



An Introduction to *CHEST*

Background

- History of CHEST
- *CHEST* Vision, Goals, and Strategies

History of CHEST

“Legacy of promoting patient-focused care through leadership, education, communication, and clinical practice”

Leadership

1935

ACCP is founded as the Federation of American Sanatoria by Murray Kornfeld.



1947

The Veterans Medical Officers Committee is established to help members returning from WWII find employment.

1940

ACCP institutes a chest x-ray program for armed forces to reduce tuberculosis cases in the military.

1950

ACCP hold international in Rome, Italy.



1942

The first convocation ceremony is held during the annual meeting to induct new members.

1943

The designation, FCCP, is introduced to signify Fellows of the ACCP.



1937

The Federation's name is changed to the American College of Chest Physicians.

1949

ACCP partners with the National Cancer Institute of the US Public Health Service to conduct research on lung cancer.



Warning: The Surgeon General Has Determined That Cigarette Smoking Is Dangerous to Your Health.

1990

ACCP plays a key role in the passage of legislation to ban smoking on domestic flights within the US.



2000

The CHEST Foundation's Ambassadors Group is created to volunteer, educate, and network on behalf of The Foundation.



2009

ACCP launches the AQUIRE Registry, a program to measure and compare practice performance.



1992

Walter Lever, MA, FCCP(Hon), becomes CEO of the ACCP and editor, publisher of CHEST.



2000

AMBASSADORS GROUP

The CHEST Foundation's Ambassadors Group is created to volunteer, educate, and network on behalf of The Foundation.



developed.

Is Dangerous to Your Health.



1995

The CHEST Foundation is founded.



2005

2001

The CHEST Foundation leads the development of the first-ever smoking cessation program for the New York City Fire Department.



1991

ACCP files an amicus curiae brief in the US Supreme Court in support of Rose Cipollone in the groundbreaking Cipollone v Liggett Group, Inc. case.

CHEST
1995



The annual meeting adopts the name CHEST (ie, CHEST 1995).

ACCP Learning Categories are introduced to organize all education activities based on instruction method used. Maintenance of Licensure designations are introduced.



1945

Postgraduate courses are offered throughout the year to help educate physicians returning from service in WWII.

1952

The Committee on Motion Pictures is organized to review and promote new films or diseases for education pu



1984

The first ACCP



2005

Simulation exercises are offered for the first time at CHEST 2005.



2000

The CHEST Foundation produces several tobacco prevention products targeting women, children, and minorities.

1991

unched.

2009

A Physician's Perspective[®] is launched.

1935

ACCP is founded as the Federation of American Sanatoria to educate the general practitioner and public about tuberculosis prevention and treatment.

1935

1935

The first annual meeting is held August 9-10 in Albuquerque, NM. There are 38 registrants.



Stop
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1995

2005

2009



2005

Simulation exercises are offered for the first time at CHEST 2005.

2006

The first ACCP sleep medicine board review course is offered.

1989

The first ACCP critical care board review course is offered.

2008

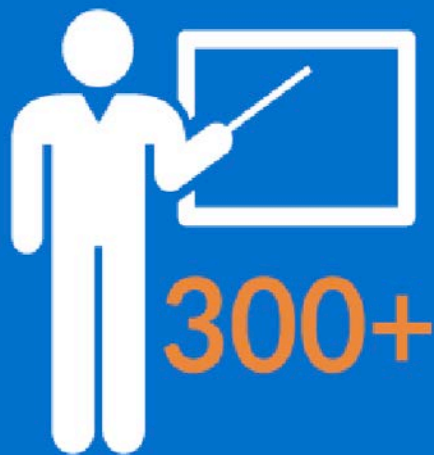
The ACCP Simulation Center opens in Northbrook, IL.

ACCP
Simulation Center
for Advanced
Clinical Education
Northbrook, Illinois

Education

CHEST Education

Annual Meeting



GENERAL SESSIONS



POSTGRADUATE
COURSES



INTERDISCIPLINARY
SESSIONS



INTERACTIVE
GAMES



UNIQUE
SIMULATION
SESSIONS



1949
ACCP publishes its first textbook, *The Fundamentals of Pulmonary Tuberculosis and Its Complications*.

1995
ACCP launches www.chestnet.org.

2009

CHEST is voted one of the 100 most influential journals over the last 100 years in medicine and biology by the Biomedical Life Sciences Division of the Special Libraries Association.

foreign language of CHEST are read in Italian and Chinese.

2009

CHEST achieves its highest impact factor score of 5.154.

2002

The CHEST Foundation creates the Critical Care Family Assistance Program.



1999

1999

2005

2009

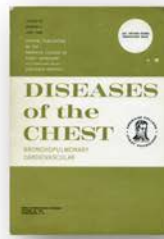
2006

is named the leading journal publication by pulmonologists.



2005
R.S. Irwin

1993
A.J. Block



1968
A. Soffer

1941
R. Matson

1935
C. Hendricks

1937
F. Burge

1946
J.A. Myers



1935
Murray Kornfeld publishes *Diseases of the Chest*.

1940
ACCP Chapters are introduced to enhance communication on a local level.

1935

1940

Communication

Past 10 Years

- **2011** - podcast series, first journal to launch a universal app for iPhone/iPad
- **2012** - began using image manipulation detection and plagiarism software
- **2013** - Ultrasound Corner first case-based series to intentionally leverage video in *CHEST*
- **2014** - rebranding of American College of Chest Physicians from "ACCP" to "CHEST" in recognition that the brand of the journal, was the *lead* brand; journal redesign employing the new blue identity scheme with the blue (for breath) as the focal color vs red
- **2016** - proactive decision to move away from self-publishing, identified Elsevier as publishing partner for an initial 7 year agreement
- **2018** - launched visual abstracts for use in social media and to convey the findings of key research in a new and easily consumable way

Clinical

1936

Effect of cigarette smoking on tuberculosis patients is questioned.



1947

College Research Program is established to gain and share knowledge.

1960

ACCP cites smoking as a probable cause of lung cancer.



1970

ACCP hosts a symposium Smoking: The Physician Benefits of

The first antithrombotic guidelines are published.

1986



1996

ACCP publishes its first specialty-specific coding book, *Appropriate Coding for Critical Care Services and Pulmonary Medicine*.

1995



2003

Patient-Focused Care Pledge is developed.



2005

The ACCP Sleep Institute is established.

Sleep Institute
American College of Chest Physicians

2004

The ACCP Critical Care Institute is established.



2000

The CHEST Foundation begins its Governors Community Service Awards program.

2009

ACCP features the use of technology and telemedicine during CHEST 2009.



1940

Committees and sections are created to address clinical issues in specific fields.



1952

ACCP endorses the Common Cold Foundation's research efforts.

1972

ACCP introduces a multidisciplinary, team-approach to smoking cessation.



2000

Practice

CHEST Top Articles

- Huges FJ, Mardis RE, Dye WE, et al. Combined intermittent regimens in the treatment of non-miliary pulmonary tuberculosis: a comparison of streptomycin every third day and para-aminosalicylic acid daily with streptomycin every third day. *Dis Chest* 1952;21:1-16.
- Volini IF, Hughes JR, Peffer JR. A comparative study of sulfadiazine, penicillin, and penicillin combined with sulfadiazine in the treatment of lobar pneumonia. *Dis Chest* 1949;15:255-267.
- Finkel S, Sullivan BH. Primary atypical pneumonia: an analysis of one hundred twenty-three cases; report of one fatality; review of fourteen cases treated with aureomycin. *Dis Chest* 1952;21:55-69.

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- Phillips RW, Phillips AM, Paull AM, et al. Chronic bronchitis: a neglected disease entity. *Dis Chest* 1954;26:520-527.
- Kannel WB, Schwartz MI, McNamara PM. Blood pressure and risk of coronary heart disease: The Framingham Study. *Dis Chest* 1969;56:43-52.
- Favaloro RG, Effler DB, Groves LK, et al. Direct myocardial revascularization with saphenous vein autograft: clinical experience in 100 cases. *Dis Chest* 1969;56:279-283.

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- Rennard BO, Ertl RF, Gossman GL, et al. Chicken soup inhibits neutrophil chemotaxis in vitro. *Chest* 2000;118:1150-1157.

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- Heart Transplants: Three Views.
 - Bronstein H. The power over life and death. *Dis Chest* 1968;54:346-348.
 - Harken DE. One surgeon looks at human heart transplantation. *Dis Chest* 1968;54:349-352.
 - Bergen RP. Legal regulation of heart transplants. *Dis Chest* 1968;54:352-355.
- Osler W. Teacher and student. *Dis Chest* 1957;32:377-387.
 - “know the best that is taught in this branch of science the world over”
 - “two aspects in which we may view the teacher – as a *worker* and *instructor* in science and as a *practitioner* and *professor* of the art.”

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CHEST EIC Comments

- “**Adapted to the needs** of clinical chest physicians and health-care professionals.”
- “Never waived from its true mission to **educate physicians about aspects of patient care**. *CHEST* has always served the practicing clinician.”
- “Focused clinical orientation with its multidisciplinary coverage of topics. **Improving patient care through education**. What do our readers need and want to read now and in the future.”
- “Crucial that *CHEST* be **relevant to ACCP members’ clinical experience**.”
- “Publish content that will be meaningful and essential to a **more diverse group of readers** and subject matter that is **easier and faster to read** and access.”

CHEST

- Adapt to the needs of pulmonary, critical care, and sleep medicine clinicians.
- Improve patient care by educating clinicians with content relevant to their clinical experience.

***CHEST* Vision, Goals, and Strategies**



QUICK HIGHLIGHTS



SERVING 19,000+ MEMBERS WORLDWIDE



OFFERING LIVE AND ONLINE EDUCATION



HOST OF WORLD'S LARGEST CLINICAL CHEST MEDICINE EVENT

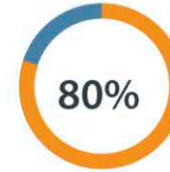


350,000+ READERS USE *CHEST*, ALSO A PREMIER RESOURCE FOR CLINICAL PRACTICE GUIDELINES

CHEST Membership



USA



INTERNATIONAL



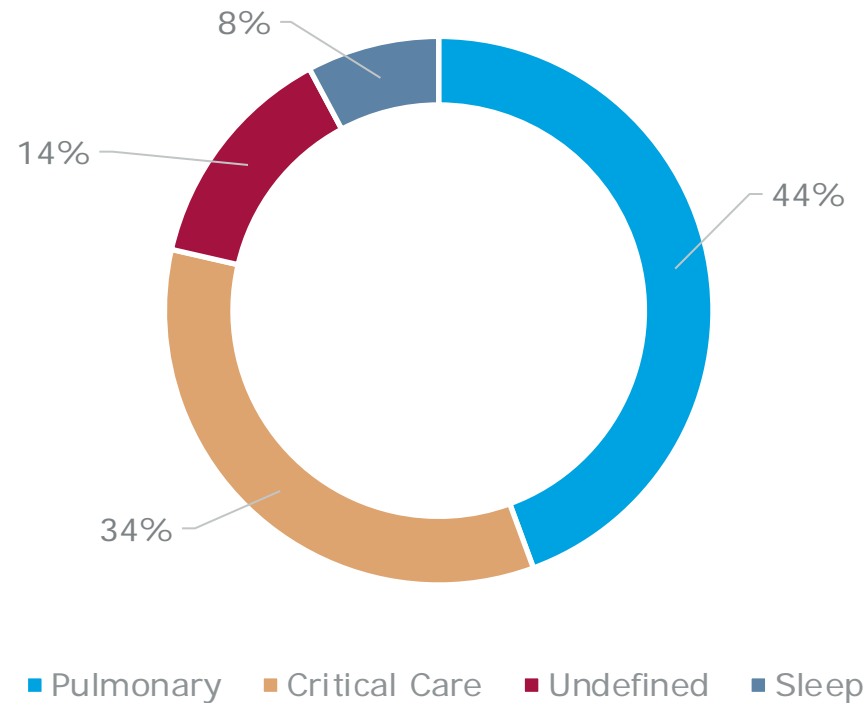
MEMBER TYPE

Physician: 77%
 Fellow in Training: 11%
 Non-Physician Clinician: 5%
 Retired: 2%
 Other: 1%



CHEST Membership

Subspecialty Identification



CHEST Strategic Plan

Vision

- CHEST will be the global leader in prevention, diagnosis, and treatment of chest diseases.

Mission

- CHEST champions advanced clinical practice, education, communication, and research in chest medicine.

Values

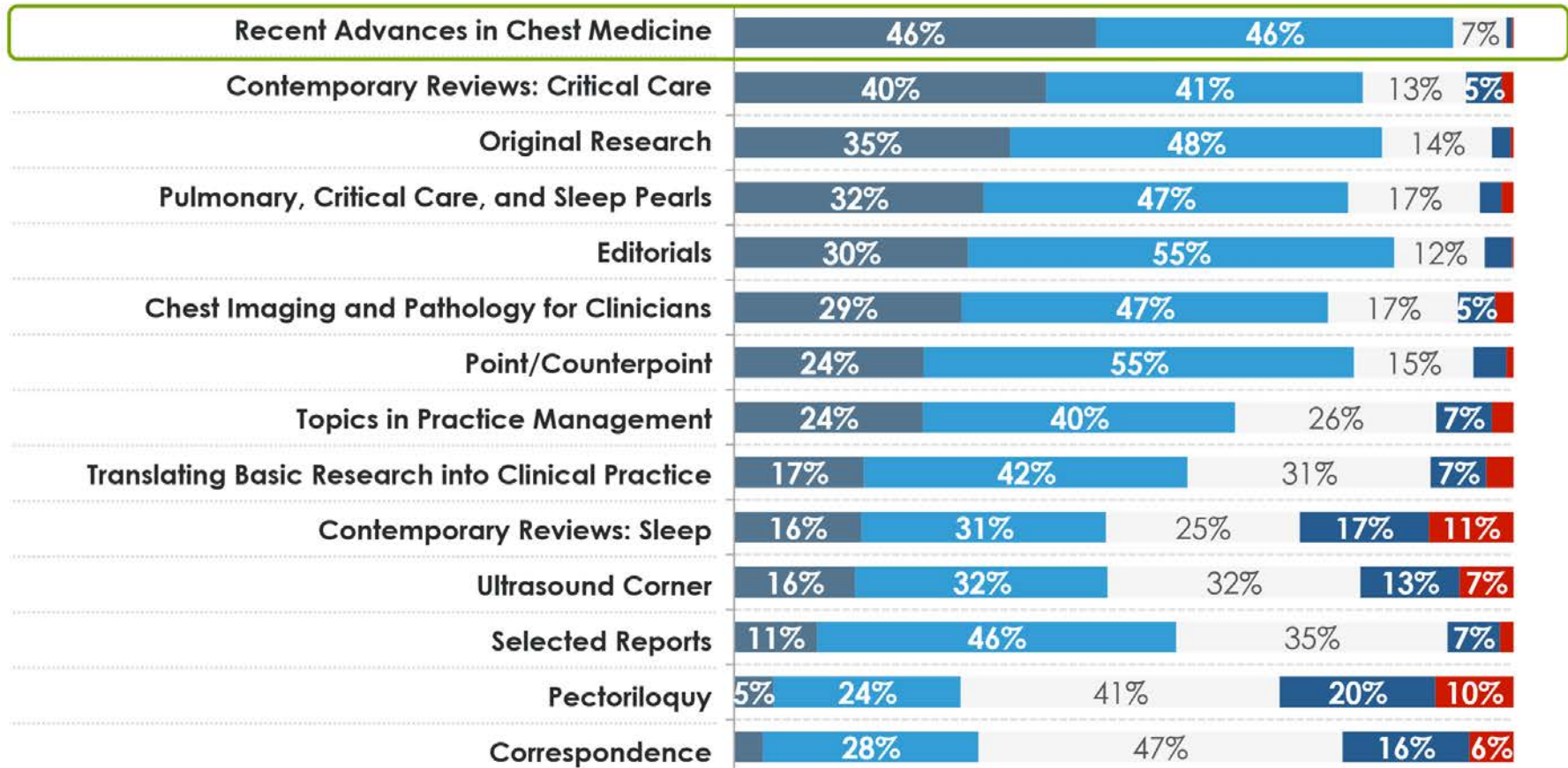
- Collegiality, collaboration, innovation, data-driven, transparency, diversity, excellence, integrity, results-oriented

CHEST Strategic Plan - Goals

1. CHEST provides **innovative education customized to individual learner needs**, designed to improve knowledge, competence, performance and patient outcomes.
2. CHEST is the **premier resource for clinically relevant scientific research, guidelines, and implementation strategies and tools**.
 - Increase access and engagement with CHEST guidelines through article downloads, social media, and citations.
 - Rank in the top five pulmonary and critical care journals as measured by *CHEST* Kantar readership scores, Impact Factor, and Eigenfactor

CHEST Strategic Plan - Goals

3. CHEST will **increase the global impact** of its education.
 - Increase access of journal content from outside the US.
4. CHEST **optimizes its assets** to achieve its mission and vision.
 - Develop and implement an integrated and coordinated publishing strategy and publications-related product roadmap.
5. CHEST has a **strong and diverse financial base**.



NOTE: For visualization purposes, values below 5% are not displayed in the chart.

- Very interested
- Interested
- Neither interested nor not interested
- Not interested
- Not at all interested

Sample: All respondents (n=465)
 Q. Please rate your interest in the information found in each of the following sections of CHEST.

Vision and Goals

CHEST will be the **most important source of clinically relevant research and patient management guidance for pulmonary, critical care, and sleep medicine clinicians worldwide.**

1. Foster the submission of high quality clinically relevant research.
2. Enhance the clinical utility of evidence driven reviews.
3. Increase access to, and the desire to view, journal content.

High Quality Clinically Relevant Research

- **Engage** with those performing research **prior to submission** decisions.
 - Develop a list of sponsored clinically relevant research in our fields.
 - Have a presence at all relevant society meetings.
 - Build relationships with major medical journals.
- **Minimize the burden** of article submission.
 - Establish minimal requirement for data entry at time of submission.
 - Provide clear and interactive descriptors of how each article type will be judged, and tools to assist with manuscript preparation (e.g. algorithm templates).

High Quality Clinically Relevant Research

- **Timely review** and the provision of **high quality feedback**.
 - Rapid review commitment for initial decisions.
 - Decrease the time it takes to provide high-quality reviews.
 - Develop tools to assist reviewers.
 - Identify articles whose review can be expedited by editorial leadership.
- **Promote** the author's work.
 - Multi-media.
 - Provide opportunities for presentation of the top content at our annual meeting.

Clinically Useful Evidence Driven Reviews

Evidence Driven Reviews

- Highest rated article type.
- >25% of our top referenced articles.
- Opportunity to impact clinical practice by promoting the implementation of clinical advances and guideline recommendations.
 - *CHEST* Reviews
 - *CHEST* “How I do it”
 - Build relationships with other societies.

[Evidence-Based Medicine]

CHEST

Antithrombotic Therapy for Atrial Fibrillation

CHEST Guideline and Expert Panel Report

Gregory Y. H. Lip, MD; Amitava Banerjee, MD, DPH; Giuseppe Boriani, MD, PhD; Chern on Chiang, MD, PhD; Ramiz Fargh, MD, FCCP; Ben Freedman, MD, PhD; Deirdre A. Lane, PhD; Christian T. Ruff, MD, MPH; Mintu Turakhia, MD; David Werring, PhD; Sheena Patel, MPH; and Lisa Moores, MD, FCCP

Check for updates

BACKGROUND: The risk of stroke is heterogeneous across different groups of patients with atrial fibrillation (AF), being dependent on the presence of various stroke risk factors. We provide recommendations for antithrombotic treatment based on net clinical benefit for patients with AF at varying levels of stroke risk and in a number of common clinical scenarios.

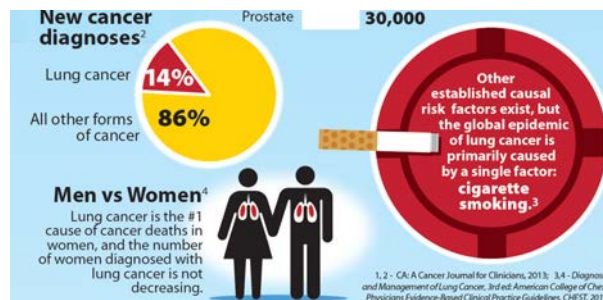
METHODS: Systematic literature reviews were conducted to identify relevant articles published from the last formal search performed for the Antithrombotic and Thrombolytic Therapy: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (9th Edition). The overall quality of the evidence was assessed using the GRADE (Grading of Recommendations, Assessment, Development, and Evaluation) approach. Graded recommendations and ungraded consensus-based statements were drafted, voted on, and revised until consensus was reached.

RESULTS: For patients with AF without valvular heart disease, including those with paroxysmal AF, who are at low risk of stroke (eg, CHA₂DS₂-VASc [congestive heart failure, hypertension, age ≥ 75 (doubled), diabetes, stroke (doubled)-vascular disease, age 65-74 and sex category

ABBREVIATIONS: ABC = Atrial fibrillation Better Care; ACS = acute coronary syndrome; ACTIVE W = Atrial Fibrillation Clopidogrel Trial with Prasugrel for Prevention of Vascular Events; ACUTE = Assessment of Cardioversion Using Transesophageal Echocardiography; AFFIRM = Atrial Fibrillation Follow-up Investigation of Sinus Rhythm Management; AFRI = atrial high-rate episode; APTT = activated partial thromboplastin time; ARISTOTLE = Apixiban for Reduction of Stroke and Other Thromboembolic Events in Atrial Fibrillation; ATRIA = Anticoagulation and Risk Factors in Atrial Fibrillation; AVERROES = Apixiban Versus Acetylsalicylic Acid (ASA) to Prevent Stroke in Atrial Fibrillation Patients Who Have Failed or Are Unsuitable for Vitamin K Antagonist Treatment; BRIDGE = Bridging Anticoagulation in Patients who Require Temporary Interruption of Warfarin Therapy for an Elective Invasive Procedure or Surgery; CAA = cerebral amyloid angiopathy; CHA₂DS₂-VASc = congestive heart failure, hypertension, age ≥ 75 (doubled), diabetes, stroke (doubled)-vascular disease, age 65-74 and sex category (female); CHAD₂ = congestive heart failure; hypertension = age, diabetes = stroke (doubled); CIED = cardiac implanted electrical device; CKD = chronic kidney disease; CMB = cerebral microbleed; COI = conflicts of interest; CrCl = creatinine clearance; DAPT = dual antiplatelet therapy; ISUS = embolic stroke of undetermined source; GRADE = Grading of Recommendations, Assessment, Development, and Evaluation; HAS-BLED = hypertension, abnormal renal/liver function (1 point each), stroke, bleeding history or predisposition, labile INR, elderly (0.65), drugs/alcohol concomitantly (1 point each); HEMORR/HAGES = hepatic or renal disease, ethanol abuse, malignancy, older, reduced platelet count/function, hypertension, anemia, genetic factors, excessive fall risk, and stroke; HF = heart failure; HF = hazard ratio; ICH = intracranial hemorrhage; INR = international normalized ratio; LAA = left atrial

appendage; LAAD = left atrial appendage occlusion; LMWH = low-molecular weight heparin; MI = myocardial infarction; MOST = Atrial Diagnostic Ancillary Study of the Mode Selection Trial; NOAC = non-vitamin K antagonist oral anticoagulant drug; OAC = oral anticoagulant; o.d. = once daily (every day); PAD = peripheral arterial disease; PCC = prothrombin complex concentrate; PCI = percutaneous coronary intervention; PREVAIL = Prospective Randomized Evaluation of the Watchman LAA Closure Device in Patients With Atrial Fibrillation Versus Long-Term Warfarin Therapy trial; PROTECT AF = Watchman Left Atrial Appendage System for Embolic Protection in Patients with Atrial Fibrillation; RCT = randomized controlled trial; RE-ALIGN = Randomized Phase II Study to Evaluate the Safety and Pharmacokinetics of Oral Dabigatran Etexilate in Patients after Heart Valve Replacement; RE-LY = Randomized Evaluation of Long-term Anticoagulant Therapy with Dabigatran Etexilate; RE-VERSE AD = Reversal Effects of Idarucicromab on Active Dabigatran; ROCKET AF = Rivaroxaban Once Daily Oral Direct Factor Xa Inhibition Compared With Vitamin K Antagonism for Prevention of Stroke and Embolism Trial in Atrial Fibrillation; RR = risk ratio; SF36-1 = Stroke Prevention in AF; TEE = transesophageal echocardiography; TIA = transient ischemic attack; t.i.d. = ter in (three times daily); TT = thrombin time; TTE = transthoracic echocardiography; TTR = time in therapeutic range; UFH = unfractionated heparin; VKA = vitamin K antagonist.

AFFILIATIONS: From the Institute of Cardiovascular Sciences, University of Birmingham, United Kingdom; Liverpool Centre for Cardiovascular Science, University of Liverpool, and Liverpool Heart and Chest Hospital, Liverpool, United Kingdom; and Aalborg Thrombosis Research Unit, Department of Clinical Medicine, Aalborg University, Aalborg, Denmark (Dr Lip); Institute of Health Informatics,

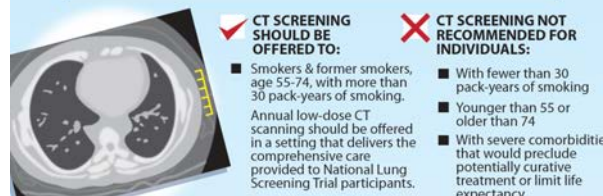


FROM THE GUIDELINES



Published as a supplement to the May 2013 issue of the journal CHEST.

SCREENING RECOMMENDATIONS





ADVANCES IN TREATMENT

Access and Desire to View Content

Multi-media and Digital Content Development

- Audio/video discussions with the authors
- Descriptive video summaries of original articles
- Slide sets that display key results of original articles for download
- Seamless digital access with content organized and displayed as in the print version

Effectiveness of Reprocessing for Flexible Bronchoscopes and Endobronchial Ultrasound Bronchoscopes

CLINICAL QUESTION	STUDY DESIGN	RESULTS
<p>To evaluate the effectiveness of real-world bronchoscope cleaning following use</p> 	<p>Multisite, prospective study</p> <p>Assessments included</p> <ul style="list-style-type: none"> • visual inspection • microbial cultures • biochemical tests • observation of reprocessing practices and storage cabinet cleanliness <p>3 centers & 24 bronchoscopes were assessed</p>	<p>Reprocessing practices were substandard</p> <p>In fully-reprocessed bronchoscopes,</p> <ul style="list-style-type: none"> 100% had visual defects 100% had residual protein 58% had microbial growth 

Despite high level disinfection, residual contamination of bronchoscopes was frequent.

Ofstead CL et al. *CHEST* 2018;154(5):1024-1034

For perspective, please read the accompanying editorial by

Mehta AC et al. *CHEST* 2018;154(5):1001-1002

CHEST Editorial Board



Subspecialty Team Tasks

- Manage the **article review process** for original article submissions within their subspecialty.
- **Recruit review articles** within their subspecialty.
- Contribute to **journal strategy**.
- Assist with review of high priority articles.
- Assist with the translation of content into multi-media formats.

Subspecialty Teams

Category	Topics
Asthma	Allergy and Airway, Occupational and Environmental Lung Diseases, Obstructive Lung Disease
Critical Care	Critical Care, Disaster Medicine, Palliative and End of Life Ethics, Respiratory Care
Chest Infections	Chest Infections, Pediatrics
COPD	Obstructive Lung Disease, Pulmonary Rehab, Respiratory Care
Diffuse Lung Disease	Diffuse Lung Disease, Occupational and Environmental Lung Disease, Pulmonary Manifestations of Systemic Disease, Transplant
Education and Clinical Practice	Education Teaching and Quality Improvement, Cultural Diversity, Imaging, Palliative and End of Life Ethics, Pediatrics, Signs and symptoms, Practice Management and Administration
Lung Cancer	Lung Cancer, Pleura, Procedures, Tobacco, Mediastinum
Pulmonary and CV	Pulmonary Hypertension, VTE, Cardiovascular, Antithrombotic
Sleep	Sleep Disorders
More than 2	Biotechnology, Genetic and Development Disorders, Imaging, Pathology, Physiology

Subspecialty Teams

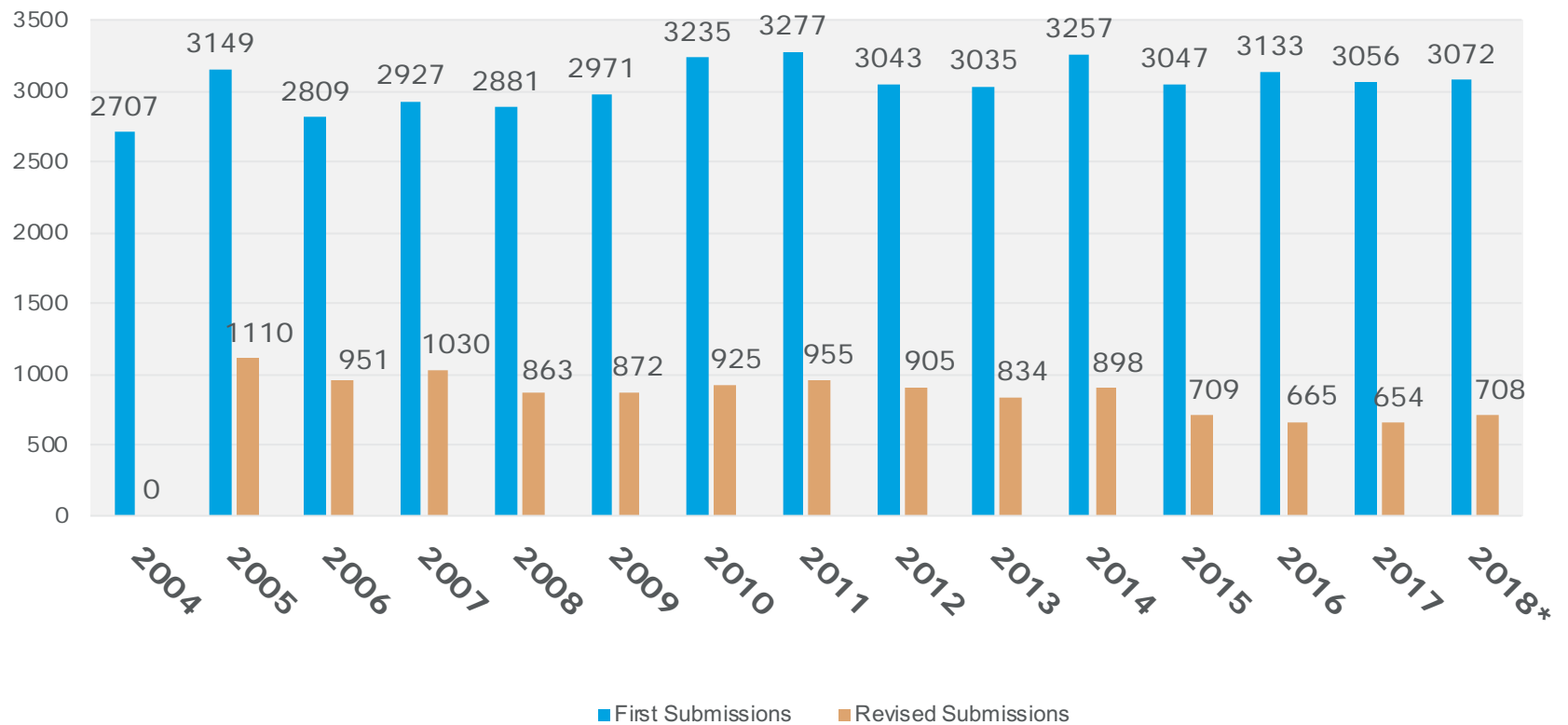
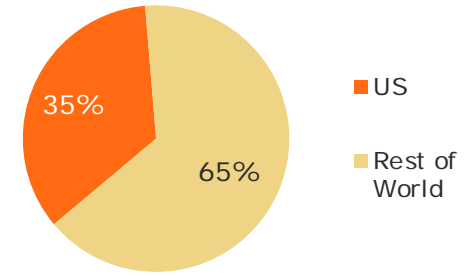
Category	Curriculum	Submissions	Publications	Journal Goal
Asthma	4	10.8	5.8	12
Critical Care	29	12.4	15.5	14
Chest Infections	6	18.2	10.8	10
COPD	10	11.8	18.5	12
Diffuse Lung Disease	8	1.6	10.0	12
Education and CP	8	7.2	4.6	8
Lung Cancer	14	8.4	12.4	12
Pulmonary and CV	6	13.3	14.0	12
Sleep	13	6.9	8.1	8

Editorial Board Composition

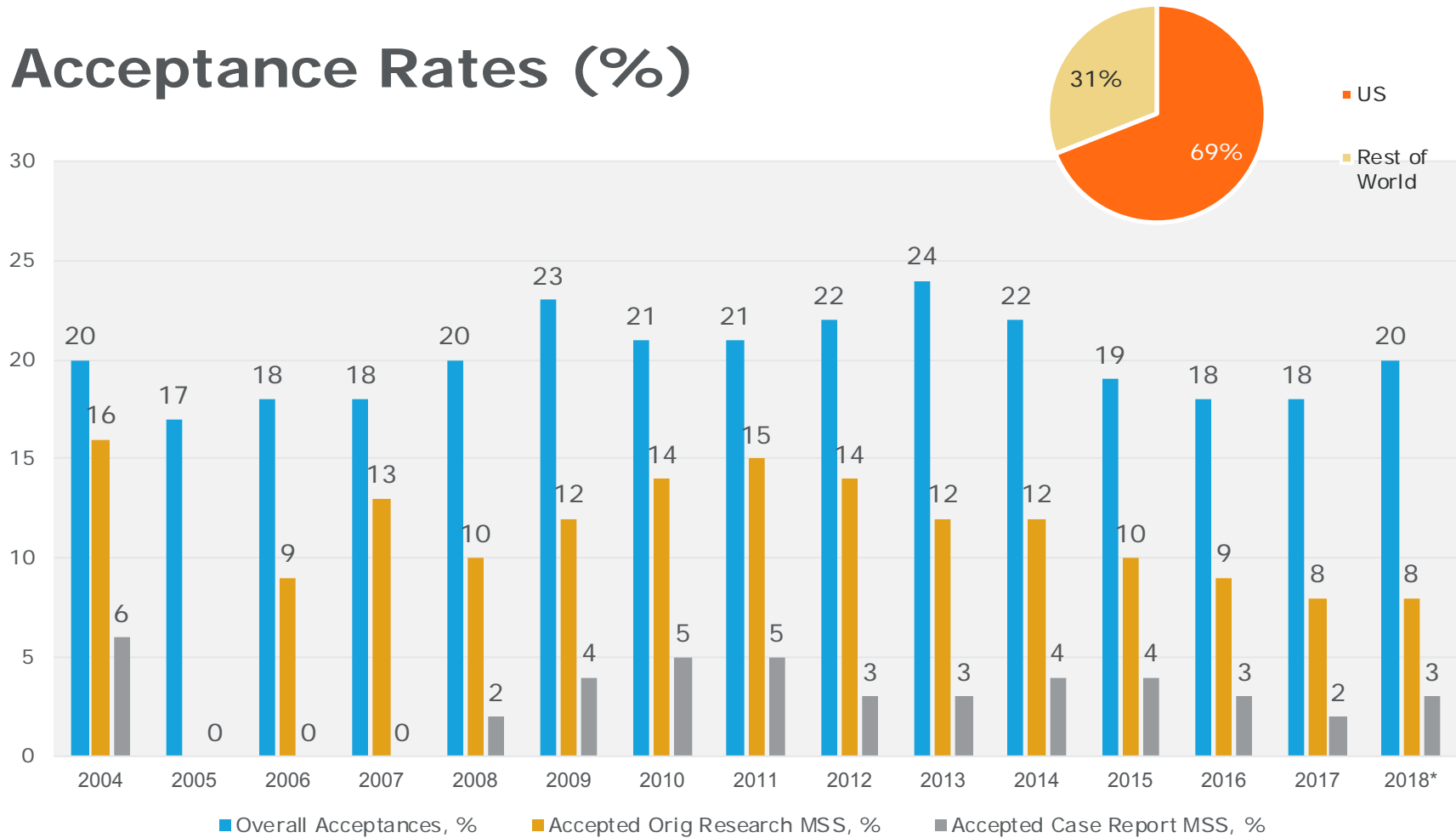
It is recommended that an **8 to 12-member subspecialty Editorial Board** be selected by the Associate Editor to serve on their team. The members should include:

- Individuals with a combined expertise that will **cover all of the content areas** assigned to the Associate Editor's subspecialty team
- A senior **key opinion leader** well-published and well-regarded in the field
- An individual(s) to champion topic selection and author recruitment for **review and invited article sections**
- An individual(s) to **work with the multi-media team** to identify content for delivery in non-traditional formats and assist with the review of these products
- Diversity of gender and geographic location, including international member(s).
- Consider inclusion of a non-physician provider.

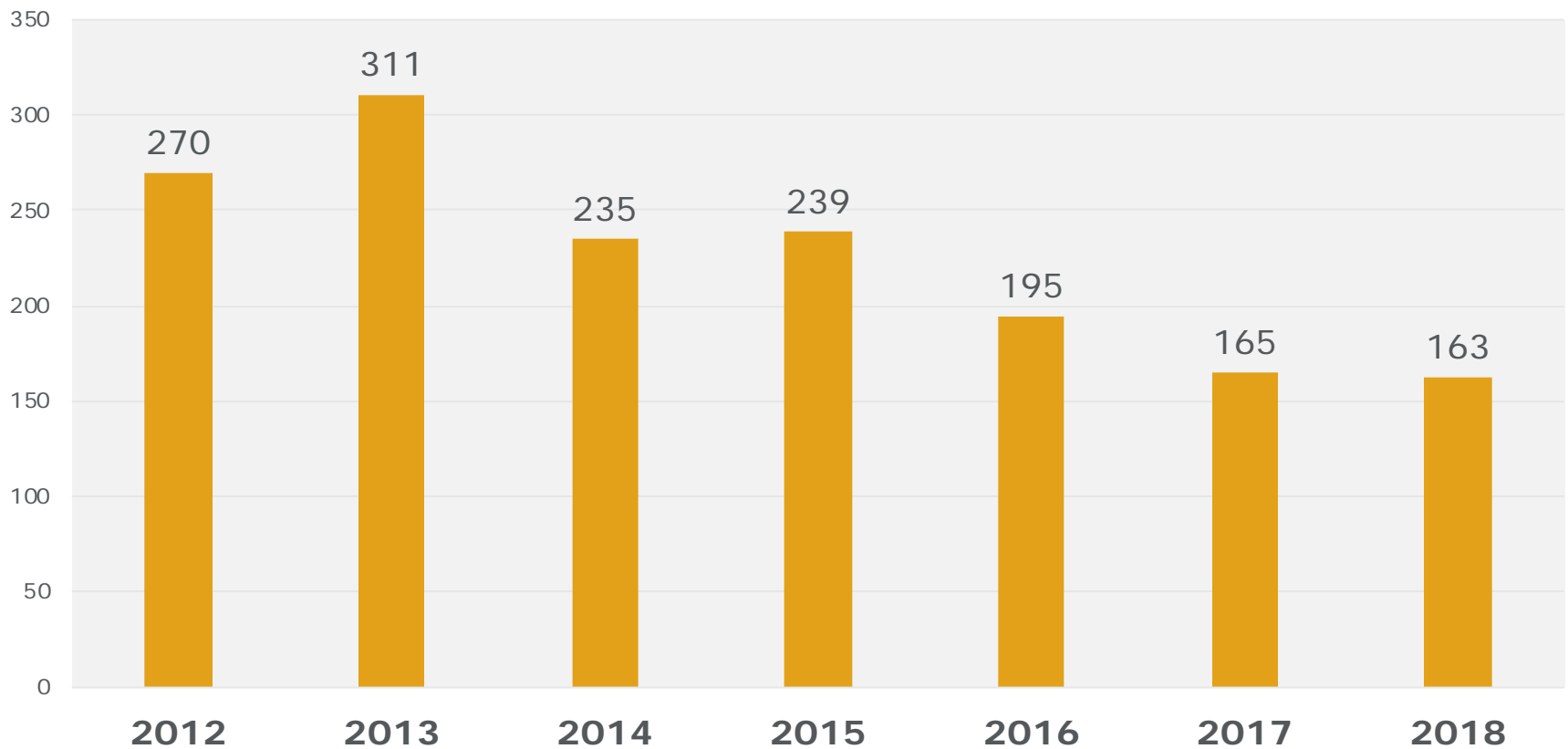
Journal Submissions



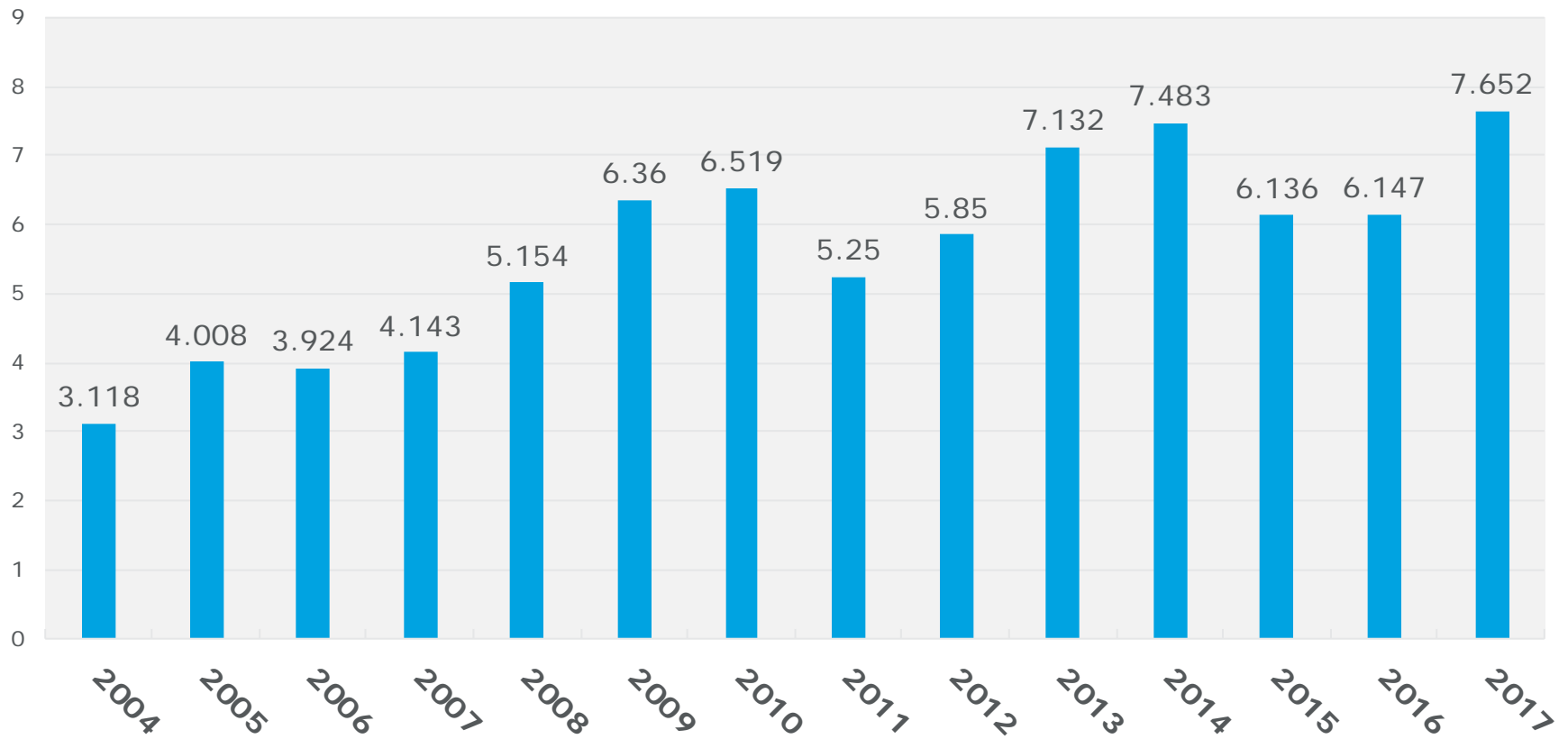
Acceptance Rates (%)



Annual Original Research Articles Published



Impact Factor Trends



Summary

CHEST will be the **most important source of clinically relevant research and patient management guidance for chest medicine physicians worldwide.**

1. Foster the submission of high quality clinically relevant research.
2. Enhance the clinical utility of evidence driven reviews.
3. Increase access to, and the desire to view, journal content.