

the Notes

News from the hospital on Harley Street | Issue 9

Managing complex lung diseases

Dr Felix Chua, Dr Adrian Draper and Dr Johnny Vlahos discuss integrating specialist knowledge with state-of-the-art diagnostic imaging

Respiratory diseases are common and range from the frequently encountered to the highly unusual. The former may occasionally present in an atypical manner while the latter may develop insidiously, often with a natural history that spans months or even years. A thorough clinical assessment includes unravelling the patient's narrative history so that diagnostic clues can be brought sharply into focus. A secure diagnosis will fundamentally influence the management that follows.

Human lungs are compartmentalised into a network of connecting airways that give rise to millions of delicate air sacs that ultimately form the gas exchange surface. These alveoli are surrounded by a fragile interstitial scaffold containing specialised cells, supporting tissue and ultra-fine capillaries. Sophisticated as the lung structure may be, symptoms of respiratory disease do not usually follow clear anatomical separations. For example, a cough may suggest an upper or lower respiratory tract disorder, or indicate disease of the distal lung

parenchyma. Breathlessness of gradual onset may signify the presence of a more established process such as chronic obstructive pulmonary disease (COPD), diffuse interstitial fibrosis or even a lung malignancy.

In a respiratory consultation, importance is attached to other symptoms and signs that occur in conjunction with the primary complaint. A variable wheeze that accompanies persistent coughing might suggest asthma as the clinical culprit. However, the presence of bronchiectasis or positive fungal serology will shift the suspicion to allergic bronchopulmonary aspergillosis (ABPA) as the unifying aetiology. Gradual breathlessness, in the context of particular spirometric changes may prompt cross-sectional imaging of the thorax that will disclose evidence of an interstitial lung disease. The presence of extra-pulmonary symptoms may focus the search for a rheumatological disorder even when the clinical syndrome appears to be dominated by pulmonary abnormalities. A comprehensive occupational history might identify potential inhalational hazards or symptom profiles that correlate in time

and place with suspected exposures. In respiratory medicine, seemingly innocuous symptoms should never be dismissed until a search for causality or association has been undertaken.

Pulmonary pathology produces a small but frequently overlapping range of abnormalities including inflammation, fibrosis, destruction or obstruction of the affected airway or region of parenchyma.

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“By enhancing our ability to visualise the consequences of normal and abnormal lung remodelling, advances in imaging technology have greatly improved our diagnostic certainty”

[Dr Felix Chua, Dr Adrian Draper and Dr Johnny Vlahos](#)



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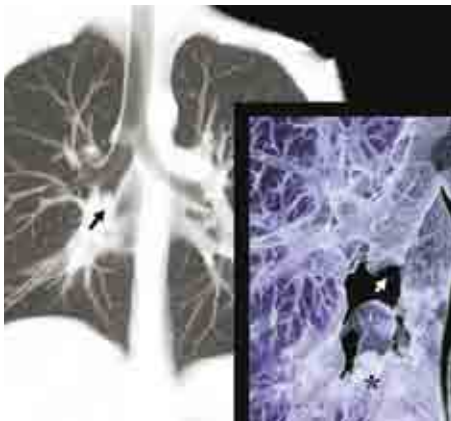


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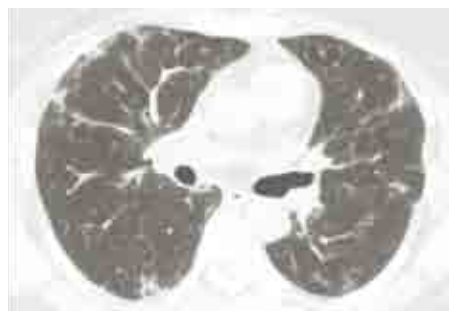
By enhancing our ability to visualise the consequences of normal and abnormal lung remodelling, advances in imaging technology have greatly improved our diagnostic certainty (figure 1). Accurate radiological information allows respiratory physicians to integrate anatomical and physiological data crucial for characterising individual diseases and determine their functional impact on the patient's health and quality of life.

Fine radiological detail, discernible by high-resolution computed tomography (HRCT), can help identify subtle air-trapping due to small airways disease, resolve lung perfusion inequalities and highlight the hallmark features of pulmonary fibrosis. In certain circumstances, inflammatory ground-glass opacities can even be distinguished from those due to early fibrosis. Such insight is vital to the treating physician tasked with balancing the priorities of controlling or even reversing disease against the possible side effects of therapy.

Complex lung diseases may also present as a chance radiological finding. The incidental observation of reticulo-nodularity or lymphadenopathy, as two common examples, is only the first of many steps in the diagnostic process. In cases where a particular disease has already been identified, evaluation of its activity and/or response to treatment becomes the next clinical concern. Thus, any means by which these parameters can be reliably or objectively determined is highly valued by the treating clinician (figure 2).

In recent years, great strides have been made in understanding how the respiratory tract may manifest the pathophysiological consequences of

an altered immune system. Patients with an acquired immunodeficiency or those receiving chemotherapeutic drugs may develop opportunistic infections, lymphoid or vascular abnormalities, unusual bronchiolitis or iatrogenic effects from such agents. Some anti-cancer compounds are more prone to induce lung toxicity than others; very occasionally, fulminant or explosive diffuse alveolar damage (DAD) may ensue. In most cases, however, the detrimental effects of such drugs on the lung are cumulative, allowing timely intervention to retard or even reverse the early pre-fibrotic changes of 'chemo lung'. Where this is achieved, the threat of permanent loss of lung function may be averted. In these and a myriad of other situations, specialist collaboration combined with the latest in cutting-edge diagnostic technology offers clear advantages to the management of challenging lung diseases.

**Figure 1**

Far left, Coronal double oblique CT reformat shows a tumour obstructing the bronchus intermedius. 3-D volume rendered analysis localises the level of bronchial interruption and demonstrates distal lobar collapse (asterisk in inset).

Left, Virtual bronchoscopic image renders a 3-D intraluminal depiction of the obstructing lesion.

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Figure 2

CT confirmation of hyper-acute diffuse alveolar damage (DAD) in a patient with polymyositis at presentation (top) and marked improvement following parenteral immunosuppressive treatment (bottom). Lung function gains occurred in parallel.

Carcinoma of the colon screening alternatives

In light of April being bowel cancer awareness month, Dr Forecast discusses the screening options available

Dr David James Forecast MRCP

Consultant Gastroenterologist and Endoscopist



Colorectal carcinoma (CRC) is the third commonest cancer in the UK and is diagnosed in 106 patients every day. 84% of patients are over the age of 60 with a median incidence at age 70¹.

Mortality rates fell by 13%, between 1999 to 2008 yet I feel that a comprehensive screening programme has the potential to significantly improve these figures. Slow tumour growth provides a long window of opportunity in which to detect and remove the malignant precursor, namely the polyp or detect the cancer at an earlier, more favourable stage. Malignancy usually develops through the adenoma-carcinoma sequence so 'detect the polyp – prevent the cancer'.

Current options available:

Guaiac Faecal Occult Blood testing

This may reduce mortality from CRC by 15-33%² yet single testing with standard non-rehydrated gFOBT detects less than 50% of cancers. Positive patients have a 3-4 fold higher risk of CRC.

Faecal Immunochemical Test

A comparative German study³ showed a wide range of CRC detection from a single sample (6-46%) using the various products available. The best identified only 25-27% of polyps with advanced neoplasia.

Stool DNA

This has potential for the future but it is still early days.

Biomarkers

A recent abstract presented at the 2010 UEGW meeting in Barcelona reported that patients without lesions could be separated from those with CRC (sens.63%, spec83%). A formal validation study begins this year.

CT Colonography

A recent study⁴ showed a 90% pick up of polyps greater than 10mm. False positive

rates were 14%. It is recommended that all patients with a polyp greater than 6mm should be referred for colonoscopy. The drawbacks to CT are the need for special expertise and training, failure to detect flat polyps and radiation exposure.

Sigmoidoscopy

A recent controlled study of 170,000 people followed for 11 years showing a 43% mortality reduction in the scoped group and a 33% reduction in CRC incidence⁵. The drawbacks are the need for an office visit, bowel preparation, discomfort and the limitation of the examination. For many, colonoscopy is more appealing, when sedation can be given, the whole colon is examined and polyps can be removed.

Colonoscopy

Although not ideal this test has much to recommend it. However, it is costly, requires operator expertise, needs optimal bowel preparation and has risks (serious adverse events occur in 0.3% of cases in experienced hands⁶). Screening colonoscopy studies have shown that CRC will be detected in 0.5-1.0% and polyps with advanced neoplasia in 5-10%.

Detection of flat polyps and their removal requires particular expertise and there is evidence that they may have a high risk of advanced histology. Right-sided retroflexion improves the detection rate of ascending colonic polyps. These points emphasise the need for a thorough and complete examination in order to reduce the incidence of CRC, particularly in the proximal colon.

All the evidence suggests that screening should commence in all average risk individuals at the age of 50 while the upper age should be individualised based on co-morbidities. While the ideal procedure is not yet available the message of this guideline is to ensure that at least one of the options is adopted.

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References

¹ www.cancerresearch.uk.org

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Watch our health awareness video about bowel cancer screening at www.thelondonclinic.co.uk

HM The Queen discussing our new radiotherapy equipment with one of our consultants



Royal seal of approval for The London Clinic

We're proud to announce that we have been granted a Queen's Award for Enterprise in the International Trade Category as a result of successfully increasing overseas income by more than £9m over the past three years.



The prestigious award represents an extremely high accolade for the Clinic and reflects our commitment to investing in the needs of international patients, offering bespoke and specialist services to visiting nationals from well over 30 countries.

Under the direction of Chief Executive Malcolm Miller, the Clinic manages all overseas business through a dedicated International Office. The team boasts excellent relationships with Embassies and health offices in London and overseas, with regular visits to the Middle East to meet the dignitaries and officials responsible for the transfer of patients to the UK for treatment. As a registered charity, the Clinic has been able to re-invest over £160m into new facilities and services in the past 5 years.

Mr Miller says; "We are all absolutely delighted to have been honoured with this special award, especially at a time when it is so important for the UK to be strengthening our ties globally and for Britain to be seen as a leader in the provision of world class health services.

"I am very proud of my team led by Mr Sanjay Shah our Chief Financial Officer who, not only worked so hard in our application for the Queen's Award but who also works tirelessly on a daily basis to ensure that all our international patients receive a warm welcome and a tailor-made service throughout their treatment and stay with us."

The London Clinic was officially opened 79 years ago in 1932 by the then Duchess of York (later to become

Queen Elizabeth The Queen Mother). More recently (March 2010) the Clinic's new £90m state-of-the-art cancer centre – housing the latest radiotherapy and radiosurgical technology – was opened by Her Majesty The Queen.

In addition to a strong business relationship with the Middle East, The London Clinic continues to look for opportunities in new markets such as Cyprus, Russia and China. We also offer a 'Second Opinion' service for overseas patients and now hope to have a greater focus on the EU market.

Mr Miller adds: "We offer a truly unique service for our international patients and it is very important for us to have been recognised and commended for our ongoing investment in the international healthcare market.

"Harley Street and The London Clinic have long been associated with the provision of medical expertise and clinical excellence for our patients both at home and abroad. We are thrilled to have been allowed to bear the emblem of the Queen's Award for Enterprise in International Trade and will 'wear' it with pride over the next five years."

“We are all absolutely delighted to have been honoured with this special award, especially at a time when it is so important for the UK to be strengthening our ties globally and for Britain to be seen as a leader in the provision of world class health services”

Chief Executive Malcolm Miller



All overseas business is managed through our dedicated International Office

Consultant Profile



Professor Simon Taylor-Robinson
Professor of Translational Medicine
and Consultant Hepatologist

Professor Simon Taylor-Robinson is Professor of Translational Medicine and Consultant Hepatologist at Imperial College London. He joined the Department of Medicine at Imperial College London as Senior Lecturer in 1997, was promoted to Reader in 2002 and Professor in 2007. He is now the Dean of the Faculty of Medicine of Imperial College London.

Professor Taylor-Robinson has an international reputation in the management of patients with abnormal liver function tests, viral hepatitis (both hepatitis B and hepatitis C), alcohol-related liver problems, autoimmune liver disease and primary biliary cirrhosis. He also manages patients with fatty liver, non-alcohol-related liver disease (NAFLD/NASH), obesity-related liver disease and diabetes-associated liver disease.

Professor Taylor-Robinson has a major interest in the management of hepatic encephalopathy, hepatocellular carcinoma and cholangiocarcinoma, having written national and international guidelines on these conditions.

Over the past 20 years, he has investigated pathogenic mechanisms in chronic liver disease using a combination of in vivo and in vitro MR spectroscopy, positron emission tomography and microbubble contrast-enhanced ultrasound. He has over 170 publications currently.

In June 1999, he was awarded a MRC Career Establishment grant for liver fibrosis.

Professor Taylor-Robinson is clinically responsible for patients with liver disease both at Hammersmith and St. Mary's Hospitals (Imperial College Healthcare Trust, London). He is currently Director of the Imperial Clinical Research Facility at St Mary's Hospital.

He was awarded the Sir Francis Avery Jones Gold Medal by the British Society of Gastroenterology in 1999 and the Young Investigator Award of the Liver Section of the European Gastroenterology Association in 1997. He was further recognised by the Royal College of Physicians of London in September 2000 when he gave the foundation Linacre Lecture.

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New CyberKnife treatment offers life saving hope to patient



When Lesley Whiting, a 56 year old charity worker from Horsted Keynes, West Sussex, discovered her breast cancer had spread to her skull, doctors feared there was little they could do because the three tumours were in a critical position in the bone at the base of her skull, next to her brain.

The dilemma for doctors treating hard to reach cancers like Lesley's is that giving patients the high dose of radiotherapy needed to destroy the tumours could potentially cause fatal damage to surrounding healthy organs and tissue. Yet without a sufficiently high-dose of radiotherapy, the treatment is ineffective and pointless.

When Lesley was told she had just 18 months to live last year, she decided to get a second opinion, and discovered that she was one of an increasing number of cancer patients being recommended for a new treatment called CyberKnife® Robotic Radiosurgery System. This high-tech robotic machine provides stereotactic radiotherapy where it delivers high doses of radiation to the tumour with pinpoint precision to avoid damaging surrounding healthy tissue.

However, the treatment, which requires only up to five sessions instead of 30, is not currently available on the NHS. Like dozens of other patients, Lesley was told her PCT would not fund the £22,000 treatment even though her NHS doctor and a panel of medical specialists at The London Clinic, one of only 2 hospitals in the UK with CyberKnife, concluded it was her best option.

"Being told they wouldn't fund the treatment was like a bombshell," says Lesley. "It is an expensive treatment but for women like me with breast cancer, CyberKnife can delay the point where you have to have expensive chemotherapy week in week out just to stay alive. In the long run, it will save the NHS money."

According to Dr Andy Gaya, a consultant clinical oncologist at The London Clinic, only 10 to 20 percent of NHS patients applying for CyberKnife funding are accepted. He says "Some PCTs are incorrectly suggesting CyberKnife is an experimental treatment, and this may lead to a postcode lottery – so whether you get the treatment or not depends on where you live. Yet there is an increasing body of evidence showing that it is very effective, and can obliterate tumours in awkward places."

Subsequent to Lesley's initial bombshell, a collaboration of funding from both The New Victoria Medical Foundation charity and The London Clinic has given her access to the life-saving CyberKnife treatment.

Lesley is one of the lucky ones. She has now undergone the treatment and is waiting to find out how successful the treatment has gone.



→ For more information about the CyberKnife® Robotic Radiosurgery System, please email info@thelondonclinic.co.uk

“It is an expensive treatment but for women like me with breast cancer, CyberKnife® can delay the point where you have to have expensive chemotherapy week in week out just to stay alive. In the long run, it will save the NHS money”

Lesley Whiting, a 56 year old charity worker from Horsted Keynes, West Sussex



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December 2010 – March 2011

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The London Clinic set to help GB Rowers make waves at championships

New three-year partnership offers 'oar-some' support to national team



Malcolm Miller training with the reigning world champion rowers, Frances Houghton and Chris Bartley

Malcolm Miller, Chief Executive of The London Clinic, donned his sports gear and put his fitness levels to the test alongside members of the GB Rowing Team¹ on Wednesday 9 February at the launch of a new three-year partnership agreement.

The partnership recognises the Clinic as an 'Associate of the GB Rowing Team'. As a result, members of the 70-strong national team will have access to our state-of-the-art facilities and technology for diagnostic testing, physiotherapy and sports injuries, managed by leading experts in sports medicine.

Such support comes at a critical time in the international rowing calendar, which will see the team competing in key championships on the world stage during the next 18 months.

Malcolm Miller comments: "The next year and a half is set to be a really exciting time for the GB Rowing Team. I'm thrilled that The London Clinic can lend our support to help ensure our national team remains in peak condition for the many championships that lie ahead.

"Our facilities and expertise in the area of sports medicine are second to none, so all members of the GB Rowing Team can feel confident they will receive the very best in treatment and patient care."

As part of the relationship, members of the GB Rowing Team will benefit from, amongst other things:

- Direct referral for investigations to enable rapid diagnosis, including, blood tests, radiology, pathology and nerve conduction studies

- Remote access to results of diagnostic investigations and images
- Rapid access to specialist opinion
- Health checks for coaches and support staff

Dr Ann Redgrave, Chief Medical Officer for the GB Rowing Team said: "We are delighted to form this link with The London Clinic. This arrangement will give us rapid access to the kind of diagnostics and services we might need to minimise days lost on the water and in the gym in the lead up to all of our top events. It's a big year for the GB Rowing Team with a World Championship in late August which doubles as the Olympic qualifying regatta for 2012."

The GB Rowing Team is currently in preparations for this year's World Rowing Championships, which take place in Bled, Slovenia (28 August – 4 September).

¹ The GB Rowing Team is the section of British Rowing that is responsible for International Rowing and the High Performance Programmes

→ For more information regarding The London Clinic's expertise in the area of sports medicine, please call Paul Apps, Deputy Director of Clinical Services on 020 7616 7765 or email p.apps@thelondonclinic.co.uk.



GBROWINGTEAM

The London Clinic is an Associate of the GB Rowing Team



Editor:
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→ Your Feedback

If there are any topics that you would like to appear in future issues of the Notes, please send your suggestions to info@thelondonclinic.co.uk