December 31st, 2018

Dear Patients,

For those of you new to our Program, it has become somewhat of a tradition to send out a yearly “State of the Union” letter to all of our patients….except I was delinquent last year…my bad! We continue to grow and are constantly evolving as we strive to improve and innovate in everything we do. We pride ourselves in offering state of the art treatments for all our patients and through our research, the opportunity to be offered therapies that may indeed in the future become state of the art. We also are constantly trying to improve efficiencies in our clinic and ensure that the time you spend with us is minimized. With that said, there will always be some waiting involved. Please don’t get frustrated by this 😐. A lot of the time the physicians and nurses are reviewing your data before entering the exam room, so in effect you are being “examined” but in a “virtual” fashion. We know that our patients and their families place a lot of faith and confidence in us, we do not take this lightly and are deeply honored for your trust and confidence in our Program.

Turn up the Volume!
From January 1-December 31st, 2018, we received 698 new referrals and evaluated 493 new patients. Between all our programs, we follow ~1526 patients. This volume underscores why we rely on partnering with primary care providers and referring physicians in taking care of all our patients and their comprehensive needs.

So you think you can drive!
17.4% of our new evaluations travel >100 miles to see us and 6.6% live more than 200 miles away, reflecting our standing as a regional and national referral center (2018 data).

Programs
This year (on November 14th) we were recognized as a WASOG Sarcoidosis Clinic (World Association for Sarcoidosis and other Granulomatous Diseases…a mouthful indeed!). As per the letter of accreditation, "This designation provides formal recognition of your team's commitment to meet the needs of sarcoidosis patients and efforts to keep abreast of the ongoing advances and findings in the space". We are one of 75 CMS accredited lung transplant centers, one of 52 accredited Comprehensive Care Centers for Pulmonary Hypertension, one of 60 Pulmonary Fibrosis Foundation Care Centers, and one of 112 Cystic Fibrosis Foundation-accredited Care Centers in the United States. Throw in the WASOG accreditation and we are now only one of 18 to hold of these designations.
I am pleased to report that we have had very little personnel turnover this past year. None of our docs, Nurse practitioners or Nurse Coordinators left….phew and yay! ☺ We added one new (and outstanding) Coordinator, Matthew Kott who joins Michelle Schreffler on the pretransplant side. On the research side, we welcomed Jennifer Pluhacek as an additional CRC (clinical research coordinator). In addition, our research assistant, Brenna Cannon has been promoted to a CRC, while Claire Collins has joined the research team as our new research assistant.

Our much loved and respected Social Worker of many years, Jane Harrison, decided to hang it up and bowed out to retirement. We lost our dietician, Leah Papazian, who moved to California but welcome Erin Lopynski to our team.

**Hot off the press- we will have two new Pulmonary Hypertension Coordinators starting with us at the end of January. We are all very happy, but no-one is happier than Denise Lewis, in welcoming Shanna Guzman and Johanna Coughlin to our team.

Dr. Kareem Ahmad, our July 2018-June 2018 Advanced Lung Disease Fellow has stayed on staff as a full-time attending. This is a fabulous addition for us (we just couldn't let him go!). Our dietician, Leah P will be moving to CA, we wish her well and thank her for her service.

Between the current six full-timers, we have been with the Program a total of of 51 years (SN-22; OS-13; AWB-8; CK 5; SA 2 years; KA-1). On the surgical side of the program, Dr. Linda Bogar continues as our surgical director, assisted by 3 our other highly skilled surgeons, Dr. Liam Ryan, Dr. Eric Sarin and Dr. Ramesh Singh. Two other docs who are integral team members are Drs. Shalika Katugaha who is our ID specialist, and Dr. Amit “Bobby” Mahajan, our Interventional Pulmonologist.

**Lung Transplants:**
Based on the most recent data from The Scientific Registry of Transplant Recipients (SRTR), our average wait time for a transplant is 3.7 months, while our survival statistics continue to be in line with the National averages; one month survival of 98.11% (U.S 97.15%), one year survival 87.91% (U.S. 88.02%) and three survival 66.37% (U.S.69.77%).

This year we performed 25 lung transplants. A new lung allocation system came into effect November 2017. Prior to this, being that ours was the only lung transplant program in the DC Metropolitan area, any donor lungs that became available within our organ procurement area (OPA) (Greater DC Metro area), we had first “dibs” on for our patients. If we didn’t use the lungs or had no suitable recipients, then the lungs would be offered out in sequential 500 mile radii. With the new system, any lungs that become available at any hospital are offered out in a 250 mile radius based on the site of the donor hospital. This system has placed us in direct competition with other large programs in the East for available donor lungs. Fortunately, this has not affected us adversely, but has rather been a “mixed
blessing”. On the plus side our numbers have increased slightly but the downside is that generally our patients' diseases have to advance for them to be sick enough to score high enough to draw lung offers. The net result is that the patients we do transplant are generally quite a bit sicker and certainly in greater need for a transplant. This has resulted in greater hospital length of stays and more rehab time. In addition, our procuring surgeons are having to fly out to get more lungs. In fact, all but 3 of the lungs transplanted this year came from outside our OPA.

Every patient that is listed for lung transplantation receives a lung allocation score (LAS). This is based on how sick the patient is and the likelihood of succumbing without a transplant with consideration also given to the likelihood of surviving a transplant. There are also certain diseases, notably COPD, where it is difficult to score high enough, no matter how compromised, to move up on the list. Invariably lungs that do slip down to lower scoring patients are “marginal” and have been turned down by others. However, “marginal” lungs can frequently be used with very good and comparable results. To meet the demand for donor lungs, we now have ex-vivo lung perfusion (EVLP) available to salvage and recondition some of these marginal lungs. EVLP basically involves placing marginal lungs on a ventilator machine outside of the body for a period of up to 6 hours to see how much improvement in function can be attained before deciding if they are useable or not. This is being orchestrated through a research protocol in collaboration with Lung Biotechnology, a subsidiary of United Therapeutics, with the Ex-Vivo facility located in Silver Springs. We have had 2 EVLP runs this year; one lung was successfully transplanted, while the other lung didn't pan out. “Marginal” lungs should not be confused with “increased risk” donors where there is a known risk factor for certain infectious diseases, such as HIV, hepatitis B and hepatitis C. What constitutes an “increased risk donor”. Examples include, medical history not well-known, jail time, history of IV drug abuse, high risk sexual behavior etc. We routinely test the donors for HIV and hepatitis, but there is a small window of time when the blood tests might not turn positive yet.

Meetings:
Do we have meetings, we love to meet, we meet about everything, we even meet to decide on new meetings! All of our meetings have but one goal and that is to provide better and more coordinated multidisciplinary care for our patients. In addition to our daily inpatient multidisciplinary rounds, our other meetings include a monthly Quality meeting, twice weekly patient care conferences, monthly interstitial lung disease meeting (with Pathology and Radiology), a monthly pulmonary hypertension collaborative multidisciplinary meeting, monthly webex meeting with the Washington Regional Transplant Consortium, monthly webex meetings with the HLA laboratory at John Hopkins, a monthly journal club as well as 1-2 weekly lunchtime educational/research lectures and a biweekly lung transplant patient care conference. Phew! I haven’t counted our individual Program meetings, for example our Cystic Fibrosis team has a number of additional meetings. In addition, we have 3 per month research meetings to include our Pharmaceutical Study meeting, our Investigator-initiated research meeting and meetings with our local research partners (George Mason and NIH).
**Patient Expectations**

I apologize (well, not really 😊) for this carry over from my letter two years ago, but a lot of this is well worth repeating because they are so important.

For all our patients, it’s important to understand that success depends on a team effort; and while we look at what we do very closely and at times critically, similarly, we ask and require of our patients to do the best they can in helping us help you. Patient-specific aspects of care that can impact outcomes include:

1. Compliance with all team requests, not running out of meds and taking all meds as instructed and when instructed.
2. Informing us of any insurance or employment changes.
3. Keeping all appointments.
4. Staying active, enjoying a good diet, and maintaining a healthy weight.
5. Exercise, exercise and more exercise. This holds true for all our patient groups. Forget apples, a push-up a day keeps the doctor at bay! If anyone wants to do pushups with me in clinic, please let your Nurse Coordinator know and if I am in clinic, I will gladly pop in and match you one for one with pushups.

We accommodate many different patients within our advanced lung disease programs. The purpose of these programs is to provide comprehensive care for our patients’ lung disease. Our goal each step of the way is to provide individualized, high quality care, with a focus on maximizing patients’ quality of life and extending their longevity. In this regard we will strive to:

1. Make sure that an accurate diagnosis has been obtained. In many cases this requires further testing. Sometimes the diagnosis evolves over time; therefore some testing might need to be repeated on a serial basis. We have a dynamic program, but patients themselves are dynamic and things change which might require new testing, repeat testing, review of old testing, change in the diagnosis (yes, this can happen!), addition to the diagnosis, subtraction from the diagnoses (“you are cured of your…..” 😊) and changes to medications.
2. Focus on comorbidities (co-existing conditions) that might have been missed and that we can treat. Many of the lung conditions are associated with comorbidities that might impact patient’s quality of life and affect their outcomes.
3. Counsel patients about their diagnosis and provide an honest and forthright opinion of what the future might hold.
4. Present the various treatment and other management options available
   a. Medications
   b. Pulmonary Rehabilitation
   c. Surgical options
   d. Palliative Care. The focus of this is to the patient’s symptoms independent of anything done (or not done) to treat the underlying condition.
   e. Address end of life issues, including the possible role of Hospice Care. We might well initiate these difficult discussions early in patient’s disease course. Please don’t be upset by the initiation of such a discussion, it does not mean that your demise is imminent or that we don’t have anything more to offer. Please think of it as akin to visiting a lawyer or paralegal to square away your last will and testimony which often takes place or should take place while folks are young, well and healthy.
5. Provide access to and information about clinical trials of which we have many at any given time. Your clinic visit will quite typically include a Research Coordinator talking to you about any trial that you could qualify for. This is your opportunity to contribute to medical science, access new treatments before they are approved, and help future patients. The decision to participate in any clinical trial is entirely voluntary, we won’t pressure you to participate but rather are striving to inform you of all options. If you decide not to participate in a clinical trial, please be assured that this will in no way affect the care we provide.
6. Medication reconciliation (creating an up to date and accurate list of current patient medications)
7. Provide access to support groups.
8. We rely heavily on co-managing patients with referring physicians. For those patients who don’t have a Primary Care Physician/Pulmonologist, we strongly encourage finding one. We strive to communicate closely (primarily through our clinic notes) with your primary care physicians, as well as your other subspecialists. If you have provided the names of your physicians during the registration process, then these docs will automatically be sent
our clinic notes once we sign off on them. If any of your docs are not getting our notes, please be sure to let us know.

9) If we feel that you are stable and we are not really adding to your care or follow-up, then we might look to discharge you from our clinic. This is usually a good thing, so please don’t interpret it that we don’t like you anymore 😊.

**Inova Advanced Lung Disease and Transplant Program: Education**

One of the missions of our Program is to educate the next generation of doctors, nurses, nurse practitioners and other healthcare providers. Frequently, you will be seen first by a Resident or Fellow, so please be patient as an extra set of eyes, hands and a sharp, young mind invariably results in better, more thorough and comprehensive care. Please don’t be frustrated if you are asked the same question twice or even three times (we are not testing your resolve and patience 😊).

We have fellows and residents rotate through with us from Carilion Health System (Roanoke), Eastern Virginia Medical School (Norfolk), Georgetown, George Washington, Howard, Walter Reed, and Washington Hospital Center. There were a record 38 residents and fellows who rotated through with us during 2018. This year also marked the third year of our Advanced Lung Disease and Transplant fellowship, with Dr. Matt Koslow joining us from July 2018 through June 2019. We were privileged also to have a Pulmonologist from Brazil join us for a one month preceptorship and next academic year we will be welcoming a French Pulmonologist to spend a year doing interstitial lung disease research with us. Our educational efforts have therefore become broader and more International with a number of case conferences orchestrated during the year with Pulmonologists in Brazil and South Africa. Our summer intern program has also continued to mature with multiple applications for our 5 summer slots. We have a formal application and interview process for these young aspiring doctors who are a joy to interact with over the summer months. Their experience includes being teamed with a mentor and embarking on a research project that they present to our group at the end of the summer. Frequently, once their research is analyzed, it results in an abstract submission to one of the International meetings. Some of these abstracts form the basis for subsequent original research manuscripts.

**Patient Education & Support Groups**

**Transplantation.** We hold a monthly transplant support group to which all our pre-transplant and post-transplant patients are welcomed. It is an expectation and requirement that our listed patients attend this as it also functions as an education forum with specific topics and speakers on a monthly basis. Attendance is taken and failure to attend these can jeopardize your staying on the transplant list. Patients who live within 1 hour of the hospital must attend FOUR in person Lung Transplant Education Groups a year to remain listed for lung transplant. Patients who live more than 1 hour away from the hospital, must call into FOUR Lung Transplant Education Groups a year to remain listed for lung transplant. Please see below for the 2019 schedule. For those folks who are “early” for transplant, it is still a good idea to attend. You do not have to be a transplant candidate or interested in transplant to attend any of these. Please bear in mind that the average wait time for a transplant at Inova Fairfax is in the range of 3 months. Therefore if you wait to be listed before attending these meetings, you may only have the benefit of hearing a few of the 11 excellent annual topics!

**IPF.** This support group is called the Pulmonary Support Group of Metropolitan Washington DC and is a monthly forum for not only IPF patients, but also those patients with any form of pulmonary fibrosis or interstitial lung disease. Patients do not have to be our clinic patients in order to attend. This support group is now supported by the Pulmonary Fibrosis Foundation and takes place the 4th Tuesday of every month at 1pm in the Physician Conference Center lower level.
Pulmonary Hypertension. There are also patient run PH support groups for all patients with any form of pulmonary hypertension. There are two Pulmonary Hypertension support groups in the area; one in Virginia (NOVA@PHASupportGroups.org) and one in Maryland (MD-SouthernMD@PHASupportGroups.org).

Physician Support group. aka lunch! (the fifth annual letter that I have left this in 😊)

For any information pertaining to our Support Groups, please contact our Social Worker, Susan Perry at susan.perry@inova.org

Nurse Coordinators, Nurse Practitioners: roles & responsibilities

- Pre-transplant Coordinators: Michelle Schreffler and Matt Kott
- Pulmonary Hypertension Coordinator: Denise Lewis (also Lead Coordinator). Soon to be joined by Shanna Guzman and Johanna Coughlin.
- Advanced Lung Disease Coordinators: Angela Scully and Latoya Albergottie-barnes
- Cystic Fibrosis Coordinator: Melissa Bowen
- Post-transplant Nurse Practitioners: Meg Fregoso and Jessica Chun.
- Inpatient Nurse Practitioner: Lauren Marinak
- Research: Edwinia Battle (Research Manager), Brenna Cannon, Danielle Dacosta, Priscila Dauphin, Merte Lemma WoldeHanna, Jennifer Pluhacek, Drew Venuto, Serina Zorrilla and Claire Collins. We up to 9 clinical research coordinators 😊. That tells you how robust, successful and broad our research endeavors are.

Time for a photo break...
Celebrating and recognizing longevity
Left to Right: Meg Fregoso, NP, Jane Harrison (Social Worker-retired), Colleen Adamson (20 years post-lung transplant), Nelson Burton (Surgical Director-retired), Steve Nathan (Medical Director)
Please check out: www.inova.org/colleenstory

New drugs and Devices
Another lean year for new drug approvals:
1) Transplantation. No new antirejection medications approved this year, and unlikely to be any new drugs in the foreseeable future 😞.
2) Pulmonary Arterial Hypertension (PAH). Nadda too!
3) Idiopathic Pulmonary Fibrosis (IPF). Nadda again 😋
4) COPD: always new inhalers, but what was particularly exciting was the FDA’s approval of two different types of endobronchial valves for endobronchial (via bronchoscopy) lung volume reduction. We aim to be one of the early Centers to offer this technology for select COPD patients in the New Year.
5) Cystic Fibrosis. The hot topic this year at the conference was “The Triple” CFTR modulator (tezacaftor/ivacaftor/VX-659/445) for patients with one or two copies of the F508del mutation. Results of phase II trials showed significant improvement in FEV1 and quality of life (NEJM 2018; 379:1599-1620). Early phase III results appear consistent. This could truly be a game changer for ~90% of CF patients and holds great promise to be FDA-approved within a year.

Chilling…
Left to right: Drs. Shlobin, Nathan, Bogar, King, Katugaha, Ahmad, Brown and Aryal
The Advanced Lung Disease Research Program was established in 1996 and has grown exponentially since then. Our site participates in numerous clinical trials for a variety of lung diseases including interstitial lung disease, lung transplantation, pulmonary hypertension, chronic obstructive pulmonary disease, and non-CF bronchiectasis. This includes industry sponsored clinical trials, Inova investigator initiated studies, and research collaborations.

The research program’s infrastructure includes:

- 4 research nurses
- 4 clinical research coordinators (CRCs)
- 1 research assistant
- 1 regulatory coordinator

Three of our research staff members (2 nurses/1 CRCs) are certified as Clinical Research Coordinators through the Association of Clinical Research Professionals (ACRP) and 1 CRC is certified as a Clinical Research Professional through Society of Clinical Research Associates (SOCRA).

Extensive experience with recruitment strategies in pulmonary trials as well as the tight integration of our clinical and research teams promotes effective communication with each other and patients. Every patient who is seen in our clinic is screened for available clinical trials on a daily basis by our research assistant. Our physicians personally discuss the importance and merit of clinical trial involvement, which raises patients’ comfort and interest in participating. Our team's willingness to collaborate with sponsors and other institutions has led to exciting and novel studies.

Our research team has biweekly morning research team meetings to address upcoming trials, track enrollment in current trials and troubleshoot barriers to enrollment, and review the budgets of ongoing research. In addition, the research team has dedicated weekly meeting times with the PI of all studies to review recruitment goals, progress of the study, and ensure all documentation is being completed appropriately and in a timely manner.

Our hospital is also home to a Clinical Trials Unit where most of our research patients are seen. The unit has two pulmonary function test rooms and a six-minute walk hallway, which allows the unit to serve as a one-stop shop for the majority of our research procedures. This unit can accommodate complex studies to include phase one trials, as well as overnight stays and multiple pharmacokinetic time points. With resources like this unit, our program continues to grow and aims to provide the best possible care for our patients.

It’s a privilege for us to be able to offer a broad array of potential research opportunities to our patients. We firmly believe that having the opportunity to be involved, while in most cases is altruistic, it is also empowering and an outlet to take a measure of control and help “fight back” against the disease. With all of these studies it is important to remember that your participation will not cost you anything and that the study drugs are paid for by the various pharmaceutical companies. The testing performed in the studies is also paid for unless it is deemed to be a part of your standard of care (testing you would have required anyway) in which case your insurance company will be billed.
Another photo break..

Left Front row: Danielle Dacosta, Kim Auguste, Drew Venuto, Serina Zorrilla, Edwinia Battle, and Julieth “Jet” Munoz. Photobombing in the back is German Anaya. Congratulations to Drew for winning the Hospital-wide annual ugly sweatshirt competition.

Right: Docs hard at work..or docs hardly work! 😊

Publications and presentations (see below for full list).
Another very successful, productive year including 14 original research manuscripts (accepted or published), 9 reviews, 1 editorial, 2 consensus papers, 2 case reports, and 35 abstract presentations at International meetings including the American Thoracic Society meeting (May San Diego), the International Society for Heart and Lung Transplantation (Nice, France April), the European Respiratory Society meeting (Paris France September) and the American College of Chest Physicians meeting (San Antonio, TX October). Between us, we also delivered ≈15 talks at these same and other International meetings. Sounds glamorous and fun, it is but it’s a lot of hard work too and some nail-biting as well. It is a privilege though to share our work with others and know that our research impacts the care of patients we never touch or see. We couldn’t do research or writings without our patients, so please know that your participation in research has the same ripple effect on other patients around the country and around the world! That’s pretty powerful stuff!

Team requests for the New Year:
This section is like gastroesophageal reflux disease, most of these are repeat items!
(You have heard of GI Joe...well that was a GI joke!)

1) With the start of a new year, please provide our office with any new insurance/prescription cards to avoid a lapse in your coverage.

2) Please try to understand if the Coordinators do not get back to you right away after a telephone call or email. The Coordinators have numerous callbacks every day, and frequently they only get to check their messages at the end
of the day when all the clinic patients have been taken care of. For true emergencies, as always, please have the on-call Coordinator paged.

3) Email is a great way to communicate, please let your Coordinator know if this is convenient for you.

4) Know your insurance.
   i. Know if you can have lab work drawn at Inova Fairfax or if testing needs to be done at an outside facility.
   ii. Please make sure that you have the appropriate referrals (if necessary) before coming to see us.

5) If you have outside labs, please bring a copy with you to your next clinic visit as sometimes we don’t receive these from the outside lab.

6) Similarly, if you have an outside CT of the chest, please bring the actual disc with you. We need to look at these ourselves and not just the Radiologist’s report.

7) Please inform us of any significant changes in your medical condition, including hospitalizations at other hospitals.

8) Please make sure we have an updated list of your other doctors.

9) Know your meds! When you travel do so with a list of your meds, if you need to go to any Emergency room, please take a list of your meds.

10) If you have been set up to get a bronchoscopy, you might receive a call from Patty (Dr. Mahajan’s scheduling coordinator). If your bronchoscopy is planned with deep sedation/anesthesia, you will need an up to date EKG, labs and you will receive a call from someone in surgical services to discuss your medical history 1-3 days prior to the procedure.

Website
We are always looking to update our website. Any new ideas for our website would be more than welcome. We are always looking for good patient stories to include on our website, so if you feel so inclined to share your story, please email it to me. Photos are also always a nice touch. Check us out at: www.inovalung.org

Inova Foundation Lung Funds.
Another way to fight back in support of our research is through contributions to one of our Foundation research funds. Three funds to consider contributing to include:

1) **The Lung Fund.** This is our broader generic fund, which we use for multiple purposes, including funding our research into all the diseases, including pulmonary hypertension, lung transplantation, sarcoidosis, cystic fibrosis, COPD and also IPF. We also rely on these funds to pay our research assistant as well as for statistical support which is essential for our original research manuscripts (see below). We do tap into it on occasion to enable our personnel to attend educational conferences as well.

2) **The Pulmonary Fibrosis Fund.** This fund remains open to receive donations from folks who wish to designate money specifically for pulmonary fibrosis research (including mostly, but not limited to IPF).

3) **Patient Assistance Fund.** We are into the fourth year of this fund whose purpose is to help patients who are financially strapped. It is not for direct medical expenses, but is tapped into for other expenses related to traveling to our hospital for medical care. This includes things such as gas cards, food vouchers and accommodation etc. If you wish to contribute specifically for this cause, then please designate so but still address it to “The Lung Fund”, since it has been set-up as a subsidiary of the Lung Fund.

We are extremely grateful to all who were kind and generous enough to donate or direct donations to our Lung Fund in 2018. Unfortunately, our research program runs in the red every year and we are under increased pressure to maintain fiscal neutrality. We will often commit to studies, even when we know we will lose money on them because they are very innovative and have potential to “move the needle” and/or the study affords us the opportunity to make promising, but yet to be approved medications, available to our patients. As we head into 2019, please consider a donation no matter how big, no matter how small, no pressure!
All donations should be addressed to either “The Lung fund”, The Lung Fund-patient assistance” or the “The Pulmonary Fibrosis fund” and sent to:

    c/o Debbie Campbell,
    Heart and Lung Outpatient Area
Thank you for your support of our Program and for putting your trust in us. On behalf of the transplant and advanced lung disease team, warm wishes to you and your families and hoping you all have a happy, festive, and medically uneventful New Year!

With warm wishes

*Steve Nathan*
Medical Director, Advanced Lung Disease and Transplant Program
Fourth row: Andrea Grajeda (Referral Coordinator); Melany Vidaurre-Llanos (PH administrative Assistant); Denise Lewis (PH and Lead Nurse Coordinator); Priscilla Dauphin (Research Coordinator); Serina Zorrilla (Research Coordinator); Quyen Duong (CF RT); Kim Auguste (Medical Assistant); Latoya Albergottie-Barnes (Nurse Coordinator).

Third row: Matthew Kott (Nurse Coordinator); Rodrick Likonko (Financial Coordinator); Sarah Scott (Office Manager); Jennifer Pluhacek (Research Coordinator); Brenna Cannon (Research Coordinator); Lori Hill (Financial Coordinator); Danielle Dacosta (Research Coordinator); Michelle Schreffler (Nurse Coordinator); Merte Lemma (Research Coordinator); Carlos Coronel (Sr. Admin Coordinator); Mathew Koslow (Advanced Lung Disease Fellow).

Second row: Adam Cochrane (Transplant Pharmacist); Jessica Chun (Nurse Practitioner); Leah Papazian (Dietician); Elizabeth Davies (Social Worker); Susan Perry (Social Worker); Deanna Ridgeway (Financial Coordinator); Tina Thronson (Quality Manager); Edwinia Battle (Research Manager); Erin Lopynski (Dietician); Astrid “Julieth” Munoz (Program Manager); Lauren Marinak (Nurse Practitioner); Meg Fregoso (Nurse Practitioner).

First Row: Shambhu Aryal, MD, Kareem Ahmad, MD; Nargues Weir, MD; Steven Nathan, MD; Oksana Shlobin, MD; Whitney Brown, MD; Shalika Katugaha, MD (Infectious Disease); Melissa Bowen (CF Coordinator); Debbie Campbell (Transplant Director).

Absent:

Interventional Pulmonologist: Amit “Bobby” Mahajan, MD
Surgeons: Linda Bogar, MD; Sandeep Khandhar, MD; Liam Ryan, MD; Eric Sarin, MD; Ramesh Singh, MD.
Pulmonologists: Chris King, MD; Osman Malik, MD.
Research: Lori Schiegel (Research Coordinator); Drew Venuto (Research Coordinator).
Nurse Coordinators: Karen Brown (PH Coordinator); Angela Scully (ALD Coordinator).
Academic Accomplishments 2018
(Inova authors bolded)

Original Research Manuscripts (accepted or published)


14. Rhodes C et al. (Nathan SD among 118 co-authors). Genetic determinants of risk and survival in pulmonary arterial hypertension. Lancet Res Med Published online December 5, 2018 http://dx.doi.org/10.1016/S2213-2600(18)30409-0

15. Nathan SD, Costabel U, Glasperle I, Glassberg MK, Lancaster LH, Lederer DJ, Pereira CA, Trzaskoma B, Morgenstern E, Limb SL, Wells AU. Incidence of Multiple Progression Events: Pooled Analysis of Patients With Idiopathic Pulmonary Fibrosis Treated With Pirfenidone. accepted to Chest November 5th 2018


Reviews


Editorial


Consensus Statements


Case Reports


Abstracts/Presentations

International Society for Heart and Lung Transplantation, April Nice France 2018


12. Jarrett H, Jonnalagadda AK, Liu SD, Bagnola AJ, Lewis D, Shlobin OA, Barnett CF. Rapid Transition from Parenteral to Oral Treprostinil in PH is Feasible and
American Thoracic Society May, San Diego, CA

1. Behr, J., Nathan, S., Harari, S., Wuys, W., Kerchgaesser, K., Bengus, M., Gilberg, F., Wells, A. Sildenafil added to pirfenidone in patients with advanced idiopathic pulmonary fibrosis (IPF) and pulmonary hypertension (PH): a Phase IIb, randomized, double-blind, placebo-controlled study. World Health Organization meeting Nice, France 2018


4. Waxman AB, Tapson VF, Smith PM, Deng C, Nathan S. A Multicenter, Randomized, Double-Blinded, Placebo-Controlled Trial to Evaluate the Safety and Efficacy of Inhaled Treprostinil in Subjects with Pulmonary Hypertension due to Parenchymal Lung Disease (Study RIN-PH-211).

5. Behr J, Nathan SD, Harari S, Wuys W, Kerchgaesser K, Bengus M, Gilberg F, Wells A. Baseline Characteristics From a Pre-specified Interim Analysis of a Phase IIb, Randomized, Double-Blind, Placebo-Controlled Trial of Sildenafil Added to Pirfenidone in Patients With Advanced Idiopathic Pulmonary Fibrosis and Pulmonary Hypertension.


15. Gersten RA, Cannon B, Bowen M, Davies E, Brown AW. Evaluation of Depression and Anxiety and their Influence on Outcomes in Adult Patients with Cystic Fibrosis. Accepted to World Symposium on Pulmonary Hypertension Nice, France Feb 2018

World Symposium on Pulmonary Hypertension Nice, France Feb 2018

Behr J, Nathan SD, Harari S, Wuys W, Kerchgaesser K, Bengus M, Gilberg F, Wells A. Sildenafil added to pirfenidone in patients with advanced idiopathic pulmonary fibrosis (IPF) and pulmonary hypertension (PH): a Phase IIb, randomized, double-blind, placebo-controlled study. Presented at World Health Organization meeting Nice, France 2018

American Society for Echocardiography 2018


European Respiratory Society 2018


Chest San Antonio, TX October 2018


2. Kareem Ahmad, MD; Christopher S. King, MD; Oksana Shlobin, MD; Nargues Weir, MD; Shambhu Aryan, MD; Steven D. Nathan, MD; A. Whitney Brown, MD. Connective Tissue Disease associated Interstitial Lung Disease and Outcomes after Hospitalization: a Cohort Study. Podium Presentation


North America Cystic Fibrosis Conference 2018

Bowen M, Duong Q, Russell C, Lambert J, Connors G, Brown AW. Development and implementation of a CF specific outpatient pulmonary rehabilitation program. Podium presentation and poster ASMB 2018

Other team and fun photos:

Top two left: Transplant Olympics...very proud of our athletes!
Top right: Demonstration of the Transplant (germ-free) elbow bump
Bottom right: Pulmonary Hypertension Education Day; left to right; Karen Brown (Nurse Coordinator), Aaron Bagnoly (PH Pharmacist), Linda Bogar (Surgical Director), Mitch Psotka (Cardiologist), Nargues Weir (Pulmonologist), Chris King (Pulmonologist), Oksana Shlobin (Medical Director, PH Program)
Bottom left corner: the “King” is revealed and revered 😊