CONSULTANT THORACIC & ROBOTIC SURGEON · GP BRIEFING

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THE ADVANCED EMPHYSEMA SERVICE

Most of your breathless COPD patients have never had a surgical opinion. Many of them should.

For patients with severe emphysema on maximal medical therapy and completed pulmonary rehabilitation, the clinical assumption is often that nothing more can be offered. That assumption is frequently wrong. A spectrum of interventional and surgical options exists — endobronchial valve placement, lung volume reduction surgery, and lung transplantation — that can materially improve breathlessness, exercise tolerance, and quality of life in appropriately selected patients. The critical step is a comprehensive specialist assessment.

Guy's and St Thomas' NHS Foundation Trust holds NHS England national commissioning for both lung volume reduction surgery (LVRS) and endobronchial valve placement (EBV). Mr Okiror is the sole operator for both procedures at GSTT and at London Bridge Hospital, and leads a monthly specialist MDT that includes respiratory physicians, a COPD clinical nurse specialist, thoracic radiologist, nuclear medicine physician, and — uniquely — a lung transplantation physician and surgeon from Harefield Hospital. This means every patient assessed has access to the full range of options: continued medical optimisation, EBV, LVRS, or transplant listing — within a single MDT discussion.

100+	Sole	Monthly	Days
Combined LVR interventions since February 2019	Operator for EBV & LVRS at GSTT and LBH	Specialist MDT including Harefield transplant team	To intervention privately vs 4–6 months NHS

WHICH PATIENTS TO REFER

Intervention is not appropriate for all COPD patients — but the eligible population is larger than is commonly recognised. Consider specialist assessment for patients with the following profile:

- GOLD stage III–IV on maximal inhaled therapy and pulmonary rehabilitation
- Upper lobe predominant emphysema on CT with significant hyperinflation (RV >150%, TLC >100%)
- FEV1 20–45% predicted; FEV1/FVC <70%
- Significant dyspnoea (mMRC ≥2) with limited exercise tolerance
- Absence of significant bronchiectasis, active infection, or significant pulmonary hypertension
- BMI <35; adequate nutritional status
- Non-smoker or confirmed smoking cessation

V/Q SPECT-CT scanning — performed as part of the assessment workup at GSTT — provides functional heterogeneity mapping to guide target lobe selection for both EBV and LVRS. A nuclear medicine physician with specific expertise in emphysema functional imaging is a standing member of the MDT.

Patients do not need to be surgical candidates at the point of referral. The MDT assessment will determine which — if any — intervention is appropriate. GPs should refer for assessment, not for a specific procedure.

THE FOUR-OPTION MDT — ALL TREATMENTS ON THE TABLE

A monthly specialist MDT at GSTT considers every referred patient. No option is excluded before the discussion begins.

1

ENDOBRONCHIAL VALVE PLACEMENT (EBV)

Bronchoscopic placement of one-way valves to achieve lobar occlusion in patients with low collateral ventilation on Chartis assessment. NICE-recommended (TA457) and supported by the LIBERATE RCT (NEJM, 2018), which demonstrated significant improvements in FEV1, 6-minute walk distance, and quality of life at 12 months. Performed under general anaesthesia. Inpatient stay of 2–3 days for monitoring and management of the risk of post-procedural pneumothorax. Reversible — valves can be removed bronchoscopically if required.

2

LUNG VOLUME REDUCTION SURGERY (LVRS)

Surgical resection of the most destroyed emphysematous tissue, typically upper lobe predominant. Performed robotically or by VATS — no thoracotomy. Supported by the CELEB trial (Lancet, 2019), the UK's direct RCT comparison of LVRS vs EBV, which confirmed both procedures are effective in appropriately selected phenotypes. Patient selection — particularly heterogeneity of destruction and absence of target lobe collateral ventilation — determines which modality offers the greater benefit. GSTT holds NHS England national commissioning for both LVRS and EBV.

3

LUNG TRANSPLANT ASSESSMENT

For patients whose disease severity, age profile, and functional trajectory make transplant listing appropriate, the MDT includes a lung transplantation physician and surgeon from Harefield Hospital — one of the UK's two major transplant centres. This means transplant candidacy is assessed within the same multidisciplinary discussion as EBV and LVRS. No patient is referred on without this conversation having taken place.

4

CONTINUED MEDICAL OPTIMISATION

Not every patient assessed will proceed to intervention. For those who do not meet selection criteria or who choose not to proceed, the MDT provides a comprehensive review of medical management — inhaler optimisation, pulmonary rehabilitation, oxygen assessment, and palliative breathlessness strategies — with a formal structured letter to the referring clinician.

SERVICE SUMMARY

100+
Combined EBV and LVRS interventions since 2019
Sole operator GSTT & LBH

NICE
TA457 recommended EBV pathway
Nationally commissioned centre

80%+
Of LVRS performed robotically or by VATS
No thoracotomy

Days
To private intervention after full workup
vs 4–6 months NHS wait

HOW TO REFER

Refer for assessment — let the MDT determine the treatment.

Patients can be referred directly for MDT assessment without specifying a preferred intervention. A brief referral letter with recent spirometry, CT chest report, and current inhaler therapy is sufficient. Private assessments are available within 2–3 working days, with intervention typically within days of completed workup — compared to an NHS wait of approximately 4–6 months. No GP referral letter is required for private assessment; patients may also self-refer.

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LOCATIONS	London Bridge Hospital · Lister Hospital Chelsea · Canary Wharf · City of London
INSURERS	AXA · BUPA · WPA · Vitality · Cigna · Aviva · and other major insurers · Self-pay

EMPHYSEMA SURGICAL SERVICE | **LUNG NODULE PATHWAY** | **ROBOTIC SURGERY SERVICE**

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Clarity before intervention.