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IN THIS ISSUE

About PJCD

The **Philippine Journal of Chest Diseases (PJCD)** [Print ISSN: 2094-1463**,** Electronic ISSN: 3028-1199] is an open-access, English language, online, medical science journal published by the **Philippine College of Chest Physicians (PCCP).**

Its editorial policies are based on the standards for scholarly publication set forth by the **International Committee of Medical Journal Editors (ICMJE) "Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals,"** as well as best practices and guidelines of the **Committee on Publication Ethics (COPE).**

The **PJCD** seeks to be a high-quality, peer-reviewed publication oriented to the practice of pulmonary medicine. The journal publishes scientific papers in the form of original clinical and laboratory investigations, case reports and series, systematic reviews, clinical practice guidelines, editorials, and other manuscripts of relevance to the art and science of pulmonary care.

The journal's target audience are local and international practitioners, clinicians, allied healthcare professionals, scientists and researchers working on pulmonary medicine. It shall accept manuscript submissions from consultants, fellows, residents, and other allied medical professions and specialties in the Philippines. Non-members of the PCCP may submit scientific manuscripts to the journal.

The **PJCD** is published by the PCCP two times a year (June and December).

CONTENTS

PRESIDENT'S MESSAGE

Greetings!

As we continue to navigate the evolving landscape of pulmonary medicine, we must recognize the critical role of research in shaping the future of the practice of pulmonary medicine. The Philippine Journal of Chest Diseases stands as an important platform for this endeavor, reflecting our college's commitment to enhancing the practice of pulmonary medicine in the country.
Our field faces numerous challenges and continuous advancements, from emerging respiratory diseases to the complexities of managing chronic conditions. Addressing these challenges requires a robust body of research to transform clinical practice. Research not only drives the development of innovative treatments but also ensures that our practices are grounded in the most current evidence, ultimately improving patient outcomes.

The value of research extends beyond theoretical knowledge and remains relevant not only for our trainees but even to our established pulmonary colleagues. It equips them with the tools needed to tackle real-world problems, fosters critical thinking, and promotes a culture of continuous learning and adaptation. By prioritizing research, we provide our clinicians with the resources necessary to stay at the forefront of medical advancements and to deliver the highest standard of care.

The Philippine Journal of Chest Diseases serves as an essential source for disseminating new findings, sharing clinical insights, and fostering collaboration within our community. We encourage all members to contribute to this body of knowledge, whether through original research, case studies, or review articles. Your contributions will play a crucial role in shaping the future of pulmonary medicine in the Philippines.

I would like to extend my heartfelt congratulations to the team behind the Philippine Journal of Chest Diseases for their dedication and hard work in producing new editions each year. By consistently providing us with updated and relevant information, you enable us to integrate these advancements into our daily clinical practice .
Thank you for your continued commitment and contributions.

Ma. Janeth T. Samson, MD, FPCCP
President, Philippine College of Chest Physicians

Embracing the Journey Ahead

Welcome to the first ever online issue of the Philippine Journal of Chest Diseases. This issue marks the journal's foray into digital publication which now allows us to bring our journal and the work of our authors to the rest of the world.

The journey to now has not been easy. Almost a year ago, the editorial team initiated the process of digitalization and further professionalizing of the journal. We crafted new policies and improved on existing ones, underwent training to better capacitate ourselves in our roles, and acquainted ourselves with the online journal management system. To ensure the adequacy of reviewers and quality of our review process, we invited reviewers outside our society and reengaged old ones. When we started to accept manuscripts for publication consideration in the early part of the year, we initially received a high volume of incomplete submissions from authors. There were also technical queries on navigating the journal portal. As our authors became more acquainted with the mechanics of the online submission process, and our reviewers with the review forms and timelines, we started experiencing a smoother and faster turnaround of manuscripts, for the most part. We still have the occasional manuscripts being archived after inactivity, and the unavoidable delays encountered in the review process but we now have an increasing number of manuscripts in our workflow with the potential to be published.

On behalf of the entire editorial team and our publisher, the Philippine College of Chest Physicians, I would like to express my gratitude to all authors and reviewers of PJCD we have worked with since:

Authors are the lifeblood of publishing without whom there will be no articles to publish. I thank them, foremost, for their interest and trust in choosing to publish their work with PJCD. Throughout the various stages of the publishing process, I am grateful for their patience and diligence in carrying out our multiple requests, as well as their grace and optimism in the face of rejection. Your honest appreciation of our feedback gives meaning to the work we do.

Peer reviewers are instrumental in academic publishing, acting as a filter to the content we publish and invaluable in improving the quality of manuscripts being considered for publication. Almost always, reviewers play multiple roles as academician, researcher, clinician, or administrator and are very busy in their own right. I cannot thank you enough for the significant time and effort spent in reviewing manuscripts for our journal. I hope that you, likewise, find your participation to be a fruitful endeavor that contributes to your intellectual growth and professional development.

While there are, and will be, challenges ahead, I look forward with confidence and optimism that PJCD will contribute in a meaningful way to advancing the practice of pulmonary medicine, both locally and internationally.

Miriam Yano Lalas, MD, FPCCP
Editor in Chief

EDITORIAL POLICIES

EDITORIAL PROCESS

Only submissions that are in scope and have passed preliminary screening for completeness and documentary requirements shall be considered by the Editor-in-Chief if these may proceed to review. The Editor-in-Chief shall assign an Associate Editor to oversee and facilitate the peer review process.

After peer review, the Editor-in-Chief shall make the final decision on the manuscript.

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Feature Article

Climate Pulmonology: When Pulmonologists Can Mitigate Climate Change and Air Pollution

Paula Teresa F. Sta Maria, MD[1]

ABSTRACT
The healthcare sector is mobilized into the frontline to address climate-related disasters and diseases but at the same time produces a lot of greenhouse gases. Climate pulmonology seeks to equip pulmonologists with the basic science of climate change and air pollution, and their impact on people and planetary health. A solid background on this issue will empower lung specialists to narrate the climate story to stakeholders and move towards a sustainable future.

Keywords: climate pulmonology; climate change; air pollution; mitigation; sustainability

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Industrialization sparked the "Great Acceleration" in the 1950s but also caused significant environmental degradation and health issues.[1] Ever since coal was discovered to fuel anthropogenic activities coupled with rapid urbanization that depleted the Earth's green spaces, unprecedented global warming has intensified heat waves and degraded air quality. Direct greenhouse gas emissions and climate change effects (e.g., increased ground-level ozone) exacerbate air pollution that kills 7 million lives prematurely every year.[2] The Intergovernmental Panel on Climate Change (IPCC) warns that a global temperature increase of 1.5 degrees Celsius will lead to loss of biodiversity and will impact human health. If no actions are taken to restore Mother Earth, the globe will scale 2.6 to 4.8 degrees Celsius warmer by the end of the century,[3] making sustainability the most critical agenda in the Anthropocene.

The ozone layer around Earth acts as a natural shield and maintains the core temperature of Mother Earth. It absorbs energy from the sun to heat the stratosphere, and absorbs infrared radiation emitted by the earth's surface. Anthropogenic activities, however, depleted the ozone layer (through chlorofluorocarbons) and produced a layer of greenhouse gases like carbon dioxide, methane, and nitrous oxides in the troposphere. Heat that is supposed to be radiated back into space is trapped within this layer creating the 'greenhouse effect' of climate change. This dense layer also contains gases like ozone, nitrogen dioxide, sulfur dioxide, carbon monoxide, and particulate matters ($PM_{2.5}$ and PM_{10}) that pollute the air. Once inhaled, these gases evoke an inflammatory response in the bronchial airways. The finer particulate matters penetrate the alveolocapillary membrane and invade the systemic circulation to cause oxidative stress and endothelial dysfunction. These manifest in strokes, heart diseases, exacerbation of respiratory illnesses like chronic obstructive pulmonary disease (COPD) and bronchial asthma. $PM_{2.5}$ also causes metabolic effects, disrupts reproductive health, brings abnormal neurological development in children, and causes cancer[4,5] – the "climate penalty" as construed by the World Meteorological Organization Air Quality and Climate Bulletin.[6]

Climate change and air pollution inevitably increase health risks and demands for healthcare. The health organization, however, moves "bidirectional" as described by Professor Jeffrey Braithwaite.[7] In its mission to be vanguards of peoples' health, the healthcare organization also produces greenhouse gases. There are three scopes of the healthcare carbon footprint based on the Greenhouse Gas Protocol: The first scope covers direct emissions (10-20%) from operating service facilities controlled or owned by the organization like vehicles, and gas anesthetic leaks in operating rooms. The second scope of the healthcare carbon footprint is indirect emissions (0.3%) from purchased electricity. The third and largest scope is indirect but optional (50-75%) that includes greenhouse gas (GHG) emissions from the procurement of disposables and consumables (pharmaceuticals, medical products and devices, dietary food), business travel, and healthcare waste.[8] Green procurement will consequently reduce the healthcare carbon footprint. Overall, the healthcare sector's carbon footprint is 4-5% of GHG emissions worldwide, spewing 2 gigatons of carbon dioxide into the environment. This is equivalent to the annual GHG emissions from 514 coal-fired power plants.[9]

How can we, as physicians, be true to our mission in both words and in actions? How do we heal and harm no one especially Mother Earth?

Physicians pledged to uphold reverence for "life from the beginning." They are trusted, credible sources of information and are able to convey complex health issues and make it more relevant to diverse patients and communities.[10] If each physician could convey the message that climate change and air pollution threaten the survival of people and Mother Earth, increasing public awareness could leverage health data toward a climate action. Healthcare professionals clearly have three buckets to fill – climate mitigation, adaptation, and resilience. Mitigation seeks to reduce GHG emissions and limit global warming. Adaptation aims to reach out and help people adjust to the current and future effects of climate change. Climate resilience is a political process that increases the ability to recover from, or to mitigate vulnerability to, climate-related events such as typhoons and floods.[11]

The way forward to restore peoples' health is to restore Earth first. The healthcare sector's carbon footprint may be lowered by addressing the three scopes of GHG emissions. Alternative sources of energy and even walking, biking, and the use of mass transit systems have always been floated but, in the Philippine context, remains an empty comment that shifts the blame and responsibility of climate change down to the common Filipino. While a cultural shift definitely needs to occur, stronger and more involved call towards good policy and good execution has to be in place. The long-debunked notion of "adding more lanes" needs to be supplanted with better bus and rail transit systems. Highway megacities that add more lanes encourage people to live further away (no one wants to live next to the noisiest streets) and drive longer distances. Bicycle lanes-turned-"free" parking spaces with car engines idling discourage initiatives to walk and bike more.

Urbanization "paved our paradise" and turned forested areas into communal living. Deforestation leads to the loss of the natural carbon sink. Trees remove carbon dioxide from the air and store carbon in them and release oxygen into the atmosphere. To augment the carbon sink, several training institutions of the Philippine College of Chest Physicians (PCCP) initiated tree-growing activities. And these are not merely pet projects, as studies by Professor Mylene Cayetano of the University of the Philippines Diliman Institute of Environmental Science and Meteorology suggest that heavily congested areas in the National Capital Region with small pockets of forests had better air quality – leading to better health outcomes.[12] This demonstrates that greener cities and sustainable urban planning are not merely for aesthetic flair, but a necessity for a sustainable tomorrow.

Healthcare waste management is one of the challenges in hospital operations as exemplified by the pile up of "infectious waste" during the Covid-19 pandemic. In an audit of healthcare waste during the pandemic in five key hospitals in the Philippines, approximately 50% of infectious waste were "non-essentials" from plastic eating utensils, wrappings, single-use plastics.[13] Segregated waste labelled "infectious" are not treated like general waste but are packed in yellow clinical waste bags, collected, stored, and transported via accredited vans of the Department of Environment and Natural Resources – Environmental Management Bureau to treatment facilities for final disposal. Each kilogram of waste from a Tacloban hospital that is transported to a treatment facility in Isabela, Leyte costs approximately Php 46 to Php 60. Thus, in municipalities of the Philippines where there are no treatment facilities, healthcare waste leaves a trail of greenhouse gases from the time waste is collected from the hospital to its movement to another region. Not only is the process hazardous, it is also very expensive. Waste incineration in treatment facilities releases Persistent Organic Pollutants (POPs) like nitrous oxide, dioxins, and furans into the environment, aggravating air pollution. Adverse health outcomes in communities near waste incinerators like reproductive dysfunction and cancers (non-Hodgkin lymphoma, bowel cancers, and soft tissue sarcoma) have been reported.[14] Sustainable waste treatment like autoclaving or recycling technologies must be reinforced. Another outcome of waste pollution is the catastrophic flooding in major cities of the National Capitol Region, not only from the massive rainfall from Typhoon Carina on July 24, 2024 and the southwest monsoon, but from sewers clogged with 1,513 tons of trash especially plastics.[15] Maintenance of sewage systems and a cultural drift from the "throw away living" and rampant littering, to discipline on proper segregation and waste disposal has to be inculcated. A collective action like bringing personal water flasks during conventions (and in our daily routine) not only reduces cost for hydration but obviates plastic pollution from refusing PET (polyethylene terephthalate) bottles and single-use plastics. A proper needle disposal system in the community and a drum to collect cooking or motor oils are simple measures to safer waste management. Clearly, a framework has to be in place. Solid waste can be limited by observing the 5 Rs of the environment – refuse, reduce, reuse, recycle, repurpose – complemented by the 5S (sort, set in order, shine, standardize, sustain) of good housekeeping not only in medical facilities but also in our homes.

Inhaler medications are central in the control of obstructive lung diseases. Earlier pressurized metered-dose inhalers contained chlorofluorocarbons but were phased out as they depleted the ozone layer. In its place, a new propellant, hydrofluorocarbon, was introduced though it is a potent greenhouse gas that contributes to global warming. Dry powder forms and soft mist inhalers are more environment-friendly options.[16] Since inhaler therapy is an important armamentarium in pulmonary care, clinical guidelines emphasizing the right indications, patient education to avoid triggers, monitoring of condition, and good compliance to inhaler medications are integral to control pulmonary diseases and reduce healthcare cost and unnecessary GHG emissions.

Physicians should reinforce proper nutrition. Consumption of more greens and seafood and less meat not only improves health but decreases carbon footprint.

Increasing temperature and carbon dioxide levels affect plant growth and are expected to alter the composition of respiratory allergens, molds, and other bioaerosols.[17] These aggravate allergic conditions and heighten exacerbations of COPD and asthma like in "thunderstorm asthma." Health professionals can protect vulnerable patients by teaching them to stay indoors during poor air quality days.

This year, heat and humidity too severe for human tolerance have been reported. Dangerous heat indices of 42 degrees Celsius and above can cause strokes, mental stress, dyspnea, heart attacks, and liver and kidney injury.[18] An advisory on the air quality index and heat index is mandatory to allow citizens to make appropriate decisions.

The PCCP tackled climate change and air pollution as a priority program. The society forged a coalition with the Philippine College of Physicians (PCP), Philippine Society of Allergy, Asthma and Immunology (PSAAI), Lung Center of the Philippines (LCP), and Health Care Without Harm Southeast Asia (HCWH-SEA) to form Health Alliance for Climate and Clean Air Philippines (HACCAP). HACCAP aims to transform researches into policies and narrate the climate and air pollution story to the masses. Another flagship program of the PCCP is the Lunghap campaign with a training module, "Blazing a Trail for Healthy Lungs and Clean Air" to educate PCCP

members on air pollution and climate change. This knowledge should resonate in daily practice to champion compleat patient care.

To recover from climate change, the Conference of the Parties United Nations (COP UN) Chief António Guterres emphasized, "The era of fossil fuels must end with justice and equity." Sustainability is not a step backward to undo the climate crisis, but needs to be innovative and enduring for generations to come. For the first time, Health Day was one of the highlights of COP28 in Dubai last December 2023 with a demand to elevate health in climate negotiations. While countries need to cooperate to make one global climate action, physicians have a contribution to make. Every patient encounter is an opportunity to tell the story that climate change and poor air quality contribute to their illnesses. This is when physicians are able to advocate for a sustainable future and close the gap of climate science to action. By winning one person at a time. For Mother Earth and her people.

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Case Report

Recurrent Pneumothorax in a Premenopausal Filipino Female: A Case Report

ANa Leandra N. Antonio, MD,[1] Luzvisminda Ares, MD,[1] Ruby Nolido-Pedroza, MD[1]

ABSTRACT

Lymphangioleiomyomatosis (LAM) is a rare progressive multisystemic cystic lung disease. It commonly presents as fatigue, progressive dyspnea, and spontaneous pneumothorax which can progress to chronic respiratory failure. Previously, patients were diagnosed with LAM through histopathological testing. In 2017, new guidelines were released by the American Thoracic Society allowing the clinical diagnosis of LAM. This is the case of a 46-year-old female with a history of recurrent pneumothorax and progressive dyspnea. During episodes of pneumothorax, she underwent multiple chest tube insertions. High-resolution chest CT scan revealed a small right pneumothorax with septations, pleurodiaphragmatic adhesions, minimal pleural effusion, diffuse cystic lung disease, and a fat-containing right renal nodule consistent with an angiomyolipoma thereby fulfilling the clinical criteria for the diagnosis of LAM. The patient eventually underwent talc pleurodesis and was started on sirolimus. LAM should be considered in women of childbearing age without co-morbidities presenting with spontaneous pneumothorax.

Keywords: lymphangioleiomyomatosis; LAM; pneumothorax; cystic lung disease; progressive dyspnea

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INTRODUCTION

Lymphangioleiomyomatosis (LAM) is a progressive disease that affects premenopausal women and is characterized by cystic lung lesions, renal angiomyolipomas (AML), and lymphatic involvement. It commonly presents as fatigue, progressive dyspnea, and spontaneous pneumothorax. There are two main types of LAM: sporadic LAM and LAM associated with tuberous sclerosis complex (TSC). The pathogenesis of LAM involves inappropriate cell growth and proliferation of abnormal smooth muscle cells, abnormal angiogenesis, and lymphangiogenesis leading to the migration of LAM cells and deposition in the pulmonary parenchyma resulting in progressive cystic destruction of the lung tissue.[1] Limited studies have reported its exact prevalence. In the United States, United Kingdom, and Switzerland, the incidence of LAM ranges from 0.23-0.31 per million women every year.[2] The epidemiology of the disease in Asia or the Philippines has not been well-documented. In the Philippines, only three case reports have been published, all of which have undergone histopathological diagnosis.[3-5] However, recent developments in the diagnosis of LAM favor a less invasive approach which allows its clinical diagnosis using nonpathological tests. This facilitates early recognition and timely intervention to avoid rapid decline of pulmonary function.

CASE PRESENTATION

This is the case of a 46-year-old female, non-smoker, who presented with recurrent pneumothorax. She was healthy and had no previous admissions. In 2011, she presented with sudden dyspnea. She was tachypneic with decreased breath sounds at the right lung field. Chest radiography revealed a pneumothorax in the right hemithorax, where a chest tube was inserted. There were also apical infiltrates and the patient was managed as a case of tuberculosis. In the interim, she had episodes of dyspnea relieved by rest.

In 2018, the patient had a sudden onset of difficulty of breathing not associated with cough and fever. On physical examination, the patient was in respiratory distress, tachycardic, and tachypneic with desaturations as low as 80% and she was hooked to nasal cannula at 4 liters per minute. There were decreased breath sounds in the right upper lung field and a pneumothorax in the right apex was seen on chest radiograph (Figure 1). Chest computed tomography (CT) scan revealed a small right pneumothorax with septations, minimal pleural effusion, diffuse cystic lung disease (Figure 2A) and an angiomyolipoma, a fat-containing right renal nodule measuring 0.8 x 0.8 cm (Figure 2B). Unfortunately, due to limited resources, measurement of serum vascular endothelial growth factor-D (VEGF-D) was not done. Screening for tuberous sclerosis was also not done as the patient did not have any family history or dermatological features such as subungual fibromas, facial angiofibromas, hypomelanotic macules and shagreen patches, hence, lessening the suspicion for such. The patient was clinically diagnosed with LAM in accordance with the 2017 American Thoracic Society/Japanese Respiratory Society Clinical Practice Guidelines (ATS/JRS CPG) wherein a clinical diagnosis of LAM can be made based on the combination of characteristic high-resolution CT (HRCT) features plus one or more of the following: presence of TSC, angiomyolipomas, chylous effusions, lymphangioleiomyomas, or elevated serum VEGF-D greater than or equal to 800 pg/ml.[6]

In March 2022, the patient was admitted for talc pleurodesis on the right but had a sudden onset of dyspnea with desaturations as low as 85%. The right chest tube was reinserted. The patient also had an anaphylactic reaction to ampicillin-sulbactam which resulted in a further delay in her scheduled pleurodesis. In June 2022, she was started on sirolimus and trough levels were maintained within target range. Between March and October 2022, four more episodes of pneumothorax were recorded. In October 2022, the patient underwent talc pleurodesis. After pleurodesis and while on sirolimus, she had another pneumothorax in May 2023 but no recurrence has been reported since then. Figure 3 shows a timeline of the recurrence of her pneumothorax.

The patient is relatively young with no known comorbidities. She is a non-smoker which reduces the likelihood of airway inflammation and respiratory bronchiolitis which can cause recurrent primary spontaneous pneumothorax.[7] In addition, smokers are predisposed to chronic obstructive pulmonary disease which is also the most common cause of secondary spontaneous pneumothorax.[8] The patient also has no family history of spontaneous pneumothorax. This makes inherited conditions such as Birt-Hogg-Dubé syndrome,

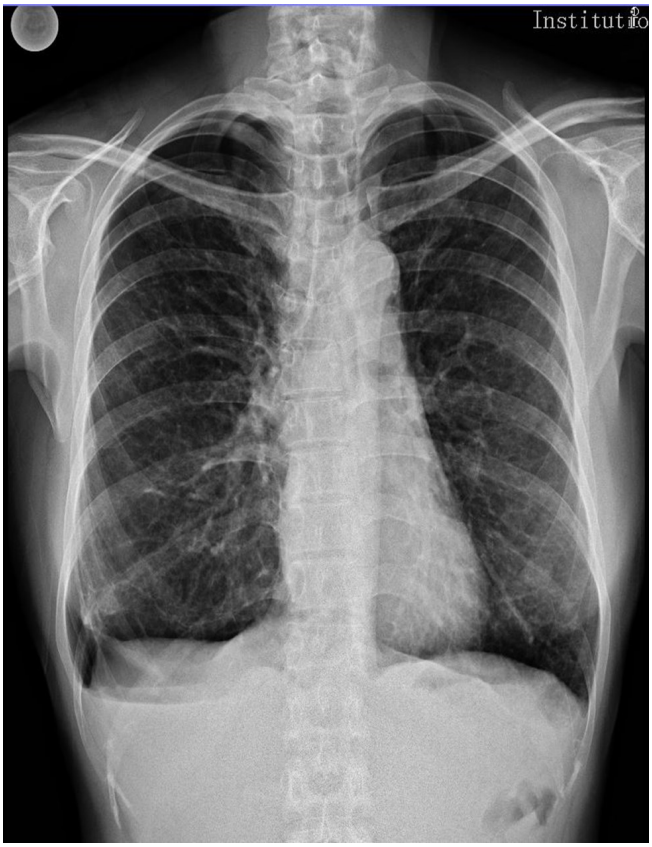

Figure 1. Chest x-ray showing minimal pneumothorax in the right apex

hyperhomocysteinemia, alpha-1 antitrypsin, and Marfan syndrome less likely.[9-10] The apical infiltrates seen on radiograph led to a differential diagnosis of pulmonary tuberculosis. With a history of recurrent pneumothorax, another consideration for this patient was a catamenial pneumothorax secondary to thoracic endometriosis. In thoracic endometriosis, symptoms begin within 72 hours after the onset of menstruation.[11] However, for this patient, the symptomatology and recurrence of pneumothorax were not related to her menstrual cycle.

The patient is currently maintained on sirolimus and has fewer episodes of dyspnea on exertion. The last pneumothorax episode was in May 2023. She no longer requires oxygenation and can now regularly exercise and perform routine daily activities. She was advised pulmonary rehabilitation and continuous professional counselling to aid in her mental and emotional well-being.

DISCUSSION

The diagnosis of LAM should be established using a stepwise approach from the least to the most invasive method, in accordance with the 2017 ATS/JRS CPG. The algorithm states that for patients with clinical suspicion of LAM and HRCT chest findings of multiple, bilateral, uniform, round, thin-walled cysts - a detailed clinical evaluation must be done to first check for the presence of TSC. If there is no clinical suspicion for such, serum VEGF-D, non-contrast CT or MRI of the abdomen/pelvis, or chylous fluid/node/mass aspiration is obtained. If any of the following is present – serum VEGF-D greater than or equal to 800 pg/ml, renal AML or lymphangioleiomyomas, or positive cytology - the diagnosis of LAM is confirmed. In cases where the findings fail to reveal features consistent with LAM, individualized decision-making on whether to do transbronchial lung biopsy or simple close monitoring of the patient should be done. Surgical lung biopsy is done as a last resort if transbronchial lung biopsy is unable to reveal a diagnosis.[6] This will minimize unnecessary intraoperative risks and lessen possible iatrogenic complications. In our local setting, measurement of serum VEGF-D is unavailable. Histopathological diagnosis is costly and most patients have difficulty proceeding with such diagnostic interventions. This results in the delay of diagnosis and management which would greatly impact the prognosis of the disease.

The annual decline in forced expiratory volume in one second (FEV1) in untreated LAM patients has been reported to range from 40 to 120 mL/year and higher.[12] The median survival for these patients is 23 years from diagnosis.[13] Approximately two-thirds of patients with LAM develop pneumothorax. The risk of recurrent pneumothorax is approximately around 70%.

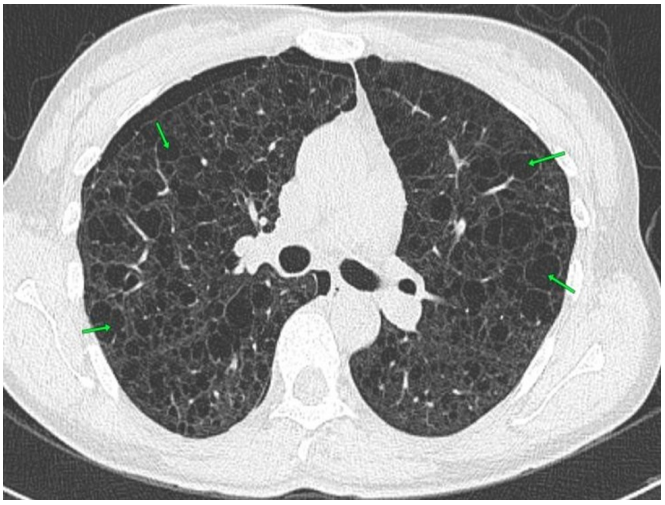

Figure 2A. Transverse cut of chest CT scan showing numerous, thin-walled, air-filled cysts of varying sizes (green arrows) with surrounding normal parenchyma signifying a diffuse cystic lung disease

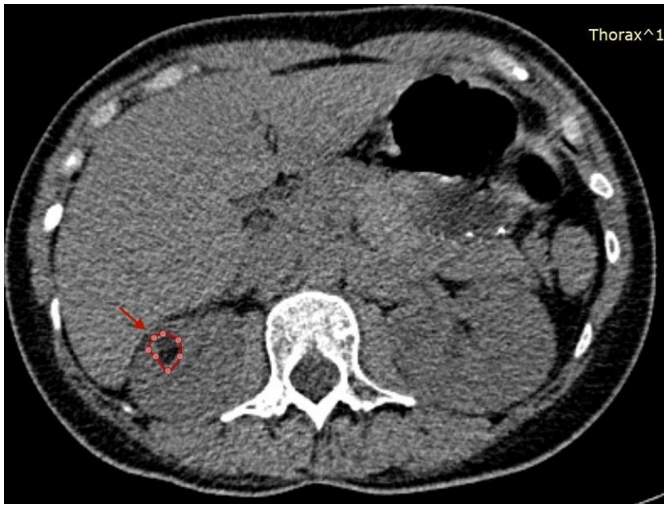

Figure 2B. CT scan showing an angiomyolipoma in the right renal cortex - a nodular focus with fat component (red arrow; lesion encircled)

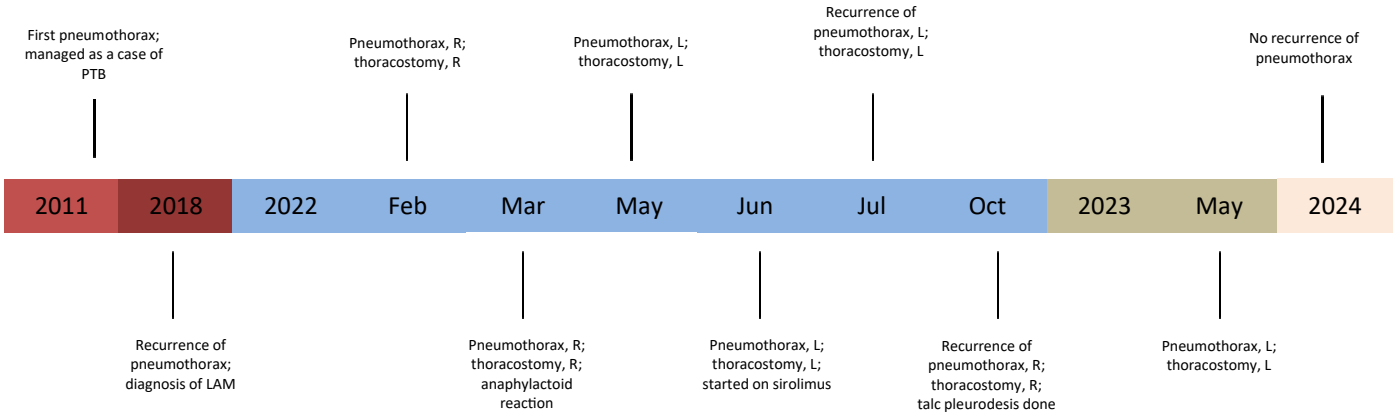

Figure 3. Timeline depicting the frequency and intervals of the patient's pneumothorax. PTB, pulmonary tuberculosis; LAM, lymphangioleiomyomatosis; R, right; L, left

Therefore, pleurodesis after the first pneumothorax is recommended.[6] The treatment for sporadic LAM is inhibition of rapamycin signalling with sirolimus (mechanistic target of rapamycin [mTOR] inhibitor). It is indicated for symptomatic patients with abnormal lung function or those with FEV1<70% of predicted. Treatment with sirolimus is suppressive rather than curative of the disease. It is generally well-tolerated and is continued indefinitely. Monitoring of serum trough levels, complete blood counts, fasting lipids and glucose, liver and renal function, and urine protein every 3 months is recommended.[14-15] However, for patients with an advanced disease, lung transplantation may be the only treatment option.

CONCLUSION

Lymphangioleiomyomatosis is a rare disease, characterized by cyst formation in the lungs and the proliferation of immature smooth muscle in affected organs. Young women presenting with dyspnea and recurrent pneumothorax who are non-smokers should raise the suspicion for LAM. A clinical approach will lead to early recognition and intervention which are crucial in maximizing pulmonary function and slowing down pulmonary decline.

Acknowledgments

Dr. Connie Rose Benjamin: Conceptualization; **Dr. Kristine Ivy Riel:** Resources

Ethical Consideration

The authors declared that appropriate written informed consent was obtained for the publication of this manuscript and accompanying images.

Statement of Authorship

All authors certified fulfillment of ICMJE authorship criteria.

Authors' Disclosure

The authors declared no conflict of interest.

Funding Source

None declared.

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ERRATUM

In the article, *"The Predictive Value of SpO2/FiO2 (SF) Ratio on the Chest CT Severity Score (CTSS) of Adult COVID-19 Patients Admitted in Chinese General Hospital and Medical Center,"* of the last print issue (Vol. 21 No. 2) of the Philippine Journal of Chest Diseases, the author's name was given incorrectly.

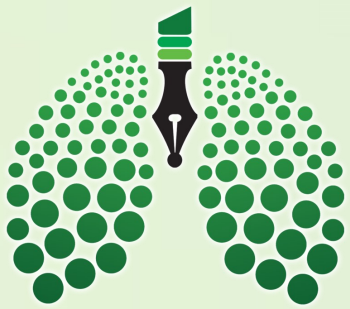
Aldrin Paolo C. Hilado, MD, and Jennylyn T. Go, MD, FPCCP was the authors list in the article and the Table of Contents.

The correct authors list should be: Paolo C. Hilado, MD, and Jennylyn T. Go, MD, FPCCP

A corrected online version of the issue has been uploaded in the archives of the PJCD journal portal. We apologize for any inconvenience caused by this error.

About the PJCD logo

The official logo of the **Philippine Journal of Chest Diseases** consists of a pen surrounded by colored dots forming the shape of the lungs. The gradient represents the process of building the manuscript from research conception to publication, ultimately forming a cohesive and coherent written work represented by the lungs.



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