6th Annual Scientific Meeting & Annual General Meeting

MALAYSIAN THORACIC SOCIETY

[dates]

19 – 20 July 2003

[venue]

The Regency Hotel & Resort
Port Dickson
Negeri Sembilan

Contents

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6th Annual Scientific Meeting / Annual General Meeting
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Dr Patrick Chan

Dr Catherine Wong

Message

It is my great pleasure to invite you to attend the 6th Annual Scientific Meeting of the Malaysian Thoracic Society on 19 and 20 July 2003. This meeting is held to coincide with the Annual General Meeting of the Society which was supposed to be during the 8th Congress of the Asian Pacific Society of Respirology. The Congress has to be postponed from 17 to 20 July 2003 to 1 to 4 December 2003 because of the SARS outbreak in the region.

The Organising Committee under the chairmanship of Associate Professor Richard Loh has prepared an exciting scientific programme and has selected a distinguished faculty of local, regional and international speakers. I hope this Meeting will provide you the opportunity to learn more about the current issues and recent advances in Respiratory Medicine as well as to meet up with old friends and to make new ones.

I look forward to welcoming you at the 6th Annual Scientific Meeting and General Annual Meeting of the Malaysian Thoracic Society.

Professor Liam Chong Kin
President
Malaysian Thoracic Society

Message

On behalf of the Malaysian Thoracic Society Committee, I warmly welcome you to our 6th Annual Scientific Meeting & Annual General Meeting here in Port Dickson, Negeri Sembilan.

As you know, this Meeting was put up rather quickly in place of the 8th Congress of Asian Pacific Society of Respirology, for which we, Malaysia, are playing host. The Congress is now postponed to the first week of December 2003. We sincerely hope you could still join us for this major regional conference, supported by an international fraternity of Respiratory Societies, namely The American Thoracic Society, The European Respiratory Society and The American College of Chest Physician.

While this short Meeting is necessary in order that our MTS Annual General Meeting could be held, it has provided a timely platform for us, respiratory and general physicians, to discuss some rapidly developing issues in Malaysia – notably the availability of combined therapy in single inhaler for chronic airway diseases, the latest evidence for the expanding role of LTRA in asthma, the new approach to COPD treatment in the context of prolonged M3 receptor blockage, and finally, the totally unexpected SARS crisis and our exposed vulnerability.

I am indebted to my colleagues in MTS committee for coming up with this Meeting's content and for help in organising speakers and chairpersons, to pharmaceutical companies for their kind support and sponsorship of international speakers and local doctors, and finally, but not the least, to Miss Y M Kong and her team for being such an efficient secretariat – unparallel to what I have ever experienced before. I thank you all.

Once more, welcome to Port Dickson and to the Meeting.

Associate Professor Richard Loh Li Cher
Organising Chairman

Programme Summary

Time	19 July 2003, Saturday	20 July 2003, Sunday
0830 – 0900 hrs		BREAKFAST / REGISTRATION
0900 – 0930 hrs		**SEVERE ACUTE RESPIRATORY SYNDROME (SARS) SYMPOSIUM** • The Epidemiology And Virology Of SARS
0930 – 1000 hrs		• SARS – Clinical Spectrum & Management
1000 – 1030 hrs		
1030 – 1100 hrs		TEA BREAK
1100 – 1130 hrs		**PNEUMONIA SYMPOSIUM** • Malaysian CPG On Childhood Pneumonia
1130 – 1200 hrs		• Community Acquired Pneumonia In Adults – The Malaysian Perspective
1200 – 1230 hrs	CHECK-IN REGISTRATION	LUNCH
1230 – 1300 hrs		
1300 – 1330 hrs		
1330 – 1400 hrs		
1400 – 1430 hrs		
1430 – 1500 hrs	**ASTHMA SYMPOSIUM** • Asthma Management – The Next 10 Years?	
1500 – 1530 hrs	• LTRA – The Debate	
1530 – 1600 hrs	• Revised Malaysian Asthma Management Guidelines	
1600 – 1630 hrs		
1630 – 1700 hrs	MTS ANNUAL GENERAL MEETING	
1700 – 1730 hrs		
1730 – 1800 hrs		
1800 – 1830 hrs		
1830 – 1900 hrs	**COPD PLENARY LECTURE** • The Potential Role Of Prolonged M_3 Receptor Blockage In The Treatment Of COPD	
1900 – 1930 hrs		
1930 – 2200 hrs	MTS ANNUAL DINNER	

Detailed Programme

19 July 2003, Saturday

1200 – 1430 hrs **CHECK-IN / REGISTRATION**

1430 – 1600 hrs **ASTHMA SYMPOSIUM**

Chairperson: Associate Professor Roslina Abdul Manap

Asthma Management – The Next 10 Years? (page 8)
Associate Professor Lim Tow Keong
Head, Department of Respiratory Medicine, National University Hospital, Singapore

LTRA – The Debate (page 8)
Professor Leif Bjermer
Department of Respiratory Medicine & Allergology, University Hospital of Lund, Sweden

Revised Malaysian Asthma Management Guidelines (page 9)
Dr Zainudin Md Zin
Damansara Specialist Hospital, Kuala Lumpur, Malaysia

1615 – 1715 hrs **MTS ANNUAL GENERAL MEETING**

1830 – 1930 hrs **COPD PLENARY LECTURE**

Chairperson: Associate Professor Richard Loh

The Potential Role Of Prolonged M_3 Receptor Blockage In The Treatment Of COPD (page 9)
Datin Dr Aziah Ahmad Mahayiddin
Head, Department of Medicine, Hospital Kuala Lumpur, Malaysia

1930 – 2200 hrs **MTS ANNUAL DINNER**

20 July 2003, Sunday

0830 – 0900 hrs **BREAKFAST / REGISTRATION**

0900 – 1030 hrs **SEVERE ACUTE RESPIRATORY SYNDROME (SARS) SYMPOSIUM**

Chairperson: Datin Dr Aziah Ahmad Mahayiddin

The Epidemiology And Virology Of SARS (page 10)
Professor Lam Sai Kit
Department of Medical Microbiology, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia

SARS – Clinical Spectrum & Management (page 10)
Dr Ong Kian Chung
Department of Respiratory Medicine, Tan Tock Seng Hospital, Singapore

1030 – 1100 hrs **TEA BREAK**

1100 – 1230 hrs **PNEUMONIA SYMPOSIUM**

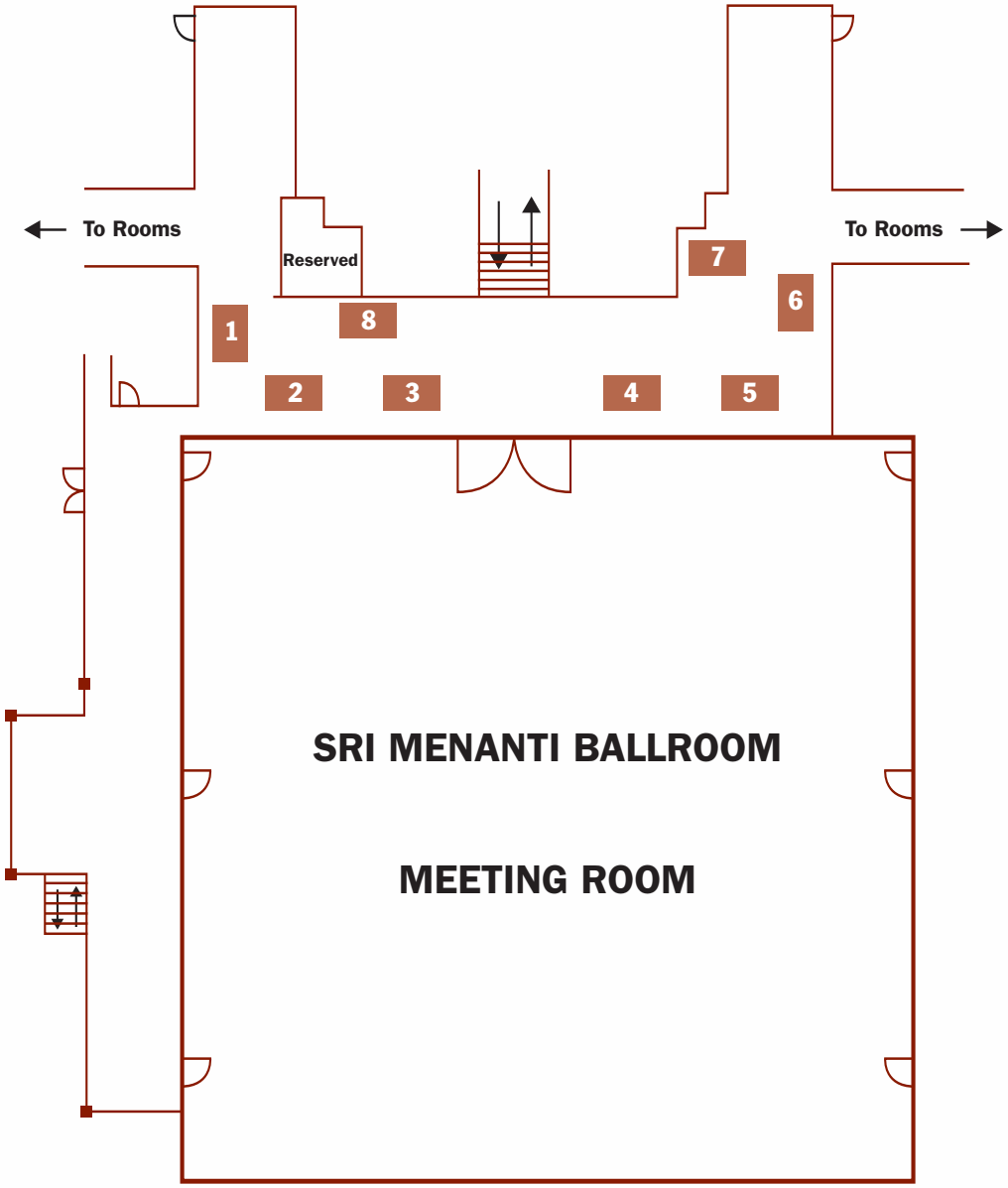
Chairperson: Dr I Kuppusamy

Malaysian CPG On Childhood Pneumonia (page 11)
Dr Norzila Mohd Zainudin
Institute of Paediatrics, Hospital Kuala Lumpur, Malaysia

Community Acquired Pneumonia In Adults – The Malaysian Perspective (page 11)
Professor Liam Chong Kin
Head, Department of Respiratory Medicine, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia

1230 – 1400 hrs **LUNCH**

Floor Plan & Trade Exhibition



Booth No	Company
1	Bristol-Myers Squibb
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Acknowledgements

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All Speakers and Chairpersons

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Heal Marketing Sdn Bhd

Kyowa Hakko (M) Sdn Bhd

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Sannotec Malaysia Sdn Bhd

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Upha Corporation (M) Sdn Bhd

Asthma Management – The Next 10 Years?

Lim Tow Keong
Department of Medicine, National University Hospital, Singapore 119074

The major advances in the management of asthma over the past decade include (a) agreement among experts on the goals and best standards of care and (b)establishment of high quality clinical evidence on the efficacy of new treatment regimens and patient education programs. However, the reality in everyday clinic practice is that asthma in most patients is poorly controlled and the quality of preventive asthma care falls far short of international guidelines for asthma management. The challenge for the practitioner in the next decade is to find the most effective ways to bridge this discrepancy between routine clinical practice and theory. Results of and experience from the Singapore National Asthma Program, which has enrolled over 2,500 patients with high risk asthma, will be presented to elucidate these issues.

LTRA – The Debate

Leif Bjermer
Department of Respiratory Medicine & Allergology, University Hospital of Lund Swede

The physiological definition of asthma is a disease with variable, reversible airway obstruction with increased reactivity to various irritative stimuli. In clinical practice, most asthma patients visiting the doctor's office have a normal or nearly normal lung function when they present and further investigations like peak flow measurement at home, on exercise or metacholine challenge test may be needed in order to confirm lung function variability. In this context, protection from getting a bronchoconstrictive response, i.e bronchoprotection, is crucial for asthma control. However, most clinical asthma trials require a reversibility to short acting beta-2 agonists as crucial inclusion criteria and improvement in lung function, i.e bronchodilatation, is often a primary variable.

In mild to moderate asthma insufficiently controlled by low to medium doses of inhaled corticosteroids, combination therapy with either a long-acting beta-2 agonist or an anti-leukotriene is advocated. In comparing these two alternatives it is important to distinguish between the need for a bronchodilator, when persistent bronchoconstriction is present, or a need for bronchoprotection when variable lung function spontaneously or as a response to stimuli is the main feature. In addition it is important to control the underlying disease activity, i.e. inflammation, and to treat systemic parts of the disease manifested by rhinitis and/or small airway involvement.

When comparing a long-acting beta-2 agonist (LABA) with a Leukotriene receptor antagonist (LTRA) as complementary therapy to inhaled (ICS) corticosteroid treatment,a favourable response depends partly on the patient profile and the defined treatment goals. LABA is a better bronchodilator, at least in the short term perspective (12 weeks trial) while LTRA provides better bronchoprotection. While LABA is associated with tolerance development towards the bronchoprotective ability, this is not seen with LTRA treatment given as regular treatment. Moreover, with the use of surrogate markers of inflammation, it is clear that LTRA, but not LABA, suppress Adenosine monophosphate reactivity and decrease the concentration of exhaled Nitric Oxide indicating that LTRA treatment better controls the underlying disease. Furthermore, LTRA treatment reaches systemic parts of the disease including such features as allergic rhinitis and small airway involvement, important aspects to consider when full control is the primary treatment goal.

Revised Malaysian Asthma Management Guidelines

Zainudin Md Zin
Damansara Specialist Hospital, Kuala Lumpur, Malaysia

The Potential Role Of Prolonged M_3 Receptor Blockade In The Treatment Of COPD

Aziah Ahmad Mahayiddin
Department of Medicine, Hospital Kuala Lumpur, Malaysia

The goals of effective Chronic Obstructive Pulmonary Disease (COPD) management are to prevent disease progression, relieve symptoms, improve exercise tolerance and health status, prevent and treat complications, manage exacerbations and reduce mortality. Managing COPD populations is very challenging as they typically has co morbidities, elderly in age and needing treatment for prolong period of time, thus medications used should have few side effects and easy to use. COPD and asthma are two very different diseases in terms of aetiology, pathogenesis and response to therapy. Differential diagnosis of COPD from asthma is therefore essential. In COPD patients, the cholinergic system is the primary determinant of resting bronchomotor tone.

Some cholinergic tone exists in normal airways, which results in a small amount of airway narrowing, since the airways are continuosly patent. In COPD, the airways also exhibit structural narrowing, therefore (because of airway geometry) cholinergic tone, and hence also anticholinergics, will have a greater impact. There are 3 types of muscarinic receptor (M_1, M_2 and M_3) that exist in human airways, and which are implicated in COPD. Tiotropium has a prolonged pharmacological effect at M_1 and M_3- receptors, and a relatively short duration of M_2- receptor blockade. Tiotropium therefore provides prolonged bronchodilation lasting over 24 hours, which makes it ideal for once-daily dosing.

The clinical development program for tiotropium (SPIRIVA®) has shown that tiotropium is a once daily, inhaled anticholinergic that has its effect through prolonged M_3- receptor blockade. Several large, long-term placebo- and active-controlled clinical trials have demonstrated that tiotropium provides superior bronchodilation compared with placebo, ipratropium, and salmeterol. In addition, in these trials, tiotropium improved dyspnea, which resulted in reduced use of rescue salbutamel, decrease the number of exacerbations end improve health status. Throughout the 1-year and 6-month clinical trials, tiotropium 18 pages given once daily, was well tolerated.

The approved indication for tiotropium in Malaysia is for the long-term maintenance treatment of bronchospasm and dyspnoea associated with chronic obstructive pulmonary disease (COPD).

The Epidemiology And Virology Of SARS

Lam Sai Kit
Department of Medical Microbiology, Faculty of Medicine, Universiti Malaya, Kuala Lumpur, Malaysia

Severe acute respiratory syndrome (SARS) is an infectious disease in humans that was first recognized in Southeast Asia in late February 2003. It is believed to have originated from a single health care worker from Guangdong Province, China, spreading to Hong Kong, Vietnam, Singapore and Canada, resulting in severe outbreaks. To date, over 8,000 cases have been reported from 29 countries with a case mortality rate of almost 10%. Most of the cases are in health care workers and among family members of SARS patients, with little evidence of community spread. Strict adherence to hospital infection control guidelines was enforced to prevent nosocomial spread. Malaysia reported a few cases in persons who had travel histories to affected countries and there was no local transmission. Draconian measures were instituted worldwide to prevent the spread of SARS which is seen as a travel-related epidemic. Transmission was primarily through infective droplets with the possibility of other routes of spread. Laboratory evidence points to a novel coronavirus as the causative agent. Several WHO collaborating laboratories around the world were assigned the task of developing laboratory tests to diagnose this new SARS coronavirus. Polymerase chain reaction using different primer sets designed from the full sequence of the virus showed promise. Serological tests based on immunofluorescence and ELISA were not able to provide early diagnosis. There is mounting evidence that the origin of this virus is from wild animals and molecularly similar virus strains have been isolated from several civet cats and a raccoon dog in China. Since SARS may re-emerge in the future, vaccine development is given priority but it may take a few years before such a vaccine will be available.

SARS – Clinical Spectrum & Management

Ong Kian Chung
Department of Respiratory Medicine, Tan Tock Seng Hospital, Singapore

On 6 Mar 2003, the World Health Organization (WHO) issued an alert on an outbreak of atypical pneumonia among health-care workers in a hospital in Hanoi. On 12 Mar it issued a global alert on an emerging infectious disease characterized by fever and atypical pneumonia, subsequently called severe acute respiratory syndrome (SARS). This condition is caused by a novel corona-virus and is characterized by an atypical pneumonia with efficient nosocomial transmission. The rapid spread of the disease worldwide has resulted in 8,360 cases and 764 deaths in 30 countries (as of 9 June 03). Almost every one of the 206 cases of SARS in Singapore could be traced back to an original source, who was a 23-year-old female who had returned from a visit to Hong Kong in Feb 03.

In the majority (approximately 80%) of patients, SARS ran a fairly benign course, with resolution of fever, hematological and biochemical abnormalities by the end of the second week of illness. 10% to 20% of patients had significant post-viral lethargy and malaise, and had difficulty concentrating and working up to a month after clinical recovery and discharge from hospital. These latter symptoms are also seen in other viral infections like Dengue fever or infectious mononucleosis, and spontaneously resolve.

Twenty percent of patients became critically ill and required MICU support and mechanical ventilation. These patients, besides severe respiratory involvement, also had a higher incidence of thromboembolic complications. The reasons for these are not known at this point, but may be due to a hyperimmune response to the virus. More than half eventually succumbed to the illness or attendant complications. Although SARS tends to have a fairly typical clinical course, it is clear that differentiating it from other illnesses such as Dengue or URTI in the initial phase, or community-acquired bacterial pneumonia when radiographic changes develop, is not an easy task. This is especially true when there are concomitant medical problems or infections that may obscure the features described above.

Since the responsibility of managing SARS was thrust upon Tan Tock Seng Hospital circa mid-March, all personnel had mucked in and, in a spirit of camaraderie, made an intrepid attempt to control the dreaded pestilence. To report the surfeit of lessons, some painfully learnt, that my institution has experienced in these few months will take a ream. Out of the conundrum of encounters, I have selected for presentation an aggregation of several front-liners' accounts of dealing with SARS, which was more often based on nous rather than knowledge.

Malaysian CPG On Childhood Pneumonia

Norzila Mohd Zainudin
Institute of Paediatrics, Hospital Kuala Lumpur, Malaysia

Community Acquired Pneumonia In Adults – The Malaysian Perspective

Liam Chong Kin
Department of Medicine, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia

The treatment of community acquired pneumonia (CAP) is largely empirical and challenging at initiation because the precise aetiology is usually unknown. The putative causative organism in about half of all adult patients with CAP is unknown even when carefully sought for in large prospective studies. *Streptococcus pneumoniae, Haemophilus influenzae* and *Mycoplasma pneumoniae* are the most commonly identified pathogens in studies conducted in the West. The microbial aetiology varies according to the age group and the presence of comorbid illness. Knowledge of the local epidemiology is particularly helpful when instituting empirical antibiotic therapy for CAP.

The microbiology of CAP in adult patients requiring hospitalization in studies conducted in Malaysia appears to be different from that reported in the West.[1-3] Gram-negative bacilli other than *Haemophilus influenzae* such as *Klebsiella pneumoniae* are more commonly isolated. This difference has also been shown by other studies performed in Southeast Asia.[4-8] In Malaysia and in other countries in the region with a high prevalence of tuberculosis, infection due to *Mycobacterium tuberculosis* may commonly present as an apparent CAP.[2-5] This difference from the pattern of microbiology of CAP as reported in the West must be borne in mind when prescribing antibiotics for initial empirical therapy of CAP in Malaysia. Recommendations for the antibiotic treatment of CAP in Malaysia should take into consideration results of studies on the microbial aetiology and the susceptibility pattern of identified pathogens conducted in the country.