



16th World Congress for Bronchology World Congress for Bronchoesophagology

13 – 16 June, 2010 | Budapest – Hungary



Endorsed by

AMERICAN COLLEGE OF
CHEST
PHYSICIANS®

PROGRAM AND ABSTRACTS

www.wcbwcbe2010.org

08.30 – 09.15

Room Buda

MEET THE PROFESSOR**ENDBRONCHIAL ULTRASOUND FROM EXPERIMENTS TO EVERY DAY PRACTICE ***

Felix Herth

Heidelberg, Germany

08.30 – 09.15

Room Pest

MEET THE PROFESSOR

A-0240

EXPIRATORY CENTRAL AIRWAY COLLAPSE

Septimiu Dan Murgu

University of California, Irvine, USA

Expiratory central airway collapse (ECAC) is a clinical syndrome characterized by airflow limitation due to excessive narrowing of the central airways during exhalation. The syndrome consists of two entities, tracheobronchomalacia (TBM) and excessive dynamic airway collapse (EDAC), which are different in terms of morphology, physiology, etiology and airway structure. Morphologic differences are noted by bronchoscopic and radiologic imaging. TBM is characterized by weakness of the airway cartilaginous wall and the flow limiting segments are localized in the central airways. In EDAC, the airway narrowing is due to excessive bulging of the posterior membrane inside the airway lumen in the absence of weakened cartilage and the flow limiting segments are predominately peripheral. Procedures targeting central airway stabilization such as membranous tracheobronchoplasty, bronchoscopic stent insertion, and noninvasive positive pressure ventilation are offered to improve symptoms and expiratory flow by increasing cross-sectional area and support the weakened airway wall structures in selected patients with ECAC. Treatment alternatives should be individualized based on functional status, extent of disease and severity of airway collapse. Novel multimodality imaging studies and physiologic assessments might be combined in order to assess airway wall structure, identify changes in flow-limiting segments before and after treatment, and provide further insights into the pathogenesis of ECAC.

08.30 – 09.15

Room Corso

MEET THE PROFESSOR

A-0224

EMERGENCY THORACIC ULTRASONOGRAPHY

Miklós Barta, Miklós Barta jr.

Meditel Ltd., Szombathely, Hungary

The emergency use of ultrasound mainly at the bedside to answer focused clinical questions is a relatively recent development in the field of Emergency Medicine. It is safe, rapid and non-invasive and can be performed by a wide range of specialists including radiologists, physicians and technicians.

The European Federation of Societies for Ultrasound in Medicine and Biology (EFSUMB) issued the minimum training requirements for 3 levels in a variety of fields in 2009. Appendix 11 addresses the field of thoracic ultrasound and appendix 13 is about intensive care. There is a substantial part in the latter describing thoracic US and US-guided thoracic interventions.

Main indications of thoracic emergency US:

- Focused Assessment with Sonography in Trauma, FAST – pericardial effusion, hemothorax, lung contusion, fractures
- targeted cardiology scanning to assess contractility and quantity of pericardial effusion
- detect pleural effusion, differentiate from consolidation, mark site for aspiration, diagnose pneumothorax
- acute pulmonary diseases: pneumonia, atelectasia, pulmonary embolism, oedema, ARDS
- US-guided intervention: vascular (eg. CV catheterization) and non-vascular procedures (pleural effusion drainage, check indirect signs of trachea tube position, PM electrode position)

The emergency thoracic ultrasonography (ETUS) is highly important in paediatrics and in fertile women, especially in case of pregnancy, making other imaging modalities avoidable. In some cases this can be the first choice of imaging method – sometimes completely replacing others – or can follow other modalities, like X-ray or CT. The role and success of ETUS heavily depends on various circumstances, like the place of investigation (ER, ICU, war zone, disaster area), clinical status, age, history of trauma. Cooperation among radiologists, emergency physicians, other specialists and technicians is essential in daily practice, research and education to define the correct role and place of ETUS. There are guidelines and recommendations already but we should get to a common, worldwide platform. The lecture demonstrates the basic principles, special diagnostic signs and major findings based on the author's image collection mainly.

09.30 – 10.15

Room Buda

HONORARY LECTURE

A-0118

SENTINEL LYMPH NODE NAVIGATION SURGERY FOR NODE-NEGATIVE HEAD AND NECK SQUAMOUS CELL CARCINOMA PATIENTS

Naoyuki Kohno, K. Yamauchi, H. Nagafuji, T. Nakamura

Department of Otolaryngology, Kyorin University School of Medicine, Tokyo

In head and neck squamous cell carcinoma (SCC), the lymph node status of the neck is the most important prognostic factor. Ipsilateral lymph node metastases are considered to decrease patient survival by as much as 50 %. Moreover, the presence of contralateral or bilateral cervical metastases deteriorates prognosis by an additional 50 %. The presence of cervical metastases cannot always be detected either clinically or pathologically by current routine clinical and histopathological methods. Ultrasound-guided fine needle aspiration cytology, which is currently the optimal procedure, still has a sensitivity of only 42-73 %. The sentinel lymph node (SLN) is the first lymph node to receive drainage from the primary tumor site, and it is speculated that cancer