ravitch & minimally invasive “Nuss” operations are very popular for correction of pectus excavatum “PE”. In these operations a metallic bar is inserted beneath the sternum, a relatively high incidence of complications of the bar has been reported. We review our experience of modified Ravitch operation where metallic bar is not used for internal fixation to avoid complications of the bar.

Methods:
This is a retrospective study of 27 patients who underwent surgical correction for Pectus Excavatum in Asir Central Hospital, Abha, and Kingdom of Saudi Arabia from 2002 to 2007. Medical charts were reviewed where clinical data and operative details were recorded. All patients had CXR PA & Lateral and CT scan where Heller’s & Pectus indices were calculated. ECG, Echocardiography, pulmonary function tests were done before & after operation. During operation, a triangular wedge of costal cartilage was placed in the osteotomy for elevation of the sternum instead of metallic bar. Patient and family satisfaction was recorded postoperatively.

Results:
The mean age of patients was 11.2 ± 4.1 years (range: 4 to 18 years). There were 21 (78 %) male patients and 6 (22 %) females with male to female ratio 3:1. Indications of surgery were psychological disturbance in 18 patients and impairment of cardiac pulmonary functions in 9 patients. Restrictive pattern in pulmonary function tests was proved in 8 patients (30 %). Pectus index was moderate (1.2-1.3) in 11 & severe (>1.3) in 16 patients. No perioperative deaths & no blood transfusion were required. Our postoperative complications were: pneumothorax (7.4%), seroma (7.4%) & wound infection (3.7%). Patient & family satisfaction was good in 18.5% & excellent in 77.8%. The standard treatment for congenital PAP due to CSF2RA gene mutation is WLL.

Conclusion:
In our study we conclude that modified Ravitch operation yielded excellent cosmetic results with high patient satisfaction and significant improvement of pulmonary functions. Also, there is short hospital stay & low morbidity avoiding the complications of metallic bar.

The Effect of Weather on Daily Activity in COPD Patients


Content: Rationale:
Chronic obstructive pulmonary disease (COPD) is characterized by breathlessness leading to reduced daily activity. Breathlessness varies depending upon the degree and intensity of physical activity. The disease is associated with airflow obstruction, breathlessness, reduced daily activity and muscle weakness. In this study we examine the effect of day-of-the-week and climate on daily step count.

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GT2017 - ABSTRACTS

The Influence of Atmospheric Pollution on Daily Activity in COPD Patients


Content: Rationale:
Pollution episodes may reduce activity as particulate matter COPD patients independently of other pollutants. Also reduces pulmonary function in COPD patients. Information concerning whether atmospheric pollution alters physical activity in COPD patients may be valuable for further assessing the harmful effects of these pollutants.

Methods:
Seventy-three COPD patients recorded on daily diary cards the number of steps taken per day measured with a pedometer, the number of hours spent outside their home, any worsening in respiratory symptoms, peak expiratory flow (PEF), and increased dyspnea. Patients also completed COPD assessment test (CAT). Daily data for atmospheric particulate matter PM2.5 levels were associated with increased dyspnea (p=0.005) but not PM10 levels (p=0.112). Conversely, over just weekdays, higher level of PM10 were associated with lower activity (p=0.018) but higher O3 levels were associated with decreased activity (p=0.005) but not PM10 levels (p=0.112).

Conclusions:
This study provides evidence of an association with atmospheric pollution and worsening of physical activity in COPD patients, and schemes to reduce levels of atmospheric pollution should be further considered.

The First Report On Immunoglobulin G And E Levels In Cystic Fibrosis (CF) Patients At KFSHRC

Hanana Banjar, MD, Dheafa Alabdaly, Sara Alkaf, Fatuma Adem, Ghada Bin Zuman, Abeer Alharbi

Content: Introduction:
Previous reports have shown that pulmonary and systemic hyperimmunoglobulinemia in patients with CF are a reflection of chronic pulmonary infection. Infection with Pseudomonas aeruginosa (PA) has been shown to have major prognostic significance for patients with CF. IgE is considered a biomarker for Aspergillus Fumigatus, Candida Albicans and Allergic bronchopulmonary aspergillosis.

Objective:
To identify the incidence of low, or high Immunoglobulin (including: IgG, and IgE) levels compared to normal level in our confirmed CF patients.

Results:
The 73 patients had a mean (±SD) age of 71.1 (±8.7) years. FEV1 1.3 (±0.47) liters, FEV1 52.9 (±16.5)%, predilected and FEV1/FVC ratio 0.48 (±0.13); 69% were male and 35.6% current smokers. Daily step count typically fell as the weather got colder, after excluding heat waves (temperatures above 22.5), it decrease by 43.3 steps per day per °C (95% CI 21.4 to 84.4; p=0.039). Weekday activity was significantly higher than weekend activity.

Conclusion:
Both IgG and IgE continued to rise with advancement of age and progression of lung disease despite normal levels at presentation. Omalizumab may have a role in the treatment of allergic asthma and ABPA in CF patients.

Comorbidities In Patients With Chronic Obstructive Pulmonary Disease

Hamdy Ali Mohammadien, Mona Taha Hussien, & Ola Ahmad Abdelrahim

Content: Purpose:
To estimate the prevalence of comorbidities in patients with COPD and to assess the relationship of comorbid diseases with age, sex, CRF & COPD severity.

Methods:
The study included 400 COPD patients. COPD diagnosis was defined by GOLD criteria (FEV1/FVC < .70 Post-bronchodilator). Information was collected on the following comorbidities: heart diseases, hypertension, diabetes mellitus, dyslipidemia, anemia, osteopenia & osteoporosis, muscle weakness, pneumonia, lung cancer, gastro esophageal reflux and psychological conditions.

Results:
400 COPD patients (68.5% male) with a mean age 61.5±9 years (range, 40–70 years), of which 35.5% Were current smokers, 40% were smokers, 35% were ex-smokers were included. Patients presented at least one comorbidity, and The most frequent co-morbidities were cardiovascular diseases (84.5%), diabetes (34.5%), dyslipidemia, anemia, osteopenia &osteoporosis, muscle weakness, pneumonia, lung cancer, gastro esophageal reflux and psychological conditions.

Conclusions:
Comorbidities are common in patients with COPD, and have a significant impact on health status and prognosis, thus justifying the need for a comprehensive and integrating therapeutic approach. Cardiovascular, Diabetes mellitus, dyslipidemia, musculoskeletal and psychological conditions are among the most prevalent and important of these.

Clinical Implications:
Extra pulmonary comorbidities are common and significant in chronic obstructive pulmonary disease (COPD), often contributing to symptoms, exacerbations, hospital admissions and mortality so that in the management of COPD all these conditions need to be carefully evaluated and treated.

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Pleural Fluid C-Reactive Protein In The Differential Diagnosis Of Infectious And Malignant Pleural Effusion At Baghdad Teaching Hospital (Single Center Study)

Kassim M. Sultan, MRCP, FRCP, Muhammed W.AliObaity, FICMS, CAMB, FICMS, Kareem Assab Kareem, MBChB

Content: Backgrounds:
C-reactive protein (CRP) is an acute phase reactant produced primarily by hepatocytes. Its production is stimulated by systemic inflammation of either infectious or noninfectious origin. The cytokines that are released during the inflammation are the main stimulants of the acute phase reactants. Interleukin-6 is the main stimulant cytokine of the synthesis of most acute-phase reactants.

Objectives:
To differentiate between infectious and malignant pleural effusions by measuring pleural fluid CRP level.

Materials and Methods:
This was a hospital-based cross-sectional study at Baghdad teaching hospital medical wards conducted from the 1st of November 2014 up to the 31th of August 2015. Fifty patients with pleural effusion proved by the history, examination, Chest imaging and pleural tapping included in this study, all proved to have an exudative pleural effusion by the light criteria.

Results:
Showing statistically significant differences in CRP level between:-
1- Parapneumonic pleural effusion (PPE) and malignant pleural effusion (MPE)
2- TB pleural effusion (TBE) and malignant pleural effusion (MPE).

Conclusions:
Pleural fluid C-reactive protein level can be used as an aid in the differentiation between some infectious causes of pleural effusion and malignant pleural effusion as there is a statistically significant difference between the Pleural fluid C-reactive protein level of the infectious pleural effusion and the malignant pleural effusion.

Recommendations:
My advice is to use pleural fluid CRP level in the differentiation between the causes of exudative pleural effusion as it is simple, rapid, available, accurate and not costly test also we need to study a larger sample to give a more accurate statistical value.

Keywords:
C-reactive protein (CRP), Parapneumonic pleural effusion (PPE), Malignant pleural effusion (MPE).

The First Report On Geographic Distribution Of Cystic Fibrosis Transmembrane Regulator Gene Mutations (CFTR) At KFSHRC

Hanaa Banjar, MD, Nabi Mohgrabi, PhD, Abdulaziz AlEnazi, MD, Ibrahim Almogarri, MD, Sami AlHaider, MD, Imran Nizami MD, Yousef Sebeh, MD

Content: Title: The First Report on Geographic distribution of cystic fibrosis transmembrane regulator gene mutations (CFTR) at KFSHRC

Introduction:
Previous reports showed that Screening of 10 CFTR mutations in Saudi Arabia can detects (69%) of positive CFTR, namely: 1548 delT, DF-508, 1123+5G>A, H135R, 2043delG, 1507delC, compared to the one that was described in North America or Europe, namely DF508 which constitutes 86% of the CFTR mutations detected.

Objectives:
To describe the First report on the geographic distribution of the most common and up-to-date CFTR mutations in Saudi Arabia.

Methodology:
A retrospective chart review as part of the CF registry data RAC # 2111016 from the period 1st January 1984-1st June 2016. All confirmed CF patients of all the age group “that have positive pathogenic CFTR mutations detected” are reported in this study.

Results:
A total of 203 patients have positive CFTR detected. 89 patients (44%) were males, 114 (56%) were females. Consanguinity of 89%, 172(85%) are alive, 30 (15%) have died. 168 (83%) were homozygous for the CFTR mutation and 35 (17%) were heterozygous. The Eastern province (E) has the highest CF patients which accounted for 95 patients (47%) of the total referrals.

Of the most common CFTR mutations: 1548delT in Exon 10 accounted for 18 patients (9%) in the Northern (N) region, 17 (8%) in the central (C) region, 12 (6%) in the (E) region. 3120+1G>A in Intron 16 mutation accounted for 20 patients (10%) in the (E) region, 12 (6%) in Intron 16 mutation accounted for 15 patients (8%) in the (E) region, 14 (7%) in the (C) region, 1138K in Intron 4 mutation accounted for 13 patients (6.5%) in the (E) region, 2043delG in Exon 4 mutation accounted for 10 patients (5%) in the (E) region.

Knowledge of the geographic distribution of the CFTR mutations will give information on how to apply the genetic counselling and where to concentrate the type of medical care that is specific for reduction of the incidence in this disease. The Eastern province accounted for >1/3 of the CFTR referrals.

Conclusion:
Comparison Of Non-Intubated Versus Intubated Video-Assisted Thoracoscopic Lobectomy For Lung Cancer

Zeead M. AlGhamdi, Lyfuxuu Lynhiavu, YoungKyu Moon, Mi Hyoung Moon, Sea Ahn, Yunho Kim, SookWhan Sung

Content: Objective:
This study was conducted to evaluate the perioperative outcomes of the non-intubated and intubated video-assisted thoracoscopic lobectomy in lung cancer in regards to feasibility and safety.

Methods:
A retrospective analysis of 62 consecutive video-assisted thoracoscopic lobectomies (31 lobectomies as non-intubated, 31 lobectomies as intubated) performed in Seoul St. Mary’s Hospital, of the Catholic University of Korea between January to December, 2016.

Results:
Both groups share comparable clinical characteristics including the age, sex, BMI, FEV1, DLCO, smoking history, lung lobes procedure, histological type and pathological staging. There was no difference in the mean of postoperative hospitalization period (6.8 days versus 7.6 days, P-value 0.578) and the total chest tube duration (5.6 days versus 4.4 days, P-value 0.943) between non-intubated and intubated lobectomy respectively. Both groups had a comparable surgical outcome for the anesthesia duration, operative time, blood loss and postoperative complications.

The operative time required for lobe-specific surgery was shorter in the non-intubated group except for the LLL (mean 121.7 minutes for non-intubated group versus 118.3 minutes for intubated group). The only statistically significant surgical outcome was the number of dissected lymph nodes between both groups (the mean number of nodes for the non-intubated group was 12.6 versus 18 nodes for the intubated group, p-value 0.003). One patient in the non-intubated group required conversion to single lung intubation and mini-thoracotomy because of bleeding with no conversion in intubated group. No mortality encountered in either group.

Conclusion:
The perioperative and surgical outcomes for the non-intubated video-assisted thoracoscopic lobectomy are comparable to the intubated technique. Non-intubated video-assisted thoracoscopic lobectomy is safe and is technically feasible. However, further prospective randomized studies are needed for a better comparison between non-intubated and intubated VATS lobectomy.
Lymphatic Invasion Is More Significant Prognostic Factor Than Visceral Pleural Invasion In Non-Small Cell Lung Cancer Of 3cm Or Less

Youngkyu Moon, Zeed M. AlGhamdi, Jae Kil Park, Seok Whan Moon, Sook Whan Sung

**Content:**
- **Objective:**
  - Visceral pleural invasion is an upstaging factor from stage IA to IB in tumors of 3 cm or less. However, the lymphatic invasion has not been associated with the TNM staging system. The purpose of this study was to compare visceral pleural invasion and lymphatic invasion as prognostic factors.

- **Methods:**
  - We retrospectively reviewed 353 consecutive patients who received curative resection for stage I non-small cell lung cancer of 3 cm or less. The patients were divided into three groups and compared. Group A contained no any invasions, group B included visceral pleural invasion only, and group C had lymphatic invasion only.

- **Results:**
  - There were no differences of age, sex, and smoking status among the three groups. Mean SUVmax and tumor size of group B and group C was larger than group A, but there was no difference between group B and group C. All of group B was stage IB; on the other hand, group A and C was stage IA. 5-year recurrence-free survival of the three groups was 86.2%, 71.5%, and 48.0%, respectively. There was a significant difference in survival between group A and C (p=0.001). On the other hand, the survival was not different between group A and B (p=0.547). In multivariate analysis, to determine risk factors for recurrence, the lymphatic invasion was an independent significant risk factor for recurrence (Hazard ratio=2.570, p=0.006) Pleural invasion was not a significant risk factor for recurrence.

- **Conclusion:**
  - Lymphatic invasion is a more significant prognostic factor than visceral pleural invasion in non-small cell lung cancer of 3 cm or less.

*(This abstract has been submitted in another meeting in 2016 but not published)*

Is Completion Lobectomy Necessary In NSCLC (≤ 2cm) With Visceral Pleural Invasion Or Lymphovascular Invasion After Sublobar Resection?

Youngkyu Moon, Zeed M. AlGhamdi, Mi Hyoong Moon, Young Kyoong Kim, Kyo Young Lee, Jae Kil Park, Sook Whan Sung

**Content:**
- **Background:**
  - The standard surgical treatment of stage I non-small cell lung cancer is anatomical lobectomy. However, in some cases, small peripheral lung cancer (≤2cm) is treated by sublobar resection. The purpose of this study was to define the necessity of completion lobectomy when the tumor was revealed as non-small cell lung cancer with pleural invasion or lymphovascular invasion after sublobar resection.

- **Methods:**
  - We retrospectively reviewed 271 consecutive patients who underwent curative resection for stage I non-small cell lung cancer of 2 cm or less. We analyzed clinicopathological findings and survival between two groups with either invasion-positive tumor (tumor with visceral pleural invasion or lymphovascular invasion) or invasion-negative tumor (tumor without visceral pleural invasion and lymphovascular invasion): sublobar resection group and lobectomy group.

- **Results:**
  - Except for age and pulmonary function, there were no differences in clinicopathological characteristics between sublobar resection group and lobectomy group with invasion-positive tumor or invasion-negative tumor. There was no difference in the 5-year recurrence-free survival rate between two groups in the invasion-positive tumor and invasion-negative tumor (78.9% vs 79.6%; p=0.928, 80.2% vs 85.4%; p=0.505).

  - In the multivariate analysis, only number of dissected lymph nodes was a significant recurrence-related factor of stage I invasive-positive non-small cell lung cancer (hazard ratio 0.914, 95% confidence interval 0.8450.888, p=0.023). Sublobar resection was not a risk factor for recurrence.

Conclusions:
- The survival between sublobar resection group and lobectomy group in small (≤2cm) non-small cell lung cancer with visceral pleural invasion or lymphovascular invasion were not different. Even though there is visceral pleural invasion and/or lymphovascular invasion microscopically, it is not necessary to do an additional completion lobectomy in small sized non-small cell lung cancer.

*(the abstract was submitted but not published in another conference in 2016)*

Significant Reduction Of Ventilator-Associated Pneumonia (VAP) Rate Due To Improvement In Compliance To VAP Care Bundle

Fahad Al Hameed, Muhammad Bhutta, Asim Al-Saedi, Yasir Tashkandi, Mansour Al-Janadi, Majid Al-Shamrani

**Content:**
- **Objectives:**
  - Ventilator-associated pneumonia (VAP) is the most common intensive care unit (ICU) acquired infection. There are conflicting results that evidenced-based interventions reduce the risk of VAP. There is controversy surrounding the importance of implementing them as a “bundle” of care. This study aimed to determine the link of implementing such evidence-based care components to VAP in ICU.

- **Design:**
  - The study is conducted at the adult medical-surgical ICU with 28 beds capacity at King Abdulaziz Medical City, Jeddah, Saudi Arabia. There were 49,600 ICU patient days including 32,100 ventilator days during the period of 2009 to 2016. Patients admitted from Jan, 2009 to June, 2016 to the ICU for 48 hours or more are evaluated.

- **Results:**
  - The cases of VAP identified according to Pneumonia Flow Diagram (NHSN 2005). Data Entry Form was created by Infection Control department to implement Pneumonia Flow diagram. Patient data was entered by respiratory therapists during the daily patient assessments. Finally, data entry forms were interpreted by Infection Control Practitioner to identify the cases of VAP. The components for the InH Ventilator bundle were implemented in 2008.

- **Interventions:**
  - Five-element consists of head-of-bed elevation, oral care (chlorhexidine gel), sedation cessation, DVT prophylaxis and peptic ulcer disease prophylaxis (PUD).

- **Results:**
  - Compliance with head-of-bed elevation 95%-100%; oral care 100%; sedation hold 87%-100%; DVT prophylaxis 99%-100% and PUD 99%-100% were reported. Overall bundle compliance rates range from 84%- 100% is reported from period of 2009 to June 2016. The 2.3 cases per 1,000 ventilator-days reduced to 0 cases per 1,000 ventilator-days (p <0.001) by improving bundle compliance from 84% to 100%.

- **Conclusions:**
  - 100% compliance with implementation of VAP prevention bundle was associated with significant reduction in ventilator-associated pneumonia incidence rate to 0. This null rate of VAP was achieved in the critical patients in a tertiary care center after the absolute implementation of the prevention bundle.

How to Manage An Acute Respiratory Distress Hypoxic Patient By U/S Step By Step Approach

Wadih Ibrahim

**Content:**
- I have a very precise and reward able protocol for bedside assessment of a patient with acute respiratory distress and hypoxia by an US machine through a clear step by step approach. First look at the IVC, if dilated non collapsing think about obstructive and cardiogenic causes of dyspnea though go to second step, look at the lung, you will expect these possibilities.

- You see homogenous B-lines with smooth thin pleura it is cardiogenic pulmonary edema and look at the heart to discover the cause.
The Emergence Of Multidrug-Resistant Pseudomonas Aeruginosa In Cystic Fibrosis Patients On Inhaled Antibiotics

Atqah AbdulWahab, Khalid Zahraldin, Mazen A Sid Ahmed, Sulaiman Abu Jarir, Shehab Fareed, Jemal M Hamid, Emad Bashir Ibrahim

Content: Introduction:
Multidrug-resistant Pseudomonas aeruginosa (MDR-PA) is an important and growing issue in the care of patients with cystic fibrosis (CF), and a major cause of morbidity and mortality.

Objective:
To describe the frequency of MDR-PA recovered from the lower respiratory samples of pediatric and adult CF patients, and its antibiotic resistance pattern to commonly used antimicrobial agents including β-lactams, aminoglycosides and fluoroquinolones.

Methods:
The lower respiratory isolates of P. aeruginosa were obtained from inpatients and outpatients CF clinics from a tertiary care teaching hospital for the period from October 2014 to September 2015. The antimicrobial susceptibility test to identify resistance of all the isolates was performed by BD Phoenix automated system according to Clinical and Laboratory Standards Institute (CLSI) guidelines and confirmed by Epi Tester test (E-test) method.

Results:
A total of 61 P. aeruginosa samples were isolated from 39 CF patients from 20 families. Twelve sputum samples were positive for MDR-PA (7 isolates non mucoid and 5 mucoid) from 5 CF patients (5 families) with moderate to severe lung disease given MDR frequency of 19.7%.

The median age of the study group was 20 (range 10-30) years. Three CF patients were on chronic intermittent inhaled tobramycin and 2 on daily nebulized colistin. The antimicrobial patterns of isolates MDR-PA showed a highest rate of resistance towards each antibiotic (Table 1), followed by 91.7% to ciprofloxacin, 75% to tobramycin, 58.3% to meropenem and 2 on daily nebulized colistin. The antimicrobial patterns of isolates MDR-PA showed a highest rate of resistance towards each antibiotic (Table 1), followed by 91.7% to ciprofloxacin, 75% to tobramycin, 58.3% to meropenem and 2 on daily nebulized colistin.

Conclusion:
The study results emphasize the emergence of significant problem in the clinical isolates of P. aeruginosa in CF patients and need further management of the antibiotic treatment strategy with frequent surveillance is recommended.

Prevalence And Risk Factors Of Heavy Metal Poisoning Among Female Students At Inaya Medical College Using Buses As A Transportation

Hawraa Alflouq, Nour Aleissa, Sahar Alhassan, Deema Babaker, Fatimah Bozaid

Content:
Heavy metal has been used by humans for thousands of years. Exposure to toxic effects of heavy metal continues to date, and is on the rise, especially in developed countries, despite the well-known harmful effects of this on human health. The main threat to human health from heavy metal is associated with exposure to lead. This has been extensively studied and the effects on human health regularly reviewed by international bodies such as the WHO (Jarup et al, 2003).

To examine the effects of heavy traffic in Istanbul, Turkey, researchers divided the city into two distinct districts Bosphorus and the European side. Particulate Matter 2.5 (PM2.5) was measured in cars, metro-buses, buses and side-walks, during rush and non-rush hours. Results indicated that during rush-hours PM2.5 levels were higher than non-rush hours. Furthermore, bus passengers had higher exposure to PM2.5 than those in the cars and metro-buses (Onat & Stakeeva 2013).

In Arnhem, Netherlands comparison between diesel, electric buses and cyclists to measure PM2.5 in one-third of the day during rush-hours for one year showed that the highest exposure of PM10 was in diesel buses and was the lowest among cyclists. Furthermore, results indicated air pollution was lowest among passengers in electric buses (Quatier et al, 2010).

PM2.5 and especially black carbon monoxide were measured in the drivers’ compartment in buses and trains in Helsinki, Finland. Findings concluded that drivers were exposed to black carbon monoxide which resulted in side effects on these drivers’ health. The highest exposure to black carbon monoxide occurred in the downtown area (Aasi et al, 2009). In a study on blood lead levels (BLL) among lead workers, results indicated an increase in BLL and a decrease in hemoglobin (Hb) levels in this group. Exposure to lead affected RBC’s membrane, enzymes; proteins and increased hemolysis.

Chronic lead exposure caused anemia more than acute exposure (Khan et al,2006). Lead metal is recognized as a powerful toxin and poisoning from this substance is recognized as a major public health concern. Lead toxicity has harmful effects which cause serious consequences in health, such as interference with various body functions with the majority of effects seen in the central nervous, hematopoietic, hepatic and renal system. This is more apparent in the developing nervous system comprising immature astroglial cells that lack lead binding proteins (Flare et al, 2012).

Exposure to lead may cause lung disorders with the possibility of developing lung cancer and/or asthma due to environmental pollution. The frequency of the respiratory symptoms were assessed in a sample of 108 lead exposure workers and 100 control subjects with similar age using a questionnaire on respiratory symptoms. The study revealed that Most lead exposure workers (63%) reported work-related respiratory symptoms, such as sputum (16%), cough (11%), wheezing (6%) and shortness of breath (26%). These symptoms were higher in lead workers than non-lead workers (Khadzid et al, 2012).

From the aforementioned brief literature review it is apparent that use of public or shared transportation is associated with increased risk of exposure to heavy metals and possibly leads as it is a major constituent of fuel used to power these vehicles. Furthermore, these means of transportation are generally old and poorly maintained which increase the risk of pollution primarily from Carbon Monoxide (CO). A large number of girls attending Inaya Medical College frequently use buses to take them to and from the college and take a 4-hour trip on weekends to their hometowns in the Eastern Region of Saudi Arabia. This extensive use of these vehicles could be a major source of heavy metal poisoning for these girls. Therefore, the aim of this study is to examine the prevalence of heavy metal poisoning among females attending Inaya Medical College who frequently use these buses.

EBUS-TBNA As A Diagnostic Tool For Isolated Mediastinal Lymphadenopathy - Results From A Tertiary Referral Centre

R.Sudhir, A.Nair

Content: Objective:
To review the efficacy of EBUS-TBNA results for non-cancer diagnosis in a tertiary referral centre in the UK.

Methods:
We reviewed the database for 450 consecutive EBUS-TBNA procedures in a single hospital from 2012 -2013, allowing for 2 years follow-up to complete surveillance time. Out of this, 200 patients had a non-cancer diagnosis from their test. A retrospective analysis was undertaken to determine the true nature of these results and we present the observations here. Out of the 200, 130 (65%) were male and 70 (35%) female.

Sarcoidosis was the commonest diagnosis 57(28.5%), benign 36 (18%), TB 12 (6%), anthracotic in 32 (16%), reactive in 7(3.5%), non-diagnostic in 8(4%) , missing information in 36 (18%) and unsuccessful needle placement or procedure in 10 (5%), colloid and pus in 1 each. Out of the patients with anthracotic lymph nodes, 20 had an underlying etiology and 12 underwent follow-up.
Max Value

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Objectives:
1. Decrease admission rate
2. Length of hospital stays
3. Administration of inpatients systemic steroid
4. Reduce number of re-admission to hospital with similar asthma diagnosis within 30 days after discharge
5. Reduce number of Emergency room re-visit within 30 with similar asthma diagnosis
6. Increase number of patients with proper discharge plan including outpatient’s appointment and home management plan

Method:
Longitudinal improvement project. All children aged 2-15 years old admitted with asthma between January 2013 December 2016 were included. Total sample size was 190. Children with episodic viral induced wheeze were excluded Individual charts were reviewed to confirm asthma diagnoses against international consensus when available and our own guidelines; we used asthma predictive index for children between 2-5 years of age. Data were collected and assessed by 3 independent reviewers.

Conclusions:
The absence of a BTS tool for auditing advanced bronchoscopy procedures previously meant that some data sets would be incomplete and settings national standards were impossible. The British thoracic society (BTS) has recently introduced national audit for bronchoscopy and advanced bronchoscopy procedures and this study highlights review from the first set of data from a single institution.

References:
1. EBUS-TBNA for the evaluation of isolated mediastinal and/or hilar lymphadenopathy (IMHL) Kah Yee Tham, Shera Tan, Kiran Sharma, Manho Sige Yo, Ati Hau Tan, Theresa Sophie Lappzee, Chain Min Loo European Respiratory Journal 2014 44: P3565;
5. Endobronchial ultrasound-guided transbronchial needle aspiration prevents mediastinoscopies in the diagnosis of isolated mediastinal lymphadenopathy (IMHL) Kah Yee Tham, Shera Tan, Kiran Sharma, Manho Sige Yo, Ati Hau Tan, Theresa Sophie Lappzee, Chain Min Loo European Respiratory Journal 2014 44: P3565;
The patient wasn’t smoker and there was no family history of a similar condition. His Chest X-Ray revealed tracheobronchial exertional dyspnoea and sometimes audible wheezes, No chest pain and no palpitations. There were no clinical, radiological or sputum of no bad odor for the last month. He has history of recurrent chest infections since late childhood. Presenting as a case of Mounier-Kuhn syndrome, tracheobronchomegaly, bronchiectasis.

Conclusion:
As tracheobronchomegaly can be overlooked on plain films, patients who have chronic respiratory infections should have a CT scan done in to rule out underlying predisposing conditions such as this.

The prognostic role of Cripto-1 and RUNX2 in Non-small cell carcinoma of the lung

Ola A. Harb, Shereen El-Shorbagy, Nehal S. Abouhashem, Ola M El- Farargy, Reham A. Salem, Loay M. Gertallah, Sameh Saber

Content: Background:
Non-small cell carcinoma of lung (NSCLC) is the commonest and most lethal among all types of lung cancer; adenocarcinoma, squamous cell carcinoma, and large cell carcinoma form its subtypes. The 5-year survival in patients with NSCLC remains very low although there are improvements in treatment modalities, so new prognostic markers and therapies need to be discovered to improve patients’ outcome. Cripto-1 (CR-1) is one of the family members of epidermal growth factor cripto FRL1 cryptic (EGF-CFC) that was needed for embryogenesis. Runt-related transcription factor (RUNX) family members form the core-binding factor (CBF) complex that attached DNA to either stimulate or de-activate transcription of many genes then regulate the survival, differentiation and maturation of many tissues. Our aim in this research is to detect the clinical significance and prognostic role of CR-1 and RUNX2 expressions in NSCLC using immunohistochemistry.

Methods:
CR-1 and RUNX2 expressions were evaluated in 59 paraffin blocks sections of NSCLC. The relationship between their level of expressions and prognosis of patients was analyzed.

Results:
CR-1 and RUNX2 were highly expressed in 59.3%, 87.8% of NSCLC patients, and there was a significant positive association between their expressions in NSCLC (p<0.015). Both markers were significantly correlated with size, grade, stage, site of the tumor within the lung, malignant (pleural and/or pericardial) effusion, presence of distant metastases, ECOG performance status of the patients (p)

The Effect of Listening to Holy Quran Recitation on Weaning Patients Receiving Mechanical Ventilation in the Intensive Care Unit

Mohammad Yadak, Khalid Ansari, Omar al-Omar, Nawal Al-Onzi, Hatem Qutub, Hajeed Otaibi, Faraz Ahmed Farooqi

Content: Background:
Patients experience high level of stress and anxiety when on mechanical ventilation. This study aimed to investigate the effect of listening to Holy Quran Recitation (HQR) on patients during weaning from mechanical ventilators.

Methodology:
This is a randomized controlled trial (RCT) in which 56 patients admitted in the intensive care unit (ICU) and on mechanical
ventilation were recruited. Patients were divided into experimental (case) and control group. All met the pre-set inclusion criteria. The experimental group, patients received 30 minutes of HQR, whereas in the control group, patients had 30 minutes of rest in bed before the start of the weaning. The physiological and/or clinical parameters of weaning are recorded. These parameters include rapid shallow breathing index (RSBB), respiratory rate (RR), heart rate (HR), oxygen saturation (SpO2), exhaled carbon dioxide (TeCO2), and blood pressure (BP). All measurements were recorded at baseline and just after the intervention in both groups.

Result: The baseline demographic data for groups were presented in tables. The mean age was 54±0.5 years for the experimental and 56±18.5 years for the control groups. The physiological and clinical parameters were compared between case and control using paired T-test. Independent T-test and showed no significant difference.

Conclusion: The findings of this study suggest that there is no negative effect of HQR on weaning patients from mechanical ventilation in the ICU. The results suggest that the utility of HQR in ICU patients should be explored further as an intervention in weaning patients off from ventilator in the ICU.

BOD And BODAS - Discriminative And Predictive Properties Of New Multidimensional Prognostic Indices Of Chronic Obstructive Pulmonary Disease In Primary Care

Khalid Ansari, MD, PhD, Niall Keaney, MD, PhD, Andrea Kay, MPhil, Monica Price, PhD, Joan Munby, PhD, Andrew Billett, MSc, Sharon Haggerty, BSc, Ian K Taylor, MD

Content: Background: The assessment of the severity of chronic obstructive pulmonary disease (COPD) should involve a multidimensional approach that is now clearly shown to be better than using spirometric impairment alone. The aim of this study is to validate and compare novel tools without an exercise test and to extend prognostic value to patients with less severe FEV1/V.

Methods: A prospective, observational, primary care cohort study identified 458 eligible patients recruited from the primary care clinics in the northeast of England in 1999-2002. A new prognostic indicator - BOD (Body mass index, airflow Obstruction and Dyspnea) together with the conventional prognostic indices ADO (Age, Dyspnea and airflow Obstruction), GOLD and new GOLD matrix were studied. We also sought to improve prognostication of BOD by adding age (A) and smoking history as pack-years (S) to validate BODS (BOD with smoking history) and BODAS (BOD with smoking history and age) as prognostic tools were validated and the predictive power of each was analyzed.

Result: The survival of the 458 patients was assessed after a median of ten years when the mortality was found to be 33.6%. The novel indices BOD, BODS and BODAS were significantly predictive for all-cause mortality in our cohort. Furthermore with ROC analysis the C statistics for BOD, BODS and BODAS were 0.56, 0.63 & 0.72 respectively (p).

Prevalence Of Symptomatic Bronchiectasis In Patients With Radiological Evidence Of Disease In Adult Patients In UAE

Shanza Akram, Suha Nasir, Nadeen El Majed, SameenToor, Khulood Al Mazroui, Ashraf Al Zaabi, Imran Saleem

Content: Background: Bronchiectasis is one of the common chronic respiratory diseases. The diagnosis is usually established clinically on the basis of chronic daily productive cough and radio graphically by chest CT scans. The prevalence of bronchiectasis remains elusive, given co-existent respiratory conditions and increasing rate of radio logically diagnosed bronchiectasis in asymptomatic patients. A wide array of causes has been reported in adults, but more than half the cases are found to be devoid of a definite etiology or association. The most common risk factor is lung infection with propensity to damage bronchi like TB, bacterial infections, whooping cough. Although the inciting infections are usually severe, bronchiectasis can also occur with minimal or silent infections. However, neither its prevalence nor its etiology is well defined.

Aims: 1) We aim to estimate the prevalence and risk factors of bronchiectasis in adult patients attending Zayed Military hospital. 2) Number of clinically symptomatic patient among radiologically proven bronchiectasis.

Methods: All CT scans of chest done in ZMH from 1st January 2011 until December 2015 were reviewed. All patients with bronchiectasis were included in the study. Medical records of these patients were reviewed to document demographic details, smoking history, clinical symptoms, haemoptysis, extent of bronchiectasis on CT, PFTs, number of exacerbations requiring hospital admissions, and pathogens grown on sputum cultures. We tried to identify the cause of bronchiectasis in these patients such as old TB, recurrent infections in early childhood, cystic fibrosis, connective tissue diseases or idiopathic etc.

Results: 1583 CT scans were done in this time period. Bronchiectatic changes were reported in 201 (13%) patients. 123 (61%) were males and 78(39%) were females with a mean age of 60 years (14-108). 38 (19%) patients were smokers and 36 (18%) were ex-smokers. Severity of bronchiectasis was categorized into mild, moderate and severe based on radiological evidence. 80(42%) had mild, 78 (39%) moderate and 38 (19%) patients had severe bronchiectasis. 121(60%) patients had bilateral and 80(40%) had unilateral changes. Chronic cough with spumon production was reported in 120 (60%) patients, however only 18% (36) patients had haemoptysis at any stage.
PFTs were available on 148 patients. Obstructive pattern was documented in 59(39.9%) and of these only 17% were smokers or ex-smokers. Sputum culture showed mixed flora in 33 patients, Pseudomonas Aureginosa in 28, H Influenzae in 15, Strep Pneumonia in 14, Klebsiella Pneumonia in 6, Mycobacterium Tuberculosis in 3 and other pathogens in 13 patients. Patients with severe disease were more likely to have Pseudomonas infection. Old or recurrent childhood infections were the cause of bronchiectasis in 85 (42%), old TB in 44 (22%) and Rheumatoid arthritis in 9(4%) of patients. In 66 (33%) patients no cause was found and these were labeled as having idiopathic bronchiectasis.

Conclusion:
In our cohort bronchiectasis is more common in males and is bilateral. Patients with severe disease are more likely to have Pseudomonas infection. Less than half (40%) are asymptomatic. Major etiological factor is old/recurrent childhood infections. Idiopathic bronchiectasis is common as well constituting almost33% patients. Obstructive Airways disease is common regardless of smoking history.

Early results of excision of 261 cases of Primary Chest Wall Tumors in 14 year period
Amer Bilal

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

Methodology:
261 patients from June 2002 to Dec 2016 were retrospectively analyzed. Patients of both sexes, aged 9-80 years, unilateral 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 surgery was involved. Patients sent to oncologist for adjuvant therapy accordingly. One year follow up were done.

Result:
Out of 261 patients, 144 were male and 117 were female, age ranges from 9-80 years with a median of 27.8 years. 192 patients experienced painless mass and 69 patients painful mass. 144 chest wall masses presented on right side, 85 left sided and 32 on sternum. Sizes were 10 cm 06, Chest wall resection and primary closure was done in 147 cases while in 114 cases resection and reconstruction done using matrix mesh done in 103 cases and reinforced with methyl methacrylate in 11 cases.

Histologically Chondrosarcoma was reported in 61.5%, Fibrosarcoma in 25%, Ewing sarcoma in 11.5% while 2% specimens were experienced painless mass and 69 patients painful mass. 144 chest wall masses presented on right side, 85 left sided and 32 on sternum. Sizes were 10 cm 06, Chest wall resection and primary closure was done in 147 cases while in 114 cases resection and reconstruction done using matrix mesh done in 103 cases and reinforced with methyl methacrylate in 11 cases.

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.

Experience Of Decortication For Empyema Thoracis
Amer Bilal

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

Methodology:
Computed clinical record of 4244 patients who underwent decortication for empyema thoracis from Jan 2003 to Dec 2016 was retrospectively analyzed. Patient of all ages, both sexes and diagnosed empyema thoracis were included. Meticulously 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 postero lateral thoracotomy. Follow up done in all cases.

Conclusion:
In our cohort bronchiectasis is more common in males and is bilateral. Patients with severe disease are more likely to have Pseudomonas infection. Less than half (40%) are asymptomatic. Major etiological factor is old/recurrent childhood infections. Idiopathic bronchiectasis is common as well constituting almost33% patients. Obstructive Airways disease is common regardless of smoking history.

Outcome of Surgical Management of Bronchiectasis
Amer Bilal

Content: Objective:
To observe the various clinical presentations of bronchiectasis and evaluate its surgical management and outcome.

Materials and Methods:
Computed clinical data of 1539 patients surgically managed were retrospectively analyzed. Detailed scrutiny of the record was carried out to determine the clinical presentation, various surgical procedures done and analyze the clinical outcome.

Result:
A total of 1539 patients underwent various surgical procedures. Male to female ratio was 3:1.Age range was 13-62 years with a median age of 33.7 years. The predominant clinical presentation was productive cough with copious sputum in 1208 (78.5%) patients. Recurrent chest infection in 1223 (79.46%), and hemoptysis in 469 (30.47%) patients. Bilateral localized bronchiectasis was present in 111 (7.21%). Etiology wise post tuberculous bronchiectasis present in 1268 (82.39%) cases, congenital in 106 (7.01%) cases, FB inhalation in 845 (54.65%) cases and post measles bronchiectasis in 79 (5.13%) cases.

The mean operative time was 68 minutes. 1127 (73.22%) patients underwent lobectomy, 214 (13.90%) patients underwent pneumonectomy, 214 (13.90%) patients underwent pleurectomy, 214 (13.90%) patients underwent thoracoplasty in 91 (5.91%) cases.

Pneumonia in 14, Hemoptysis in 6, Mycobacterium Tuberculosis in 3 and other pathogens in 13 patients. Patients were seen in 111 patients postoperatively. One year follow up of all 254 alive patients were tumor free.

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

Outcome of Surgical Management of Pulmonary Aspergillosis
Amer Bilal

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

Materials and Methods:
Computed clinical record of 558 cases of diagnosed Pulmonary Aspergillosis were retrospectively analyzed from June 2002 to Dec 2016. Patients of all ages, both sexes, medically fit and unilateral Pulmonary Aspergillosis 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.

Result:
Out of 4244 patients, 2673 (62.98%) patients were male and 1571 (37.01%) were female, age ranges from 2 to 71 years with a median age of 33.12 years. 2639 (62.18%) underwent right thoracotomy and 1665 (37.81%) left thoracotomy. Bronchopleural fistula was present in 1310 (30.68%) patients and empyema necessitans in 298 (7.02%). Pneumonia and tuberculosis were seen in 1670 (39.34%) and 2108 (49.67%) cases respectively.

Mean duration of postoperative chest drain was 14 days. Follow-up ranged from 15 days to 6 months. Mortality was 137 (3.22 %) including wound infection 62, atelectasis 41, bleeding 15, failed decortication 28. Mortality was 78 (1.83%) including respiratory failure 58, 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.
Retrosternal Goiter and Surgical Approaches- Peshawar experience of 162 Cases
Amer Bilal

Content: Objective: A retrospective analysis was carried out to analyze the clinical presentation, Surgical procedures, histopathology of specimens and outcome.

Methodology: The procedures performed were Lobectomy in 456 (81.72%) cases, Bilobectomy 47 (8.42%), wedge resection 34 (6.09%), Pneumonectomy 21 (3.36%). Postoperative complications occurred in 37 (8.63%) patients, of which 19 (3.4%) had prolonged air leak, 9 (1.61%) had significant postop bleeding out of which two required re-exploitation, 5 (0.89%) patients developed Empyema and wound infection occurred in 4 (0.71%) patient. 30 days Mortality was 13 (2.32%) of which 11 patients died due to respiratory failure and two 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

Content: Objective: To assess the results of surgery for treatment failure Multidrug- Resistant Tuberculosis.

Methodology: Retrospective analysis was done in 153 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 Jan2002 to Dec 2016.

Results: There were 90 male and 63 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=37], bilobectomy [n=38] and lobectomy [n=63]), while primary thoracoplasty with apicoplasty was done in 15 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 (-ve Sputum microscopy & Culture) was achieved in 128 patients.

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

Pneumonectomy for Benign Lung Disease: Peshawar Experience of 936 Cases
Amer Bilal

Content: Objective: To assess the surgical outcome of Pneumonectomy for benign lung disease.

Material and Methods: 936 patients who underwent pneumonectomy for benign lung diseases were retrospectively analyzed carefully for surgical outcome. Routine workup, sputum for AFB, CT scan chest with IV contrast, pulmonary function test, echocardiography in elderly patients, exercise testing in patients with marginal pulmonary function test. All patients had conventional posterolateral thoracotomy. Stump closure was done in 2 layers with reinforcement of stump with intercostals muscle flap or pleural flap was done in all cases. Specimen sent for histopathology and follow up was done in all cases.

Results: Out of 936 cases 523 were male and 413 female, age range from 4 months to 74 years with a median age of 32.5 years. Clinical presentation was recurrent chest infection with copious amount of foul smelly sputum in 442 cases (47.22%), recurrent hemoptysis in 504 cases (53.84%) and chest pain in 71 cases (7.58%). Tuberculosis was present in 649 cases (69.33%), while primary thoracoplasty with apicoplasty was done in 15 patients. Post operatively 2nd line anti tubercular chemotherapy was prescribed for 24 months. There were 90 male and 63 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=37], bilobectomy [n=38] and lobectomy [n=63]), while primary thoracoplasty with apicoplasty was done in 15 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 (-ve Sputum microscopy & Culture) was achieved in 128 patients.

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

Surgical Resection of Pulmonary Hydatid-An Experience of 729 Cases
Amer Bilal

Content: Objective: To observe outcome of surgical resection of pulmonary hydatid disease.

Methodology: All patients admitted to cardiothoracic unit from June 2002 to Dec 2016 with pulmonary hydatid cysts were evaluated retrospectively as to age, sex, symptoms, diagnostic procedures, anatomic location of cysts, surgical procedures, complications, and outcomes.

Result: Total of 729 patients were operated for hydatid cystectomy. 477 were male and 252 female. Median age was 39.14 ± 16.8 years (range, 16-69 yr). 457 of these were symptomatic, with hemoptysis in 254 and chest pain in 120 cases. 83 Patients presented
with ruptured hydatid leads to Pneumothorax in 32 cases and Empyema in 52. 272 patients were asymptomatic, found to have Hydatid cyst incidently. There were 397 Hydatid cysts on the right side while 332 on the left side. Hydatid cystectomy was done in 572 cases, wedge resection 93, Lobectomy 45, Bilobectomy 11 and Pneumonecomy was done in 8 patients. Abendazole was prescribed to all patients postoperatively. Patients were followed up for a period of 13 ± 15.4 months (range, 2–36 months).

40(5.4%) patients had postoperative complications including wound infection in 20 patients, bronchopleural fistula in 8 patients and recurrence in 6 patients. Mortality was 14 (1.92%) including respiratory failure 10 and septicemia in 4 patients.

Conclusion: The principal involved in surgical resection of pulmonary Hydatid included; en toto 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.

Thoracoplasty, An Experience of 720 Cases in 14 Years Period in a Developing Country
Amer Bilal

Content: Objective: To assess that thoracoplasty is still a useful space obliterating collapse procedure.

Methodology: This retrospective observational study was conducted in Thoracic surgery unit Lady Reading Hospital, Peshawar from Jan 2003 to Dec 2016. 720 patients who had thoracoplasty done as a collapse therapy in last 14 years were included in this study. The demographic data, operative findings, outcome of procedure in terms of postoperative complications, 30 day mortality and duration of ICU and hospital stay were recorded from the data base of patient's record of the ward.

Result: Study included 480 male and 260 female patients, age ranges from 16 years to 70 years (median age 31 years). Out of 720 patients, 430 had complete thoracoplasty, while 290 had partial thoracoplasty. 36(5%) thoracoplasties were done in failed decancellation, 594 (82.5%) combined with decortication, 27 (3.75%) in post lung resection without BPF and 36 (5%) with BPF and 26 (3.61%) in poor PFT’s with hemoptysis as collapse therapy. Mortality was 455(25.2%) including wound dehiscence in 7 patients, 25 wound infection, 5 patients with partial thoracoplasty were re-opened to do complete thoracoplasty and 8 patients had persisting sinus. Mortality was 17 (2.36%). 8 patients did not recover from anesthesia, and 9 of them had persistent sepsis, septicemia and cachexia. Mean ICU stay was 2 days and mean hospital stay was 5 days.

Conclusion: Thoracoplasty is indicated in;
1. Infected space with no viable lung ± BPF
2. Infected post resectional space ± BPF

Unusual Presentation Inflammatory Myofibroblastic Tumors
Yousaf Abu Asbeh, MD, Amit Katz, MD, Ori Haberfeld, MD, Ran Kremer, MD

Content: Inflammatory myofibroblastic tumors (IMTs) is a relatively benign tumor occurs in the lung, they can also arise from different anatomical locations in the lung they can represent as a solitary pulmonary nodule but they also can represent as locally invasive lesion. We discuss a case of a 15 year old male patient presented with occasional hemoptysis, chest CT scan showed cavity lesion in the right lower lung lobe, thorascoscopic segmental resection was performed and the pathological result was Inflammatory myofibroblastic tumiors (IMTs), to the best of our knowledge, there is a very limited reports in the English literature of a IMTs of lung

His skin condition improved and lincomycin was discontinued. He was treated initially as a case of asthma/ABPA with IC, nasal problems which he received on and off for 3 years.

15 Years Old Boy with Mediastinal Mass
Mariyam Gohar Ali, Ali Bin Sarwar Zubairi

Content: Introduction: Hyperimmunoglobulin E Syndrome/JOBS syndrome is a rare multisystem inherited disorder affecting skin, skeletal system, causing recurrent staphylococcal infections and pulmonary infections. Common presentation is with recurrent skin and sinus infections. We here describe a rare presentation of this rare disease with mediastinal mass. Case Presentation: 15 years old boy presented to Aga Khan Hospital with the complaints of shortness of breath, cough, hemoptysis and fever. He was in good health till the age of 9 years and then he developed asthma like symptoms, started having recurrent upper respiratory tract infections, recurrent skin problems like eczema and blisters formation. He was given intramuscular lincomycin for his skin problems which he received on and off for 3 years.

His skin condition improved and lincomycin was discontinued. He was treated initially as a case of asthma/ABPA with IC, nasal antigens, antihistamines and systemic steroids. He did not show much improvement and continued to have symptoms on and off

Therapy for hemoptysis in patients not fit for lung resection.

1. Infected space with no viable lung ± BPF
2. Infected post resectional space ± BPF

Conclusion:
- Dr. Mariyam Gohar Ali, Dr. Ali Bin Sarwar Zubairi
- Dr. Mariyam Gohar Ali, Dr. Ali Bin Sarwar Zubairi

The Role of FeNO in Predicting Asthma Relapse and Clinical Relevance in Children on Inhaled Corticosteroid
Abdul Rehman Syed MD

Content: Objective: The aim of the study to find the possible clinical relevance of FeNO in asthma management and FeNO is helpful in predicting asthma relapses in children who discontinue ICSs because of clinical remission.

Method:
- Two groups of children were recruited, one group received ICSs and the other group did not receive ICSs.
- FeNO measurements were taken before, 2, 4, 8, and 12 weeks after withdrawal of ICSs.
- The data were analyzed using statistical software.

Result:
- FeNO measurements were a very useful additional parameter for the management of asthma, which is able to avoid unnecessary inhaled corticosteroid anti-leukotrienes therapies, however, maintaining a treatment sufficient to obtain a meaningful improvement of asthma. Twelve patients relapsed.
- Twelve patients relapsed after withdrawal of ICSs. FeNO in children who were about to relapse was found to be higher than in those who did not relapse. Raised FeNO value 43ppb at 4 weeks after discontinuation of steroids had the best combination of sensitivity and specificity for asthma relapse.

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**Bilateral Catamenial Hemopneumothorax Secondary To Thoracic Endometriosis Syndrome**

Saja A. Al Aqeel, Yasser M. Al Jehani, Arwa S. Al Shamekh

**Content:**

Endometriosis is the presence of endometrial tissue outside the uterine cavity, most likely found in the pelvis. Extra-pelvic endometriosis (EPE) has been reported as pulmonary endometriosis, bowel-omental endometriosis, urinary tract endometriosis, or other, less common, locations. Many theories have tried explaining the underlying pathogenesis of endometriosis, such as the metaplasia theory, embolization theory, retrograde menstruation theory, intraperitoneal air theory, and many more.

The thorax is the most common location for EPE, aptly named thoracic endometriosis syndrome (TES), a rare disorder that involves involvement of the lungs, pleura, azygos, and diaphragm. TES encompasses four clinical entities, which are catamenial pneumothorax (CP), catamenial hemithorax (CII), catamenial hemoptysis, and lung nodules. In this case report, we describe a rare manifestation of TES, bilateral catamenial hem pneumothorax.

**Case Report:**

A 34-year-old Saudi female presented with progressive shortness of breath for the preceding 4 days. She is known to have lung bullae. Her first episode of pneumothorax occurred 3 years prior and was treated by bullectomy and pleurodesis three times by means of an open thoracotomy of the right chest. Despite chest tube drainage, a persistent air leak necessitated thoracoscopic exploration of the left chest with mechanical pleurodesis. Thoracoscopic did not demonstrate any parenchymal abnormalities or endometrial pleural implants. It was unclear if the diaphragm was inspected for defects. She denied dyspnea, fever, cough, or hemoptysis. There was no history of chest pain, night sweats, or other constitutional symptoms. Her gynecological history revealed menarche at 14 years, with irregular menstruation.

**Diagnosis:**

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Molecular Surveillance Of Pneumococcal Carriage Among Indian Hajj Pilgrims In The Year 2016

K L Ravikumar, MD, Feroze A Ganaie, MD, Vandana Govindan, Geetha Nagaraj

Content: Background and Aim:
The Hajj is one of the biggest and geographically diverse mass gatherings in the world. Due to the population flow and dynamics during Hajj, this event has the potential to increase pneumococcal carriage among pilgrims. Limited information is available in relation to the prevalence, transmission, and serotype distribution of S. pneumoniae. Most of these studies depend on conventional methods which are of low sensitivity, subjective to interpretation bias and labor intensive. This multi-site longitudinal surveillance study was designed to evaluate molecular surveillance protocol with traditional methods. The secondary objective was to assess potential variations of pneumococcal carriage in Pre and Post Hajj cohorts from India.

Materials and Methods:
807 Pilgrims were recruited from 4 cosmopolitan cities of India– Delhi (157), Mumbai (75), Hyderabad (252) and Bangalore (323). A total of 328 pre Hajj nasopharyngeal and oropharyngeal swabs (1614±1614) were collected with an interval of 40±5 days. The samples were investigated for S. pneumoniae carriage, serotype distribution, antibiogram and genetic relatedness. Pneumococcal carriage was identified by culture and quantitative multiplex real time PCR (qmPCR). Serotyping was performed with PneuTest (Queuing reaction) Kit, PCRSeqTyping and Fragment analysis.

Results:
An increased incidence of Pneumococcal carriage was detected by qmPCR in comparison to culture in Pre & Post Hajj samples respectively (20.3% Vs 23% & 7.4% Vs 8%). 2386 of culture isolates and 658 of qmPCR positive samples belonged to 28 different serotypes. The common serotypes identified were 19F, 35B and 15F during pre-hajj and 19F, 1, 9V and 11A during post-hajj. Fragment analysis could detect multiple serotype carriage in 76 pilgrims (2 serotypes in 63, 3 serotypes in 13). High resistance to Trimethoprim/Sulfamethoxazole was observed in both Pre and Op samples (60% and 78%) Increase in resistance to antibiotics Erythromycin (11%-24%), Levofloxacin (19%-27%) and Tetracycline (22%-34%) was observed in pre and post-hajj cohorts. Resistance to Penicillin, Ceftriaxone and Cefotaxime was not been seen in all the tested samples. Significant increase in multidrug resistance strains (40%-59%) was also observed in pre and post Hajj cohorts.

Conclusion:
Our results confirm high acquisition rate of S. pneumoniae in pilgrims and highlight its potential spread to home countries upon their return. Increased drug resistance to Co-trimoxazole, Erythromycin, Levofloxacin and MDR strain needs to be addressed with suitable and timely use of antibiotics. The appropriate use of pneumococcal vaccines is crucial to reduce the burden of pneumococcal carriage. Addition of Molecular techniques with conventional methods in large longitudinal cohort studies helps to provide useful information.

Audit on the Use of Omalizumab at a Tertiary Care Centre in Saudi Arabia


Content: Background:
Anti-IgE therapy is being increasingly prescribed for difficult asthma & has been added to asthma management guidelines. To date, there are no studies on any aspects of its use in the Gulf region.

Methods:
Information on the prescription of Omalizumab was collected from medical records & interviews on all patients who received a minimum of 6 months of Omalizumab, including data on indications, dose, subjective & objective response, reduction in ER visits, hospitalisations & other asthma medications, adverse effects, setting of delivery, and difference in prescription practices between Pulmonology & Allergy physicians.

Results:
A total of 50 patients (% 35 females), mean 46.3 ± 9.2 age years fulfilled the criteria. A total of 28 patients (56%) fulfilled all the manufacturers criteria for the prescription of Omalizumab (18 (72%) by the pulmonary physicians and 10 (40%) by Allergists). (Pnt in particular to dosing & setting of delivery. Omalizumab is a useful addition in the armament in the management of difficult asthma.

Conflict Of Interests: None

Inhaler Technique - Are We Doing It Correctly?

Sameen Toor, Khulood Al Mazrouei, Malak Hamza, Mahnoor Azeem, Ashraf Al Zaabi, Imran Saleem

Content:
Asthma and COPD are common chronic respiratory diseases, which impose a substantial burden on healthcare systems and society. There are a broad range of options available for the management of asthma and COPD. Controller medicines, such as inhaled corticosteroids (ICS), long-acting muscarinic antagonists (LAMA), long-acting P2 agonists (LABA) are taken preventatively to manage asthma and COPD.

In contrast, short-acting muscarinic antagonists (SAMA) and short-acting P2 agonists (SABA) are used as rescue medications to provide immediate relief. For patients with persistent asthma and COPD, global clinical guidelines recommend treatment with a fixed-dose combination (FDC) of ICS-LABA, either as a controller medication or as both controller and rescue medication. Use of DPIs has been associated with poor inhalation technique, which can lead to increased healthcare resource use and costs. Asthma and COPD medicines are currently administered using either a pressured metered dose inhaler (pMDI) or a dry powder inhaler (DPI).

The choice of medicine and inhaler is critical for achieving successful management. Critical inhaler errors defined as errors which significantly reduce, or prevent entirely, deposition of medicine in the lungs can be considered a measure of poor inhalation technique. Evidence suggests that significant proportion of patients have poor inhalation technique and up to 94% of DPI users made at least one inhaler error when examined by a healthcare professional (HCP). HCPs may also demonstrate poor inhalation technique. Multiple studies have shown that at least a third of and in some cases all HCPs performed at least one critical error with pMDIs and DPIs.

This indicates that commonly prescribed inhalers are difficult to use. Poor inhalation technique among HCPs may result in patients receiving incorrect or inconsistent advice and training. Therefore, poor inhalation technique presents a potentially considerable, and avoidable, burden to healthcare organizations and patients alike. Assess the inhaler technique in patients attending respiratory clinics and admitted to medical ward, and health care professionals at Zayed Military Hospital.

Methods:
Inhaler technique was objectively assessed based on a 7-step inhaler technique score (ITS) and further categorized as GOOD (score 8-10), ACCEPTABLE (6-7), or POOR (less than 4). ITS was done on all inhalers separately that the patients were using to further assess technique based on the inhaler type. Education was given regarding the correct inhaler technique at the end.

Results:
100 consecutive patients (86% males, mean age 40 years), on inhalers, assessed by pulmonary team in clinic and medical ward were included in the study. 20 health care professionals including nurses, respiratory therapists and medical residents were also included: Mean age of patients was 40 years. The underlying diagnosis requiring inhaler therapy was Asthma in 81%, COPD in 15% and others in 4% of patients. 48% of patients were 41% women vs single inhaler, 47% on 2 inhalers and 5% on 3 inhalers. The different types of inhalers used were ventolin 81%, seretide 29%, Symbicort 28%, Spiriva handhaler 16%, Spiriva Respimat 7% and Alvesco in 5% of patients. 47% of patients had poor technique, 32% acceptable and only 21% had good technique. Among health care professional results also showed poor technique in 10%, acceptable in 4 and good in 6 participants. Use of DPI was associated with poorest technique.

Conclusions:
A significant number of Asthma and COPD patients and health professionals have poor inhalation technique. This correlates with reduced disease control, unnecessary addition of inhalers, and increased use of healthcare resources, which in turn negatively impacts patient health-related quality of life (HRQoL). Measures that can improve inhalation technique with DPIs, such as easier-to-use inhalers or better patient training, could offer benefits to patients and healthcare providers through improving disease outcomes and lowering costs.

Prevalence of Sleep Apnea in Patients Attending Zayed Military Hospital, Abu Dhabi

Khulood Al Mazrouei, Sameen Toor, Shanza Akram, Yussra El Mahi, Mahnoor Azeem, Ashraf Al Zaabi, Imran Saleem

Content:
Obstructive sleep apnea (OSA) is a common disorder affecting 24% of the adult population. It is characterized by repetitive pauses in breathing during sleep caused by airway obstruction (obstructive sleep apnea) or altered control of breathing (central obstructive sleep apnea).
sleep apnea). Sleep apnea is increasingly recognized for its health impacts, leading to growing interest about the management and consequences of this common disorder. Cardiovascular, metabolic and neurocognitive consequences of OSA underline the need for early diagnosis and treatment of the disorder. The diagnosis of OSA is based upon the combined assessment of clinical features alongside the objective demonstration of sleep-disordered breathing, using an appropriate sleep study. Nevertheless, OSA is a heterogeneous disorder with a broad range of nocturnal and daytime symptoms that may not conform to the typical history and physical findings, particularly among females, the elderly, during pregnancy, or in the presence of other disorders. Since OSA is associated with adverse cardiovascular outcomes, increased awareness of the atypical presentation of OSA in different patient populations is warranted. Substantial economic growth of gulf region over the last decades has led to sedentarization and major changes in diet and lifestyle. This has resulted in increased prevalence of obesity, diabetes and related diseases. Obesity (body mass index BMI 30kg/m2) now affects around one-third of the adult population of this region. In the UAE, it has been reported that 32.7% of adults and 12.1% of adolescents (10-19 years) were obese. The role of obesity as a risk factor for the development of obstructive sleep apnea is well established.

Aims:
Aim of our study was to estimate the prevalence of OSA and OHS, and co-morbidities in patients referred to our sleep clinic with suspected sleep disordered breathing.

Methods:
All patients who had overnight polysomnography in our sleep lab in ZMH from 2014-2016 were included in the study. All sleep studies done in sleep lab in ZMH from Jan 2014- Dec 2016 were reviewed. Patients who had a positive sleep study (AHI >5) were included in the study. Medical records of these patients were reviewed to document demographic details, BMI, AHI, ABG results, co-morbidities such as hypertension, diabetes, dyslipidemia and thyroid abnormalities. Patients with co existent OHS were identified. Results of titration studies were also reviewed to assess the choice of NIV with prescribed pressure settings. Compliance was also assessed from medical records.

Results:
209 sleep studies were done in the time period. Study population comprised of 140 male and 69 female patients with mean age of 53 years. Average BMI was 36(range 20-130). Approximately 50% (104) patients had hypertension. 65 patients were diabetic and 36 patients had IHD. A high number 165(79%) of studies were positive for sleep apnea. Average AHI was 29. 52 were diagnosed with mild, 42 with moderate and 71 patients with severe sleep apnea. 22(13%) patients had no co existent OHS. After titration studies 91 patients were commenced on CPAP therapy with average pressure of 9.5 cmH2O. 22 patients required BIPAP treatment. Compliance was poor in majority of patients.

Conclusion:
There is high prevalence of obesity and undiagnosed OSA in Middle East. Sleep Apnea is common in patients attending ZMH and a significant number of sleep studies are positive. OHVS is not uncommon so it should be suspected and investigated in high risk patients. Compliance with NIV remains a major issue of concern and patients should receive proper education and counseling prior to prescription and during follow up visits. There is an urgent need to educate public through different media channels and to organize educational programs targeting the patients with obesity and OSA.

Non-Invasive Ventilation In Different Clinical Settings
Mohammed AIAlhmarri, PhD, RRT, CTTS, FAARC

Content:
Non-invasive positive ventilation refers to the application of ventilator support by delivering a pressurized gas via external interfaces. Over the past few decades the initiation of non-invasive ventilation has become a core therapy in acute and non-acute care management. Non-invasive ventilation has been used as a useful replacement for invasive mechanical ventilation.

In acute settings, non-invasive ventilation provides mainly an alternative choice of ventilation to invasive intubation with a therapeutic goal to preserve physiological functions, airway patency and prevention of respiratory tract infections. In the non-acute settings, non-invasive ventilation provides ventilatory support giving the opportunity to medical care, ambulante, travel and domiciliary Care. This oral presentation will review the literature and recommendations regarding the application of non-invasive mechanical ventilation in different settings, from pre-hospital care into intensive care units.

Drug Delivery Devices For Neonates Patients
Mohammed AIAlhmarri, PhD, RRT, CTTS, FAARC

Content:
The oral presentation will describe the appropriate application of nebulization, dry powder inhaler, and metered dose inhaler in neonates’ population. It will also describe advantages and disadvantages of common aerosol delivery devices: factors affecting performance of common aerosol delivery devices; the common patient’s errors in using aerosol delivery devices; and various aerosol delivery devices adjuncts and its functions. Proper cleaning/disinfection of aerosol devices will be discussed.

Characteristics of Patients undergoing Bronchial Thermoplasty for Severe Asthma in the UAE
Yaser Abu El Samed, Govinda Bodi, Mateen Uzbeck, Ali Wahla, Mohsen Nasir, Mohamed AbuZakouk, Zaid Zoumou

Content: Background and Objective:
Bronchial thermoplasty (BT) is a novel bronchoscopic intervention for the treatment of severe asthma poorly controlled despite optimal medical therapy. This abstract summarises the characteristics of patients who have undergone BT in the past 12 months since setting up the BT service at our institution.

Methods:
Retrospective analysis of all patients who underwent BT procedure at our center to date. The following data were measured prior to BT. Patients demographics, Spirometry, Asthma Control Questionnaire Test (ACT) scores, Maintenance medication use, and Patients allergy evaluation among others.

Results:
Sixteen patients underwent BT procedure from February 2015 to date. All patients met the ERS/ATS definition of severe asthma. At the time of abstract submission, 12 patients had completed the three BT sessions and four patients had completed their first BT session, with a total of 40 BT procedures performed to date. The remaining BT session for the second group of patients are currently planned according to guidelines. The majority of patients were females (12/16). The mean age was 40.8 (range 29 to 62) years. The mean BMI was 29.3 (range 21.2 to 42.9). Eleven patients were UAE local citizens and the remaining were expatriate UAE residents. The mean FEV1 was 67.9 (range 40 to 90) % of predicted. Fourteen of the 16 patients had eosinophil counts more than 150 x10^9/L. The mean Ige level was 149.7 (range 13.2 to 2058) IU/L, with 4 patients on omalizumab therapy and three others having failed or not tolerated treatment. The mean baseline ACT score prior to BT was 13.18 (range 5 to 20) points. All patients were on combination LABAICS therapy with 13 also on LAMA. Fourteen patients were on montelukast and three on continuous daily maintenance oral corticosteroids.

Conclusion:
There is predominance of females in their 4th and 5th decade of life in our cohort of patients requiring BT in the UAE. Most patients were overweight or mildly obese, and had allergic asthma with the majority considered for or receiving omalizumab therapy. Most patients had moderate airway obstruction. ACT scores were consistent with uncontrolled disease despite being compliant with optimal pharmacological therapy. Follow up report with focus on patients’ outcomes and response to BT will be shared in the near future.

The material was not published or presented in any prior conferences and did not receive any awards.

Unusual Presentation Of Trichomoniasis
Dalal Alkhudair, Khalid AIObaid, Fahad Al-Ghimlas

Content:
We describe a case of pulmonary infection with marked eosinophilia due to Trichomonas species. Its rare pulmonary presentation associated with persistent eosinophilia is the first described case in Kuwait. A 72 years old Indian male presented with 10-day history of persistent dry cough, associated with chronic anorexia, estimated of 4 kilograms weight loss over the past several
A 30-Year-Old Man with Acute Myocardial Infarction, Normal Coronaries and Hypoxia
Saheer S, Sundar Kumar, Madhujith P and Shailendra

Content: A 30-year-old male labourer patient of Asian origin presented to our emergency room with complaints of chest pain of 9 hours duration. He is smoker with pack years of 20 and not a known diabetic or hypertensive. Clinical examination showed features of chest, offebre, pulse rate of 115 per minute, respiratory rate of 22 per minute, blood pressure of 110/70 mm of Hg and oxygen saturation of 98% at room air. Chest auscultation revealed scattered crepitations with normal heart sounds. His chest x-ray showed prominent bronchovascular markings and electrocardiogram revealed elevated ST segment in precordial leads suggestive of anterior Myocardial Infarction. Blood parameters revealed normal haemoglobin (13.5g/dL), Low hematocrit (36.4%), Low RBC count(9.4L), normal leucocyte(10.14x10^9/L) and Platelet count(262x10^9/L). He had normal renal functions, C reactive protein within normal limit. Total bilirubin 18.45micromole/L, Direct bilirubin 2.22micromole/L. SGPT 45.1 U/L, SGOT 91 U/L, Alkaline Phosphatase 128 U/L. Patient had elevated troponins (0.03 microgram/L, normal 0.01-0.023), natriuretic peptide (612 pg/ml, normal 125 pg/ml) and hypokalemia. Patient slowly recovered from hypoxia and was discharged in a stable condition and is doing well in last seven months of follow up. Patient father came at the time of discharge and he recalls blood transfusion history for the patient but does not remember any clinical diagnosis for his son. This case gives us the following learning points- the need of proper health education for the patient and family which will prevent delay in future treatments, the need of proper clinical correlation of simple radiology and laboratory parameters, all hypoxia is not due to cardiac or respiratory disease and finally myocardial infarction is not always secondary to atherosclerotic changes.

A Study On Etiology Of Mediastinal Lymph Node Enlargement And Role Of Endobronchial Ultrasound In The Diagnosis Among Patients Presenting To Pulmonary Services At A Tertiary Health Care Centre.
Saheer S, DJ Christopher, Balamugesh T, Barney Isaac, Belvandra Antoniswamy, Aparna Irodi.

Content Background: Mediastinal adenopathy is one of the common reasons for making referrals to Pulmonologists. Various diagnostic modalities are available for histopathological confirmation; endobronchial ultrasound (EBUS) has been extensively used in evaluating these nodes in malignant and non-malignant cases. Limited literature is available on the etiological diagnosis, comparison between efficacy of EBUS and conventional diagnostic modalities. The aim of this current study was to find out the etiology of mediastinal adenopathy and the role of EBUS in diagnosis among the patients attending a tertiary health care institute.

Method: Retrospective analysis was performed in 397 patients who underwent evaluation during between August 2012 and July 2013.

Results: Amongst the study population, definite aetiology for mediastinal adenopathy was achieved in 344(86.6%) patients. The most common cause for adenopathy was malignancy (51.1%), followed by tuberculosis (15.6%) and sarcoidosis (9.5%) in descending order of frequency. Adenocarcinoma (51.7%) was the most common type, followed by squamous cell carcinoma (16.7%). Conventional bronchoscopy guided procedures was the technique that yielded the most for positive pathologic specimens (150 out of 344; 43.6%). EBUS was helpful in only 7.8% patients (33 out of 344).

Conclusions: Malignancy is the most common cause of mediastinal adenopathy in Indian population. The role of EBUS in evaluation of mediastinal nodes are limited to selected clinical cases.
Follow-up Chest X-Ray showed complete resolution in 46 (57.5%) partial resolution of more than 50% from the initial X-ray was achieved in 29 (36.25%) patients. 3 (3.75%) patients developed persistent air leak and required surgical intervention. 1 (1.25%) patient expired due to septicemia.

Conclusion:
Rigid thoracoscopy done under local anesthesia by pulmonologists is a useful technique for dealing with chronic empyema in resource constrained countries/institutions where facilities for thoracic surgery are not widely available. Using this technique tuberculous empyema is most common cause in our setup.

Application Of Bipap Through Endotracheal Tube In Comatose Patients With COPD Exacerbation

Nousheen Akhter, Nadeem Rizvi

Content: Background:
The recommended treatment option for comatose COPD patients with hypercapnic respiratory failure is mechanical ventilation. In resource poor countries this is not feasible for all such patients.

Objectives:
To evaluate the effectiveness and safety of using BiPAP through endotracheal tube in comatose COPD patients with hypercapnic respiratory failure.

Methods:
Prospective, observational study including all comatose COPD patients with hypercapnic respiratory failure admitted during January 2015 till January 2016. Patients with apnea and other causes of coma were excluded.

Results:
The success rate of BiPAP through endotracheal tube was 76% (15/20). Improvement in Glasgow coma scale (GCS) score (p value 0.011). Three patients had partial success and two had no success.

Acceptance of Mandatory Vaccination Policy for Seasonal Influenza Vaccine among Healthcare Workers at a Tertiary Care Hospital in Saudi Arabia.

Hassan Kasim Haridi, Khaled Ahmad Salman, Eshraq A. Basaif, Dahi Khalaf Al-Skaibi

Content: Background:
Influenza vaccination of health care workers (HCWs) is essential for patient safety, their own safety and to prevent any drop in hospital operation due to an influenza outbreak. However, despite its strong recommendation, studies indicate a low rate of vaccine uptake. Due to lower rates of the vaccine uptake among (HCWs) despite efforts to reach good vaccination coverage and considering the high vulnerability of pilgrim patients using healthcare facilities in Hajj seasons, Ministry of Health in Saudi Arabia, recently adopted mandatory vaccination policy for HCWs in all healthcare facilities in Makkah and Madinah to reach an acceptable level of vaccination. This paper aims to assess acceptance of mandatory influenza vaccination policy among HCWs and factors independently affecting their acceptance or non-acceptance.

Methodology:
A cross sectional survey was carried out during October 1-16, 2015, among HCWs in King Abdullah medical city in Makkah, Saudi Arabia. A self-administered, anonymous questionnaire was distributed to assess the uptake of influenza vaccine and to examine potential predictors of acceptance and non-acceptance.

Results:
Out of 600 HCWs approached, 447 returned valid self-reported questionnaires with response rate 89.4%. Overall, 88.3% of the participants reported receiving vaccination during 2014-2015 season, higher than 2013/2014 season (61.2%) and 54.5% for 2012/2013 season. Four factors were independently affecting their acceptance or non-acceptance: role in frontline in Eis, level of awareness of potential benefit of vaccination, exposure to influenza patient and personal belief regarding vaccination. Among HCWs, 9.9% agreed that influenza vaccine is not beneficial to them.

Role of Medical Thoracoscopy in the Management of Multiloculated Empyema Thoracis

Kamran Khan Sumalani, MD

Content: Background:
Despite the advances in antibiotic therapy, thoracic empyema remains a common clinical entity. Mainstay of treatment of pleural empyema is the treatment of ongoing infection and the prevention of recurrent infection and late restriction. Treatment also includes drainage of complicated pleural effusion, full expansion of the underlying lung and elimination of the pleuropulmonary infection with antimicrobial agents. Antimicrobial therapy along with thoracocentasis is usually adequate treatment in early empyema thoracis but chronic cases may require aggressive intervention. In under developed countries like Pakistan most of the empyema patients present late to the tertiary care hospitals.

Objective:
To analyse the experience of management of multiloculated, exudative and fibrinopurulent empyema via rigid medical thoracoscopy under local anesthesia at tertiary care hospital in Karachi, Pakistan.

Patients And Methods:
It is a case series of 80 patients admitted at Jinnah postgraduate medical centre Karachi, Pakistan (a tertiary care hospital), from September 2014 to August 2016, patients were selected and evaluated through non probable consecutive sampling, who underwent medical thoracoscopy under LA. Data was analyzed on SPSS software. In 70 patients chest X-Ray showed complete resolution in 46 (57.5%) partial resolution of more than 50% from the initial X-ray was achieved in 29 (36.25%) patients. 3 (3.75%) patients developed persistent air leak and required surgical intervention. 1 (1.25%) patient expired due to septicemia.

Conclusion:
Rigid thoracoscopy under local anesthesia by pulmonologists is a useful technique for dealing with chronic empyema in resource constrained countries/institutions where facilities for thoracic surgery are not widely available. Using this technique tuberculous empyema is most common cause in our setup.
Physical Activity And Sedentary Behaviour Of Saudi Males With Chronic Obstructive Pulmonary Disease: A Comparison With Age And Gender Matched Healthy Controls

Mohammed Alyami, Sue Jenkins, Hani Lababidi, Kylie Hill

Content Background:
In health and disease, the benefits of regular participation in moderate to vigorous intensity physical activity are well established. To date, studies that have measured the level of physical activity in Saudi population used questionnaire only. However, quantifying physical activity using subjective measures has been shown to be inaccurate, particularly in older people, when compared with objective measures (e.g., pedometers or accelerometers).

Information on physical activity and sedentary behaviour in Saudi nationals with chronic obstructive pulmonary disease (COPD) obtained using robust objective methods have not been reported.

Objective:
To: (i) compare physical activity and sedentary behaviour in COPD with age and gender matched healthy controls, and (ii) report associations between the quality and emotional components of the Dyspnea-12 (D-12) questionnaire with physical activity and sedentary behaviour in people with COPD.

Methods:
Physical activities in daily life were evaluated in 30 males with COPD (age 62.0 ± 5.0 years; FEV1 46 ± 15% predicted) and 29 gender-matched healthy controls (age 63.0 ± 4.3 years; FEV1 91 ± 5% predicted), using the Step Watch TM Activity Monitor during their waking hours for eight consecutive days. Walking based activity was defined as ≥ 1 step/min and sedentary behaviour was defined as 0 steps/min.

Results:
A total of 219 confirmed COPD patients. The mean age at diagnosis was 4.13 ± 6 years, median age at follow up was 6.54 ± 5.39 years. The most common radiological finding at presentation were: Diffuse bilateral infiltrate in 70 (30.56%), Hyperinflation in 49 (21.40%), Bronchiectasis in 44 (19.21%), Fibrinous Changes in 9 (3.53%), Nodular changes in 7 (3.06%), Cystic changes in 9 (3.53%), Interstitial Changes in 33 (14.41%), Atelectasis Changes in 38 (16.60%), and Increased Vascularity in 10 (4.37%).

Conclusion:
Chest radiography is an important tool to evaluate the severity of pulmonary involvement and to institute proper treatment early to prevent progression of the disease. More than 40% of COPD patients at KFSHRC had severe x-ray changes with BS score >20 points that may require lung transplantation or may have progressive disease.

Safety Outcomes From A Recently Established Advanced Diagnostic And Therapeutic Bronchoscopy Service in the UAE


Content Background:
A state-of-the-art bronchoscopy service was established and started functioning at the Cleveland Clinic Abu Dhabi (CCAD) in February 2015. We report our experience with regards to the different types of standard and novel advanced bronchoscopic procedures and their safety outcomes over a two year period.

Methods:
Retrospective analysis of electronic medical records for patient demographics, the type of bronchoscopic procedure, sedation type: the use of any advanced diagnostic or therapeutic interventional pulmonology (IP) modality in the tracheobronchial tree and any major adverse events including severe bleeding or arrhythmia needing treatment, seizures, myocardial infarction or pulmonary edema, pneumothorax needing intervention, over sedation needing ventilator support or reversal agents, unexpected hospitalization or ICU admission and death were recorded [1].

Results:
A total of 240 bronchoscopic procedures were performed between February 2015 and Jan 2017. The mean age was 51.81 years (SD 18.79) with 139 female (57%) and 101 male (43%) patients. All patients had an evaluation with flexible bronchoscopy and 3 patients were intubated via a rigid bronchoscope. Moderate sedation was used in 59 cases (24%) while the rest of the procedures were done under general anesthesia or monitored anesthesia care. The majority of cases, 230/240 (96%) were performed in the procedural area/bronchoscopy suite. 131 (54%) had a bronchoalveolar lavage (BAL) and 42 (18%) had transbronchial biopsies (TBB) using real-time fluoroscopy. 47 patients (20%) had advanced diagnostic bronchoscopy (35 Endobronchial ultrasound (EBUS)– guided transbronchial needle aspiration: 10 underwent electromagnetic navigational (EMN)– guided biopsy: 2 radial EBUS– guided biopsy). 28 patients (11%) had intervention in the form of debulking, airway stent placement, the use of balloon dilation, argon plasma coagulation (APC) or electrocautery for the management of benign and malignant central airway obstruction. 16 patients underwent bronchial thermoplasty (40 procedures) for difficult to treat asthma and 5 patients had bronchoscopic lung volume reduction. 2 using endobronchial valves and 3 using lung volume reduction coils. A total of 4 (0.01%) major adverse events occurred with no pneumothorax or death (2 patients needed ICU care, 1 patient had an MI and 1 required reversal of sedation).

Conclusion:
Out of the first 240 bronchoscopic procedures at the CCAD bronchoscopy suite, 96 (40%) were performed using advanced diagnostic and therapeutic techniques and the vast majority were performed in our state-of-the-art bronchoscopy suite. Despite the novel set up and recruitment of staff from diverse backgrounds, safety outcomes were favorable and the complication rates low. 1. British Thoracic Society guideline for advanced diagnostic and therapeutic flexible bronchoscopy in adults- Thorax 2011;66:i1- li21 doi:10.1136/thoraxjnl-2011-200713
Excellence in Performance, Hope to Believe and a Goal to Achieve

Ashraf EL-Molla, MD, Mohamed Daabis, MD, Rashed AL-Otaibi, MD

Content: Introduction: Health care system is an extremely risky domain as the third leading cause of death in the United States of America is medical errors, and more than 400,000 patients are dying annually, half of them in the operating room (OR), intensive care unit (ICU), as well as in emergency department (ER).

Multiple Case Reports: We will discuss and describe multiple cases in which various factors have led to a human error which induced medical and in particular anesthetic crises. We will explain an approach to try to counteract this great threat in health care system through a Multi-Dimensional Vision via pre and post graduate program of continuous education on HROs that exhibit closed loop communication, information exchange, situation awareness, back up behavior, shared mental models, assertiveness, collective orientation, expertise adaptability, flexibility, planning, error management, feedback, team self-correction. Comprehensive studies in human factors as well as understanding the key types of cognitive errors specific to operating room in general and anesthesia in particular can be the first step towards training in metacognition de-biasing strategies which may improve patient safety.

Conclusion: We strongly recommend a goal directed approach to counteract medical malpractice through an adopting Multi-Dimensional Vision via pre and post graduate program of continuous education on HROs that exhibit closed loop communication, information exchange, situation awareness, back up behavior, shared mental models, assertiveness, collective orientation, expertise adaptability, flexibility, planning, error management, feedback, team self-correction. Comprehensive studies in human factors as well as understanding the key types of cognitive errors specific to operating room in general and anesthesia in particular can be the first step towards training in metacognition de-biasing strategies which may improve patient safety.

References:

They are expressed as: art of decision making, task management, situation awareness, communication, and team work in addition to stress management (3). We will also explain the science of High Reliability Organization (HROs) which are those organizations like commercial aviation flight industry and nuclear power stations which are running high risk jobs with excellent safety records. We are going to show the behavioral markers by which HRO teams promote safety (4). Crises Resource Management and the different coordination strategies that are used leading to improve safety profile in anesthetic and surgical team (5). Finally we will explore the different components of excellence in performance (6).

Oxygenation And Haemodynamic Status In Airway Pressure Release Ventilation Vs. Conventional Ventilation Modes In Moderate And Severe ARDS: A Prospective Study From A Tertiary Care Centre In Saudi Arabia

Ashraf EL-Molla, MD, Mohamed Daabis, MD, Rashed AL-Otaibi, MD

Content: Background: The efficacy of conventional mechanical ventilation (CV) in managing hypoxic patients with acute respiratory distress syndrome (ARDS) has been well documented; however, considerably less evidence can be found in the literature concerning hypoxemic and haemodynamic status during airway pressure release ventilation (APRV) mode in patients without spontaneous breathing.

Objective: To compare oxygenation (as represented by arterial oxygen tension/inspiratory oxygen fraction ratio (PaO2/FiO2)) and specific haemodynamic indicators including mean arterial pressure (MAP) and heart rate (HR) during CV and APRV in non-spontaneous breathing patients with ARDS.

Design: Prospective cohort study.

Setting: A 68-bed adult intensive care units (ICUs) at a tertiary referral care centre.

Patients: All mechanically ventilated patients with ARDS refractory to CV and being transitioned to APRV between 2011 and 2013. Patients that our eligibility criteria such as being refractory to CV, having signs of bilateral lung decerebration, and having no spontaneous breathing. Patients had a variety of pathologies with a median (interquartile range [IQR]) PaO2/FiO2 9.1 kPa (IQR 7.3 – 13.1 kPa).

Measurements:

Three datasets including demographic data, PaO2/FiO2 ratio, MAP, HR, and mean airway pressure (Pmean) were recorded for each patient (N = 56 datasets). The median values for PaO2/FiO2 were 9.1kPa (IQR 7.3-13.2 kPa) during CV vs. 17.2 (IQR 12.8-26.9) kPa and 22.2 (IQR 14.0-34.7) kPa during APRV1st and APRV2nd, respectively (both had p < 0.001). The median values for MAP were 72.8 (IQR 63.8-84.3) mmHg during CV vs. 78.5 (IQR 69.0-89.1; p = 0.09) and 81.7 (IQR 71-88.7; p = 0.004) mmHg during APRV1st and APRV2nd, respectively. The median values for HR during CV were 100.5 (IQR: 89.5-118.3) beats/min vs. 101.0 (IQR: 80.0-120.0; p = 0.11) beats/min during APRV1st and APRV2nd, respectively.

Results: Of the 54 patients enrolled in this study, 134 datasets met our eligibility criteria. 26 patients (48.1%) had had three datasets (i.e. during CV, APRV1st, and APRV2nd) for each patient (78 datasets) whilst 28 patients (51.9%) had only two datasets (CV and APRV2nd) for each patient (56 datasets). The median values for PaO2/FiO2 were 9.2 kPa (IQR 7.3-15.2) kPa during CV vs. 17.2 (IQR 12.8-26.9) kPa and 22.2 (IQR 14.0-34.7) kPa during APRV1st and APRV2nd, respectively (both had p < 0.001). The median values for MAP were 72.8 (IQR 63.8-84.3) mmHg during CV vs. 78.5 (IQR 69.0-89.1; p = 0.09) and 81.7 (IQR 71-88.7; p = 0.004) mmHg during APRV1st and APRV2nd, respectively. The median values for HR during CV were 100.5 (IQR: 89.5-118.3) beats/min vs. 101.0 (IQR: 80.0-120.0; p = 0.11) beats/min during APRV1st and APRV2nd, respectively.

Conclusion: In this study, when compared to conventional ventilation modes in patients with ARDS, APRV without spontaneous breathing was associated with significant and consistent improvement in PaO2/FiO2, haemodynamic status and Pmean in a relatively short time.
**Minute Ventilation And Carbon Dioxide Elimination In APRV Vs. Conventional Ventilation Modes In Moderate And Severe ARDS: A Prospective Study From A Tertiary Care Centre In Saudi Arabia**

Abdulmohsen M. Alahmad, MD and Valerie A. Zimmerman, PhD

**Content:**

**Background:**
The efficacy of conventional mechanical ventilation (CV) in removing carbon dioxide (CO2) in patients with ARDS has been well documented; however, little evidence can be found in the literature about CO2 removal during APRV mode without spontaneous breathing.

**Objective:**
To compare MV and PaCO2 during CV and APRV in patients with severe and moderate ARDS.

**Method:**
In adult intensive care units at a tertiary care centre, all mechanically ventilated patients with ARDS refractory to CV and being transitioned to APRV between 2011 and 2013 were enrolled.

Patients had a variety of pathologies with a median (Interquartile Range [IQR]) PaO2/FiO2 9.1 kPa (IQR 7.3 – 13.1) which indicates severe ARDS according the Berlin definition. Each patient had MV, PaCO2, and PaO2/FiO2 measured during both CV and APRV. The time of each phase of respiratory cycle (THigh and TLow) during APRV was also recorded.

**Results:**
Data from 54 patients were analysed. The mean (SD) reduction in PaCO2 after switching the mode from CV to APRV was 0.92 (1.68) kPa (0.70 - 1.43 kPa; 95% CI; p < 0.001) while the median (IQR) reduction in MV was 2.6 Liters/minute (l/min) (IQR 1.2 – 4.1 l/min); p < 0.001). The median (IQR) of PaO2/FiO2 was significantly higher during APRV than that of CV 21.7 kPa (IQR 14-32) vs. 9.1 kPa (IQR 7.0-13); p < 0.001). The mean (SD) THigh and TLow during APRV were 4.42 (1.0) sec and 0.5 (0.1) sec, respectively. Patients showed such significant improvement in both oxygenation (higher PaO2/FiO2) and ventilation (lower PaCO2) within a median time of 04:47 (IQR 01:14-09:24) hr:min.

**Conclusion:**
In this study, when compared to conventional modes, APRV was associated with significantly lower PaCO2 and better PaO2/FiO2 at significantly lower MV in patients with moderate and severe ARDS.
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