



Department of Internal Medicine

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I thank you for giving me the opportunity to offer a public comment at the Meeting of the Advisory Board on Toxic Substances and Worker Health. I am board certified in Pulmonary and Occupational Medicine, the only occupational pulmonologist at the University of New Mexico and in our great state, and I routinely take care of Energy workers. I have reviewed the Procedure Manual and the Advisory Board recommendations as well as the DOL response to the same, on the Internet. I want to specifically comment on four issues- shortage of providers and issues related to asthma, chronic obstructive pulmonary disease (COPD) and chronic beryllium disease (CBD).

Shortage of providers for Energy workers:

Energy workers of New Mexico are cared for primarily by primary care providers and not specialists. Not only is there a severe shortage of providers but those taking care of Energy workers tend to avoid any interaction with the Division of Energy Employees Occupational Illness Compensation program for multiple reasons. At the University of New Mexico, we have a specialized occupational lung diseases clinic for Energy workers. Our clinic is overbooked routinely above 200% of its capacity and has a six-month wait time, a wait time that no physician would ever wish for his or her patients. In an attempt to provide care for Energy workers in their own rural communities, the University has started the novel Project ECHO Miners' Wellness Tele-Echo Clinic, a tele-mentoring program to build and sustain teams of rural professionals but more needs to be done.

Asthma diagnosis and causation:

In my experience, work-related asthma is an undercompensated but a common condition in this cohort. I would like to emphasize the need for having simple, practical, and clearly written strategies in diagnosing and establishing work relatedness for asthma, that an average clinical provider in New Mexico can understand and use. Using a methacholine challenge test in the diagnosis of asthma is not practical in New Mexico since only one laboratory in the state offers this test (see page 524 of the procedure manual). Bronchodilator reversibility of FEV1 is neither sensitive nor specific for the diagnosis of asthma (see page 524 of the procedure manual). It is not uncommon for New Mexico workers to underestimate their respiratory symptoms, to ignore their connection with the workplace, and to not see a physician for years after the onset of symptoms. It is also not uncommon for physicians to make diagnoses years later, to make the wrong diagnoses, and to ignore the connection with the workplace. Evidence of contemporaneous diagnosis of occupational asthma during covered part E employment will miss many cases of work-related asthma. Further, an unsophisticated worker cannot specifically identify one of the multiple potential causative exposures or triggering mechanisms. Indeed, most physicians including University-based pulmonologists would fail this test. The requirements for work related change in FEV1/peak expiratory flow rates/bronchial hyperresponsiveness/positive response to specific inhalational challenge, to establish occupational causation, as noted in page 568 of the procedure manual, are neither simple nor practical in our clinic environment.

COPD diagnosis and causation:

COPD Diagnosis: Multiple statements on COPD in the Procedure Manual are inaccurate. For example, bronchoscopy, as noted on pages 216/566 of the procedure manual, is not used to make a diagnosis of

COPD but an abnormal diffusing capacity is helpful. A diagnosis of COPD can also be made without spirometric obstruction, which is not recognized by the procedure manual. Importantly, the chronic bronchitis phenotype of COPD is always diagnosed based upon presence of symptoms and may not be associated with spirometry or imaging abnormalities (Page 566 of the procedure manual). A history of smoking is irrelevant to the diagnosis of occupational COPD (Page 566 of the procedure manual).

COPD Causation: I want to point out that COPD secondary to dust and irritant exposure is a very common condition that I see in Energy workers. This exposure does not necessarily have to be silica or even asbestos but may include mixed dusts such as construction dust or fumes such as diesel exhaust. A 20 year exposure duration is set at too high a threshold, when studies indicate that 5 years or less duration exposures may also be significant contributory factors. The use of the more general term Vapors Gases Dust and Fumes (VGDF) as a risk factor, as recommended by the Advisory Board, is supported by the scientific literature.

CBD presumption in beryllium exposed patients with sarcoidosis

Given the limited availability of the beryllium lymphocyte proliferation/transformation test in blood and bronchoalveolar lavage fluid in New Mexico and the significant rates of false negative tests, covered beryllium exposed employees who are diagnosed to have sarcoidosis should be presumed to meet the ‘more likely than not’ criterion for CBD under Part E or Part B, even if the results of the beryllium lymphocyte proliferation/transformation test are normal or if the test was never performed. This is recommended by the Advisory Board and I agree with the same.

I want to conclude by recognizing the efforts of the Advisory Board in this regard. This Board represents outstanding multidisciplinary scientific expertise and has submitted simple and practical recommendations on asthma, COPD and Sarcoidosis/CBD, a feat that unfortunately does not always happen. I thank the Board members for their recommendations on these diseases and urge the DOL to accept the same.

Sincerely



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