Editorial: Endobronchial Treatment of Benign Airway Obstruction

Waël C. Hanna, MDCM, MBA, FRCSC, Assistant Professor, McMaster University

Waël C. Hanna
Dr. Hanna is a Thoracic Surgeon at McMaster University. His personal interests include tennis, skiing and eunology.

In this issue of the journal, Drs. Kyskan and Amjadi present an excellent review of endoscopic techniques for the treatment of benign airway tumors. The authors successfully highlight three very important points to carry home. First, and perhaps most importantly, benign lesions of the airway should be treated in a multi-disciplinary fashion. Unlike patients with malignant airway obstruction, patients with benign airway lesions are expected to live a long time (1). As such, the proposed treatment should not only be effective, but also be durable and provide good quality of life. Surgery has been the mainstay of treatment for these conditions, as it is associated with the best long-term outcomes (2). Exceptions to this rule are some particular benign airway tumors that can be successfully treated with disease-specific endoscopic therapy (3). Fibroadenomas, which extend from a small stalk of mucosa can be resected with snare electrocautery via a flexible bronchoscope. Amyloid tumors are first treated with laser debulking, followed by brachytherapy in refractory cases. Airway papillomatosis is most safely treated with cryotherapy, which has the lowest risk of tumor vaporization (3). The importance of a careful and multi-discipline approach cannot be overemphasized in these conditions.
Second, endoscopic treatment is usually a multi-step approach, requiring repeat endoscopy and intervention. Web stenoses, such as those encountered in granulomatous disease, are particularly resistant to endoscopic therapy because of extensive fibrosis. Simple dilatation, via a rigid scope or pneumatic balloon, has a very high recurrence rate. Better results are obtained when the scar tissue is incised with an electrosurgical knife prior to dilatation, allowing for sustained airway patency (4). Unfortunately, stricture recurrence after dilatation is seen in almost all cases, even when adjunct treatments such as mitomycin C, argon coagulation, or laser surgery are used (5).

Third, although stents are attractive options for regaining airway patency, they are associated with many problems that the patient should be cautioned about (6). Metallic stents should be avoided because they stimulate tissue ingrowth and erode through the airway with time (7). Silicone stents and other hybrid (metallic covered) stents are easy to remove but have a higher rate of displacement in the airway (8). For carinal lesions, Ystents have been associated with the best results, but are notoriously difficult to place.

It is important to note that, due to the absence of prospective trials, all evidence for the use of the aforementioned techniques is derived from case series and retrospective reviews. The success of these interventions is largely dependent on the personal experience of the endoscopist and their team. The future of airway disease will likely be drastically different in the next decade. With advances in tracheal transplantation and prosthetic airway reconstruction (9), surgery will become possible for airway lesions that are now considered inoperable. In the meantime, the rapid advancement in endobronchial technology will continue to improve the outcomes of patients with benign airway disease.

REFERENCES:

Feature Article: Flexible bronchoscopy intervention for nonmalignant tracheobronchial obstruction

Robert Kyskan, MDCM, and Kayvan Amjadi, MD, FRCPC

Dr. Robert Kyskan
Dr. Kyskan is a Respirologist for the Fraser Health Authority in British Columbia. He has completed an Interventional Pulmonology Fellowship at the University of Ottawa. He enjoys basketball, running, hiking, golfing, skiing and cooking.

Dr. Kayvan Amjadi
Dr. Amjadi is an Assistant Professor of Medicine and the Director of Interventional Pulmonology at the University of Ottawa. His research interests include endoscopic assessments of thoracic malignancies. In his spare time he enjoys spending time with his wife and daughters, running, skiing, and a glass of Brunello

Obstruction of the central airways (trachea and mainstem bronchi) have been linked to a wide variety of disease processes. Although a significant proportion of these patients have obstruction related to malignancy, a number of nonmalignant processes can result in significant morbidity and mortality. In many cases, patients can be
misdiagnosed as refractory obstructive lung disease prior to recognition and treatment.

The tracheal diameter is typically up to 22mm in males and 18mm in females. The trachea will often be significantly narrowed to less than 8mm before exertional dyspnea becomes apparent and less than 5mm for stridor or symptoms at rest to be present (1). At that point there is very little reserve present should there be any increase in secretions or edema. Certain features such as persistent unilateral wheeze or blunting of the flow-volume loop may also not be present until later in the disease process.

There is a relative paucity of data regarding optimal management of this patient population. This stems in part from the inability to compare different pathological processes or anatomic locations of disease. A number of patients will present acutely in respiratory distress, while others will experience more gradual onset and progression of symptoms. Additionally, many different therapeutic options are available and the choice of modality can sometimes be the result of expertise or equipment available at an institution. In an unstable patient, securing the airway is of primary importance and may necessitate endotracheal intubation or urgent tracheotomy.

Traditionally, surgical resection of the stenotic region has been the mainstay of treatment with clinically significant improvement in 90% of patients (2, 3). However, surgery is often not definitive, and approximately 10% of patients develop recurrence. Surgical complications are reported to be in the range of 8 – 12%, with a mortality rate of 5% (4, 5). Furthermore, many patients are unable to undergo surgery due to their comorbidities.

Endoscopic modalities can now be safely and efficiently used as first line therapy for patients with airway stenosis. This review will focus on the use of these modalities mainly in patients with relatively stable disease and discuss their role in management of nonmalignant airway obstruction as well as our experience with management of such conditions at The Ottawa Hospital (TOH).

Etiology

While malignancy is typically the more commonly assessed cause of airway obstruction, there are a wide array of non-malignant conditions that can result in central airway obstruction. Benign airway stenosis is generally caused by an inciting injury to the tracheal or bronchial mucosa that results in abnormal re-epithelialization and ultimate replacement of normal airway mucosa by fibrous tissue. The most common cause is iatrogenic injury resulting in focal lesions may be more likely to represent granulation tissue from prior insult.

Some of the more common causes of benign airway stenosis are briefly described below.

Postintubation & Post-tracheostomy Tracheal stenosis

Since its first description in 1880 (7) there have been several publications highlighting postintubation tracheal stenosis (PITS) and post-tracheostomy stenosis (PTS) as serious complications related to insertion of a central airway prosthesis.

Although the reported rate of PITS can vary from 0.6 – 21% of intubated patients, only a minority (1 – 2%) will present with symptoms. Stenosis generally develops in stages, beginning with mucosal ulceration secondary to diminished blood flow at the inflated cuff level of endotracheal tube (ETT). This results in exposure of the underlying cartilage and development of perichondritis. This is followed by development of granulation tissue and ultimate deposition of more rigid fibrotic tissue. In more extreme cases, the changes may result in complete destruction of the cartilage and loss of airway integrity (8).

PTS generally follows the same sequence of events outlined above and affects area of stoma where the tracheostomy tube curves downwards. Granulation tissue formation above the level of the tube is also seen, often leading to deposition of stiff fibrotic material. Presence of localized infection (mucositis or tracheitis) may contribute to the development of stenosis (9). Reported rate for PTS is also quite variable. One study involving 100 patients reported that tracheal stenosis developed in 31% of patients, but only 20% of these patients were symptomatic (10). Another study involving 214 patients reported symptomatic tracheal stenosis in 8 (3.7%) patients (11).

Idiopathic Tracheal Stenosis

Idiopathic tracheal stenosis (ITS) is thought to be an inflammatory process of unknown etiology characterized by “whorl-like”, circumferential, fibrous stenosis of the subglottic region. The diagnosis is one of exclusion and is therefore applied once all other potential etiologies have
been ruled out. Since the region of stenosis is similar to PITS, careful attention to patient’s surgical history is prudent. Generally ITS affects women in their 3rd to 5th decade of life. They often present with some combination of progressive dyspnea, wheezing, or stridor. Furthermore, patients often report having had these symptoms for many months or even years prior to their presentation. It is not uncommon for patients to be misdiagnosed as having difficult-to-treat asthma or COPD (12). A multicenter study involving 23 symptomatic patients with ITS who were treated endoscopically revealed that 96% of patients were women with an average age of 45 +/- 16 years. The lag time between patients’ onset of symptoms and diagnosis was 19 +/- 18 months (13).

**Classification of Benign Central Airway Stenosis**

There are several classification systems currently available for assessing severity, length, location and endoscopic appearance of the stenotic airway. They have been generated to improve communication between physicians involved in the care of these patients and to help develop specific definitions that can be applied in research settings aimed at generating treatment algorithms for these complex conditions (14,15,16). Although details of these classification systems are beyond the scope of this review, we would like to highlight the fact that exact measurement of the airway stenosis remains a challenge for endoscopists. The severity of stenosis and the size of the airway lumen is generally an approximation that can be applied in research settings aimed at generating treatment algorithms for these complex conditions (14,15,16). Although details of these classification systems are beyond the scope of this review, we would like to highlight the fact that exact measurement of the airway stenosis remains a challenge for endoscopists. The severity of stenosis and the size of the airway lumen is generally an approximation that can be applied in research settings aimed at generating treatment algorithms for these complex conditions (14,15,16). Although details of these classification systems are beyond the scope of this review, we would like to highlight the fact that exact measurement of the airway stenosis remains a challenge for endoscopists. The severity of stenosis and the size of the airway lumen is generally an approximation that can be applied in research settings aimed at generating treatment algorithms for these complex conditions (14,15,16). Although details of these classification systems are beyond the scope of this review, we would like to highlight the fact that exact measurement of the airway stenosis remains a challenge for endoscopists.

**Initial approach**

Review of literature would highlight the fact that management of benign airway stenosis is not standardized or unified worldwide. However, we feel that a multidisciplinary approach involving a team of dedicated and experienced physicians is absolutely essential and axiomatic.

After a thorough history and physical examination, testing with oximetry and chest radiography is typically done and will be often normal. Findings of lung function testing will not be discussed in great detail here, but may provide clues as to the location of a potential obstruction. Serologies may be of utility depending on the clinical context and sometimes include inflammatory markers and a screen for autoimmune conditions. Clinically most patients present with symptoms once they approach the fibrotic phase of the disease, with minimal evidence for local inflammation at the time of their endoscopy. Stridor is always a sign of severe tracheal or laryngeal obstruction, however, presence of a fixed wheeze does not always correlate with the site of airflow limitation. In other words, auscultation of a fixed wheeze over the trachea does not necessarily indicate that the source of obstruction is trachea (17).

Chest and neck computed tomography (CT) is often one of the initial tests requested. Although its sensitivity for detecting stenosis is limited, it may be of utility in identifying other parenchymal or soft tissue abnormalities that can provide diagnostic clues (figure 1). If available, 3-dimensional reconstructions of the airway can be helpful, particularly in characterizing the longitudinal extent of abnormalities (18).

---

**Figure 1: Saggital and coronal CT views of stenotic lesion in trachea**
Direct bronchoscopic visualization continues to be the gold standard for confirmation of airway obstruction. This can be helpful in differentiating intrinsic from extrinsic compression. It also can provide a quantification of severity and allows biopsies to be performed in hopes of obtaining a tissue diagnosis. It is essential to have a plan for definitive airway management in place prior to starting any procedure on patients in this population given their potential for airway occlusion in the setting of edema or secretions. This is why discussion of these cases in a multidisciplinary setting is often suggested and can aid in preparedness. The use of radial probe endobronchial ultrasound (EBUS) can provide additional information as to the extent of a lesion when planning intervention. One of the larger series combining both malignant and non-malignant disease found that EBUS was useful in guiding or changing management in 43% of cases (19). The initial choice of therapeutic modality is dependent on the type and location of the stenosis, its length, its severity, integrity of the airway, and patient’s comorbidities. While rigid bronchoscopy is often the preferred instrumentation for unstable patients or those in whom significant bleeding is expected, our experience has been that flexible bronchoscopy can safely be used in appropriately selected patients and in conjunction with a number or airway interventions. In many instances multiple modalities may be complementary depending on the underlying pathology of the lesion as well as its endoscopic characteristics. Surgical interventions are typically reserved for relatively short length tracheal lesions and are beyond the scope of this review. If surgical intervention is thought to be a possibility, we would recommend discussing the case with a surgeon or in a multidisciplinary setting prior to embarking on endoscopic interventions as some of them may affect feasibility of future surgical resection. Several endoscopic modalities have been evaluated for relief of endoluminal obstructions. These include mechanical dilation with rigid scope or balloon, heat-based therapies with laser, electrocautery, and argon plasma coagulation as well as cryotherapy and various airway stents.

Endoscopic procedures combined with localized drug therapy with intrallesional injection of corticosteroids or topical applications of mitomycin C have also been evaluated with variable outcomes (20,21).

**Balloon dilation**

Dilation of the airways, or balloon bronchoplasty, is one of several therapeutic modalities that can be used via the fiberoptic bronchoscope. The balloon is positioned across a selected lesion, sometimes over a guidewire, and repeated cycles of inflation/deflation can then be conducted. This is typically most useful in patients with a focal and relatively short segment of disease resulting in a fixed narrowing. Possible advantages of this technique over dilation with a rigid bronchoscope include less mucosal trauma and granulation tissue. The use of general anesthesia and operating room time can also be avoided as this procedure is typically performed under conscious sedation in a properly equipped bronchoscopy suite. Balloon bronchoplasty, via either rigid or flexible bronchoscopy, has been shown to provide immediate improvement in airway diameter and symptoms when used alone or as an adjunct to other therapeutic modalities (22). However, there remain concerns as to whether its use alone will promote future proliferation of granulation tissue given repeated mucosal stretching and trauma. Balloon dilatation has been found to be effective in tracheobronchial stenosis when used in conjunction with Nd:yttrium aluminum garnet (YAG) laser photoresection, stent placement and various other modalities (23,24). It is thought that the use of balloon dilation will also facilitate placement or deployment of a stent in some instances. A more recent retrospective review also suggested immediate improvement in airway dimensions and symptoms with balloon dilation, with the eventual need for additional treatment with laser or stent placement in the majority or patients (25). While these studies demonstrated that balloon dilations can be performed safely via flexible bronchoscopy, appropriate patient selection is required as rigid bronchoscopy was opted for in some patients. Many centres now use controlled radial expansion (CRE) balloons via fiberoptic bronchoscopy, which allow for various lengths and diameters of dilation. The main side effects of balloon bronchoplasty include airway rupture resulting in pneumothorax or pneumomediaestinum, mediastinitis and bleeding (26).

**Ablative therapies**

A variety of endobronchial ablative therapies have been used to reduce the burden of intraluminal disease in hopes of improving symptoms and preventing recurrence of disease. This includes methods that require direct contact of a probe with the lesion, but also includes several non-contact methods. The major absolute contraindication to these therapies is narrowing due to extrinsic compression of the airway, with the exception of brachytherapy which will not be discussed in this review (27). Other relative contraindications include distal airway obstructions, airway obstructions present for greater than 4 weeks, obstructions longer than 4cm and patients who require more than 40% fraction of inspired oxygen (to reduce the risk of airway fires) (28). As is the case with balloon dilation, ablative therapies are often most effective when combined with other modalities such as balloon bronchoplasty or airway stenting.
Electrocautery and argon plasma coagulation (APC)

Electrocautery treatment involves the flow of electrical current from the probe to the tissue in contact with the probe resulting in tissue necrosis. The result is immediate effect to the area directly contacted as well as delayed effects on the tissue area adjacent. The effects are dependent on several variables including the type of lesion, current waveform properties, power setting, machine mode and type of probe used. Waveform settings with a high frequency result in a cut mode, whereas lower frequency waveforms result in coagulation mode. The more high power settings are used to vaporize tissue and also will result in greater depth penetration (29). Similarly, argon plasma coagulation (APC) uses an electrical current to induce tissue ablation without direct probe-tissue contact. This method uses argon gas emitted through a Teflon tube passed through the flexible bronchoscope along with an electrode at the tip of the catheter that results in the flow of current from the tip of the catheter to the target tissue. APC is most useful for relatively superficial lesions due to its limited tissue penetration of only 1-2mm (6). This makes it an excellent option for superficial lesions or bleeding. Due to the somewhat random dispersion of the gas this method affords the opportunity to treat lesions adjacent to the probe or around a bend otherwise not accessible to laser or direct contact with a probe. Electrocautery and APC are currently the 2 more commonly used methods of thermal ablative therapy at our centre and have come into more widespread use over the last 10-20 years. Before this, due to safety concerns and lack of experience supporting electrocautery, the Nd:YAG laser was the primary tool used for ablative therapy at many major centres. This utilizes a tissue-light interaction leading to thermal tissue damage and allows tissue penetration up to 10mm. This method is best suited to lesions that are central, intrinsic and less than 4cm with a visible distal endobronchial lumen. This modality has been studied extensively for both malignant and nonmalignant disease and is highly effective at restoring airway diameter and improving symptoms such as dyspnea and hemoptysis (6). That being said its widespread use was somewhat limited by its cost and the bulky size of the machine. The use of electrocautery has been shown to be safe and highly effective at a lower associated cost. This may be in part related to the fact that most health centres have electrocautery machines readily available. One of the larger retrospective reviews of 117 procedures found endoscopic improvement in 94% of cases undergoing electrocautery with only one major complication and no perioperative mortality (30). Another advantage of electrocautery is the instruments that are available such as probe, snare, knife and forceps. This allows the operator to select the most appropriate tool for any given scenario.

Cryotherapy

Cryotherapy uses the application of extreme cold for local destruction of tissue. A rapidly expanding gas (usually nitrous oxide or liquid nitrogen) flows to the catheter tip and cools to a temperature of -40°C (27). The probe is moved to different contact points and the freezing and thawing cycle is repeated. Cryotherapy can be safely used in a high oxygen environment as there is no risk of airway fire. It can also facilitate removal of clots or foreign bodies by making them easier to extract after freezing. It can be time consuming given the need for repeated cycles and it has a relatively shallow treatment effect when compared with laser or electrocautery treatments (31). Cryotherapy also does not have an immediate treatment effect and repeat bronchoscopy is often performed to remove slough tissue and repeat treatment as needed. Its delayed treatment effect makes it a poor choice for the acute setting where immediate effect would be required. Therapeutic outcomes are comparable to those from “hot” ablative therapies and complications of bleeding and transient airway obstruction from swelling occur in less than 5% of cases (27). At TOH, we tend to use cryotherapy mostly for removal of clots or foreign bodies in addition to treatment of relatively shallow lesions in patients who are agreeable and able to comply with multiple repeat bronchosopic assessments.

Airway Stents

Airways stents are hollow prosthetic devices aimed at establishing and maintaining airway patency. These devices are often used in conjunction with one of the therapeutic techniques previously described in order to derive maximal sustained therapeutic benefit. There have been many different types of stents introduced since the first completely endoluminal stent was introduced by Dumon in 1990 (32). The two main types of stents are metal or silicone, with metal stents being relatively easy to place but difficult to remove primarily due to proliferation of granulation tissue. Historically, silicone or polymer based stents came with introducer systems designed for rigid bronchoscopy while metal stents were amenable to deployment via flexible bronchoscopy. More recently, the development of hybrid stents that can be deployed via flexible bronchoscopy has aimed to combine the best of both worlds. Metal stents now come with a partial or full silastic or polyurethane covering to minimize tissue growth into the stent. The covering is often absent at either end of the stent to allow proper anchoring in an attempt to reduce migration, which is one of the major pitfalls of silicone stent placement.

While the benefits of airway stenting are clear in patients with focal airway narrowing, the benefits of stenting in
hyperdynamic airway conditions such as tracheobronchomalacia remain less clear. The concern in these patients is that stenting performed may simply result in the migration of the site of maximal flow limitation to a more distal location (33). This may limit the utility of stenting in this population, particularly in those with more diffuse disease.

**Summary of “The Ottawa Experience”**

Our experiences with this patient population have shown that there is no single approach widely applicable in patients with nonmalignant tracheobronchial obstruction. Management typically involves therapy with a combination of the previously described modalities. Decisions as to the optimal choice are made after efforts have been made to determine the etiology and quantify the extent of impairment or obstruction. Often the endoscopic assessment will be of utmost importance as there is no substitute for direct visualization of a lesion.

Initial assessments are most often made in our multidisciplinary complex airway clinic. This outpatient clinic allows discussion of patient between Interventional Pulmonology, Thoracic Surgery and Otolaryngology. Specifically, a surgical opinion is often valuable in considering resection, particularly in the setting of very focal disease. If a patient is not deemed a surgical candidate immediately, a trial of endobronchial therapies via flexible fiberoptic bronchoscopy is undertaken. This typically involves some combination of either electrocautery, APC or cryotherapy in addition to possible stent placement and/or balloon bronchoplasty. Biopsies of the lesion are also performed at the time of initial bronchoscopic assessment and intervention. After therapeutic airway interventions we will usually provide an outpatient setting with clinical and radiographic follow-up arranged within 4-6 weeks post procedure. If the patient reports sustained benefit from the procedure, we would follow up every three months for the first year, every 6 months for the second year and annually thereafter. Patients with recurrence will be offered repeat endoscopic procedure along with intrallesional corticosteroids or mitomycin C application (figure2). Depending on the length of time between recurrences and the underlying cause for the stenosis, patients may be offered up to 2 additional endoscopic interventions. After the 4th recurrence, those who are surgical candidates undergo surgical resection of the stenotic lesion. Non-surgical patients are offered airway stenting, tracheostomy tube, or Montgomery Ttube based on their needs. All patients with tracheal prosthesis are assessed routinely for potential complications. We offer removal of airway stents 2 years post-insertion, as we have noticed airway remodelling and stiffening that would facilitate maintenance of airway patency. Individuals who fail stent removal will often have stent placement permanently.

Unfortunately, given the diversity of this patient population, we currently lack large randomized trials that can provide us with meaningful guidelines. However, we feel that the multidisciplinary approach in a centre with experience in treating nonmalignant airway obstruction is essential in order to optimize outcomes given the wide variety of pathology and clinical scenarios encountered. We believe that the best approach is one that is offered after careful evaluation of the patient and their type of injury while considering the local expertise, equipment availability, and, perhaps most importantly, the patient’s preferences.

**Figure 2:** Panel A – Pre-intervention airway of a patient with tracheal stenosis resulting from granulation tissue growth with prior metal airway stent. Panel B – The same trachea post-APC therapy. Panel C – Trachea of the same patient being treated with mitomycin C soaked gauze. Panel D – Trachea of the same patient post mitomycin C treatment.

**References:**

2) Rea F, Callegaro D, Loy M, Zuin A, Surendra N, Narnes S, Gobbi T, Grapeggia M, Sartori F. Benign tracheal and laryngotracheal...

The Better Breathing Conference 2015... At a Glance

The Better Breathing Conference is one of Canada’s leading respiratory meetings. Congratulations to Dr. Marcel Tunks and the planning committee for preparing an excellent program!

The theme was Global Threats, Local Responses. The Plenary Session featured Dr. Kamran Khan, Scientist and Staff physician at St. Michael’s Hospital. He described how big data and web-GIS technology can be used to anticipate and respond to the threat of globally emerging respiratory pathogens with pandemic potential.

Dr. Prabhjot Jha, Founding Director, Centre for Global Health Research, St. Michael’s Hospital, followed with a presentation identifying the global impact of smoking, focusing on the implications in the developing world.

Scientific sessions continued throughout the day, providing participants with the ability to: recommend when to consider new treatments in CF, identify physical comorbidities in COPD and explain how new practice guidelines integrate into practice and, analyze new ways to manage sleep-disordered breathing. As per tradition, the Saturday sessions of the Better Breathing conference...
concluded with well-attended, highly informative and humorous debates.

Other highlights included our award recipients: **Dr. Jonathan Draper** as the recipient for the *Breathe New Life Award*, 2013, **Drs. Shawn Aaron, John Granton, and Charles George** for the *Meritorious Service Award*, 2014, 2013, 2012 respectively, **Dr. Allan Coates** for the *Honorary Life Membership Award*, 2014, and **Dr. Melanie Chin** was presented with the 2015-2016 *Cameron C. Gray Fellowship Award*: This award is a prestigious respirology fellowship that is awarded to a respiratory resident to pursue a third year of clinical training.

The OTS thanks the OLA, and all Better Breathing delegates for helping to make this conference successful. We look forward to seeing you all at Better Breathing 2016 on January 29–30.

Right: Drs Shawn Aaron, John Granton, and Charles George each received the Meritorious Service Award (2014, 2013, 2012 respectively) as acknowledgement and thanks for their ongoing contributions and endless work on behalf of the OTS Thoracic Society.

Left: Dr. Allan Coates receiving his Honorary Life Membership Award 2014 from Dr. Thomas Kovesi, Chair, Ontario Thoracic Society.

*George Habib, President & CEO, Dr. John Granton, Chair of the Board, Andrea Stevens Lavigne, Vice President, Provincial Programs, Dr. Thomas Kovesi, Chair, Ontario Thoracic Society, and Dr. Marcel Tunks, Chair, OTS Better Breathing 2015 Planning Committee*
OLA Updates: Helping Patients’ Voices Be Heard: Ontario Lung Association and Patient Submissions

Jody Hamilton, Health Promotion Project Manager, Ontario Lung Association

The Government of Ontario has a process to allow patients and their caregivers to contribute to the province’s drug review process. Ontario’s Committee to Evaluate Drugs, in their consideration of drug approvals and funding, would like to understand the real impact that diseases and treatments have on the daily lives of patients and caregivers. The Ontario Lung Association (OLA) became a registered patient advocacy group in June 2012, and since then has made a total of 14 patient submissions on a range of drugs indicated for chronic obstructive pulmonary disease, pulmonary hypertension, idiopathic pulmonary fibrosis and lung cancer. We have collected information, input and feedback from more than 100 patients and their caregivers, about how lung disease affects their day-to-day lives and about what is most important to them when considering new drug therapies.

Living with lung disease impacts all areas of a person’s life. As one patient said: “this disease causes you to go downhill bit by bit. You are constantly having to re-adjust your life based on your diminishing abilities.” The key treatment outcomes that patients and their caregivers would most like addressed are: to reduce shortness of breath, reduce coughing, reduce fatigue and improve appetite. They would like an increased ability to fight infection and to have a higher energy level. Ideally, patients would like to experience an improved quality of life and improved lung function.

“It is important for patients’ voices to be heard regarding key decisions that affect lung health,” says Andrea Stevens Lavigne, vice president of provincial programs, Ontario Lung Association. “Hearing first-hand what the real needs and wishes are of those living with lung disease, makes our program and resource planning more meaningful and our advocacy efforts better targeted.”

The Ontario Lung Association hopes to broaden our reach with future surveys, so if you or your patients might be interested in receiving e-mails or phone calls regarding future patient submissions, please contact the Lung Health Information Line at 1-888-344-LUNG (5864).
Cameron C. Gray Fellowship Award

The Cameron C. Gray Fellowship Award is a prestigious fellowship that is given annually to a trainee from an Ontario Respirology residency program, for salary support during a third year of clinical training. It is given in the name of Dr. Cameron C. Gray, a remarkable man who contributed enormously to the science and humanity of Respiratory Medicine both here in Ontario and in North America through his abilities as a teacher, administrator and physician. This year’s recipient is Dr. Melanie Chin, who is presently in her fifth year (PGY5) of respirology training at The University of Ottawa.

Dr Chin obtained her Bachelors of Medical Laboratory Science and Doctorate of Medicine at the University of British Columbia. She has completed her Internal Medicine Training at the University of Calgary, and is currently in her second year of her Respirology Fellowship at the University of Ottawa. Her clinical experiences have fostered an interest in cystic fibrosis and upon completion of her respirology fellowship she hopes to complete a one-year clinical fellowship in CF at both the University of Toronto and The Prince Charles Hospital in Brisbane Australia. Dr. Chin was also the recipient of the Keith Morgan Award for Excellence in the Resident Case Competition.

Join the Ontario Thoracic Society (OTS) or Renew Your Membership

OTS Membership term - April 1, 2015 to March 31, 2016

OTS Active membership is open to individuals with a medical degree and scientists holding a PhD or equivalent degree of training. The 2015-2016 fee is $95.00.

The OTS Associate Membership is available to interns, residents or graduate students in medical or allied health science, and to fellows during their period of training. Associate members do not pay fees and may not vote or hold office in the Society but enjoy all the benefits of a membership.

To join the OTS or renew your membership for 2015-2016, call (416) 864-9911 ext. 254 for information on OTS programs and services, visit http://www.on.lung.ca/ots

Online OTS Registration is Now Open at www.on.lung.ca/ots-membership-renewal-2015-16

Upcoming Events

Save the Date

January 29-30, 2016

Dr. Melanie Chin receiving the Cameron C. Gray Fellowship award from Dr. Shawn Aaron, RAC Chair at Better Breathing 2015