Host: Welcome to the podcast series from the specialists at Penn Medicine. I'm Melanie Cole. And today, we're examining thoracic patient care, back to the basics, the fundamentals of caring for thoracic patients. Joining me is Dr. Taine Pechet. He's the Chief of Surgery at Penn Presbyterian Medical Center.

Dr. Pechet, it's a pleasure to have you join us today. So what are these basics that we're discussing today? And do we need to return to them? Have things shifted to the point that what used to be fundamentals of thoracic care has changed? Tell us a little bit about what's going on in the field today.

Dr. Pechet: Thanks, Melanie. And I appreciate the chance to speak with you today. No, really the fundamentals haven't changed and we've never really gotten away from them. Sometimes they get hidden slightly, but in general, most of us and all our referring physicians really stick to the same things. And I would say that the first tenet of the basic care for thoracic patients is that prevention is better than treatment. We all work really hard at getting people to stop smoking.

One of the things that would be great to disseminate a little bit broader is that vaping, although probably better than smoking and certainly less well studied, still carries a big risk. And I can tell you certainly in my personal practice and most of us have seen it, I'm seeing more and more patients who are marijuana smokers who develop lung cancer. And I think that part of what the future holds is that we'll discover that that is also a significant risk.

There are obviously lots of risk factors for lung cancer beyond smoking. And certainly radon is the number two cause of lung cancer in America, is one that we all need to pay attention to. But some of the risks really can't be changed and aren't preventable and are particularly important in our current day in time where racial and ethnic differences we know make a difference. African-American men have a higher incidence of lung cancer than white men, but black women have a lower incidence. And so we all need to be sensitive to that. And I think everybody pretty much is.

Other sort of basic tenets, early detection reduces the risks of dying, that means screening. Earlier stages are easier to treat and cure, but even later stages, we can now very effectively cure them. There are treatment options. I think everybody needs to know, and that's always been a basic tenet and we're much better at some of the treatment options that go beyond basic surgery and radiation therapy.

The other one that I think we all need to keep in mind is that specialty care really is important and critical and seeing an expert at a center or a practice or a hospital that has the depth of expertise that can be offered here at Penn or other similar eye-level places is really important to getting the best care we can.

Host: What important points that you made, Dr. Pechet. So what about things like telehealth? Not necessarily basic, but has this added to your available outreach and capabilities? And do you see this as something that while it was present during COVID and important will be continued to be used in the future?

Dr. Pechet: Telehealth has been great for us, but really in very specific fashion. It allowed us to get a headstart on patients in understanding where they stood in the process and then the testing and the evaluation. Certainly in thoracic surgery and much of our medical and radiation oncology colleagues, we ended up not using a lot of telehealth for new patients, but for followup visits, it became critical. And obviously, one of the things that's very important about lung cancer care is ongoing followup after we treat it and hopefully cure or think we've cured a lung cancer. People need routine followups.

And so, you know, for instance, we resect a stage I lung cancer, patients, we'll ask them to get chest CT scans every six months for four years and then once a year for life, particularly if it's an adenocarcinoma. And so somebody who's three years out in the middle of a pandemic, we could get them to get their chest CT safely, but then we were able to telehealth visit and I could screen share and show them the scan and point out the stability of nodules and do our follow-up visit that way. And that was very successful.

Host: So while we're discussing basics and fundamentals, who should be screened for lung cancer and when? Tell us about any screening recommendations that have changed in the last few years and what you'd like other providers to know, especially primary care providers to know, about recommending these screenings or referring to thoracic care.

Dr. Pechet: Absolutely. And that's a critical point because it was only in March of 2021 that the US Preventative Services Task Force changed the official recommendation on screening for lung cancer, so only a few months ago. So now, it's adults 50 to 80 years old. So they dropped the age and they dropped the number of pack years. So it's adults 50 to 80 years old with a 20-pack year history who either still smoke or who quit within the past 15 years should have a chest CT every year until either 15 years after they've quit or they developed some other important health issue that will be life-limiting. And that's a change and it's new enough that the specialty societies are just now working on revising their recommendations to be in line with the new guidelines from the USPSTF.

Host: So tell us about the basic algorithm for thoracic care at Penn Medicine. What happens, Dr. Pechet, from the moment someone in the program gets that call from a referring provider? Tell us a little bit about how the program works and even your multidisciplinary approach as patients come through the center.

Dr. Pechet: That's obviously one of my passions and one of the things that I feel strongest about is that wherever a patient enters our system and our lung cancer care system, they get the same level of outstanding expert care. But to accomplish that, it takes a little bit of work behind the curtain, so to speak.

So initially when we first get contact, we try and figure out, is it a known or just a suspected cancer? If it's suspected, do we need to prove it before we initiate treating? Or could it be proven during treatment? For instance, is this something that we should just take straight to surgery and resecting it will provide a diagnosis as well as optimal treatment?

If we do know it's a cancer, can we tell how advanced it is from the information we have at initial contact? And then we've got to also try and figure out, "Well, how healthy and how fit is the patient?" And then we use that to figure out, "Well, who is the best type of physician to see the patient?" You know, so for instance, if their initial studies showed bone metastasis, then that's not a patient that we should ask to be seeing a thoracic surgeon. That patient is going to be better off seeing a medical oncologist or a radiation oncologist at the outset.

But if we have a patient who's got a heavy smoking history and has a very suspicious nodule, then that's somebody that maybe should see either thoracic surgery or interventional pulmonary to work on getting a diagnosis. And we actually have clinics that are dedicated to these sort of intake concepts, so that we can get all the information on patients and understand what's actually been done for them already. One of biggest challenges is obtaining all the records of tests that have already been done. And any member of our team who comes in contact with this pretty much within a few minutes can figure out, "Okay. Well, we need these other three tests in order to make the patient's initial visit be most valuable and to avoid wasting their time."

And one of our huge challenges is figuring out how do we get those tests ordered and the results back before the patient shows up, so that we can maximize use of their time and get them as quickly through as possible? One of our limitations is that until we've met the patient, we really can't order the test. So we depend on working with the referring physician or the primary care physician to try and accomplish that. And it's hugely appreciated by both all the members of our lung cancer team and the patients also, because then when they show up, we have something to really tell them.

Our goal is their initial visit is within seven to 10 days of our first contact. Our ambitious goal then is from the point of initial contact, we want to be able to start treatment within two to three weeks. So that means there's a huge time pressure to get all these studies together. Really it's all the staging studies to figure out, early, late stage. And then if it's an early stage, figure out, well, are they suitable for surgery? How's their cardiac condition? How's their pulmonary condition?

And some of the obvious things that referring providers can do to really move things along, if a patient's going to be seen by a thoracic surgeon, pretty much always they're going to need pulmonary function testing. So one of the things that is really appreciated is if the referring physician and the primary care physician can order it and get those going and obtain them. In that way, when we see the patient in the office, we can talk about whether they'd be able to tolerate a lung resection.

When we think about team concept, it's not just our team here at Penn, it extends out to the local team and the patients referring and primary care physicians so that we can really move the patient along. And that's what's necessary to be able to initiate treatment within two to three weeks of our first time.

Host: Well, thank you for that. So Dr. Pechet, where is thoracic care headed? Will surgery always be a part of this management in the future? Where do you see this whole field going?

Dr. Pechet: So I think that we're going to see progression of what we've seen in the last handful of years, where we get increasingly targeted and personalized care based on the molecular characteristics of a particular tumor, what we now like to call personalized medicine. We're also, I think, going to see more combinations of treatments. So for instance, surgery followed by immunotherapy. I think surgery is always going to have a role to play at least in specific circumstances, but which patients and which circumstances may change and what surgery it looks like we'll probably change.

So for instance, about three years ago, we changed our entire perioperative pain protocol. And now, most patients only need about four, maybe five narcotic pills their entire recovery. And as part of that whole process, we're now able to get patients up and walking within 60 minutes of the end of the operation. Literally, our postoperative care unit nurses have them up and walking within an hour. And that really starts their recovery. So lots of things have changed. And I do think surgery is still going to play a role as we move forward, but it'll just look different.

Host: What an exciting time to be in your field. And Dr. Pechet, as we wrap up who at the core of the patient population needs to be referred to a thoracic surgeon? And who should see a pulmonologist or other specialists instead? Give us your best advice and let other referring providers know when it is important to refer to thoracic care at Penn Medicine.

Dr. Pechet: First off, we're always happy to receive the referral. And if it's not right, we'll take it upon ourselves to redirect that patient to the right person. But I would say more specifically, people with known or suspected early stage lung cancer or people with suspicious abnormalities or nodules on their CAT scan are kind of the core group to refer to a thoracic surgeon.

But there's also a lot of non-cancerous reasons to see a thoracic surgeon such as emphysema surgery, particular types of mediastinal cysts and things like that. For our pulmonologists, and I specifically think of our interventional pulmonologists who are a key component of our lung cancer care team, those are going to be patients who may just have an undiagnosed nodule or a persistent infiltrate that you're worried about. And that's really kind of a toss up. They can come see a surgeon first or they could see an interventional pulmonologist first. And what we try and do is have them wind up in the same place.

Host: That's great information, Dr. Pechet. Thank you so much for joining us today and really sharing your incredible expertise on thoracic patient care. To refer your patient to Dr. Pechet at Penn Medicine, please visit our website at pennmedicine.org/refer or you can call (877) 937-PENN. That concludes this episode from the specialists at Penn Medicine. Please remember to subscribe, rate and review this podcast and all the other Penn Medicine podcasts. I'm Melanie Cole.