

MEETINGS CALENDAR

2007

> January 18–21 – Arizona – USA

Sleep Medicine 2007: The American College of Chest Physicians

Information: ACCP Customer Relations.
Tel: 800 3432227;
E-mail: accp@chestnet.org

> January 22–26 – Leicester – UK

Postgraduate Course in Respiratory Physiology - Respiratory Function and its Application to Clinical Practice

Chair: A. Wardlaw.

Information: X. Whitfield-Grace, University of Leicester, University Road, Leicester, LE1 7RH, UK.
Tel: 44 1162522522; Fax: 44 1162522200;
E-mail: wwl@le.ac.uk;
Internet: www.le.ac.uk

> February 16–18 – Orlando – USA

13th Annual Advances in Diagnosis and Treatment of Sleep Apnoea and Snoring

Information: B. Rosen, University of Pennsylvania Health System, Dept of Otorhinolaryngology, 5 Ravdin, 3400 Spruce Street, Philadelphia, PA 19104, USA.

Tel: 215 6622137; Fax: 215 6624515;
E-mail: bonnie-rosen@uphs.upenn.edu;
Internet: www.uphs.upenn.edu/pennorl

> February 23–24 – Milan – Italy

2nd International Meeting "Rare Pulmonary Diseases and Orphan Drugs in Respiratory Medicine (RIPID)" on "Old and New Targets for Therapies in Diffuse Lung Diseases"

Chair: S. Harari.

Information: F. Rovelli.
Tel: 39 02089053524; Fax: 39 02201395;
E-mail: francesca@victoryproject.it

> March 2–3 – London – UK

Clinical Consensus on COPD

Chair: P. Calverley.

Topics: COPD: burden of disease; Therapeutic approaches; Exacerbations; Extrapulmonary

manifestations.

Information: C. Carey, Conference Manager.
Tel: 44 2089107933;
E-mail: charlotte.carey@reedexpo.co.uk;
Internet: www.clinical-consensus-copd.com

> March 23–25 – Sicily – Italy

Fifth ERS Lung Science Conference

"Hypoxia in Lung Biology and Disease"

Topics: Hypoxia-dependent gene regulation; Chronic lung vascular remodelling in hypoxia; Hypoxia-driven angiogenesis; Hypoxia in lung development and alveolar remodelling; Hot topic session.

Information: European Respiratory Society, 4, Ave Sainte-Luce, CH-1003, Switzerland.
Tel: 41 212130101; Fax: 41 212130100;
E-mail: info@ersnet.org;
Internet: www.ersnet.org/lsc

> March 26–30 – Edinburgh – UK

Sleep Medicine Course

Information: R.L. Riha, Dept of Sleep Medicine, Royal Infirmary Edinburgh, 51 Little France Crescent, Little France, EH16 4SA, Edinburgh, Scotland.
E-mail: rriha1@staffmail.ed.ac.uk;
Internet: www.show.scot.nhs.uk/sleep

> May 18–23 – San Francisco – USA

International Conference: American Thoracic Society 2007

Topics: Respiratory disease; Basic and clinical science; Epidemiology and social; Biobehavioural; Psychosocial; Education aspects.

Information: 61 Broadway, New York, NY 10006-2755, USA.
Tel: 212 3158600; Fax: 212 3158653;
E-mail: ats2007@thoracic.org;
Internet: www.thoracic.org

> June 2–9 – Hamburg via Dresden to Prague

Surfactant Congress 2007. International Floating Congress

Chair: B. Lachmann.

Information: L. Visser-Isles, Dept of Anesthesiology, Erasmus Medical Center Rotterdam, Postbox 1738, 3000 DR, Rotterdam, The Netherlands.
Fax: 31 104089450;
E-mail: b.lachmann@erasmusmc.nl

> June 16–20 – Tours – France

International Society for Aerosols in Medicine 16th International Congress

President: P. Diot

Information: Internet: www.isam.org

> June 22–25 – Istanbul – Turkey

World Asthma Meeting

WAM'2007 Istanbul

Chair: E. Dagli.

Topics: Epidemiology; Middle-low income countries; Pathogenesis; Clinics and management.

Information: Figur Congress Organization Services, Ayazmaderesi Cad. Karadut Sok. No. 7, 34394 Dikilitas, Istanbul, Turkey.

Tel: 90 2122586020; Fax: 90 2122586078;

E-mail: wam2007@figur.et;

Internet: wam2007.org

> September 15–19 – Stockholm – Sweden

ERS 17th Annual Congress

Information: European Respiratory Society, 4 Ave Sainte-Luce, CH-1003, Lausanne, Switzerland.

Tel: 41 212130101; Fax: 41 212130100;

E-mail: info@ersnet.org;

Internet: www.ersnet.org

Instructions to authors

Breathe – Continuing Medical Education for Respiratory Professionals, an official educational journal from the European Respiratory Society (ERS) and the ERS School, publishes four issues per year. *Breathe* provides up-to-date information on topics of interest for pneumologists, general practitioners and allied health professionals in their daily practice. Articles published in *Breathe* will focus on introducing basic concepts and state-of-the-art methods, rather than on reporting scientific work in progress, and will share educational information and offer readers the opportunity to have access to expert advice and views on selected topics.

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Submission

All manuscripts must be submitted to breathe@ersj.org.uk in word format.

Before submitting a manuscript, please read and carefully follow the instructions below. A more detailed list of house rules for *Breathe* and examples of all the articles and important points for consideration can be found at www.breathe-cme.org.

Format of articles

The format of articles to be published in *Breathe* will be different than that of

“traditional” peer-reviewed scientific journals. It is critical that all material be understandable by the target audience (pneumologists in private practice, general practitioners, allied health professionals).

Categories of articles

1. Review/Clinical update articles

Max. length of text: 5,000 words (~10 printed pages); references, figures and tables excluded.

Authors need to supply enough images to illustrate each article, at least one per printed page. References should be limited as much as possible.

For each article, authors should define clear educational aims (2–3 aims per article). Authors should identify the long-term aims for the readers and short-term aims of their articles.

Summaries or abstracts need to be short, less than 100 words, and it should refer to the educational aims of the article. Authors might wish to raise questions in

summaries or abstracts.

Key points should be indicated in highlighted boxes, to emphasise the essential points that readers should remember after having read an article.

Authors can include a personal statement, or ask one of their colleagues to do so. This could be particularly important in areas of controversy. Personal statements may also be used as a stylistic tool to express a different view than the one in the main article.

Authors should encourage readers to look for additional articles (2–5 further reading references should be provided for each article). A commentary of 2–3 sentences should accompany each reference.

Authors can also include links to non-commercial websites that they wish to recommend. A commentary of 2–3 sentences on the information provided by the site cited in reference should also be provided.

Some of the words used in an article might need clarification or a definition. A total of 5–10 words can be highlighted within each article and explained in more detail in a separate Glossary box.



REVIEW

The ERS evaluates the educational activity for a member of the ERS. For more information on how to contribute, see page 100. The results are available on the ERS website.

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Pulmonary arterial hypertension

Educational aims

- 1 To improve awareness of PHA.
- 2 To describe the novel classification of PHA.
- 3 To provide information regarding the therapeutic approach of PHA.

Summary

Pulmonary arterial hypertension (PAH) is a rare condition characterised by elevated pulmonary arterial resistance, leading to right heart failure. PHA can be sporadic (idiopathic or PAH), familial or related to other conditions. Echocardiography is the investigation of choice for non-invasive screening. Measurement of haemodynamic parameters during right heart catheterisation (RHC) is mandatory to establish the diagnosis. Recent advances in the management of PHA include prostaglandins, endothelin-receptor antagonists and PDE5 inhibitors. Lung transplantation is the last option for patients who deteriorate despite medical treatment. This review aims to update the reader on all these aspects of PHA.

Glossary

PHA is a disease of the small pulmonary arteries, characterised by vascular proliferation and remodeling [1, 2]. It results in a progressive increase in pulmonary vascular resistance (PVR) and, ultimately, right ventricular failure and death. PHA is defined by RHC showing a pre-capillary pulmonary hypertension (PH) (mean pulmonary arterial pressure (MAP) >25 mmHg at rest or >30 mmHg during exercise, with a normal pulmonary artery wedge pressure (PAWP) <15 mmHg) [1]. The current clinical classification of PHA comprises apparently heterogeneous conditions that share compatible clinical and haemodynamic features and virtually identical pathological changes of the lung microcirculation [1, 2]. PHA includes the idiopathic (IPH), formerly termed “primary pulmonary hypertension” and familial forms (FPHA), and is associated with various conditions, such as scleroderma and other connective tissue diseases, congenital heart defects with systemic to pulmonary shunts, portal hypertension, HIV infection, exposure to drugs and toxins, and other more rare settings (e.g. thyroid disorders, glycogen storage disease, Cushing’s disease, hereditary haemorrhagic telangiectasia, haemoglobinopathies, myeloproliferative

Key points

- 1 PHA is defined by RHC, showing a pre-capillary PH.
- 2 Clinical suspicion of PH should arise in the case of symptoms such as dyspnoea and/or chest pain, without overt signs of specific heart or lung disease.
- 3 RHC is required to confirm the diagnosis of PHA, to assess the severity of the haemodynamic impairment and to test the reversibility of the pulmonary circulation.
- 4 Variables that have been shown to predict prognosis in PH include baseline NYct, functional classification, history of right heart failure, baseline 6-minute walk distance, and baseline haemodynamics.
- 5 RHC categorises PH as an isolated dominant PHA, isolated PHA with associated systemic hypertension, or combined PHA with associated systemic hypertension. Combined PHA/SH has been detected in at least 50% of the families studied to date, as well as in cases of isolated PHA.
- 6 Basic PHA therapy includes oxygen, diuretics and warfarin.
- 7 Chronic treatment with oral CCBs should be considered for PHA patients who respond to acute vasodilator challenge.
- 8 Cohort analysis of PHA patients receiving continuous intravenous epoprostenol, as compared to historical control groups, clearly demonstrated clinical benefits in NYct, functional class II and IV patients.
- 9 Two double-blind, randomised, placebo-controlled trials have supported the efficacy of oral bosentan in patients with PHA class II.
- 10 Two double-blind, randomised, placebo-controlled trials have supported the efficacy of oral sildenafil in patients with symptomatic PHA.
- 11 Lung transplantation is the ultimate alternative for severe PHA cases who cannot be managed medically.

Useful web links

The Grace Initiative

www.grace-lrti.org

This European Network of Excellence aims to integrate and coordinate the activities of physicians and scientists from many institutions in 14 European countries to combat antibiotic resistance in community-acquired lower respiratory tract infections. The educational part of the project, jointly run by the European Respiratory Society and European Society of Clinical Microbiology and Infectious Diseases (ESCMID), includes learning material developed through this initiative.



Disease Outbreaks

www.who.int/wer

The Weekly Epidemiological Record (WER) serves as an instrument for the rapid dissemination of epidemiological information on cases and outbreaks of communicable diseases, including emerging or re-emerging infections. A new report is posted each Friday.



Information for European patients

www.european-lung-foundation.org

Now available in four languages (English, German, French and Spanish), the European Lung Foundation (ELF) website provides information to European patients about lung health and diseases. Let your patients know about these resources and the ELF activities.



EU Reports

www.ec.europa.eu/health

The official website of DG Health and Consumer Protection provides access to European Union Health reports and main documents. A section of the site is dedicated to information about health status indicators collected within the European Community Health Indicators (ECHI) project, including data on lung cancer.



Next Issue March 2007

future review titles in *Breathe* include

- > Ireland's workplace smoking ban
- > Causes and management of exacerbations of COPD
- > Asthma and pregnancy

And...

- > Case presentations
- > Hot topics
- > Educational activities



Breathe is also available online at www.breathe-cme.org

Access the online version and discover additional educational material from the ERS School.

Please feel free to send your comments, suggestions and questions to breathe@ersj.org.uk

ERRATUM

Loddenkemper R, Severin T, Eiselé J-L, *et al.* HERMES: a European Core Syllabus in Respiratory Medicine. *Breathe* 2006; 3: 59-69.

Unfortunately, references 22-24 were not included in the reference list. These are as follows:

22. Goodman CM. The Delphi technique: a critique. *J Adv Nurs* 1987; 12: 729-734.
23. Powell C. The Delphi technique: myths and realities. *J Adv Nurs* 2003; 41: 376-382.
24. Walker AM, Selfe J. The Delphi method: a useful tool for the allied health researcher. *Br J Ther Rehabil* 1996; 3: 677-681.

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1. Read the articles upon which the module is based. You may also read the article online.
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3. Answer the multiple-choice and/or true-false questions.
4. Submit the CME form either by fax or by e-mail (online form).
5. CME credits will be awarded for successful completion of a test with a grade of 70% or higher.

CME Exam and Evaluation

(2 CME credits)

To receive CME credits, read the 2 CME articles in this issue, indicate the correct responses and complete the requested information below. The form is also available in electronic format at www.breathe-cme.org. To return the form, you can either:

- > use this form and return it completed by FAX to +41 212130103
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2. Please evaluate *Breathe* by circling/underlining your response.

How would you rate the different sections of *Breathe*:

	Excellent	Good	Fair	Poor
Review articles	4	3	2	1
Case presentations	4	3	2	1
Hot topics	4	3	2	1
Editorials	4	3	2	1

Amount of time I spent reading *Breathe*: ... hour(s)

How would you rate the following:

	Excellent	Good	Fair	Poor
Value of the topics	4	3	2	1
Relevance to practice	4	3	2	1
Scientific quality	4	3	2	1
Meet educational needs	4	3	2	1
Quality of information	4	3	2	1
Impact on practice	4	3	2	1
Absence of industry bias	4	3	2	1

3. Educational questions. Answer by marking the correct answer.

1. Which of the following is the ATS definition of refractory asthma based on: The presence of airway remodelling. The occurrence of at least three respiratory infections per year. The amount of anti-asthma medication required. The degree of airway hyper-responsiveness. All of the above.
2. Which of the following clinical phenotypes of severe asthma is rare: Aspirin-sensitive asthma. Brittle asthma type II. Asthma with frequent exacerbations. Steroid-dependent asthma. Asthma with chronic persistent airflow limitation.
3. Which of the following factors is not a known risk factor for a (near-) fatal asthma attack: Lower socio-economic status. Depression. Illicit drug abuse. Genetic predisposition. Emergency visits for asthma in the past year.
4. Telecare, telemonitoring and telemedicine programmes will change: Modality of hospital access. Relationships between healthcare teams. Methods of drug prescription. All of the previous. None of the previous.
5. Telemedicine has to be considered as: A new mandatory alternative to hospital admission. A new supplement care instrument to use alongside conventional systems.
6. Scientific evidence has demonstrated the superiority of telemedicine versus standard follow up models. True. False.