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Optimizing NTM Care: Expert Insights on Diagnosis and Treatment

Announcer:
You're listening to *Deep Breaths: Updates from CHEST* on ReachMD, and this program is produced in partnership with the American College of CHEST Physicians and is sponsored by Insmed Incorporated. Here's your host, Dr. Ashwin Basavaraj.

Dr. Basavaraj:
This is *Deep Breaths: Updates from CHEST* on ReachMD. I'm Dr. Ashwin Basavaraj, Associate Professor of Medicine at NYU Grossman School of Medicine and Section Chief of Pulmonary Critical Care and Sleep Medicine at New York City Health and Hospitals, Bellevue. I'm also the Director of the Bronchiectasis and NTM Education Program at NYU Langone Health. Joining me to discuss the diagnosis and treatment of bronchiectasis and nontuberculous mycobacteria, or NTM for short, are Dr. Keren Bakal, Dr. Nathan Falk, and Ms. Amy Springer.

Dr. Basavaraj:
Dr. Bakal is a pulmonologist in the community, also specializing in critical care medicine at Overlook Medical Center and Morristown Medical Center in New Jersey. Dr. Bakal, welcome to the program.

Dr. Bakal:
Thanks so much for having me. Happy to be here.

Dr. Basavaraj:
And not only is Dr. Falk board-certified in Family Medicine, but he's also a Professor and the founding Residency Director for Family Medicine at Florida State University, in partnership with BayCare Health System. Dr. Falk, it's great to have you with us as well.

Dr. Falk:
Thanks for having me. Excited to be here.

Dr. Basavaraj:
And lastly, we're joined by Ms. Amy Springer, who's a Senior Nurse Practitioner at NYU Langone Health and who I work closely with. Ms. Springer, thanks for being here as well.

Ms. Springer:
Thank you so much for having me.

Dr. Basavaraj:
So, Dr. Falk, let's start with you. As a primary care physician, can you tell us about the current diagnostic gaps that you see in practice and how we can improve the initial work-up of bronchiectasis and NTM?

Dr. Falk:
Yeah, that's a great question. I think it often starts with recognition. So we really need to increase that index of clinical suspicion and expand our differential beyond just COPD and asthma because we know that not every respiratory disease that walks through our office, as a primary care physician, really falls into one of those two categories. This is especially the case when we're seeing folks who are maybe younger in age, and we start thinking that this non-smoker who's young has COPD. And that really shouldn't be the case. And we really need to think about expanding that differential and getting the education out there, particularly expanding our national education in the PCP community. For example, I know at our conferences a lot in family medicine, we need to work on expanding the

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access to education there beyond just COPD and asthma at our National Conferences and within our literature as a whole. And then, once we start working at expanding that differential and thinking outside of just COPD and asthma, we really need to start that basic work-up and making sure that we're not just presumptively diagnosing and treating folks because we know that even Choosing Wisely, for example, recommends not diagnosing and treating asthma without spirometry. We see this done in the community by PCPs quite often where they're trying to make a clinical diagnosis, and we know that that clinical diagnosis is not always the most accurate. So we really need to start a true work-up at the beginning and make sure that we are having this complete differential diagnosis along the way.

Dr. Basavaraj:
Now if we turn to you, Dr. Bakal, and hear your perspective as a pulmonologist in the community, do you see similar gaps that Dr. Falk had mentioned? And how do you approach your patients in diagnosing bronchiectasis and NTM?

Dr. Bakal:
Yes, I definitely see similar gaps in the delay of diagnosis. We see it on the other side where patients may go on for years with a chronic cough and have had a couple of chest X-rays here and there or maybe they were treated with antibiotics for recurrent bronchitis, and then by the time they come to see one of the pulmonologists in the office, we start to do the work-up and realize that they may have fairly advanced bronchiectasis. And so we definitely see that delay in diagnosis in the community as well. We also have some other gaps that we see in the community with diagnosis of bronchiectasis and management. So from the standpoint of the community pulmonologist, a lot of times what we'll see when patients come to us is they may not have had chest imaging that's appropriate or they might have just had some chest X-rays, so typically, I'll order a CAT scan of the lungs to diagnose the bronchiectasis and then do a work-up on the etiology of bronchiectasis. And a lot of times, we do want to get sputum on these patients, and that's a gap that we identify in the community where it may be very difficult to get that sputum sample. Maybe we can't do a sputum induction in the office—that's one big reason—or there may be issues with the labs in the community just not getting the results of the culture that's accurate. So not diagnosing the NTM that may be ongoing and sometimes having to resort to even doing a bronchoscopy to get those cultures and get the diagnosis.

Dr. Basavaraj:
With all this in mind, let's zero in on the importance of multidisciplinary care. Amy, who's a part of our team, has your role as nurse practitioner fit in in the overall treatment of bronchiectasis and NTM? And what's the role of all the specialties that are involved in bronchiectasis care?

Ms. Springer:
So as a nurse practitioner, I am part of the first-line of contact for the patients. I receive all patient calls and questions, so I'm very involved in patient care and patient education. I focus on airway clearance teaching and education, management and follow-up for bronchiectasis exacerbations, prior authorizations for antibiotics and/or airway clearance devices, as well as monitoring patients on outpatient intravenous and oral antibiotics. In addition, I provide resources to my patients, such as online videos for further airway clearance education and access to local support groups.

And then going further, management of patients with bronchiectasis involves a multidisciplinary team in order for patients to have the best possible outcomes. For bronchiectasis patients, part of our initial work-up is identifying possible causes of bronchiectasis. This includes referrals to GI for further work-up of possible GERD or aspiration, which typically includes manometry and pH impedance studies, and sometimes requiring endoscopy as well as referral to ENT if there's any sign of symptoms.

In addition, we refer patients to CHEST physical therapy as this helps individualize airway clearance to promote successful mobilization of secretions, and we also recommend pulmonary rehab programs as this is beneficial to many patients who are deconditioned and short of breath.

Dr. Basavaraj:
For those just joining us, this is *Deep Breaths: Updates from CHEST* on ReachMD. I'm Dr. Ashwin Basavaraj, and I'm speaking with Dr. Nathan Falk, Dr. Keren Bakal, and nurse practitioner Ms. Amy Springer about diagnosing and treating nontuberculous mycobacteria.

So now I'd like to take a few moments to talk about some of the resources that are available to clinicians and our patients. One resource is the Patient Support Network, or NTM IR. This is a patient advocacy group that provides a lot of important information for our patients, and they have this information on their website: ntminfo.org. They also hold support meetings in their respective communities and is really a helpful resource for patients to hear from others who may be going through a similar situation.

The COPD Foundation also has helpful educational materials on their website—BronchiectasisandNTMinitiative.org—in managing patients with bronchiectasis and NTM. The COPD Foundation is also overseeing the formation of the National Network of Bronchiectasis and NTM Centers, the Clinical Care Networks, which will provide standardized care to patients with bronchiectasis and NTM and offer

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support and advanced therapies as a referral center for those in the area that need it. Our goal for the Bridging Specialties Program is to develop an additional educational resource for primary care physicians and pulmonologists to increase the understanding of bronchiectasis and NTM and to really achieve early diagnosis, recognition of exacerbations, and improved treatment outcomes for our patients. There will be future podcasts in development as well as educational resources created on the CHEST website as part of this program, where providers can learn more about early diagnosis in bronchiectasis and NTM.

Now, this is an exciting time in the field of bronchiectasis and NTM as there are a number of clinical trials that are in development that can help direct our patient's approach and patient care. A number of trials that recently have been completed and in development focus on targeting neutrophilic inflammation, which is the predominant pathophysiologic mechanism in bronchiectasis. It's known that about 80 percent of patients with bronchiectasis have neutrophilic inflammation involved. The hope is by targeting inflammation, patients can have a reduction in the number of bronchitis exacerbations that they encounter. There are also a number of other trials in development focusing on various novel ways to treat NTM infection, which again, we hope holds some promise to treatment for these patients.

Well, we certainly covered a lot today, so before we close, I'd like to ask each of our panelists to share one call-to-action for your colleagues. Dr. Falk, can you start us off?

Dr. Falk:
Yes, of course. I think from the PCP standpoint, I really would implore people with the need to increase their level of diagnostic suspicion and ensure that we start a work-up thinking that not all pulmonary symptoms are due to one of two conditions—COPD or asthma—and to not start presumptive treatment too early without doing a work-up to start with. Because we know that sometimes if these patients are misdiagnosed presumptively with asthma or COPD and you start them on, particularly, an inhaled steroid, they may feel better for just a little bit to start with. But we're certainly not doing any favors with this chronic infection by just throwing inhaled steroids at them, and then eventually they'll start to feel worse, and we get into this cycle that can prolong the diagnosis.

Dr. Basavaraj:
And how about you, Dr. Bakal?

Dr. Bakal:
I also agree. The call-to-action would be to try to diagnose these patients early as much as we can. Refer early. We'll see these patients in the office and if we can diagnose them early, they will have a better outcome. We can treat them. And just getting more education out there to our community doctors about bronchiectasis and having it on their radar in these patients with chronic cough.

Dr. Basavaraj:
And Ms. Springer, I'll give you the final word.

Ms. Springer:
My call-to-action would be that as the number of nurse practitioners in the field is increasing, it is very important for adequate education and resources to be provided for the nurse practitioners in order for patients to receive top quality care and best patient outcomes.

Dr. Basavaraj:
Well, with those calls-to-action in mind, I want to thank my guests for joining me to discuss nontuberculous mycobacterium bronchiectasis. Dr. Bakal, Dr. Falk, and Ms. Springer, it was great having all of you on the program.

Dr. Bakal:
Thanks for having me.

Dr. Falk:
It was great to be here today.

Ms. Springer:
Thank you so much.

Announcer:
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