



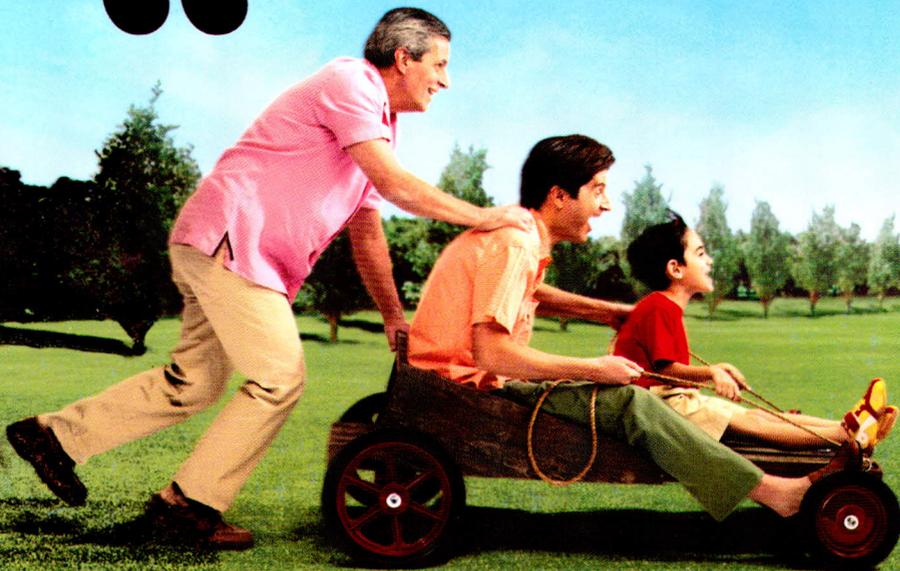
INSPIRE

الجمعية اللبنانية للأمراض الصدرية
عدد رقم ٤ - كانون الثاني ٢٠٠٨

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INSPIRE

January 2008
No. 4



Edito

STRENGTHEN YOUR SOCIETY Strengthen your practice

Dear colleagues, times we are living are very difficult indeed. Internal strife is at its peak, terrorist attacks haunt our daily life... But life must go on. Lebanese people will win the challenge; Lebanon will remain a beacon of hope for those yearning for freedom, coexistence, and tolerance; Lebanon will maintain its regional leadership in Medicine. Our society has grown from mere 30 members in 1990 to not less than 150 members today. Past presidents had great achievements. Continuous medical education is a première in Lebanon; many successful meetings took place despite some very difficult moments; a new office with a permanent secretary is operational at the Lebanese Order of Physicians... just to name a few. Today you are reading the 4th issue of Inspire, an issue I hope you will find even more instructive and interesting.

I was honored to take stand as the President of the Lebanese Pulmonary Society for the years 2007-2009. During my tenure, and with the help of each and every member, I plan to create a website for the Lebanese Pulmonary Society, collaborate with drug companies and launch media campaigns hoping to increase public awareness on asthma, COPD, smoking cessation, tuberculosis... Regional meetings will continue after the unavoidable stop due to the well-known circumstances. The latest meeting took place in Northern Lebanon on January 13th, 2008, and had focused on COPD & pneumonia. Our next yearly meeting will take place in April 2008; hopefully with a strong international participation and collaboration. I also plan to strengthen our relationship with international Societies. LPS members should be encouraged to join such Societies. Contacts were already made with the European Respiratory Society (ERS), hoping to get support from the ERS in the form of sponsorship for scientific events and meetings. We will also rely on the ERS to provide us with a list of key speakers for lectures during our conferences.

Hope to see you all in our next events, and remember, every effort you invest in your Society will empower your practice.

Dr. Wajdi Abi Saleh

President of the Lebanese Pulmonary Society

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Tuberculosis

Historical landmarks *



Dr. Nadim Kanj

“Where other epidemics might last weeks or months, the epidemics of tuberculosis would last whole centuries and even multiples of centuries. Tuberculosis rose slowly, silently, seeping into homes of millions, like an ageless miasma. And once arrived, it never went away again. Where the flesh slowly fell from their bones and they were consumed in the years long fever, their minds brilliantly alert until, in apocalyptic numbers, they died, like the fallen leaves of a dreadful and premature autumn”.

*The Forgotten Plague:
How the War against Tuberculosis was Won - and Lost
Frank Ryan, 1992*

It is presumed that the genus *Mycobacterium* originated more than 150 million years ago. TB was documented in Egypt, India, and China as early as 5,000, 3,300, and 2,300 years ago, respectively. The term phthisis (meaning consumption, to waste away) appeared first in Greek literature. Around 460 BC, **Hippocrates** identified phthisis as the most widespread disease of the times: *“Yet the captain of all these men of death that came against him to take him away was consumption, for it was that that brought him down to the grave”.*

♦The TB epidemic in Europe, later known as the “Great White Plague”, probably started at the beginning of the 17th century and continued for the next 200 years. Death from TB was considered inevitable and, by 1650, TB was the leading cause of mortality. The high population density and poor sanitary conditions that characterized the enlarging cities of Europe and North America at the time, provided the necessary environment, not met before in world history, for the spread of this airborne pathogen. The epidemic spread slowly overseas by exploration and colonization.

♦Precise pathological and anatomical descriptions of the disease began to appear in the 17th century. **Franciscus Sylvius de la Bøe** of Amsterdam (1614-1672) was the first to identify the presence of actual tubercles as a consistent and characteristic change in the lungs and other areas of consumptive patients. The English physician **Richard Morton** (1637-1698) confirmed that tubercles

were always present in TB of the lungs.

Gaspard Laurent Bayle (1774-1816) definitely proved that tubercles were not products, or results, but the very cause of the illness. The name ‘tuberculosis’ appeared in the medical language at that time in connection with Bayle’s theory. More precisely, the name ‘tuberculosis’ was coined in 1839 by the German professor of Medicine **Johann Lukas Schönlein** (1793-1864), to describe diseases with tubercles.

Discovery of the tubercle bacillus

♦On the evening of March 24, 1882, in Berlin, before a skeptical audience composed of Germany’s most prominent men of science from the Physiological Society, **Robert Koch** (1843-1910) made his famous presentation *Die Aetiologie der Tuberculose*. Using solid media made of potato and agar, Koch invented new methods of obtaining pure cultures of bacteria. His colleague **Julius Richard Petri** (1852-1921) developed special flat dishes (Petri dishes), which are still in common use, to keep the cultures. Koch also developed new methods for staining bacteria, based on methylene blue. In 1890, at the 10th International Congress of Medicine held in Berlin, Koch announced a compound that inhibited the growth of tubercle bacilli in guinea pigs when given both pre- and post-exposure. It was called ‘tuberculin’ and was prepared from glycerol extracts of liquid cultures of tubercle bacilli. Clinical trials using tuberculin as a therapeutic vaccine were soon initiated. The results were published in 1891 and revealed that only few persons were cured, at a rate not dif-

ferent from that of untreated patients. But, although results for treatment were disappointing, tuberculin was proven valuable for the diagnosis of TB.

Sanatorium & initial therapies

♦**Hermann Brehmer** (1826-1889) a Silesian botany student suffering from TB, was instructed by his doctor to seek out a healthier climate. He traveled to the Himalayas where he studied the mountain’s flora. He returned home cured and began to study medicine. In 1854, he presented his medical dissertation *Tuberculosis is a Curable Disease*. Brehmer then opened an in-patient hospital in Gorbersdorf, where patients received good nutrition and were continuously exposed to fresh air. This became the model for all subsequent sanatoria. A young doctor named **Edward Livingston Trudeau** (1848-1915) established the most famous sanatorium in the United States at Saranac Lake, in New York’s Adirondak Mountains. Trudeau established the Saranac Laboratory for the Study of Tuberculosis. It was the first institution devoted to TB research in the United States (US). During the early ‘60s, many sanatoria started to close. By the middle of that decade only a few beds remained available for patients suffering from TB. Yet, the real end of the TB sanatorium began even earlier, when the depressing era of helplessness in the face of advanced TB was substituted by active therapy.

♦The Italian physician **Carlo Forlanini** (1847-1918) discovered that the collapse of the affected lung tended to have a fa-

vorable impact on the outcome of the disease. He proposed to reduce the lung volume by artificial pneumothorax and surgery, methods that were applied worldwide after 1913. These and other initial therapies are now considered dangerous and, at least, controversial.

♦ From 1908 until 1919, **Albert Calmette** (1863-1933) and **Camille Guérin** (1872-1961) in France serially passed a pathogenic strain of *M. bovis* 230 times, resulting in an attenuated strain called Bacille Calmette-Guérin or BCG, which was avirulent in cattle, horses, rabbits, and guinea pigs. BCG was first administered to humans in 1921 and it is still widely applied today.

♦ In the middle of World War II, came the final breakthrough, the greatest challenge to the bacterium that had threatened humanity for thousands of years - chemotherapy. In 1943, streptomycin, a compound with antibiotic activity, was purified from *Streptomyces griseus* by **Selman A. Waksman** (1888-1973) and his graduate student **Albert Shatz** (1920-2005). The drug was active against the tubercle bacillus in vitro and following infection of guinea pigs. It was administered to a human patient at the end of 1944. In 1943, **Jörgen Lehmann** (1898-1989) wrote a letter to the managers of a pharmaceutical company, Ferrosan, suggesting the manufacture of the para-amino salt of aspirin because it would have anti-tuberculous properties. Para-aminosalicylic acid (PAS) was produced and first tested as an oral therapy at the end of 1944. The first patient treated with PAS made a dramatic recovery (Lehmann 1964). The drug proved better than streptomycin, which had nerve toxicity and to which *M. tuberculosis* could easily develop resistance. The spirit of optimism that followed was encouraged by the discovery of a series of new anti-tuberculosis drugs. The drug company Lepetit discovered that the mold *Streptomyces mediterranei* produced a new antibiotic, Rifamycin B. Chemical manipulation of this compound by CIBA resulted in the production of rifampicin, which has a remarkable potency against *M. tuberculosis*. Other compounds with anti-tuberculosis activity were

discovered: pyrazinamide, ethambutol, cycloserine, and ethionamide.

♦ At the end of the '70s, the primary care of TB patients moved from specialized institutions to general hospitals and ambulatory care services.

♦ In around 1985, cases of TB began to rise again in industrialized countries. Several inter-related forces drove this resurgence, including increase in prison populations, homelessness, injection drug use, crowded housing and increased immigration from countries where TB continued to be endemic. Above all, the decline in TB control activities and the human immunodeficiency virus / acquired immunodeficiency syndrome (HIV/AIDS) epidemic were two major factors fueling each other in the reemergence of TB.

♦ In the early '90s, an extensive outbreak of highly resistant TB affected more than 350 patients in New York City. The strain was resistant to all first-line antituberculosis drugs and almost all patients had HIV/AIDS. The hospital environment was the setting where more than two thirds of the patients acquired and transmitted the infection. As a consequence, this outbreak affected mainly HIV infected patients and health care workers. At that time, New York City became the epicenter of drug-resistant TB, where one in three new cases were found resistant to one drug and one in five to more than one drug.

♦ Supervised treatment, including sometimes direct observation of therapy (DOT), was proposed as a means of helping patients to take their drugs regularly and complete treatment, thus achieving cure and preventing the development of drug resistance. The Directly-Observed Treatment, Short-course (DOTSC) strategy was promoted as the official policy of the WHO in 1991. World Health Organization declared TB a global health emergency in 1993. In 1998, the IUATLD joined with the WHO and other international partners to form the Stop TB Initiative, a defining moment in the re-structuring of global efforts to control TB. The original Stop TB Initiative has evolved into a broad Global Partnership, Stop TB Partnership with partners gath-

A global health emergency

Someone in the world is newly infected with TB bacilli every second.

- ▶ Overall, one-third of the world's population is currently infected with the TB bacillus.
- ▶ 5-10 % of people who are infected with TB bacilli (but who are not infected with HIV) become sick or infectious at some time during their life.
- ▶ People with HIV and TB infection are much more likely to develop TB.

World Health Organization
Fact sheet N° 104
(Revised March 2006)

ered in Working Groups to accelerate progress in seven specific areas: DOTS Expansion, TB/HIV, MDR-TB, New TB Drugs, New TB Vaccines, New TB Diagnostics, and Advocacy, Communications and Social Mobilization.

♦ The World Health Assembly of 2000 endorsed the establishment of a Global Partnership to Stop TB and the following targets:

- By 2005: 70% of people with infectious TB will be diagnosed and 85% of them cured.
- By 2015: the global burden of TB disease (deaths and prevalence) will be reduced by 50% relative to 1990 levels.
- By 2050: The global incidence of TB disease will be less than one per million population (elimination of TB as a global public health problem)

♦ In spite of these global efforts, TB continues to pose a dreadful threat. A notorious example is the sudden emergence in 2005, in a rural hospital located in Kwa-Zulu-Natal, a South African province, of a deadly form of TB associated with HIV/AIDS. This outbreak illustrates the devastating potential of what came to be called extensively drug resistant TB (XDR-TB). XDR-TB was defined as MDR-TB with further resistance to second-line drugs.

♦ Nowadays, treating TB is feasible and effective, even in low income countries, if based on reliable public health practice, including good laboratory infrastructure, appropriate treatment regimens, proper management of drug side-effects and resources to maintain adherence and prevent spread. The emergence of XDR-TB should stimulate the improvement of these basic control measures.

(*) See also www.TuberculosisTextbook.com

The Surviving Sepsis Campaign

Re-evaluating the Evidence *



Dr. Mirna Waked

Sepsis is a complex medical condition that begins with an infectious stimulus, and results in an exaggerated immune response. The inflammatory response that was initiated to fight the infection ultimately leads to damage in various organs and the syndrome known as "multiple organ failure". Details – and therapy – follow.

Our understanding of the pathophysiology of sepsis has substantially increased in the past decade^[1,2], which has led to new treatment modalities. Although, worldwide, sepsis is an increasingly common condition and consumes a large amount of healthcare resources, sepsis-related mortality has been declining over the past 20 years, perhaps from improved supportive care and better understanding of the derangements inherent to sepsis.^[3]

The development of new treatment modalities has resulted in a spate of treatment algorithms, often promulgated by medical societies and healthcare improvement organizations. One of the greatest endeavours to date is the Surviving Sepsis Campaign (SSC)^[4] that was originally launched in 2002 with the stated goal to reduce mortality by 25%. The primary method to achieve this goal was the development of evidence-based sepsis care guidelines that were published in 2004.^[5]

Fluid Resuscitation

The original SSC guidelines stipulate that fluid resuscitation should begin as early as the condition is recognized (especially in septic shock) and should

consist of approximately 20 cc/kg of isotonic crystalloid, followed by boluses of up to 1000 ml of crystalloid or 500 ml of colloid solution given over 30 minutes to achieve adequate resuscitation. The general resuscitation targets are a central venous pressure of 8-12 mm Hg, a mean

arterial pressure (MAP) of at least 65 mm Hg, urine output of at least 0.5 cc/kg/hour and a central venous oxygen level of $\geq 70\%$.^[6] These recommendations are based, in part, on the findings of the Early Goal-Directed Therapy study conducted at Henry Ford Hospital showing that early resuscitation of patients in septic shock to targeted endpoints reduced illness severity and improved survival.^[7] In that study, both crystalloids and colloids were used, and since that time, the Saline vs. Albumin Fluid Evaluation (SAFE) trial has been completed.

The SAFE trial randomized 7000 acutely ill patients requiring fluid resuscitation to receive isotonic crystalloid (normal saline) or iso-oncotic colloid (4% albumin).^[8] Overall, the study found no difference in mortality rate or the development of organ dysfunction. However, the subset of patients with

septic shock was reported to have a RR of dying of 0.87 if given albumin. Thus, it appears that fluid resuscitation with either crystalloids or colloids is equally effective with respect to mortality, although smaller differences may exist for septic shock that require further study. On the basis of these findings, it is unlikely that the fluid resuscitation recommendations for management of septic shock in the SSC guidelines will

change.

Vasopressors

The original SSC guidelines do not dictate specific vasopressor therapy, but rather focus more on the adequacy and immediacy of therapy. For patients not responding to fluid resuscitation, intravenous vasopressors should be administered to maintain tissue perfusion, with the general goal of reaching a MAP ≥ 65 mm Hg.

Norepinephrine was considered a better first-line choice because it is a more potent vasoconstrictor than phenylephrine and because of increased risk for arrhythmias with dopamine, increased risk for myocardial or splanchnic ischemia with epinephrine, and insufficient data with the use of vasopressin (AVP). Dopamine specifically, is not recommended for preservation of renal function, on the basis of the lack of efficacy data showing for this outcome.^[9]

The Vasopressin in Septic Shock Trial (VASST) was recently completed.^[10] VASST analyzed 779 patients in septic shock requiring vasopressors for at least 6 hours and having at least 1 additional dysfunctional organ system present for less than 24 hours, who were randomized to receive AVP or norepinephrine (NE). Overall there was no difference in 28-day survival between groups. However, the groups were stratified according to severity of hypotension (requiring > 15 mcg/min or

Sepsis-related mortality has been declining over the past 20 years

Evidence-based sepsis care guidelines were published in 2004

(*) This text is a compilation of highlights of the (American) Society of Critical Care Medicine, which were delivered at the 36th Critical Care Congress 2007, Orlando, Florida

< 15 mcg/min of NE at enrolment), and the patients taking lower-dose NE had improved survival with AVP. This result persisted at 90 days, when mortality was 35.8% vs. 46.1%. There were no differences in MAP, although the addition of AVP to NE predictably resulted in a reduction in NE dose. Digital ischemia was somewhat more common in the AVP group, while cardiac arrest was slightly more common in the NE group.

Another recently completed European clinical trial compared NE with epinephrine for hemodynamic support in 330 patients with septic shock.^[11] The study endpoint was mortality rate at 28 days. There were no differences in mortality rate, blood pressure, time to hemodynamic stability, duration of vasopressor therapy, or time to resolution of organ dysfunction. There were similar adverse events (i.e., cardiac and neurologic effects) associated with both drugs.^[12]

Antibiotics

There is an increasing body of literature showing that antibiotics in sepsis must be administered early and adequately. Multiple studies have documented that mortality is increased in sepsis patients whose first-prescribed antibiotic does not adequately cover the pathogen causing the sepsis.^[13,14] More recently, there is strong evidence that antibiotic therapy must be administered early in the course of sepsis, and that delays as short as 6 hours can lead to an increase in mortality.^[15] Therefore, and chosen empirically based on the suspected source of infection and local organism resistance patterns.

Corticosteroids

Perhaps one of the most controversial areas of sepsis therapy — the use of corticosteroids — has seen the most evolution of evidence in the past few years. Since the publication of the seminal Annane study^[16] in 2002, there has been continued debate about the

appropriate use of corticosteroids in septic shock.^[17] Furthermore, there continues to be debate about how to define “relative adrenal insufficiency” in critically ill patients.^[18] A landmark piece of evidence has recently emerged from the CORTICUS trial,^[19] a randomized, controlled study comparing hydrocortisone to placebo use in septic shock. This study

enrolled 500 patients over 3 years from 52 European centers before being suspended before reaching its original goal of enrolling 800 patients. There was no difference in the overall 28-day mortality rate (33% for hydrocortisone patients vs. 31% for placebo patients), although the duration of shock was shorter in patients who received corticosteroids. Although it was believed that the effect of corticosteroids would be most apparent in patients with relative adrenal insufficiency (as defined by the adrenocorticotropic hormone stimulation criteria of Annane),^[20] there was no apparent benefit for hydrocortisone replacement therapy in this subgroup. Furthermore, the incidences of hyperglycemia, nosocomial sepsis, and recurrent septic shock were higher in the hydrocortisone-treated patients.

Glycemic Control

Glycemic control in critically ill patients took center stage in 2001 with the publication of results from van den Berghe and colleagues^[21] showing improved survival and reduced nosocomial complications in surgical patients treated with intensive glycemic



control compared with more normal glucose control.

Subsequent studies have suggested that the benefit of tight glycemic control results from maintenance of normal blood glucose rather than from the administration of insulin.^[22,23] However, while some studies have suggested that tight glycemic control is cost effective,^[24] others have questioned the efficacy of tight glycemic control and the adverse effects associated with such aggressive insulin administration.^[25,26] These concerns are exacerbated by the Volume Substitution and Insulin Therapy in Severe Sepsis study and the Glucontrol study that were stopped early due to lack of efficacy and safety concerns.^[27] Finally,

van den Berghe and colleagues^[28] found less impressive results from intensive insulin therapy in medical intensive care unit (ICU) patients, where any survival benefit was only evident in patients who stayed in the ICU more than 3 days.

Drotrecogin Alfa (Activated)

Drotrecogin alfa (activated) is human activated protein C. The approval of drotrecogin alfa (activated) for treatment of patients with severe sepsis was heralded as a landmark breakthrough in a field where no specific pharmacologic therapy had been found to date.^[29] However, subsequent studies

Antibiotics should be ordered immediately upon the diagnosis of sepsis

Guidelines do not recommend routine pulmonary artery catheterization

have not documented a clear benefit in various patient populations, such as children, adults with lower severity of illness, and surgical patients with only 1 dysfunctional organ system.^[30,31] This has resulted in reduced use of a potentially efficacious drug and substantial controversy regarding its efficacy, safety and cost.^[32] The SSC may revise the evidence-based position for the use of drotrecogin alfa (activated) in treating severe sepsis, primarily focusing on potential treatment of severely ill patients where the benefit outweighs the risk, and according to local prescribing guidelines.

Hemodynamic Monitoring

A growing body of evidence supports the concept that pulmonary artery catheterization (PAC) does not improve outcomes for most groups of critically ill patients.^[33-35] Most recently, the Acute Respiratory Distress Syndrome Network reported that management of patients with acute lung injury (ALI; approximately 35% of whom were in shock) with PAC was not superior to management with a standard central venous catheter.^[36] Although routine PAC has fallen out of favour, other monitoring technologies have increased in acceptance, particularly when they provide a unique or novel advantage over old technology.^[37-39] However, no single strategy has been shown to improve outcomes in broad groups of critically ill patients. For that reason, the SSC guidelines do not recommend routine PAC.

Respiratory Support

For sepsis patients in whom ALI or acute respiratory distress syndrome develops, ventilator management now routinely utilizes low tidal volume ventilation (6 mL/kg predicted body weight) to keep plateau airway pressures < 30 cm H₂O.^[40] With the recent determination that conservative fluid balance reduces the

duration of mechanical ventilation for these patients,^[41] the standard is now also to limit fluid intake and to promote diuresis when possible.

Miscellaneous

Other recent developments in the field of sepsis include the conclusion of the LIPOS Trial 3,^[42] which failed to show benefit for an antiendotoxin emulsion in the treatment of severe sepsis, and the growing implementation of “sepsis teams,” “medical emergency

teams,” and “rapid response teams.” This latter concept provides a way to diagnose sepsis more quickly and prevent morbid complications (i.e., shock and respiratory failure) in broad groups of acutely ill patients, including those with sepsis. While their use has not yet been shown to improve outcomes in the hospital,^[43] they are increasingly familiar in the hospital landscape. Finally, increasing evidence shows the benefit of care pathways and “bundles” to improve the management of patients with sepsis.^[14, 44, 45] In general, these pathways follow the guidelines promulgated by the SSC and other groups, such as the Institute for Healthcare Improvement.

Pathways improve the management of patients with sepsis

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Mise à jour

Projet de Formation Médicale Continue

La formation continue, idée de longue date de notre Société, a démarré l'année passée, bien qu'à petite échelle. Cette année, 2008, on compte la consacrer.



Dr. Georges Khayat

La première étape (mai - juin 2007) de notre projet de formation médicale continue consistait à organiser deux évaluations anonymes des membres de notre Société, séparées par une formation intégrée au congrès de juin 2007. Ces évaluations concernaient les pneumonies communautaires, la bronchopathie chronique obstructive et la maladie thromboembolique. 19 candidats ont présenté la première évaluation et 14 candidats ont présenté la deuxième. Pour ceux ayant présenté les deux évaluations, les résultats de la deuxième étaient supérieurs (voir tableau).

Suite à cette première étape organisée par Dr. Mirna Waked et moi-même, le comité exécutif de la SLP a créé un Comité d'Éducation Médicale Continue composé des Drs Mireille Sfeir, Joseph Yammine, Mirna Waked, Salah Zeineddine et présidé par l'auteur de ces lignes. Ce comité s'est donné pour premier objectif d'organiser, au cours de l'année

2008, deux évaluations anonymes qui se tiendront en avril et en septembre et qui porteront sur les différentes recommandations internationales concernant « les pneumonies communautaires » et « la maladie asthmatique », pour avril, et « les bronchopathies chroniques obstructives » et « la maladie thromboembolique » pour septembre.

Ceux qui sont intéressés peuvent préparer ces évaluations en consultant les documents disponibles dans l'espace virtuel « Société Libanaise de Pneumologie » auquel ils peuvent se connecter de la manière suivante :

- 1- Site : <http://moodle.usj.edu.lb/>
- 2- Saisir le matricule et le mot de passe. Ceux-ci peuvent être obtenus en envoyant un courriel à la SLP : lop_lps@yahoo.com. Ils vous seront adressés dans une enveloppe cachetée de manière à préserver l'anonymat.

3- Cliquez en haut à gauche sur « Société Libanaise de Pneumologie », ce qui permet d'accéder à différents documents scientifiques en relation avec les activités de notre Société, dont plusieurs recommandations internationales sur lesquelles se baseront les évaluations de l'année 2008.

Des certificats signés par les présidents de la Société Libanaise de Pneumologie et de la Société de Pneumologie de Langue Française, et accordant des points de crédits de l'Ordre des médecins, seront remis à tous les participants au cours d'une soirée spécialement organisée pour l'occasion, en octobre 2008.

Un tirage au sort permettra à trois des participants aux deux évaluations de gagner, chacun, un lot de valeur.

% de variation de la note de chaque candidat entre la première et la deuxième évaluation / % of variation of every candidate score between the first and the second assessment

Candidats	PAC/CAP	BPCO/COPD	MTE/TED
2	+17.9%	+3.2%	+11.33%
10	-7.79%	+6.71%	+4.38%
31	+2.11%	+26.74%	+13.14%
35	+1.07%	+4.28%	+6.66%
40	+28.6%	+5.85%	+7.16%
41	+12.7%	+1.46%	+13.77%
42	+21.9%	+4.98%	+13.02%
43	+2.96%	-3.06%	+5.98%
45	+11.92%	+21.89%	-2.5%

Update

Continuing Medical Education Project

The Continuing Medical Education project, a long-lasting idea, started in 2007, though on a limited scale.

This year, 2008, we intend to pursue it further.

The first phase (May - June 2007) of our Continuing Medical Education Project was to hold two anonymous evaluations for members of our Society, separated by a learning session included in the June 2007 Conference. These assessments were related to community-acquired pneumonia, chronic obstructive pulmonary disease and thromboembolic disease. 19 candidates underwent the first evaluation and 14 candidates underwent the second. For those who presented the two evaluations, the results of the second were higher (See Table).

Following this first phase organized by Dr. Mirna Waked and myself, the Executive Committee of the LPS created a committee of Continuing Medical Education counting Drs Mireille Sfeir, Joseph Yammine, Mirna Waked, Salah Zeineddine and chaired by the under-

signed. The committee set, as a first goal, the organization, during the year 2008, of two anonymous evaluations to be held in April and September, which will focus on various international guidelines pertaining to "community acquired pneumonia" and "asthma" in April, and "chronic obstructive pulmonary disease" and "thromboembolic disease" in September.

Those who are interested can prepare these assessments by checking the documents available in the virtual space "Lebanese Pulmonary Society" to which they can connect in the following way:

- 1- Internet address: <http://moodle.usj.edu.lb/>
- 2- Enter the "matricule" (ID number) and the "mot de passe" (password). These can be obtained by sending an email to the

LPS: lop_lps@yahoo.com. They will be sent to you in a sealed envelope in order to preserve confidentiality.

3- Click on the top left on "Lebanese Pulmonary Society" page, which allows access to various scientific papers related to the activities of our Society, including several international guidelines which will be the references of the 2008 assessments.

Certificates signed by the presidents of the Lebanese Pulmonary Society and of the "Société de Pneumologie de Langue Française (SPLF)" and granting credit points from the Order of Physicians, will be given to all participants during a special gathering in October 2008.

A random draw will allow three of the participants in the two evaluations to win, each, a valuable award.

لقاء شتورة العلمي

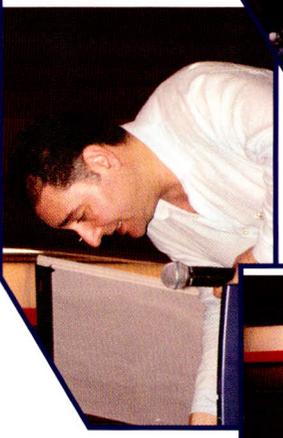
بالنشاطات الترفيهية فمنهم من ذهب الى سوق البقاع وتعرّف إلى معالمه السياحية ومنهم من قرر الإستجمام فاستفاد من مسبح الفندق وشمس أيلول المشرقة.

وعند إنتهاء المحاضرات العلمية، جُمع الحفل حول مأدبة الغذاء، في لقاء إجتماعي حافل.

وقد نظّمت الجمعية لقاءً علمياً للأطباء نُوقش خلاله موضوعا الربو والإنسداد الرئوي الزمن بعد محاضرات متخصصة ألقاها الدكتور جدي أبي صالح، موسى رياشي، نقولا معكرون، وجورج خياط.

وفي هذا الوقت تمتعت عائلات الأطباء

في ٩ أيلول ٢٠٠٧، وضمن الإجتتماعات العلمية المناظقيّة، تمّ تنظيم يوم علمي مخصص لأطباء منطقة البقاع في فندق شتورا بارك أوتيل. ضمّ ٤٣ من أطباء الأمراض الصدرية حيث قدموا مع عائلاتهم من كافة الأفضية البقاعية إضافةً إلى بقية الحافظات.



الجمعية والأطباء في اللقاء السنوي الأوروبي

طبيباً شاركوا بالمحاضرات العلمية والرحلات السياحية.

وسوف تشارك الجمعية في المؤتمر القادم، الذي سيعقد في ألمانيا - ميونيخ من ٤ وحتى ٨ أيلول ٢٠٠٨. وما لا شك فيه أنّ الجمعية اللبنانية للأمراض الصدرية حُبذ وجود أعضائها في مثل هذه المؤتمرات الطبية والتنقيفية، أملين مشاركتكم!

ألسي خوري أبو جودة

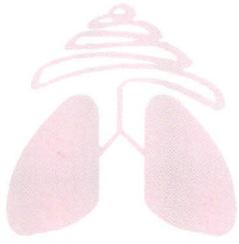
وعرّضت على شاشة كبيرة بعض الافلام السياحية عن لبنان وغيرها عن مؤتمرات الجمعية، بما جذب الأطباء كافة والعرب منهم خاصة، فاستمتعوا جميعهم بالضيافة اللبنانية من حلويات عربية وغيرها.

كما وقد لفت الجمعية حضور أطباء الصدر اللبنانيين المقربين الذين أكدوا على ضرورة التواصل العلمي المستمرّ مع الجمعية اللبنانية والمشاركة بمؤتمراتها، أمّا الحضور اللبناني الخلي فكان لافتاً بحضور حوالي ٣٠

في إطار توثيق علاقات الجمعية اللبنانية للأمراض الصدرية بالجمعيات العالنية، وكما جرت العادة، شاركت جمعيتنا بمؤتمر الجمعية الأوروبية للأمراض الصدرية (European Respiratory Society-ERS) الذي إنعقد من ١٥ ولغاية ١٩ أيلول ٢٠٠٧ في استوكهولم.

جاءت مشاركة الجمعية اللبنانية عبر منصة خاصة بها ضمن القاعة العامة، أسوة بالجمعيات الأوروبية المتخصصة، وأرتفع على المنصة علم لبنان وعلم الجمعية معا. كما





“Annual Meeting 2008

**The Annual Congress of The Lebanese Pulmonary Society 2008
The 6th Meeting of the Franco-Lebanese Society of Thoracic-
Pathology**

With the participation of

The Franco-Lebanese Association of Pulmonary

17 | 20 April 2008 Beirut - Lebanon

**Le congrès Annuel de la Société Libanaise de Pneumologie 2008
Le 6ème congrès de la Société Franco-Libanaise de Pathologie
Thoracique**

Avec la collaboration de

L'Association Franco-Libanaise de Pneumologie

Let us meet

Dear colleague. It is time, once again this year, to meet. A rich and varied program, with international & national speakers await you. So let us step away from the daily routine and controversies & meet again. See you in April 17 – 20 2008.

Bienvenue

Cher collègue, il est temps encore une fois cette année, de nous réunir. Un programme riche et varié avec des conférenciers internationaux et locaux vous attend. Eloignons nous de notre routine et polémique journalière pour nous réunir. Au plaisir de nous revoir cet Avril 17 – 20, 2008.

*Dr Wajdi Abi Saleh
President of the Lebanese Pulmonary Society*

First Announcement”

Topics

- 1 | Asthma, COPD
- 2 | Interstitial Lung Diseases
 - a | New Classification
 - b | Clinical - Radiological Correlation
 - c | Diagnostic Strategies
 - d | New Treatment Strategies
- 3 | Bronchology
- 4 | MDR - XDR - TB
- 5 | Bronchiectasis
- 6 | Lung cancer
 - a | Early Detection
 - b | Pet Scan

Thèmes

- 1 | Asthme, BPCO
- 2 | Les pathologies Interstitielles
 - a | Nouvelle Classification
 - b | Corrélation clinico-radiologico-pathologique
 - c | Stratégies diagnostiques
 - d | Nouveaux traitements
- 3 | Bronchologie
- 4 | MDR - XDR - Tuberculose
- 5 | Dilatation de bronches
- 6 | Cancer Bronchique
 - a | Détection précoce
 - b | TEP

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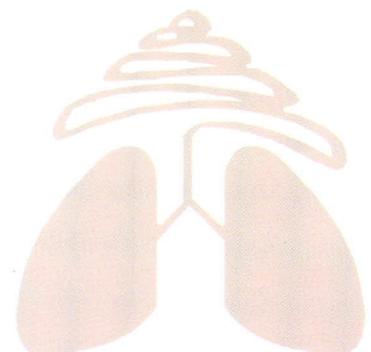
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Congrès annuel 2007

Le Bristol, 15-16 juin

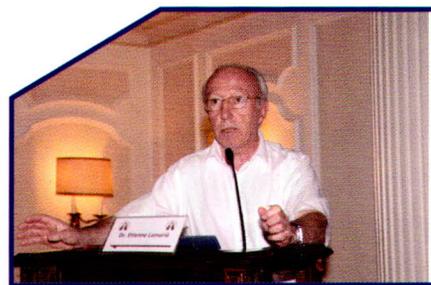
Le climat général n'était certainement pas propice à la tenue du congrès annuel au printemps 2007, entre une déflagration...et une menace d'une autre déflagration. Mais la détermination du Comité exécutif a eu le dessus et maintenu cette réunion traditionnelle. Les intervenants français étaient au rendez-vous, fidèles à leur engagement, ainsi que les compagnies pharmaceutiques qui ont décidé de se joindre à ce pari. Même l'assistance, plus nombreuse que prévue, a fait honneur à la science d'abord ... et à l'effort récréatif ensuite.



Vue d'ensemble des participants au congrès durant la pause café, face aux stands des compagnies pharmaceutiques.



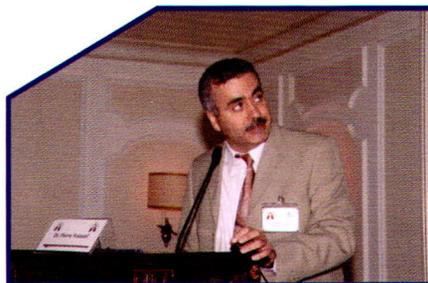
Dr. Olivier Sanchez (Hôpital Georges Pompidou, Paris), maîtrisant devant l'assistance l'expertise en maladies thromboemboliques.



Dr. Etienne Lemarié, vice-président de la Société de pneumologie de langue française, considérant « la médecine basée sur les preuves ».



Dr. Georges Dabar se penche sur la problématique de « l'épanchement pleural ».



Dr. Pierre Youssef dissèque « la chirurgie d'emphysème ».



Dr. Wajdi Abi Saleh se charge des « cas de pneumonies difficiles ».



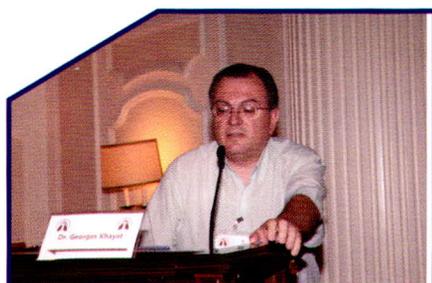
Drs. Zouheir Alameh et Mireille Sfeir modèrent l'acuité des pneumonies, au cours de la séance réservée à cette maladie.



Dr. Antoine Saadé, représentant l'OMS, est en bonne position pour donner une vue générale sur la « tuberculose multi-résistante »



Dr. Joudy Bahous, intervenant valeureux au nom du public.



Dr. Georges Khayat professe au sujet de « la formation médicale continue ».



Les pneumologues femmes, rares parmi une communauté masculine.



Dr. Etienne Lemarié avec la présidente de la SLP et son ex.



Dr. Mohamad Halimi épelle les bénéfices de la réhabilitation dans la BPCO.



Dr. Rafic Hobeiter, un des grands de la pneumologie libanaise, présent permanent dans l'assistance francophone dominante.



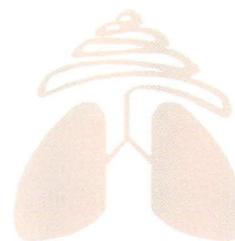
Dr. Ghassan Jamaledine, au cours de sa dernière apparition publique avant de quitter, malheureusement, le pays.



Ambiance studieuse durant cette journée arachée à la médiocrité extérieure.



En fin de journée laborieuse, tout le monde souffle et se dirige vers l'air extérieur.



Le congrès, côté récréatif

Le congrès fut clôturé par un dîner de gala au Regency Palace. Entre-temps, un nouveau Comité exécutif fut élu avec à sa tête Dr. Wajdi Abi Saleh et la participation d'une dizaine d'autres membres (voir la composition du Comité et des commissions spécialisées en page 3).



Le président Wajdi Abi Saleh avec 3 prédécesseurs à la tête de la Société de Pneumologie.



Face à la plus belle baie du monde, sous un ciel étoilé, nos invités au dîner.



Elsy Abou Jaoudé, la cheville ouvrière du congrès, assistant la présidente sortante.



Remise des diplômes aux participants à l'évaluation de la Formation médicale continue.



Délégation du Nord : Dr. Hilmi Darwiche et son épouse, Dr. Zahia Chahine.



Sammy Khayat a entraîné tout le monde dans les complications de son « Star-epidemy », une maladie incurable.



Guides allergy patients' journey to wellness

