Editorial: Tunneled Pleural Catheters in the Management of Malignant Pleural Effusions

Alain Tremblay, MDCM, FRCPC
Associate Professor of Medicine, Department of Medicine and Director of Interventional Pulmonary Medicine, University of Calgary, Calgary

Malignant pleural effusion (MPE) is a common complication in advanced malignancy that causes debilitating symptoms. Unfortunately, the majority of these patients have incurable cancer and a prognosis measured in months. The primary purpose of treatment should therefore focus on symptom control, while minimizing time that the patient spends in our institutions, away from the comfort of their own homes, family and friends.

While previous treatment approaches have focused on the achievement of pleurodesis, the past decade has seen the successful introduction of tunneled pleural catheters (TPC) as a safe, effective outpatient treatment option for these patients.1

In this issue of the Ontario Thoracic Reviews, Graver and Amjadi describe the Ottawa experience with this new technique in a large case series of 643 catheter insertions in 558 patients with malignant pleural disease. Their results are similar to those published by others, suggesting that the vast majority of patients treated experience relief in dyspnea, that nearly half of all patients eventually experience “spontaneous pleurodesis” and that overall complication rates are very low.

An important characteristic of this treatment approach is its broad applicability with very few absolute contraindications to placement. TPCs can be used successfully in patients with trapped lung as well as in those with poor performance status, two common findings in this patient population for which few other treatment options exist 1,2. When TPCs are used in patients otherwise fit for pleurodesis procedures, higher spontaneous pleurodesis rates are seen (70%) and symptomatic improvement occurs in all patients3.

The outpatient nature of treatment is of particular importance in the setting of our Canadian health care system and our overcrowded hospitals. The ability to avoid a one week hospitalization for a palliative intervention and replace it with a simple and effective outpatient procedure should appeal to patients and administrators alike.

Nevertheless, it is important to point out that administrative and financial support of dedicated treatment teams is critical for successful implementation of such techniques. Anyone planning to offer this treatment to their patients should realize that placement of the catheter is by far the simplest step in the process. Funding for catheters and supplies, linkages with and training for home care staff, management of complications,
patient education as well as coordination of the overall care of these patients are but some of the issues which need to be tackled for such programs to be successful.

Critics will point out that although reports of safety and efficacy of TPC use in MPE are growing, no study has yet compared this technique with talc pleurodesis, arguably the current gold standard. Complications can and do arise, the most common being symptomatic loculation of fluid seen in 8.4% of patients\textsuperscript{1}, and the most severe being empyema seen in 3.2% of cases\textsuperscript{1} although this is similar to the rates reported for thoracoscopic talc poudrage\textsuperscript{4,5}. A theoretical concern regarding the potential negative impact of chronic drainage of proteinaceous fluid on nutritional status has been raised, but has not been well described or documented.

Length of drainage of 2-3 months is often seen as an undue burden imposed on patients and families although in our experience patients accept this with ease. Nevertheless, strategies to reduce the length of TPC drainage while minimizing side effects could be of benefit.

I congratulate the authors on their successful outpatient MPE clinic, which has no doubt significantly improved the quality of life and overall care of this patient population in their area. It does take a champion to lead the implementation of such a clinic and I certainly encourage chest physicians involved in the care of cancer patients to consider putting into service a coordinated approach to the treatment of MPE in their own centers.

Reference List

Outpatient Management of Malignant Pleural Effusions: The Ottawa Experience
*Alison Graver MSc, MD, FRCPC and Kayvan Amjadi MD, FRCPC*

**Introduction**

Pleural effusions complicate many advanced stage malignancies. The presence of a malignant effusion portends a poor prognosis with an estimated median survival of between 3 and 12 months after diagnosis [1]. Malignant pleural effusions (MPEs) are most commonly associated with bronchogenic carcinomas, found in as many as one third of patients [2]. Breast cancer and lymphoma represent the next most common causes of MPE, followed by mesothelioma, ovarian cancer and gastrointestinal cancers [3]. In approximately 5-10% of MPEs, no primary tumour site can be identified [2].

The etiology of an MPE is often multifactorial and depends on both type of malignancy and patient comorbidities [6]. In general, a malignant effusion can develop whenever tumour cells disrupt the normal pleural fluid turnover, often through direct obstruction of pleural lymphatics or invasion of lymph nodes or pulmonary vasculature [1].

Significant morbidity is associated with the development of an MPE. Dyspnea is the most prominent symptom, although patients may also experience decreased exercise tolerance, cough and chest pain [1]. The development of a malignant effusion can have a profound impact on the overall quality of life experienced by cancer patients in the terminal stages of their illness [4].

The optimal management of MPEs has long been a concern for physicians caring for patients with end stage cancer. Current management strategies vary widely amongst institutions and range from surgical procedures requiring hospitalization to treatment on an outpatient basis. Arguably, the ideal management of MPEs would effectively palliate patient symptoms while minimizing complications, cost, and time in hospital [5,6]. A significant body of research over the last decade supports the efficacy of outpatient management of MPEs using indwelling pleural catheters and home drainage [3-8]. However, currently available guidelines on the management of MPEs do not adequately reflect this recent literature or an increasing wealth of physician experience with outpatient programs. In this paper, we briefly review the advantages and disadvantages of available management strategies and our experience with outpatient management of malignant effusions.

**Management Strategies**

The effective management of malignant effusions is complicated by their extremely high rates of symptomatic recurrence [1, 3]. For example, an early study described the re-accumulation of pleural fluid within 4.2 days of initial drainage [9], while a 30 day recurrence rate of 98% has been reported elsewhere [10]. The management of an MPE thus requires both short term palliation of symptoms and a means to prevent or
control recurrence of the effusion. Traditionally, management options have included therapeutic thoracentesis, tube thoracostomy or thoracoscopy and pleurodesis, and pleuroperitoneal shunts. More recently, ambulatory drainage by means of a small bore indwelling pleural catheter has become increasingly utilized [1]. Each management technique has associated advantages and disadvantages.

Repeat therapeutic thoracentesis has in the past been advocated as a viable option for frail patients with a very limited life expectancy for the rapid relief of dyspnea. However, the high recurrence rate of MPEs often makes this option impractical and exposes the patient to repeat hospital visits and significant risks such as pneumothorax and infection [1].

Pleurodesis, by effectively eliminating the pleural space, is widely accepted as a more effective means to manage recurrent effusions. However, the optimal way to achieve pleurodesis has been a matter of some debate and the literature reflects significant variability in both technique and outcome [11]. Surgical or medical thoracoscopy with insufflation of a sclerosing agent such as talc is a common means to achieve pleurodesis and treat MPEs. This modality is effective, with short term rates of successful pleurodesis ranging from 71% to 97% [12]. Thoracoscopy has the added benefits of facilitating lysis of adhesions or loculations when present and providing a diagnostic tool when the etiology of an MPE is uncertain. However, thoracoscopy is a relatively more invasive and costly procedure. Careful selection of patients with a high performance status (ie. ECOG < 2) is often required due to the need for increased sedation or even general anaesthesia [12]. The associated hospitalization is also often perceived to be a significant disadvantage by terminally ill patients.

Chest tube drainage with instillation of a sclerosing agent is also an effective strategy and has long been used in the management of malignant effusions [1, 12]. While the chest tube drains the pleural space allowing pleural apposition, a chemical agent such as talc, doxycycline or bleomycin provokes an inflammatory response within the pleural space ultimately leading to pleurodesis. Successful pleurodesis rates of 71% to 96% have been reported for procedures using talc as a sclerosant [12]. However, a number of significant disadvantages are associated with chemical pleurodesis. For example, hospitalization is usually required with a median stay of approximately 7 days [13]. Re-accumulation of fluid requiring a second procedure and common procedural side effects such as chest pain are also recognized disadvantages [12]. In addition, a significant subset of patients with an MPE fail to respond to chemical pleurodesis. Poor response is usually attributable to factors preventing adequate apposition of pleural surfaces including a large intrapleural tumour burden, endobronchial obstruction or pleural loculations leading to trapped lung [12, 14, 15]. Dresler et al. (2005) found that up to 30% of patients considered for pleurodesis were ultimately deemed poor candidates due to the presence of trapped lung [15].
Although a number of sclerosing agents are available for use in chemical pleurodesis, sterile talc has been shown to be the most effective in a number of studies including a recent meta-analysis [1, 16]. Talc was first used as a sclerosant in 1935 and continues to be widely utilized. However, data on the efficacy of talc are primarily limited to small scale, single center clinical studies. Many of these studies are limited by the use of variable definitions of pleurodesis, short post-procedure follow up, and limited data on long term symptom control or impact on patient quality of life. In addition, the safety of talc has been questioned. Adverse effects associated with talc instillation in the pleural space range from fever, dyspnea and chest pain to the development of acute respiratory failure and ARDS [12]. Talc particle size appears to be a significant factor, with increased complications observed with smaller particle size [12]. To date, only one large randomized prospective trial has addressed both the efficacy and safety of talc pleurodesis. Dresler et al. (2005) compared thoracoscopic talc poudrage and thoracostomy with talc slurry in 482 patients with MPE. Based on the primary end point of lack of radiographic recurrence at 30 days, the efficacy of the two modalities was found to be similar. However, significant treatment associated morbidity was observed, with respiratory failure in 4% of patients who received talc slurry and 8% who underwent talc poudrage. In addition, a Kaplan-Meier estimator used to evaluate the distribution of recurrence after 30 days demonstrated a roughly 50% rate of MPE recurrence by 4 months post pleurodesis [15].

Pleuroperitoneal shunting is an alternative option for the palliation of MPEs. The shunt consists of a valved chamber with attached pleural and peritoneal catheters. This option can be effective in patients with trapped lung or with MPEs otherwise uncontrolled with pleurodesis. However, recognized disadvantages to pleuroperitoneal shunting include tumour seeding of the peritoneal cavity, infection and shunt occlusion. Rates of shunt occlusion of 12% to 25% have been reported [1] with overall complication rates of approximately 15% [12].

Current guidelines published by the British Thoracic Society [1] and the American Thoracic Society [2] advocate chest tube drainage and chemical pleurodesis as the preferred management of MPEs when lung re-expansion can be demonstrated. In their algorithm for the management of malignant effusions, the BTS guidelines suggest consideration of indwelling pleural catheters only when there is a failure of lung re-expansion or recurrence of effusion post-pleurodesis [1]. However, in the six years since publication of the BTS guidelines a number of studies have demonstrated the efficacy of indwelling catheters and outpatient management of MPEs [3-8].

Unlike traditional tube thoracostomy, catheters designed for long term use are tunnelled in the subcutaneous tissue, reducing the risks of both tube displacement and infection [3]. Tunneled pleural catheters can be inserted at the bedside as an outpatient procedure with local anaesthesia. Pleural fluid drainage can be performed in the patient’s home on an intermittent basis with the frequency of drainage determined by the rate of fluid re-accumulation. The presence of an indwelling
catheter also commonly leads to pleurodesis at least in part due to the mechanical irritation and inflammation caused by the catheter itself [4]. Spontaneous pleurodesis was reported in 40% to 58% of patients after 2 to 6 weeks in recent studies [3, 5]

The advantages associated with the outpatient management of MPEs have been well described. Indwelling pleural catheters are consistently associated with significant symptom control, high rates of spontaneous pleurodesis and low risk of complications [3-8]. In a prospective randomized study, Putnam et al. (1999) compared an indwelling Pleurx® catheter to doxycycline pleurodesis in 144 patients with malignant pleural effusions. They found that the two modalities were equivalent with respect to symptom control, safety and overall efficacy [13]. A recent cost-effectiveness study has also demonstrated the comparability of the Pleurx® catheter and talc pleurodesis [17]. A number of studies have demonstrated that indwelling pleural catheters are effective in the management of MPEs associated with trapped lung [14] and in patients with MPE irrespective of their suitability for talc pleurodesis [8].

The primary disadvantages of indwelling catheters in the treatment of MPEs include catheter related complications and the significant infrastructure requirements. In their retrospective analysis of 250 tunneled pleural catheter insertions, Tremblay and Michaud (2006) reported catheter related complications such as empyema (3.2%), pneumothorax (2.4%), cellulitis (1.6%), dislodged catheters (1.2%), bleeding (0.8%) and rare tumour seeding (0.4%) [5]. However, overall complication rates are relatively low and compare favourably to other treatment modalities [3-5]. A more significant limitation to the use of chronic indwelling catheters is the infrastructure needed for the long term care of these patients. An outpatient based MPE program requires sufficient clinic time for both the initial catheter placement and the follow up visits. Frequent scheduled follow-up is necessary both to assess symptom control and to monitor for complications. Ideally, a mechanism should be in place to rapidly address catheter related complications and thus avoid emergency department visits and unnecessary hospitalizations. Considerable community resources are also required to facilitate catheter management and pleural drainages in the patient’s home. Infrastructure requirements and resource availability may be factors limiting the utility of outpatient based malignant effusion management in many institutions.

The Ottawa Experience
At The Ottawa Hospital, malignant effusions are managed in a designated MPE Clinic, a joint initiative of Interventional Respirology and the Ottawa Regional Cancer Center. The aim of the clinic is to provide comprehensive outpatient palliative management of MPEs without the need for invasive procedures or hospitalization.

As of March 2010, a total of 558 patients have received 643 indwelling Pleurx® catheters (Denver Biomedical Inc; Golden, CO) as part of the MPE program in our center. The characteristics of our patient population are comparable to published data from other programs [5] (see Table 1). Our patients have a mean age of approximately 67 years,
with a consistent trend towards greater frequency of right sided effusions and effusions in women. Consistent with other centers, bronchogenic carcinoma represents the most common etiology for malignant effusion. The functional or performance status of patients referred to our clinic tends to be quite poor, reflected in a mean ECOG score of 3.

Table 1. Pleurx Catheter insertions 2006-2010 (N=643)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Age (range)</td>
<td>67.2 (26 – 95)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>325</td>
</tr>
<tr>
<td>Male</td>
<td>233</td>
</tr>
<tr>
<td>Mean ECOG (median)</td>
<td>3.2 (3)</td>
</tr>
<tr>
<td>Side of Effusion</td>
<td></td>
</tr>
<tr>
<td>Right</td>
<td>378</td>
</tr>
<tr>
<td>Left</td>
<td>265</td>
</tr>
<tr>
<td>Primary Cancer</td>
<td></td>
</tr>
<tr>
<td>Lung cancer</td>
<td>200</td>
</tr>
<tr>
<td>Breast</td>
<td>98</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>31</td>
</tr>
<tr>
<td>Mesothelioma</td>
<td>26</td>
</tr>
<tr>
<td>Other</td>
<td>203</td>
</tr>
</tbody>
</table>

The MPE Clinic at the Ottawa Hospital currently provides service to the city of Ottawa and the surrounding LHIN. During two full clinic days per week, outpatient referrals are seen and assessed by an interventional respirologist, a trained clinical nurse and a palliative care team. Pleural catheter insertions are performed during the clinic using ultrasound guidance and local anaesthesia. Initial drainage of pleural fluid is physician supervised and drainage is limited only by patient symptoms such as persistent cough and chest tightness indicating lung re-expansion. Following a post-procedure chest x-ray, patients are free to return home without any need for hospitalization. When
required, pleural catheters are also routinely placed for hospitalized patients in a bedside procedure utilizing ultrasound guidance.

In order to ensure proper care of the Pleurx® catheter and successful home drainage, all patients are provided with community homecare services. Homecare nurses receive special training in the management of the catheter and provide home pleural drainages on a schedule individualized to each patient, typically three times per week. Homecare nurses are provided with a troubleshooting algorithm and both patients and homecare staff are able to contact a dedicated MPE clinic nurse or physician with questions or concerns regarding the catheter. The accessibility of clinic personnel is a central feature of our program and in our experience is an important factor in limiting catheter related complications and subsequent hospitalizations. Patients are seen in follow up two weeks following catheter insertion and then every 6 weeks or as required until catheter removal or death. Catheters are routinely removed when pleural drainage is less than 50 ml on three separate occasions and no change in the chest x-ray is observed. During clinic visits, symptom control is assessed using the validated baseline dyspnea index (BDI) and transition dyspnea index (TDI).

Table 2 summarizes our experience with the outpatient management of MPEs. The successful palliation of symptoms observed amongst our patients is similar to the results of published studies [3-5,8]. Likewise, the 40% spontaneous pleurodesis rate we have observed is comparable to other centres [5].

Table 2. Outcome of Pleurx Catheter Insertions (N=643)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful insertion (%)</td>
<td>643 (100)</td>
</tr>
<tr>
<td>- Bilateral insertions</td>
<td>48 (7.5)</td>
</tr>
<tr>
<td>- Re-insertions</td>
<td>37 (5.8)</td>
</tr>
<tr>
<td>Relief of Dyspnea (%)</td>
<td>557 (99.8)</td>
</tr>
<tr>
<td>- BDI (range)</td>
<td>2.0 (0 – 10)</td>
</tr>
<tr>
<td>- TDI (range)</td>
<td>6.9 (0 – 9)</td>
</tr>
<tr>
<td>Spontaneous Pleurodesis (%)</td>
<td>260 (46.6)</td>
</tr>
<tr>
<td>- Time to pleurodesis (range)</td>
<td>77 days (1 – 753)</td>
</tr>
<tr>
<td>Patients deceased with Pleurx® (%)</td>
<td>167 (30)</td>
</tr>
<tr>
<td>- Length of survival (range)</td>
<td>60 days (1 – 480)</td>
</tr>
</tbody>
</table>

Complications associated with Pleurx® insertion are summarized in table 3. Complication rates have been low and include symptomatic loculation (4.0%), cellulitis (2.2%) and dislodged catheter (1.2%). Other complications occurring in less than 1% of
patients included positive pleural fluid culture, pain requiring catheter removal, fluid oozing at the exit site and hospitalization.

<table>
<thead>
<tr>
<th>Table 3. Complication Rates (N=643)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complication</td>
</tr>
<tr>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Symptomatic loculation</td>
</tr>
<tr>
<td>Positive C&amp;S pleural fluid</td>
</tr>
<tr>
<td>- At time of insertion</td>
</tr>
<tr>
<td>- Upon follow up</td>
</tr>
<tr>
<td>Cellulitis</td>
</tr>
<tr>
<td>Dislodged Pleurx®</td>
</tr>
<tr>
<td>Pain requiring removal</td>
</tr>
<tr>
<td>Fluid oozing at exit site</td>
</tr>
<tr>
<td>Hospitalization</td>
</tr>
</tbody>
</table>

**Conclusion**

MPEs represent a significant source of morbidity and reduced quality of life amongst patients already struggling with terminal malignancies. Current practice in the management of malignant effusions varies widely and, despite considerable research, the most effective management strategy remains a matter of some debate. Currently available practice guidelines suggest a rather limited role for outpatient management by means of indwelling pleural catheters while emphasizing the efficacy of tube thoracostomy and talc pleurodesis. As discussed, the significant safety concerns with intrapleural talc make it less attractive as a palliative therapy. In contrast, indwelling catheters are associated with successful palliation of symptoms, high rates of pleurodesis and relatively fewer serious complications. It has thus been suggested that indwelling pleural catheters and outpatient care should be considered first line for the management of symptomatic MPEs. In our experience, indwelling pleural catheters and home drainage provides a highly efficacious means of palliation. The current guidelines require revision to better reflect the published data and increasing physician experience with the outpatient management of malignant effusions.
References


BETTER BREATHING 2011
January 28-29, 2011
MARRIOTT TORONTO DOWNTOWN EATON CENTRE
525 Bay Street, Toronto M5G 2L2

UPDATE FROM THE CHAIR OF THE OTS BETTER BREATHING COMMITTEE

Better Breathing 2011, the annual conference of the Ontario Lung Association and the Annual General Meeting of the Ontario Thoracic Society is coming soon.

The Planning Committee is very excited about the topics and speakers for Better Breathing 2011. Plan now to attend. The focus of the Friday morning Plenary Session is “Old Challenges, New Opportunities: Emerging Technologies in Respirology”. The objective is to update attendees and explore advances in respiratory medicine and emerging technologies in lung diseases. We are very fortunate to have two highly regarded plenary speakers. Dr. James Mahony (Hamilton) will discuss “Molecular Technology – Impact on Diagnosis and Epidemiology of Respiratory Infections”. Dr. David Manson (Toronto) will talk about “Contemporary Imaging of the Lung”.
The mid-morning OTS/ORCS Joint Session, “What’s New in Lung Health” will feature two members of the Ontario Thoracic Society and one member of the Ontario Respiratory Care Society. Dr. Martin Kolb, (Hamilton) will discuss “Update: Pulmonary Fibrosis – Progress is Slow but it is Happening”. Dr. Margaret Fitch (Toronto), a member of the Ontario Respiratory Care Society, will give a presentation on “Supportive Care Needs of Individuals with Lung Cancer”. Dr. Sheldon Magder, a renowned Cardiologist from Montreal, will complete the session with a discussion on “Patient Can’t Breathe: Is it the Heart or the Lungs? Puffers or Diuretics?”

During lunch-time on Friday, attend the General Lunch with the exhibitors or select one of three “Lunch with a Professor Series”. One lunch session is “As your Mother Said-Enough but not too much; Resuscitation in the Critically Ill” (Dr. Sheldon Magder, Montreal). A second lunch session will discuss “Approach to Massive Pulmonary Embolism – Supporting the Right Ventricle” (Dr. John Granton). The third session is the André Péloquin Case Presentations from Community Respirologists and is dedicated to the memory of Dr. André Péloquin. The case presentations are facilitated by Dr. Steven Bencze (Ottawa) and this year’s case presenters are Dr. Peter Bikangaga (Toronto), Dr. Anil Dhar (Windsor) and Dr. Mark Jany (St. Catharines). Be sure to book early for the lunch-time clinical sessions as seating is limited.

The Friday afternoon program, “State of the Art in Respiratory Medicine”, will feature presentations on “What is New In Asthma Therapy” (Dr. Parameswaran Nair, Hamilton) and “Tomorrow and Tomorrow and Tomorrow: The New Age of Therapeutics in Pulmonary Vasculitis, a Rheumatologist’s Perspective” (Dr. Nadar Khalidi, Hamilton). The popular, humbling, and entertaining Resident Case Presentations, facilitated by Dr. Lori Whitehead (Hamilton), will follow the Friday afternoon talks. The afternoon session concludes with the OTS Annual General Meeting.

On Saturday morning, return to the OTS Sessions for the ever-popular and provocative debates: “Controversies in Pulmonary Medicine”, chaired by Dr. Shawn Aaron, Ottawa. This year’s speakers will debate controversial statements including: All Early COPD Should be Treated (Dr. Denis O’Donnell and Dr. Matthew Stanbrook); Pseudomonas Aeruginosa Eradication is useful in Cystic Fibrosis (Dr. Felix Ratjen and Dr. Joe Reisman) and Rationing Should not Be Part of Universal Healthcare (Dr. Robert Butcher and Dr. Allan Detsky). Don’t miss these entertaining (if polarized!) debates. Saturday morning will also feature the OTS/OLA Research Update, “Pulmonary Rehabilitation – Past and Future” (Roger Goldstein, Toronto).

I want to thank all the members of the OTS BBC 2011 Planning Committee for their hard work in organizing this exciting roster of speakers and interesting topics. Exhibitors will display their products and services and draw prizes will be awarded throughout the conference.
The program and registration forms for the conference and satellite sessions are available online at www.on.lung.ca/bbc. Mark January 28-29, 2011, on your calendar and register early!

Don’t forget to purchase your tickets to the annual Breathe! Gala, January 27, 2011. Purchase your tickets now at www.on.lung.ca/breathe, where Rebecca Skloot author of The Immortal Life of Henrietta Lacks, will address the controversy over the origins of the HeLa cell and the implications of ownership of patient cells and DNA. Registrants of the Better Breathing Conference will receive a $25 discount to their registration.

Jae Yang, MD, FRCPC
Chair, OTS Better Breathing Planning Committee, 2011

**Patients First – Towards an Ontario Lung Health Strategy**

The Ontario Lung Association including its two professional societies, the Ontario Respiratory Care Society (ORCS) and the Ontario Thoracic Society (OTS) is playing a leadership role in advocating to the Government of Ontario for an Ontario Lung Health Strategy. As such, we have launched a number of new advocacy and communications initiatives that we refer to as “Patients First”.

**TO PLEDGE YOUR SUPPORT FOR A LUNG HEALTH STRATEGY FOR ALL ONTARIANS, PLEASE JOIN OUR PLEDGE PAGE BY VISITING:**  www.on.lung.ca/olhs

Lung diseases have a major effect on millions of people living in Ontario and affect all ages – from birth to the end of life. Despite progress achieved over the years in both prevention and treatment, respiratory diseases continue to have a devastating impact on both the physical and economic health of people living in Ontario, taking a huge toll in lost lives, lost economic productivity, and costs to our health care system. But perhaps the most significant impact is on the long-term quality of life for individuals and families who are affected by lung disease. Everyone living in Ontario is at some level of risk for respiratory disease, making respiratory health everybody’s business.

The Ontario Lung Association aims to bring this compelling health issue to the forefront in the hearts and minds of consumers and government policy makers. Our overarching goal is to improve lung health and prevent respiratory illness and disease among Ontarians through the development of a comprehensive Ontario Lung Health Strategy, that:

- Promotes respiratory health among Ontarians
• Accelerates investment in all areas of lung health research
• Recognizes the importance of prevention, detection and early intervention
• Improves indoor and outdoor air quality in Ontario
• Includes a province-wide smoking cessation system offering a variety of supports and assistance
• Ensures fair and equitable patient access to all proven and effective classes of medication, devices and evidence-based supports, that have been endorsed and supported by the Canadian Thoracic Society Respiratory Guidelines and/or medical experts in the area of lung health

As a first step, we plan to draw attention to the seriousness of the problem with the release of a comprehensive “Life and Economic Burden Report”, specific to lung disease. The Ontario Lung Association is working with an independent, health policy consulting organization and a panel of subject matter experts to produce a base model that will detail the health and economic impact of lung disease in Ontario. This report will aim to:

• Project the prevalence and burden of lung disease in Ontario for the next 30 years;
• Provide a platform for evaluating and comparing proposed intervention strategies to mitigate the societal impact of lung disease
• Generate a solid, evidence-based foundation upon which a strategic and comprehensive plan of action can be built; and,
• Reveal the risks of not taking action to the community and policy makers in government

The report will be a key element in the Ontario Lung Association’s long-range advocacy strategy for the development of an Ontario Lung Health Strategy.

We are also developing a broader government relations strategy that began with a successful Lobby Day at Queen’s Park on October 6, 2010. Our COPD Ambassadors and along with OLA representatives, members of our Board and our professional societies met with 23 individual MPPs and/or their staff to advocate for a comprehensive smoking cessation system, as part of a broader lung health strategy for Ontario. The day ended with a reception for all MPPs including special guests, the Minister of Health Promotion and Sport, Hon. Margarett Best, and one of our lung champions, Walter Gretzky.

Another major component of our plan is an on-line stakeholder survey, which has allowed us to gather input from health care providers and others in the field of lung health on what they believe the top priorities should be for an Ontario Lung Health Strategy. The survey used the National Lung Health Framework activities as a base, and provided people with an opportunity to give additional ideas. The results of the survey
will be integrated with the outcomes of the study – both critical elements of a longer-term communications plan.

**Join our effort today and pledge your support for an Ontario Lung Health Strategy by visiting the OLHS Pledge Page: [www.on.lung.ca/olhs](http://www.on.lung.ca/olhs).**

If you would like additional information about this initiative, please contact Andrea Stevens Lavigne at the OLA office at 416-864-9911, x229 astevens@on.lung.ca or Sherry Zarins at 416-864-9911, x267 szarins@on.lung.ca.

**Volume 22, Number 3**  
**Fall 2010 Ontario Thoracic Reviews**

For more information on the Ontario Thoracic Reviews, please contact otr@on.lung.ca