Clinical Reference Group Meeting

Tuesday 20 December 2016
6:30 – 8:00pm
School of Rural Health building, LRH upstairs Tutorial Room 4,
Round Building and by Zoom video conferencing

Minutes

1. Welcome and introductions

In Attendance: Associate Professor Joseph Tam (Chair), Professor Michael Abramson, Dr Ryan Hoy

Apologies: Associate Professor Paul Lee, Professor Andrew Tonkin, Dr Jill Blackman, Dr Fred Edwards, Angela Scully, Associate Professor Alistair Wright, Dr Ian Webb, Dr David Monash, Dr Jo McCubbin

Observers: Dr Sharon Harrison (Minutes), Kylie Sawyer

The Chair noted that a number of members were not in attendance. Sharon Harrison advised that several members had advised that they would attend the meeting. The Chair delayed the commencement of the meeting to give other members the opportunity to arrive. Those in attendance discussed the issue of quorum for the meeting.

Michael Abramson noted that Andrew Tonkin was unfortunately a late apology for the meeting, but had provided advice regarding the Clinical Pathway for any abnormal results that are identified through cardiovascular testing.

2. Minutes from meeting held 15 November 2016 for confirmation

Michael Abramson suggested that instead of referring to the number of children with high CRIES scores, the minutes could simply refer to the 'group of children with high CRIES scores'. Ryan Hoy agreed that this would not take away from the record of the discussion. The minutes of the meeting held on 15 November 2016 were endorsed by the group and confirmed as a true and accurate summary subject to the amendment above.

It was suggested that the minutes of the previous meeting should be kept confidential given the matters that were discussed.

Action: Sharon Harrison to adjust the minutes of the CRG meeting on 15 November 2016.

3. Respiratory Stream - Clinical Pathway for Adverse Findings (Ryan Hoy)

Ryan Hoy provided an outline of the clinical testing that will be completed for the Respiratory Team. Respiratory testing will take around two hours to complete and will involve:

- The European Community Respiratory Health Survey questionnaire
- The Asthma Control Questionnaire in subjects with asthma
- Lung function tests before and after bronchodilator (spirometry) following the spirometry guidelines of the European Respiratory and American Thoracic Societies
- Exhaled nitric oxide (eNO) test to measure lung inflammation using the European Community Respiratory Health Survey procedures. The eNO test is a newer test that is simple, non-invasive and reproducible measure of airway inflammation. Testing using this technique is easier for patients.
- Multi breath nitrogen washout (MBNW) technique to measure the function of the small airways
- Transfer factor for carbon monoxide ($T_L$co) which is a simple measure of the gas exchange properties of the lung following the guidelines of the European Respiratory and American Thoracic Societies
- Forced oscillation technique (FOT) for measuring lung stiffness in children. The stiffness of the lung changes very early in the progression of lung disease.

Ryan Hoy noted that Bruce Thompson has provided advice regarding the baseline assessment.

Health assessments will be done in years 3, 6 and 9 to assess the decline in lung function over time.

Michael Abramson reported that the sample size for decline in lung function (FEV_1) has been revised due to the lower recruitment level in Sale, advising that the sample will include 226 participants in Sale and 451 in Morwell subject to final Adult Survey recruitment numbers. This sample size will ensure 90% power to detect accelerated decline in FEV_1.

Ryan Hoy reported that ethics approval has been received and clinical testing is due to commence in March 2017.

The CRG discussed the issue of a clinical testing site at the Latrobe Regional Hospital. It was noted that Marita Dalton and Tracey Minster had come to look at the rooms at the LRH. Fay Johnston has expressed concern that there is no separate waiting area for children. Joseph Tam advised that it depends on the day of the week. Joseph Tam's clinic days are Monday and Wednesday. The waiting room he uses would be available on the days that he does not hold clinics. This waiting room is on the ground floor, close to the upstairs clinic room that would use for the Latrobe Early Life Follow-up clinical testing.

It was noted that some of the clinical testing techniques being used for the Respiratory Stream are experimental and are not widely used in clinical practice. It was suggested that these results might be confusing for local GPs and may not be helpful to participants. It was also felt that GPs sometimes struggle with interpreting spirometry results.

Michael Abramson suggested that undiagnosed chronic obstructive pulmonary disease might be identified through clinical testing. It was proposed that the Clinical Pathway in such cases could be to recommend that the GP refer the patient to a respiratory specialist or respiratory testing. Michael Abramson referred to an European Respiratory Society / American Thoracic Society (ERS/ATS) paper on clinical pathways for abnormal respiratory function test results.

It was noted that in the case of reduced gas transfer researchers will know if it is likely to be caused by COPD and further information could be provided. High levels of eNO by itself should not be used for a diagnosis and that interpretation needs to be done in the setting of other results.

It was emphasized that there is no agreed reference range or guidelines for eNO. Michael Abramson suggested that this issue be discussed further with Bruce Thompson and Ryan Hoy.

Action: Ryan Hoy agreed to come back to the next meeting of the CRG with a clinical pathway outline for abnormal investigation results in the Respiratory Stream.

4. Cardiovascular Stream - Clinical Pathway for Adverse Findings

Michael Abramson advised that Andrew Tonkin provided the following list of cardiovascular conditions that might be identified through cardiovascular testing:

- Atrial fibrillation or atrial flutter (depending on whether this was previously identified)
- Left bundle branch block
- Myocardial infarction (if no previous history)
- Left ventricular hypertrophy with strain
- Complete heart block or Mobitz 2 block (the latter would obviously be very rare on ECG, and included only for completeness re indication for pacing)
- Supraventricular tachycardia with rate more than 130 bpm (Sinus tachycardia obviously very difficult to differentiate)
- Heart rate less than 35 bpm (could argue whether this is necessary)
- QTc interval 500 msec or more

Michael Abramson reported that Danny Liew has suggested that if subjects consent to it, then all investigation results should just be forwarded to their GPs. He emphasized that the study should not itself take responsibility for abnormal findings, which are difficult to interpret out of clinical context.

Andrew Tonkin agreed with Danny Liew's suggestion, but cautioned that it may increase costs and may not be sufficient for the Health Department, who will probably want the study to flag abnormalities.

The CRG discussed the idea of giving everyone their ECG results. It was noted that local GPs would usually rely on the report from the ECG.

The CRG discussed the issue of delays in getting results. Danny Liew had suggested that most patients with abnormal results would probably have mild disease and thus a one or two month delay in getting results should not be a problem.

Michael Abramson noted that the Planned Burn Study had sent letters to participants in the case of abnormal blood results, advising them to follow up with their GP. In many cases these abnormal results were subtle, this led to unnecessary concerns for participants. In some cases these participants called him to seek advice about the letter. It was emphasized that there is clearly an ethical obligation to advise participants if the findings indicate that they have for example undiagnosed COPD or AF. However, in other cases, a letter could be sent to participants advising them of abnormal findings and recommending that they see their GP.

5. Update Schools Study Clinical Pathway

Michael Abramson acknowledged the contributions made by Paul Lee, Joseph Tam, Jo McCubbin and Dennis Moore in reviewing the Schools Study Fact Sheet and letter to the parents. In accordance with the Directive of the Chief Health Officer, the letter and Fact Sheet were sent out to parents and were accompanied by the Headspace information sheet on

trauma. The information has also been sent out via the Latrobe Health Network and to school principals and school nurses. Schools Study Researcher Emily Berger spoke at the Annual Community Briefing and also did some media appearances.

6. Other business

Joseph Tam proposed that the next CRG meeting be held in February and suggested that a Doodle Poll be set up to check the availability of CRG members to attend a meeting in February.

Action: Sharon Harrison to set up a Doodle Poll for the February CRG meeting.

It was noted that Judi Walker was scheduled to be back at work in January.

Meeting closed at 7:15pm