

An Interview with Dr. Albert Rizzo

Elizabeth Healy, MPH

Dr. Rizzo is the chief of Christiana Care's Pulmonary and Critical Care Medicine. He served as medical director for Pulmonary Disease Management. This role included developing guidelines for treating and discharging patients with lung-related illnesses such as asthma, pneumonia, emphysema and bronchitis. In addition, he is on the Lung Cancer Health Improvement Team and the Pharmacy and Therapeutics Committee.

Dr. Rizzo earned his medical degree from Jefferson Medical College of Thomas Jefferson University in Philadelphia. He was an intern and resident in internal medicine at the university's hospitals and completed his fellowship in pulmonary medicine at Georgetown University Hospital in Washington, D.C. He received specialized training in sleep medicine through a preceptorship sponsored by the Robert Wood Johnson medical system at Kennedy Hospital.

Dr. Rizzo practices with Pulmonary Associates, which has offices near Christiana Hospital and in Wilmington. He is board-certified in internal medicine, pulmonary disease and critical-care medicine and sleep-medicine disorders. He is a fellow in the American College of Physicians (FACP) and the American College of Chest Physicians (FACCP).

He currently serves as a clinical professor of medicine at Jefferson Medical College. He is also medical director and on the Medical Advisory Board for the School of Respiratory Care at Delaware Technical & Community College. Dr. Rizzo is an active researcher and lecturer. He has served as principal investigator for numerous drug studies related to treating respiratory illnesses. His lectures have covered topics ranging from the diagnosis and treatment of lung-related illnesses to the effects of sleep disorders on heart health.

He is deeply involved in the American Lung Association. He has been on the local organization's board of directors since 1987 and has served as chairman of that board on two occasions. He has been active at a national level for the association and is currently the speaker of the American Lung Association Nationwide Assembly. The national organization has recognized him four times with honors that included the John Janvier Black, M.D., Award for Community Service and the Volunteer Excellence Award in Program Innovation.

Dr. Rizzo's other professional and community activities include serving as chairman of the Pharmacy and Therapeutic Committee, which creates a preferred drug list for Delaware's Medicaid program. He was appointed to the position by the secretary for Delaware Health and Social Services. He is also on the state Drug Utilization Review Board.

LH: How did you first gain an interest in medicine and then specifically, in pulmonology?

AR: Well, the interest in medicine was there for a long time, I just can't explain it. The easier question for me is pulmonary... I think a lot of physicians have some preconceived notion of what they want to do, but mine was based really on the physicians I met along the way, when you do different rotations and spend time at different hospitals. When I was an intern and did my respiratory intensive care unit rotation at Jefferson... the teachers that I had there made it very interesting, they made the physiology interesting, the treatment modalities we had to treat these

patients interesting, and it just looked like something that made sense and I decided that was something I wanted to do.

LH: What do you find to be one of the biggest challenges in the field, and in your position?

AR: Well, I don't know if challenging in the right word, but certainly we know that a lot of pulmonary diseases could be prevented if we could get people off of cigarettes, and I do a lot of teaching about that; it's rewarding to get people off [of cigarettes] when I can, but the challenge is many people have been smoking for many years, and it's a chronic disease, so the most I'm going to be able to do for some of these patients is to help them have a better quality of life, but I can't necessarily cure them.

So COPD, lung cancer, the challenges of curing those conditions is handling them way up front, getting them off the cigarettes, finding the lung cancer before it's causing symptoms, a lot of it is screening, to some degree.

LH: Is there one condition you have found most difficult to treat, or a condition that requires the most steps involved in treatment?

AR: Well many pulmonologists, myself included, when you're doing pulmonology, you're doing intensive care as well. Many patients end up in intensive care because of respiratory diseases, severe pneumonia, a flare up in COPD or asthma, post operation complications, those patients can become very, very ill, and can spend days, if not weeks in the intensive care units. So you're balancing not only the pulmonary aspect of the disease, with all the other complications of fluid and electrolyte balance and infections, but also dealing with a very trying time for a patient and their family. So I think as far of the intensity and complexity, it's those critically ill patients that we deal with can be the most challenging.

LH: Are most pulmonary conditions genetic, or are they typically developed over time?

AR: I would say most of them are acquired in say, now we could say the tendency to acquire certain conditions is something somewhat related to your genetics - we know we can have people who smoke everyday of their life and live to 95 and have no trouble, or we can have people who smoke a pack a day for ten or fifteen years that are already having trouble. So, I think a lot of it is acquired, but there are genetic predispositions as well. Environmental exposure, tobacco exposure, infections, all of those can lead to or trigger pulmonary problems that can be chronic.

LH: What are some of the most effective prevention tactics you share with your patients?

AR: First, not smoking, as we've already mentioned. And if there is something, like asthma, where the patient has seasonal symptoms, the best thing is to identify potential triggers, or seasons when they have triggers, also being evaluated for specific allergies. The other thing is in patients who are otherwise feeling good, but do smoke. If they fall into the category of getting screened for cancer, I certainly encourage that, as a preventative or wellness approach... there are things they can do if they can't get off cigarettes, for example, they can at least get themselves screened for lung cancer that can be found earlier.

LH: Is there a certain population that you find more at risk? Smoking habits may play a factor in this as well.

AR: I would say my personal experiences mirrors what is often noted in the statistics: we know that the socioeconomics of an individual can play a big role in how much they observe wellness advice; smoking is more prevalent in lower socioeconomic groups; I think my experience probably mirrors that, we have harder nuts to crack in terms of different parts of the population.

LH: How have you seen air quality affecting some of your patients? Have you seen people from certain pockets of the state come in more than others as a result of problems related to air quality?

AR: I think in general the air quality issue is certainly improving, but we have a ways to go. If we look back at socioeconomics, some people have to live right by I-95 in downtown Wilmington, and the fumes from cars and trucks can certainly affect them much more if they have asthma or any other conditions. Each environment has its potential reasons why some people may have more symptoms than others. I can educate people on improving air quality in their home, most people can't just get up and move their home, however.

LH: Have you seen any trends throughout the state or throughout the US with pulmonary conditions? What do you think the future of these conditions holds in your opinion?

AR: Well I don't think they're going to go away right way, even if everyone stopped smoking today, these issues would still exist. And although the environment is improving, we still have challenges of trying to improve the air further, and the additional challenges of what climate change does to seasonal variation, longer allergy seasons, more wildfires, which affect air pollution, things like that, so I think the future for someone who wants to go into pulmonary will be good, I think they will be busy, but I don't want to minimize the strides we've made with getting smoking rates down and improving air quality.

LH: How have treatments for some of these conditions changed over the course of the 20th century? Are there any conditions that are now treatable that were previously untreatable?

AR: I think there's been a big change with asthma treatment and medications since the end of the 20th century, the development of inhaled steroids to help treat asthma I think is a big progress with regard to maintaining better control for patients with asthma and in trying to reduce the number of people who have died from asthma attacks. Inhaled medications especially inhaled steroids, long acting bronchial dilators; those have changed our ability to help control symptoms, especially in asthma and some in COPD as well. The other technologies have mainly to do with some of the things that are in the hospital, as far as the technologies in ventilators to help with respiratory failure, noninvasive devices to help monitor the critically ill, so as far as critical care space there have been a lot of technological advancements. With regards to other medications, we don't want to ignore the fact we now have smoking cessation drugs that were not available prior to the 80's 90's, so all of the FDA approved nicotine replacements and smoking cessation medications have helped, not doing as well as we would like, but they have helped.

LH: Similarly, what is the best thing you have seen happen in the field since you have started working in it?

AR: The development of some of the better non-invasive diagnostic techniques, a bronchoscopy is one of the procedures a pulmonary specialist does, this allows you to biopsy things farther out in the lung, by way of ultrasound, and navigate through the lungs by way of a cat scan, they've made it easier and less invasive for patients to get the diagnosis, so to be able to cut down on the amount of surgery needed prior to making that diagnosis has been a significant advancement.

LH: Your outpatient practice covers pulmonary and sleep disorders primarily, how do those two areas overlap for someone who is not familiar with their connection?

AR: Sleep apnea is usually in the range of a pulmonary specialists because it is a disorder of breathing during the night where the oxygen level drops as a result of airway narrowing. It is more common in individuals who are overweight or obese, or those who have stiff necks, so that doesn't mean they necessarily have a lung problem, but it's a condition that often coexists with lung conditions like COPD or asthma, and obesity sometimes coexists with that, and also the same reason that cardiac disease sometimes overlaps with lung disease and obesity and sleep apnea is there too. Sleep apnea cuts across a lot of specialists, and certainly pulmonary is in there as well, but not everyone with sleep apnea has COPD or asthma, but many of them can, and that may be how I end up seeing them.

LH: What would you tell someone who is thinking about getting into the field of pulmonary? Any words of advice?

AR: I think usually the person who is asking that is usually at the level of medical school or later, but I think I would tell them the same thing that got me excited about it- understand the physiology of how the lungs work, ventilation, blood flow, and the fact that it's a field that is something stable and the patients you see mature in the sense of controlling their asthma or to the other extreme of patients who have chronic life threatening end stage disease who often need to be in the intensive care units. It's a wide range of patients that you can deal with... but it's a broad range of patient experiences you gain and a diverse range of diseases, some mild, some chronic and life threatening.

LH: How about someone looking for volunteer opportunities, or maybe do research in this area, or get involved in this area in another way?

AR: Again, I think it's a disease which touches most people and their family so it's a field of diseases that is prevalent and common: asthma, emphysema, COPD, lung cancer - so if you're looking for something that is very broad and able to be recognizable by a variety of individuals it may be something you want to volunteer in, but again I think it depends on why you are volunteering and what you're looking to get out of a volunteer experience.

LH: Is there anything you wish the public knew more about or any facts you wish were more widely broadcasted? Or is there any information that may be well

known by the medical community that may not have been broadcasted to the rest of the general population?

AR: I think everyone probably knows smoking is not good, so that's not the answer, and I think everyone knows the air quality should be better, so that's also not the answer. I guess the main message, not only for people with lung disease, especially chronic cases, is how important it is to communicate effectively and truthfully with the physicians, and nurse practitioners, and your care team, because we can only help and advise as much as we think the patient understands and follows through with some of the recommendations and treatments. There is no question that some of that drugs that we recommend are expensive and can't always be filled by the patients, we know the patients are scared at times about the process they're going through, and they may need some emotional support to help them and their family go through it, so I think being upfront with your caregiver and asking questions, not being afraid to ask 'why am I being given a certain medication?' or 'what should I expect from my diagnosis or from the medication I'm about to take?' Being a more involved patient is probably best advice I would recommend.

LH: What is one of your biggest accomplishments, both personally and professionally?

AR: My involvement with the American Lung Association has been very rewarding because I've stuck with it so long and the reason I got involved with it in the first place is as a pulmonary physician I just thought it was part of my job, part of my career was to help move among the mission of the American Lung Association, help them prove lung health. Whether it's by advocating for a new law that promotes clean air, or whether it's educating patients and caregivers about lung disease and the medications, I just felt that was a way I could use my pulmonary expertise to elaborate and affect more people, rather than just the patients I see in my office every 20 minutes. Helping a state law pass for clean air does a lot more good for a lot more people than just saying stop smoking in my office, so I think my greatest accomplishment has been being able to stay so involved with the American Lung Association, and I was able to stick with it and be involved both regionally and nationally... I've enjoyed that and I think it has been very well worth it.

LH: With all the different positions you have held with the American Lung Association, have there been any people who have influenced your decision along the way to continue being involved in this organization?

AR: Well, I think the people who I've worked with, both locally and nationally, who are staff at the American Lung Association, they and other volunteers, who maybe didn't have the medical background or medical commitment some people did, but had the family history, family stories, and personal stories about how lung disease effected them and just seeing how they felt so strongly and passionately about the mission made me say I definitely want to stick with this. I saw this as almost a duty as a pulmonary physician, but I worked alongside people who were really doing this because they were touched by the disease and they were making the effort to spend more time and promote the mission, which just helped reinforce my willingness to be involved.

LH: What are your hopes for the future with some of these conditions, within the field of pulmonology, with patient knowledge, and patient advocacy?

AR: If we're going to get disease specific for a few minutes, I think the recent development of lung cancer screening I'm hoping is going to make a big dent in the death toll with lung cancer, I think the survival rate with lung cancer right now is dismal, and finding lung cancer early we will create an improvement in the at risk population, so that's hopeful and positive movement. If you stick with lung cancer the very significant advancement with generics and the ability to develop chemotherapy drugs we're seeing extended survival with some of the more advanced patients. As far as lung cancer, screening and development of more personalized chemotherapeutic agents have been a big step forward and it think will make more of an impact on survival with lung cancer. I think the COPD population unfortunately is going to be very much a product of smoking that occurs. Luckily, we have treatments from a symptomatic standpoint, but I would hope that we would have the development of better drugs to help reverse the process then to help control the symptoms, but we just don't seem to have that yet. I think those would be things I would look forward to.

LH: On the topic of cigarettes and smoking, what are your thoughts on e-cigarettes?

AR: I knew you'd ask me that! The short answer is we don't know enough about it. I think the public health community has individuals who look at it at as a safer cigarette, and we just don't know that, some people look at it as a way to quit smoking and we don't know that, we just don't have the evidence that e-cigarettes are all their carried to be.

First of all, we don't know what people mean when they say e-cigarettes, all different products, all different varying degrees of temperature that's generated when they're used, chemicals that came out of them, dosages of nicotine, carcinogenics that are contained in them, they're all different products, they aren't a standardized product that allows people to make knowledgeable assessments about them.

I certainly don't include them as a routine effort for smoking cessation. I have patients who do start them on their own, and come in and tell me they are using them, and I say the same thing, we don't know a lot about them, I'm not going to tell you to quit, but I am asking you what they're doing it for you as a smoking cessation process, some of them admit they are able to cut down cigarettes for awhile, and some will say they are still smoking cigarettes but they're using these when they aren't smoking regular cigarettes. So it's an unknown. I think a lot of people are apprehensive about what to do about e-cigarettes because even the FDA hasn't been able to come out and speak clearly about what they're going to recommend.

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