Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/clinicians-roundtable/endobronchial-valves-copd-selection-safety/54225/

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Endobronchial Valve Therapy in COPD: Selection Criteria and Safety Insights

Announcer:
Welcome to *Clinician's Roundtable* on ReachMD. On this episode, we'll hear from Dr. Frank Sciurba, who's the Director of the Emphysema and COPD Research Center and the Pulmonary Function Exercise Physiology Laboratory at the University of Pittsburgh School of Medicine. He'll be discussing selection criteria and safety considerations for using endobronchial valves to treat patients with COPD, which he spoke about at the 2026 American Thoracic Society Conference. Here's Dr. Sciurba now.

Dr. Sciurba:
Selection criteria in recent years have been clarified for both endobronchial valves in recognition that other potential therapies may, in a precision way, include different selection criteria for endobronchial valves. The pivotal trials were performed in heterogeneous patients with a residual volume of 175 percent predicted. We've learned that in more homogeneous patients, if we allow a higher residual volume we can get effectiveness with those endobronchial valves. I'm not a big absolute cutoff type person, but I do respect the results of evidence-based clinical trials, and so I'm reluctant to move below 175 percent predicted residual volume, except in cases where there's exceptional heterogeneity. We'll straddle the line just below that in patients that are very heterogeneous with one lobe on the same side being much more affected than the adjacent lobe. But in general, we like to use the 175 percent cutoff for residual volume. And with regards to the more homogeneous patients in general, residual volume is greater than 200 percent and will now include those homogeneous patients that are more hyperinflated.

Regarding the risk of pneumothorax with endobronchial valve therapy, we are recognizing that it is a fairly common event, and it could occur into up to a third of patients that undergo the procedure. But this has to be incorporated into the program where patients are admitted to the hospital, and we're prepared to put in chest tubes if in fact there is a pneumothorax. Often, as long as the program's established, it's a safe environment, and patients are in the hospital, most pneumothoraces will occur in the first two to three days after the procedure. And this is what I mean with regards to making sure you have an established program—you have an approach, and this isn't a surprise that we're getting these pneumothoraces because we have the right people in place to manage those with low risk to the patient.

In fact, some of the patients that get pneumothoraces can have some of the best results because when the lobe goes down completely, that creates the risk of a pneumothorax. And those are also the features of an individual that has the potential to respond to endobronchial valve placement. There's been strategies including lowering FIO2 on the general anesthesia while the valves are being placed. There's not really strong data to support that one way or another. But there's evolving anecdotal data that suggests that it results in a slower collapse of the lung because nitrogen is absorbed more slowly than oxygen and that this can reduce the risk of pneumothorax. So it'd be nice to have some stronger evidence for that, but it is a technique that a lot of the bronchoscopists are using these days.

Announcer:
That was Dr. Frank Sciurba sharing best practices for using endobronchial valves to treat patients with COPD. To access this and other episodes in our series, visit *Clinician's Roundtable* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!