

WABIP Newsletter



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Vision and Future Direction of the WABIP



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The World Association for Bronchology and Interventional Pulmonology has traveled a long road, defining and being defined by the history of bronchology procedures themselves. This organization, formerly known as the "World Association for Bronchology" (WAB), was created in Japan in 1978 by Dr. Shigeto Ikeda, a Japanese thoracic surgeon and bronchologist. In the late 1960s, he was responsible for the creation of the flexible fiberoptic bronchoscope and was the first Chair of the Association.

Thanks to the development of bronchoscopy and related techniques, which became essential in the diagnostic-therapeutic pathways of many respiratory pathologies, the WAB grew with the adherence of many colleagues from different parts of the world. In this process of growth, the work of various Chairs who succeeded Dr. Ikeda (Professors Hirokuni Yoshimura, Udaya Prakash, Pablo Diaz Jimenez, Hiroaki Osada, Henri Colt, Zsolt Papai, Silvia Quadrelli, and Hideo Saka) was fundamental.

Major changes in the organization of the Association were made in 2010-2012. The name of the organization was changed to "World Association for Bronchology and Interventional Pulmonology" (WABIP) to include not only bronchoscopy but also all the procedures (e.g., thoracoscopy, pleural drainage, esophageal procedures) that are within the competence of Interventional Pulmonology.

Furthermore, in an effort to be more inclusive and transparent, an idea of Henri Colt approved by the Board of Regents led to the adoption of a new membership modality. No more single membership, but the inclusion of Member Societies (national, regional, or local pulmonology or interventional pulmonology societies or groups). This change in membership modality allowed the adoption of a significantly reduced cost, facilitating relationships with many national pneumological associations and exponentially increasing the number of Members from 2014

(Fig. 1). Fig. 2 shows the distribution of WABIP Members by Region.

WABIP has already played a vital role in promoting the discipline of Interventional Pulmonology and enhancing patient care, particularly in nations with limited access to education. In addition to its mission of bringing together healthcare professionals interested in Interventional Pulmonology and providing them with opportunities for networking, education, and collaboration, WABIP has devoted the majority of its efforts to ensuring that all interventional pulmonologists around the world possess a minimum level of skills and knowledge. The operations of WABIP are based on the belief that medical educators have a responsibility to democratize knowledge. WABIP views its purpose of enhancing the abilities of interventional pulmonologists as a means to promote the health and well-being of patients around the world, in light of its belief that access to high-quality health care is a fundamental human right. All individuals, regardless of socioeconomic status, gender, race, ethnicity, religion, or geographic location, should have equal access to high-quality healthcare services, and the first step in achieving this objective is to ensure that these individuals have access to well-trained physicians.

With this in mind, WABIP (now with over 10,000 Members from 100 countries) has developed free standard teaching and evaluation tools, organized hands-on courses in basic and advanced bronchoscopy in more than 20 countries (the last in Uruguay, Argentina, Chile, and Ecuador), organized webinars on the different aspects of Interventional Pulmonology, and provided grants for visiting professors and scholarships for rotations in highly specialized Interventional Pulmonology Units for doctors working in countries with fewer resources.

WABIP also aims to assist each member country in acquiring the basic resources and support for research and innovation in bronchology and pleural diseases.

With the aim to diffuse Interventional Pulmonology in the world, It must be mentioned also the recent creation of the WABIP Interventional Pulmonology Institute (IPI), thanks to the commitment

and passion of Dr. Ali Musani. IPI aims to collaborate with countries that have large or public private Hospital via local WABIP members to offer Interventional Pulmonology training and related service in the region. The IPI will offer well-designed fellowship training with WABIP faculty available on site for 2-4 weeks at a time with volunteers covering the entire years. After training completion, the fellows will receive a certificate issued by the WABIP and will be able to start their own program in their Country, train more people and open more center in the region.

Recently, substantial changes have been made to the bylaws with the approval of the Board of Regents. Particularly, to increase participation and involve the leadership of WABIP in the decision-making processes, the Chairs of the main Committees (Education, Finance, and Membership) and the Editor of the Newsletter have been included in the Executive Board. The restructuring of the Executive Board reflects WABIP's commitment to staying at the forefront of Interventional Pulmonology and enhancing the organization's ability to serve its Members and promote its mission of improving patient care worldwide.

The Executive Board's primary responsibility is to ensure that all WABIP activities are designed and implemented with cultural sensitivity and respect for diversity, taking into account the cultural values, beliefs, and traditions of the communities involved. No education can be effective if it does not respect and safeguard the rights and dignity of individuals and communities, including their cultural history and identity.

WABIP Newsletter, thanks to the wonderful and great commitment of Kazuhiro Yasufuku, serves as a vehicle for updates, publishing in each issue a synthesis of the newest technologies in Interventional Pulmonology and practical tips and suggestions from experts. Newsletters are sent to more than 7,500 recipients and read online by about 2,000 colleagues.

One of the purposes of WABIP, as a scientific association, is also to propose documents and guidelines for the standardization of procedures. In the past, a complete guideline for the acquisition and preparation of conventional and endobronchial ultrasound-guided transbronchial needle aspiration specimens was published (*Respiration* 2014; 88: 500-517). A document on "Proposed quality indicators and recommended standard reporting items for EBUS bronchoscopy performance" has been prepared by a group of colleagues, under the guidance of Daniel Steinfors, and is ready for publication. A document on airway stenting is ongoing and will be ready soon.

For the tenth consecutive year, WABIP continues its tradition of providing reduced subscription rates for its official journals: *Respirology*, *Respiration*, and the *Journal of Bronchology and Interventional Pulmonology*, supporting its Members with the opportunity for continuous updates.

WABIP programs were made possible by the generosity and selfless cooperation of specialists from a variety of nations who trained themselves as instructors and volunteered their time, effort, and knowledge in various communities. WABIP knows that to ensure international cooperation is equitable, sustainable, and respectful of the dignity and rights of individuals and communities, it must be based on ethical values. To ensure the fundamental ethical principles of the autonomy of individuals and communities, WABIP is a truly democratic organization in which each member country has a representative (Regent) whose vote carries the same weight regardless of the country's size, population, level of bronchology development, or economic strength. In this way, WABIP attempts to ensure that collaboration is founded on partnerships that are equitable and respectful of the needs and ambitions of the communities concerned, and not on imbalances of power.

Since the creation of WABIP, a lot has been done, but much still needs to be done. We must prepare for the future that is just around the bend. Due to developments in technology, changes in healthcare delivery, and evolving societal needs, the future of medical education is likely to undergo substantial transformations. We may need to include training in artificial intelligence, telemedicine, and other technologies to equip our medical community for the digital healthcare environment.

With the reorganization of the "Social Media Committee," now renamed "Media Committee," we will try to give further visibility to our Association, with the aim of involving an increasing number of colleagues and member countries.

New webinars on the different aspects of Interventional Pulmonology and new documents on the standardization of procedures are in the pipeline, as well as the creation of interest groups in which it will be possible to exchange experiences and opinions on individual cases or procedures.

WABIP must increasingly become a global community, driven and dominated by the passion for Interventional Pulmonology and love for patients suffering from respiratory diseases. In spite of the fact that Interventional Pulmonology is a field that is highly dependent on technological advancements, we must never forget that we are human doctors who deal with human patients, make decisions, provide human care, and preserve the rights of patients.

WABIP is well-prepared for the education of the future, being familiar with the most recent technological advances while at the same time maintaining a tradition of educational philosophy that will fit the needs of medical education in the coming decades, which will increasingly emphasize patient-centered care, making

empathy, communication, and cultural competence more significant.

WABIP believes that by collaborating in a spirit of partnership, we can create a more equal and just world for everyone. We require the assistance of each and every Member of our Association. Your ideas, feedback, and initiatives serve as the basis for our work. We call on you to join us in our work: there is a long road ahead and much work to be completed.

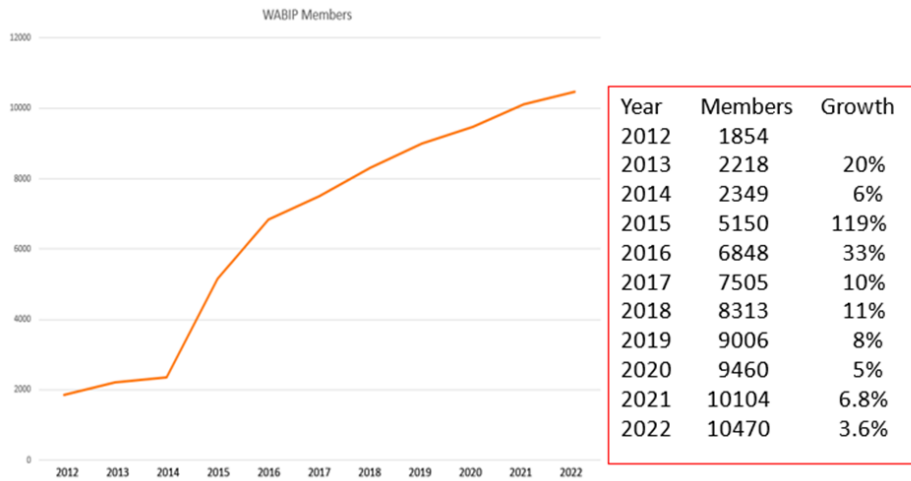


Figure 1. Number of WABIP Members from 2012 to 2022

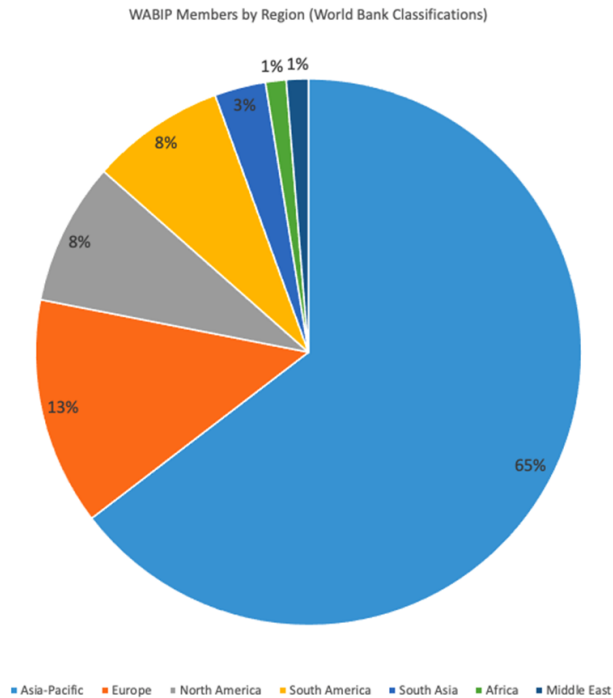


Figure 2. Distribution of WABIP Members by Region

Technology Corner

Robotic Technology in Thoracic Surgery



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Introduction

Robotically augmented surgery is becoming an increasingly essential piece of a modern thoracic surgeon's workflow. Constant and rapid innovation in the field has enabled surgeons to perform complex procedures with reliability and precision. Robotic surgery has decreased the prevalence of open thoracotomy cases, improved patient outcomes, and reduced complications for many lung resection procedures (2). Three platforms currently available in thoracic surgery are the DaVinci Xi, Hugo RAS, and CMR Versius.

DaVinci Xi



Overview of the DaVinci Xi ([intuitive.com](https://www.intuitive.com))

The DaVinci Xi is a robotic surgical system that has four slim boom-mounted arms, extended reach, guided targeting, and many integrated auxiliary features. This platform is the first entrant to the market in surgical robotics. The adjustability of the Xi is a strong point, with configurable patient clearance joints in each arm of the robot. The many arms of the Xi permit four-quadrant access during surgery. The system also boasts a two-camera installation, permitting 3D view of the subject (2). The DaVinci Xi currently has been studied in all areas of Thoracic Surgery, including lung resection and mediastinal resection.

Hugo RAS



Overview of the Medtronic Hugo RAS (medtronic.com)

The Hugo RAS (robotically assisted surgery) system is a modular and customizable system. Each arm is its own isolated unit, which means it can be fitted with its own tool and positioned to the surgeon's specifications for the procedure. It is less all-inclusive than the Versius, but more versatile than the DaVinci Xi. The open console also permits 3D vision of the operating field, but requires the operator to wear 3D glasses, which can potentially cause some discomfort (2). In terms of regulation, the Hugo RAS has regulatory approval in Canada for general surgery, gynecological surgery, and urological surgery. The first cases to have utilized the Hugo RAS were done at the University Health Network, at the University of Toronto.

CMR Versius



Overview of the Versius Surgical System. (4)

The Versius' defining feature is its open console, which allows flexible operation from either a standing or seated position (1). This is a clear advantage as it allows each operator to work from a more comfortable position for them. The system also includes up to 7 modular arms, although having that many is an experimental approach that has not been used in real clinical practice. The CMR Versius, like both previous systems, possesses a 3D view in the surgeon console, although again, requires 3D glasses like the Hugo RAS. The platform has been studied in preclinical trials using cadavers. Of 24 thoracic procedures were tested using the Versius, and only one failed due to a platform error (4). Out of 18 lobectomies, one was not completed due to cadaver anatomy, and out of 3 thymecto-

mies, one failed due to a console system error (4). All 3 diaphragm plications were completed without fault (4). These results suggest confidence in the Versius for robotically augmented thoracic surgery.

Discussion

After reviewing some of the platforms viable for robotically augmented thoracic surgery, there are many factors to consider when choosing a system to use.

The DaVinci Xi has the obvious advantage of time. It is the most established name in robotic thoracic surgery. It has many publications attesting to its reliability in improving patient outcomes. Clinics adopting the DaVinci Xi have found an almost 20 percent reduction in post-operative complications (8). They also measured a general decrease in readmission and length of stay.

The Hugo RAS has not received regulatory approval yet, and would therefore tend to be a more pioneering choice for a platform. It does boast some unique features, and has been proven in other fields.

The Versius has the advantage of being tested through publicly-available preclinical evaluations, although with the caveat that they were performed on cadavers. Other evaluations include testing its proficiency at performing procedures in small, enclosed spaces (4). These tests attempt to emulate the environment the Versius would be performing in, being minimally invasive thoracic surgery.

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Intra-lesional injection of Bevacizumab for Recurrent Respiratory Papillomatosis



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Introduction:

Recurrent respiratory papillomatosis (RRP) is a benign neoplasm of the airways caused by the human papillomavirus (HPV), most commonly type 6 and 11 but rarer types 16, 18, 31, and 33 have been reported. (1) RRP is characterized by the proliferation of benign squamous papillomas involving the aerodigestive tract. This entity predominantly affects the laryngeal structures, with the vocal cord being the commonest; however, it can affect any areas of the aerodigestive tract and has been reported to involve tracheobronchial tree in up to 9% and pulmonary parenchyma in up to 2% of the cases. (2). Management of RRP is complicated by its multifocal and recurrent pattern, requiring multidisciplinary and frequent interventions. Herein we describe the procedural technique and literature to support the multimodal treatment approach and intra-lesional administration of an anti-VEGF agent, bevacizumab.

Background:

The natural course of RRP is variable with a small proportion of cases obtaining either spontaneous remission or persisting as stable disease requiring periodic interventions. Many patients, however, have an aggressive form that requires frequent local and systemic treatments. No clear prognostic factors have been defined for worse outcomes. However, HPV type 11 has been associated with a more aggressive nature compared to type 6. Other patient-related factors such as younger age and laryngeal involvement at diagnosis, laryngopharyngeal reflux, and smoking have all been considered as poor prognostic factors. Although a histologically benign disease, RRP is associated with significant morbidity and in its aggressive form, requires frequent surgical treatments primarily aimed at excision of the papillomas to restore airway caliber and palliation of symptoms. Several endoscopic interventions such as microdebrider, laser surgery (KTP, CO₂), argon plasma coagulation, and photodynamic therapy have been successfully reported in the literature. As the name implies, RRP usually follows a relapsing, remitting course posing a significant burden to patients and the health system. Hence, adjuvant systemic or intra-lesional treatments are considered to potentially improve disease burden, decrease the frequency of procedures and possibly achieve remission. There are no clear criteria for which patients might benefit from additional therapies; however, the need of more than four procedures per year, rapid re-

growth of papilloma with airway compromise, and distal spread of the disease have been considered as factors to be considered for offering adjuvant treatments. Literature reports that 10-20% of patients with RRP receive adjuvant treatment, with some of the options available being anti-viral agents (cidofovir, ribavirin, acyclovir), interferon, retinoids and histamine blockers. (3) More recently, targeted interventions focusing on immune modulation using monoclonal antibodies with checkpoint inhibition, such as anti-program death ligand-1 (PDL-1) and vascular endothelial growth factor (VEGF) inhibition, have been used.

Clinical Application:

How we do it:

At our institution, patients with RRP are evaluated by a multi-disciplinary complex airway team comprising interventional pulmonologists (IP), otorhinolaryngologists (ENT), and thoracic surgeons. In cases involving both laryngeal and tracheobronchial tree, ENT and IP teams work together in a combined procedure to target both upper and central airways simultaneously. All procedures in our institution are done under general anesthesia using suspension microlaryngoscopy (by ENT) for treating laryngeal disease and the rigid bronchoscope for treating tracheobronchial disease (by IP). A multimodal treatment approach comprising various endoscopic interventions such as laser surgery utilizing CO₂ (laryngeal) and KTP (tracheobronchial), microdebrider (laryngeal), and cryosurgery (tracheobronchial) with repeated freeze-thaw cycles are used to establish adequate airway patency. After restoring adequate airway patency (typically less than 20-30% lumen narrowing), we use a 25g needle for intra-lesional delivery of the anti-VEGF agent, bevacizumab (37.5 mg). Sites of injection are selected based on the areas with high disease burden or recurrent areas after previous treatments. Patients are followed up on an outpatient basis. This procedure is repeated at an interval of 3 months (for 3-4 sessions) or earlier if symptoms recur. Additional interventions are then performed depending on the symptoms or at scheduled 6–8-month intervals if disease response is favorable and patients remain clinically stable (Figure. 1).

Supporting literature:

Bevacizumab is a recombinant human monoclonal antibody that targets and binds to VEGF and inhibits interaction with the VEGF receptor, preventing angiogenesis. The inherent vascularity of papillomatosis has a potential pathogenic role in the recurrence of these lesions, and hence bevacizumab is being considered in the prevention of neoproliferative growth of RRP. Bevacizumab has been used successfully in other neovascular diseases involving the eyes, telangiectasias. Zeitels et al. combined intra-lesional bevacizumab with laser (KTP photoangiolytic) for patients with RRP affecting the vocal cords and noted no discernible disease in 15% of the patients and overall improvement in another 85% of the patients after four injections (4). In another study in the pediatric population looking at Derkay scores (A functional and anatomic assessment scoring designed by the RRP task force), the time interval between injections and voice outcomes showed an overall improvement of 58% in Derkay score and all patients having increased interval between injections. (5) Dosing of bevacizumab delivered intralesional-

ly is much less than the typical systemic dose of 5-10mg/kg and hence it is well tolerated. A safety study monitoring physiologic and lab parameters with dosing regimens varying from 10mg to 80mg per treatment episode with a median dose of 30mg did not show any systemic side effects, and all patients tolerated the medication well (6).

Conclusions:

RRP is a benign neoplasm with a high morbidity and mortality secondary with only a small proportion of patients undergoing malignant transformation. Nevertheless, frequent endoscopic interventions are the norm in the management of these patients and the addition of adjunct local pharmacological therapies may help decrease the disease burden, avoid side effects of systemic therapy and improve the quality of life in these patients. Hence, the efficacy of intra-lesional injections of medications such as bevacizumab, or other novel therapies such as anti-PDL1 agents (avelumab) should be evaluated in multi-center, randomized studies.

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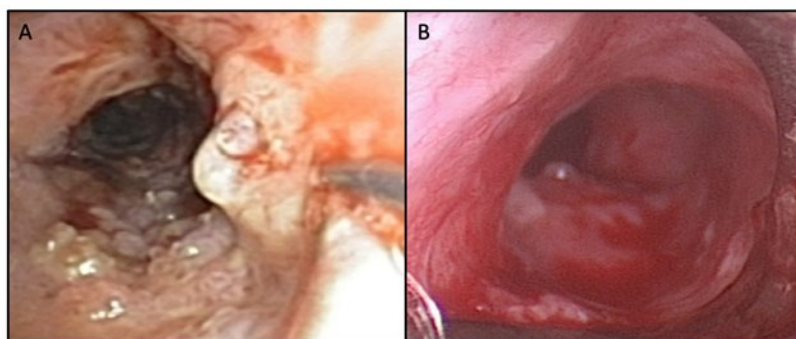


Figure. 1: Pre and post treatment of RRP with cryotherapy and intralesional injection of bevacizumab

A: Diffuse airway involvement comprising of exophytic lesions from RRP, immediately after cryotherapy (note the diffuse blanching) At 3 o'clock position, the needle is seen being advanced in the mucosal lesion as Bevacizumab is being injected.

B: Follow up bronchoscopy shows significant decrease in airway papillomatosis

Humanitarian News

Humanitarian Aid During War Times, Challenges and Limitations

Since the 2022 invasion of Ukraine by Russian forces, countless lives have been lost, and many more have been destroyed or displaced by continuous shelling and air strikes. Millions of people have become refugees, and many more have been displaced within the country. UN different agencies have reached close to 16 million people with humanitarian assistance, including the world's largest humanitarian cash response, thousands of convoys, generator deliveries to critical facilities, and repairs to damaged homes. Urgent needs continue, and it is anticipated \$3.9 billion will be necessary in 2023 to help over 11 million people out of nearly 18 million in need.

Humanitarian workers are accustomed to the rigours of armed conflicts, but the war in Ukraine presents them with unprecedented challenges, not only due to the severity of the humanitarian crisis, but also due to the contradiction with their fundamental principles of conduct. Humanitarian help is predicated on the idea of neutrality, which requires relief workers to stay unbiased and not take sides in a crisis or political situation. The neutrality principle assures that aid is delivered solely on the basis of need, without discrimination or bias towards any particular group or ideology. In practise, neutrality dictates that aid workers should not engage in any actions that could be interpreted as taking sides or favouring one group over another. Humanitarian workers must maintain tight independence and avoid any political or military participation that could damage their impartiality.

The Ukraine conflict will test the neutrality concept. How neutral must humanitarian organisations remain in the face of an allegedly unprovoked military aggression and violations of International Humanitarian Law, lest they be accused of aiding and abetting these abuses? How impartial are international actors supported by nations politically and militarily active in Ukraine, including the International Committee of the Red Cross? How does the idea that Ukrainian actors are sometimes militarily active and often politicised affect the behaviour of international actors? How should humanitarian organisations handle their public messaging and image when information is a primary weapon of war? The neutrality/partisanship conundrum is not new, but given the geopolitical context of the crisis, its worldwide repercussions, and the continuous real-time attention it receives online, it may take on a bigger significance. During the Iraq War, American Army officers were extremely tough on French organisation volunteers, just as during the Kosovo War, a non-NATO passport was required to negotiate with the Serbs. But for the majority of "Western" relief workers, these conflicts were far enough for them to feel able to divorce the positions of their governments from their humanitarian work. But, the direct impact of the Ukraine conflict on their daily lives, the extensive engagement of their governments, and the unwavering stance of the mainstream media create a different scenario.

During this conflict, many humanitarian groups and the countries that sponsor them will depart from the notion of humanitarian neutrality, which has so dominated western humanitarian help in wars over the past three decades. Several humanitarians have instead chosen for political solidarity with Ukrainians and view humanitarian help as an integral part of the Ukrainian fight to Russian violence and oppression. It implies that some established humanitarian agencies, as well as the majority of new ones spawned by this crisis, prefer to function in political solidarity with the Ukrainian government and the humanitarian administration and resistance networks that emerge in response to the conflict. Two traditions of humanitarian aid have always existed: the impartial humanitarianism cultivated by the Swiss-founded Red Cross organisation, and an activist legacy of opposition humanitarianism based on specific political commitments. Throughout the 20th century, resistance humanitarianism played a crucial role in rescue missions from Nazi-occupied Europe, campaigns against apartheid and Latin American tyrants, and independence movements in a number of nations. Certain nongovernmental organisations, such as Médecins sans frontières, Médecins du Monde, and Première Urgence, place a high priority on documenting and reporting human rights breaches. But the concern associated with the unprecedented extent of this new viewpoint of "solidarity" is that, while some abuses of international law and human rights are evident and well-documented, the question of whether a particular war is just is ultimately a matter of perspective and interpretation. Others may disagree with those who believe that certain wars fit the conditions for a just war. And relief workers who are nationals of one of the belligerent parties (directly or indirectly) may be significantly impacted by the prevalent public opinion of their countries and the information accessible in the area in which they reside, both of which are inherently skewed during wartime.

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Mainly Western governments and multilateral organisations have allocated or pledged billions of dollars in bilateral aid to the governments of Ukraine and refugee-hosting countries. They are also the primary supporters of the traditional international humanitarian network of UN agencies, Red Cross/Red Crescent groups, and international non-governmental organisations (NGOs), which is mostly administered by the Office for the Coordination of Humanitarian Affairs (OCHA). Similar to the challenge of impartiality, financial sources frequently dictate where humanitarian organisations operate. Those primarily financed by Western nations operate mostly in areas controlled by the Ukrainian government. They may even be instructed to do so by their funders in order to demonstrate their support for the Ukrainian government and contribute to easing the strain on its economy and infrastructure. On the other hand, some NGOs actively refuse financing from Western governments to avoid co-optation and preserve their independence in identifying the most urgent needs and the most effective responses.

The way humanitarian finance is usually channelled – from donor agencies with specific mandates to large UN agencies also with specific mandates – will largely determine to which populations, groups or sectors resources flow, instead of an allocation based on severity of need. Western donor funding (whether labelled humanitarian or not) is likely to be deliberately channelled to parts of the country, population groups or organisations that are actively resisting Russian forces. As a result, it is more likely that the majority of funding will be directed to areas where it is easiest to operate, i.e., refugee-hosting countries and government-controlled areas in Ukraine. Hard-to-reach areas, such as those under Russian control where fewer people live, could be overlooked. This is in spite of such areas potentially having more acute needs due to the intensity of the conflict and the breakdown of national and local safety nets.

In Ukraine, Russia, neighbouring nations, the West, and elsewhere, governments, the media, public opinion, and humanitarian organisations' own messaging form narratives about humanitarian crises and aid. These narratives have a direct impact on the "cultures" of help, the relationships between aid organisations and their funders, parties to the conflict, and host governments, and ultimately the efficacy of the response and its accountability to impacted individuals. What influence do principles, beliefs, and interests have on these narratives? Can distinct stories coexist? Who exercises authority over them, and for what purpose? How do they impact others?

How donor countries support and convey their money will impact the size and shape of the response as well as the capacity of humanitarian organisations to handle the aforementioned difficulties. How organisations solicit and receive private donations will also have an effect. Donors who direct where and how funds are allocated and promote their humanitarian assistance as part of a package of political and military support for Ukraine will influence the attitudes of the grant beneficiaries. How may humanitarian giving be reconciled with political and military objectives? Humanitarian workers (international cooperation professionals or volunteers) live within this narrative, which moulds their perspectives and, whether we like it or not, can be influenced by the same misinformation as the general population.

For ages, philosophers, theologians, and political theorists have contested the concept of a "just war" as a contentious and complicated issue. The view that war is occasionally necessary to fight against aggression, preserve innocent lives, or advance a just cause is fundamental to the concept of a just war. The conflict must be waged for a morally justified purpose, such as self-defense or the protection of innocent lives. Except in instances of self-defense or when authorised by the United Nations Security Council, the United Nations Charter forbids the use of force or the threat of force against the territorial integrity or political independence of any state. Thus, the Russian Federation's invasion of Ukraine is a violation of international law and may result in sanctions or other actions by the international community. But, the devil is in the details. In spite of the majority of UN member states' condemnation of the invasion, Russia maintains that it acted in self-defense because its national security was threatened. In fact, we have all observed, over the past decades, a number of countries successfully arguing the same concept and justifying the invasion of a foreign country as an act of self-defense, even when the country in question was kilometers away or had an obvious incapacity for real damage. Ultimately, the question of whether a just war exists is a matter of perspective and interpretation. While some may believe that certain wars meet the criteria for a just war, others may disagree and argue that all wars are inherently unjust, and that peaceful means should always be used to resolve conflicts.

Humanitarian aid has been subject to intense scrutiny in recent years. It has been accused of perpetuating conflicts by failing to address their core causes, promote peace, and encourage development. Humanitarian help is many times thought to foster dependence on external aid and may not be sustainable over the long run. Most humanitarian workers (who frequently risk their own lives in the course of their work) are convinced that humanitarian aid is essential for saving lives and allevi-

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ating suffering during war and conflict. However, most of them also acknowledge that humanitarian aid is frequently insufficient to meet the needs of those affected by conflict and that aid is merely a bandage for a major wound. And that is because the tragedy of war is simply unimaginable, it can be sanitised so the audience can consume it with their breakfast news or romanticised to generate valour and patriotism where there is only violence, death, disgusting mixtures of blood and mud, and decaying corpses. Frequently, the most gruesome and horrid parts of battle are those that are not presented to the public. These unseen tragedies of war serve as a vivid reminder of the devastation that armed conflict can inflict on both individuals and entire society, as well as the urgent need to resolve disputes peacefully.

Yet, this war persists and appears to have a protracted future. The continuance of war is a systemic failure of the political and economic structures that govern our planet, which are frequently designed to promote the powerful's interests at the expense of the many. Elite ambitions, motivated by the pursuit of profit, resources, and geopolitical influence, frequently fuel this and any other war. The media and other powerful institutions play a critical role in legitimising war as a necessary evil, while downplaying its horrific human costs. In addition, the psychological damage inflicted on both military and civilians adds to a culture of violence and dehumanisation that diminishes our empathy and compassion. Also, the most vulnerable and marginalised members of society are disproportionately affected by war's brutality, displacement, and destruction, as well as, in this new globalised world, their economic repercussions, even if they reside thousands of kilometres away. The costs of any battle are borne by regular citizens. To fight the politics of war, we must target the underlying power structures and work to build a more democratic, fair, and accountable society that prioritises the needs and ambitions of all individuals over the narrow interests of the affluent and powerful.

It seems not to be in anyone's agenda to bring the horrors to an end before they become much worse. Ukraine is utterly devastated, the estimated military fatalities exceeds 250,000, which should be added to the anticipated number of 400,000 severely injured military personnel and probably around 10,000 civilian fatal casualties. More than 13 million people remain uprooted from their homes, including nearly 8 million refugees across Europe and more than 5 million internally displaced people within Ukraine, people that probably will not be able to return in a very long time, because their homes, employment opportunities and living conditions no longer exist. Slowly, even official voices from "the collective West" begin to warn that the quantities of ammunition requested by the Ukrainian government cannot be supplied. The final outcome of the war does not appear promising, and it is evident that the continuation of the conflict is not helping Ukrainian civilians because of the terrible suffering and death toll it is causing, nor the ordinary citizens of many countries not even officially involved in the conflict who suffer the economic consequences and live in fear of the potential consequences of the conflict's escalation.

Several nations have eagerly applauded the February 2023 UN General Assembly's demand to embrace the concept that "Clearly, the world desires peace, and Ukrainians deserve peace. But, not any peace, but just peace". The problem is that not every country has a realistic understanding of what a "fair peace" can be at this point in the war. Some may argue for a return to normalcy. But what would this return to normalcy entail beyond the return of McDonald's, Ikea, and H&M? Does this imply, for example, that Moscow welcomes Ukraine's membership in the EU and NATO? That the Schengen regime is extended to the Ukrainian-Russian border? That Ukraine regains control of Crimea and Sevastopol becomes a NATO naval base? Is this notion of "normality" realistically possible? Each peace agreement necessitates concessions to make possible to avoid the perpetuation of a war, particularly when there are evident imbalances in military might. Probably the question is how important avoiding war is when the price is paid by a proxy.

If the benefits of the perpetuation of the war can at least be debated, why is it lasting? So, cui bono? Who stands to benefit from this war? In any war, in spite of the widespread destruction, loss of life, and suffering, some individuals and groups may benefit from war. From military contractors to big corporations including political leaders and economical elites. But there is one more collateral gain for the West in this war, an ideological one. Western publics are now vindicated in their self-delusion that criminal wars are waged only by non-democracies like Putin's Russia and that there are good, heroic, chivalrous warriors on one side and evil monsters that are responsible of the only atrocities of the war on the other side. This is simply not true. The report by the Office of the High Commissioner for Human Rights (OHCHR) covering the period from 1 August 2022 to 31 January 2023 declares that Russian strikes on critical energy infrastructure since October 2022 have killed 116 civilians and injured 379, causing electricity shortages and damaging medical and educational facilities and documenting the killings of 21 civilians and 214 cases of enforced disappearances and arbitrary detentions by Russian armed forces. But also stated that Ukrainian armed forces and law enforcement agencies were also responsible for 91 cases of enforced disappearances and arbitrary detentions. OHCHR interviewed eight individuals prosecuted for "collaboration activity" and docu-

Humanitarian News

mented the arbitrary detention of 88 Russian civilian sailors. War is (and has always been) a brutal and dehumanizing force and not an exercise of chivalry. However, after many years of ethical instability, or in Artemy Magun's terms, ethical negativity, this war supports the illusion that good and evil are distinct, all significant political subjects are ethically marked as heroes or as villains, and, most importantly, the self-identification of individuals as ethical subjects has acquired a total and universal character. Act in such a way that the Kantian maxim of your will can be acknowledged as a universal law. But probably, that is just a delusional phantasy, hard to sustain in a moment when the legitimacy of opinion leaders, mainstream media, government institutions, and national or international legal bodies is severely criticised by a huge portion of society

Everybody should keep in mind that persisting on its present course, the war will come to vindicate the view of much of the world outside the West that this is a U.S.-Russian war with Ukrainian bodies — increasingly corpses. Not even a well-functioning doctrinal system in which “unpopular ideas can be silenced, and inconvenient facts kept dark, without the need for any official ban,” (to borrow George Orwell’s description of free England in his introduction to *Animal Farm*) will prevent that.

Do opportunities for diplomacy still remain? As fighting continues, positions predictably harden. Right now, Ukrainian and Russian stands appear irreconcilable. That is not a novel situation in world affairs. It has often turned out that “Peace talks are possible if there is a political will to engage in them”. However, if the only available language is mutual vilification and demonization, often accompanied by grandiose rhetoric about the cosmic struggle between the forces of light and darkness and for prioritization of geopolitical interests and imposition of one's own worldview, the chances of a just and realistic peace will remain remote.

As educated citizens we have a responsibility to give our own informed opinions on all the important topics that impact on our societies, because our opinions carry weight and can influence others. We have a responsibility to enhance democracy, and for a democracy to function, individuals must be well-informed and free to express their opinions. We may contribute to the promotion of critical thinking by encouraging others to engage in logical debates and critical thought, and by combating disinformation. Indifference is an unattainable luxury. We, who have the advantage of a higher education, are the ones who must consult multiple sources to gain a comprehensive understanding of what is occurring, who must examine the evidence to support both sides of the argument, and who must avoid confirmation bias by avoiding looking at the information in a way that confirms our preconceived notions. If we wish to live in a democracy, we must have the participation of a critical mass of citizens who do not follow or give credence to popular opinion or just repeat what is told by the mainstream media, but instead coin and communicate their own opinions and demand accountability from policymakers.

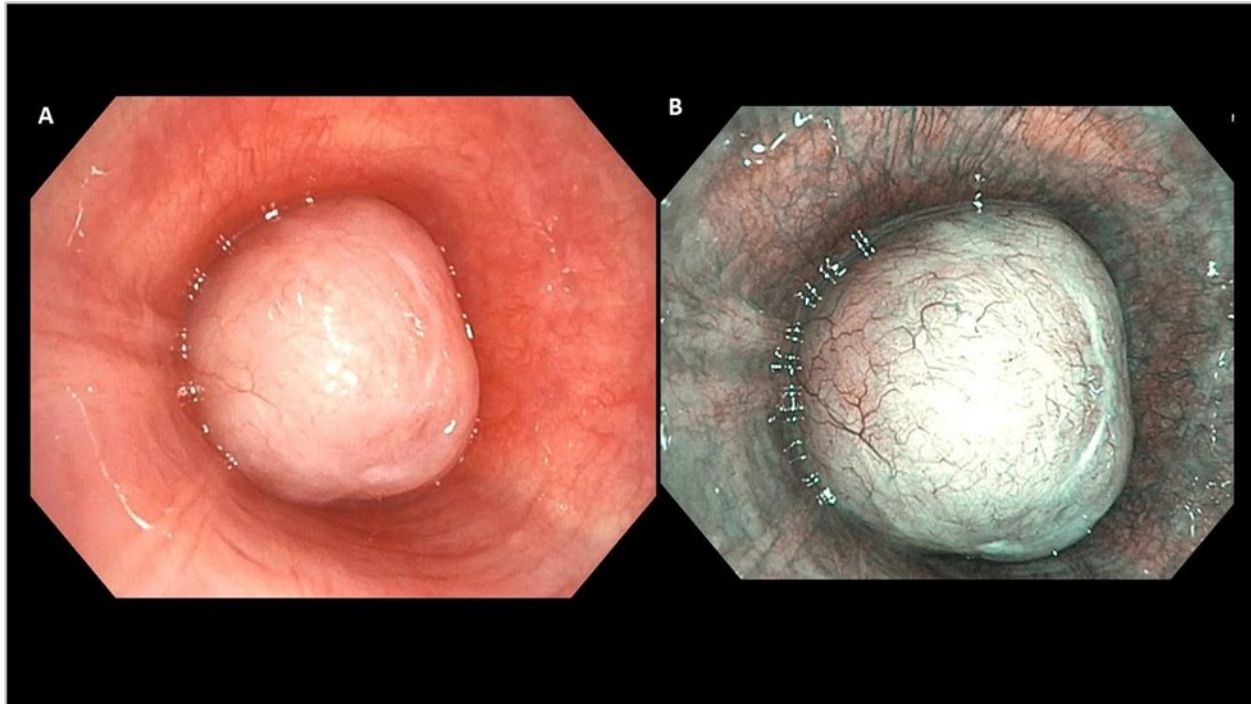
And as regular citizens, we must acknowledge that war is not a solution, but rather a symptom of more fundamental social and political issues that require innovative and compassionate answers. We can only hope to create a more just and peaceful society for ourselves and future generations if we cultivate a spirit of cooperation, understanding, and mutual respect, whichever our ideological differences. By working together and taking responsibility for our collective future, we can create a society that is more equitable and sustainable for everyone. Otherwise, any humanitarian aid will be a charade, a palliative for the real needs of the suffering, and a sedative for our consciences.

Polarisation is characteristic of the current era, and many readers will disagree with these opinions. These are the sentiments of someone who has spent the last three decades sloshing through enough mud, dragging too many corpses, and witnessing too many atrocities. And who believes that if we are unable to discover a major transformation in how we manage national and international differences, Hell will remain empty because all the devils will remain here.

**The views expressed in this article are those of the author (Silvia Quadrelli) and do not necessarily reflect the official positions of the Executive Board or International Board of Regents of the WABIP.*

Best Image Contest

Best Image Contest 2023 (2 of 3)



Description: Endobronchial Leiomyoma of the Left Main Bronchus

A. White Light Image

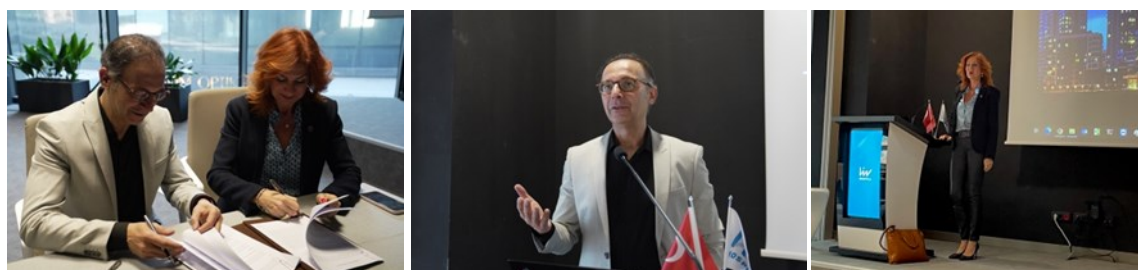
B. Narrow Band Image

Submitter(s): Hari Kishan Gonuguntla, Preeti Vidyasagar, Aravind Ram

This image is 1 of 3 selected among 100+ submissions to our Best Image Contest held in late 2022. Our next Image Contest will open later this year. We look forward to receiving your image submissions.

The 1st Interventional Pulmonology Institute (IPI) of the WABIP Inaugurated in Istanbul, Turkiye

<https://www.wabip.com/institute>



Meri İstiroti, CEO of the LIV hospital system, and Dr. Ali Musani, chair of the Interventional Pulmonology Institute, signed the landmark contract between the two institutions before outlining their visions in front of the audience

On Sunday, April 30th, 2023, during a beautiful ceremony in Istanbul, the leaderships of the World Association for Bronchology and Interventional Pulmonology (WABIP) and the LIV hospital, Istanbul (Vadistanbul) signed the first-of-its-kind agreement to inaugurate the first Interventional Pulmonology Institute (IPI). This remarkable contract between a non-profit conglomerate of more than 50 national interventional pulmonology societies (WABIP) and a private hospital chain in Istanbul Turkiye was signed by Meri İstiroti, CEO of LIV hospital system, and Dr. Ali Musani, chairman of the 1st Interventional Pulmonology Institute. This collaboration starts a new chapter in medical teaching and training of doctors from developing countries by the hundreds of IP faculty from dozens of countries worldwide to disseminate science and skills of IP without geographical or political restrictions.

The ceremony was followed by the first IPI conference, where Dr. Musani presented the mission, vision, organizational structure, educational goals, and details of the partnership between the two organizations. He outlined the short-term and long-term plans of the IPI and introduced the different committees, including the fellowship selection committee, education/curriculum committee, and IPI committee. He emphasized that IPI's fundamental goal is to train pulmonologists from the developing parts of the world in IP, free of charge, so they can go back and serve their countries and educate/train others in the IP field. Soon after the ceremony and introductory speeches from Meri İstiroti and Dr. Musani, the academic portion of the conference started.

WABIP News



The front desk of the LIV Hospital, Vadistanbul Turkiye

The conference had several international speakers from Europe and the USA representing the WABIP. Attendees from different parts of Turkiye participated in the conference and brought complex IP cases to seek expert opinions from the international faculty.



IPI faculty and attendees at the first IPI conference on 4/30/2023 in Istanbul, Turkiye



Dr. Levent Dalar, Director IPI Istanbul

FELLOWSHIP:

This day also marks the official announcement of the beginning of the IP fellowship at the IPI.

Pulmonologists and thoracic surgeons worldwide are welcome to apply for the WABIP-IPI Interventional Pulmonology (IP) fellowship starting Oct 1st, 2023. Please review the details of the IP fellowship requirements and curriculum (<https://www.wabip.com/institute>) before applying for the fellowship. Please fill out the application forms available at <https://www.wabip.com/institute> and send them to Dr. Javier Flandes, chair of the fellowship selection committee (jflandes@quironosalud.es), and Dr. Levent Dalar, director for the IPI Istanbul (leventdalar@gmail.com) at least four months before the start date of the fellowship. Please see below for the fellowship application deadline.

Application Deadlines:

Fellowship Start Date	Application Deadline The application and supporting material should be received by
Oct 1st	July 1st
Jan 1st	September 1st
April 1st	December 1st
July 1st	March 1st

The selection committee will respond to your application in three weeks to allow you ample time to finalize your travel preparations. The IPI will happily provide you with a letter of acceptance to help you obtain a Turkish visa. You should not engage in any employment or illegal activities in Turkiye. IPI will fully cooperate with the legal authorities in providing information regarding you if asked. IPI does not pay salaries or any financial support to trainees and fellows. You should not expect any financial support from IPI or the LIV hospital.

EDUCATION AND TRAINING:

The fellowship will be three months long, starting Oct 1st, 2023. As outlined above, one or two new fellows will start every three months. The fellows will be required to stay in Istanbul for three months and work with the local and international visiting faculty of the WABIP. They will be provided with limited malpractice coverage by the LIV hospital and a temporary trainee license from Istinye University, Istanbul, to perform procedures under the supervision of the local IP faculty. The fellows will be expected to work six days a week, including Saturday, and go to other hospitals with the IP faculty to perform procedures.

WABIP News

IPI will provide a reading list, a library of procedural videos, and review material. We expect every fellow to study all the pre-fellowship training material prior to starting the fellowship. All fellows will undergo pretesting in theory and skills of IP procedures. The purpose of the pretest is to gauge their improvement after the fellowship with a posttest/certification test. The pretest will not be used to select or reject candidates from the fellowship.

If your budget allows, we would like you to travel to Athens, Greece, Florence, Italy, or Ancona, Italy, for a week of free simulation training with high-fidelity simulators and cadavers under WABIP faculty. This training is not mandatory but will help you get comfortable with more complex procedures, such as rigid bronchoscopy, airway stenting, etc. We plan to do this training in the early weeks of each fellowship period.

1. Levent Dalar (Turkiye)	2. Shaheen ul Islam (USA)	3. Javier Flandes (Spain)	4. Mohammed Munavvar (UK)	5. Grigoris Stratakos (Greece)
6. Lorenzo Corbetta (Italy)	7. Stefano Gasparini (Italy)	8. Atul Mehta (USA)	9. Semra Bilaceroglu (Turkey)	11. Ali Musani (USA)
12. Sinem Nedime Sökücü (Turkiye)	13. Cengiz Ozdemir (Turkiye)	14. Daniela Gompelmann (Austria)		

IPI Faculty

FEE and EXPENSES:

The IPI will not charge any fee for training fellows, but the fellows will be responsible for all their expenses, including flights, stay for three months in Istanbul, and food during their fellowship. WABIP is trying to raise funds with donations and scholarships to support a few fellows yearly, but we don't expect any support for at least one year. We encourage fellows to obtain health insurance in Turkey to avoid unnecessary charges if they get sick while training in Istanbul. IPI does not pay trainees and fellows. You should not expect any financial support from IPI. We encourage you to seek support from your respective governments, hospitals, industry grants, scholarships, etc. We will gladly furnish supporting documents to help you obtain these grants if needed.

VISA:

IPI will help you obtain a visa by providing a letter of acceptance by the WABIP-IPI Istanbul. You are expected to apply for the visa at least three months in advance so that in case of your inability to obtain a visa in a timely fashion, we can offer the fellowship spot to other candidates. We expect you to have your visa and tickets ready and emailed to the selection committee at least three months before your fellowship start date.

Certification:

Each fellow will be tested during the last week of their three months of training. This test will comprise of didactic and skills testing. Please see the skills testing document. You will be trained in skills and steps of IP procedures the same way as you will be tested. Each fellow must pass both didactic and skills test to obtain the certificate of completion of the IP fellowship at the WABIP-IPI. This certificate does not give you a license to practice IP/bronchoscopic and pleural procedures at your institute, in your country, or in any other country. To practice these procedures, you must still fulfill your country's and institution's requirements, such as local credentialing and licensing. Due to a relatively short training period, we cannot guarantee that you will be fully competent in your skills to perform IP procedures independently after just three months of training. The required number of procedures for IPI training is reduced substantially to allow you to finish the training in three months.

WABIP News

You will be more than welcome to apply for the same fellowship again to obtain more experience. You must undergo the same selection process as the first time. You should do some supervised procedures at your home intuition to be comfortable doing them and fulfill your national and institutional credentialing and licensing requirements. We strongly recommend some supervised training before performing IP procedures independently. We also strongly recommend at least 1-2 years of practice with four times, or a greater number of procedures done/required during the IPI fellowship before teaching others in your country or starting a formal training program. We will try to organize a symposium for all the IPI fellows at the World Congress of Bronchology and Interventional Pulmonology (WCBIP) every other year. WABIP-IPI will gladly stay in touch with all its graduates and provide continued education and guidance.

Code of Conduct:

The fellows will be required to follow the code of conduct of the LIV hospital in their day-to-day work and social interactions while training there. The fellows must follow the hospital's and IP program's rules and policies. The IPI director and the chair reserve the right to expel any fellow who misbehaves and does not follow the rules and regulations of the institution or is disrespectful and disruptive. In case of expulsion from the program, the fellow must return to their home country within two weeks, and they will be deemed incompetent to receive IPI certification. IPI also reserves the right to inform immigration authorities of any illegal activities and take legal action if any criminal activity is suspected. IPI fellows are supposed to refrain from engaging in any employment while in Turkiye for training at the IPI. They will be reported to immigration if any such activity is brought to IPI's attention.

In conclusion, IPI training will give you a strong foundation to build your IP career. Our faculty of world experts have developed a robust training program to train you in as many skills as possible in a short time. We will stay engaged with you long after your fellowship to provide you with mentors, educational opportunities, and advice when asked to make sure that you have all the professional and moral support you need to start a successful program in your home country and educate the next generation of doctors and continue the mission of elevating the level of health care in your country.

Sincerely,

The Interventional Pulmonology Institute Committee of the WABIP

<https://www.wabip.com/institute>



Education

WABIP Workshop in Buenos Aires March 2023

The World Association of Bronchology and Interventional Pulmonology (WABIP) recently hosted the 3rd Bronchoscopy Course-Workshop in Buenos Aires, Argentina. Attended by 35 respiratory medicine professionals from Argentina and neighboring countries, the workshop catered to individuals with intermediate or advanced levels of prior bronchology training who are actively working in bronchoscopy.

The course and workshop were led by renowned international expert Dr. Sara Tomassetti from Italy, alongside highly experienced local instructors Artemio Garcia, Silvia Quadrelli, Patricia Vujacich, Hugo Botto, Marcos Las Heras, and Jose Rodríguez Jiménez from Argentina, as well as David Lazo from Chile. After a day of informative lectures, participants enjoyed a full day of hands-on training at various stations, covering reusable bronchoscopes, rigid bronchoscopy, cryotechniques, stenting, EBUS, difficult tracheal intubation, and laser.



Under the watchful guidance of the course instructors, each participant had the chance to practice each technique using a diverse array of inanimate models. This learner-centered educational experience maintained a low student-teacher ratio, allowing local and international experts to offer more personalized attention to each student. Instructors were able to assess individual strengths, weaknesses, and learning styles, tailoring their teaching methods to meet specific needs and providing customized feedback for improvement. The local team skillfully organized the two-day program, resulting in a memorable and enriching experience for all. The unusual hot weather in Buenos Aires prompted the selection of a beautiful location in the Delta islands, where participants could appreciate nature and forge friendships. Attendees greatly valued the opportunity to network with WABIP professionals in an environment that fostered camaraderie, curiosity, and passion.



WABIP would like to extend its gratitude to the bronchoscopy training instructors and the organizing team for their commitment to expanding global bronchoscopy training. The ultimate goal is to develop procedures that are not only safer and more reliable but also completely comfortable for all patients, regardless of their geographic location. The exceptional visiting educator, Dr. Sara Tomassetti, played a crucial role in the event, and her contributions were greatly appreciated by all participants.



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Research

Can You Smell Cancer?



Ali I. Musani MD, FCCP
University of Colorado School of Medicine,
Denver

Stratification of lung nodules is indeed the bane of lung cancer screening and early diagnosis. Even in the meticulously selected patients in the National Lung Cancer Screening Trial (NLST), more than 95% of the patients diagnosed with pulmonary nodules were benign after surgical resection.

Our quest for accurately identifying high-risk pulmonary nodules goes on. We have gained some ground with PET scans, proteomics, and genomics, but we still need to achieve desired precision and efficiency (less invasive and accurate). Although our technological advances in accurately sampling pulmonary nodules with state-of-the-art robotics, ancillary technologies, cone beam CT scanners, and the like have evolved rapidly, we still biopsy more benign nodules than we should. Our struggle for more precise identification of malignant nodules goes on.

Exhaled breath contains a gas mixture of volatile organic compounds (VOCs) that result from tissue metabolism. In unique physiologic and pathological conditions, the VOCs differ in their compositions. The analysis of VOCs in different conditions to understand and diagnose physiologic and pathological states has been of great interest over the decades. For a long time, recognizing specific patterns or signatures of VOCs in different conditions with reasonable accuracy has been the research topic. Gas chromatography-mass spectrometry and mimicking olfaction with mechanical noses have shown promise in diagnosing cancer in early work.

Exhaled breath analysis of VOCs in lung cancer has been studied for quite some time, but validation studies and clinical implementation still need to be improved. Recently, a very interesting publication in CHEST 2023 from the Netherlands showed promising results in diagnosing non-small cell lung cancer (NSCLC) by exhaled breath profiling using an electronic nose. The study from Kort et al. (1) looks at two important questions; 1, can a prediction model be validated to distinguish non-small cell lung cancer patients from patients without non-small cell cancer 2, would adding this test to other clinical information available will improve lung cancer diagnosis?

Five-minute normal breathing into a handheld electronic nose (aeoNose) test was performed on 376 subjects in a multicenter study in the Netherlands. The trial resulted in a 95% sensitivity and 51% specificity and a negative predictive value of 94%. The study suggests that combining clinical information with exhaled breath data can distinguish patients with non-small cell cancer from subjects without non-small cell lung cancer in a non-invasive manner.

Research

Multiple studies in the past have alluded to similar outcomes in different study designs and cohorts. The study from Kort et al. (1) showed significant improvement in the prediction of NSCLC when breath analysis of VOC was added to clinical information commonly used in other prediction models for lung cancer. Using newer predictive models with VOC analysis in high-risk patients with pulmonary nodules and clinical data, CT, and PET scans could make lung nodule stratification more precise.

Due to its simplicity and non-invasive application, this test can be used as a “point-of-care” test that can be easily implemented in the early diagnosis of lung cancer (lung nodule clinics or lung cancer screening programs) in an outpatient setting.

Reference:

1. Kort S. *Chest*. 2023 Mar;163(3):697-706.

WABIP ACADEMY- WEBCASTS

The WABIP has started a new education project recently: *THE WABIP ACADEMY*. The WABIP Academy will provide free online webcasts with new and hot topics that will interest pulmonologists and interventionalists.

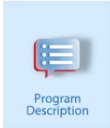
Current webcast topic: **Tissue acquisition for biomarker directed therapy of NSCLC**

Webcast

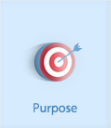
Small Sample Tissue Acquisition and Processing for Diagnosis and Biomarker-driven Therapy of NSCLC

Welcome to WABIP's free online learning tool to increase knowledge regarding the appropriate selection, acquisition, and processing of cytology and histology samples from patients with known or suspected lung cancer.


Click an icon to begin




Program Description



Purpose



General Learning Objectives



Specific Learning Objectives


[TABLE OF CONTENTS >](#)

Each fictitious clinical case scenario is based on a conglomerate of real patient data. Cases have been modified to avoid any possibility for patient identification and to help meet educational objectives. Any resemblance to real persons, living or deceased, is purely coincidental.

The content for these webcasts has been developed by members of the World Association for Bronchology and Interventional Pulmonology. All content was reviewed by an independent multidisciplinary team of experts. Unless otherwise specified, all content is the property of WABIP.

A collaborative project with Pfizer Oncology

[Credits >](#)



You can reach these webcasts by using this link: <http://www.wabipacademy.com/webcast/>

Links

www.bronchology.com	Home of the Journal of Bronchology	www.chestnet.org	Interventional Chest/Diagnostic Procedures (IC/DP) NetWork
www.bronchoscopy.org	International educational website for bronchoscopy training with u-tube and facebook interfaces, numerous teaching videos, and step by step testing and assessment tools	www.thoracic.org	American Thoracic Society
www.aabronchology.org	American Association for Bronchology and Interventional Pulmonology (AABIP)	www.ctsnet.org	The leading online resource of educational and scientific research information for cardiothoracic surgeons.
www.eabip.org	European Association for Bronchology and Interventional Pulmonology	www.jrs.or.jp	The Japanese Respiratory Society
		sites.google.com/site/asendoscopiarespiratoria/	Asociación Sudamericana de Endoscopia Respiratoria

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END0 90992 AA

This article has summarized the historical advances in the design and performance of needles used for EUS-guided procedures. Since the early 1990s, EUS-FNA has played a clear and vital role in oncological care and has become the standard procedure for sampling tissues with high diagnostic accuracy.

Reference:

Current Status of Needles in the Optimization of Endoscopic Ultrasound-Guided Procedures.

Akashi Fujita, Shomei Ryozaawa *, Yuki Tanisaka, Tomoya Ogawa, Masahiro Suzuki, Tatsuya Noguchi, Hiromune Katsuda and Masafumi Mizuide Department of Gastroenterology, Saitama Medical University International Medical Center, 1397-1, Yamane, Hidaka, Saitama 350-1298, Japan