

# Mouthpiece



## President's Address

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Welcome to the 1<sup>st</sup> issue of Mouthpiece for 2001 and the final President's report from me. I hope everybody enjoyed their Christmas and New Year celebrations and are now refreshed enough to take on the challenges of another year.

This is my last report in Mouthpiece as President and consequently a good time to reflect on the New Zealand influences on the Society during our term. We are proud of what we have achieved but I am amazed at how quickly two years have passed.

One of our objectives was to put a system in place for formally acknowledging members for their contributions to the Society. This was established with the introduction in 2000 of special Society awards, the Life Membership and the Society Fellow. We have been in existence for 21 years and can be proud of the recognition we now receive as a professional body as we are well respected and acknowledged internationally. I am often surprised by compliments made in relation to our professionalism and the contributions we have made to the field of respiratory science. This is a direct result of the dedication and unselfish commitment of time by many members.

In keeping with the aims of the Society we have used accumulated Society funds to establish ANZSRS Education Scholarships. Two scholarships have been awarded for 2001 and both recipients are studying for the Respiratory Diploma in Respira-

tory Science at the Charles Sturt University. We wish both of them well with their study.

In an effort to encourage younger members to develop their research and presentation skills we also instigated the young investigator award at the Annual Scientific Meeting.

By the time we hand over the Executive duties we will have completed an Executive Handbook which documents procedures and guidelines for Society management. This will help smooth the transition between present and future Executive committees. It is an adjunct to the constitution and was developed to assist with ensuring consistency and clarification of Society management as well as documenting Society records. The handbook will be a 'living' document to be enhanced and amended by future Executive committees.

We are pleased to report progress on the issue of the relative value study. We have analysed the costs from four laboratories to provide a sensible parallel comparison of costs with those of PricewaterhouseCoopers. Our costs include two privately run laboratories and two public hospital laboratories with a range of annual test numbers. ANZSRS and the TSANZ have worked very closely on this project and will shortly send a joint letter from the TSANZ President, the Chairman of the Professional Standards TSANZ and ANZSRS to the Medicare Schedule Review Board at the Department of Health. The letter points out the disparity in

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## President's Address

*(Continued from page 1)*

costs as well as documentation of the gross undervaluing of our work and the implications for laboratory survival.

### Society Web Page

When we took office in 1999 our first urgent task was to find a new Editor for Mouthpiece. We were very fortunate when Belinda Breust generously volunteered for this important role. Belinda has continued to develop Mouthpiece as a very professional publication. The Society Web page ([www.anzsrs.org.au](http://www.anzsrs.org.au)) continues to provide instant access to Society resources and utilities, currently there is an average of 7 visitors per day. This forum has enhanced Society communication and will continue to develop. Jeff Pretto is to be congratulated on the successful introduction of this web page and his continued management of posting relevant items. The continued success of both of these initiatives is dependent on the contribution from the members.

### Infection Control

During September last year we had the opportunity to forward a submission regarding infection control guidelines for respiratory laboratories. We were heartened by the support of the membership and how well communication among each regional branch of the Society allowed a consensus to be reached at such short notice. Recently we had an opportunity for final comments on our submission and now look forward to the publication of this document.

### Annual Scientific Meeting

The ASM is nearly upon us and most of the organising is complete. There have been many issues behind the scenes but the most worrisome has been reluctance by some of our traditional sponsors to come on board to support the meeting. The primary reason given was a perceived lack of appreciation and acknowledgment of their generosity. This is a major concern and affects the viability of future meetings. We must all be aware of the important symbiotic relationship between our profession and the equipment companies. Please make an extra effort to visit the trade booths at every opportunity, the program does allow more time than previous years for this. It is crucial you spend time with the trade people and show appreciation for their support. Spending time with the trade also satisfies our pro-

fessional requirement to keep up to date with equipment and resources for the best delivery of service to patients. The presence of a wide range of suppliers allows the opportunity for us to comment on and suggest future developments.

### Society Logo

The search for a new Society logo has been an interesting exercise, suffice to say we still have our original!

The information as supplied by the membership for the Society Register has been documented and we welcome suggestions for its application/publication at this year's AGM.

We extend a warm welcome to all the new Board members and wish them well in their important role with the Society. We are also very pleased to announce that we now have a board member representing the regional branch of Western Australia.

Finally I wish to thank all those who have offered their support over the last two years. I would especially like to thank Kevin Gain and John Martin. It has been a pleasure working with them. We are proud of what we have achieved and believe we leave the Society in a strong position for the future. We have put a great deal of time and energy into our endeavours as members of the Executive but the Society has also given back to us as well and we are grateful for the experience.

We wish the new Queensland Executive well in their role and hope they too enjoy the opportunity to put their stamp on the Society in its 21<sup>st</sup> year.

Best wishes and kind regards to you all.

*Maureen Swanney, CRFS  
President*

### **International Society for the Prevention of Tobacco Induced Disease (PTID-Society)**

is a new international, non-profit, academic, scientific society aiming at disease prevention. Membership is open to both individuals and health related societies.

To obtain more information please visit the society's homepage at  
**[www.ptid.org](http://www.ptid.org)**

## From The

## *editor*

Welcome to the first edition of Mouthpiece for 2001. I trust everyone has had a relaxing and enjoyable holiday for at least part of the festive season. As a uni student (albeit a much older and wiser one) I had forgotten the delights of 3 months holidays. Sorry to rub it in! Despite the "break", the publication of Mouthpiece has yet again been another frantic session of preparations, as it always seems to be. Thanks for the co-operation of all those who contributed to this edition.

I am sure everyone is anticipating the upcoming ASM with interest. I would like to bring your attention Brenton's ASM update on the following page, and in particular his mention about trade sponsorship.

May I remind everyone to ensure that membership fees are up to date. This Executive has worked diligently to organize the Society's administration and, having done so, will be limiting the distribution of Mouthpiece to current members only. If anyone would like an update on their status, or need to advise a change of address (both snail mail and e-mail), please

do not hesitate to contact Kevin Gain (kevin.gain@wnhealth.co.nz).

The survey form is still in use and I encourage any members who have not completed a form to do so in the near future. An updated email list is also provided. Please note that I receive all details regarding postal and email addresses from the Secretary's register (which is constantly updated), therefore any changes or additions to member's details should be forwarded preferably to Kevin.

My thoughts for a future edition of Mouthpiece include a focus on Accreditation issues so I would greatly appreciate any thoughts, comments or contributions from the readership.

Belinda Breust, CRFS  
Editor

## *Education Scholarships for 2001*

Congratulations to the first recipients of the ANZSRS Education Scholarships:

*Anita Brake,*

Dept, of Thoracic Medicine, Royal Brisbane Hospital  
and

*Patricia Lyeell,*

Monash Medical Centre, Melbourne.

Both recipients are studying for the Graduate Diploma in Respiratory Medicine at Charles Sturt University.



# 2001 Annual Scientific Meeting

## *Update*



The 2001 local organizing committee have been hard at work getting the final pieces in place for the 2001 Annual Scientific Meeting. It promises to be an enjoyable meeting with a pleasant mix of intellectual and social activities.

Our invited speaker, Professor David McKenzie from the Prince of Wales Hospital in Sydney, will provide 2 presentations on the theme “**Beyond 11503: Advanced Respiratory Function Tests**”. The first presentation will cover lung and airway mechanics, cardiopulmonary exercise testing and respiratory sensations. The second presentation will cover control of breathing including respiratory reflexes and respiratory motor function (diaphragm mechanics).

Once again ANZSRS members from throughout Australia & New Zealand have provided a first class selection of both oral and poster presentations of varied topics. We wholeheartedly thank all those who have submitted abstracts.

An integral part of the Annual Scientific Meeting, one which is often overlooked by many delegates, is the Trade Display Exhibition. The companies comprising the Trade Display provide generous financial support to our society and we would encourage you to show your appreciation of this support by ensuring you visit all trade exhibits. We would also like to acknowledge our Gold Sponsors for the meeting: Anaesthetic Supplies, Boehringer Ingelheim, Compumedics, 3M and RJ & VK Bird.

The social program has a very Queensland feel to it, so much so that all social activities are to be informal, with no jackets or ties permitted at any of the social functions. The Welcome Reception, kindly sponsored by GlaxoSmithKline (Australia), will be held overlooking the Brisbane River at Rydges Rooftop. On Saturday evening a ferry will convey delegates to the Riverside Function Centre for the Annual Dinner, kindly sponsored by Profile Therapeutics.



On Sunday the joint ANZSRS/TSANZ/ISAM Aerosols Symposium will commence. This symposium will showcase many of the new developments in aerosol technology, plus medical aspects of aerosol use. The society last touched upon Aerosols at the 1991 Annual Scientific Meeting in Lorne. At that meeting we were confronted with the newest thing in drug delivery

– the Turbuhaler. Who knows what new technology presented at this symposium will be in routine use in a few years time.

On behalf of the local organizing committee, (Mike Brown, Annette Dent, Pauline Lynn, Geoff Foote, Leanne Rodwell and Andrew Coates), we hope to see you in Brisbane in March for the 2001 Annual Scientific Meeting.

*Brenton Eckert, CRFS  
President Elect*

## “The Connective Tissue Diseases – Potential Impact on Respiratory Function”

The “Connective Tissue” (C.T.) Diseases are a group of chronic, auto-immune disorders. They are characterised by inflammatory reactions which cause degenerative changes in connective tissue at various sites around the body.

Typical examples of C.T. Diseases are Rheumatoid Arthritis (R.A.), Scleroderma and Systemic Lupus Erythematosus (S.L.E.). These disorders manifest systemically, may vary in severity from one individual to another, and are usually typified by a course of exacerbations and remissions. Respiratory Scientists often test patients with these disorders, possibly not correlating potential respiratory dysfunction with the other more obvious signs and symptoms of the subject's disease. The bulk of lung tissue (stroma) is in fact elastic connective tissue, so for this reason, an outline of the pathophysiology of the C.T. disorders may prove helpful in understanding the reasons for pulmonary involvement.

In the C.T. auto-immune conditions, some unknown trigger (Viral? ;genetic?; environmental?) causes certain connective tissue components to become ‘antigenic’. The immune system then mistakenly recognises these ‘antigenic’ entities as foreign and stimulates an immune response. Specific antibodies are produced to immobilise the antigens. Antigen - antibody complexes form and are deposited at various sites causing inflammation. Inflammation is a non-specific form of defense mounted by the immune system in response to any form of insult to the body. Fibrotic tissue changes may subsequently develop secondary to the inflammatory process.

In order to fully appreciate the systemic nature of the Connective Tissue Diseases, all of which tend to affect the same organ systems and share similar clinical features (with a high degree of overlap), it is important to briefly revise the basic properties of connective tissue.

Of the 4 fundamental tissue types making up the human body - epithelial, connective, nervous and muscu-

lar - connective tissue is the least ‘cellular’ and the most widespread and abundant. In contrast, epithelial tissue, for example, is made up of sheets of cells [single / multi-layered] and is avascular - deriving its metabolic needs from blood vessels in adjacent layers of connective tissue. ( Figure 1)

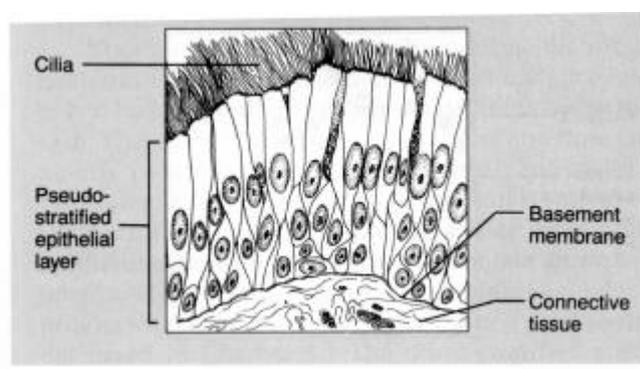


Figure 1

Connective Tissue, on the other hand, is composed of organic fibres (collagenous, elastic and reticular) embedded in a ground substance / matrix. Both fibres and matrix are secreted and maintained by resident cells, examples of which may differ with each form of connective tissue. The matrix contains inorganic elements which vary with each tissue type and which confer special properties to that tissue e.g. calcium salts in bone matrix confer hardness. (Figures 2 and 3)

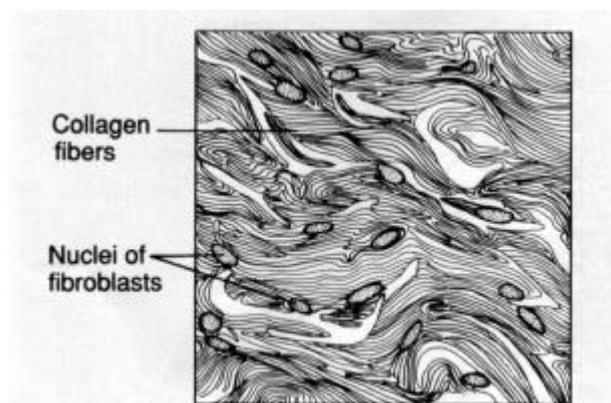


Figure 2

## “The Connective Tissue Diseases – Potential Impact on Respiratory Function”

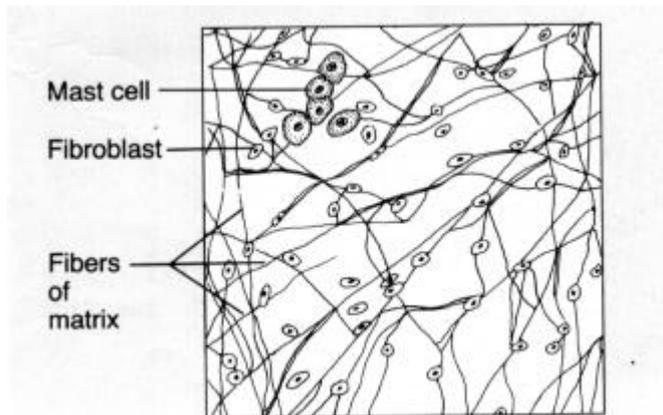


Figure 3

Common examples of connective tissue types are blood, bone, cartilage, ligaments and tendons. Less obvious forms are the loose and dense connective tissues, which pack, bind and support structures throughout the body.

The loose forms of connective tissue provide a ‘service inlet’ for capillaries, lymphatic vessels and nerves to maintain other adjacent tissue types, e.g. the complex, epithelial G.I.T. mucosa is serviced by the sub-mucosal layer of connective tissue which provides the mucosal cells with a source of blood, autonomic nerve fibres and lymphatic vessels. Similarly, the endothelium of blood vessels is maintained by a sub-endothelial connective tissue layer, and an outer connective tissue layer, called the adventitia, which binds blood vessels to adjacent structures. (Figure 4)

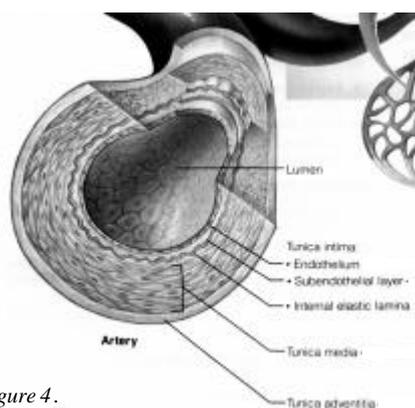


Figure 4.

Bearing in mind the widespread and abundant nature of connective tissue, it is easy to understand how inflammatory and fibrotic changes occurring in these tissues as a result of auto-immune complex formation, could have major systemic sequelae.

In Rheumatoid Arthritis (RA), the IgG class of plasma gamma globulins (protein) becomes antigenic. Antibodies - called Rheumatoid Factor - are produced by the immune system and form complexes with the antigenic IgG. Deposition of these complexes in the synovial fluid and synovial membrane of joints, sets in train a sequence of events which culminate in the common signs and symptoms characteristic of R.A. - most noticeably - cartilage erosion within the joint capsule followed by growth of granulation tissue called ‘Pannus’. Connective tissue layers in small and medium sized arterioles can also be involved, causing vasculitis. More relevantly for Respiratory Scientists, the alveolar - capillary membrane may exhibit fibrotic changes following inflammation, thereby leading to interstitial fibrosis.

A typical restrictive pattern may then be demonstrated in the physiology lab, with dyspnoea often severe and out of proportion to the spirometry changes.

The aetiology of Scleroderma is unclear as with all the C.T. disorders. A possible sequence of pathophysiological changes has been proposed which suggests auto-immune activity and inflammatory reactions in the sub-endothelial space and adventitia of small arteries (again – involving connective tissue layers). Subsequent fibrosis results in sclerotic blood vessels, which compromises blood flow to associated organs, e.g. skin, lung, G.I.T. Ischaemic changes then herald widespread / systemic inflammation leading to fibrosis. The characteristic facial appearance of a person with Scleroderma demonstrates the excessive collagen formation, due to fibrosis, within the dermis of facial skin. (Figure 6). Respiratory wise, diffuse interstitial fibrosis, peribronchial fibrosis and

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## “The Connective Tissue Diseases – Potential Impact on Respiratory Function”

thickening of alveolar tissue (which may lead to septal rupture and bullous emphysema) are possible lung complications. Pleural involvement and even aspiration pneumonia due to oesophageal dysfunction, may also arise.



Figure 6

Systemic Lupus Erythematosus (S.L.E) is more commonly called ‘Lupus’, due to the characteristic butterfly shaped rash across the bridge of the nose and cheeks, which occurs in 40% of S.L.E. patients. ‘Lupus’ is Latin for ‘wolf’, so named because this rash was thought (in the 1800’s) to resemble the bite of a wolf. (Figure 7)



Figure 7

Briefly, in S.L.E., formation of autoantibodies and then immune complexes, can affect the connective tissue of virtually any organ system with potentially serious consequences. From the respiratory viewpoint, serositis (inflammation of the serous membranes) can lead to pleurisy and pleural effusions. Interstitial lung disease can develop in some SLE patients. A peculiar syndrome called ‘Shrinking Lung’ has been documented, and this causes a reduction in lung volumes due to diaphragmatic dysfunction.

In conclusion - this brief discussion of Auto-Immune Connective Tissue Disease is an obvious understatement of the complexity of these disorders. However, by recognising the widespread and permeating nature of connective tissue in the human anatomy, Respiratory Scientists should be able to think beyond the superficial features of C.T. disease - the gnarled and twisted fingers of R.A., the mask like face of Scleroderma and the butterfly facial rash of S.L.E. - to the real possibility of pulmonary dysfunction.

*Rosemary Hawkins  
Respiratory Scientist  
John Flynn Hospital  
Gold Coast*

### Bibliography:

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John B West – 1992

## Profiler

# Peter Rochford

Peter Douglas Rochford commenced his career in respiratory science more than 20 years ago, after recognising the limitations offered by his chosen field of anatomical pathology. It was the late seventies and, sporting bell-bottomed wranglers and a wide-lapelled body shirt, Peter stumbled across one David Peter Johns (also similarly attired) frequenting the staff cafeteria in the bowels of the Austin Hospital. We may never know what transpired at those animated morning tea breaks, suffice to say that a career change resulted when a junior technical position became available at the Respiratory Function Unit (RFU) at the Heidelberg Repatriation Hospital.



The year was 1980 and unbeknownst to all at that time, the coming decade was to see major changes in all aspects of respiratory medicine. Being a federally funded institution, the Repat Hospital was insulated from the tightening purse strings of State-run hospitals and therefore well placed to capitalise on the emerging technologies and techniques in respiratory medicine. The RFU resembled an explosion in a Heath Robinson factory in those early days, a legacy of Hennig Imberger's pioneering work in body plethysmography in the sixties and seventies. Pete spent the majority of the eighties performing 4 tasks: swearing at pre-DOS desktop computers, extricating over 200 miles of electrical cabling from the RFU ceiling, finding novel and varied uses of silicone sealant (being mentored by Hennig - the best in the business), and placing his head up the wrong end of a Centronics mass spectrometer. Peter also found time to be an active member of the Society and to act as sub-editor for the Society journal 'Volume'.

Sleep disorders medicine was in its infancy in the early eighties when Peter, and the RFU, first became involved in this speciality. Clinicians were becoming concerned about the condition known as Obstructive Sleep Apnoea, and at that time the treatment choice was limited to tracheostomy... or nothing. Colin Sullivan's breakthrough CPAP treatment radically changed the scene, and Peter found much of his time being dedicated to innovative experimentation with glues, plumbing and prosthetic appliances in setting up these very tolerant (and very sleepy) patients. The Sleep Laboratory consisted of

a mobile 2-channel chart recorder (monitoring oronasal airflow and SaO<sub>2</sub> - why would you ever need anything else?) that was wheeled to the patient's bed, set up, and left all night. Peter was

instrumental in developing this primitive set-up into the first Sleep Laboratory in Victoria, and now into one of the largest and busiest laboratories in the country.

However, away from the cold, hard surfaces of the clinical laboratory, Peter does allow the surprising duality of his persona to express itself. Just as within every block of marble lies a Venus de Milo, within Peter's modestly unpre-

tentious exterior lays an Adonis-like athlete with an unquenchable competitive appetite, as anyone who has been foolish enough to tackle Peter on the sporting arena soon comes to appreciate. From his aggressive and downright life-threatening wielding of the table-tennis bat, to his uncompromising, gritty determination on the lawn bowls pitch he rarely takes prisoners. From competitive sailing to long distance cycling (having completed the Port Phillip 210 km Around-the-Bay-in-a-Day ride on 3 occasions), Peter will give most things a try - despite (or possibly because of) an acute disability not to be able to see anything beyond arm's reach.

Despite his rapidly-advancing years (after all he is closer to 60 than to 20), Peter's incisive mind and unparalleled memory continue to impress. His ability to recall specific details of obscure articles published before the dawn of recorded history demonstrates either this uncanny memory, or alternatively an innate ability to authoritatively make things up on the fly - I have yet to categorically determine which of these 2 qualities he possesses to a greater degree.

These days as Head Scientist in Respiratory Medicine at the Austin & Repatriation Medical Centre, Peter calmly oversees all scientific activities of one of the busiest clinical respiratory departments in the country from his luxuriously appointed yet modestly humble office and as any visitor will attest, his talent to make even remotely palatable coffee is yet to be discovered.

Jeff Pretto  
Senior Respiratory Scientist  
Austin & Repatriation Medical Centre  
Melbourne



## The Australian and New Zealand Society of Respiratory

### Executive Committee

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## CRFA Examination

During 2001, CRFA examinations are planned for:  
**May 19, July 20 and November 23.** Applications to sit the exam are accepted up to one month prior to these dates. The fee remains at AU\$50.

For further information, please visit the ANZSRS Society webpage at [www.anzsrs.org.au](http://www.anzsrs.org.au) or contact:

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You are invited to contribute short articles, meeting reports and calendar details etc. These should be sent to :

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