Helen Reddel
"We need to improve tools for diagnosis and assessment"
– P. 5

Vicent Mak
"I tis vital that the patient is considered holistically"
– P. 8

Rafael Stelmach
Construindo e consolidando o conhecimento nas doenças respiratórias
– P. 13

Miguel Román--Rodriguez
What works in education inhalers?
– P. 10

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Jornal Médico Congresso
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1st Ibero-American Primary Care Respiratory Meeting
&
9th IPCRG World Conference
Porto, Portugal
31 May - 2 June 2018

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A maior Conferência de sempre
The largest Conference ever


Carlos Gonçalves, Luís Amorim Alves, Jaime Correia de Sousa e Rui Costa

1050* participantes de 48 países

***Às 19 h. de ontem**

Jaime Correia de Sousa passou ontem o testemunho a Ioanna Tsiligianni, a sua sucessora na presidência do IPCRG.

Sessão de abertura

MIGUEL GUIMARÃES, BASTONÁRIO DA OM, DIZ SER ALGO "ESSENCIAL"

Formar os melhores médicos para continuar a aplicar a melhor prática clínica

"A formação médica e o progresso científico continuam a ser uma prioridade para a Ordem dos Médicos e para os médicos portugueses." A afirmação é de Miguel Guimarães e foi proferida, ontem à tarde, na abertura da 9.ª Conferência Mundial do IPCRG/1.ª Conferência Ibero-Americana de Saúde Respiratória em Cuidados Primários.

De acordo com o bastonário da OM, a formação médica e o progresso científico não contribuem só para a ativação do conhecimento e da experiência, mas constituem "um sinal para a sociedade civil".

"É essencial formarmos os melhores médicos para continuarmos a aplicar a melhor prática clínica tanto a nível nacional como internacional", sublinhou, acrescentando que "a promoção da Saúde e a prevenção da doença têm de ser o enfoque para tratar melhor os doentes".

"A troca de conhecimentos faz progredir a Medicina. Esperamos, no nosso sistema de saúde, poder continuar a prestar os melhores cuidados de saúde, nomeadamente nos CSP", referiu.

Miguel Guimarães fez ainda questão de expressar o seu contentamento em relação ao IPCRG pelo "trabalho fantástico" que tem feito, felicitando, em particular, o "enorme" contributo de Jaime Correia de Sousa para o desenvolvimento dos cuidados respiratórios.

(Continua na pág. 2)

PUBLICIDADE

(Continuação da pág. 1)

Rui Moreira, presidente da Câmara Municipal do Porto, também marcou presença na cerimónia de abertura, tendo dado as boas-vindas aos conferencistas, nomeadamente às quase cinco centenas de estrangeiros.

Por sua vez, e ainda na qualidade de presidente do IPCRG, Jaime Correia de Sousa, que ontem, ao final da tarde, passou o testemunho a Ioanna Tsiligianni, da Grécia, salientou o sucesso do evento, que somou mais de um milhar de inscrições, o que faz desta Conferência a maior de sempre do IPCRG.

Seguiram-se duas palestras, uma proferida por Rafael Bengoa, de Espanha, intitulada *"New vistas for the inevitable transformation of health care"*, e a segunda por Vincent Mak, do Reino Unido, que incidiu sobre o tema *"What is value in respiratory care?"*. A apresentação de ambos os palestrantes foi da responsabilidade de Luís Amorim Alves, presidente da Comissão Científica da Conferência.

GRESP lança guia sobre cuidados personalizados aos doentes adultos com asma

O GRESP lançou, ontem, o guia "Cuidados personalizados: adultos com asma", que tem como objetivo ajudar os profissionais dos CSP

a promover cuidados personalizados aos doentes adultos com asma, oferecendo orientação prática sobre o que perguntar, o que aconselhar e que ações realizar nas consultas. O documento resulta da tradução para português de um documento publicado pelo International Primary Care Respiratory Group (IPCRG)

Inaladores que ganham vida ao som da música...

Na abertura do evento, a Orquestra de Bandolins de Esmoriz apresentou os *metroinhalers*, em que os sons dos inaladores se transformaram num metrónomo musical, ao som da música *Plink Plank Plunk*. Eurico Silva, médico de família da USF João Semana, integra a orquestra há mais de 25 anos, como dirigente e músico.

Todas as sessões plenárias que decorrem na *Archive Hall* têm tradução em simultâneo em inglês e português. Por sua vez, as sessões do programa Ibero-Americano foram em português e/ou castelhano, com a apresentação de *slides* nos dois idiomas.

Ioanna Tsiligianni é a nova presidente do IPCRG

Ioanna Tsiligianni, da Grécia, assumiu, ontem, a presidência do IPCRG, sucedendo no cargo a Jaime Correia de Sousa. Durante a Assembleia-Geral, ficou a conhecer-se também o nome do presidente seguinte, Janwillem Kocks, da Holanda.

JORNAL MÉDICO CONGRESSO

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Liliana Silva, José Eduardo Oliveira, Eurico Silva, Maria do Carmo Cordeiro e Isabel Portela Ferreño

Curso de um dia para enfermeiros, farmacêuticos e profissionais de saúde

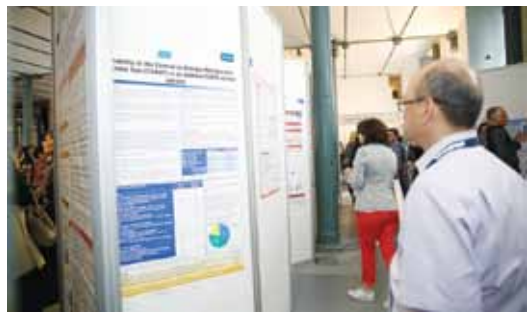
Realizou-se, ontem, durante todo o dia, um curso para enfermeiros, farmacêuticos e profissionais de saúde. De acordo com o seu coordenador, Eurico Silva, o objetivo do curso, que contou com 45 participantes, foi, sobretudo, "capacitar e formar a equipa de saúde que trabalha na área das doenças respiratórias".

O curso, ministrado por dois médicos e três enfermeiros, foi uma iniciativa conjunta do GRESP e do GRAP, este último representado pela enfermeira Isabel Portela Ferreño, uma das formadoras.

Rui Costa, coordenador do GRESP-APMGF, Sónia Martins, coordenadora do GRESP Brasil, e Enrique Mascarós Balaguer, presidente do GRAP (Espanha)

5.as Jornadas
GRESP
12 e 13 de abril
2019

A próxima Conferência Mundial do IPCRG terá lugar em 2020 e será na Irlanda ou na China, os dois países que se propuseram acolher o evento.



9th IPCRG World Conference

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Pedro Fonte (member of GRESP)
Tiago Maricoto (member of GRESP & OF the Board of APMGF)
Ana Margarida Cruz (member of GRESP)
Cláudia Vicente (member of the Board of GRESP - Secretary)

Grupo de Estudos de Doenças Respiratórias (GRESP) apresenta projeto CAPA

O IPCRG apresentou ontem o projeto ARC - *Asthma Right Care,* iniciado em quatro países-piloto, onde se inclui Portugal, através do GRESP-APMGF, com o nome de CAPA - Cuidados Adequados à Pessoa com Asma.

De acordo com o Grupo Coordenador do CAPA, Cláudia Vicente e Nuno Pina, membros do GRESP, o principal objetivo deste projeto é promover o diálogo entre profissionais e entre estes e os doentes e cuidadores, criando um movimento social. Este movimento pretende consciencializar para a melhoria dos cuidados na asma e, consequentemente, para um melhor controlo da doença.

Numa sessão que decorreu ao final da tarde desta quinta-feira, foram apresentados os materiais educativos que também serão usados nesta campanha, tendo como base a primeira ideia que, conforme refere Cláudia Vicente, consiste em "reduzir o uso abusivo dos broncodilatadores de curta duração (SABA) no tratamento da asma".

Segundo Nuno Pina, internacionalmente, já existem algumas ferramentas (apresentadas na sessão), como a régua e baralhos de cartas, que poderão ser utilizados quer no contacto com outros profissionais de saúde, quer com os doentes, com o intuito de "consciencializar e sensibilizar os doentes e os profissionais para o sobreuso dos SABA."

A iniciativa envolve vários parceiros, em particular a Sociedade Portuguesa de Pneumologia, a Fundação Portuguesa do Pulmão, a Associação Nacional das Farmácias, a Associação de Farmácias de Portugal, a Sociedade Portuguesa de Alergologia e Imunologia Clínica, a Associação Portuguesa de Asmáticos e a Sociedade Portuguesa de Pediatria. As Farmácias Holon e profissionais de Enfermagem e de Cardiopneumologia também se associaram ao projeto.

Cláudia Vicente e Nuno Pina

HELEN REDDEL, RESEARCH LEADER AT THE WOOLCOCK INSTITUTE OF MEDICAL RESEARCH, UNIVERSITY OF SYDNEY:

"To improve prescribing, we need to improve tools for diagnosis and assessment, and ensure that they are feasible for use in primary care"

Yesterday, in the Conference, Helen Reddel talked about how a primary care physician chooses the most appropriate treatment for a patient who presents with respiratory symptoms, and how and when the patient's response to treatment should be assessed. She is a respiratory physician mainly working on primary care and population research about chronic airways disease, together with clinical practice guidelines for asthma and COPD. She is also a Research Leader at the Woolcock Institute of Medical Research, University of Sydney; Chair of the Science Committee of GINA; Clinical Adviser for the Australian Centre for Airways disease Monitoring (ACAM); and a member of the Australian Asthma Handbook Guidelines Committee.

"The primary care physician has an essential role in the treatment of respiratory diseases"

***Just News* (JN) – What role does the primary care physician play when it comes to the treatment of respiratory diseases?**

HR – The primary care physician has an essential role in the treatment of respiratory diseases, because most of the common acute and chronic respiratory diseases are diagnosed and managed in primary care, and only a small proportion need referral to a specialist.

JN – In your communication you will talk about "Right Treatment and right review". Can you please define "Right treatment" and also "Right review"?

HR – "Right treatment" means treatment that is most appropriate for the patient, based on their symptoms and diagnoses (or most likely diagnoses), evidence for the benefits and risks of relevant treatment options, and the availability of these treatments (including any local eligibility criteria). In addition, the physician should take into account whether the patient has any phenotypic characteristics, comorbidities or risk factors that affect their future risk or their likely treatment response compared with other patients and, for inhaled medications, whether they are able to use the device correctly. "Right treatment" also means taking into account the patient's own personal preferences and goals, whether they are likely to be adherent, and whether they can afford the medication.

JN – In your opinion, what can be done in clinical practice to make sure that the right treatment is prescribed to the "right" patient?

HR – To improve prescribing, we need to improve tools for diagnosis and assessment, and ensure that they are feasible for use in primary care. In respiratory medicine, we currently have few high quality tools that provide clear direction for treatment recommendations, so we need further studies to identify factors that are associated with better or worse outcomes to treatment, or safety concerns, in a broad range of patient populations. We should also ensure that the evidence upon which treatment recommendations are made does not only include their efficacy and safety from closely regulated studies in highly selected, highly adherent, populations (essentially demonstrating proof of concept), but that it also includes their efficacy and safety in real-life populations, with the sort of comorbidities and behaviors typically seen in patients in clinical practice.

JN – In your point of view, what is the importance of a good communication/relation between patients and doctors or nurses?

HR – Good communication between patients and health care professionals is essential! Good communication involves establishing a two-way relationship of mutual respect and trust between the patient and the health professional, and I believe that this is an essential requirement for good clinical and humanistic outcomes.

JN – Which are the direct consequences and implications of prescribing an appropriate treatment to a patient who has a chronic respiratory disease? What is the direct and indirect impact of choosing "the right treatment"?

HR – The aim of prescribing the right treatment for an individual patient with chronic respiratory disease is to maximise the potential for a positive clinical benefit (reduced burden of symptoms, improved quality of life, and reduced risk of adverse outcomes such as exacerbations or accelerated decline in lung function) and to minimise the potential for negative impact (e.g. side-effects or financial hardship). The indirect impact of choosing the right treatment at the personal level is that the patient is more likely to be able to perceive the benefit of the treatment, and is therefore more likely to continue taking the medication; and at the population level, that the cost-effectiveness of the treatment will be optimised. From the opposite perspective, an inappropriate treatment may lead to greater burden of disease, greater risk of side-effects, and greater cost to the health care system.

JN – Do you think that doctors should involve patients in medical education, especially when it comes to teach the patients how to use the devices properly – since the appropriate use of the devices can influence the clinical outcomes?

HR – Patient education is an essential part of management of any chronic condition. This not only involves providing information about the patient's medical conditions and diagnoses, but also explaining to them why treatment may be needed, how it works, what are the potential benefits and risks, and what the patient should do if the treatment does not appear to be working or if they develop new symptoms. For chronic respiratory diseases such as asthma or COPD, many of the currently available treatments are given by inhalation, but most patients (up to 80-90% patients in some studies) do not use their inhalers correctly. It is even more challenging with the large range of different inhaler types that are now available, each with varying instructions for correct use. Evidence from primary care demonstrates that simple interventions can improve inhaler technique and improve clinical outcomes, but that inhaler technique needs to continue to be checked and corrected on an ongoing basis in order to sustain this improvement. A further striking finding is that many doctors, nurses and pharmacists also do not know how to use different types of inhalers correctly, so education of health professionals about inhaler technique is an area of substantial need.

JN – What messages do you want to clarify in your presentation?

HR – Chronic respiratory disease is a particularly challenging area for implementation of the concept of "right treatment", because there is no clear distinction between the definitions of asthma and COPD, and many patients have features of both conditions. In addition, asthma and COPD are heterogeneous conditions, but most evidence to date is from highly specific populations at the opposite ends of the spectrum of airways disease. Importantly, this evidence demonstrates striking safety signals that have led to diametrically opposite clinical recommendations for treatment of asthma and COPD (i.e. treatment of COPD should be started with a long-acting bronchodilator alone, and inhaled corticosteroids should only be used in a subset of patients; and by contrast, most patients with asthma should be treated with an inhaled corticosteroid, and patients with asthma should never be treated with a long-acting bronchodilator alone, without ICS).

We are currently only just beginning to understand the mechanisms behind various clinical, pathological or immunological phenotypes that overlap between the extremes of 'classic' asthma and 'classic' COPD, and the different treatment approaches that may be beneficial, so current treatment recommendations for patients who have features of both asthma and COPD are interim, and based on safety. There is a great need for further studies in broad populations with chronic respiratory symptoms, in order to be able to develop more specific treatment guidelines for patients with chronic respiratory disease. The opportunities at present for precision medicine in chronic respiratory disease are limited, but personalised medicine can be implemented for all patients, by taking a patient-centered approach and involving the patient in shared decision-making.

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DAVID PRICE, PRIMARY CARE RESPIRATORY SOCIETY PROFESSOR OF PRIMARY CARE RESPIRATORY MEDICINE AT THE UNIVERSITY OF ABERDEEN:

"Studies have shown that ICS use is associated with increased risk of adverse effects"

David Price, Managing Director of Observational & Pragmatic Research Institute (Singapore) and Optimum Patient Care (Australia, Singapore, and UK) and Primary Care Respiratory Society Professor of Primary Care Respiratory Medicine at the University of Aberdeen (UK), will talk about "Overuse of ICS in COPD". In an interview with *Just News* he tells the messages he wants clarify.

***Just News* (JN) – How do you summarize the main topics of your presentation?**

David Price (DP) – My presentation will highlight current guideline recommendations for ICS prescribing, and how this compares to ICS use in real life. It will also discuss the safety risks surrounding ICS use, and how to identify which patients should be prescribed ICS.

JN – What can be the implications of ICS Overuse in COPD?

DP – There are numerous safety concerns when looking at ICS overuse in COPD. Studies have shown that ICS use is associated with increased risk of adverse effects, including pneumonia, tuberculosis, osteoporosis, diabetes, and oral thrush.

JN – Which are the direct consequences and implications of prescribing an appropriate treatment to a patient who has a COPD?

DP – Prescribing an appropriate treatment to a patient with COPD can greatly improve outcomes and overall health-related quality of life. Some direct consequences include reduced COPD symptoms, improved lung function, and reduced rate and severity of exacerbations.

JN – What messages do you want to clarify in your presentation?

DP – Due to the safety risks surrounding ICS use, the messages I wish to clarify are the importance of considering the risk/benefit ratio of ICS use, and adopting a personalised approach to ICS prescribing. This includes identifying patients who would benefit from addition of ICS to their regimen, and how ICS withdrawal can be safely achieved in appropriate patients.

"There are numerous safety concerns when looking at ICS overuse in COPD"

Tailored intervention for ANxiety & Depression Management in COPD (TANDEM)

Hilary Pinnock

Professor of Primary Care Respiratory Medicine, The University of Edinburgh. Asthma UK Centre for Applied Research, NIHR Global Health Research Unit on Respiratory Health (RESPIRE). Allergy and Respiratory Research Group, Usher Institute of Population Health Sciences and Informatics, Doorway 3, Medical School, Teviot Place, Edinburgh EH8 9AG. General Practitioner, Whitstable Medical Practice

Many people with chronic obstructive pulmonary disease (COPD) also suffer from anxiety and/or depression. The UK TANDEM randomised controlled trial (Tailored intervention for ANxiety and DEpression Management in COPD) is looking at the benefits of offering people with moderate to severe COPD and mild or moderate anxiety or depression, one to one psychological support and advice delivered by a trained respiratory health care professional (nurse, physio or occupational therapist) prior to attending pulmonary rehabilitation.

The intervention uses the principles of Cognitive Behaviour Therapy (CBT), combined with practical advice and support from the SPACE (Self-management Programme of Activity, Coping and Education) COPD manual™ http://www.spaceforcopd.co.uk/ developed by the University Hospitals of Leicester NHS Trust, and will encourage and support patients to attend and complete pulmonary rehabilitation.

Both pulmonary rehabilitation and CBT improve anxiety/depression and symptoms of breathlessness, so by combining both treatments in the TANDEM intervention, the researchers hope that patients with both COPD and anxiety/depression will get additional benefit. The intervention is being delivered by trained respiratory health care professionals (including practice nurses with expertise in respiratory health) to patients in their own homes or other convenient venue, supported by a clinical psychologist throughout the study. The team is co-led by Prof Stephanie Taylor, Barts and The London School of Medicine & Dentistry, Queen Mary University of London and form me, who will present an overview of the trial.

This session will describe the evidence for TANDEM, update with the learnings from the pilot phase, and open up discussion about its value for a global audience.

Many people with chronic obstructive pulmonary disease (COPD) also suffer from anxiety and/or depression.

RASTREIO DO CANCRO DO PULMÃO

Saber se a redução da mortalidade justifica sobrediagnóstico e falsos positivos

Bruno Heleno, médico de família da USF das Conchas, no Lumiar, vai tentar sintetizar hoje, numa palestra, o que atualmente se sabe sobre cancro do pulmão.

Em declarações à *Just News*, o professor auxiliar de Medicina Geral e Familiar na NOVA Medical School/Faculdade de Ciências Médicas, da Universidade Nova de Lisboa afirma que "sempre que há um novo tratamento ou uma nova forma de prevenção devemos primeiro parar para pensar se os benefícios ultrapassam os malefícios e, depois, analisar se existem alternativas".

Segundo o médico, há, pelo menos, duas estratégias para reduzir a mortalidade de cancro do pulmão em Portugal: o seu rastreio e a cessação tabágica.

E relata que houve um ensaio clínico que demonstrou uma redução da mortalidade específica por cancro do pulmão e uma redução da mortalidade por todas as causas com rastreio com TC de baixa dose.

Nesse ensaio clínico, explica, "ficou também claro que o rastreio com TC de baixa dose leva a sobrediagnóstico de cancro (isto é, à deteção de cancros que não evoluiriam para sintomas durante a natural esperança de vida do doente) e a falsos positivos (isto é, a deteção de alterações no exame de rastreio em pessoas sem cancro do pulmão)".

A grande dificuldade é, nas suas palavras, "saber se a redução de mortalidade nalguns indivíduos rastreados justifica que haja sobrediagnóstico e falsos positivos noutros indivíduos".

Bruno Heleno

Na palestra, contrastará também com o que se sabe sobre impacto da cessação tabágica intensiva que, conforme refere, reduz a mortalidade específica de cancro do pulmão, de doenças cardiovasculares e a mortalidade global, não levando a sobrediagnóstico e a falsos positivos.

Na sua ótica, "com recursos ilimitados, faz mais sentido aumentar a acessibilidade à estratégia que tem melhor relação entre benefícios e malefícios".

HENRIQUE BARROS, PRESIDENT OF THE INSTITUTE OF PUBLIC HEALTH FROM THE UNIVERSITY OF PORTO AND OF THE INTERNATIONAL EPIDEMIOLOGICAL ASSOCIATION:

"Health is an essential component of our social make-up"

In addition to being Physician, Henrique Barros, one of the speakers in the Conference, are professor of Epidemiology at the Faculty of Medicine of the University of Porto (FMUP), president of the Institute of Public Health from the University of Porto and also of the International Epidemiological Association. You are also been involved in the creation of Master's degrees in Public Health (which coordinates), Epidemiology, Health Education and Sociology and Health. In an interview, he says that "health is an essential component of our social make-up".


"Without research we are back to darkness"

***Just News* (JN) – What is more attractive to you in your work?**

Henrique Barros (HB) – Teaching and training people complements research – this is the expected role of a university professor whatever the field of interest. For someone trained as a clinician it also continues the reason of a professional choice: loving to work with people and making their life something better.

JN – What is the role of public health schools and academic centres?

HB – Making health a human right!

JN – How important is public health research?

HB – Public health sciences provide evidence for policy choices and more effective population programs. Without research – in particular basic research or what Abraham Flexner called in the late thirties of the 20th century the "usefulness of useless knowledge" – we are back to darkness, arbitrariness or irrationality, but mainly continued inequity.

JN – Your communication is entitled "Health as Social Movement". In what perspective can health be a social movement?

HB – Health is an essential component of our social make-up. And by definition it reflects the movement of ideas, concerns, power relations and consensus of societies. It moves as populations move: in all geographies and all biological settings.

JN – What kind of social movements can exist in health?

HB – The same as in the overall society. Which results in complex structures and balances along centuries. Plus the subtle changes in biopolitics now enriched or, if we want, confused by the explosion of medical devices and technologies, and how we organize and finance access to them what we call access to healthcare

JN – What is their relevance?

HB – In the end, they determine for how long and how (quality of life) we survive!

JN – What are the main topics of your presentation?

HB – As the famous Portuguese poet (Camões) put it long ago: that life is a perpetual movement of change. As it is health and the way we perceive it.

O papel dos doentes nos cuidados respiratórios

Isabel Saraiva, vice-presidente da RESPIRA - Associação Portuguesa de Pessoas com DPOC e outras Doenças Respiratórias Crónicas, será uma das palestrantes da sessão de encerramento, que incidirá sobre o tema *Respiratory 2030: Our vision for value-based encounters in respiratory care: how to create a movement for change*.

A RESPIRA é uma instituição particular de solidariedade social (IPSS) que visa contribuir para a prevenção e tratamento das doenças respiratórias e ser um pilar na defesa dos direitos e interesses das pessoas com doença pulmonar obstrutiva crónica (DPOC) e outras doenças respiratórias crónicas.

Focando o papel dos doentes no centro das discussões sobre as doenças respiratórias, tanto a nível público como privado, Isabel Saraiva apresentará dois exemplos de sucesso. Um prende-se com o facto de os doentes estarem integrados na Agência Europeia do Medicamento (EMA) desde 1995. "Hoje, a EMA está preparada para trabalhar com os doentes de uma forma muito profissional, havendo, inclusivamente, legislação que ajuda os doentes a melhor se integrarem nas suas estruturas", afirma, prosseguindo:


Isabel Saraiva

"A presença dos doentes na EMA é duplamente importante, na medida em que os mesmos são peritos na sua própria doença. E, além de poderem influenciar a aprovação dos medicamentos, também é um processo interessante de aprendizagem para eles próprios."

O outro exemplo é o da European Lung Foundation, da qual Isabel Saraiva é presidente. Esta estrutura, que se insere na European Respiratory Society, destina-se a transmitir informação ao público e aos doentes em particular, envolvendo os últimos em atividades ligadas à área respiratória.

Na palestra, a vice-presidente da RESPIRA abordará, também, o papel dos doentes nos sistemas nacionais de saúde, em particular no que respeita às questões ligadas ao acesso, ao financiamento e à equidade.

"Sabemos que o sistema de saúde se defronta hoje com um conjunto alargadíssimo de problemas. Mas, se ouvirmos os doentes, as questões ligadas à sustentabilidade do sistema, ao acesso e à equidade são mais facilmente abordadas."

Explorará, também, a área da pesquisa, em que os doentes assumem papéis importantes, sobretudo nos ensaios clínicos, na farmacovigilância e nas prioridades da pesquisa.

Isabel Saraiva alertará ainda para a necessidade de ajudar os doentes a navegar dentro dos sistemas de saúde, que, refere, "são muito complexos". "Um doente que esteja informado e saiba navegar num sistema de saúde adere melhor ao tratamento e, no limite, está mais bem integrado no seu tratamento, permitindo uma poupança de recursos humanos e financeiros."

Também chamará a atenção para a necessidade da integração de cuidados de saúde (primários, hospitalares e paliativos).

A vice-presidente da RESPIRA termina mencionando o quão "mau" é ter falta de ar, sublinhando que os doentes necessitam de ajuda e o facto de a Associação ser chamada a participar na Conferência é um "excelente passo para a ajuda se concretizar".

"A presença dos doentes na EMA é duplamente importante, na medida em que os mesmos são peritos na sua própria doença."

Investir nos problemas relacionados com a poluição

A RESPIRA foi criada há 10 anos e durante este tempo tem desenvolvido diversas atividades, com o intuito de chamar a atenção para as doenças respiratórias.

Na próxima década, a Associação vai continuar a investir nestas atividades, acrescentando alguns aspetos novos que estão relacionados com problemas emergentes, como a poluição, "fator de agravamento das doenças respiratórias".

"As questões da qualidade do ar, interior e exterior, têm de ser tidas em linha de conta quando nós falamos de doenças respiratórias. Só há relativamente pouco tempo é que começa a ser feita uma ligação absolutamente objetiva entre a qualidade / falta de qualidade do ar e as doenças respiratórias", salienta.

Entre as diversas atividades desenvolvidas pela RESPIRA, Isabel Saraiva destaca as idas às escolas para sensibilizar para os perigos do tabagismo e o espetáculo "RESPIRA a cantar". "Há uma ligação grande entre o canto e a respiração. A pessoa que não consegue respirar bem não consegue cantar e quando canta tem de saber respirar."

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1st Ibero-American Primary Care Respiratory Meeting
&
9th IPCRG World Conference
Porto, Portugal

VINCENT MAK, CONSULTANT PHYSICIAN IN RESPIRATORY INTEGRATED CARE AT THE IMPERIAL COLLEGE HEALTHCARE TRUST, LONDON:

"It is vital that the patient is considered holistically and not just the organ system or the disease that we are interested in"

Vincent Mak is one of the Conference's speakers. He is currently a consultant physician in respiratory integrated care in Imperial College Healthcare Trust, London, and the Respiratory Medical Lead and Chair of the NHS London Procurement Partnership Responsible Prescribing and Value in Healthcare workstream. He was a Clinical Co-Lead in the NHSE London Respiratory Network and the Clinical Director of the Outer NWL Integrated Care Program, and then the Whole Systems Integrated Care Programme Board for North West London.

***Just News* (JN) - What is the real meaning of "value" in Respiratory Care?**

Vincent Mak (VM) - Healthcare resources have always been constrained and it is up to us as healthcare professionals to make the most of the resources we have. That means that we should ensure that we can achieve the best and most meaningful outcomes using the resources we have, not just for individual patients, but for the whole population of patients with a common need.

JN - What can be done in clinical practice to improve the "value "in Respiratory Care?

VM - We need to examine carefully what we do. A lot of what we do, may not add "value" but we continue to do them because we have always done them and have never questioned why. For instance, does monitoring FEV1 yearly in patients with COPD change outcomes for that patient? Does regular monitoring of FEV1 make any difference to the population of COPD patients as a whole? If not, then we should abandon it and spend the time and resources on doing interventions with higher value such as ensuring that the patient stops smoking. We have to examine what is of low value and redirect resources (be that time or money), to do more of what is high value. In order to achieve this, we need access to data that shows us clinical and financial variation across care providers. It is only then that we can see differences in outcomes and degrees of variation. This should stimulate the debate of whether this variation can be explained or is unwarranted.

"Keeping people in the best health possible should be better for the patient and more cost effective"

JN - Which goals can be achieved when we optimize the Respiratory Care, adding "value"?

VM - The ultimate goal would be to have a high quality, affordable and sustainable healthcare system that focuses on the needs of the patient and the population rather than just increasing the throughput of the system hoping that will produce quality. We should aim to provide proactive health maintenance rather than current reactive healthcare at times of crisis. Keeping people in the best health possible should be better for the patient and more cost effective than treating them when they are sick.

JN - Do you consider that the models based on a patient centred care approach can be a way of adding value?

VM - Absolutely. Doing what is right for an individual patient at the right time, in the right place by the right person first time, should deliver quality and value. However, we must not forget that value must also be considered in the wider patient population and employ interventions that will benefit everyone (such as improving air quality and providing opportunities for increasing physical activity and exercise).

JN - Which models can be implemented and what kind of value can be achieved?

VM - There is no one single model. Care should be considered as a continuum from disease prevention or limitation through to advanced and palliative care and commissioned as such. It is vital that the patient is considered holistically and not just the organ system or the disease that we are interested in. For this to happen, we must escape the silo working that is so common now. This is enabled by working in an integrated manner involving all care providers and facilitated by good communication and sharing of information (preferably using a single common record).

JN - What are the main challenges in Respiratory Care in nowadays?

VM - The main barriers to achieving value is not knowing how well or badly we are doing – ignorance is bliss. We all think that we are doing a good job, but how do we know that we cannot do better? Ignorance also gives rise to resistance to change. We all think that we follow best practice guidelines, but if that is so, why is there so much unexplained variation. Knowledge of how our own service performs against similar care providers gives us an opportunity to see if we can do better. Providing this information is vital. We all come to work to do the best we can; knowing that we are not providing the best care will stimulate us to change.

Another barrier is the structure of working in silos. There is often a culture of "I only deal with the lungs". However, there are so many other factors that can influence the outcomes of the patients, we should be able to deal with as many of these aspects within our own team or draw in expertise to work with us rather than wash our hands of the problem. We need to carry out all care in a holistic manner and be sure that we deal with our patients as people rather than just a pair of lungs.

JN - Besides these topics, could you please explain with some detail the other issues that will be highlighted in your presentation? How would you sum up your communication, in a few sentences?

VM - Value also involves minimising waste. Poor adherence to medication and poor inhaler technique wastes enormous amounts of financial resource that could be used elsewhere. We have known about poor compliance with medications for decades and little has changed. So perhaps we need to have a new paradigm of treatment that embraces human behaviour rather than continue doing the same thing again hoping for a different outcome.

Providing value should be a priority for all of us to help provide a high quality sustainable healthcare system for the future. We have a responsibility to patients and to those who fund the healthcare system to deliver not just the highest quality care we can, but also the best value care in a increasingly resource constrained world. As Sir Muir Grey said: "clinicians will need to accept that they are responsible for the stewardship of resources and not just their use".




Treating tobacco dependence workshop: what works?

Noel Baxter

General Practitioner, UK

Tobacco harm is a well-recognised problem that has seen successful public health and legislative interventions but the impact on patient outcomes is not being acknowledged and acted on by the health system

As the prevalence of smoking diminishes in many countries – with fewer than 1 in 10 now smoking in some regions – tobacco dependency increasingly exists within a population that is less well-off, has multiple health conditions and uses most health resource including high cost beds and interventions.

Healthcare providers and those responsible for providing high value healthcare systems must now consider a new approach towards the tobacco-smoking problem to sustain and build on the good progress made by public health interventions and legislation.

It is health professionals who see these patients who remain tobacco users but the expertise, and resource does not currently sit within the health system to deal with it. An urgent shift in skills, knowledge, education and resource is thus required.

Smoking is increasingly viewed both as a multi-morbid and long-term relapsing condition that usually starts in childhood.

Treating tobacco dependency systematically and effectively will thus have a significant impact on the triple aim of improved individual health outcomes and quality of life for some of the most vulnerable and deprived groups in society; equitable distribution of healthcare resources, and improved population outcomes.

In the UK the average annual number of visits per person to their GP surgery is now approximately six and is likely to be higher in people who smoke because tobacco smoking causes ill health; smokers are over-represented in total attendances compared to never smokers, creating a wealth of additional opportunities to tackle their tobacco dependency in general practice.

Diagnosing tobacco dependency in clinical practice

If we consider that tobacco dependency is a long-term condition then we need to diagnose and then work with patients to plan a short, medium and long-term plan, as we would say with treating Diabetes or Hypertension.

Depending on the clinical setting we can use one or more of these methods:

- Very Brief Advice - The first constituent of VBA is the 'ASK', a question that yields a self-reported status when the clinician asks in a neutral manner such questions as: "Do you smoke?" or "Your records say you smoke, has that changed?" The precise wording and approach will depend on clinical judgement and the relationship (brief encounter or long-standing) with the patient. This step can and should be taken by both prescribers and non-prescribers in order to gain information about status, provide information about how best to quit and it may initiate a conversation around smoking that will result in the following measures being taken.
- Objective analysis. This provides the most compelling evidence of present or recent tobacco use, though these data have limitations with regard to past use and current levels of use:

a. The exhaled carbon monoxide (CO) test. This detects carbon monoxide inhaled in the last 12 hours. Higher levels (parts per million) equate with greater inhalation of tobacco smoke assuming the cause is tobacco smoking

b. The Fagerstrom test which provides a score for nicotine dependency. For time pressured clinical environments, the one question that is most helpful in determining a high nicotine addiction is: **How soon after waking do you smoke your first cigarette (use tobacco)?** Patients can respond with i) <5mins ii) upto 30 minutes

c. Heaviness of smoking index (HIS)

d. Pack years (https://www.smokingpackyears.com/)

e. Number of years smoked

2. Other evidence (clinical signs and symptoms, or reports from informed third parties)

a. Lung age

Levels of dependency

It may be important to stratify those likely to need more intensive intervention to quit. This might include:

- Those who continue using tobacco as they age
- People with severe mental illness
- Those who continue to use tobacco whilst experiencing a severe, life shortening, disabling or frightening co-morbid problem

Interventions to support a quit attempt

England's National Institute for Clinical and Care Excellence (NICE) has described those interventions at person, organisation and system level that have a clinical and cost effectiveness evidence base. In the workshop we will look at the right behavioural change interventions, the prescribing of Nicotine replacement therapy and how to ensure the right dose if given in the right way. We will also look at other pharmacological options and explore what populations these can be used in. Finally we will explore the use of vaping in harm reduction for people who currently smoke and want to reduce the risk of tobacco smoking.

The patient as a decision-maker

Juliëtte Kamphuis

Patient representative, the Netherlands

It has been roughly two years ago that International Primary Care Respiratory Group (IPCRG) gave me the opportunity to held a presentation during 8th IPCRG World Conference, May 2016, in Amsterdam the Netherlands, for the opening session "Working Together To Reduce the Asthma Burden". Having asthma myself I spoke about the ups-and-downs of difficult to manage asthma, from my personal point of view. Asthma does not only affect my quality of life, but also the lifes of 235 million people suffering from asthma world-wide. Pitfalls of difficult to manage asthma, such as; wrong diagnosis, ineffective inhalation therapy, non adherence or poor compliance, misinterpretation of self-management or ineffective communication between patient-physician, needs to be solved.

My view on this, is that one of the key elements to work on these pitfalls is that physicians and patients need to work together as a team and that they make a shared decision in how to manage the disease. This shared decision-making approach will involve for example, mutual sharing of information, taking into account patient's preferences and values, and common agreement on kind of treatment.

Part of the official programme of the 9th IPCRG World Conference is the symposium "Shared Decision Making in Patient-Centred Care", presenting the topics such as "Supported Self-Management for Asthma" and "The Patient as Decision-maker". The symposium will focus on the views of patients and physicians in the shared decison-making approach, and it will give the opportunity to share lessons learned and to discuss how to incorporate the shared decision-making approach into daily practice and to improve care for people with asthma.

Early 2017 I joined the IPCRG Scientific Programme Committee for the 9th IPCRG World Conference in Porto. Since that time I got know IPCRG as a very active clinically-led charitable organisation with a network of committed primary care professionals from al over the world.

The role off APP & Allergy Diaries

Jean Bousquet

Emeritus Professor of Pulmonary Medicine at Montpellier University, France

Allergic Rhinitis and its Impact on Asthma (ARIA) has evolved from a guideline using the best evidence-based approach to care pathways suited to real-life using mobile technology in allergic rhinitis (AR) and asthma multimorbidity. MASK (Mobile Airways Sentinel networK), the Phase 3 ARIA initiative, is based on the freely available MASK app (*the Allergy Diary*, Android and iOS platforms, 22,000 users). MASK is available in 16 languages and deployed in 23 countries. Key results include a novel phenotypic characterization of the patients, impact of allergic rhinitis on work productivity and treatment patterns in real life. Most patients appear to self-medicate, are often non-adherent and do not follow guidelines.




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1st Ibero-American Primary Care Respiratory Meeting
&
9th IPCRG World Conference
Porto, Portugal

VIVIENNE PARRY, SCIENCE WRITER AND BROADCASTER, HEAD OF ENGAGEMENT AT GENOMICS ENGLAND:

"People want to be in charge and more and more people will use this approach to get better health"

Vivienne Parry, science writer and broadcaster, is one of the Conference's speakers. She also has a part time role as Head of Engagement at Genomics England. She'll be talking about social movements which will result in the widespread adoption of a different sort of health care, enabled by technology, but driven by people. In her opinion, "people want to be in charge and as more and more people use this approach to get better health, so a social movement will grow".

***Just News* (JN) – What is the role of media in health education?**

Vivienne Parry (VP) – When I worked at a newspaper, the news editor did not say to me 'what shall we educate the public about today Vivienne?'! Health professionals like to think that the media is there to educate the public but education is what teachers do. Only public broadcasters, supported by public taxation like the BBC (whose mission is 'to educate, inform and entertain') are mandated to educate. Having said all that, the media very often focuses on telling people's stories, frequently of course, they concern health and in doing so, they educate and bring awareness to subjects. The media can be immensely powerful in driving health agendas, for example through storylines in TV soaps that bring neglected health issues to the fore or TV documentaries on health issues, and also when they provide factual details which educate in connection with a news story. For instance, the British Prime Minister, Theresa May has Type 1 diabetes which has meant a lot of 'education' about what it means, the importance of controlling obesity to prevent it and so on. That's the conventional media. Social media has no remit to educate so despite huge quantities of good quality information on the net from groups whose purpose is to educate and inform, disinformation can easily triumph. But here patients can be very important in bringing information to others.

JN – Your communication is entitled "The future for people powered Health". What are the main topics of your presentation?

VP – I think we have reached a tipping point when AI and portable devices give people the power to own their own health in a way that has not been possible in the past. Even if you have a chronic disease, you will spend less than 0.1% of your time with a health professional. But the combination of personal data and AI, combined with coaching will increasingly drive outcomes. People want to be in charge and as more and more people use this approach to get better health, so a social movement will grow.

JN – How would you sum up the main ideas of your presentations?

VP – I talk about social movements which will result in the widespread adoption of a different sort of health care enabled by technology but driven by people. This will mainly focus on wellness and prevention rather than illness.

JN – How do you define the concept of human-powered health?

The media can be immensely powerful in driving health agendas

VP – For me, human powered health is where patients are in the driving seat.

JN – Do you think that prevention and health education can really improve the health outcomes?

VP – Lots of people were pleased when they left school and resent 'education' about their lifestyle, seeing it as finger wagging and blaming. We need to make it easy for people to do the right thing and to want to do it. Getting people to interact with others – for instance by singing in a choir, make big differences to people's wellbeing. We know that rehab for pulmonary disease works so if we can smuggle the rehab into fun social things like dance, it's highly likely that will work too.

What works in education inhalers?

Miguel Román-Rodríguez

Family physician, Balearic Health Service, Palma de Mallorca (Spain). Chair of the Primary Care Chronic Respiratory Diseases Research Unit at the Balearic Health Research Institute (IdisBa), Palma de Mallorca

What works in education? How to teach inhaler technique?

Asthma is a chronic respiratory disorder characterized by symptom variability and episodes of acute worsening. Given that 235 million people are reported to have asthma worldwide, this is an important global health problem. The long-term goals of asthma management are to control symptoms and reduce the risk of acute severe attacks (exacerbations). When asthma is well-controlled, patients experience fewer symptoms, use fewer reliever medications, and are at lower risk of exacerbations.

Inhaled medication has proven its efficacy for the management of asthma and meta-analyses of observational studies and randomized controlled trials have reported that all inhaler devices have comparable effectiveness if used correctly. However, asthma medications are less effective in daily practice than they are in clinical trials.

There are several potential reasons for this discrepancy, but ineffective inhaler technique is particularly important and well known. There is also evidence linking incorrect inhaler technique with poor outcomes, such as treatment failure, unnecessary treatment escalation, and increased exacerbations, leading to unplanned service use and hospitalization.

Despite the established importance of a good inhaler technique, many patients still do not use their inhalers correctly. In an observational cohort of 3,911 patients with asthma and chronic obstructive pulmonary disease (COPD), 75% of those using a pMDIs and 49%–55% using a DPI made at least one mistake.13 In a primary care asthma and COPD service, at initial assessment, over 60 % had inappropriate inhalation technique.

> When asthma is well-controlled, patients experience fewer symptoms, use fewer reliever medications, and are at lower risk of exacerbations.

It remains an issue that as many as 69% of healthcare workers cannot demonstrate correct inhaler use, including doctors, nurses, and pharmacists. The lack of education and training for patients and professionals alike, and the lack of repeated instruction could be important reasons for the continued high rates of incorrect inhaler technique.

In order to get patients performing a proper inhalation to ensure their medication is inhaled correctly and effectively reaches the lungs, guidelines advocate that inhaler skills training is given to patients (and professionals). Other important clues for patients to get a good inhalation technique are that patient's inhaler technique is observed and compared with a device-specific checklist, and it is frequently rechecked.

Initiatives aimed at improving this situation have been many and varied, and have included the following: regular training programs for patients and professionals; printed instructional materials, videos, and software; and measures and easier-to-use inhalers that make inhalation easier. Nevertheless, there is still a lack of a common methodology that has proven to be effective to reach a continued long-time education assuring a good inhalation technique.

> It remains an issue that as many as 69% of healthcare workers cannot demonstrate correct inhaler use.

In this workshop, a multinational team from the Netherlands, Spain and Portugal will try to show the current situation and to offer the attenders a new approach which could improve results in inhalers' education. The IPCRG audience will be excellent to pilot this new initiative and will give the opportunity to explore its accuracy and feasibility.

1st Ibero-American Primary Care-Respiratory Meeting
&
9th IPCRG World Conference
Porto, Portugal

Tratamento da asma grave resistente ao tratamento

"A asma é uma das doenças crónicas mais comuns e afeta cerca de 330 milhões de crianças, adultos e idosos em todo o mundo. A maioria dos casos de asma apresenta tosse, dispneia e chiado, que são desencadeados por inalação de irritantes, por resfriados ou por exposição a alérgenos." A afirmação é de Álvaro Cruz, docente da Faculdade de Medicina da Universidade Federal da Bahia, Brasil, e vem a propósito da palestra que irá proferir esta sexta-feira sobre o tratamento da asma grave resistente ao tratamento.

Segundo o palestrante, que é também coordenador do Núcleo de Excelência em Asma da Universidade Federal da Bahia, os sintomas, em geral, melhoram espontaneamente ou com medicação específica:

"Os doentes que têm sintomas persistentes necessitam de tratamento regular com corticosteroides inalados, que podem ser combinados com broncodilatadores de ação longa, quando preciso. Este tipo de tratamento é capaz de controlar a maioria dos casos de asma, se usado de forma regular. No entanto, algumas pessoas que sofrem com a asma não respondem bem ao tratamento com os corticosteroides inalados em doses altas e broncodilatadores de ação longa."

Álvaro Cruz adverte que, enquanto a maioria dos casos de asma pode e deve ser tratado por profissionais dos cuidados de saúde primários, na asma que necessita de doses altas de corticosteroides inalados combinadas com broncodilatadores de longa ação (asma resistente ao tratamento), é importante consultar um especialista em Imunoalergologia ou Pneumologia.

"A primeira coisa que deve ser feita é verificar a adesão ao tratamento prescrito e o uso correto do inalador. Em seguida, é importante rever o diagnóstico. O doente tem mesmo asma? Há alguma enfermidade que mimetiza manifestação da asma? Há uma enfermidade associada à asma que dificulta o seu controlo? O doente está livre de exposição a irritantes?", questiona.


Álvaro Cruz

Se o doente tem realmente asma, usa regularmente e de forma adequada as medicações prescritas e não tem qualquer comorbidade que dificulte o controlo da doença, devemos atentar para medidas não farmacológicas que podem ajudar: atividade física, dieta saudável, adequação da massa corporal, mas deve-se considerar novas alternativas de tratamento.

O preletor menciona que, segundo a Iniciativa Global contra a Asma (GINA), podem ser consideradas as seguintes alternativas terapêuticas de medicina personalizada e de precisão: omalizumab, um anticorpo monoclonal humanizado anti-IgE, que impede reações inflamatórias desencadeadas por processos alérgicos e reduz ataques de asma; mepolizumab, benralizumab ou reslizumab, anticorpos monoclonais humanizados anti-IL5, que reduzem a inflamação nas vias aéreas, os sintomas da asma e os ataques de asma.

O especialista menciona que outros medicamentos semelhantes estão em fase avançada de desenvolvimento clínico, sublinhando: "Todas estas medicações são novas e de alto custo, requerendo critérios rigorosos para a sua indicação. No caso do omalizumab, há que se comprovar alergia em pessoa com asma grave resistente. No caso dos anticorpos anti-IL5, é preciso ter números elevados de eosinófilos no sangue, além de ter asma grave resistente."

E conclui, afirmando: "Nem todos os pacientes respondem bem a estes tipos de tratamento. Propõe-se algoritmo de tratamento que inclui como opção inicial a terapia Anti-IgE, quando há critérios para o seu uso, ou Anti-IL5. Para o omalizumab, é preciso determinar o índice de massa corporal para calcular, de acordo com os níveis de IgE Total, a dose da medicação, administrada 1 vez a cada 15 ou 30 dias por via subcutânea. No caso do mepolizumab, do benralizumab ou do reslizumab, o critério de prescrição é baseado no número total de eosinófilos no sangue periférico, um biomarcador de inflamação eosinofílica, muito comum na asma."

My patient is breathless & obese: challenge of diagnosis?

Noel Baxter
General Practitioner, UK

It was in 1990 as a medical student during my tutorials with behavioural psychology teachers that I learned one of the most important things that has stayed with me through my career. That is, I can only hold a certain amount of information in my immediately available consciousness and there is a risk of overusing what comes to mind most quickly, what most interests me today - my bias - and what the last teacher or researcher I respect has taught me. It is important to have aids and systems to support my primitive brain! Today this is getting easier with digital innovations.

In the UK we have a well-documented problem of over, under, and mis - diagnosis for people who experience daily disabling breathlessness. We might come to the problem with assumptions and biases. People with breathlessness who smoke have COPD don't they? Not always, or maybe it's not the only cause.

Do we always start out objectively, consider all options, test and examine holistically? Do we listen carefully and respond to cues and are we sufficiently trained in consultation skills to explore difficult to talk about issues that may really lie below the cause and causes of breathlessness.

Two thirds of breathlessness are cardiorespiratory but one third is not. It is often that multiple causes exist so goal setting and co-creation of the next steps, now, in a week and in a year and beyond will be key to ongoing reassessment of cause and intervention.

High value diagnosis and management of chronic breathlessness in the patient with obesity will rest on good communication and thoughtful and responsible prescribing not just pharmacological but also social. Weight management through healthy diet and physical activity that is realistic and achievable for them and even fun will yield greater value than the inhaler.

Breathlessness predicts for early death, more hospitalisation and in general greater use of health resource. Getting the right approach to earlier and comprehensive diagnosis will provide value in our health and social systems.

In this talk I will share how we in our local area of Southeast London have developed a logical and comprehensive approach to ensure that our patients with breathlessness get the right diagnosis and the right choice of treatments and very importantly at no extra cost to the system. We often have the right parts in the system but fail to join up the system so we achieve a sum greater than its parts and an outcome that our patients have asked for.

Childhood asthma disparities

Jim Stout
Professor, Department of Pediatrics. Adjunct professor, Department of Health Services Pediatrician, Odessa Brown Children's Clinic, University of Washington

There are significant asthma disparities among poor and non-poor children in the US. Although prevalence is greater among low income youth, the striking difference is in measures of morbidity -- in particular hospitalization for asthma. We will discuss these differences both nationally and regionally in King County, where Seattle, WA is located. We will discuss the social determinants that drive these disparities. One successful solution -- Community Health Workers integrated with primary care practices -- will be described.

There are significant asthma disparities among poor and non-poor children in the US.




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1st Ibero-American Primary Care Respiratory Meeting
&
9th IPCRG World Conference
Porto, Portugal

Breathe well: building research across the world in lung disease

Rachel Jordan

Reader in Epidemiology & Primary Care, Institute of Applied Health Research, University of Birmingham, Edgbaston

Chronic obstructive pulmonary disease (COPD) is a long-term incapacitating respiratory condition, responsible for substantial ill health and is the 4th leading cause of death worldwide. The main causes, including smoking and exposure to indoor and outdoor air pollution are more common in low & middle income countries (LMIC).

However, awareness of COPD is very low. Over half of people who have COPD do not know they have the condition and are not receiving treatment which could help them. Local community healthcare systems are in development and limited treatment is available, especially in poorer areas. Services to help smokers quit are patchy, inhaler medications are often too expensive and other forms of effective treatment eg education, support for physical activity and management of breathlessness are rarely available.

Disease burden disproportionately affects the most disadvantaged populations in LMICs. Improving access to healthcare and identification of cost-effective approaches for earlier detection, smoking cessation and pulmonary rehabilitation for people with COPD are part of the WHO four global priorities for non-communicable diseases.

The NIHR Global Health Research Group on Global COPD in Primary Care, University of Birmingham, UK, known as "Breathe Well" was formed in June 2017 and is led by Dr Rachel Jordan and Professor Peymané Adab. The research team in Birmingham have developed a growing international track record in COPD research in community/primary care settings.Using this knowledge and expertise the Directors have formed partnerships with teams in four LMICs – China, Brazil, Georgia and FYR Macedonia and the International Primary Care Respiratory Group (IPCRG) to co-develop the capability, networks & platform to deliver targeted and effective research and healthcare outcomes in COPD, within 3 broad research themes related to our existing expertise:

Theme 1: Case finding for undiagnosed COPD

Theme 2: Promotion of smoking cessation in the community

Theme 3: Behavioural interventions to improve disease management

In Autumn 2017 we created and undertook a novel rapid research prioritisation process with key stakeholders in each country including patients, clinicians, healthcare managers and policymakers, the results of which are presented in the Porto conference this week. The prioritisation meetings were successful and well-received in all countries and patients particularly appreciated being involved. The findings suggest our approach is a feasible way to identify priority research areas in LMICs.

In the Porto conference this week we also present the protocols of 4 prioritised projects which will be carried out over the next 12 months:

A study to evaluate the effectiveness and cost-effectiveness of different screening strategies for identifying undiagnosed COPD in Brazil, amongst patients (≥40 years) with systemic arterial hypertension in primary care

A study to evaluate the effectiveness and cost-effectiveness of different screening strategies for identifying undiagnosed COPD in China, amongst residents (≥40 years) in four cities

Feasibility of an RCT to determine the effectiveness of a PR programme adapted to the Georgian context compared to usual care for patients with symptomatic COPD of MRC grade 2+

Effectiveness of combining feedback about lung age or exhaled CO levels with very brief advice (VBA) for smoking cessation in primary care compared to giving VBA alone in Macedonia

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A BREATH OF FRESH AIR

Global action to counter non-communicable lung diseases

Niels H. Chavannes

Professor of Primary Care Medicine. Strategic Chair of eHealth Applications in Disease Management. Head of Research. Department of Public Health and Primary Care, Leiden University Medical Centre

Non-Communicable Lung Diseases (NLCDs) are a major burden on public health, and even more so in low-resource settings. EU-funded researchers of FRESH AIR are working to improve outcomes for populations across the world, by ensuring the implementation of culturally tailored, evidence based interventions targeting NLCDs.

About 80 million people suffer from COPD globally and a further 300 million are affected by asthma. Their impact is particularly severe in low-resource settings. According to World Health Organisation (WHO), over 90% of COPD deaths and over 80% of asthma deaths occur in these settings. Although the evidence base for clinically sound and cost-effective treatments in high-resource settings is well developed, translating this knowledge to low-resource settings remains a challenge.

The EU-funded FRESH AIR project sets out to address the growing burden of chronic non-communicable disease by improving the prevention, diagnosis, and treatment of these diseases in low-resource settings. The project uses an implementation research approach to explore how existing knowledge and evidence-based interventions that have been proven to work in high-resource settings can be adapted to the practical challenges experienced in low-resource settings. Its implementation is taking place in four settings: Greece, Uganda, Vietnam and Kyrgyzstan.

From theory to practice

FRESH AIR is an implementation research project. Hence, it aims to improve the context specific fit and acceptability of evidence-based interventions. For example, after church under a tree, Ugandan health workers taught their communities about the dangers of household air pollution. Several groups of Greek and Vietnamese COPD patients successfully completed a culturally tailored pulmonary rehabilitation course. And in Kyrgyzstan, a training seminar on smoking reduction was delivered to a large group of general practitioners.

In the short term, FRESH AIR continues to improve the health outcomes both of communities in general and of the COPD and asthma patients who received the tailored interventions. Healthcare workers involved in these intervention also acquired improved skills, knowledge and experience. For instance, healthcare professionals in all four countries were trained in the accurate use of spirometry through a remote training program. The project also helped to reduce household air pollution in all four countries through raising awareness and the distribution of clean cook stoves. A collaboration with the World Bank resulted in scaling-up the project, so that 5000 extra clean cook stoves are now being distributed in Kyrgyzstan.

FRESH AIR is actively collaborating with other research projects focusing on asthma and COPD, such as RESPIRE and BREATHWELL, as well as with the World Bank and the Global Alliance for Chronic Diseases (GACD). The FRESH AIR knowledge base that is being designed will also be available for other projects to share lessons learnt and disseminate their results.




1st Ibero-American Primary Care-Respiratory Meeting
&
9th IPCRG World Conference
Porto, Portugal

Implementing and rolling out PACK: identifying champions and developing capacity

Jorge Zepeda

Brazilian family physician.
PhD student at the University of Leeds, UK.
Former director of primary care in Florianopolis, Brazil (2010-2015). Supporter of the PACK programme

Brazil has made progress towards universal health coverage mainly through a singular approach to primary care (PC), the Family Health Strategy, with teams of doctor, nurse and community health workers providing medical treatments, preventive care, and access to other services. This strategy reduced inequalities of access and improved infant mortality and hospital admissions, but coverage is still incomplete, and challenges remain in quality and capacity to implement changes (Macinko and Harris, 2015).

Florianopolis stands out as the first capital to achieve universal PC coverage in 2015, and is nationally acknowledged for healthcare innovations, among which PACK, a programme developed by the Knowledge Translation Unit of the University of Cape Town (Fairall *et al.*, 2015). PACK is a game-changing strategy for improving PC, based on integrated evidence-based guide to common problems and on-site training, which has been adapted, piloted and evaluated in Florianopolis since 2015 with support from the programme developers. PACK has proven effectiveness in improving clinical outcomes in African countries, and the Brazilian pilot has contributed to the understanding of the programme's potential to strengthen systems' capacity to implement evidence-informed practice.

PACK requires adaptation to local system requirements, including drugs and supplies, professional rules, other existing guidance etc., a crucial step to engage local stakeholders, address barriers, and make room for the programme in the local system. In Florianopolis, implementation was led by local champions with political agency, clinical background, and ability to navigate system's borders, and local clinical leaders were identified to support the guide localisation and provide training. Such engagement strategies contributed to acceptability and adoption of the programme among doctors and nurses, and PACK is now widely used in PC visits, team meetings, professional training, and also other practice scenarios like A&E clinics.

The localisation provides an unique opportunity to address system issues using clinical language (drug choices, referral thresholds, professional tasks), thus creating a safe space for clinicians and managers to work collaboratively in the benefit of patients. The communication channels developed for this process were maintained to allow continuous feedback and suggestions from PACK utilization. The ownership of the programme among practitioners has contributed to a feeling of collective accountability for the quality of clinical practice. PACK also demands clear definition of professional roles, mainly during colour-coding of doctors' and nurses' tasks in the guide. In Florianopolis this step was coupled with the building of nursing protocols and referral criteria to specialist care, local interventions that once mutually aligned provided additional support to PACK. This also helped to consolidate PACK as the reference source to solve contradictions between distinct guidance, integrating the support made available to practitioners.

The acceptability of the programme among clinicians, the integration with local interventions, and a responsive approach to implementation provided leverage to sustain PACK and related interventions across a recent period of political turmoil. This reflects two key principles of successful knowledge mobilisation embedded in the programme: developing existing capacity instead of building from scratch; and moving from programme-specific to higher-order capabilities, allowing local systems to adapt and innovate (Kislov *et al.*, 2014)which raises concerns about the long-term sustainability of implementation and improvement. It is becoming increasingly recognised that the translation of research evidence into practice has to be supported by developing the internal capacity of healthcare organisations to engage with and apply research. This process can be supported by external knowledge mobilisation initiatives represented, for instance, by professional associations, collaborative research partnerships and implementation networks. This conceptual paper uses empirical and theoretical literature on organisational learning and dynamic capabilities to enhance our understanding of intentional capacity building for knowledge mobilisation in healthcare organisations. The discussion is structured around the following three themes: (1. The lessons from the Florianopolis pilot show that, beyond an effective approach to evidence-informed PC, PACK may be a powerful tool to engage managers and practitioners in bottom-up, clinically-driven health system strengthening.

> PACK is a game-changing strategy for improving PC, based on integrated evidence-based guide to common problems and on-site training.

CONEXÃO PORTUGAL-BRASIL

Construindo e consolidando o conhecimento no cuidado aos pacientes com doenças respiratórias

Rafael Stelmach

Professor de Pneumologia da Universidade de São Paulo, Brasil

Quase cinco anos se passaram desde que tive a oportunidade de conhecer e compartilhar do convívio dos colegas portugueses do GRESP – Grupo de Estudos de Doenças Respiratórias da Associação Portuguesa de Medicina Geral e Familiar (APMGF). De facto, membros do GRESP participantes do IPCRG – International Primary Care Respiratory Group, ofereceram seus conhecimentos e recursos para apoiar um projeto-piloto estratégico, com base em educação em saúde, para melhorar o diagnóstico e manejo das doenças respiratórias crônicas no Brasil.

O sistema de saúde público português, uma referência hoje na Europa, tem conhecimento e experiência acumulados para auxiliar um incremento de qualidade ao sistema de saúde brasileiro, denominado SUS (Sistema Único de Saúde). Minha visão sobre o SUS, na atualidade, é que precisamos trabalhar com qualidade para garantir equidade, resolutividade e sustentabilidade do maior sistema público de saúde do mundo. Sabe-se que este desafio é global, e maior nas doenças respiratórias crônicas, historicamente negligenciadas em relação a outras morbidades crónicas.

Ao adotar a Estratégia de Saúde da Família (ESF) como alicerce do SUS, a divisão de tarefas e a hierarquia de atenção ao cuidado exige a integração de médicos generalistas/de família com especialistas, além da participação ativa dos outros profissionais de saúde, usando as melhores evidências de ciência, aplicando a medicina translacional em benefício dos pacientes.

> O sistema de saúde público português, uma referência hoje na Europa, tem conhecimento e experiência acumulados para auxiliar um incremento de qualidade ao sistema de saúde brasileiro, denominado SUS (Sistema Único de Saúde).

Na belíssima cidade do Porto, realiza-se a 1.ª Conferência Ibero-Americana de Saúde Respiratória em Cuidados Primários e 9.ª Conferência Mundial do IPCRG. Uma oportunidade imperdível de participar de um encontro quadrilíngue – em Inglês, Português, Espanhol e "portunhol" –, focado na temática central: "Acrescentar valor num mundo com recursos limitados", tema este que permite aprofundar o debate sobre o tripé equidade, resolutividade e sustentabilidade no cuidado de doenças respiratórias, com a participação de professores e colegas internacionais e ibero-americanos.

Dentro do programa oficial da Conferência, teremos o Simpósio Manejo Integrado de Cuidados Primários para Doenças Respiratórias (Integrated Primary Care Management for Respiratory Diseases), apresentando uma estratégia de educação abrangente para cuidados na atenção primária, incluindo as doenças respiratórias, criado e desenvolvido na África do Sul. O "Package of Care Kit (PACK)", utilizado com sucesso como instrumento de qualidade em países com recursos restritos, esta estratégia envolve aprendizado de assistência a saúde baseado em evidencias científicas, aplicado de maneira translacional no dia a dia dos profissionais de saúde.

O Simpósio discutirá as lições aprendidas na África na implementação do PACK, o potencial desta estratégia para melhorar o diagnóstico e manejo das doenças respiratórias no Brasil, e a experiência da adaptação e adequação para implementação do PACK em Florianópolis (capital no sul do Brasil). Certamente esta translação para o português será uma janela de oportunidade para que esta estratégia se difunda nos países ibero-americanos, até porque a Aliança Global contra as Doenças Crónicas (GARD) da Organização Mundial da Saúde tende a adotar o PACK como um projeto mundial.

SABA Overuse

Alan Kaplan

Chair Family Physician Airways Group of Canada. Immediate past-Chairperson. Respiratory Medicine Special Interest Focus Group, College of Family Physicians of Canada. Vice President Respiratory Effectiveness Group

Guidelines review Asthma control based on symptoms, particularly on how much SABA is used per week as a measurement. GINA guidelines recommend < 3 times per week. But practicing doctors know that the patient reality is different. They value their rescueinhaler and use it as needed, often underusing their controller medication.

Historically we can look back to data from New Zealand where there was an epidemic of asthma deaths in the 1980s due to regular use of extra-potent fenoterol1. Further Canadian data2 from the early 1990s showed that there was a direct correlation between the number of SABA inhalers used to the death rate; for every one SABA increased, the death rate doubled!

Pathophysiologically, we understand the need for ICS and not SABAs, but this does not stop over-reliance with our guidelines suggesting SABA as the first line therapy[3] (figure 1). Asthma is a well-known eosinophilic inflammatory condition. We do understand that SABAs will resolve the immediate bronchospasm of an allergic trigger, but it does not do anything for the delayed phase. Regular use of SABAs have been shown to worsen the delayed phase response[4], which could explain why regular use of SABAs are actually bad for the patient. The other concept well recognized is that of beta cell desensitization with recurrent use[5].

In the National Review of Asthma deaths, a review of 192 patients in the UK who died from Asthma, it was clear that there was a significant overuse of SABAs with 39% receiving 12 SABA per year, and 4% receiving 50 SABA inhalers in one year[6]! Use of controllers was low, with 80% receiving less than the optimal 12 doses per year and 38% receiving less than four per year. Another study of >35,000 asthmatic UK patients[7] showed a direct relationship between the frequency of SABAs prescribed and risk of hospital admission for asthma beyond the baseline of prescription of SABA inhalers of 1-3 per year. Their conclusion was that there is a progressive risk of hospital admission associated with the prescription of more than three SABA inhalers a year.

A qualitative article reviewed the patients approach.[8]. Young adults gave coherent reasons why they overused SABA inhalers, including thoughts including wanting a short term quick fix, cost, poor adaptation to illness, reduce stigma of having a chronic illness, asthma having career and social issues, fear of symptoms anger at having illness, feeling that they cannot survive without it (blue one), but that they could survive without (eg.) the purple one. These issues require education and reinforcement.

It has been shown that shared decision making between the patient and clinician[9] improves adherence. It did require four additional steps:

i) Identifying patient goals and preferences

ii) Summarizing patient goals and preferences

iii) Discussing relative merits of different treatment options in relation to goals and preferences

iv) Negotiating a decision about a treatment regimen

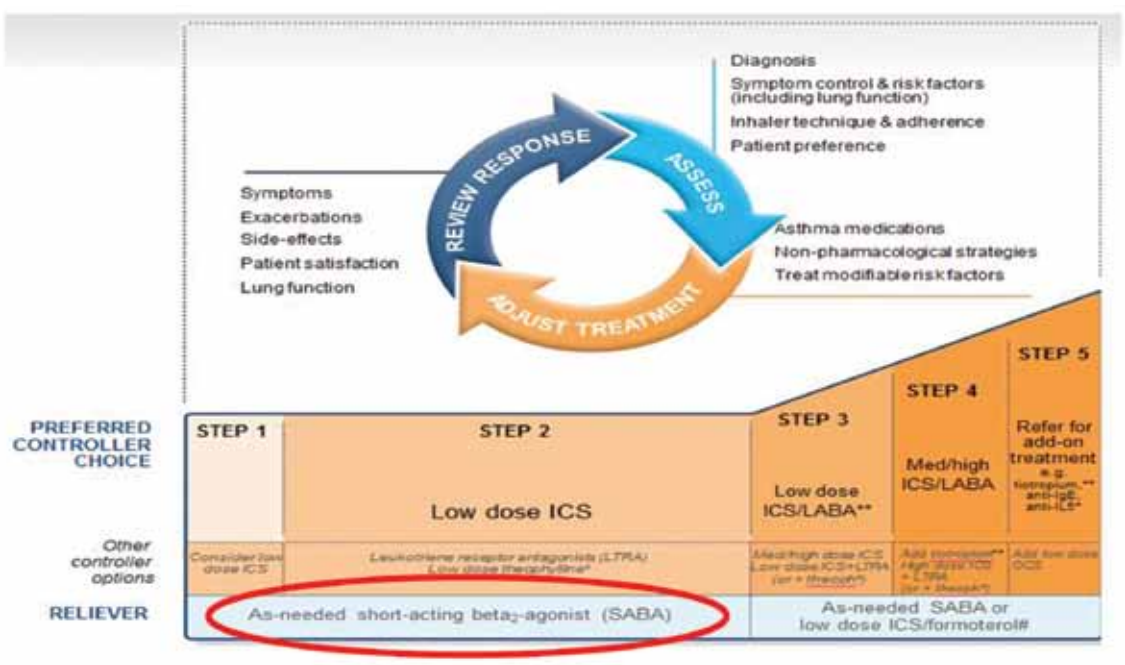
After one year, they showed that there was an increased total days' controller Rx by an average of 77 days and by 9.6 BDP canister equivalents, increased QoL by 0.4 points + reduced unscheduled asthma physician visits, reduced SABA acquisition by 1.6 canister equivalents and a doubled the likelihood of having well controlled asthma.

Conclusion:

SABA overuse continues and leads to bad outcomes for our patients with asthma. While this is scientifically understood, both patients and clinicians continue to reinforce this behavior. We need to review this issue with all asthma patients and come up with a strategy to change it. If we cannot, perhaps an alternative treatment strategy could be considered.

References:

1. *Crane et al, Prescribed Formoterol and Risk of Death in New Zealand, Lancet 1989, vol 333; p 917-922.*
2. *Spitzer NEJM 1992 volume 326.*
3. *GINA guidelines 2018.*
4. *Gauvreau GM, et al. Am J Respir Crit Care Med 1997;156:1738–45.*
5. *Lohse M et al, Multiple pathways of Rapid B12 adrenergic receptor desensitization, The Journal of Biological Chemistry Volume 265, No. 6, Feb 25, 1990: 2302-3209.*
6. *Royal College of Physicians. Why Asthma Still Kills? The National Review of Asthma Deaths (NRAD) [online] 2014. Available from: https://www.rcplondon.ac.uk/projects/outputs/why-asthma-still-kills.*
7. *Asthma prescribing and risk of hospitalization, NPCRJ 2016. 26; 16049.*
8. *Cole S, Seale C, Griffiths C, The blue one takes a battering' why do young adults with asthma overuse bronchodilator inhalers? A qualitative study BMJ Open-2012-002247.*
9. *Wilson et al AJRCCM 2010; 181: 566–577.*



PROGRAMA

1st Ibero-American Primary Care Respiratory Meeting — THURSDAY 31 MAY

0800-0900 REGISTO — **RÉS-DO-CHÃO OESTE**

0815-1100 IPCRG Research Sub-Committee — **ARRÁBIDA**

ROOM	INFANTE	D. MARIA	D. LUÍS
0900-1030	**DOS SINTOMAS AO DIAGNÓSTICO** *Apresentações em Português e Castelhano / Projeção de slides em Português e Castelhano* **Moderação:** Dr Carlos Gonçalves & Dr Jaime Gonzalvez **0905 Sibilância em crianças** Dr Mário Morais de Almeida, Portugal **0930 Tosse crónica** Dr Montserrat Llort Bové, Espanha **0955 Dispneia e aperto torácico** Prof Rafael Stelmach, Brasil	**Curso de 1 dia para Enfermeiros, Farmacêuticos e Profissionais de Saúde** **0910 Introdução às doenças respiratórias** Dr Eurico Silva & Dr José Oliveira **0930 Educação na promoção da saúde respiratória** Enf Carmo Cordeiro **0950 Avaliação do autocontrolo** Dr Eurico Silva & Dr José Oliveira **1005 Fármacos inalados** Enf Carmo Cordeiro	**Resumos em Português e Castelhano – Apresentações orais** **Moderação:** Dr Silvia Álvarez & Dr João Ramires 8 x 10 minutos

1035-1100 REFRESCOS — **SALÃO NOBRE**

1100-1330 IPCRG Education Sub-Committee — **ARRÁBIDA**

ROOM	INFANTE	D. MARIA	D. LUÍS
1100-1245	**A GESTÃO CLÍNCA DA ASMA, DPOC E ACO** **Moderação:** Dr Sara Núñez Palomo & Dr William Salibe Filho **1110 Asma** Prof João Fonseca, Portugal **1140 DPOC** Dr Jesús Molina, Espanha **1210 ACO** Dr Rui Costa, Portugal	**Técnica de utilização dos dispositivos inalatórios** Enf Carmo Cordeiro & Enf Isabel Portela	**Resumos em Português e Castelhano – Apresentações orais** **Moderação:** Dr Pedro Fonte & Dr Pere Simonet Aineto 9 x 10 minutos

1245-1345 ALMOÇO — **SALÃO NOBRE**

1345-1515
1345 Técnicas de respiração e tosse Enf Liliana Silva
1415 Técnicas de conservação de energia Enf Liliana Silva
1430 Adesão e gestão do regime terapêutico Enf Liliana Silva & Enf Isabel Portela

1515-1600 REFRESCOS — **RÉS-DO-CHÃO OESTE**

1600 **Casos clínicos finais – todos os formadores**

9th IPCRG World Conference Porto, Portugal — FRIDAY 1 JUNE

0800-0900 **SYMPOSIUM 2** — **ARCHIVE HALL**
Asthma Management: What works in Primary Care Clinical Practice?
Supported by GlaxoSmithKline (Additional info on page 24)

ROOM	ARCHIVE HALL	D. LUÍS	D. MARIA
0900-1015	**3.1** **LEADERSHIP SKILL MIX & MANAGEMENT** **Chair:** Prof Rafael Stelmach & Dr Sundeep Salvi **0910 Principles of the Package of Care Kit (PACK) - Lessons from Africa** Prof Lara Fairall, South Africa **0930 PACK in Brazil: Potential for Improving the Management of Respiratory Diseases** Prof Rafael Stelmach, Brazil **0950 Implementing & Rolling Out PACK: Identifying Champions & Developing Capacity** Dr Jorge Zepeda, UK	**3.2** **LUNG SOUNDS IN RESPIRATORY PATIENTS WORKSHOP** **Chair:** Dr Alda Marques & Prof Hasse Melbye **0900 Introduction & Terminology for Lung Sounds** Prof Hasse Melbye, Norway **0915 Lung Sounds in the General Population** Dr Juan Carlos Aviles Solis, Norway **0930 Lung Sounds in Stable & Exacerbated COPD** Ana Oliveira, Portugal **0945 Usefulness of Electronic Stethoscopes & Smartphones** Prof Cristina Jácome, Portugal **1000 Computerized Lung Auscultation** Dr Alda Marques, Portugal	**3.3** **Oral Abstracts 3** **ASTHMA & INHALER DELIVERY** **Chair:** Dr Tan Tze Lee & Dr Dyna Torrado 5 x 15 mins *(See page 20)*

ROOM	ARCHIVE HALL	D. LUÍS	D. MARIA
1020-1120	**4.1** **ALLERGY & RHINITIS** ***With EAACI Primary Care Group*** **Chair:** Prof Janwillem Kocks & Prof Aziz Sheikh OBE **1020 Who Develops Allergies & Why?** Prof Adnan Custovic, UK **1040 The Role of Apps & Allergy Diaries** Prof Jean Bousquet, France **1100 Role of Allergen Immunotherapy: A Primary Care Perspective** Prof Aziz Sheikh OBE, UK	**4.2** **INDICATORS OF GOOD RESPIRATORY CARE WORKSHOP** **Chair:** Prof Lara Fairall & Dr João Ramires **Speakers:** Prof Luís Alves, Portugal Dr Viktoria McMillan, UK	**4.3** **SOLVING COMPLEX CASES** **Chair:** Dr Kerry Hancock & Dr Björn Stallberg **My Patient...** **1020 ..Is Breathless & Obese: Challenge of Diagnosis?** Dr Noel Baxter, UK **1040 ..Is Asthmatic & Obese: A Scientific Approach** Prof Renata Barros, Portugal **1100 ..Has Sleep Apnoea** Dr Cláudia Vicente, Portugal

1120-1150 REFRESHMENTS, POSTER VIEWING & EXHIBITION — **GROUND FLOOR WEST**

ROOM	ARCHIVE HALL	D. LUÍS	D. MARIA
1150-1300	**5.1** **SHARED DECISION-MAKING IN PATIENT-CENTRED CARE** **Chair:** Prof Helen Reddel & Prof Steph Taylor **1155 The Clinician as Decision-Guider & Decision-Maker** Prof Glyn Elwyn, USA by film **1210 Discussion** **1220 Supported Self-Management for Asthma** Dr Luke Daines, UK **1235 The Patient as Decision-Maker** Juliëtte Kamphuis, Netherlands **1250 Discussion**	**5.2** **TREATING TOBACCO DEPENDENCE WORKSHOP: WHAT WORKS?** **Chair:** Dr Vidal Barchilon & Prof Onno van Schayck **Speakers:** Dr Noel Baxter, UK Prof Kamran Siddiqi, UK	**5.3** **GPS IN THE FOREFRONT OF THE FIGHT AGAINST INFLUENZA** **Chair:** Dr Mateja Bulc & Dr Seneth Samaranayake **1150 Epidemiology of Flu in the Last Decade** Prof Ab Osterhaus, Germany **1205 Who's at Risk? Evidence for Flu Vaccination of the Elderly, Young Children, Pregnant Women & People with Diabetes** Dr Ted van Essen, Netherlands **1220 The Role of Primary Care Physicians in Influenza Vaccination** Prof Jaime Correia de Sousa, Portugal **1235 Why should GPs worry about Influenza?** Dr Mateja Bulc, Slovenia

1300 LUNCH, POSTER VIEWING & EXHIBITION — **GROUND FLOOR WEST**

1st Ibero-American Primary Care Respiratory Meeting & 9th IPCRG World Conference Porto, Portugal

9th IPCRG World Conference Porto, Portugal

THURSDAY 31 MAY

1230-1330 REGISTRATION, REFRESHMENTS & EXHIBITION — GROUND FLOOR WEST

1345-1530 SESSION 1 Opening Plenary — ARCHIVE HALL
Respiratory Health: Adding Value in a Resource-Constrained World
Chair: Prof Luís Alves & Prof Jaime Correia de Sousa

1345-1400 **Esmoriz Mandolin Orchestra**
1400-1410 **Welcome to Porto**: Dr Rui Moreira, Mayor of Porto
1410-1420 **Medicine in Portugal:** Dr Miguel Guimarães, President, Portuguese Medical Association (Ordem dos Médicos)
1420-1450 **New Vistas for the Inevitable Transformation of Health Care** Prof Rafael Bengoa, Spain
1450-1520 **What is Value in Respiratory Care?** Dr Vince Mak, UK
1520-1530 **Discussion**

Simultaneous Interpretation from English to Portuguese

1530-1605 REFRESHMENTS, POSTER VIEWING & EXHIBITION — GROUND FLOOR WEST

ROOM	ARCHIVE HALL	INFANTE	D. LUÍS	S. JOÃO
1605-1735	**2.1**	**2.2**	**2.3**	**2.4**
	RIGHT CARE **Chair**: Dr Nick Hopkinson & Prof Helen Reddel 1610 **Right Care in Respiratory** Amy Bowen, UK 1630 **Right Diagnosis & Right Communication** Prof Steph Taylor, UK 1650 **Right Treatment & Right Review** Prof Helen Reddel, Australia 1710 **Right Care, A Patients' Perspective** Dr Mário Morais de Almeida, Portugal	**BREATHING PROBLEMS IN KIDS: DIAGNOSTIC CHALLENGES** **Chair:** Prof Harry Campbell & Cynthia Hallensleben 1610 **Challenges in Paediatric Pneumonia Diagnosis Globally** Prof Harry Campbell, UK 1630 **Under Diagnosis of Asthma in LMIC - and Consequences** Prof Marianne Østergaard, Denmark 1650 **Under-Diagnosis of Asthma in Urban America** Prof James Stout, USA 1710 **Psychosocial Determinants of Childhood Asthma** Dr Javiera Corbalán, Chile	**Oral Abstracts 1** **RESEARCH IDEAS** **Chair:** Dr Rachel Jordan & Prof Ee Ming Khoo 9 x 10 mins *(See page 20)*	**Oral Abstracts 2** **TOBACCO DEPENDENCE** **Chair:** Dr Jørn Ossum & Dr Rianne van der Kleij 6 x 15 mins *(See page 20)*

1735-1825 NETWORKING RECEPTION — GROUND FLOOR WEST

ROOM	INFANTE	D. MARIA
1735-1825	ASAMBLEA GENERAL GRAP	IPCRG AGM

1830-1930 SYMPOSIUM 1 — ARCHIVE HALL
Asthma Right Care: An IPCRG Initiative
Supported by AstraZeneca (Additional info on page 24)

INFANTE	S. JOÃO	ARRÁBIDA
3.4	**3.5**	**3.6**
Programa Ibero-Americano **OUTRAS DOENÇAS PULMONARES** **Moderação:** Dr Enrique Mascarós & Prof José Augusto Simões 0905 **Tuberculose** Prof Raquel Duarte, Portugal 0925 **Controle da asma grave resistente ao tratamento: uso de imunobiológicos e opções não farmacológicas** Prof Álvaro Cruz, Brasil 0945 **Cancro do pulmão** Dr José Tomás Gómez Sáenz, Espanha	**Oral Abstracts 4** **COPD IN HIGH INCOME COUNTRIES** **Chair:** Dr Derek Forde & Prof Antonius Schneider 5 x 15 mins *(See page 20)*	**Digital Poster Discussion 1** **TEACHING & BEHAVIOURAL INTERVENTION** **Chair:** Dr Knut Weisser Lind & Juliet McDonnell 7 abstracts on 1 slide each: 5 min presentation & 5 min discussion *(See page 20)*

INFANTE	S. JOÃO	ARRÁBIDA
4.4	**4.5**	**4.6**
Programa Ibero-Americano **WORKSHOP DE ESPIROMETRIA** **Palestrantes:** Dr Juan Enrique Cimas, Espanha Dr Javier Perez, Espanha Dr Rui Costa, Portugal Dr Pedro Fonte, Portugal	**Oral Abstracts 5** **COPD IN LOW & MIDDLE-INCOME COUNTRIES** **Chair:** Prof Niels Chavannes & Dr Beraki Ghezai 4 x 15 mins *(See page 21)*	**Digital Poster Discussion 2** **ASTHMA MANAGEMENT** **Chair**: Dr Kerstin Romberg & Dr Pedro Teixeira 6 abstracts on 1 slide each: 5 min presentation & 5 min discussion *(See page 21)*

INFANTE	S. JOÃO	ARRÁBIDA
5.4	**5.5**	**5.6**
Programa Ibero-Americano **WORKSHOP DE REABILITAÇÃO RESPIRATÓRIA** **Moderação:** Dr Daniel Castro & Dr Maria Mar Martínez **Palestrantes:** Enf Liliana Silva, Portugal Enf Isabel Zaldua, Espanha	**Oral Abstracts 6** **RESEARCH IDEAS** **Chair:** Prof Janwillem Kocks & Dr Kristian Høines 8 x 10 mins *(See page 21)*	**Digital Poster Discussion 3** **INNOVATIVE RESEARCH IN LOW AND MIDDLE-INCOME COUNTRIES** **Chair:** Prof Bruno Heleno & Dr Karin Lisspers 6 abstracts on 1 slide each: 5 min presentation & 5 min discussion *(See page 21)*

ARCHIVE HALL
Simultaneous Interpretation from English to Portuguese

INFANTE
Apresentações em Português e Castelhano/ Projeção de slides em Português e Castelhano

9th IPCRG World Conference Porto, Portugal

FRIDAY 1 JUNE

1320-1425 SYMPOSIUM 3 — ARCHIVE HALL
Optimizing COPD Care in our Daily Practice
Supported by Boehringer Ingelheim (Additional info on page 25)

ROOM	ARCHIVE HALL	D. LUÍS	D. MARIA
1425-1545	**6.1**	**6.2**	**6.3**
	HARM OF OVER- & UNDER-DIAGNOSIS Chair: Prof Shawn Aaron & Prof Ee Ming Khoo 1425 **Over-, Mis- & Under- Diagnosis: Lessons for Primary Care** Prof Jaime Correia de Sousa, Portugal 1450 **Asthma: Here Today, Gone Tomorrow** Prof Shawn Aaron, Canada 1515 **Lung Cancer Screening** Prof Bruno Heleno, Portugal **Discussion**	**WHAT WORKS IN EDUCATION?** **HOW TO TEACH INHALER TECHNIQUE WORKSHOP** **Chair:** Juliëtte Kamphuis & Dr Catalina Panaitescu **Speakers:** **IPCRG Inhaler Group** Dr Tiago Maricoto, Portugal Dr Esther Metting, Netherlands Dr Miguel Román-Rodríguez, Spain	**Oral Abstracts 7** **COPD & PULMONARY REHABILITATION** **Chair:** Dr Nuno Pina & Prof Sally Singh 4 x 15 mins *(See page 22)*

INFANTE	S. JOÃO	ARRÁBIDA
6.4	**6.5**	**6.6**
Programa Ibero-Americano **WORKSHOP DE DEPENDÊNCIA TABÁGICA** 1425 **Tratamento farmacológico na Cessação Tabágica** Dr Vidal Barchilon, Espanha 1450 **E-cigar e IQOS – Novas formas de fumar?** Dr Carlos Gonçalves, Portugal 1515 **Como proceder perante uma recaída** Dr Sonia Martins, Brasil	**Oral Abstracts 8** **ASTHMA & INHALER DELIVERY** **Chair:** Prof Peymané Adab & Prof Aziz Sheikh OBE 5 x 15 mins *(See page 22)*	**Digital Poster Discussion 4** **DIAGNOSIS & ASSESSMENT** **Chair:** Dr Pedro Fonte & Dr Hanna Sandelowsky 7 abstracts on 1 slide: 5 min presentation & 5 min discussion *(See page 22)*

1545-1620 REFRESHMENTS, POSTER VIEWING & EXHIBITION — GROUND FLOOR WEST

ROOM	ARCHIVE HALL	D. LUÍS	D. MARIA
1620-1750	**7.1**	**7.2**	**7.3**
	HARM OF OVER- & UNDER-TREATMENT **Chair**: Dr Anders Østrem & Prof David Price 1620 **Antibiotics Overuse** Prof Carl Llor, Spain 1640 **SABA Over Reliance in Asthma** Dr Alan Kaplan, Canada 1700 **ICS Overuse in COPD** Prof David Price, Singapore 1720 **Responsible Oxygen Prescribing** Dr Irem Patel, UK 1740 **Discussion**	**TREATING THE MIND & THE BODY** **Chair:** Dr Len Fromer & Prof Steph Taylor 1620 **The Value of Psychology & Psychologists in Supporting Respiratory Patients** Dr Jane Hutton, UK 1650 **Tailored Intervention for ANxiety & DEpression Management in COPD** (TANDEM) Prof Hilary Pinnock, UK 1720 **Discussion**	**Oral Abstracts 9** **CHILDREN** **Chair:** Dr Jesper Kjærgaard & Prof Marianne Østergaard 8 x 10 mins *(See page 22)*

INFANTE	S. JOÃO
7.4	**7.5**
GRESP SIMPOSIUM **Mundipharma** *em Português* **ACO-Consenso Português para uma melhor prática clínica** **Moderador**: Prof José Agostinho Marques, Portugal **Palestrantes:** Dr Mário Morais de Almeida, Portugal Dr João Cardoso, Portugal Prof Jaime Correia de Sousa, Portugal	**GRAP SIMPOSIUM** **BI** *en español* **Control del paciente EPOC actual y futuro: Síntomas y exacerbaciones** **Ponentes:** Dr Miguel Román-Rodriguez y Dr Daniel Ocaña

1800-1900 SYMPOSIUM 4 — ARCHIVE HALL
Personalized Medicine in COPD – Prime Time for Primary Care?
Supported by Novartis (Additional info on page 25)

2000 CONFERENCE DINNER — NOBLE HALL / SALÃO NOBRE

9th IPCRG World Conference Porto, Portugal

SATURDAY 2 JUNE

0800-0900 IPCRG RESEARCH & EDUCATION NETWORK – *COME ALONG & GET INVOLVED* — S. JOÃO

ROOM	ARCHIVE HALL	D. LUÍS	D. MARIA
0900-1015	**8.1**	**8.2**	**8.3**
	"TAPAS - PETISCOS" BEST PRACTICE FROM IPCRG MEMBERS: ADDING VALUE TO YOUR PRACTICE **Chair:** Dr Miguel Román-Rodriguez & Siân Williams **11 Projects from the IPCRG Community** 2 slides x 5 mins each presenter *(See page 23)*	**DESIGN OF RANDOMISED CONTROLLED TRIALS WORKSHOP** **Chair:** Prof Luis Alves & Dr Rachel Jordan **Speakers:** Dr David Culliford, UK Prof Amanda Lee, UK	**SOLVING COMPLEX CASES** **Chair:** Dr Maria João Barbosa & Dr Jiska Snoeck-Stroband 0905 **Asthma in Children: Getting Real in Primary Care** Dr Javiera Corbalán, Chile 0920 **Discontinuation of ICS in COPD in Primary Care, Sense or Nonsense** Prof Onno van Schayck, Netherlands 0935 **Severe Asthma** Prof João Fonseca, Portugal 0950 **COPD - Palliative Care** Dr Karin Lisspers, Sweden

S. JOÃO	ARRÁBIDA
8.4	**8.5**
IPCRG & PHFI COLLABORATION ON COPD & ASTHMA COURSE FOR PRIMARY CARE PHYSICIANS 0905 **Welcome & Introduction** Prof Jaime Correia de Sousa & Prof Hilary Pinnock 0915 **PHFI & Capacity Building Initiatives** Dr Sandeep Bhalla, India 0945 **Certificate Course in Management of COPD & Asthma** Dr Haresh Chandwani, India	**Oral Abstracts 9** **USE OF DATA** **Chair:** Dr Lynn Josephs & Prof David Price 4 x 15 mins *(See page 23)*

ROOM	ARCHIVE HALL	D. LUÍS	D. MARIA
1020-1125	**9.1**	**9.2**	**9.3**
	PRIZE WINNING ABSTRACTS **Chair:** Dr Rachel Jordan & Prof Kamran Siddiqi 4 x 15 mins *(See page 23)* **Prize Winning Authors:** Esther Metting Jiska Snoeck-Stroband Mathijs Veenendaal Kay Wang	**EXPERIENCE OF PULMONARY REHABILITATION PROGRAMMES** **Chair:** Prof Rupert Jones & Prof Sally Singh 1020 **A Physiotherapy-Led Service** Dr Alda Marques, Portugal 1035 **A Nurse-Led Service** Enf Liliana Silva, Portugal 1050 **Where, When & Who should Deliver Pulmonary Rehabilitation** Prof Sally Singh, UK 1105 **Discussion**	**Oral Abstracts 10** **COPD & THE ENVIRONMENT** **Chair:** Prof Niels Chavannes & Dr Mariam Maglakelidze 6 x 10 mins *(See page 23)*

INFANTE
9.4
IPCRG & PHFI COLLABORATION ON COPD & ASTHMA COURSE FOR PRIMARY CARE PHYSICIANS (continued) 1025 **Implementation Modalities & Strategies** Dr Sourabh Sinha, India 1050 **Monitoring & Evaluation Protocols & Parameters** Dr Haresh Chandwani & Dr Sourabh Sinha, India 1120 **Closing Remarks & Way Forward** Dr Sandeep Bhalla, India

1125 REFRESHMENTS, POSTER VIEWING & EXHIBITION — GROUND FLOOR WEST

1155-1315 SESSION 10 Closing Plenary — ARCHIVE HALL
Respiratory 2030, Our Vision for Value-Based Encounters in Respiratory Care - How to Create a Movement for Change
Chair: Prof Jaime Correia de Sousa & Prof Ioanna Tsiligianni

1155 **Health as a Social Movement** Prof Henrique Barros, Portugal
1220 **The Role of Patients** Isabel Saraiva, Portugal
1240 **The Future for People Powered Health** Vivienne Parry OBE, UK
1305 **Reflections on Porto 2018 – Looking forward to Bishkek 2018, 2019 & the 2020 Conferences** Prof Ioanna Tsiligianni, President IPCRG

1315 LUNCH, POSTER VIEWING & EXHIBITION — GROUND FLOOR WEST

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