INSPIRE

الجمعية اللبنانية للامراض الصدرية
عدد رقم ١ – حزيران ٢٠٠٦

INSPIRE

أيّها الزملاء الكرام

أحبّائي ،

إنّ مجلّة الجمعيّة تعود إليكم، بحلّة جديدة. وقد أطلقنا عليها عنواناً جديداً «INSPIRE» نسبة للشهيق في الفرنسيّة والإنكليزيّة، وأيضاً للإلهام أو التواصل الأكبر بين أعضاء الجمعيّة.

يسرّني أن أكون أوّل من يكتب الإفتتاحيّة في العدد الأوّل، و من يقدّم لكم أعضاء هيئة التحرير .

هذه المجلّة مجلّتكم، فيها من الأخبار العلميّة ما يهمّكم عن الأحدث والأكثر تداولاً من المواضيع، فيها من الانباء المتعلّقة بنشاطات الهيئات العلميّة في الجمعيّة، و أيضاً من الأخبار الإجتماعيّة التي توطد معرفتنا بعضا ببعض .

بإمكان أي منكم أن يرسل ما يكتبه الى المجلّة أكان علمياً ، إجتماعيّاً أوحتى في مجال الشعر أو النثر .

لتكن هذه المجلّة التي سوف تصدر أربع مرّات في السنة، منبرا نعبّر فيه عن آرائنا، نقدّم فيه إقتراحاتنا للتحسين، والسير قدماً نحو مستوى تحريري علمي للجمعيّة.

في زمن رديء، ضاق ذرعنا منه، لتكن هذه مساهمة منّا لاستشراف نور في آخر النفق، شمعة نضيئها بدلاً من أن نلعن الظلام .

د. ميرنا واكد

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نقابة أطباء لبنان

مكتب الجمعية اللبنانية للأمراض الصدرية

ص.ب: ١١–٦٤٠ بيروت، لبنان

تلفاكس: ٤٢٢٥٨٢ ١ ٩٦١

بريد الكتروني: lop_lps@yahoo.com

4 Annual Meeting

President, LPS: Mirna Waked

The Lebanese Pulmonary Society
Lebanese Society of Allergy and Immunology

October 7-9, 2005 - Habtoor Grand Hotel - Beirut-Lebanon

Botanical varieties at Wadi Qannoubine
Les variétés botaniques à Wadi Qannoubine
Elias Khairallah
Co-Président du Congrès

Co-Chairmen of the Congress
Co-Président du Congrès
Georges Khayat

Chest medicine through the ages
Histoire de la pneumologie au Liban
Michel Khoury & Francis Khoury

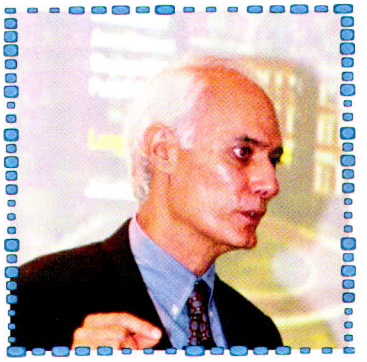
Neoadjuvant chemotherapy in non small cell lung cancer
La chimiothérapie néoadjuvente dans le traitement du cancer non à petites cellules
Jeanne Marie Brechot

Small cell lung cancer:
new therapeutic alternatives
Le Cancer à petites cellules: nouvelles modalités thérapeutiques
Taha Bazarbachi

Is there a role for surgery in small cell lung cancer?
Y'a-t-il une place pour la chirurgie dans le traitement du cancer à petites cellules?
Pierre Youssef

Brain Metastasis: new approach in 2005
Prise en charge des métastases cérébrales en 2005
Tony Rizk

SYMPOSIUM:
Pulmonary Rehabilitation
SYMPOSIUM:
Réhabilitation Pulmonaire
Bernard Douary



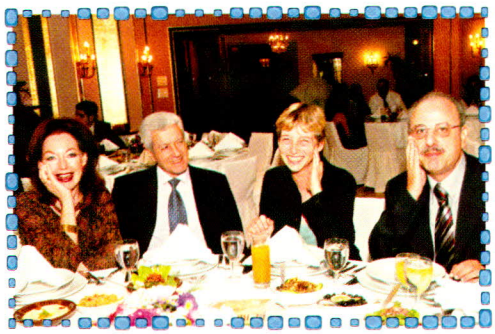
Novel therapies. Pathophysiology, natural history and diagnosis of PAH
Nouveaux traitements. Physiopathologie, histoire naturelle et diagnostic de l'HTAP
Paul Hassoun

Treating Asthma or asthmatics
Traiter l'asthme ou traiter l'asthmatique
Daniel Vervolet

Natural history and long term outcome of childhood asthma
Histoire naturelle et évolution à long terme de l'asthme de l'enfant
Fares Zeitoun

Hygiene hypothesis
Hypothèses d'hygiène
Carla Irani

Venom Hypersensitivity: Immunotherapy
Hypersensibilité au venin d'hymenoptère/Immunothérapie
Ali Hochaimy



SYMPOSIUM MSD: Asthma with allergic rhinitis: one-airway, one disease, one approach to patient care
SYMPOSIUM MSD: Asthme et rhinite allergique: une même maladie, une même prise en charge
David Price

Swallowing Disorders - Troubles de Déglutition

Pulmonary standpoint
Point de vue du pneumologue
Nadim Kanj

Gastroenterology standpoint
Point de vue de gastro-entérologue
Khalil Honein

ENT standpoint
Point de vue de l'ORL
Amine Haddad

Neurology standpoint
Point de vue du neurologue
Raja Sawaya

Therapeutic options for sarcoidosis, old and new.

Mireille Sfeir, MD

The decision to treat a patient is dependant on many factors. The most important being whether the patient is symptomatic.

*Initial systemic therapy for **symptomatic sarcoidosis** usually includes corticosteroids. Most of these patients will require months to years of therapy. Therefore alternatives to corticosteroids have been studied. These include cytotoxic drugs which work in the majority but not all patients.*

*There are **refractory sarcoidosis** patients, who have persistent disease despite high dosage of corticosteroids agents which block tumour necrosis factor (TNF) have been shown to have benefit for some of these refractory cases. With the array of available agents, the clinician can choose to use either single agent or combination to treat the individual sarcoidosis patient.*

The goal of therapy is to minimize symptoms with the lowest risk to the patient.

*Treatment options varie because, no treatment is a cure of the disease, but a mean to control symptoms. At least, 1/3 of sarcoidosis patients are **asymptomatic** and therefore never require treatment.*

I- Corticosteroids :

A - For the **asymptomatic patient** with persistent parenchymal infiltrates, the trend is not to treat with the systemic corticosteroids, because there is a concern that the institution of corticosteroids therapy may increase the likelihood of development of chronic disease.

Some studies have found that high dosages of **inhaled budenoside** but not **fluticasone** are useful in controlling pulmonary disease.

B- The use of **systemic therapy** is usually driven by symptoms. The absolute need for systemic therapy includes manifestations which are life or organ threatening: pulmonary, neurological, cardiac or hepatic. For pulmonary disease 20 to 40 mg /day, tapered progressively to less than 20 mg/day during the next six months. Cardiac or neurological diseases need higher dosages.

C- **Topical steroids** treatment appear more successful in controlling anterior uveitis and skin lesions. (The other therapy for refractory cutaneous lesions is **tacrolimus**).

II- Cytotoxic drugs :

Could take up to six month for objective evidence of effectiveness.

A **Methotrexate** -MTX- (used with **Folic acid** or **Leucoverine**, for high dosage) effective in at least 2/3 of cases, for various disease manifestations (cutanous, pulmonary, arthritic, ocular or neurological). Not to be used in patient with significant renal impairment.

a. **Acute toxicity : leucopoenia, gastrointestinal disturbances and mucosal ulcers.**

b. **Chronic toxicity : hepatotoxicity** (with cumulative dosage>1g), **pulmonary** (at anytime but more with cumulative dosage); To be noted, **Leflunamide** an analogous for MTX with less significant toxicity has been used in combination with MTX.

B- **Azathioprime** : efficacy in pulmonary, neurological and hepatic disease (less than MTX) usual dosage, 2-3 mg/Kg; **major toxicity** : leucopoenia and GI disturbances.

C- **Cyclophosphamide** : for refractory sarcoidosis (neurological). Associated with increased risk of malignancy when used for more than one year (bladder). Only intermittent IV regimen for neuro-sarcoidosis.

III- Anti-microbial agents :

A- **Anti-Malarial agents :**

Hydroxychloroquine and **Chloroquine** (overall effectiveness 50%, **Toxicity** : ocular chloro > hydroxyl chloro, Gastrointestinal) used in :

a. **cutaneous sarcoidosis**
b. **hypercalcemia** due to sarcoidosis
c. some selective cases of **neurosarcoidosis**

B- **Minocycline and doxycycline** for cutaneaous sarcoidosis

IV- Immune modulators :

Anti TNF factor

⟶ TNF as a key cytokine in chronic sarcoidosis.

1- **Pentoxifylline** : suppresses cytokine release by alveolar macrophage.

2- **Thalidomide** : cutaneous sarcoidosis : 100 - 200 mg/day ; Toxicity: peripheral neuropathy and rash, teratogenic drug.

3- **Infliximab** : refractory sarcoidosis : cutaneous, pulmonary, ocular or neurological

4- **Etanercept** : is a TNF receptor antagonist useful and ocular disease

⟶ infliximab > etanercept : increased risks for TB and similar infections ; allergic reaction and anaphylaxis an association with non-hodgkin lymphoma.

Conclusion: ***The therapy for sarcoidosis has become a matter of choosing the best agent for each patient.***

Reference: Copenhagen ERS Meeting, September 2005

IDIOPATHIC PULMONARY FIBROSIS - Therapeutic options

Zouheir Alameh M.D

Idiopathic pulmonary fibrosis (IPF) is one of the most frustrating disorders to manage, since treatment is largely ineffective[1,2]. The onset of the disease is usually indolent, but it progresses relentlessly, resulting in respiratory failure within 5 years after onset of symptoms. Median survival generally reported as 2 to 3 years from the time of diagnosis.[3]

Recognizing the lack of large, randomized trials to define optimal treatment approaches for IPF patients, the ATS/ERS suggested treatment using therapy with anti-inflammatory and immunosuppressive therapies such as corticosteroids in combination with either azathioprine or cyclophosphamide, for patients who well-informed of the risks and benefits of treatment. [4]

Summary of ATS/ERS -Suggested Treatment Options

Treatment Option	Dosing Regimen	Side Effects
Prednisone or equivalent	▪ **0.5 mg/kg** LBW/d orally for 4 wk, ▪ **0.25 mg/kg** LBW/d for 8 wk, ▪ Taper to **0.125 mg/kg** LBW/d or ▪ **0.25 mg/kg** LBW every other day. *LBW =Lean (ideal) body weight*	Peptic ulcer disease, cataracts, hypertension, endocrine and metabolic alterations, musculoskeletal complications, psychological change.
Azathioprine	▪ **2-3 mg/kg** LBW/d to a maximum (max)dose of 150 mg/d orally; ▪ **25-50 mg/d** starting dose of and increase gradually, by **25-mg** increments, every **7-14 d** until max dose is reached.	Hepatocellular injury, rash, bone marrow suppression, gastrointestinal irritation,and alopecia.
Cyclophosphamide	▪ **2 mg/kg** LBW to a max dose of **150 mg/d** orally; ▪ **25-50 mg/d** starting dose, increase gradually by **25-mg** increments every **7-14 d** until the max dose is reached.	Hemorrhagic cystitis, cancers, cardiotoxicity, bone marrow suppression, GI irritation, and alopecia

Interferon-γ-1b

The agent that has drawn most interest over the last 6 years as a potential therapy for IPF has been Interferon-γ-1b. IFN-γ-1b inhibits the proliferation of lung fibroblasts in vitro and down-regulates transforming growth factor-ß1-mediated transcription of profibrotic molecules. Transforming growth factor-ß1 has been shown to cause fibrosis in animals.[4] Clinical interest in the drug was sparked by a small pilot study[5] that purported to show that IFN-γ-1b (**200 µg**, three times per week, subcutaneously) was effective in patients with IPF who had been resistant to 3 months of therapy with high-dose glucocorticoids. The combination therapy of low-dose prednisolone and IFN-γ-1b administered to nine patients was compared to therapy with low-dose prednisolone alone in a control group of nine patients. Lung function was evaluated at baseline and after 3, 6, 9, and 12 months of treatment and appeared to be evidence of improvement in physiologic indices among patients receiving IFN-γ-1b /prednisolone relative to those receiving prednisone alone.

In a large, randomized, double-blind, multinational study[6] of IFN-γ-1b efficacy in patients with IPF who were unresponsive to corticosteroid therapy. IFN-γ-1b did not affect progression- free survival (free survival-time to death or disease progression), pulmonary function or the quality of life.

N-Acetylcysteine

Clinical use for N-Acetylcysteine (NAC) is suggested by a prospective cohort study in which reduced glutathione

(GSH) levels were restored in IPF patients with high-dose oral NAC therapy for a 12-week period.[7] NAC therapy was associated with an improvement in the combined end point of lung mechanics and oxygenation.

Pirfenidone

In a prospective, open-label study, pirfenidone was investigated in the treatment of patients with advanced and terminal stages of IPF who had failed or refused conventional therapy.[8] Lung function and diffusing capacity of carbon monoxide stabilized in the majority of patients examined 1 year after initiation of therapy, and adverse effects were relatively minor. One- and 2-year survival rates with treatment were 78% and 63%, respectively. While these findings suggest a benefit to patients with IPF, this apparent benefit may have been a survivorship effect.

In another double-blind, randomized, placebo-controlled trial, 107 patients were prospectively evaluated for efficacy of pirfenidone which improved VC and prevented
acute exacerbation of IPF during the 9 months of follow-up.[9]

Further phase III studies are either underway or planned and the publication of the NAC study together with the awaited analysis of the Infliximab (Etanercept) and Bosentan will hopefully provide further encouragement[10].

Currently, therapy for IPF most commonly consists of corticosteroids alone, an approach that clearly lacks efficacy and has a high degree of associated adverse effects. Thus, alone corticosteroid therapy should no longer be used in the treatment of IPF.

Small minorities of patients with new-onset IPF experience a marginal improvement with prednisone and azathioprine, but the vast majority continues to deteriorate.

It is hoped that the next decade will finally see significant advances in the treatment of this lethal disease.

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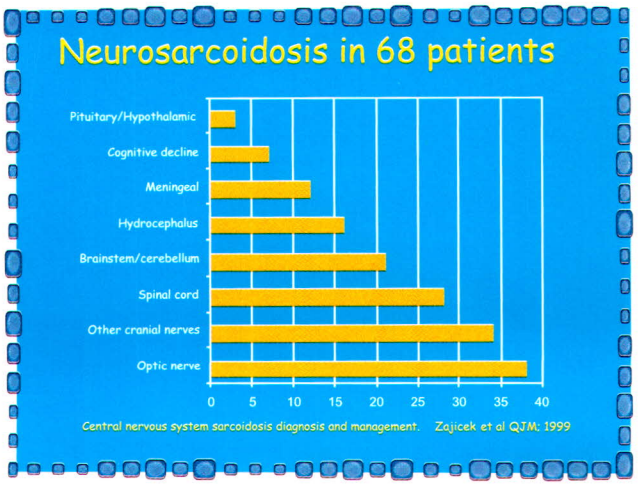
1. Hubbard R, et al. Chest 1998; 113:396-400.
2. Gay S, et al. Am J Respir Crit Care Med 1998; 157, 1063- 1072.
3. Collard, HR, et al. Am J Respir Crit Care Med 2003; 168,538-542
4. Am J Respir Crit Care Med 2000; 161,646-664.
5. Ziesche R, et al. N Engl J Med 1999; 341, 1264-1269.
6. Raghu G, et al. N Engl J Med 2004; 350,125-133.
7. Behr J, et al. Am J Respir Crit Care Med 1997; 156:1897-1901
8. Raghu G, et al. Am J Respir Crit Care Med 1999; 159:1061-1069
9. Arata Azuma, et al. Am J Respir Crit Care Med 2005; 171:1040-1047.
10. Roland M. du Bois. ERS meeting, Copenhagen 2005.

NEUROSARCOIDOSIS

Mirna Waked, M.D

- First reported in 1905 (Winkler): clinical findings are seen in about 5% of sarcoid cases. At autopsy in 15% of cases. The mean age is 44 yrs. It has a predilection for African-Americans and is more common in females.

CLINICAL FINDINGS



1-SEIZURES are the most common finding and are associated with poorer prognosis, followed by headache, encephalopathy, and hypothalamic-pituitary axis dysfunction like Diabetes insipidus and hypogonadism.

Bullmann C et al Eur J Endocrinol 2000; 142: 365-72-
Rollin p et al Int Med 2004; 43:960-6.

2- PERIPHERAL NEUROPATHY is seen in 15 - 40 %of the cases.

- Acute, chronic, or relapsing
- Mononeuritis multiplex, polyradiculopathy
- Guillain-Barré syndrome
- Symmetric polyneuropathy; sensory, motor, mixed
- Ulnar, peroneal nerves commonly involved
- Paresthesia, root pains, weakness, wasting

3-MYOPATHY IN SARCOIDOSIS is rare: 1 - 26 %, asymptomatic, with non-caseating granuloma in 25 - 75 %. Symptomatic myopathy is usually subacute with chronic nodules; localized proximally, symmetrical

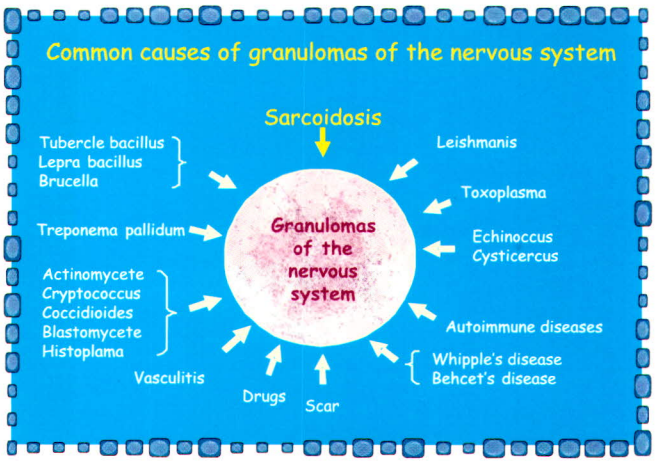
with atrophy. The female:male= 1:8; mostly menopausal. Muscle enzymes usually are normal.

Differences between myopathy caused by sarcoidosis and caused by steroids

	Steroid induced myopathy	Sarcoid myopathy
Features	Myalgia, proximal weakness	Myalgia, weakness palpable nodules, cramps
CK	Mostly normal	Sometimes elevated
Frequency	2-21% in patients receiving steroids	50% have muscle granulomas often asymptomatic
EMG	Low amplitude MUPs,	Fibrillations, positive sharp waves, Low amplitude MUPs, short latency
Biopsy	Type 2 fiber atrophy	Myositis, nodules

4-SMALL FIBER NEUROPATHY is rather common (70% in chronic sarcoidosis).
Clinical signs are: rather 'vague' symptoms, fatigue, pain, restless legs and autonomic dysfunction.

5-DIFFERENTIAL DIAGNOSIS



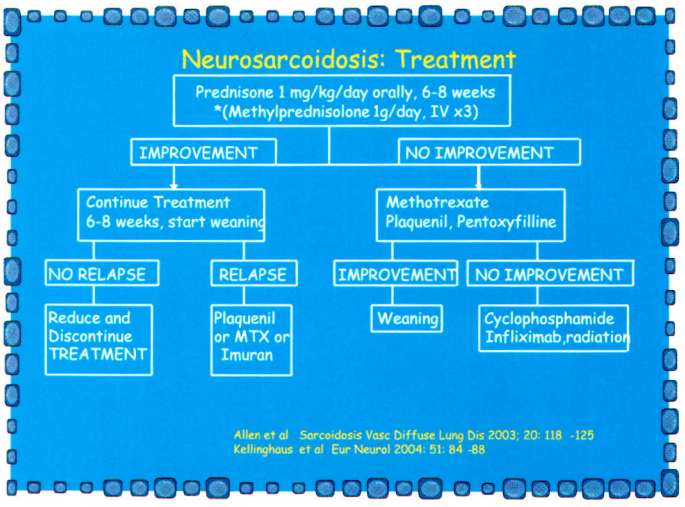
Differences between a non-specific local cerebral sarcoid-like granulomatous reaction and multisystemic sarcoidosis

Features	Local sarcoid reaction	Multisystem sarcoidosis
Organ involvement	Usually one	More than one
Age, years	Any	20-50
Chest radiograph	Normal	Abnormal in 90%
Kveim-Silzbach test	Negative	Positive >75%
Elevated serum ACE	<5%	>60%
BAL lymphocytosis	Absent	Present
Silt lamp examination	Normal	Positive 15-20%
Hypercalcemia	Absent	Present in 13%
Gallium scan	Localized uptake	Multisystem uptake

Willian JW. Proc Roy Soc Med 1967;60:38
Davis et al Eur Neurol 1991;31:229

SUMMARY

- Sarcoidosis may affect any part of CNS
- Clinical heterogeneity makes the diagnosis difficult
- Peripheral neuropathy including SFN most common
- Peripheral neuropathy, seizures: poor prognosis
- Limited CNS sarcoidosis is a difficult diagnosis
- BAL, ACE, Gallium 67, VEP, EMG: limited value
- CT and MRI: helpful
- Histological confirmation: essential, but difficult
- Corticosteroids, MTX, hydroxychloroquine, anti-TNF-α



FINAL CONCLUSIONS

As sarcoidosis is a multisystemic disease with an unpredictable clinical presentation a multidisciplinary approach and patient management are mandatory.

REFERENCES

Marjolein Drent, Sarcoidosis Management Team University Hospital Maastricht, the Netherlands 15th ERS Annual Congress 2005. Copenhagen, Denmark. September 18th 2005.

10 Activities of the COPD Board: 2004 - 2005

The COPD board launched a COPD awareness campaign on September 2004, which includes **six actions:**

- First: a ***spirometry testing campaign*** was organized during with period the support of Red Cross in the following Lebanese regions, as seen in Table 1 & 2: Mobile Spirometry Testing

- Second: a ***spirometry questionnaire*** was partly filled by Hotline operator as callers called to schedule an appointment for spirometry testing (Hotline on 03-932133).

- Third: ***leaflets and posters*** having a theme about "COPD is not Asthma," were distributed in all Lebanese hospitals beginning on World COPD Day in November 16, 2005 and lasted for three days in: Downtown, Verdun, Hamra, Sassine, Mar Elias, Tripoli, Saida, and nationwide hospitals.
  Leaflets and posters distributed to the participants during the Beirut Marathon in october 2005.

- Fourth: many ***public conferences*** given by doctors' members of COPD board with the collaboration of WHO were held in different Lebanese regions for increasing awareness about COPD by explaining meaning of the disease, its clinical manifestations and its evolution with and without treatment; see Table 3 for more details on regions, dates of conferences and number of participants.

-Fifth: a press conference focusing on previous results of 2004 spirometry testing and initiating the launching of 2005 campaign was held by all members of the COPD board in November 15, 2005. Journalists were offered free spirometry testing. This press conference was followed by media interviews with members of COPD board for supporting the awareness campaign. Members of COPD board were interviewed in 9 TV channels, 7 Radio stations and 35 printed News Papper & Magazines.

-Sixth: one full day medical conference was held on october 19, 2005 and was attunded by more than 70 primary care physicians from all over Lebanon. It outlined key facts on Chronic Obstructive Pulmonary Disease (COPD), a disease that continues to be under-diagnosed in Lebanon and around the globe while the WHO already classifies it as the world's fourth leading cause of death. Dr. David Price, Professor of Primary Care Respiratory Medicine at the University of Aberdeen in Scotland, and Dr. Daryl Freeman, General Practitioner in Norfolk, United Kingdom, both global authorities on COPD, came to Lebanon to present the latest findings on the disease at the invitation of the Lebanese Pulmonary Society (LPS), its COPD Board task force, and pharmaceutical company Boehringer Ingelheim. "Primary care physicians are often at the forefront of diagnosing all diseases, and tend to be the first to encounter COPD among their patients," said Dr. Mirna Waked, LPS President. "Most doctors in Lebanon and around the world however still confuse COPD with other ailments, especially asthma, since both have similar characteristics."

Table 1: Mobile Spirometry Testing

REGION	FUNCTION	# of pt tested	DATE
MERSACO	free test	221	2004
Chekka	public lecture	26	23/01/05
Bekaata/Chouf	Red Cross	46	01/03/05
Tarik Al Jadida	Red Cross	17	02/03/05
Jounieh	Mar Maroun Church	95	11/03/05
MERSACO	free test	20	21/03/05
MERSACO	free test	19	31/03/05
Jounieh	Red Cross	35	04/04/05
Jbeil	Red Cross	36	07/04/05
Jezzine	Red Cross	40	09/04/05
Tripoli	Red Cross	21	11/04/05
Antelias	Red Cross	44	14/04/05
Saida+Tyr	Red Cross	34	16/04/05
Jounieh	Saint Coeur School	66	20/04/05
Jounieh	St. Georges Church (pub.lect.)	53	21/04/05
Jounieh	Saint Coeur School	45	25/04/05
MERSACO	free test	31	16/05/05

Table 2: Mobile Spirometry Testing (cont)

HDF	No Smoking Day	125	31/05/05
MERSACO	free test	21	02/06/05
Jezzine	Red Cross	36	13/08/05
Zahle	Red Cross	39	13/09/05
Baalbeck	Red Cross	118	15/09/05
Tarik Al Jadida	Al Inaya Bil Oum wal Toufoul	22	27/09/05
Jounieh	Red Cross		06/10/05
Furn El Chebak	Red Cross	54	10/10/05
Bauchrieh	Red Cross		11/10/05
Jal El Dib	Red Cross		12/10/05
Chiah	Red Cross		14/10/05
Furn El Chebak	Red Cross		25/10/05
Sassine	Red Cross		26/10/05
Jal El Dib	Red Cross		02/11/05
Total		1264	

Table 3: COPD Public Lectures, in collaboration with WHO in 2004-05

Region	Date	#persons tested
Red Cross, Tyre	2-Jun-04	
Zgharta, Order of Malta	22-Jun-04	
Zahle	26-Aug-04	63
Makassed	12-Oct-04	32
Chekka dispensary	23-Jan-05	26
Sacre Coeur School	20-Apr-05	66
St. Georges Church	21-Apr-05	53

يقع **الموعد السنوي للمؤتمر الأوروبي للأمراض الصدريّة في ميونيخ في ألمانيا** من ٢ لغاية ٦ أيلول ٢٠٠٦ .

كانت تجربة السنة الماضية ناجحة جداً بما يختصّ بـ Stand الجمعيّة اللبنانيّة للأمراض الصدريّة في قلب قاعة العرض في كوبنهاغن . نأمل بتطوير هذا الوجود سنة ٢٠٠٦ وندعوكم الى هذا المؤتمر.

الى اللقاء، في **ميونيخ** .

Projet de Formation Médicale Continue de la Société Libanaise de Pneumologie

C.M.E Project of the Lebanese Pulmonary Society

1ère étape : Evaluation anonyme des connaissances des membres de la société

1st step: an anonymous assessment of the knowledge of the LPS members.

For any information /Pour toute information :

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حدّدت لجنة ال **Sleep Apnea** ٣ أهداف لها وهي:

١- حملة توعية تتوجّه الى المواطن والطبيب للتعرّف إلى هذا المرض.

٢- الإعتراف بـــــال Sleep Medicine كإختصاص فرعيّ للأمراض الصدريّة من قبل وزارة الصحّة ونقابة الأطباء والهيئات الضّامنة.

٣- مراقبة الجودة في الفحوصات والعلاجات التي تقدّم في مراكزعديدة في لبنان.

تنظم **لجنة مكافحة التدخين في الجمعيّة اللبنانيّة للأمراض الصدرية**، بمشاركة لجنة الصّحة في أندية الـLion'sوبرعاية وزارة الصحّة ومنظّمة الصحّة العالميّة، ندوة بمناسبة اليوم العالمي للإقلاع عن التدخين .

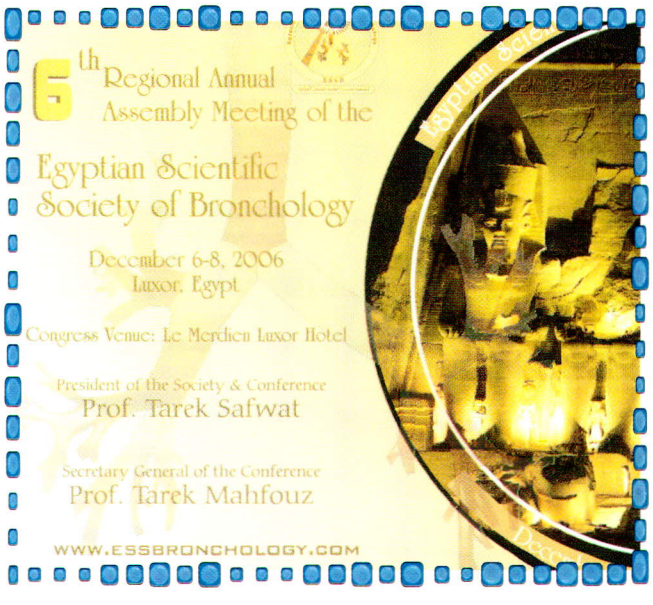
تقام الندوة في نقابة الأطباء بيروت ، قاعة المحاضرات الكبرى وذلك نهار الأربعاء الواقع في ٣١ أيّار ٢٠٠٦ من تمام الساعة الخامسة بعد الظهر وحتى الساعة السادسة والنصف مساءً .

تتمحور الندوة حول : آفات التدخين وسبل مكافحته.

L'Union Méditerranéenne de Pathologie Thoracique (UMPT) qui regroupe les sociétés nationales pneumologiques des pays du pourtour méditerranéen, dont la Société Libanaise de Pneumologie, organise son 5ème congrès à Montpellier du 22 au 24 juin 2006.

Vous pouvez obtenir plus de détails et vous inscrire à ce congrès parrainé par l'ERS et la SPLF en vous connectant au site suivant:

http://www.remcomp.fr/asmanet/umpt2006-congress-pathologie-thoracique.html



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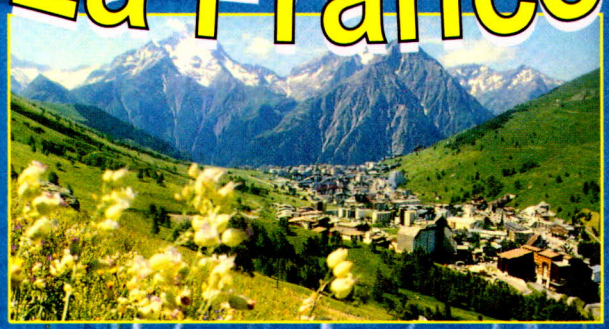

Possibilité de Credit de 6 à 12 mois

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