August 31, 2023

CTS INSPIRATIONS

CTS NEWS

President's Message

Dear CTS Community:

March 19, 2023 marked the conclusion of the 2023 CTS Annual Educational Conference in Monterey, CA. For three days we featured esteemed speakers, non-CME events on topics such as well-being and women in PCCSM, a trainee reception and poster session, and welcomed the most attendees we've ever had. That evening, our executive office and committee sat around a conference table on circus-striped chairs to resume strategic planning for CTS. Our first task that night was to update our mission statement.

We pondered observations, criticisms, plaudits, and aspirations compiled from stakeholder interviews. We drafted a contemporaneous statement and included three declarations:

The California Thoracic Society (CTS) is a professional society committed to improving California lung health and advancing the science and practice of pulmonary, critical care, and sleep medicine through advocacy and education.

We elevate, nurture, and support the professional development of future clinicians, educators, scientists, and leaders.

We value Diversity, Equity, Inclusion, and Belonging.

We foster collaboration between multidisciplinary professionals essential to lung health.

These statements reflect our values, assert our societal identity, rededicate us to whom we serve (you), and define why we—the largest chapter of the American Thoracic Society--exist.

A smattering of announcements:

- We've entered a new chapter agreement with the American Thoracic Society (ATS). Thank you to our Council of Chapter Representatives (CCR) Drs. Nick Kolaitis and Ni-Cheng Liang (overall ATS CCR chair) for negotiating on our behalf and for leading this effort.

- On 4/21/2023 CTS and the ATS submitted a joint letter to the California Attorney General's Office alerting them that the tobacco industry had been marketing products containing WS-3, a synthetic menthol-derivative cooling agent, as "non-menthol" to circumvent the California Senate Bill (SB)-793 menthol product sale ban. On 5/3/2023 the California Department of Justice responded by notifying RJ Reynolds Tobacco Company and ITG Brands, LLC that products made with WS-3 shall henceforth be considered menthol-containing products and banned under SB-793.

- CTS Education Committee Chair Dr. Shazia Jamil and our CTS fellows Dr. Solmaz Afshar and Dr. Laura Glassman are busy preparing a panel event featuring PCCSM Division Chiefs and fellowship program directors. The goal of this special program is to share professional development wisdom with fellow-level PCCSM trainees. We hope you can join us on September 29th 2023!

- Wayne A. Walls MBA, RRT-ACCS, RRT-NPS, RCP is passing the California Society for Respiratory Care (CSRC) presidency to Jolene Burgess MBA, BSRT, RRT-NPS. Thank you, Wayne, for your leadership and partnership! Congratulations, Jolene, we look forward to working with you!

- In March 2023, the California Respiratory Care Foundation (CRCF) was taken under the umbrella of the CSRC. The CRCF supports the education of respiratory care practitioners and research in respiratory care. Please learn more https://www.csrc.org/crcf-foundation.

- Congratulations and appreciation to friends of CTS Chris Garvey FNP, MSN, MPA, FAACVPR (CTS President 2018-2019), Trina M. Limberg RRT, FAARC, MAACVPR, and Abebaw M. Yohannes PhD for their roles in publishing the long-awaited ATS Clinical Practice Guideline (CPG) for pulmonary rehabilitation for adults with chronic respiratory disease. Pulmonary Rehabilitation for Adults with Chronic Respiratory Disease: An Official American Thoracic Society Clinical Practice Guideline | American Journal of Respiratory and Critical Care Medicine (atsjournals.org)

- Compassion for the those affected by storm-related disasters here in the U.S., around the world, and current catastrophic flooding in Libya.

- Our Colleague and friend, Dr. Christine Fukui, shares thoughts from Hawaii:

  I feel a special connection to Lahaina as I went there monthly to see patients at a small Kaiser clinic two blocks from Front Street, which is on the ocean where all the buildings burned. The clinic has also burned down to the ground. I'm still in contact with my nurse who fortunately lives in Wailuku on the other side of Maui. In the past, Lahaina and Maui did not depend on tourism; they depended on sugar. All of Lahaina "mauka" (towards the mountains) was sugar cane. Pioneer Mill's smokestack can still be seen after the fires. The Kaiser clinic was built there because the sugar workers wanted healthcare. I have stayed at the historic Pioneer Inn and have walked a lot on Front Street. It's hard to imagine it is all gone. The buildings on the "makai" (ocean side) of Front Street were old wooden structures built over the water. There were great restaurants like Cheeseburger in Paradise there. Those buildings will never be rebuilt in the same way. I'm afraid "old" Lahaina town is lost.

  For those who may want to know about tourist travel to Maui: At present avoid West Maui i.e. Lahaina. The areas past Lahaina, Nāpili and Kapalua were not affected by the fire. Right now, the Kapalua Resort evacuated all 1,000 guests and is housing employees, FEMA workers etc. All other areas such as Kihei and Wailea are open and need your support. Pray for the people of Lahaina; when you read the individual personal stories it just breaks your heart.

  The best way to help is monetary contribution. I would be careful as there are lots of scammers out there.

  I have given to the Hawaii Community Foundation at https://www.hawaiicommunityfoundation.org/. Other good organizations include the American Red Cross (you can donate to Maui at https://www.redcross.org/) and the Aloha United Way at https://www.auw.org.

Dr. Fukui is a retired Kaiser PCCSM physician who served "for decades" as the Hawaii Thoracic Society representative on the ATS Council of Chapter Representatives (CCR). Dr. Fukui trained at UCSF as a medical student, resident, chief resident, and fellow before returning to care for the citizens of Hawaii in 1980.

I wish you all a safe and inspired fall season.

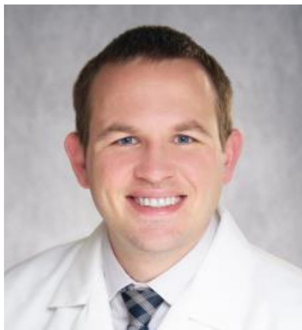
Respectfully yours,

George Su

Thanks to our newsletter Editor in Chief Angela Wang MD!

The CTS Inspirations Newsletter editorial staff including Sachin Gupta, Florence (Flo) Chau-Etchepare, Erica Lin and Chris Garvey extend our heartfelt thanks to Angela Wang MD, our newsletter Editor in Chief for several years. Angela also served as CTS president from 2015-2017 during the society's most challenging time. Angela's newsletter leadership embodied her tireless dedication to CTS' vision, as well as her scholarly ideology and collaborative approach to improving pulmonary care, science and the needs of our California community. Angela has been a mentor to countless clinicians, including those on this editorial team. Her leadership will be missed. We wish you all the best, Angela!

Lung Cancer Screening in California – A Call to Action



Bryce Duchman, MD and Mark Fuster, MD

Division of Pulmonary, Critical Care, Sleep Medicine, & Physiology, University of California, San Diego

- Lung cancer is the leading cause of cancer death, and low-dose CT lung cancer screening (LDCT LCS) is effective at greatly augmenting the ability to diagnose lung cancer at Stage I and reducing lung cancer mortality.
- USPSTF LCS guidelines were expanded in 2021 to include individuals aged 50-80 years old with 20 or more lifetime pack-years exposure that are current smokers or quit within the last 15 years.
- Among all states, California has the worst rate of LCS utilization in the entire nation with only 1% of Californians eligible for LCS being screened. We must improve implementation for all eligible groups while recognizing an especially grave problem of elevated risk plus reduced access among certain minority groups.
- Targeted interventions are necessary to overcome multi-leveled barriers to LCS to improve LCS implementation, particularly in vulnerable and/or underserved populations.

Lung cancer remains by far and away the leading cause of cancer death in the United States, accounting for 21.4% of all cancer deaths [1]. This is largely because lung cancer is the 3rd most common cancer in the U.S., characterized by high metastatic aggression, and is typically diagnosed late – with 55% of patients already having metastatic disease at the time of diagnosis [2]. In addition to tobacco cessation program efforts, steps to improve lung cancer mortality include screening to diagnose the disease at earlier and potentially curative stages, improving lung cancer treatments overall, and improving access to said treaments. Regarding lung cancer screening (LCS), the National Lung Screening Trial (NLST) demonstrated that low-dose computed tomographic (LDCT) LCS in high-risk populations is effective at identifying lung cancer lesions, more frequently diagnosing lung cancer at stage I, and reducing lung cancer mortality by 20% [3]. The NELSON LDCT LCS trial confirmed similar findings, reducing 10-year lung cancer mortality by 24% [4].

The American Lung Association (ALA) recently published its 2022 State of Lung Cancer report [5], which is the first time the annual report includes screening data since the USPSTF's revised and expanded 2021 LCS guidelines. The USPSTF guidelines were expanded to include individuals aged 50-80 years old (previously 55-80 years old) with 20 or more lifetime pack-years exposure (previously 30 or more pack-years) that are current smokers or quit within the last 15 years [6]. The State of Lung Cancer report also demonstrates that implementation of LCS programs to reach eligible high-risk individuals remains extremely low, particularly in California, along with highlighting several other areas in need of improvement [5].

Fortunately, California has the nation's 2nd lowest smoking rate (9%) and 3rd lowest lung cancer incidence rate (40 per 100,000). California Medi-Cal also covers LCS without requiring prior authorization or copays, and, as of 1 year ago, Medicare expanded its coverage to match the new 2021 USPSTF recommendations. These expanded coverages should theoretically improve access to LCS in California. However, among Californians that qualify for LCS per USPSTF guidelines, 2021 screening data showed that **only 1% of these high-risk individuals are being screened**. This was the worst rate in the entire U.S. In contrast, the 2021 national screening rate was 6%, while the best rate for a state was 16% (Massachusetts). These rates are still unacceptably low, but substantially better than 1%. In addition, California ranks 46th for patients with lung cancer receiving no treatment, with 26% of cases not receiving any treatment. In comparison, the national average is 21%, and the best rate for a state is 14% (North Dakota) [5].

Lung Cancer in California Compared to the Nation (2021 data) [05]:

	National Avg	Best State	California
Incidence of Lung Cancer (per 100,000)	57	27	40
5-Year Survival Rate	25%	31%	25%
Early/Localized Stage at Time of Diagnosis	26%	32%	25%
Cases Treated with Surgery	21%	31%	22%
Cases with No Treatment	21%	14%	26%
Screening of High-Risk Persons	6%	16%	1%

It is also important to note that the majority of LDCT LCS trials included very few minorities. For instance, the NLST only included 4% Black Americans and 2% Latinx Americans [3]. Many of the European LCS trials did not provide racial/ethnicity data and likely incorporated even fewer minorities. Therefore, the generalizability of recommendations based on these studies to minority populations is debatable. Indeed, prospective data on incident lung cancer in southern California suggest that Black Americans are more likely to be diagnosed with lung cancer at an earlier age and/or fewer pack-years exposure than White Americans [7]. Moreover, secondary analysis of NLST data suggests that the mortality-reduction benefit of LCS is more favorable in Black Americans than White Americans [08]. For instance, models that take race into account (along with other criteria), such as the PLCOm2012, demonstrate that some Black Americans less than 55 years old and/or with fewer than 30 lifetime pack-years had a higher risk of lung cancer than some White Americans that qualified for screening per USPSTF 2013 guidelines [9] [10]. In fact, the USPSTF's 2021 revision was done at least in part to address such disparities and inequities [11]. However, guidelines based solely

on age, pack-years, and quit-years cannot eliminate disparities due to racial/ethnic and sex differences [12].

Unfortunately, more recent data from California, and much of the nation, continue to reverberate racial disparities and inequities. Notably, the State of Lung Cancer report demonstrates that Black Americans in California have a higher incidence of lung cancer, a lower likelihood to be diagnosed at an early stage, a lower rate of surgery, a higher rate of no treatment, and a lower 5-year survival rate compared to White Americans in California. Latinx Americans in California have a lower rate of surgery and a higher rate of no treatment compared to White Americans in California. Nationwide, Latinx Americans also have a lower 5-year survival rate compared to White Americans [5]. The State of Lung Cancer did not report on differences in screening rates between races/ethnicities. However, numerous prior studies have well documented that vulnerable populations, including Black Americans, are less likely to undergo LCS than White Americans [13].

Racial Differences Within California Populations [05]:

	Black Americans	Latinx Americans	White Americans
Incidence of Lung Cancer (per 100,000)	51	24	46
5-Year Survival Rate	21%	N/A	25%
Early/Localized Stage at Time of Diagnosis	22%	21%	27%
Cases Treated with Surgery	18%	20%	23%
Cases with No Treatment	29%	30%	25%

Barriers to LCS are present at multiple levels, including at the patient, provider, and healthcare-system levels [14]. Strategic interventions are necessary to overcome these barriers and increase overall LCS utilization, particularly in vulnerable and/or underserved populations, such as Black Americans. ATS has published a statement addressing this issue, recommending a multipronged approach with the concurrent implementation of outreach, education, telehealth, patient navigators, and health-equity performance monitoring to address disparities in LCS. Rivera, et al address many important points, including improving access to tobacco treatment, allocating resources toward LCS education/awareness of providers and underserved patient groups, integrating LCS coordinators and patient navigators to systematically address barriers, generating LCS evidence in diverse populations, and addressing differences in cultural beliefs, language, and literacy [13]. Patient navigators would help all populations, but particularly those with multiple barriers and access issues, which are more likely to occur in underserved minority groups. Further, tobacco treatment should always be addressed alongside LCS discussions. This is particularly important for populations with higher tobacco use rates, such as Black Americans [7], because smoking cessation has a greater mortality benefit than lung cancer screening [6].

Overall, the ALA's State of Lung Cancer report laid bare some critical deficiencies when it comes to lung cancer screening, diagnosis, and treatment in California. The report also highlighted important discrepancies between racial/ethnic groups, most notably for Black Americans in California. Lung cancer remains the leading cause of cancer death, and LDCT LCS is an effective tool for diagnosing lung cancer more frequently at stage I and reducing lung cancer mortality. Thus, we must work hard to address barriers at our respective institutions to improve LCS for all high-risk patients, especially for patients in vulnerable populations.

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CSRC CORNER

Women in Leadership- Meet the Incoming CSRC Executive Board

By Krystal Craddock MSRC, RRT, RRT-NPS, AE-C, CCM

On September 1st, the CSRC begins their new year with an all-female leadership team. This will be the first time in our history that only women hold the president, vice president, secretary, treasurer positions and the majority of the CSRC Executive BOD. These women are bringing energy and new exciting ideas to promote the profession and meet the needs of the CSRC members. In beginning this term, the CSRC will also be releasing their new strategic plan which was created by a diverse group of CSRC members and leaders. The CSRC thanks past-president Wayne Walls for his leadership and mentorship. His initiative to support the creation and release of the CSRC RT Preceptor Program will also be revealed after September 1st. If you're a member of the CSRC and interested in volunteering, please contact one of the board members on our website: https://www.csrc.org/board-of-directors.

Jolene Burgess – President

Jolene is the incoming CSRC President coming from the Treasurer position she held these past two years. She began her respiratory career in 2003 in Northern California. She currently holds the position of Manager of Respiratory Care Services and Neurodiagnostics at Enloe Medical Center in Chico. She holds both a BSRC and MBA from Boise State University. Jolene has a passion for Leadership and believes a good Leader works for their people, supporting them in safe patient practices, standard of care, and evidence-based medicine. When she isn't volunteering for CSRC, Jolene can be found gardening in her yard, spending time with her family, and traveling.

Theresa Cantu – Vice President

Theresa continues as the Vice President of the CSRC. She is a Pediatric Clinical Respiratory Specialist at Valley Children's Medical Center, a 358 bed free-standing children's healthcare organization. She holds a graduate degree in Respiratory Care from Boise State. Theresa focuses her work in quality improvement and research measures, focusing on the ED treatment of asthma exacerbations and HFNC weaning in bronchiolitis. Her passion is to improve outcomes in a rural area health system serving 1.3 million children. She also has served as the Government Affairs Committee chair for the CSRC since 2019.

Krystal Craddock – Secretary

Krystal is the Clinical Programs Manager and COPD Case Management Coordinator at UC Davis Health. Her favorite part of her position is the direct patient care she provides as part of the interdisciplinary team in the University of California Asthma Network (UCAN) Clinic, case managing in the UC Davis Comprehensive COPD Clinic Endobronchial Valve Program and RPM Program. She received her graduate degree in Respiratory Care from Boise State, along with her colleague Theresa Cantu, in 2020. Her quality improvement research focuses on patient outcomes, especially those with COPD, as well as the impact RT's working in transition of care and ambulatory settings can have on these outcomes. She continues her second year as Secretary and continues as the chair for the Professional Advancement Committee and CTS Liaison.

Jacqueline Crum – Treasurer

Jacqueline is the Director of Respiratory Care, Electrocardiology, Neurodiagnostics, and Rehab Services at Mercy Medical Center, a 267-bed facility in Redding. She holds a Master of Science in Allied Health and a Bachelor's of Respiratory Care. She has also obtained her Neonatal Pediatric Specialist credential as well as the Adult Critical Care Specialist credential. She enjoys working for a facility that provides a broad variety of services to rural communities that serve approximately 9 counties, covering 6000 square miles. She is the newest member to the Executive Board of the CSRC.

Southwest Journal of Pulmonary Critical Care and Sleep SWJPCC:

Robbins RA. Who Should Control Healthcare? Southwest J Pulm Crit Care Sleep. 2023;27(3):33-35.
doi: https://doi.org/10.13175/swjpccs039-23
The editorial has been posted on the Southwest Journal of Pulmonary, Critical Care & Sleep web site https://www.swjpcc.com/editorials/2023/9/3/who-should-control-healthcare.html.
FOR ALL SUBSEQUENT CORRESPONDENCE OR QUESTIONS REGARDING THIS MANUSCRIPT, IT IS IMPORTANT THAT YOU CONTACT THE EDITOR AT rickrobbins@cox.net; swjpcc@cox.net; or https://www.swjpcc.com/contact-the-editor/

The SWJPCCS for 1-1-23 to 7-20-23 continue on the next page.

SWJPCCS 1-1-23 to 7-20-23							
Title (Click on title to open the manuscript)	Journal Section	First Author	Year	Vol	Issue	Pages	Date Posted
Book Review: One Hundred Prayers: God's answer to prayer in a COVID ICU	Editorials	Robbins RA	2023	27	1	14	7/17/23
The Two-Digit Rule and Winter's Formula	Correspondence	Raschke RA	2023	27	1	11-13	7/10/23
One Example of Healthcare Misinformation	Editorials	Robbins RA	2023	27	1	8-10	7/4/23
Kern County Hospital Authority Accused of Overpaying for Executive Services	News	Robbins RA	2023	27	1	7	7/3/23
July 2023 Medical Image of the Month: Primary Tracheal Lymphoma	Imaging	Jokerst C	2023	27	1	4-6	7/2/23
July 2023 Sleep Case of the Month: Fighting for a Good Night's Sleep	Sleep	Bright M	2023	27	1	1-3	7/1/23
A Case of Progressive Bleomycin Lung Toxicity Refractory to Steroid Therapy	Pulmonary	Dossett CS	2023	26	6	90-96	6/10/23
June 2023 Medical Image of the Month: Solitary Fibrous Tumor of the Pleura	Imaging	Jokerst C	2023	26	6	87-89	6/2/23
June 2023 Pulmonary Case of the Month: An Invisible Disease	Pulmonary	Wesselius LJ	2023	26	6	83-86	6/1/23
May 2023 Medical Image of the Month: Methamphetamine Inhalation Leading to Cavitary Pneumonia and Pleural Complications	Imaging	Ghiassi K	2023	26	5	80-82	5/2/23
May 2023 Critical Care Case of the Month: Not a Humerus Case	Critical Care	Ogle CS	2023	26	5	76-79	5/1/23
Doctor and Nurse Replacement	Editorial	Robbins RA	2023	26	4	72-75	4/24/23
Essentials of Airway Management: The Best Tools and Positioning for First-Attempt Intubation Success (Review)	Critical Care	Schmitz ED	2023	26	4	61-69	4/9/23
SWJPCCS Associate Editor has Essay on Reining in Air Pollution Published in NY Times	News	Robbins RA	2023	26	4	59-60	4/3/23
April 2023 Medical Image of the Month: Atrial Myxoma in the setting of Raynaud's Phenomenon: Early Echocardiography and Management of Thrombotic Disease	Imaging	Mahdi AA	2023	26	4	56-58	4/2/23
April 2023 Imaging Case of the Month: Large Impact from a Small Lesion	Imaging	Gotway MB	2023	26	4	48-55	4/1/23
Associations Between Insomnia and Obstructive Sleep Apnea with Nutritional Intake After Involuntary Job Loss	Sleep	Batool-Anwar S	2023	26	3	37-47	3/4/23
Combating Physician Moral Injury Requires a Change in Healthcare Governance	Editorial	Robbins RA	2023	26	3	34-36	3/3/23
March 2023 Medical Image of the Month: Spontaneous Pneumomediastinum as a Complication of Marijuana Smoking Due to Müller's Maneuvers	Imaging	Mahmoud KA	2023	26	3	31-33	3/2/23
March 2023 Critical Care Case of the Month: A Bad Egg	Critical Care	Robbins RA	2023	26	3	28-30	3/1/23
How Much Should Healthcare CEO's, Physicians and Nurses Be Paid?	Editorial	Robbins RA	2023	26	2	24-27	2/8/23
February 2023 Medical Image of the Month: Reversed Halo Sign in the Setting of a Neutropenic Patient with Angioinvasive Pulmonary Zygomycosis	Imaging	Jokerst C	2023	26	2	21-23	2/2/23
February 2023 Pulmonary Case of the Month: SCID-ing to a Diagnosis	Pulmonary	Wesselius LJ	2023	26	2	18-20	2/1/23
The Effect of Low Dose Dexamethasone on the Reduction of Hypoxaemia and Fat Embolism Syndrome After Long Bone Fractures	Critical Care	K A	2023	26	1	11-17	1/24/23
Improving Quality in Healthcare	Editorial	Robbins RA	2023	26	1	8-10	1/13/23
January 2023 Medical Image of the Month: Abnormal Sleep Study and PFT with Supine Challenge Related to Idiopathic Hemidiaphragmatic Paralysis	Imaging	Jokerst C	2023	26	1	5-7	1/2/23
January 2023 Sleep Case of the Month: An Unexpected EEG Abnormality	Sleep	Baratz DM	2023	26	1	1-4	1/1/23

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