Although national tobacco sales decreased by 17.43% between 2005 and 2009, US pharmacies increased their sales by 22.7% during the same period.1 Pharmacies account for almost 5% of total cigarette sales in the country. Independently owned pharmacies are less likely to sell tobacco products than retail chain pharmacies.2 The majority of professional organizations, including the American Society of Health System Pharmacists with a 36,000-plus membership, strongly opposes the sale or distribution of tobacco products in all establishments where health-care services are rendered.3 Despite the overwhelming professional opposition, the sale of tobacco products by chain pharmacies and grocery markets that contain pharmacies continues to increase.

Tobacco use is a major leading preventable cause of chronic illness and death in the United States. It is responsible for one in five deaths annually in the United States and increases health-care spending by $193 billion annually.4 The Institute of Medicine recommended in 1994 to ban tobacco sales in US pharmacies as part of a comprehensive strategy to reduce tobacco use among young people.5 However, with the exception of a few cities, pharmacies and health-care facilities are not legally prohibited from selling tobacco products.6 All the stakeholders involved in health-care delivery and the advocates of patient safety need to collaborate to ban tobacco sales in pharmacies across the country. The moral incentive of first do no harm to the patients should arise as a priority before the financial incentive. With the majority of pharmacists not supporting tobacco sales in pharmacies, the right time to act is now.

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REFERENCES


Simulation-Based Bronchoscopy Training

To The Editor:

We read with great interest an article by Kennedy and colleagues1 in a recent issue of CHEST (July 2013) in which a systematic review and meta-analysis of studies revealed significant improvements in skills and behaviors when comparing simulation-based bronchoscopy with no intervention. However, the article also identified gaps in evidence, such as the lack of clear understanding of optimal design or choice of modalities in relation to simulation-based bronchoscopy training. Based on our experience of setting up a regional simulation bronchoscopy program, we are able to address these issues.

We established five clinical skills laboratories that deliver simulation bronchoscopy training. We also set up a group of regional experienced bronchoscopists responsible for the development of simulation bronchoscopy training. We have run 15 courses and trained >60 candidates. Although initially we used different formats for the courses, the trainees’ overall experience of simulation-based bronchoscopy was extremely positive. Based on our initial experience, we established that the optimal design for delivering simulation-based bronchoscopy courses should incorporate a blend of short lectures, e-learning, and hands-on experience using simulation. To be successful, simulation-based bronchoscopy requires a high trainer-to-trainee ratio (ideally 1:2), and, therefore, we established a faculty of experienced bronchoscopists with a special interest in procedural training. Our results confirmed significant improvement, for both novices and more experienced trainees, in the technical ability of handling bronchoscopes, their understanding of anatomy and identification of bronchial segments, and their knowledge of the procedure; the improvements were in the range of 20% and 30% when using high fidelity alone and in combination with low-fidelity bronchoscopy simulation, respectively.2 We observed that the best outcomes were achieved by combining sessions on a virtual reality bronchoscopy simulator with low-fidelity manikin and real scope modules. Our real-life experience showed that it is possible to set up a large and successful regional simulation bronchoscopy training program, which is now offered to all of our trainees (before exposure to patients).

Training in bronchoscopy is a complex process and has been traditionally based on an apprenticeship model, which raised concerns of patient safety and variable level of experience, with reports suggesting that one-fifth of trainees may not be achieving the required number of procedures.3 Although simulation-based bronchoscopy can overcome many of these issues, it has only been incorporated into 36% programs in the United States.4 The article by Kennedy and colleagues1 and our experience, therefore, provide important evidence to encourage wider use of simulation for bronchoscopy training.

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Obstructive Sleep Apnea and Sodium Intake

What Is the Mechanism?

To the Editor:

We read with keen interest the study by Pimenta et al\(^1\) in a recent issue of CHEST (April 2013). These researchers enrolled 97 patients with resistant hypertension (RHTN) and screened them with overnight polysomnography for the presence of obstructive sleep apnea (OSA). In addition, 24-h urinary sodium and aldosterone levels were measured. It was found that 77.3\% of the patients with RHTN had OSA, which is much greater than the prevalence of OSA in the general population.\(^2\) On the other hand, 29.9\% of the patients with RHTN were found to have hyperaldosteronism. It was found that the urinary sodium level was an independent marker for OSA severity in the patients with hyperaldosteronism (no such association was found in patients without hyperaldosteronism). We congratulate the authors, who contributed extensively to the topic of OSA and aldosterone metabolism. We would like to mention some of the possible mechanisms that may explain this association.

It is well known that patients with RHTN (including hyperaldosteronism), congestive heart failure, and advanced renal disease have a greater prevalence of OSA.\(^3\) Fluid overload associated with these conditions and rostral fluid shift may lead to narrowing of the upper airways, with resultant OSA. This hypothesis is bolstered by the fact that therapies aiming to remove excessive body fluid are associated with an improvement in OSA severity. Nevertheless, additional pathobiologic pathways may be implicated in the development or worsening of OSA severity. Research data point out that aldosterone may mediate multiple detrimental effects, such as tissue fibrosis, systemic inflammation, and oxidative stress.\(^4\) These mechanisms are believed to be responsible for an aldosterone-mediated increase in cardiovascular disease.\(^4\)


REFERENCES


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