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HIGHLIGHTS

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Highlights of International Congresses. Report from our Representatives at the Following International Events

Highlights de los Congresos Internacionales. Informe de nuestros representantes en los siguientes eventos internacionales

1 ATS (American Thoracic Society) 2025, May 16 to 21
2 panish Society of Pulmonology and Thoracic Surgery (SEPAR, by its Spanish acronym; Sociedad Española de Neumología y Cirugía Torácica) 2025, June 12 to 14

ATS 2025 CONGRESS ON INTERSTITIAL LUNG DISEASES

Significant advances were presented at the ATS 2025 Congress with regard to interstitial lung diseases. Below are three of the most relevant studies, with additional updates to be shared in future educational activities of the AAMR:

1. New treatment for pulmonary fibrosis: For the first time in 11 years, a new drug for pulmonary fibrosis has been approved: Nerandomilast. In the Fibroneer IPF and Fibroneer ILD studies (DOI: 10.1056/NEJMoa2414108 and DOI: 10.1056/NEJMoa2503643), this drug was shown to reduce the rate of decline in forced vital capacity (FVC) in patients with progressive pulmonary fibrosis, both with and without concomitant antifibrotic treatment. Although patients without concomitant treatment showed a slower decline in FVC, these results should be interpreted with caution, as differences in disease severity and duration between groups probably exist. In addition, a reduction in mortality was observed in patients treated with Nerandomilast in the Fibroneer ILD study.
2. First-line treatment in pulmonary sarcoidosis: The PREMETH Study (DOI: 10.1056/NEJMoa2501443) compared methotrexate and prednisone as initial treatment for pulmonary sarcoidosis. At 24 weeks, both treatments produced similar improvements in FVC, and methotrexate was found to be non-inferior to prednisone. Although side effects were comparable between the groups, prednisone was associated with greater weight gain, insomnia, and increased appetite, while methotrexate caused more nausea, fatigue, and liver abnormalities. These findings suggest that methotrexate could be considered a first-line option, particularly in patients concerned about steroid-related side effects.
3. Evaluation and management of interstitial abnormalities: According to the ATS Clinical Statements (DOI: 10.1164/rccm.202505-1054ST), interstitial lung abnormalities are defined as bilateral changes on computed tomography (such as ground-glass opacities, reticulations, and honeycombing) affecting more than 5% of a lung area. The updated definition no longer excludes high-risk populations. Screening for ILA/ILD (interstitial lung abnormalities/interstitial lung disease) is recommended in lung cancer imaging studies, in adults with connective tissue diseases, and relatives of patients with familial pulmonary fibrosis. In addition, it is essential to assess baseline symptoms and lung function, and to follow up every 2-3 years.

This summary was prepared by the Interstitial Lung Disease Section of the AAMR.

PARTICIPATION REPORT
58TH CONGRESS OF THE SPANISH SOCIETY OF PULMONOLOGY AND THORACIC SURGERY (SEPAR)

Bilbao, Spain – June 2025
Santiago Larrateguy,
Physiotherapist– Specialist in Respiratory Rehabilitation, Active member, AAMR

1. Talk: *Physiological and Neuroscientific Mechanisms of Dyspnea*

Speakers: Dr. Ane Arbillaga and Dr. Javier Gascón

Chronic dyspnea continues to be one of the most complex symptoms in the management of respiratory diseases. In this session, recent advances in the understanding of dyspnea were discussed from a neuroscientific perspective, recognizing its central processing as a key component, beyond the traditional peripheral approach.

Main concepts addressed:

- **Role of pulmonary rehabilitation:** Recognized as one of the most effective interventions to relieve dyspnea, although its exact mechanisms are still unknown. Current hypotheses include:
  - Optimization of respiratory and peripheral muscle function.
  - Reduction of ventilatory demand.
  - Cognitive and affective improvements that modulate symptom perception.
- **Breathing-Thinking-Functioning (BTF) Model:** This clinical framework was proposed to understand the interaction between anxious thoughts, respiratory alterations, and functional decline. This cycle perpetuates dyspnea even in the absence of objective structural impairment.
- **Nociplastic dyspnea:** An analogy with chronic pain was used to describe situations where dyspnea persists without an evident functional equivalent, suggesting central sensitization mechanisms.
- **Clinical decoupling:** The low correlation between dyspnea and traditional parameters such as FEV1 or the mMRC scale was highlighted. The need to assess dyspnea as a multifactorial subjective experience was emphasized.
- **Current gaps:**
  - Lack of knowledge regarding the degree of participation of chemoreceptors.
  - Unclear interactions between psychological factors and the perception of dyspnea.

Important references:

- Herigstad M, et al. Respir Med. 2011.
- Parshall MB, et al. Am J Respir Crit Care Med. 2012.
- Pavlovic M, O'Daly O. Semin Respir Crit Care Med. 2022.
- Booth S, et al. Prim Care Respir J. 2013.

2. Teaching workshop: *Motivational interviewing (MI) in patients with chronic respiratory disease*

A practical activity was conducted focusing on the application of motivational interviewing as a clinical tool to improve adherence and facilitate behavior change in the context of rehabilitation.

Key areas addressed:

- Importance of MI in respiratory rehabilitation:
  - Effective approach to ambivalence toward change.
  - Strengthening the therapeutic alliance through empathy, active listening, and affirming language.
  - Particularly useful in patients with fear of dyspnea or frequent relapses.
- Techniques covered:
  - OARS: use of open-ended questions, affirmations, reflections, and summaries.
  - Strategies for eliciting motivation and collaborative planning.
  - Respectful, patient-centered feedback.

It was emphasized that MI should not be considered merely a communication technique, but rather an intervention with strong evidence to induce sustainable changes in health behaviors.

3. Talk: *Physical Activity Interventions in Patients with Exacerbations*

Speaker: Dr. Marian Ramon – Vall d'Hebron, Barcelona

The lecture focused on the negative impact of respiratory exacerbations on physical activity and functionality, and the need for early intervention in the recovery process.

Main points:

- Exacerbations significantly reduce functional capacity, muscle strength, and emotional well-being.

- A significant gap was identified between the intention to remain active and actual behavior after hospital discharge.
- Factors such as depression, fear, an unfavorable environment, and comorbidities contribute to inactivity.

Proposed interventions:

- Consider the exacerbation as a key moment to initiate structured interventions.
- Integrate programs that include:
  - o Motivational interviewing
  - o Individualized goals
  - o Identification of barriers and facilitators
  - o Systematic follow-up of progress

Clinical conclusion:

The implementation of individualized strategies during the post-exacerbation stages can prevent functional decline, improve quality of life, and optimize long-term prognosis.

Cited references:

- Pitta F. Chest. 2006
- Ramon MA. Eur Respir J. 2018
- Valeiro B. ERJ Open Res. 2025
- Feil K. Br J Sports Med. 2023

4. Institutional meetings and collaboration opportunities

During the congress, informal meetings were held with directors of the Respiratory Physiotherapy Area of SEPAR, where a strong interest was expressed in establishing collaborative links with the Respiratory Rehabilitation Section of the AAMR.

Below are some possible joint actions:

- Invitation to virtual lectures: Dr. Ane Arbillaga expressed her willingness to deliver the talk on dyspnea in a virtual format for professionals in Argentina.
- Intersocietal research projects: the possibility of generating multicenter research involving both societies was discussed.
- Strengthening the academic connection: plans were made to continue institutional dialogue to coordinate future educational and scientific actions in a collaborative manner.

These initiatives represent a strategic opportunity to enhance the development of respiratory rehabilitation in the region, facilitating the exchange of knowledge and experiences among Spanish-speaking professionals.

Acknowledgement

I sincerely thank the authorities of the Argentine Association of Respiratory Medicine (AAMR) for their support and the opportunity to participate in this international event. The possibility of representing the institution in a high-level academic setting such as the SEPAR Congress not only allowed for rigorous scientific updating but also the development of strategic connections that could lead to future inter-institutional collaborations.

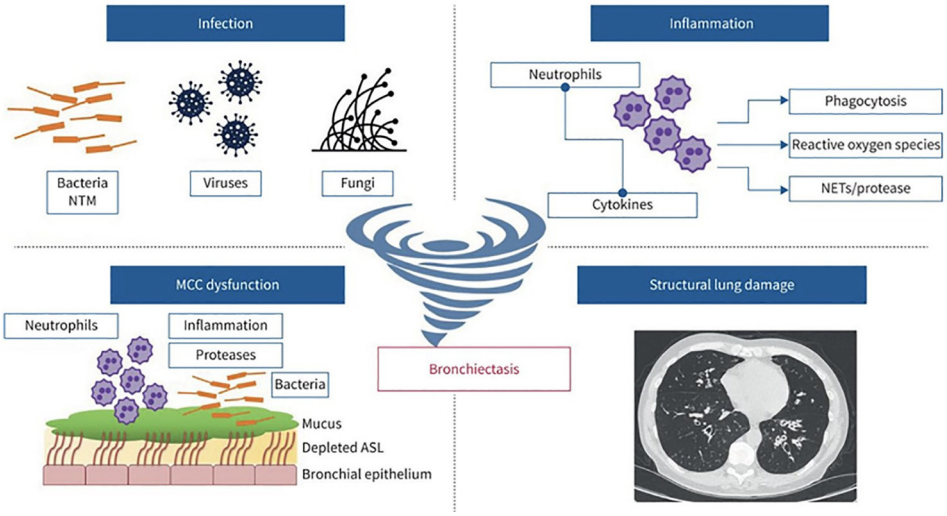
PRE-CONGRESS COURSE ON BRONCHIECTASIA IN THE FRAMEWORK OF THE 58TH SEPAR CONGRESS IN THE CITY OF BILBAO, SPAIN, PRE-CONGRESS COURSE ON BRONCHIECTASIA

Bilbao, España - Junio 2025
Dra. Eugenia Alais
Pneumonology Department Hospital Alemán

In the introduction, the diagnostic algorithm from the SEPAR guideline published in 2018 was reviewed, with its update expected by the end of 2025. The physiopathology was also addressed, replacing the traditional model of inflammation, infection, and structural damage with four key factors in disease development and progression: infection, inflammation, impaired mucociliary clearance, and structural damage. Instead of being represented as a circle, the new model is depicted as a whirlwind or twister, where each component can independently affect the others.

Causes to consider include disorders related to CFTR (cystic fibrosis transmembrane conductance regulator) when cystic fibrosis (CF) has been ruled out. Suspicion should arise if the patient presents with specific clinical features (phenotypes), after excluding CF, or if there is evidence of partially functional CFTR protein with activity levels below the threshold for CF. The most frequent forms of clinical presentation are: bilateral bronchiectasis, ABPA (allergic bronchopulmonary aspergillosis), chronic rhinosinusitis, recurrent acute or chronic pancreatitis, primary sclerosing cholangitis, and absence of the vas deferens.

Another major causal group is related to rheumatologic diseases. The prevalence of bronchiectasis in rheumatoid arthritis (RA) is 3-30%, and it is associated with advanced arthropathy and greater morbidity and mortality. Risk factors include advanced age, longer RA duration, and



genetic variants. In primary Sjögren's syndrome, the prevalence is 7-54%, usually cylindrical in type, predominantly affecting the lower lobes (70%), and is associated with older age, hiatal hernia (50%), and positive anti-SMAs (smooth muscle antibodies). In systemic lupus, prevalence ranges from 13 to 21%, though it remains unclear whether this is due to the disease itself or a consequence of recurrent infections. Those associated with vasculitis occur more frequently in women and with positive ANCA (antineutrophil cytoplasmic antibody).

The diagnostic criteria for ABPA (allergic bronchopulmonary aspergillosis) were reviewed, noting a lack of consensus among societies, as criteria vary depending on the underlying disease, and active screening is not routinely performed. For example, in corticosteroid-dependent asthma, the prevalence is 2-5%; in CF, 8-9%; in COPD (chronic obstructive pulmonary disease), 1-2.9%; and in bronchiectasis, 6%. Currently, four phenotypes of ABPA are considered, but treatment remains similar, with the objectives of controlling the immune response, reducing fungal load, improving symptoms, and preventing exacerbations and progression of bronchiectasis.

When to suspect primary ciliary dyskinesia? Symptoms include: persistent productive cough, situs inversus, chronic rhinitis/rhinosinusitis, congenital heart disease, otitis media/hearing loss, and frequent respiratory infections. For diagnosis, high-speed video analysis has a sensitivity of 95-100% and a specificity of 93-95%, evaluating coordination, amplitude, and pattern of ciliary movement.

Among immunological causes, the most frequent is common variable immunodeficiency (CVID), with a bronchiectasis prevalence of 34-68%, and it should be suspected in patients with frequent respiratory infections, pneumonias, severe sinus disease, and otitis. CVID is also associated with meningitis, endocarditis, abscesses, osteomyelitis, and sepsis. Within the bronchiectasis algorithm, all patients should have IgA, IgG, IgM, IgE, and C3/C4 levels measured. In selected cases, IgG subclasses and B, T, NK phenotyping should also be performed.

Bronchiectasis and digestive disorders: the lung–gut axis has a common origin, a specialized epithelium, physical barriers (mucus, ciliated or secretory cells), mucosa-associated lymphoid tissue (MALT), shared microbiota, and similar immunological responses. Reflux is associated with NTM (nontuberculous mycobacteria) and bronchiectasis (BQ), but reflux itself was not found to be a causal factor of BQ. Similarly, inflammatory diseases of the colon may have a positive genetic correlation with BQ but do not have a direct causal effect.

Other causes of BQ include accessory tracheal bronchus, tracheobronchomalacia, tracheal or bronchial stenosis, bronchogenic cyst, pulmonary sequestration, William-Campbell syndrome, yellow nail syndrome, Mounier-Kuhn syndrome, Young's syndrome, and alpha-1 antitrypsin deficiency.

Finally, different causal pathologies of BQ were reviewed, which we must keep in mind in our daily practice and not settle for idiopathic causes without investigating their origin.