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Asian Pacific Association for Bronchology and Interventional
Pulmonology
(APAB)

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Newsletter



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Dear APAB Members,

It is my pleasure to present APAB News Letter No.6, and I would like to express my sincere appreciation for your continued support of the Asian Pacific Association for Bronchology and Interventional Pulmonology. Our community continues to grow through the dedication of clinicians, educators, and researchers across the Asia-Pacific region, and it is encouraging to see our shared commitment reflected in every APCB meeting.

The 10th APCB 2025, held in Taipei, was an outstanding success. Under the leadership of President Prof. Yuh-Min Chen and the Taiwan Society of Pulmonary and Critical Care Medicine, the congress brought together experts from across the region to discuss advances in interventional pulmonology, precision medicine, and emerging diagnostic technologies. The scientific sessions and hands-on workshops highlighted the rapid evolution of our field and reinforced the importance of multidisciplinary collaboration in improving patient care.

Looking ahead, the 11th APCB will take place March 2–4, 2027, at the Edsa Shangri-La in Manila, Philippines. The Manila congress will continue to expand opportunities for young investigators, strengthen regional training programs, and provide a platform for sharing innovations in bronchology and interventional pulmonology. I encourage all members to participate actively and contribute to shaping the next stage of our collective progress.

This issue also features my article, “Practical Cytological Evaluation in Bronchoscopy for Lung Cancer Diagnosis.” As precision oncology becomes increasingly central to lung cancer management, the role of bronchoscopists in obtaining high-quality cytological specimens has never been more important. The article highlights the practical value of rapid on-site evaluation (ROSE) in ensuring sample adequacy for biomarker testing, and it outlines the clinical interpretation of the newly adopted five-category cytology reporting system, particularly the categories Atypical and Suspicious for malignancy. I hope these insights will support your daily practice and strengthen diagnostic accuracy across our region.

Thank you for your dedication to advancing bronchology and interventional pulmonology throughout the Asia-Pacific. I look forward to our continued progress and to seeing many of you in Manila in 2027.

Sincerely,

Summary of 10th APCB 2025

Post Event Report for the 10th Asian Pacific Congress on Bronchology and International Pulmonology (APCB), 20th – 22th June 2025.

The 10th Asian Pacific Congress on Bronchology and Interventional Pulmonology (APCB) was held in Taipei, Taiwan. This landmark event was hosted by the Taiwan Society of Pulmonary and Critical Care Medicine (TSPCCM), which led the planning and organization of the congress.

APCB 2025 served as a premier platform for experts from the Asia-Pacific region and beyond to engage in meaningful discussions, share the latest advancements, and explore collaborative opportunities in bronchology and interventional pulmonology. Set against the vibrant backdrop of Taipei, the congress offered attendees an excellent opportunity to exchange knowledge and insights.

The congress featured an in-depth exploration of key topics in interventional pulmonology, addressing the latest advancements and techniques. Attendees delved into cutting-edge approaches for diagnosing and treating peripheral lung nodules, essential mediastinal staging through EBUS-TBNA, and innovative procedures for managing COPD and asthma.

The program also covered strategies for central airway obstruction, advances in navigational bronchoscopy, and the evolving role of pleuroscopy in pleural disease.

Pediatric bronchoscopy, including airway anomaly management, was also a significant focus, ensuring comprehensive coverage of the field.

The congress was attended by 966 delegates, including 105 International Delegates and 861 Taiwanese Delegates from Asian-Pacific countries. The 10th APCB was a successful congress that provided a valuable forum for the exchange of knowledge and ideas in the field of interventional pulmonology. The congress is expected to be held again in 2027 in Manila, Philippines.

Grand Opening and Distinguished Leaders

The congress officially commenced with a grand opening ceremony on **June 21, 2025**. The event was highlighted by the presence of several distinguished figures, including:

- **Prof. Pyng Lee**, President of the World Association for Bronchology and Interventional Pulmonology (WABIP), who delivered a keynote address.
- **Prof. Kiyoshi Shibuya**, President of the Asian Pacific Association for Bronchology and Interventional Pulmonology (APAB), who also addressed the delegates.
- **Prof. Yuh-Min Chen**, 2025 APCB President.
- **Dr. Chao-Chi Ho**, Congress Chairman, and key organizing members **Dr. Chih-Yen Tu** (Congress Secretary General) and **Dr. Kun-Ta Chou** (TSPCCM Secretary General).



Plenary Focus: The Future of the Field

A major highlight of the scientific program was the Plenary Session held in Room 101. The session featured world-renowned expert Dr. Felix Herth, who delivered critical keynote lectures titled “Unmet Needs in Interventional Pulmonology” and “Future of Interventional Pulmonology.”

Chaired by Dr. Kiyoshi Shibuya, the session provided attendees with Dr. Herth’s insightful perspectives on the field’s future development and the clinical challenges faced by specialists.



Dr. Fernandez-Bussy, a distinguished authority in interventional pulmonology, delivered a comprehensive keynote address including the value of the Ion robotic bronchoscopy system and the future of pulmonology.

Hands-On Learning in Workshops

The congress placed a strong emphasis on practical skills and emerging technologies through a dedicated workshop. Leading specialists demonstrated cutting-edge techniques, including:

- **Dr. Sonali Sethi on Augmented Fluoroscopy.**



- **Dr. Noriaki Kurimoto presenting on Bronchial Tracing.**



- **Dr. Yei-San Hsieh discussing The Role of Rigid Bronchoscopy for the Management of Central Airway Obstruction.**



Looking Ahead to Manila

The congress officially concluded with the closing ceremony, which included the traditional passing of the host torch. Congress Chairman Dr. Chao-Chi Ho formally passed the responsibility to Dr. Julius Dalupang of the Philippines, signaling the next congress destination. This transfer of leadership confirms that the next edition of the APCB is anticipated to be held in Manila, Philippines, in 2027, ensuring the ongoing collaboration and advancement of interventional pulmonology across the Asia-Pacific region.



11 th APCB Manila, Philippines, on March 2 to 4, 2027

Please save the date for the 11th Asian Pacific Congress on Bronchology and Interventional Pulmonology, which will be held on March 2 to 4, 2027 at the Edsa Shangri-La, Manila, Philippines. This will be a joint event with the 46th Annual Chest Convention of the Philippine College of Chest Physicians.

We are excited to bring you opportunities for in-depth learning and engagement through hands-on workshops, scientific sessions, and research presentations. Interesting updates on malignant and benign diseases involving the airways, lung parenchyma, mediastinum and pleura will be discussed by leading experts. Advanced and innovative techniques and approaches in the diagnosis and management of these diseases will also be presented.

Meet and engage with new and old friends who share the same passion in the field. Beyond these, explore the vibrant culture, stunning attractions of Manila and its surrounding islands, and experience the world-famous brand of Filipino hospitality.

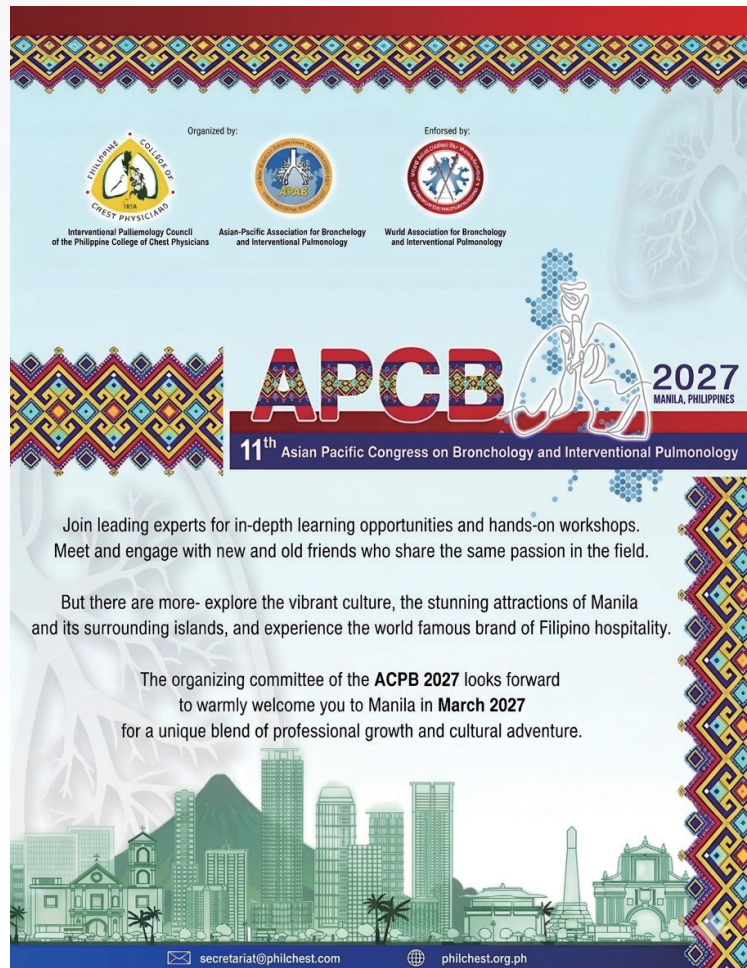
The organizing committee of the Philippine College of Chest Physicians, in collaboration with the Asian-Pacific Association for Bronchology and Interventional Pulmonology and with the endorsement of the World Association for Bronchology and Interventional Pulmonology, looks forward to warmly welcome you to Manila in March 2027 for a unique blend of professional growth and cultural adventure.






Julius J. Dalupang,
Chair



Christine L. Chavez, Co-chair
APCB 2027 Organizing Committee



Organized by:  **Philippine College of Chest Physicians**
 Interventional Pulmonology Council of the Philippine College of Chest Physicians

Enforced by:  **Asian-Pacific Association for Bronchology and Interventional Pulmonology**
 **World Association for Bronchology and Interventional Pulmonology**

APCB 2027
 MANILA, PHILIPPINES

11th Asian Pacific Congress on Bronchology and Interventional Pulmonology

Join leading experts for in-depth learning opportunities and hands-on workshops. Meet and engage with new and old friends who share the same passion in the field.

But there are more- explore the vibrant culture, the stunning attractions of Manila and its surrounding islands, and experience the world famous brand of Filipino hospitality.

The organizing committee of the **APCB 2027** looks forward to warmly welcome you to Manila in **March 2027** for a unique blend of professional growth and cultural adventure.

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Practical Cytological Evaluation in Bronchoscopy for Lung Cancer Diagnosis



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 Kiyoshi Shibuya, M.D. Ph.D.

INTRODUCTION

Bronchoscopy is an essential procedure in the diagnosis and management of lung cancer. Bronchoscopists routinely insert endoscopes of various calibers into the trachea and bronchi to diagnose and treat respiratory diseases. With continuous advancements in endoscopic accessories, clinicians can now estimate access routes to lesions, devise new approaches, and collect cellular and tissue samples for cytological, histopathological, microbiological, and even cutting-edge genetic analyses. In this lecture, I will present practical aspects of cytology in bronchoscopy, focusing on the following two topics:

1. The significance of rapid on-site evaluation (ROSE)

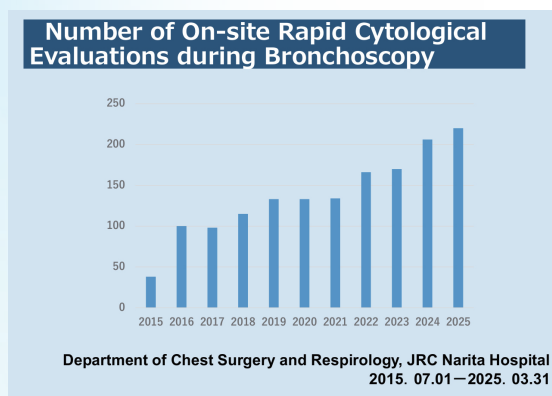
2. Practical application of the newly defined diagnostic categories for respiratory cytology as outlined in the revised 9th edition of the General Rules for Clinical and Pathological Record of Lung Cancer (January 2025), with particular emphasis on the cytological features and clinical interpretation of the categories “Atypical” and “Suspicious for malignancy,” illustrated with case examples.

1. The Significance of Rapid On-Site Evaluation (ROSE)

At the Department of General Thoracic Surgery, Graduate School of Medicine, Chiba University (formerly the First Clinical Research Division of the Chiba University Lung Cancer Research Institute), where I trained, ROSE was routinely performed during bronchoscopic procedures. In suspected lung cancer cases, transbronchial fine needle aspiration cytology (TBAC) was initially performed, and the prepared smears were promptly delivered to the cytopathology unit for evaluation (not yet on-site at the time). Cytotechnologists stained the samples using Cyto Quick or Diff-Quik methods and examined them microscopically. The presence or absence of malignant cells was immediately determined, guiding subsequent procedures such as bronchial brushing, cytology, or transbronchial lung biopsy. If malignant cells were not identified, TBAC was repeated.

This environment enabled bronchoscopists to directly observe and diagnose cytological specimens under the microscope. After my appointment at Narita Red Cross Hospital in July 2015, with the full cooperation of our cytotechnologists, we implemented on-site ROSE during bronchoscopic procedures (Figures 1. Rapid on-site evaluation (ROSE) during bronchoscopy.

Five cytotechnologists rotate to provide on-site support, with one assigned to the bronchoscopy suite at a time. Using Diff-Quik staining, they perform immediate evaluations. The stained specimens are examined on-site to assess sample adequacy, cellularity, and the presence of atypia.



In addition to improving diagnostic accuracy, the benefits of ROSE can be summarized in four key points:

(1). Improved Sample Quality

In the current era where biomarker testing is essential, ROSE allows real-time confirmation of whether high-quality and sufficient samples have been obtained (1).

(2). Reduced Patient Burden

If malignant cells are not detected, additional sampling may be required, possibly from different bronchial sites. ROSE helps minimize the number of sampling attempts and may prevent the need for repeat bronchoscopies on separate days.

(3). Educational Value for Operators

Real-time observation of cytological features allows estimation of tumor type (e.g., adenocarcinoma, squamous cell carcinoma, or small cell lung cancer) and assessment of the appropriateness of the puncture site, thereby contributing to skill development.

(4). Timely Adjustment of Diagnostic Strategy

In rare cases, suspected lung cancer may turn out to be lymphoma or granulomatous disease. ROSE enables immediate preparation for flow cytometry using unfixed specimens.

Numerous domestic and international studies have demonstrated the utility of ROSE (2-4). Nakajima et al. reported that among 438 lung cancer patients undergoing EBUS-TBNA, the nondiagnostic rate was 4.0% across 965 lymph nodes, with a 94.3% concordance rate between ROSE and final diagnosis, zero false positives, and a diagnostic accuracy of 98.2%. Oki et al., in a prospective randomized trial, showed that ROSE significantly reduced the number of punctures (mean 2.2 vs. 3.1, $p < 0.001$) and the rate of additional testing for non-primary lesions (11% vs. 57%, $p < 0.001$). Barisione et al. reported an 82.7% concordance rate between endoscopist-performed ROSE and pathologist evaluation, suggesting its utility even in resource-limited settings. These findings support the value of ROSE in improving diagnostic accuracy, procedural efficiency, and operator education.

2. Newly Defined Diagnostic Categories in Respiratory Cytology

The 9th edition of the General Rules for Clinical and Pathological Record of Lung Cancer, published in January 2025, revised the diagnostic categories for respiratory cytology based on the 2022 WHO Reporting System for Lung Cytopathology. The traditional three categories (Negative, Suspicious, Positive) used since 1978 were replaced with five categories: Unsatisfactory, Negative, Atypical, Suspicious for Malignancy, and Malignant (5). Although the use of the Papanicolaou classification was officially discouraged, some institutions continued to use or reference it in practice (6). (Figure 2: Transition of cytology report format from three categories to five categories).

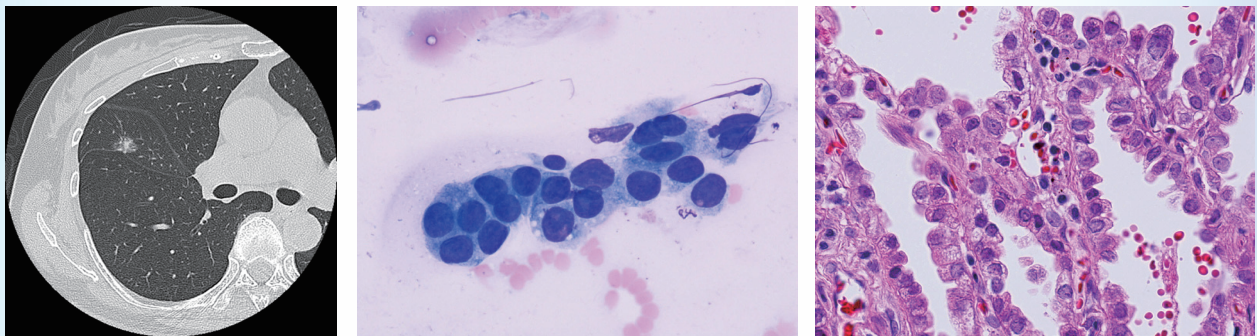
Transition of cytology report format from three categories to five categories

Three Categories		Five Categories		Papanicolaou (corresponding)
		Unsatisfactory		
Negative		Negative (benign)		I,II
Suspicious	Suspicious for malignancy; unable to determine benign versus malignant.	Atypical	predominantly seen in benign lesions and minimal features that may raise the possibility of a Malignant lesion, but with insufficient features either in number or quality to diagnose a benign or Malignant process or lesion	IIIa
Suspicious	Suspicious for malignancy; unable to determine benign versus malignant.	Suspicious for malignancy	suggestive of malignancy but with insufficient features either in number or quality to make an unequivocal diagnosis of malignancy	IIIb
Positive	Malignant	Malignant cells	Unequivocally Malignant	IV,V

Among the five categories, “Atypical” and “Suspicious for malignancy” require particularly cautious clinical interpretation.

『Atypical』

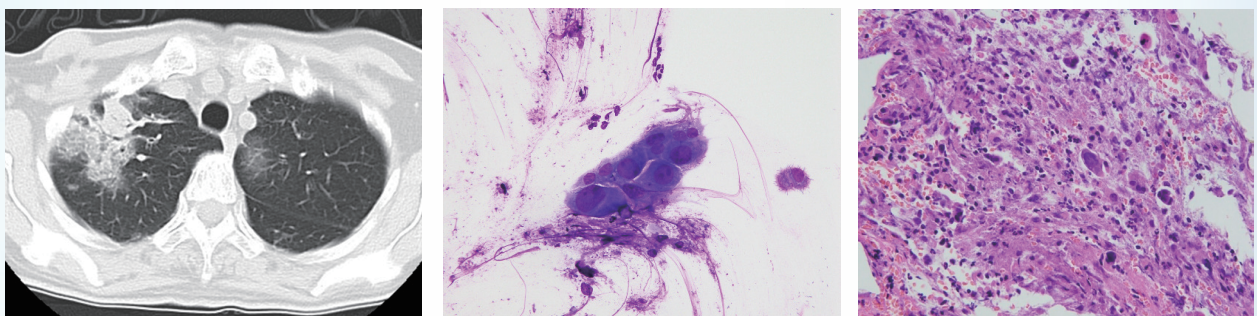
A specimen categorized as “Atypical” demonstrates features predominantly seen in benign lesions and minimal features that may raise the possibility of a Malignant lesion, but with insufficient features either in number or quality to diagnose a benign or Malignant process or lesion (7). Atypia may arise from acute or chronic irritation due to inflammation, smoking, radiation, chemotherapy, or viral infection, and can be observed in all respiratory cell types, including stratified squamous epithelium, bronchial epithelium, bronchiolar epithelium, alveolar epithelium, and alveolar macrophages. Distinguishing between neoplastic transformation and reactive changes from normal to atypical cells is critical (5). The 9th edition presents four cases of “Atypical” cytology, including atypical type II pneumocytes, alveolar macrophages, bronchial epithelial cells, and squamous metaplasia—none of which were lung cancer cases. However, the WHO system notes that precursor lesions of squamous cell carcinoma and adenocarcinomas presenting as ground-glass opacities on CT may fall into the “Atypical” category (7). At our institution, we have classified some cases with flat sheet-like atypical cells observed in bronchoscopic cytology of adenocarcinoma in situ and minimally invasive adenocarcinoma as “Atypical,” in Figure 3: TABC specimen diagnosed as “Atypical”: a sheet-like cluster of a few atypical cells with round to oval nuclei; final diagnosis: adenocarcinoma in situ.



Comparative examples of non-malignant atypical cases are shown in Figure 4.

Bronchial brushing cytology specimen diagnosed as “Atypical”: atypical cells with round to oval nuclei and low nuclear-to-cytoplasmic ratio; final diagnosis: inflammatory changes with marked cellular degeneration.

Inflammatory changes with marked cellular degeneration: prominent cellular breakdown with intermixed epithelial cells showing enlarged, hyperchromatic nuclei. Pulmonary tissue architecture is disrupted and difficult to assess. (BAL positive for Aspergillus antigen.)



『Suspicious for Malignancy』

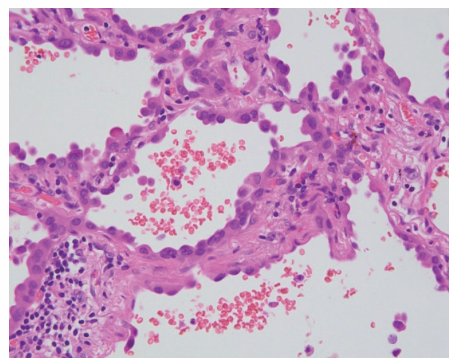
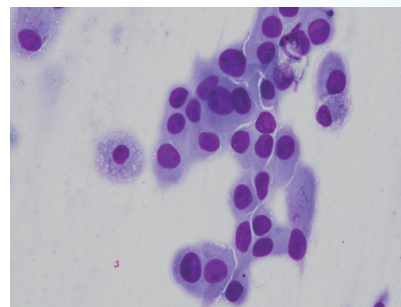
A specimen categorized as “Suspicious for malignancy” demonstrates some cytopathological features suggestive of malignancy but with insufficient features either in number or quality to

make an unequivocal diagnosis of malignancy. The category “Suspicious for malignancy” is generally used in respiratory cytopathology to indicate a degree of uncertainty regarding the diagnosis of malignancy and offers a risk stratification for a Malignant diagnosis. This category is often used when there is insufficient quality or quantity of cellular material in an adequate specimen for a definite diagnosis of malignancy (7).

The 9th edition presents three such cases:

1. Suspected adenocarcinoma with very few suspicious cells
2. Suspected adenocarcinoma with weak atypia
3. Suspected non-small cell carcinoma with marked degenerative changes due to chemotherapy

The WHO system also notes that well-differentiated adenocarcinomas with a lepidic pattern may yield flat sheets of cells with low nuclear atypia, often categorized as “Suspicious for malignancy.” This category is known for high interobserver variability, depending on the cytopathologist’s experience, specimen type, and degree of atypia. At our institution, we have classified many cases with flat sheet-like atypical cells observed in bronchoscopic cytology of adenocarcinoma in situ, minimally invasive adenocarcinoma, and lepidic adenocarcinoma as “Suspicious for malignancy” (Figure 5. TABC specimen diagnosed as “Suspicious for malignancy”: a sheet-like cluster of atypical cells with round nuclei showing variation in inter-nuclear distance; final diagnosis: lepidic adenocarcinoma.



In both categories, correlation with clinical and imaging findings is essential, and detailed discussions between clinicians and cytopathologists are crucial. Cell block specimens, histopathological diagnosis, and immunohistochemistry may be required to determine whether observation or treatment is appropriate.

Conclusion

This presentation has outlined the implementation of ROSE in bronchoscopy and the practical application of the newly defined diagnostic categories in respiratory cytology, with a focus on “Atypical” and “Suspicious for malignancy.” Respiratory cytology plays a pivotal role in diagnostic accuracy, and close collaboration between clinicians and cytopathologists enhances its clinical relevance and practical value.

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Postscript



Takehiko Fujisawa, M.D., Ph.D.
(Chiba Foundation for Health Promotion and Disease Prevention)

The newsletter included the summary of the last APCB, the message of the next Congress, and President Shibuya's cytological diagnosis of lung cancer.

I am really glad to know that 10th APCB was held under the direction of President Yuh-Min Chen, resulting in active and fruitful discussion. Eleventh APCB will be held by Chair Julius J. Dalupang and co-chair Christne L. Chavez, under the auspices of Philippine College of Chest Physicians in Manila, March, next year.

I am looking forward to attendance of the members of APAB as many as possible. The mission of the APCB is to contribute further progress of the art and science of bronchology and interventional pulmonology in the Asian-Pacific region, and spread them all over the world. Continuity is the father of success. I strongly hope that APCB will continue forever with your strong cooperation and support.



CURIOSITY 発見はいつも 好奇心から。

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