

March 2006



## Contents

- [World Asthma Day 2005](#)
- [An Attempt at Establishing a Research Network](#)
- [Simple Flu Prevention Strategies](#)
- [ABC's of COPD](#)
- [Difficult Extubation in Children - The Approach](#)
- [Scientific Updates](#)
- [Essential Bronchoscopist®](#)
- [News Flash](#)
- [From The Editors](#)

---

### EDITORS

Richard Loh Li-Cher  
Norzila Mohd Zainudin

### EXCO OFFICE BEARERS 2005/2006

#### President

Professor Dr Liam Chong-Kin

#### Vice President

Associate Professor  
Dr Roslina Abdul Manap

#### Secretary

Dr Norzila Mohd Zainudin

#### Assistant Secretary

Dr Patrick Chan Wai-Kiong

#### Treasurer

Associate Professor  
Dr Jessie A de Bruyne

#### Assistant Treasurer

Professor Dr Richard Loh Li-Cher

#### Members

Dr Norrashidah Hj Abd Wahab  
Dr Pang Yong-Kek  
Dr Fauzi Mohd Anshar  
Dr Ashari Yunus  
COOPTED MEMBER  
Dr Zainudin Md Zin

---

## World Asthma Day 2005 Penang State Event

By Dato' Dr Hj Abdul Razak Muttalif, Penang Hospital

World Asthma Day 2005 fell on 3 May 2005. Due to other activities in the state, the celebration was held only in the month of June and July 2005. Two different functions were organized to commemorate this auspicious day. On 14 June 2005, a workshop on asthma was conducted for all doctors and paramedics from all district hospitals and health clinics in the Penang state. A total number of 50 took part in this event. Penang is fortunate to have adult and paediatric respiratory physicians. Dr Rus Anida, paediatric respiratory specialist, gave a lecture on asthma management in children and Dr Cedric Gunaratnam, lecturer from Penang Medical College, delivered a lecture on the pathophysiology and immunology of asthma. This was followed by Dr George Kutty

Simon, adult respiratory physician, Hospital Alor Setar, who talked on the asthma guideline in adults and finally Dr Rosalind Toh Beng Hong, respiratory speciality trainee, Hospital Pulau Pinang talked on complications in asthma management. In the afternoon, workshop was conducted for all the participants. They were divided into three groups and given a case scenario on asthma to be discussed and later to be presented to all the participants. The day finished with a short post-workshop evaluation and presentation. All the participants gave a very good evaluation of the course. Our thanks to the State Health Department for releasing the participants and GlaxoSmithKline for sponsoring the whole event in a nice hotel.

On 30 July, another event, Asthma Camp, took place in Penang to celebrate the World Asthma Day 2005. This time the location was the beautiful green and clean environment of the Youth Park at the Waterfall Road. The Camp was done for the asthmatic patients and their family members. A total of 150 members took part. The patients again were from all districts in Penang.

The event was officiated by the state health director and the hospital director. Several fun games, aerobic and tele-match were planned. The patients and the family had a wonderful time and towards the other half of the morning, a short lecture on asthma awareness and management was given to the members. This whole event was co-organised by the State Health Department and the Respiratory Department of Penang Hospital. Once again a sincere thanks to all parties involved in the organization and the staff of Respiratory Department Hospital Pulau Pinang did a good job in organizing the two major events for the World Asthma Day 2005.



[\[Back to Contents\]](#)

---

## An Attempt at Establishing a Research Network (Malaysian Respiratory Research Network)

by Professor Richard Loh Li-Cher

International Medical University Clinical School, Seremban

While research is always considered important, whether to improve ourselves in our daily work of treating patients, or in the advancement of science, doing research ourselves may prove hard or unnecessary. Indeed, this should not be a calling for every medical professional, but for some, especially those in academic institutions or those in today's postgraduate training, doing research is mandatory. Personally, I started doing research out of necessity during my earlier years of clinical training, but in later years, I have actually developed interest to decide on a career path of an academician, while maintaining active clinical duties.

Yet it is true that doing quality research can be tough and challenging. With the maturity of the research community to date, it is not surprising that more is required from research by means of originality and robustness of research methodology. Malaysia is also going through its own growing pains in medical research with many important initiatives from Ministry of Health e.g. clinical research centers. The acute proliferation of medical schools in Malaysia will undoubtedly provide impetus to this development too.

Seeing all this development, it seems obvious that there is also a need to exchange research ideas and collaborate with one another in a meaningful way. Respiratory research in Malaysia, no different from others, can achieve more if there is platform where different researchers from various institutions interested in particular respiratory research can meet, discuss and develop friendship. To this end, we thought of the opportunity afforded by being in Malaysian Thoracic Society (MTS), perhaps during its annual congress, to form a convenient platform for such meeting of minds and friends. This seems apt in view of the escalating number of scientific abstracts we have been receiving over the years, indicative of the kinds of participants coming to our Annual Congress.

This research platform, preliminary named as 'Malaysian Respiratory Research Network' is what MTS is proposing to have in the coming 9th Annual Congress to be held in Penang in July 2006. The main objectives are follows:

1. To link up researchers interested in respiratory research in Malaysia, to enable exchange of ideas, collaboration and friendship;
2. To enable better dissemination of important research information from sources made available by members of MTS e.g. research priorities and grants from government or other organizations on respiratory diseases;
3. To perhaps develop into clinical and scientific assemblies consisting of doctors and scientists interested with certain disease or research; such focus groups can help to solicit country-wide disease-specific data and play active role in organization of MTS activities relevant to their field.

However, it is important to explain that at present stage, it is hard to predict how this network would turn out, since we plan to leave it very much up to individuals and simply providing the some form of loose structure for meeting. Its further development is very much dependant on ourselves. I personally take the view that unless MTS takes this low-stake risk (i.e. if it dies a natural death, it really doesn't cost anything) of organizing this network, we will never know about its possible potential. So let's see.

**If you like to respond to this article, please email:**  
[richard\\_loh@imu.edu.my](mailto:richard_loh@imu.edu.my)

**For information:**

Professor Martyn Partridge from London,  
Past President of British Thoracic Society,  
will deliver the inaugural lecture for the proposed  
Malaysian Respiratory Research Network  
on 14 July 2006, 9th MTS Congress in Penang:  
**"Is it possible to be a full time clinician and  
an active researcher at the same time?"**

[\[Back to Contents\]](#)

---

## Simple Flu Prevention Strategies

By Dr Leong Oon Keong

Consultant Chest Physician, Leong Oon Keong Chest & Medical Clinic Sdn Bhd, Ipoh,  
Perak

The flu virus is mainly transmitted from person to person via droplets created by an infected person during coughing or sneezing.

Vaccination remains the best method of prevention against the flu. However during the flu season, vaccines may not be readily available. Furthermore, vaccination does not confer complete protection against the flu. Some reasons for failure include a poor immune response to the vaccine, inappropriate viral antigens in the vaccine, an unstable or denatured vaccine due to poor handling and storage.

During a flu pandemic it will take about 6 months before an appropriate pandemic vaccine can be produced. In the meantime, we must rely on simple ways of preventing the transmission of the flu virus. Here are a few suggestions: -

- Protecting Others
  - Practise cough etiquette. Cover the mouth and nose with tissue when coughing or sneezing. When tissue is not available use the upper sleeve of the shirt or blouse instead but not the hands. Dispose off used tissues properly. Wear a mask if necessary, especially when visiting health care facilities.
  - Practise frequent hand washing to prevent contamination of articles handled. Wash adequately with ordinary soap and water. Use alcohol based hand rubs when soiling is minimal and when water is not readily available
  - Practise self isolation. Do not go to work or school if one has the flu.
- Protecting Oneself
  - Practise distancing. Stay 3 feet away from anyone who is coughing and sneezing. Expelled droplets normally settle within a distance of 3 feet. Avoid crowded places.
  - Practise frequent hand washing. Wash carefully after contact with persons who have flu-like symptoms.
  - Wear a mask particularly if one is in the high-risk group and cannot avoid

getting up close with possible flu sufferers. High-risk groups include people aged 55 years and older, those who live in a longterm care facilities, children aged 6-23 months, pregnant women, and those with certain medical conditions (e.g. heart disease, lung disease and immunocompromised individuals)

- Replace handshakes and hugs when greeting each other with a "wink and a nod" instead.
  - Use anti-viral medication after contact especially if one is in the high risk group and during major flu outbreaks.
  - Stay healthy by eating balanced meals and nutritional supplements. Exercise regularly. A healthy body will be able to fight the flu virus better.
  - Stay healthy by eating balanced meals, taking nutritional supplements and drinking adequate amounts of fluids. Exercise regularly.
  - A healthy body will be able to fight the flu virus better.
- Making Clinics Safer
    - Post visual alerts at facility entrances instructing both patients and those accompanying, to alert the staff if they have symptoms of a respiratory infection.
    - Signs should instruct those with symptoms to follow recommendations for respiratory hygiene and cough etiquette.
    - Ensure there are adequate supplies of tissues, no touch waste receptacles, soap, water and alcohol based hand rubs in the clinic for doctors and patients to perform hand hygiene.
    - Offer surgical masks to persons who are coughing.
    - Coughing patients should be encouraged to sit at least 3 feet away from other patients.
    - These measures should be implemented throughout the year.
    - Healthcare personnel should observe Droplet Precautions in addition to Standard Precautions, when examining patients with symptoms of a respiratory infection, especially when fever is present.
    - Droplet Precautions include the use of a surgical mask and eye protector for close patient contact.

These simple flu prevention strategies are effective and should be enforced throughout the year. These strategies should also apply during a flu pandemic. WHO advises all health care personnel to practise Airborne Precautions during the initial stage of a flu pandemic until the mode of transmission of the pandemic flu virus is clearly established.

- Useful Websites:
  - Interim guidance for the use of mask to control influenza transmission: <http://www.cdc.gov/flu/professionals/infectioncontrol/maskguidance.htm>
  - Infection control: <http://www.hhs.gov/pandemicflu/plan/pdf/S04.pdf>
  - Cover your cough: <http://www.cdc.gov/flu/protect/covercough.htm>  
<http://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm>
  - Pandemic Influenza Health Tips: <http://www.cdc.gov/flu/pandemic/healthtips.htm>
  - Stopping the germs at home, school and work: <http://www.cdc.gov/flu/protect/stopgerms.htm>
  - Standard precautions: [http://www.cdc.gov/ncidod/dhqp/gl\\_isolation\\_standard.html](http://www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html)
  - Droplet precautions: [http://www.cdc.gov/ncidod/dhqp/gl\\_isolation\\_droplet.html](http://www.cdc.gov/ncidod/dhqp/gl_isolation_droplet.html)

[\[Back to Contents\]](#)



## ABC's of COPD

This article is contributed by the Malaysian Thoracic Society (MTS) to Star Newspaper on November 20, 2005

The acronym COPD still remains an alien term to most Malaysians, despite the fact that approximately 448,000 people from our country suffer from moderate to severe COPD<sup>1</sup>. Shocking statistics show that COPD is already ranked as the 5th cause of death worldwide alongside with other global diseases such as HIV/AIDS, heart disease, cancer and tuberculosis. According to a World Health Organization (WHO) report, this silent killer claims nearly 3 million lives annually worldwide.

And it is expected to be the largest cause of death and disability due to respiratory disease in the year of 2020.

COPD is a respiratory disease that progressively worsens lung function and limits airflow in and out of the lung especially during exhalation. The main cause of COPD is smoking, with more than 90% of COPD sufferers being smokers or exsmokers. Other causes include environmental factors such as excessive air pollution, chemical fumes and rarely genetic factors.

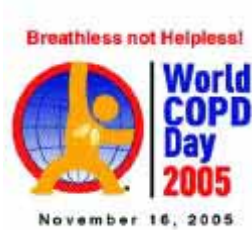
COPD is "chronic" because it lasts for a long period of time marked by frequent recurrence of symptoms. It is "obstructive" because it affects the lungs by hindering air-flow, causing patients to suffer from shortness of breath even when performing simple daily tasks. The two disease conditions under the umbrella of COPD are chronic bronchitis (chronic inflammation of the breathing tubes in the lung accompanied by excessive mucus buildup within these airway passages) and emphysema (breakdown of the walls of the air-sacs in the lungs). Once a patient is diagnosed with COPD, the damage to the lungs is permanent. Lung function will continue to decline. However, with the various treatment methods available today, there are many ways to manage the disease, to alleviate the symptoms of COPD and to allow the patients to live life to the fullest.

The common symptoms of COPD include breathlessness, cough and increased phlegm production but they are not always recognized for their real implications. Most of the time, COPD is misdiagnosed as asthma, or it may simply be attributed to ageing. Hence, it is essential to distinguish COPD from asthma as both diseases respond to different treatments. While COPD symptoms are progressive and typically worsen with age, asthma symptoms are typically more episodic, and stable over time.

The acronym ABCs of COPD helps one to recognize if one is at risk of having COPD:

- A - Age 40 years or above
- B - experience Breathlessness
- C - chronic Cough with sputum (phlegm) & Cigarette smoking

It is therefore imperative that one pays attention and seek advice from a doctor if one identifies with the ABCs of COPD above. Many are unaware of the threat of COPD until



they are no longer able to perform normal daily activities such as walking up the stairs, running for a bus or carrying the groceries. If COPD is left to worsen over time, the sufferer will consequently become a burden to his loved ones. If left untreated, it can lead to early death. So please consult a doctor today if you identify with the ABCs of COPD.

### **Do YOU know the ABC's of COPD?**

5 Questions:

1. Do you cough several times most days?
2. Do you bring up phlegm or mucus most days?
3. Do you get out of breath more easily than others your age?
4. Are you older than 40 years?
5. Are you a current smoker or an ex-smoker?

If you who answered "yes" to three or more of the questions above, you are advised to consult your doctor.

### **About World COPD Day**

World COPD Day, November 16, 2005: Breathless Not Helpless!

World COPD Day 2005 fell on November 16, 2005. The event was organized by GOLD (the Global Initiative for Chronic Obstructive Lung Disease, [www.goldcopd.org](http://www.goldcopd.org)), with support from the American College of Chest Physicians (ACCP) and its national chapters, the US COPD Coalition, the International COPD Coalition (ICC, [www.internationalcopd.org](http://www.internationalcopd.org)), the World Organization of Family Doctors (WONCA), and the International Primary Care Respiratory Group (IPCRG). It represents a partnership between health care groups and respiratory educators to raise awareness about Chronic Obstructive Pulmonary Disease (COPD).

COPD, a highly prevalent disease, has a large impact on the quality of life for patients and their families, and kills millions of people worldwide. The early stages of COPD are often unrecognized, but it is very easy to determine whether a person is at risk. If COPD is detected early, treatments are available to prevent further deterioration of lung function.

The theme of World COPD Day 2005 was "Breathless not Helpless." The theme was chosen to emphasize that breathlessness and other symptoms of COPD are not simply a normal part of aging, and that there is treatment available to help people with COPD. This positive slogan aimed to empower patients and others who have symptoms of COPD to visit their doctors and get help.

<sup>1</sup> Tan, Wan C. et al (2003) COPD prevalence in 12 AsiaDPacific countries and regions: Projections based on the COPD prevalence estimation model. *Respirology* 8, 192D198.

[\[Back to Contents\]](#)

---

## **Difficult Extubation in Children**

By Dr Norzila Mohd Zainudin, Institute of Paediatric, Hospital Kuala Lumpur

Prolonged dependence on supportive mechanical ventilation occurs as a result of acute critical illness or as a result of an underlying chronic illness.

The aetiology of difficult extubation can be divided into four major causes.

1. Central Nervous system failure-Congenital central alveolar hypoventilation;
2. Spinal cord failure. Examples are spinal cord compression, atlantoaxial dislocation commonly found in children with Down syndrome;
3. Neuromuscular disease . Examples are spinal muscular atrophy, muscular dystrophies and Duchenne Muscular dystrophy;
4. Pulmonary failure Examples are airway abnormality such as tracheomalacia, craniofacial abnormality and intrinsic lung pathology

Ventilatory dependency can be defined as reliance on ventilatory support for at least 6hours /day for >30 days. Patients who failed weaning from the ventilatory support should meet the following criteria:

- i. medical and surgical disorders which have led to the initiation of mechanical ventilation have been reversed;
- ii. medical and surgical underlying problems have been resolved, if possible;
- iii. medications including sedatives, hypnotics, bronchodilators, steroid therapy have been optimized and,
- iv. failure to wean as evidenced by multiple weaning trials by skilled and experienced respiratory care team over a period for at least 4 weeks when medical conditions are stable.

Table 1: Data in the UK showing the various aetiologies in children requiring long term respiratory support in 1997.

<b>Diagnostic group</b>	<b>Number in hospital (n = 39)</b>	<b>Number at home (n = 84)</b>
Neuromuscular disease	10	25
Spinal injury	6	10
Ondine's curse	5	13
Bronchopulmonary disease	5	1
Craniofacial syndrome	0	4
Obstructive sleep apnoea	1	3
Others	12	28

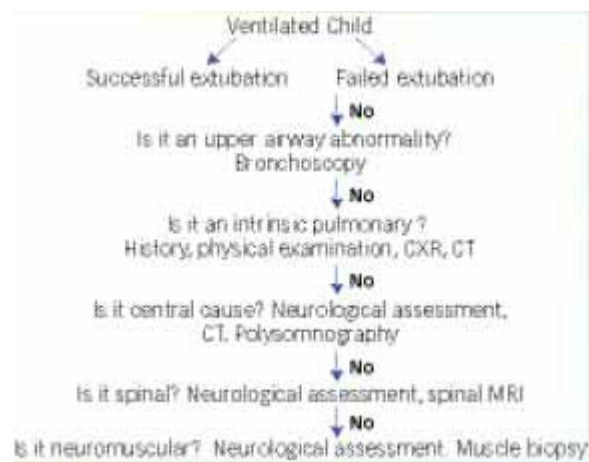
Comparing to the local data from the Respiratory unit in Paediatric Institute the underlying causes of children that required long term ventilation are shown in Table 2.

<b>Diagnostic group</b>	<b>Number</b>
Neuromuscular disease	9
Spinal cor compression	2
Central alveolar hypoventilation	3
Upper airway abnormality eg vocal cord paralysis and tracheomalacia	3
Lower airway abnormality eg diaphragmatic paralysis, broncomalacia	4
Craniofacial syndrome	6
Mitochondral cytopathy	4

### **Approach Of A Child Who Fails To Be Extubated**



In approaching the underlying aetiology, basic history and physical examination are important. In upper airway obstruction, history of stridor following extubation may raise a suspicion of subglottic edema or narrowing or tracheomalacia. This may be confirmed by bronchoscopy. Physical examination may reveal syndromes such as Crouzon and Pierre Robin syndrome. Craniofacial abnormalities due to mandible/ maxillary hypoplasia may cause upper airway obstruction that leads to failure of extubation.



The diagnosis of central alveolar hypoventilation (CCHS) can be confirmed by performing an overnight polysomnography. However it is important to rule out other causes of hypoventilation such as an underlying metabolic disease. In severe case of CCHS the patient will require a 24 hour ventilation while in milder case the child may only need ventilation during sleep.

Underlying neuromuscular diseases can be diagnosed on the history of hypotonia, delayed milestones and a detailed neurological examination. Investigations may include muscle biopsy and electromyogram (EMG).

A suspicion of spinal involvement can be excluded based on Spinal MRI. Underlying lung pathology will be based on history and physical examination. A High resolution computed tomogram is performed to detect changes such as bronchiectasis, or bronchiolitis obliterans. Bronchoscopy is performed to diagnose underlying airway abnormality such as bronchomalacia or tracheomalacia.

## Management

In children with upper airway obstruction, patient may be treated using continuous positive airway pressure machine (CPAP) via face mask to overcome the airway obstruction. In group of children that need full ventilatory support, Bilevel positive airway pressure via nasal mask or via tracheostomy is used to treat the hypoventilation. In children diagnosed with severe subglottic stenoses or vocal cord palsy tracheostomy is performed to relieve the obstruction.

A child with ventilation dependency may be considered for home ventilation when the medical condition is stable:

- The presence of stable airway
- Stable oxygen requirement usually less than 40%
- pCO<sub>2</sub> levels that can be maintained within safe limits on ventilatory equipments that is operable by the family in their home
- Nutritional intake adequate to maintain expected growth and development

- All other medications are well controlled

## Conclusion

It is important to determine the underlying cause in ventilated children who failed extubation. Common causes such as upper airway obstruction or hypoventilation syndrome either central or due to neuromuscular in origin need to be excluded.

## References

1. Jardine E, o'Toole M, Paton JY, Wallis C. Current status of long term ventilation of children in the UK questionnaire survey. *BMJ* 1999 318;295-99
2. Faroux B, Lafaso F. Non- invasive mechanical ventilation. *Euro Resp Mon* 2001;16:244-58.
3. Edwards EA, et al. Sending children home on tracheostomy dependent ventilation: pitfalls and outcomes. *Arch Dis Child* 2004;89:251-5

[\[Back to Contents\]](#)

---

## Scientific Updates

By Professor Richard Loh Li-Cher, International Medical University Clinical School

### High-Dose Acetylcysteine In Idiopathic Pulmonary Fibrosis

Demedts M, Behr J, Buhl R, et al *N Engl J Med.* 2005 Nov 24; 353(21): 2229-42.

Idiopathic pulmonary fibrosis is a chronic progressive disorder with a poor prognosis. The authors conducted a double-blind, randomized, placebo-controlled multicenter study that assessed the effectiveness over one year of a high oral dose of acetylcysteine (600 mg three times daily) added to standard therapy with prednisone plus azathioprine.

A total of 182 patients were randomly assigned to treatment (92 to acetylcysteine and 90 to placebo). Of these patients, 155 had confirmed usual interstitial pneumonia. Fifty-seven of the 80 patients taking acetylcysteine (71 percent) and 51 of the 75 patients taking placebo (68 percent) completed one year of treatment.

Acetylcysteine slowed the deterioration of vital capacity and DL(CO): at 12th month, the absolute differences in the change from baseline between patients taking acetylcysteine and those taking placebo were 0.18 liter (95 percent confidence interval, 0.03 to 0.32), or a relative difference of 9 percent, for vital capacity (P=0.02), and 0.75 mmol per minute per kilopascal (95 percent confidence interval, 0.27 to 1.23), or 24 percent, for DL(CO) (P=0.003). Mortality during the study was 9 percent among patients taking acetylcysteine and 11 percent among those taking placebo (P=0.69).

There were no significant differences in the type or severity of adverse events between patients taking acetylcysteine and those taking placebo, except for a significantly lower rate of myelotoxic effects in the group taking acetylcysteine (P=0.03).

The authors concluded that therapy with acetylcysteine at a dose of 600 mg three times daily, added to prednisone and azathioprine, preserves vital capacity and DL(CO) in patients with idiopathic pulmonary fibrosis better than does standard therapy alone.

Importance of the study: This is the first major study to address the effectiveness of acetylcysteine in treating idiopathic pulmonary fibrosis and the outcomes appeared promising. It may represent a very attractive treatment given its few toxicity, especially when compared to treatments like high-dose corticosteroids and azathioprine. However, the key question arising from this study is whether the addition of acetylcysteine here had direct beneficial effect to the lung or simply preventing the toxic effect of prednisolone plus azathioprine. The question unfortunately prevented any firm conclusion until trials have directly compared acetylcysteine alone with prednisolone plus azathioprine, which in the latter, there actually has not been any real demonstrable disease-modifying benefit anyway. Acetylcysteine is available in Malaysia, but not in Ministry of Health essential drug list.

### **Montelukast, Compared With Fluticasone, For Control Of Asthma Among 6- To 14-Year-Old Patients With Mild Asthma: The Mosaic Study**

Garcia Garcia ML, Wahn U, Gilles L, Swern A, Tozzi CA, Polos P. Pediatrics. 2005 Aug; 116(2): 360-9.

The Montelukast Study of Asthma in Children (MOSAIC study) was a 12-month, multicenter, randomized, double-blind, noninferiority trial to determine the effect of once-daily, orally administered montelukast (5 mg) (n= 495), compared with twice-daily, inhaled fluticasone (100 microg) (n= 499), on the percentage of asthma rescue-free days (RFDs) (any day without asthma rescue medication and with no asthma-related resource use).

Patients 6 to 14 years of age had mild persistent asthma (average percentage of predicted forced expiratory volume in 1 second: 87.2%). Montelukast would be considered not inferior to fluticasone if the upper limit of the 95% confidence interval for the difference in mean percentages of RFDs (fluticasone minus montelukast) was above -7% (a difference of approximately 2 days/month).

The mean percentage of RFDs was 84.0% in the montelukast group and 86.7% in the fluticasone group. The proportion of patients requiring systemic corticosteroids and the number of patients with an asthma attack were greater in the montelukast group. Both montelukast and fluticasone were well tolerated.

The authors concluded that montelukast was demonstrated to be not inferior to fluticasone in increasing the percentage of RFDs among 6- to 14-year-old patients with mild asthma. Secondary end points, including percentage of predicted forced expiratory volume in 1 second value, days with beta-receptor agonist use, and quality of life, improved in both groups but were significantly better in the fluticasone treatment group.

Importance of the study: Guidelines recommend daily controller therapy for mild persistent asthma. Montelukast has demonstrated benefit in controlling symptoms of asthma and may be an alternative, orally administered, nonsteroidal agent for treating mild asthma in children, probably non-inferior to inhaled corticosteroids.

[\[Back to Contents\]](#)

---

**Essential Bronchoscopist®**

**Introducing A Free Educational Website**

By Professor Liam Chong Kin, University Malaya Medical Centre



**The Essential Bronchoscopist®** has been intentionally designed for self and guided learning of bronchoscopy-related theory, developed by Professor Henri Colt, Director of Interventional Pulmonology at University of California, Irvine, who is also the co-author with Dr Lee Pyng, Singapore, the recently published 'Flex-rigid Pleuroscopy, Step by Step' (see last issue of Breathe).

The modular 'question-answer sets' exposes readers to a variety of ideas, images, and techniques. A mandatory 100 percent correct response score the first time the reader takes each module's post-test helps assure mastery of bronchoscopy knowledge. It is however best used to complement existing educational programs, patient-based learning experiences, textbook study, hands-on practice and other postgraduate and subspecialty training programs.

The Essential Bronchoscopist® can be accessed free on:

<http://www.ucihs.uci.edu/com/pulmonary/bronchoscopy>

It certainly provides a very comprehensive and in-depth study in bronchoscopy and interventional pulmonology.

The Malaysian Thoracic Society endorses the website as part of continuing education for the pulmonary community as well as a good tool for the training of our pulmonary trainees.

[\[Back to Contents\]](#)

---

## News Flash

### **9th Annual Congress of Malaysian Thoracic Society**

This year 2006 Annual Congress will be held in Penang from July 14 to 16, 2006, housed in the beautiful historical Eastern & Oriental (E & O) Hotel of Farquhar St. The theme 'Unexplored Respiratory Frontiers of Malaysia' seeks to capture discussions to improve our understanding of the many respiratory diseases in Malaysia and to better ourselves in treating our patients. For the first time, we are having three pre-congress workshops and are attempting to set up a research network in Malaysia (see full article in this issue). For application forms and submission of scientific abstracts, please contact Academy of Medicine of Malaysia ([acadmed@po.jaring.my](mailto:acadmed@po.jaring.my)) or visit our website at [www.my-mts.org](http://www.my-mts.org).

### **World Asthma Day Jogathon**

This year the Malaysian Thoracic Society together with the Asthma Council Malaysia (ACM) will be organizing a jogathon to celebrate the World Asthma Day. It will be held on Sunday 7 May at Padang Merbok. This event is supported by GSK.

At the moment the organizing committee chaired by Dr Norzila Mohamed Zainudin, is in the midst of preparing the event. Similar to last year, it will be a 5 km run for adults and 3 km for the children 12 years and below. We are targeting for 1,000 participants. Participation will be free. There will be goodies such t-shirts, food and drinks for the runners. There will be prizes for the first 8th winners in each categories. There will be a colouring competition for the children as well. Announcement will be made in the papers in late April. Participation forms can be obtained from the Federal Territory Athletic Amateur Association (FTAAA) office.

To all the doctors particularly members of MTS, put on your jogging shoes and start training. We don't want seat warmers. We want a doctor to win the competition as well. We're sure there will be a winner among you. Mark your calendar 4th May! Run for a good cause! Run for asthma and breathe easy.

### **Malaysian Thoracic Society 'Lung Foundation'**

The long awaited 'Lung Foundation' is finally registered under Company as a Limited Company for purpose of charity in early this year 2006. The huge effort and perseverance by Dr Zainudin Md Zin has finally paid off. The 'Lung Foundation' is set on benefiting our patients and community. More on this in the next 'Breathe' issue.

[\[Back to Contents\]](#)

---

### **From The Editors**

(via [acadmed@po.jaring.my](mailto:acadmed@po.jaring.my))

We hope you enjoy this issue of 'Breathe'. You have probably noticed that this issue remained 'expanded' like the recent issue. This is because of positive feedback encouraging us for issue of this size. Nevertheless, like most societal newsletter, we thrive on receiving contributions from members and we need your support on this. In fact, simple e mail replies to contribute comments, articles or news will go a long way to help in the 'Breathe' production. Do encourage us editors here.

For this issue, we wish to thank Merck, Sharp & Dohme (IA) Group for sponsoring.

### **Becoming Members Of Malaysian Thoracic Society**

MTS has over 100 members and welcomes all doctors with an interest in respiratory medicine, whether hospital or communitybased, to join us. The fee for life membership currently still stands at RM300 and application forms are available by writing to the Academy of Medicine of Malaysia ([acadmed@po.jaring.my](mailto:acadmed@po.jaring.my)) and downloadable from our website [www.my-mts.org](http://www.my-mts.org).