

09:21:45 Why have ET at all if 6mwt is more than sufficient?

09:22:04 how long is the inpatient assessment and what does it involve?

09:22:09 Is smoking an absolute contraindication?

09:23:04 Are there any survival calculations/ scores that you use or you think are particularly useful?

09:23:13 do you need to must have all the investigations prior to the referral like angiogram?

09:23:24 There is broad range of Psychological disorders . Any specific diseases in relative or absolute contraindications

09:23:35 Are other indices weighed in the same way as exercise tolerance when deciding fitness for transplant? eg, does echo pulmonary hypertension exclude a 60 yr old but not a 25 yr old with severe lung disease?

09:31:47 exercise tolerance is a subjective impression while 6mwd is an objective evidence

09:34:16 If my patient says they stopped smoking, do I need to routinely do nicotine blood levels before referring to LT?

09:36:49 active psychological condition would be an issue

09:37:35 One of main issues with psychology is potential to impact on compliance post transplant.

09:37:40 Mostly would be looking at how someone takes responsibility and whether they have adaptive coping strategies

09:37:47 You seem to distinguish between substance addiction (including cigarette smoking) and alcohol use. What do you regard as acceptable alcohol use?

09:41:51 what is the criteria for substance abuse in choosing a transplant donor? Especially in view of smoking tobacco and other inhaled drugs!

09:45:46 A high proportion of lung donors have a smoking history (40%) and a number are current smokers. The total tobacco exposure is reviewed in the donor assessment process. Older donors with extensive smoking history are less attractive as lung donors than younger donors with shorter smoking histories even if both are current smokers. Other substance abuse is taken into account such as IVDA in overall assessment of donor risk vs suitability.

09:50:05 Do you have any calculators/tools you would use to calculate survival estimate?

09:52:54 <https://www.odt.nhs.uk/transplantation/tools-policies-and-guidance/risk-communication-tools/>

09:54:32 how does the unstable critical clinical admission fit with the super urgent category?

09:54:38 any infection is reversible causes so why absolute c/i

09:56:34 if someone is on the referral list (or awaiting assessment) and we F/U every 3 months ourselves - how often would you suggest PFTs at F/U? every 6 months, or more or less often?

09:57:55 Health inequality and social support sometimes impact each other. Do you find that this impacts the referrals from these underserved areas, and is the transplant service set up to support patients who may not have robust support but are engaged?

09:58:17 In remote areas, it can be time consuming getting some investigations such as oesophageal studies. Will you accept profromas that are only 90-95% complete?

09:58:46 In systemic disorders such as CF, Alpha one anti trypsin deficiency and Connective tissue disease related (such as SS), How lung transplant helps when ongoing genetic defect or disease is always there to involve the lungs again?

10:03:04 In order to consider a patient with IPF for Tx should they have first been considered/had for antifibrotic therapy?

10:04:30 Severe CTD ILD and RV dysfunction in a young patient - is it an absolute contra indication?

10:04:53 Is there an absolute age cut off?

10:06:10 is there financial support to cover transport cost for more deprived but engaged pts

10:19:49 Papworth team also run satellite clinics - agree these are really beneficial for patients living distant from transplant centre

10:23:56 Approximately what proportion of patient's indicate they would not want lungs from categories such as recent smokers / older donors?

10:24:51 And how do you counsel patients about accepting or rejecting these "more risky" lungs? What factors do they need to consider?

10:30:16 Why do you need an abdo ultrasound as part of your in-patient tests?

10:32:13 Sabrina this is part of a safety assessment to look for any evidence of cirrhosis/liver disease/ GB stones/Renal architecture etc

10:32:14 why do we no longer do two single transplants together?

10:33:07 Is fatty liver an absolute contraindication?

10:35:34 For conditions such as ILD/COPD Is it that the outcomes are better per individual patient if they have a double lung transplant rather than giving two patients a single lung transplant each?

10:37:07 Your experience of reduced infection rates during covid is interesting. Would you recommend patients with eg IPF are put on prophylactic antibiotics eg azithro while on a waiting list?

11:29:36 The >300 patients COVID transplanted, could I clarify if they had active infections or if it was due to irreversible damage as mentioned in the proposed criteria?

11:30:34 Defined as being "due to a combination of COvId related ARDS and fibrosis". Not active covid - needed negative test.

11:30:59 Thanks, Chevanthy. Defined as being "due to a combination of COvId related ARDS and fibrosis". Not active covid - needed negative test.

11:42:56 T2 RF could be treated NIV and NTM is one of the infection could be contraindicated

12:04:56 could you talk more about how pleuridesis affects surgical selection and how this affects how we council patients with pneumothorax who may be transplant candidates in future

12:10:36 T2RF could be treated but the development of T2RF is itself concerning of deterioration. NTM is a big concern.

12:11:16 why is an aspergilloma contraindicated in CF lung transplant? is it because of its persistence, or because of friability of the cavity risking spillage during surgery?

12:12:56 What are the implications for patients with one lung larger than the other (as I think was being demonstrated in last CF case)?

12:14:43 Hi Stuart! Great question. Any previous thoracic procedure can create adhesions which make the removal of the lung more challenging. It could mean a longer operation, higher risk of bleeding, more requirements for transfusions and other products. All of these can affect the early post operative outcomes. Pneumothorax if NOT treated with pleurodesis is not a concern at all. Any pleurodesis is concerning (talc is probably the worst) and it should be discussed with the transplant team

12:16:45 Hi Sharon. Nice question. It's not an absolute contraindication and at Harefield we have certainly trasnsplanted patients with Aspergilloma. However, if they are big, close to the pleura they can be challenging to reset, there is risk of spillage in the pleural cavity and more importantly they can bleed significantly peri-operatively. In summary, they are a risk factor that merits careful consideration.

12:19:40 Hi Angela. Unfortunately I did not have the time to share the last CXR. This patient was successfully transplanted with a double lung transplant. It was possible for both lungs to be removed perioperatively and the mediastinum shifted back centrally. However, it can be challenging and we have recently has a similar case (ILD not CF) where the second lung could not be transplanted (the patient has a single lung transplant in that case and the final decision was made intraoperatively by the surgeon - patient had been made aware in advance of that possibility)

12:38:32 Is the time to wait longer comparing to adults?

12:39:14 Depends on blood group, size, etc but overall can be longer I think it is fair to say

12:39:23 If RH can remodel well is there a severity of PH that would certainly require Heart/Lung transplant? Is it the same in adults/ children?

12:40:36 We know the long term complications of transplant in adults (CNI related, malignancy, and cardiovascular stuff too), how much more so in paed? Do lung transplants last a certain time period in general?

12:41:02 I can focus on PH remodelling in my session

13:43:26 how long does a lung transplant take? (what is the surgical operating time)

13:43:53 What is the average duration of stay in ICU post lung transplant?

13:44:08 Are there specific complications intraoperatively from patients who have previously had pleurodesis?

13:45:20 clarithromycin should not be given

13:45:35 5-7 days minimum 3 days rarely 2 months most patient 60 percent go home 3 weeks after operation

13:46:25 Maureen, re pleurodesis, risks are failure to be able to explant the lung and/or profound bleeding, often exacerbated by use of cardiopulmonary support during surgery.

13:54:38 If patients have been on azithromycin immediately prior to transplant, does the long-term binding to tissues lead to interaction with immunosuppressant drugs given immediately after wards and for how long?

13:57:58 early period of transplant the immunosuppression level is monitored religiously more often daily

13:58:16 so the dosing of the drugs can be titrated

13:59:39 left lower pole of hilum lesion

14:00:21 PTLD?

14:02:33 Rejection and atypical infections

14:05:01 If you use home spirometry for patients post-transplant, is it offered to those on the waiting list as well? Which devices do you use?

14:14:28 I wonder if any of the UK centres are involved in the trials for creating universal donor lungs for transplant with some sort of enzyme therapy for the ABO blood system (apologies if a myth only source so far is press releases)

14:16:07 its a non clinical trial in toronto - they have a huge EVLP programme (clinical and research). EVLP is still not widely used at the moment in UK

14:16:48 I suspect that it will progress to clinical trials over in Toronto in the near future

14:17:02 Group in Cambridge doing this for Kidneys but not being done for lungs yet - more work awaited from Toronto on this topic for lungs

14:23:18 Azithromycin is a neomacrolide that doesnt really interact with immunosuppression, we always check after starting to be sure though.

14:40:22 Sorry if this has already been answered but what is the average length of stay in high care/ITU and then in hospital overall post op that patients have?

14:41:38 ITU stay can be variable good outcome early no PGD, can be 2 to 3 days then transplant ward round. PAH prev higher risk, improved with new measures,

14:43:41 we havent used many CFTR modulators either, some for GI or sinus issues

15:40:05 PROTECT study for prophylactic Sotrivimab. - Dr R Smith from Cambridge the PI. I was approached by one of the Birmingham researchers Dr Dosanjh.

15:57:57 is tacrolimus filtered out with haemofiltration?

15:59:57 any chance of getting cryptosporidial diarrhea in lung transplant ?

16:00:35 Post lung transplant-correction

16:03:23 How to rule out GVHD as a cause of diarrhea

16:09:36 Do people use heliox any more?

16:12:11 Not sure but SCE this time had one MCQ on it 😊

16:22:45 X ray abdomen erect and supine

16:22:54 blood gas to look at lactate

16:23:13 CT abdo and discuss with surgeons to review

16:23:26 riles tube to decompress the stomach and prevent vomiting --> aspiration

16:23:30 culture- bloods, stool etc

16:23:46 supportive cares hydration renal function check tac levl

16:24:33 Stool cultures ? OCP and enteric cultures

16:30:34 Atypical infections. Tb. Fungal infections

16:30:34 ntb

16:30:40 ntm

16:30:40 metastases

16:30:44 ntm

16:30:53 PTLD,infection

16:30:55 NTM

16:32:22 bronchoscopy

16:32:22 biopsies

16:32:27 Bronchoscopy

16:32:28 full infective screen

16:35:33 Is there any articular histologicaltype of lung cancer in transplanted lungs?

16:39:20 Bloods sputum culture for M . Cs

16:39:21 Does she need a bronchoscopy ? PJP

16:39:23 Get cxr

16:39:26 Tb culture

16:45:23 How many lung pathologies has she had?

16:46:00 Amazing case, thank you

16:47:21 does her child have any evidence of alveoli protienosis?

16:52:22 Is there any role of Inhaled NO in transplant patients?