Transcript Details

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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Modernizing Pulmonary Assessment: Reassessing Race-Neutral Interpretation in Practice

Announcer Introduction:
You're listening to *Project Oncology* on ReachMD. On this episode, we'll hear from Dr. Ajay Sheshadri, who's an Associate Professor in the Department of Pulmonary Medicine at the University of Texas MD Anderson Cancer Center. He'll be discussing the real-world impacts of race-neutral pulmonary function testing. Here's Dr. Sheshadri now.

Dr. Sheshadri:
The main concern for using race-neutral interpretation is the possible increase in inequity basically in, I would argue, three major categories. The first is patients who are undergoing lung resection surgery. The second is patients who are being evaluated for hematopoietic cell transplantation. In this case, pulmonary function is used in a similar way to determine candidacy. And the final one would be eligibility for certain occupations, such as firefighting, which is probably the most prominent one, where spirometry is used to determine fitness and the ability to tolerate some of the hazards associated with firefighting, like exposure to smoke.

So these are three scenarios where race-neutral spirometry is going to shift the interpretation in a way that a Black American is going to have potentially a lower lung function than he would have otherwise. This also begs the question of why we have such discrete cutoffs for these things. Of course, part of that is just for the ease of being able to figure out if somebody's eligible or not, but in fact, the risk functions in almost all these cases are going to be continuous estimates, which would mitigate this.

So if we think about the percentage, about five to eight percent are going to be reclassified based on race-neutral interpretation. And so for those five to eight percent, we may actually be increasing the disparities in access to these potentially life-saving therapies or to these occupations that might be of interest.

And so as we move towards this, we also need to think about the tools that we use, and we particularly need to think about whether those tools need to be refined or updated. Some of these risk calculators are 20 to 30 years old. Surgical techniques are much better, for example. The surgical techniques that we use now are associated with lower complications. The recovery times are shorter. A lot of the historical data from even 20 years ago may not be relevant to the way that thoracic surgeons operate right now or the way that hematopoietic cell transplantation is done now. So every few years, there needs to be a critical re-examination of the way that we do the entire selection process for these therapies.

When there are things that are accepted as medical dogma, it is important to re-examine the data that led to those conclusions, and when those data may seem either suspect or perhaps not perfectly appropriate for modern times, it is important for us to start to think about what studies need to be done for us to do the best job for our patients.

The medical sciences move at a very rapid pace, and so sometimes, by the time you publish a risk calculator or suggest a way to select patients, within five to 10 years, that data may already be outdated. That's challenging because it takes quite a bit of time to do these studies properly and to have the resources to do these studies. But it is really important because if we don't take the time to reflect and to design the appropriate studies and really understand if we're doing the right thing for our patients, then we may be harming our patients by not being critical like this.

Announcer Close:
That was Dr. Ajay Sheshadri talking about how race-neutral pulmonary function testing can affect patient care. To access this and other episodes in our series, visit *Project Oncology* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!