EUROPEAN RESPIRATORY SOCIETY STATEMENT ON FAMILIAL PULMONARY FIBROSIS
Although there is an increasing availability of gene sequencing, the genetic assessment of patients with interstitial lung disease (ILD) to identify familial pulmonary fibrosis (FPF) has not become integrated into clinical practice. Borie and colleagues (Eur Respir J 2023;61:2201383) review the latest evidence to form an European Respiratory Society statement on FPF. The task force developed several narrative questions to guide clinical practice. Recommendations include identifying patients who may benefit from further genetic evaluation including those with ILD and a first or second-degree family members with fibrotic ILD, with a relative with a known related genetic mutation, with short telomere syndrome or presentation of ILD before the age of 50 years. The task force reviewed evidence indicating a worse prognosis for patients with FPF compared with non-familial forms of ILD. When performing genetic testing, typical telomere and surfactant-related genes should be covered and measurement of telomere length should be considered. However, genetic polymorphisms were not felt to be useful in routine patient workup. Patients with FPF and progressive disease should be treated with antifibrotic drug regimens as per current international guidance. It was recommended that all first-degree relatives (FDR) of patients with FPF are offered periodical clinical evaluation. Chest CT and pulmonary function tests should be performed if respiratory symptoms are declared and all relatives should be advised on appropriate risk reduction behaviour such as smoking cessation. The guidance is a useful addition given the paucity of data in this area to guide clinicians.

PRECLINICAL PULMONARY FIBROSIS IN FDR OF PATIENTS WITH FAMILIAL FIBROSIS: ASSOCIATED WITH REDUCED SURVIVAL AND PROGRESSIVE SYMPTOMS
FDRs of patients with FPF are at increased risk for developing fibrotic lung disease. But few data exist on incidence or impact of preclinical pulmonary fibrosis (PrePF defined as high-resolution CT abnormalities without symptoms). Steele et al (Ann J Respir Crit Care Med 2023;207:587) completed a repeat evaluation on 296 out of 493 FDR 4 years after the first evaluation on 168 patients. They found a total of 15.8% of FDR at repeat screening. PrePF developed in 6.3% of FDR between screening studies (16 new cases out of 252) which is equivalent to an annual incidence of 1.6%. Out of 44 subjects with PrePF at baseline, 38.4% subjects had worsening dyspnoea compared with 15.4% of those without PrePF (P = 0.002). Along with the presence of PrePF, severity of fibrosis and presence of a usual interstitial pneumonia pattern at baseline were found to be risk factors for worsening dyspnoea. Finally, PrePF at the initial screening was associated with decreased survival (p < 0.001). These data suggest an approximate 100-fold increased risk of idiopathic interstitial pneumonia in FDR of patients with FPF and raises questions on the need for screening of this at-risk group but it is not known whether early intervention could alter the progression to clinical disease.

NEBULISED TOBRAMYCIN IN ADULTS WITH BRONCHIECTASIS: PSEUDOMONAL SUPPRESSION IS SAFE BUT OF LIMITED CLINICAL BENEFIT
Recurrent pseudomonal infections in patients with bronchiectasis are a challenge and inhaled antibiotics are an approved approach for prophylaxis especially in cystic fibrosis (CF) patients. However, few large-scale data exist on the efficacy of inhaled tobramycin solution. Guan and colleagues (Chest 2023;163:64) in a phase 3 multicentre randomised study assessed this question. Adults with non-CF bronchiectasis and positive sputum culture for pseudomonas aeruginosa (Pa) were randomised to inhaled tobramycin (167 patients) or usual care (172 patients). The intervention group received nebulised tobramycin (300 mg two times per day) in 28-day treatment blocks separated by a 28-day off treatment period. The usual care group received placebo saline in the same treatment blocks. Nebulised tobramycin significantly reduced the Pa density in sputum (adjusted mean difference 1.74 log10 colony forming units/g; 95% CI 1.12 to 2.33; p < 0.001) and was associated with significant improvement in quality-of-life score (quality of life in bronchiectasis respiratory symptoms score: adjusted mean difference 7.91; 95% CI 5.72 to 10.11; p < 0.001) on day-29, the coprimary outcome. It should be noted that the treatment effect on quality of life was below the established minimum clinically important difference for this test of 8. While there were some other clinical benefits in reduction in sputum volume and purulence, there was no reduction in exacerbation frequency or improvement in lung function. There were similar adverse events in both the tobramycin and placebo groups (81.6% vs 81.5%). The results provide reassuring safety data for nebulised tobramycin and some encouraging signs of a potential treatment effect but more data are needed for this to be adopted as usual clinical care.

SEQUENTIAL THIN AND ULTRATHIN BRONCHOSCOPY FOR PERIPHERAL PULMONARY LESIONS: IMPROVES DIAGNOSTIC YIELD
Peripheral pulmonary lesions (PPLs) have become a common challenge in clinical practice, especially in countries where a lung cancer screening programme is implemented. Radial probe endobronchial ultrasound (rEBUS) is the main diagnostic modality in many countries, but diagnostic yield remains suboptimal. Although, ultra-thin bronchoscopes have been shown to be of higher diagnostic yield when used, Oki et al (Respirology 2023;28:152) raised the question whether sequential ultrathin bronchoscopy with rEBUS as an add-on to thin bronchoscopy with rEBUS would be of benefit for the diagnostic yield of PPLs when the lesion cannot be visualised. In their non-randomised multicentre study, 87 out of 340 patients with PPLs proceeded to ultrathin bronchoscopy following failed visualisation of the lesion with thin bronchoscope. The successful location of the rEBUS into the lesions via the ultrathin bronchoscope was improved significantly (thin bronchoscopy 39/87, ultrathin 77/87, p < 0.001). The diagnostic yield with ultrathin bronchoscopy was significantly better than thin bronchoscopy (thin 12.6%, 11/87; ultrathin 41.4%, 36/87; p < 0.001). There are some methodological considerations when interpreting the results as this study was conducted as part of a larger randomised clinical trial examining the use of guided-sheath method during EBUS restricting the ability of the bronchoscopist to modify this part of the procedure. Notwithstanding this limitation the improved performance of ultrathin bronchoscopy indicates this technique could be a useful adjunct for lesions not visualised with rEBUS through a thin bronchoscope.

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