SPEAKER: So for the clinician presented with patients with NTM disease, the huge-- well, a huge question, really-- is, who should be treated, and who do I not yet need to treat? It's a huge dilemma for many clinicians seeing many patients. And I think there are a few important considerations to keep in mind.

As a background statement, in general, this is a somewhat indolent disease process. And in general, hasty decisions do not need to be made. I would argue that hasty decisions probably never need to be made because this isn't that rapidly an evolving infectious disease process.

But there are some guidelines. Cavitary disease is-- whether it's MAC or other pathogens-- is a poor prognostic circumstance. And cavitary disease will probably advance faster than the other typical nodular bronchiectasis pattern. And cavitary disease absolutely should be managed aggressively, and the patient should be aware that this could be a more problematic issue.

And in the majority of cavitary disease states, there might be need for added agents. By the consensus ATS/IDSA guidelines, they point out that in addition to routine oral antimicrobials dependent upon drug susceptibility, the use of IV therapies should be strongly considered-- if not universally used-- for cavitary disease. And that will, generally speaking, include agents such as IV amikacin.

So for the clinician, when presented with cavitary disease, they need to make sure the patient knows that this is a more substantial feature. They also need to consider that if they are unfamiliar with or uncomfortable with the use of multidrug regimens that include IV agents for NTM disease including MAC, that this would be the point at which they would consider referral to a center with a large volume and a lot of expertise in management of these more complex subset MAC-infected patients.

So if we walk back from the cavitary disease population and look at the more numerous more typical nodular bronchiectasis patient population, there are some of those patients where their symptoms are of substantial magnitude and clearly of a worsening character. The patient may report that six months ago or a year ago or three or four years ago their performance status was noticeably better. The clinician may have spirometric evidence that pulmonary function was better and now has clearly worsened, and they could potentially tie that with symptom status and with CT scan evidence to make a fairly compelling case of disease progression.

And there are reasons that some might consider waiting. And some of those reasons might be the uncertainty about the disease progression on the part of clinician, the uncertainty about worsening symptoms on the part of the patient. And while I think it's-- and I think the community that deals with NTM infections would broadly agree that careful decision-making and a pause in decision about management is appropriate, one should have that conversation with a patient so that he or she knows there are reasons to want to treat, particularly if symptoms worsen or if the burden of disease looks great either by serial cultures or by CT scan evidence.