|  |
| --- |
| **CONTROL ID:**1988566 |
| **PRESENTATION TYPE:**Poster |
| **CURRENT CATEGORY:**Cancer |
| **TITLE:**Age no bar for Lung carcinoma - Case of Squamous Carcinoma in Non Smoker Young man |
| **AUTHORS (FIRST NAME, LAST NAME):**Amrit Pal Kansal1, Gopal Chawla1, Naresh Kumar1, Komaldeep Kaur1 |
| **INSTITUTIONS (ALL):**1. Government Medical College , Patiala, Punjab, India. |
| **ABSTRACT BODY:  INTRODUCTION:**Common age group of lung cancer is 40-80 years, only less than 10% occur below 30 years. Only 2.7% are due to squamous cell carcinoma. Lung cancer in young age with pleural effusion is rather an atypical one and high index of suspicion is required for its diagnosis. Here we report a case of a 26year old male presenting with Pleural effusion that was ultimately diagnosed with Stage IV non small cell carcinoma.     **CASE PRESENTATION:**A 26 year old immunocompetent male presented with intermittent fever, cough with mild expectoration, chest pain more on right side and breathlessness for two months, already on anti tubercular therapy on radiological basis, not responding even after one month. He was not a smoker and takes alcohol occasionaly but was bettle nut chewer. He had cervical lymph node left side measuring 1 X 1 cm.Chest radiograph revealed right sided pleural effusion with right lower zone heterogeneous infiltration. Pleural tap yielded 100 ml of hemorrhagic pleural fluid. MGG(May-Grünwald-Giemsa**)** and PAP(Papanicolaou stain**)** stained cytological smears showed small and large clusters malignant squamous epithelial cells with occasional keratin pearls, suggesting squamous cell carcinoma with primary possibly in lung. CECT showed bronchogenic carcinoma, mass in right lower lobe and mild pleural effusion with mediastinal and cervical lymphadenopathy Thus, the patient was given a diagnosis of pT2bN1M1a stage IV disease .On bronchoscopy multiple nodules were seen in right lower lobe bronchus. Endobronchial lung biopsy was taken which confirmed diagnosis of squamous cell carcinoma.    **DISCUSSION:**It is unknown why younger carcinoma patients are first seen with advanced disease like in our case in Stage IV. Because bronchogenic carcinoma in this age group is rare, both public and professional awareness is limited. Young patients may not suspect serious illness. Moreover, physicians often may not suspect an underlying carcinoma despite persistent pulmonary symptoms or abnormal findings on chest roentgenograms. The mean duration of symptoms before diagnosis is usually 4 -5 months. The patients who have persistent signs of pulmonary disease and a history of heavy smoking, regardless of age or sex, must be considered at risk for lung cancer. Diagnostic tests should be performed early to exclude the possibility of lung cancer.  If non-small cell bronchogenic carcinoma is diagnosed and signs of distant metastasis are lacking, exploration should be done because improved survival depends on surgical resection.  **CONCLUSIONS:**While considering the diagnosis of a case of pleural effusion, in context of India, many prefer to consider tuberculosis as the first differential, while diagnosis of malignancy as the least likely.This case is rare because of the patient’s age, histology and background. The risk factor for lung cancer is unclear. Because the rarity of the disease often delays the correct diagnosis of cancer, it is very important for all clinicians to consider the possibility of lung cancer in young patients. The consideration and aggressive treatment may lead to an earlier diagnoses and a better prognosis.   **Reference #1:**Ramalingam S, Pawlish K, Gadgeel S, et al. Lung cancer in young patients: analysis of a surveillance, epidemiology, and end results database. J Clin Oncol 1998; 16: 651-7.  **Reference #2:**Jubelirer SJ, Wilson RA. Lung cancer in patients younger than 40 years of age. Cancer 1991; 67: 1436-8.  **Reference #3:**Zhang J, Chen SF, Zhen Y, et al. Multicenter analysis of  lung cancer patients younger than 45 years in Shanghai.  Cancer 2010; 116: 3656-62. |
| **KEYWORDS:**Cancer, Pleural, Bronchology. |
| **Training Program Dates:** |
| **Grant Identification Information:** |
| **CONTROL ID: 1989122** |
| **PRESENTATION TYPE: Abstract Slide/Poster Presentation** |
| **CURRENT CATEGORY: Adult Pulmonary** |
| **TITLE: "Asthma For ABPA: Though Major, But Not Obligatory"** |
| **AUTHORS (FIRST NAME, LAST NAME): Gopal Chawla1, Amrit Pal Kansal1, Komaldeep Kaur1, Kamal Deep1, Prabhleen Kaur1** |
| **INSTITUTIONS (ALL): 1. Government Medical College , Patiala, India.** |
| **ABSTRACT BODY:  PURPOSE: Allergic bronchopulmonary aspergillosis (ABPA) is a complex immunological pulmonary disorder caused by hypersensitivity to Aspergillus species mainly Aspergillus fumigatus. The presence of asthma is one of the minimal essential diagnostic criteria for ABPA. Cases of ABPA in nonasthmatic patients have been occasionally reported in the literature.  METHODS: This study was conducted in patients presenting to the Department of Pulmonary Medicine in tertiary centre where diagnoses of ABPA was established using Rosenberg-Patterson criteria and each case was analysed for presence or absence of asthma  RESULTS: During study period , 22 cases were diagnosed to have allergic bronchopulmonary aspergillosis conforming to the usual Rosenberg-Patterson criteria. Out of them in 6 patients, there was no history of asthma and there was no clinical evidence of airflow obstruction at the time of the diagnosis either. Symptom duration in these patients varied from 2 months to 1 year. On investigations, chest x-ray revealed lesions and peripheral blood eosinophilia was present. Then they were subjected to total and specific IgE antibodies and other investigations to prove the diagnosis of ABPA  CONCLUSIONS: The diagnosis of ABPA is based on hematological, radiological and immunological criteria along with presence of asthma, and occasionally, cystic fibrosis. ABPA is rarely thought of in the absence of asthma, as this is the first criterion for diagnosis. Because of the absence of bronchial asthma, these cases are often mistaken initially for other pulmonary disorders. This leads to unnecessary delay in the diagnosis and treatment initiation. Furthermore, the remarkable radiologic similarity to pulmonary tuberculosis has important clinical implications in high tuberculous prevalent areas. This cases reflects the difficulty in recognizing ABPA in the absence of clinical asthma Therefore, ABPA should be included in the differential diagnosis in patients with radiographic abnormalities and peripheral eosinophilia even in those patients who have no history of asthma.   CLINICAL IMPLICATIONS: ABPA most commonly occurs in patients with pre-existing bronchial asthma, a high index of suspicion should  be maintained in the absence of asthma. ABPA without clinical asthma can and does pose diagnostic difficulties as in our case. Thus ABPA should be kept as a diagnostic possibility in patients with radiographic abnormalities and peripheral eosinophilia but no history or symptoms related to bronchial asthma.** |
| **Training Program Dates:** |
| **Grant Identification Information:** |
| **Permission to Record:** |
| **IRB Approval:** |
| **SUBMISSION ROLE: Abstract** |

|  |
| --- |
| **CONTROL ID:**1989352 |
| **PRESENTATION TYPE:**Poster |
| **CURRENT CATEGORY:**Infectious Diseases |
| **TITLE: Pulmonary Nocardiasisis in immunocompetetent host : Unusual Response** |
| **AUTHORS (FIRST NAME, LAST NAME):**Saurabh Kansal2, Amrit Pal Kansal1, Gopal Chawla1, Kamal Deep1 |
| **INSTITUTIONS (ALL):**1. Government Medical College , Patiala, India.  2. Amar Hospital, Patiala, India. |
| **ABSTRACT BODY:  INTRODUCTION:**Pulmonary nocardiosis (PN) is an infrequent and severe infection due to *Nocardia*spp., microorganisms that may behave both as opportunists and as primary pathogens**.** The risk of pulmonary or disseminated disease is more in persons with deficient cell mediated immunity.Pleural involvement is common in pulmonary nocardiosis and was detected in 36% of the cases using computed tomography of chest.Pleural involvement in nocardiosis is rarely documented in India.Diagnosis is extremely difficult because nocardiosis is not well known by clinicians and the culture of *Nocardia* is not easy (it is important to inform biologists that *Nocardia* should be checked for). Dissemination of the bacteria is also possible and worsens the prognosis.   **CASE PRESENTATION:**A 38 year old labourer presented with chief complaints of progressive breathlessness which increased from grade I to grade III over a period of one month, chest pain and mild dry cough for last 10 days. CXR revealed homogenous opacity left side pushing mediastinal structures to the other side. CECT chest showed left sided massive effusion with complete collapse of ipsilateral lung along with mediastinal lymphadenopathy. Intercostal chest tube drainage was done and around 6 liters of fluid drained over a period of 6 days. The patient was non reactive to HIV, non-diabetic and was not on any other medication and there was no other finding suggestive of immunosupression. LBC(liquid based cytology) and MGG(May Gruenwald giemsa) smear of pleural fluid showed features those of pleural effusion due to nocardiosis.The pleural fluid grew *Nocardia*after 2weeks of culture on Sabourauds dextrose agar at 37 °C. Patient started on trimethoprim-sulfamethaxazole and oral steroids. The patient responded well to treatment.    **DISCUSSION:**Nocardiosis  is an acute, sub-acute or chronic infectious disease that occurs in cutaneous, pulmonary and disseminated forms. Pulmonary nocardiasis is usually in form of pneumonitis and is mostly seen in immunocompromised patients. Pulmonary nocardiasis in form of massive unilateral pleural effusion in immunocompetant host without underlying pneumonitis is a rare condition.   **CONCLUSIONS:** In nocardiosis, pleural involvement occurs through direct spread from the chest wall or the lung parenchyma and pleural fluid may be the only source of diagnosis.Pulmonary nocardiosis mimics pulmonary tuberculosis in both clinical symptoms, being chronic in nature and radiological characteristics, and it is often wrongly treated with anti-tuberculosis drugs.The similarity of the radioclinical appearance between tuberculosis and nocardiosis demands that a search is made for the latter on all HIV positive patients and in negative cases a search for Koch's bacillus and empirical antibiotic therapy ought to have a spectrum of activity that would include nocardia.  **Reference #1:**Singh M, Sandhu RS, Randhawa HS, Kallan BM Prevalence of pulmonary nocardiosis in a tuberculosis hospital in Amritsar, Punjab.Indian J Chest Dis Allied Sci. 2000;42(4):325-39  **Reference #2:**Minero MV, Marin M, Cercenado E, et al. Nocardiosis as the turn of the century. Medicine 2009; 88: 250–261 |
| **KEYWORDS:**Pleural, Dyspnea, Infections. |
| **Training Program Dates:** |
| **Grant Identification Information:** |
| **Permission to Record:** |
| **SUBMISSION ROLE:**Global Case Report |

|  |
| --- |
| **CONTROL ID:**1992304 |
| **PRESENTATION TYPE:**Abstract Slide/Poster Presentation |
| **CURRENT CATEGORY:**Adult Pulmonary |
| **TITLE:**Effect of Literacy and Family support on Smoking Cessation |
| **AUTHORS (FIRST NAME, LAST NAME):**Gopal Chawla1, Amrit Pal Kansal1, Vishal Chopra1, Naresh Kumar1, Komaldeep Kaur1 |
| **INSTITUTIONS (ALL):**1. Government Medical College , Patiala, Punjab, India. |
| **ABSTRACT BODY:  PURPOSE:**As the burden of tobacco epidemic is now moving from developed countries to developing countries, there is an urgent need of tobacco cessation intervention studies to be conducted in less researched developing countries such as India.This paper aims to analyse the effect of literacy level and family support on smoking cessation outcomes .  **METHODS:**A prospective study was done in patients who were smokers and visiting a teaching hospital in Northern India. Information on socio economic, nicotine dependence, family/medical history, baseline stage‑of‑change, and treatment initiated were seeked using performa and verbal questionnaire and repeated behavioural counselling for smoking cessation was done over period of 6 months and results were analysed for relation between smoking cessation stage and literacy level and presence of family support.  **RESULTS:**In the present study, 207 patients participated.The mean age of study subjects was 50.74±14.74. Majority 64.3% patients belong to lower class.117(56.5%) were laborers or farmers. 83.4% started smoking before age of 26. 81.1%of smokers started smoking  under influence of friends and relatives. According to health elief model 44 (21.3%) were in Pre contemplation stage, 93 (44.9%) in Contemplation stage, 57 (27.5%) in Preparation stage and 13 (6.3%) in Action stage 133(64.3%) were illiterate, 24(11.6%)have taken education upto primary level , 29(14.0%) were matric and 21 (10.1%) were graduates.92 had family support while 115 didn’t. At end of 6 months of repeated behavioral counselling, it was seen 56.4% of illiterate, 33.3% of primary educated , 55.2% of matric pass and 33.8% of graduates were in maintanence stage while 11.3% of illiterate, 25% of primary educated, 10.6% of matric pass and 28.6 % of graduates relapsed. Out of 115 smokers without and 92 with family support, 46% and  57.6% ended up in maintainence stage respectively.        **CONCLUSIONS:**Literacy  and family support are not significantly related with stage after counselling as p value is more than 0.5, strengthening the fact literacy levels and presence or absence of family support not hamper behavioral counselling as intervention in quitting smoking   **CLINICAL IMPLICATIONS:** Health professionals have the greatest potential  to promote a decrease in tobacco use; and thus, a decrease in Smoking induced mortality and morbidity. Repeated attempts are worth the effort, patient and attendants visiting health care setting are more receptive to smoking cessation counselling as they are on receiving end of illness. |
| **Training Program Dates:** |
| **Grant Identification Information:** |
| **Permission to Record:** |
| **IRB Approval:** |
| **SUBMISSION ROLE:**Abstract |

|  |
| --- |
| **CONTROL ID:**1993256 |
| **PRESENTATION TYPE:**Abstract Slide/Poster Presentation |
| **CURRENT CATEGORY:**Adult Pulmonary |
| **TITLE:**Comparison of Pulmonary Function Tests among Smokers and Non Smoker attending North Indian Chest Hospital |
| **AUTHORS (FIRST NAME, LAST NAME):**Naresh Kumar1, Amrit Pal Kansal1, Gopal Chawla1, Komaldeep Kaur1, Kamal Deep1, Sunil Kumar1 |
| **INSTITUTIONS (ALL):**1. Government Medical College , Patiala, India. |
| **ABSTRACT BODY:  PURPOSE:**In India smoking is a common habit prevalent in both urban and rural areas. Cigarette smoking has extensive effects on respiratory function and is clearly implicated in the etiology of a number of respiratory diseases, chronic bronchitis, emphysema, and bronchial carcinoma. Because of the long delay between the cause and full effect, people tend to misjudge the hazards of tobacco To study the effects of type, quantity and duration of smoking on the pulmonary  function tests.(FEV1,FVC, FEV1/FVC%, PEFR, FEF25%, FEF50%, FEF75%, FEF25-75%)   **METHODS:**The pulmonary functions were done on a computerized spirometer in 300  subjects comprising of 150 smokers and 150 non smokers attending department of pulmonary medicine  **RESULTS:**Amongst 300 study subjects, 114 (38%) had normal lung functions whereas 186 (62%) had impaired lung functions, out of which 134 (72.04%) were smokers and only 52 (27.95%) were non-smokers.The association between smoking and impaired PFT was statistically highly significant.  In this study bidi smoking was most common. Almost all the pulmonary function parameters were significantly reduced in smokers and obstructive pulmonary impairment was commonest.Respiratory symptom like cough, expectoration, breathlessness were more in smokers as compared to non-smokers. In smokers, restrictive and mixed pattern in majority seen among heavy smokers 60% and 80% respectively. Obstructive pattern in majority seen with moderate smokers 45.6% and normal pattern only with light smokers.  **CONCLUSIONS:**Tobacco smoking in any form, bidi, cigarette or both has significantly deleterious effects on pulmonary functions. The smoking epidemic is so huge that every effort is needed to launch effective campaign to protect our people and maintain a good quality health life.    **CLINICAL IMPLICATIONS:**Spirometry by a trained health professional gives an indication of lung health by measuring airway obstruction. As a screening tool in smokers it has the potential to detect early changes before any significant symptoms are evident.It has been seen smokers diagnosed with COPD stopped smoking significantly more often than those with normal lung function. |
| **Training Program Dates:** |
| **Grant Identification Information:** |
| **Permission to Record:** |
| |  | | --- | | **CONTROL ID:**1988569 | | **PRESENTATION TYPE:**Poster | | **CURRENT CATEGORY:**Miscellaneous | | **TITLE:**COUGH MAKING GROUND FOR SYNCOPE: A CASE REPORT | | **AUTHORS (FIRST NAME, LAST NAME):**Komaldeep Kaur1, Amrit Pal Kansal1, Gopal Chawla1, Naresh Kumar1 | | **INSTITUTIONS (ALL):**1. Pulmonary Medicine, Government Medical College,Patiala, NEW DELHI, Delhi, India. | | **ABSTRACT BODY:  INTRODUCTION:**Syncope  is defined as a transient loss of consciousness with subsequent spontaneous recovery, resulting from global cerebral hypoperfusion. Cough syncope was first described by J.-M. Charcot (1825-1893) in 1879 as “laryngeal vertigo” Cough syncope refers to syncope upon coughing, the pathogenesis of which is unclear and probably multi-factorial. Cough syncope is a well-recognized but uncommon phenomenon. We present a case of 34yrs obese male having cough as a cause for his syncope.  **CASE PRESENTATION:**A 34 years-old male presented with a 2 weeks  history of multiple episodes where he lost consciousness during or after cough. The syncopal events lasted for durations ranging from 30 seconds to about one minute. All this was disturbing his routine life at home and at workplace. . There was history of brief jerky movements of body during the episode but no history of incontinence or tongue biting. He was not on any medication in the past. Chest x-ray and pulmonary function tests were normal.He initially presented with these symptoms to another facility where a 2D-ECHO was performed which was suggesting nothing more than mild concentric left ventricular   hypertrophy with EF of 60%. He was transferred to our hospital  for further evaluation. He was a chronic alcoholic. His weight was 97kgs and BMI was 32.4. During his hospital stay, many witnessed episodes of cough-induced syncope occurred. During an episode, his systolic blood pressure showed a reduction from 110 mmHg  to 80 mmHg. His face became congested and he lost his conscious. The blood pressure returned to baseline as soon as the symptoms resolved. CECT chest was normal except for an incidental finding of osteochondroma of 3rd and 4th right thoracic ribs. Symptomatic management of patient was done with cough suppressants and bronchodilators. Dietary and life style modification was advised to the patient. He was discharged a few days later for outpatient follow-up and is having no more syncopal attacks  **DISCUSSION:**Syncope is a loss of consciousness due to transient global cerebral hypoperfusion characterized by rapid onset , short duration, and spontaneous complete recovery. Cough syncope is classified as situational syncope. Situational syncope traditionally refers to reflex syncope (neurally-mediated) associated with some specific circumstances (micturition, cough, defecation, swallowing). Intrathoracic pressure increases during cough and obstructs the venous outflow, which leads to an acute decrease of heart output and blood pressure.4-6 As a consequence of the above mechanisms, the decrease of cerebral perfusion results in loss of consciousness Recurrent syncope has serious effects on the quality of life as was seen in our patient. Majority of cough syncope was reported in male, middle-aged, overweight and chronic bronchitic smokers. Cough syncope may result with serious problems such as traffic accidents, falls leading to brain and extremity injuries. Physicians should be aware of this easily recognizable cough induced syncope in all subjects admitted with syncope and should screen possible underlying sources of cough.  **CONCLUSIONS:**The differential diagnosis of cough syncope includes epilepsy and cataplexy. Cough syncope may present with clonic movements during the syncopal episode which might be confused with epilepsy. Careful history is needed to differentiate these two conditions as cough syncope always occurs with a coughing episode. The onset of symptoms in cough syncope is usually at an older age and patients deny any postictal confusion, tongue bite, bladder or bowel incontinence. Cough syncope tends to improve with treatment of underlying pulmonary dysfunction  **Reference #1:** Kapoor WN: Evaluation and management of the patient with Syncope.*JAMA* 1992, **268**(18)**:**2553 2560  **Reference #2:**McIntosh HD, Estes EH, Warren JV. The mechanism of cough syncope. Am Heart J. 1956 Jul;52(1):70–82 | | **KEYWORDS:**Vascular, Cardiology, Dyspnea. | | **Training Program Dates:** | | **Grant Identification Information:** | | **Permission to Record:** | | **SUBMISSION ROLE:**Global Case Report | |
|  |