Non-Profit Organization
Asian Pacific Association for Bronchology and Interventional Pulmonology (APAB)

No3. 2022

# Newsletter

## Theme: APCB acts to conquer COVID-19

## President remarks

Kiyoshi Shibuya M.D. Ph.D.
President, Asian pacific association for bronchology and interventional pulmonology (APAB)
Chiba Foundation for Health Promotion and Disease Prevention Shin-minato 32-14, Mihama-Ward, Chiba 261-0002, Japan
TEL: +81-043-246-0350
FAX: +81-043-246-8640
Professor, Lung Cancer Treatment Center in JRC Narita Hospital, Chiba University Hospital
Director, Department of Chest Surgery, JRC Narita Hospital

Welcome everyone to the Asian pacific association for bronchology and interventional pulmonology (APAB). We'd like to extend a special thanks to our member, who will be interested in this 3rd newsletter.

Every 2 years, from the 1st Asian pacific congress for bronchology and interventional pulmonology (APCB) was held in Chiba, Japan 2005, a total of eight times APCB were held.

However, 9th APCB in Malaysia on 8-10th October 2021 were postponed due to the COVID-19 Infection explosion in Malaysia. After that, we changed 8-10th October 2021 APCB in Malaysia to 26-28 May 2023 and 2023 APCB congress in Taiwan to 2025.

COVID-19 pandemic is still now around the world including Asian-Pacific countries. COVID-19 death in Japan is now more than 29,700. I would like to express our deepest condolences. I worried about how serious this pandemic would be continued to be endless. I also worried about both COVID-19 invasion to human being and Russian invasion to Ukraine. I pray both invasions would disappear.

This 3rd newsletter included seven intormations with the COVID-19 and bronchoscopy. I also hope increased APAB presence, in which a next APCB would be held every 2 years in future in close cooperation with the WABIP.

Thank you to everyone! Best wishes.

## 9th APCB Postponement

The 9th APCB Organizing Committee has arrived at a difficult decision to reschedule the Congress to 2023 due to the uncertainties with regards to COVID-19 in Malaysia. The 9th APCB (virtual) was originally planned to be held on the 8-10th October 2021 but the dates coincided with the peak of COVID-19 in Malaysia and most of us were busy handling COVID-19 then. We were unable to focus on the Congress preparations due to COVID-19.

The situation improved significantly when a significant proportion of the Malaysian population were vaccinated against COVID-19. The number of daily cases has reduced significantly.

The 9th APCB will now be held on 26-28 May 2023 as an in-person congress in Kuala Lumpur, Malaysia.

We feel APCB in a virtual format will not be useful since there is no opportunity for hands-on sessions for delegates who wish to improve their procedural skills. We hope to invite many experts from around the globe to share their insights and experience with the delegates. The 9th APCB website will be activated very soon to allow for online registration.

Currently in Malaysia, the average number of COVID-19 cases per day was around 4,000 cases in January 2022 but this has increased to 10,000 cases lately due to the Omicron variant surge.

However, the majority of the cases are in category 1 and 2 only (99% of the cases). Only 1% of the cases are in categories 3,4 and 5. Currently, all overseas travellers need to quarantine for 5 days when they arrive in Malaysia.

Given the current COVID-19 situation, we plan to limit the number of delegates to 200 only with strict SOP.

We apologize for any inconveniences and look forward to seeing you in Malaysia, come April 2023.

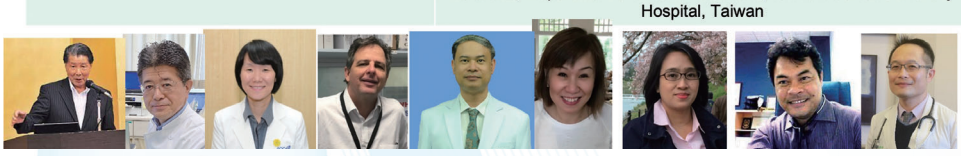
Thank you.

Dr Jamalul Azizi Abdul Rahaman MD

Congress President

## Summary of the Virtual APCB Meeting（17th of June, 2021）

| | |
|---|---|
| Takehiko Fujisawa | Former President, Asian pacific association for bronchology and interventional pulmonology (APAB) |
| Kiyoshi Shibuya | President, Asian pacific association for bronchology and interventional pulmonology (APAB) |
| Bin Hwangbo | Center for Lung Cancer, Research Institute and Hospital, National Cancer Center, Goyang, Korea. |
| David Fielding | Director Bronchology,<br>Royal Brisbane and Womens Hospital<br>Australia |
| Jamsak Tscheikuna | Division of Respiratory Disease and Tuberculosis Department of Internal Medicine Faculty of Medicine, Siriraj hospital Mahidol University, Bangkok, Thailand |
| Pyng Lee | Director of Interventional Pulmonology, National University Hospital, Singapore |
| Sita Andarini | Department of Pulmonology and Respiratory Medicine, Faculty of Medicine Universitas Indonesia, Persahabatan Hospital, Indonesia |
| Jamalul Azizi Abdul Rahaman | Consultant Pulmonologist, Department of Pulmonology, Serdang Hospital, Malaysia |
| Chih-Yen Tu | Professor and Chair, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine, China Medical University Hospital, Taiwan |



We held the first virtual meeting on June 17th, 2021. Instead of opening the face-to-face meeting, it forced us to do it virtual; Because of an ongoing global pandemic of COVID-19.

Thankfully, these doctors joined this meeting: Dr. Shibuya, the organizer of this meeting, Dr. Fujisawa, Dr. Bin from Korea, Dr. Jamsak from Thailand, Dr. Pyng Lee from Singapore, Dr. Jamalul from Malaysia, and Dr. Chih-Yen Tu from Taiwan.

First, Dr. Shibuya introduced participants for this meeting. At the same time, stated his gratitude for joining the meeting during the pandemic in his opening remarks. Then, Dr. Fujisawa expressed a huge thank you to everyone who supported APCB activities. Next, they exchanged views on the situation in each other's countries. Dr. Bin mentioned the current situation in Korea. According to that, they have seemed to control the pandemic. Even though they struggled with it, they did not face nationwide lockdowns, except for any limitation. Dr. Jamalul told us about the situation in Malaysia. He apologized for the event postponement, which was supposed to take place around October 2021 in Malaysia. He mentioned how serious the situation in Malaysia was. He saw around 10 thousand cases per day: Although they had to control the pandemic, they couldn't focus on the congress and delayed the event to 2023. Then, Dr. Jamsak told us about the situation in Thailand very similar to the situation in Malaysia. The government has tried to reduce the number of deaths by taking various measures such as closing stores, but it is still increasing. Next, Dr. Pyng Lee told us about the situation in Singapore. She expressed the present situation was like a roller coaster as it went up and down. Then Dr. Shibuya told us about his patients and the situation in Japan.

After that, Dr. Jamalul who is the 9th president gave us a proposal about the next APCB, which was supposed to hold in 2021 and postponed to 2023. As we discussed the dates for the next congress in 2023, we will host it in person, from 7th to 9th April in 2023. Depending on future circumstances, conference participants may need a vaccine passport. We sincerely hope things will return to normal as soon as possible so that we can have the next meeting.

After that, Dr. Chih-Yen Tu, the securetary general of the 10th APCB meeting, brought up the topic of congress in Taiwan in 2025. He said it was too bad to postpone the congress, but we have no choice under these difficult circumstances. He wanted to help altogether to make congress successful in the future.

Finally, Dr. Shibuya ended the meeting successfully. We hope to see you in person at the next congress in 2023. Thank you for taking the time to read this summarizes.

## Bronchoscopy and interventional pulmonology during the COVID-19 pandemic

Takahiro Nakajima, MD, PhD
Associate Professor
Department of General Thoracic Surgery
Dokkyo Medical University

Under the COVID-19 pandemic circumstance, the use of endoscopy, including bronchoscopy, was regarded as an aerosol generating, high-risk procedure for spreading SARS-CoV-2 infection for the medical staff. Each academic society's action was fast and announced the statement and guidelines on using bronchoscopy during the COVID-19 pandemic [1]. American Association for Bronchology and Interventional Pulmonology (AABIP) classified bronchoscopic procedures into three categories: emergent, urgent, and non-urgent for limiting the indication of bronchoscopy [2]. The European international expert panel announced the practice statement mainly focused on bronchoscopy in the intensive care unit [3]. Their quick correspondence was helpful for the bronchoscopist for continuing clinics using bronchoscopy because there were patients who needed bronchoscopic interventions (Figure 1).

One of the headaches for bronchoscopist was the lung cancer diagnosis during the COVID-19 pandemic. IASLC announced bronchoscopy should be avoided whenever possible to reduce the risk of spreading SARS-CoV-2 infection. On the other hand, we are afraid of increasing the mortality of lung cancer due to the delay of diagnosis and starting treatment. In the US, the number of newly diagnosed lung cancer patients decreased during the COVID-19 pandemic [4]. Lung cancer mortality was suspected to increase approximately 5% after five years in the UK [5]. In the COVID-19 pandemic circumstances, we need to select the most efficient procedure to perform bronchoscopy. Endobronchial ultrasound-guided transbronchial needle aspiration has a higher diagnostic yield than other diagnostic modalities [6] and shortens the period of diagnosis and staging of lung cancer [7].

COVID-19 pandemic also affected the medical staffs' CME activities. Most international and domestic medical conferences were forced to convene on the web. We need to think about how we should hold CME activities, especially hands-on sessions (Figure 2). The Japan Society of Respiratory Endoscopy developed an e-learning system for young members by the grant for medical education by GSK Japan. Bronchoscopy and interventional pulmonology are necessary even during the COVID-19 pandemic, and we need to seek a better way of performing safe and efficient procedures for the patients.

Figure 1

The patient developed acute respiratory distress with COVID-19 related necrotic pneumonia due to Aspergillus infection. We decided to perform bronchial occlusion using Endobronchial Watanabe Spigot (EWS). We could manage massive air leakage and perform lobectomy on the patient.

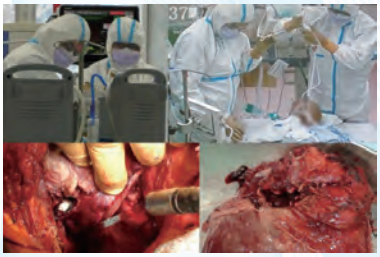
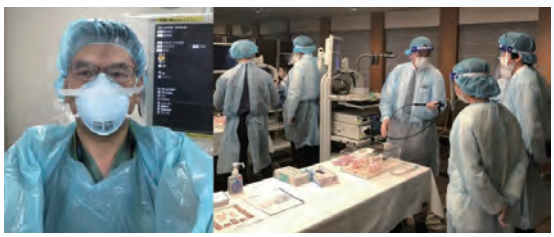


Figure 2

Personal protective equipment before performing bronchoscopic procedures. Trainer and trainee wearing PPE are joining hands-on training course.



References
1. Lentz RJ, Colt H. Summarizing societal guidelines regarding bronchoscopy during the COVID-19 pandemic. Respirology. 2020;25(6):574-577.
2. Wahidi MM, Lamb C, Murgu S, et al. American Association for Bronchology and Interventional Pulmonology (AABIP) Statement on the Use of Bronchoscopy and Respiratory Specimen Collection in Patients With Suspected or Confirmed COVID-19 Infection. https://aabronchology.org/wp-content/uploads/2020/03/AABIP-Statement-on-Bronchoscopy-COVID_3-12-2020-Statement-plus-3-19-2020-updates-V3.pdf 3. Luo F, Darwiche K, Singh S, et al. Performing Bronchoscopy in Times of the COVID-19 Pandemic: Practice Statement from an International Expert Panel. Respiration. 2020;99(5):417-422.
4. Kaufman HW, Chen Z, Niles J, et al. Changes in the Number of US Patients With Newly Identified Cancer Before and During the Coronavirus Disease 2019 (COVID-19) Pandemic. JAMA Netw Open. 2020;3(8):e2017267.
5. Maringe C, Spicer J, Morris M, et al. The impact of the COVID-19 pandemic on cancer deaths due to delays in diagnosis in England, UK: a national, population-based, modelling study. Lancet Oncol. 2020;21(8):1023-1034.
6. Silvestri GA, Bevill BT, Huang J, et al. An Evaluation of Diagnostic Yield From Bronchoscopy: The Impact of Clinical/Radiographic Factors, Procedure Type, and Degree of Suspicion for Cancer. Chest. 2020;157(6):1656-1664.
7. Navani N, Nankivell M, Lawrence DR, et al. Lung cancer diagnosis and staging with endobronchial ultrasound-guided transbronchial needle aspiration compared with conventional approaches: an open-label, pragmatic, randomised controlled trial. Lancet Respir Med. 2015;3(4):282-9.

## Strategy for Safe Bronchoscopy during COVID pandemic

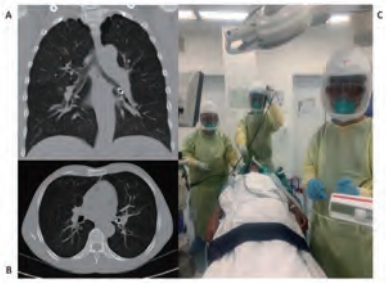
Wei-Yang Lim, MRCP (UK), Bryan Ng, FRCA (UK), Chun-Kiat Lee, MSc, Jiayi Shen, MBBS, S'pore, Calvin Koh, MRCP (UK), Pyng Lee, FRCP (UK), FCCP

PII: S0003-4975(21)01747-1

This paper is published in The Annals of Thoracic Surgery

ABSTRACT

Aerosol generating procedures are avoided for COVID-19 patients to lower the risk of transmission to healthcare providers. However, when bronchoscopy is indicated, it remains unclear if the procedure performed under general anesthesia leads to contamination of the surroundings and if standard endoscopy reprocessing methods are effective in eradicating SARS-CoV-2. We share our experience of bronchoscopic retrieval of airway foreign body under general anesthesia in a patient tested positive for novel 2019 coronavirus disease (COVID-19). We focus on anesthesia techniques to minimise aerosolization.



# Bronchoscopy in the COVID-19 pandemic: A single center experience from Taiwan

Wen-Chien Cheng, MD; Chih-Yen Tu, MD, PhD
Division of Pulmonary and Critical Care, Department of Internal Medicine,
China Medical University Hospital, Taichung, Taiwan.
Corresponding author information

Email: chesttu@gmail.com

Bronchoscopy is an essential method in the diagnosis and treatment of respiratory diseases and is widely used in clinical practice. Since 2019, severe acute respiratory syndrome due to Coronavirus-2019 (SARS-CoV-2) has caused significant morbidity and mortality worldwide.[1]

The virus is transmitted from person to person via droplets, contaminated fomites, and inhalation of contaminated aerosols. Bronchoscopy, which is an open airway procedure, poses a significant risk of SARS-CoV-2 transmission.[2] Several healthcare facilities have changed their organizational plans of bronchoscopy to protect healthcare workers (HCW) and patients worldwide. Further, we made some modifications to perform bronchoscopy, thus minimizing the risk of SARS-CoV-2 transmission in our clinical practice.

We reviewed the need for every outpatient bronchoscopy procedure to assess the indications and urgency, and bronchoscopy should be deferred for nonurgent indications. A study showed the stratification of outpatient bronchoscopy procedures by urgency.[3] When bronchoscopy is indicated, the patients and their caregivers should be asked about their symptoms, contacts, and travel history before the planned procedure date. Furthermore, the patients should obtain a negative SARS-CoV-2 test, which should be within 3 days of the procedure date. Upon the arrival at the outpatient department, the temperature is assessed for both the patient and their caregiver before entering the bronchoscopy suite. Bronchoscopy is discouraged and should not be a first-line testing modality for patients with highly suspected or confirmed SARS-CoV-2, except for emergent reasons, such as severe bronchial stenosis, massive hemoptysis, foreign body aspiration, and migration of stent. If alternative diagnosis is needed to change management in intubated patients, procedures to obtain respiratory specimens from endotracheal tube aspirate are performed. Bronchoscopy exam with bronchoalveolar lavage (BAL) samples in highly suspected or confirmed patients shell not the first consideration.

The HCW should wear N-95 respirators and personal protection equipment (PPE) including face shield, gown, and gloves (Figure 1). Essential persons were only included; visitors and students should not be present during the whole procedure. During the procedure, the patient should also wear surgical mask and their faces should be covered with treatment towel (Figure 2). Intravenous sedation with midazolam and local spread of lidocaine were provided to reduce cough during the procedure. To minimize the risk of procedure-related transmissions, the procedure time should be shortened as much as possible. The standard specimen containers should be placed in the biohazard bags by following universal precautions. All transportation of specimens to the laboratory should follow routine protocols. To indicate the samples of patient suspected with SARS-CoV-2 infection, proactive communication is conducted with the receiving laboratory using double bagging specimens and via labeling them as “suspected

SARS-CoV-2.” Finally, the process is followed by immediate hand hygiene.

In summary, to protect HCW and patients during SARS-CoV-2 pandemic, bronchoscopy should not be used as a first-line testing modality in the evaluation and treatment of patient with highly suspected or confirmed SARS-CoV-2. Bronchoscopy should be deferred for non-urgent indications. The HCW should wear PPE while performing the procedure, and the patients should comply with relevant regulations before the procedure.

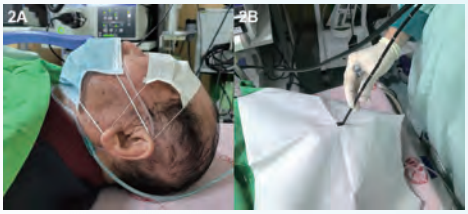
Figure legends

Figure 1.

The healthcare worker should wear N-95 respirators and personal protection equipment, including face shield, gown, and gloves.

Figure 2.

The patient should wear surgical mask, and their faces should be covered with treatment towel during the bronchoscopy.




## Successful management of patients with COVID-19 and pneumothorax

Kiyoshi Shibuya M.D. Ph.D.

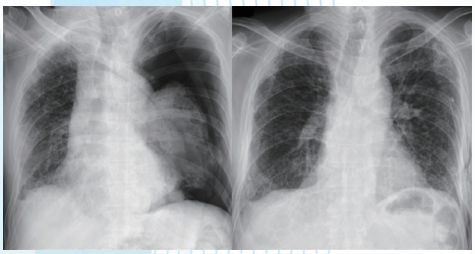
In some cases of Covid-19 infection, pneumothorax may occur due to damage to the alveolar and pleural tissues caused by the infection or fibrotic changes. We reported 2 cases of COVID-19 related pneumothorax successfully treated by lung suturing.

A 73-year-old male presented with sever dyspnea due to Intestinal pneumonia. Patient had a history of COVID-19 pneumonia 133 days prior to the current disease. He was treated both with steroid administration and with antibiotics. Twenty-one days after admission, the chest roentgenogram and CT showed the left side pneumothorax, which was managed pleural drain insertion(Figure1). However, because of the continuous air leak during 14 days drainage, thoracotomy was performed. Detailed inspection of the lung surface showed small hole with air leak. Double sutured with pledged were performed(Figure2). No residual air leak was noticed after operation and drain was removed on postoperative day 3.

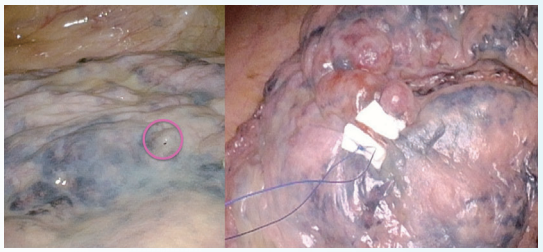
A 49-year-old male presented with sever dyspnea, fever and diagnosed with PCR positive for COVID-19. He was intubated for acute severe respiratory insufficiency and started mechanical ventilation. After one day, the patient deemed to be refractory to mechanical ventilation and determined to initiate ECMO. ECMO support were continued during 24days and after that, he was changed to only non-invasive oxygen support. He was treated as pneumonia and pulmonary abscess both with steroid administration and with antibiotics. Twenty-eight days after diagnosed with positive for COVID-19, the chest xp and CT showed the right side pneumothorax and pyothorax, which was managed pleural drain insertion. However, because

of the continuous air leak during 30 days drainage, thoracotomy was performed. Detailed inspection of the lung surface showed small bleb with air leak. Double sutured with pledged were performed. No residual air leak and pyothorax were noticed after operation and drain was removed on postoperative day 7.

(Figure 1.) The chest roentgenogram showed the left side pneumothorax, which was managed pleural drain insertion.



(Figure 2.) Detailed inspection of the lung surface showed small hole with air leak. Double sutured with pledged were performed.
No residual air leak was noticed after operation



## COVID-19 Pandemic Decreased approximately 30% of Community-based Cancer Screening 2020 in Japan

Takehiko Fujisawa M.D. Ph.D.

COVID-19 pandemic causes fatal lung disorders and finally death.

The death rate by cancer, however, is known to be higher than that of COVID-19. It became clear that residents feared COVID-19 infection and did not undergo cancer screening including gastric endoscopy or barium stomach fluoroscopy, fecal occult blood test, chest roentgenogram, mammography and cervical smear tests in Japan. I introduced several researches regarding the influence of COVID-19 pandemic on cancer screening and mortality, and the importance of cancer screening was emphasized.

Japan Cancer Association including Chiba Foundation for Health Promotion and Disease Prevention reported that approximately 30% of residents did not have cancer screening in 2020 among a major 5 cancers; stomach, colorectal, lung, breast and cervical cancers, in comparison to the rate of 2019[1].

Kuzuu K and coworkers aimed to evaluate stage at diagnosis among patients with gastrointestinal cancer in Japan before and during the COVID-19 pandemic and reported that significantly fewer patients were diagnosed with stage I gastric and colorectal cancers during the COVID-19 pandemic, presumably due to the decrease of screening-detected cancers. This paper is considered to indicate the importance of cancer screening once every year even during the COVID-19 pandemic [2].

Jacob L and coworkers reported similar study design with Kuzuu K and clarified that the COVID-19 pandemic has been associated with a decrease in the number of patients newly diagnosed with cancer in general and specialized practices in Germany. This paper strongly suggested that public intervention was urgently warranted to mitigate the deleterious effects of this health care crisis 0n cancer diagnosis [3].

In Italy, Ricciardiello L and coworkers reported impact of SARS-CoV-2 pandemic on colorectal cancer screening delay, in particularly, effect on stage shift and increased mortality, and concluded that screening delays beyond 4-6 months would significantly increase advanced colorectal cancer cases, and also mortality if lasting beyond 12 months [4].

All report and researchers indicated the strong recommendation of cancer screening even though during COVID-19 pandemic. COVID-19 each variant has different characteristics of clinical manifestations. Omicron strain has less tendency to be severe stage, therefore, residents should undergo regional-community-based cancer screening.

References

[1] The Mainichi, Japan 2020 cancer diagnoses fall as COVID impedes screening, hospital visits. https://mainichi.jp/english/articles/20211106/p2a/00m/01i/017000c

[2] Kuzuu K, Misawa N, Ashikari K, et al. gastrointestinal cancer stage at diagnosis before and during the COVID-19 pandemic in Japan. JAMA NETW OPEN 2021,26334

[3] Jacob L, Kalder M, Kostev K. Decrease in the number of patients diagnosed with cancer during the COVID-19 pandemic in Germany. J Cancer Res Clin Oncol 2022 Jan 18;1-7.doi:10.1007/s00432-022-03922-5.

[4] Ricciardiello L, Ferrari C, Cameletti M, et al;Impact of SARS-CoV-2 pandemic on colorectal cancer screening delay: Effect on stage shift and increased mortality. Clin Gastroenterol Hepatol 2021 Jul; 19(7):1410-1417.

## Notes from the editor

I have been engaging APCB activities since 2021. By this time, our life was turned upside down by COVID-19. It leads us to experience lot of restrictions; such as going outside, meeting friends, and even meeting relatives who are living pretty far.

According to this News Letter, we can comprehend how each doctor is facing a crisis of a scale and magnitude unprecedented in our recent history, by sharing their experience and situation in each country. I consider that everyone must be experiencing such an intense period as well as people, work in the front lines; since we are forced to be patient in ourselves.

At the same time, we learn something new; we can make communicate that isn't the time or place specific. Even COVID-19 pandemic made our human relationship fade, recent high internet system helps us a lot: So that, we could hold the online meeting for first time.

In addition, I think we should not forget to support each other at any time. In these circumstances, a lot of issues occur not only in an epidemic but also in conflict. Although we are facing difficult situation, let's make sure to help together.

Lastly, I wish you all of your health and happiness and also hope to get our normal life back soon. Thank you.

(Risa Fukuda)