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ATS NEWS

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JOURNALS CME

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The ATS is solely responsible for all content. Questions and comments may be addressed to Suzy Logan at slogan@thoracic.org.

Vol. 35 No. 5 May *ATS News* (ISSN 0892-8916) is published monthly at 61 Broadway, New York, NY 10006. Copyright 2009 by the American Thoracic Society.



ATS News is the winner of the 2008 APEX Award for publication excellence.

VACCINE FOR THE INFECTED? NEW TB VACCINE CLEARS IMPORTANT HURDLE

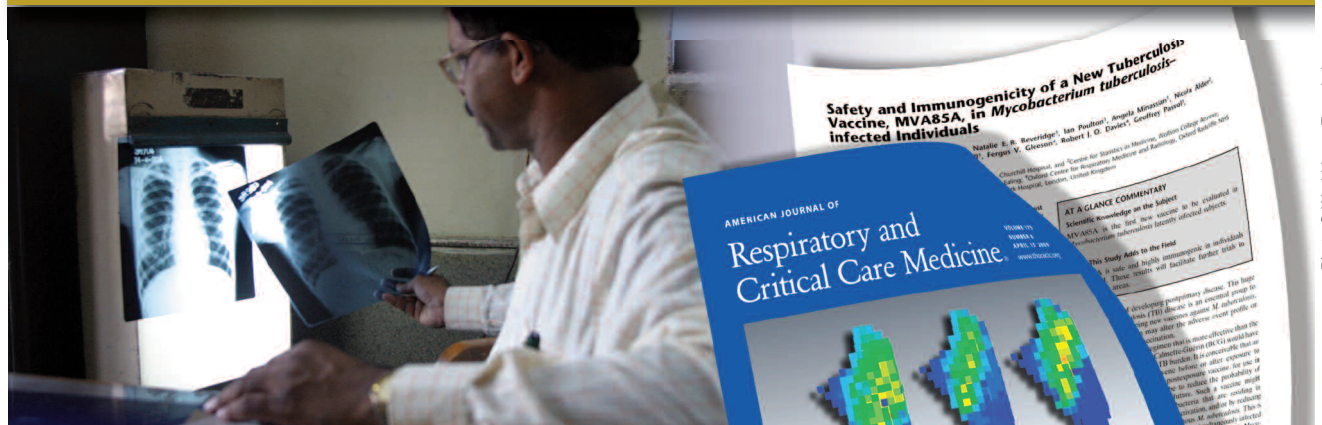


Photo © World Lung Foundation

An urgently needed new tuberculosis vaccine cleared a vital step in testing, an important advance at time when a third of the world's population is believed to have latent tuberculosis infection (LTBI), which, when re-activated, can cause full-blown disease.

The results of the Phase I trial of a leading new TB vaccine, MVA85A, appeared in the April 15th issue of the *American Journal of Respiratory and Critical Care Medicine*. MVA85A is scientific shorthand for Recombinant Modified Vaccinia Ankara expressing Antigen 85A.

"A more effective vaccine regimen than the currently available bacillus Calmette-Guérin (BCG) would have a major impact on the global TB burden, and ultimately, will be the most efficient way to control this pandemic," wrote principal investigator, Helen McShane, M.D., Ph.D., reader in vaccinology and Wellcome senior fellow at the University of Oxford's Jenner Institute in England.

One-third of the world's population is latently infected with *M. tuberculosis*. Any new TB vaccine must be developed with this huge reservoir of infection in mind, as latent infection may decrease the therapeutic value of new vaccines or worsen vaccine-related adverse events. With this in mind, Dr. McShane and fellow researchers investigated the effects of MVA85A specifically in individuals who had LTBI.

"While BCG gives good protection against severe forms of TB...it does not provide adequate protection against adult pulmonary TB," noted Hazel Dockrell, Ph.D., and Ying Zhang, Ph.D., in an accompanying editorial. They went on to note that one of the primary issues with developing new vaccines is the critical public health challenge of carrying out vaccination campaigns in settings where individuals may have latent infections. "There have been concerns that induction of a strong immune response in infected individuals might produce immunopathology and that it would not be possible to exclude such individuals from vaccination in settings such as Africa," they wrote.

To test the safety of the MVA85A vaccine in that vulnerable population, Dr. McShane and colleagues recruited 12 individuals who were confirmed to have LTBI and did not have other complicating factors, such as HIV or hepatitis for a year-long study.

"We had two aims in mind with this study," the researchers explained. "First, we wanted to demonstrate that

MVA85A was safe in individuals with LTBI, and to ensure we were not inducing any immunopathology with this vaccine. Secondly, we wanted to investigate the immunogenicity of this vaccine in individuals with LTBI and compare that with previous findings in individuals who had been BCG vaccinated."

The investigators found the vaccine was safe and did not induce any immunopathology in this group, and also that the vaccine was as immunogenic in this group, as in the BCG-vaccinated individuals. Dr. McShane calls these results "very important in the further development of this vaccine."

Each patient was vaccinated with the MVA85A vaccine and followed for 12 months. The researchers used blood tests and diary cards to identify any adverse reactions to the vaccine and monitored serum inflammatory markers to monitor for any signs of immunopathology.

None of the subjects reported fever of more than 37.5°C (99.5°F), the only previously recorded objective symptom associated with MVA85A vaccination. All other symptoms were subjective. Mild local side effects at the site of vaccination were common, and mild systemic side effects—such as headache and fatigue—occurred in up to 50 percent of subjects, but these all resolved spontaneously. There were no significant increases in serum inflammatory markers.

Interestingly, vaccination with MVA85A in LTBI-infected individuals seemed to produce a powerful/potent immune response comparable to previous trials in BCG vaccinated people. It had previously been demonstrated that the combined immunogenicity in people vaccinated with both BCG and MVA85A is significantly greater than in those vaccinated with BCG alone.

"This is the first subunit TB vaccine to enter clinical trials in *M. tuberculosis*-infected subjects since Robert Koch experimented with his 'remedy' of culture filtrate protein in 1890 with devastating consequence," said Dr. McShane. "We can happily report that the MVA85A had no such ill

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MESSAGE FROM THE PRESIDENT

Jo Rae Wright, PhD

The two most common questions I'm asked as ATS President are, "Would you do this again?" and "Is it a lot of work?"

My answers are, "In a heart beat" and "No, it isn't a lot of work." The truth is that I'm busy, and, yes, I've had to learn how to keep track of thousands of e-mails, but it doesn't feel like work.

And when I compare what I've learned, personally and professionally, over the course of this past year, with the increase in my workload, I know that I've received many more times what I have given.

I have had the opportunity to meet people from all over the world and learn about their research and work. I've learned how others—whether they work in a laboratory in Cleveland, Ohio, or see patients in Istanbul—view the issues that the ATS cares most about. I've learned the importance of keeping the patient's perspective central to all we do as a Society.

And I've observed many personal styles of communication and leadership. I've come to realize that there's no "right" way to do anything, that people can be equally effective as communicators or leaders, even by taking very different approaches to the task at hand.

But, of all that I have gotten back, I treasure most the friendships I have made. Some of my best friends in the world are part of this remarkable Society. Would every presidency of a scientific and medical society such as ours provide the same opportunities for professional and personal growth?

I don't think so. The ATS is a remarkable organization. The diversity of our members and staff is our greatest strength. Though diverse, members and staff have a deep commitment to our mission of research and care in pulmonary, critical care and sleep medicine and to translating science into treatments and cures. And they recognize how much impact their work through the ATS can make worldwide.

“Would every presidency of a scientific and medical society such as ours provide the same opportunities for professional and personal growth? I don't think so. The American Thoracic Society is a remarkable organization.”

As a basic scientist, it's invigorating to be part of an organization that is largely made up of physicians and other clinical professionals who have embraced Ph.D.s and made them an integral part of the organization. I think both groups have benefited tremendously from the interaction.

And I think clinicians, clinical researchers, basic scientists and translational scientists and all the other groups that make up our membership have benefitted from ATS PAR, our patient arm. In the end, everything we do comes down to our mission of finding ways to prevent illness and to alleviate suffering, so that people everywhere can enjoy healthy lives.

Although this past year seems to have flown by in the blink of an eye, it's impossible to sum up all my impressions of the ATS and to fully convey what a wonderful experience this has been. Perhaps what is most striking, though, when I reflect upon the year, is how much it has been a labor of love. For me and those who I've been privileged to know as a member or meet as the ATS President, it is the Society's mission that makes it so.

I extend my heartfelt thanks to all of the ATS members, the Executive Committee members (past and present), and the staff for giving me this opportunity, for your support and friendship, and for making this a remarkable year. ■

Important News **The ATS International Conference & The Outbreak of 'Swine Flu'**

At press time, the Society continues to monitor the public health issues raised by the outbreak of H1N1. Based on available current data from WHO and CDC, the Society is still planning to hold the 2009 International Conference in San Diego, from May 15 to 20. If the situation changes and the ATS needs to modify these plans, we will notify you as quickly as possible.

The Society is also planning to add a special session with experts in influenza and public health to the International Conference program. With thousands of clinicians and scientists who are experts in respiratory health gathered from around the world, the International Conference is the ideal venue for presenting the latest information about this public health challenge. Not only is this an important public health and medical care issue, but this outbreak underscores the importance of having and maintaining resources for research into respiratory illnesses.

Please check the ATS Web site at www.thoracic.org/sections/meetings-and-courses/international-conference/2009/swine-flu.html for the most up-to-date information on the meeting and other resources of potential use to you.

NEWS BRIEFS

ATS MEMBER NEWS

In February, **Holger J. Schünemann, M.D., Ph.D., M.Sc.**, became chair of the Department of Clinical Epidemiology and Biostatistics at McMaster University, in Hamilton, Canada.



Appointed as professor of clinical epidemiology, biostatistics and medicine, he holds the endowed Michael Gent Chair in Healthcare Research and is a member of the CLARITY (Clinical Advances through Research and Translation) group at McMaster University, where he has been a part-time faculty member since 2001. He also holds a volunteer faculty appointment at SUNY Buffalo.

Dr. Schünemann conducts research about guideline development, systematic reviews, health-related quality of life issues, determinants of pulmonary function and clinical trials. He is also involved in a number of international guideline projects and is a leader of the international Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group, which has developed a common approach to grading quality of evidence and strength of recommendation that has been adopted by many standard-setting organizations, including the ATS.

He leads the ATS initiative to bring together organizations from around the globe to collaboratively develop guidelines and reduce unnecessary duplication of efforts. Since 2005, he has served as the inaugural chair of the ATS Documents Development and Implementation Committee and the Society's first documents editor.

ATS GRANTS 20 TRAVEL AWARDS TO RESIDENTS

In April, the ATS awarded 20 internal medicine and pediatric residents a stipend of \$1,000 to travel to the 2009 International Conference in San Diego.

Supported by a grant from Merck & Co., Inc., this new program is just one way the ATS is addressing the growing U.S. shortage of physicians in the fields pulmonary and critical care medicine.



"Medical and pediatric residents often choose a subspecialty based on some combination of clinical experience, exposure to research and educational opportunities and active mentoring by physicians in the subspecialty," said Louis S. Libby, M.D., chair of the Society's Clinicians Advisory Committee. "All of these things are available in large supply at the ATS International Conference, and we hope exposure to them will encourage these residents to pursue careers in pulmonary and critical care medicine."

The ATS will also provide recipients with complimentary registration for ATS 2009 and one year of in-training ATS membership. To ensure awardees get the most out of the Society's annual meeting, the CAC will pair each resident with a mentor, who will personally guide them through the many educational and networking opportunities at ATS 2009.

CONTINUITY & COMMUNICATION KEY TO NON-ABANDONMENT



Providing continuity of care and facilitating closure of therapeutic relationships are vital to ensuring dying patients and their families do not feel abandoned by their doctors around the time of death, according to a recent qualitative study published in the *Archives of Internal Medicine*. A number of national and international news outlets covered the study's findings, including the *New York Times* and *USA Today*.

Although the researchers did not set out to address non-abandonment, they found that the issue kept coming up in interviews with patients, families, doctors and nurses during a previous study that appeared last year in the *Journal of Palliative Medicine*.

"Our initial aim was to better understand how patients and families balance competing concerns—supporting patients' hopes on the one hand, while also giving truthful prognostic information about a terminal or life-limiting illness," said ATS President-Elect J. Randall Curtis, M.D., M.P.H., one of the article's senior authors.

Finding the appropriate balance to supporting hope and providing prognosis, he added, can be a real barrier to discussing end-of-life care for many physicians. "We found that some physicians are afraid that providing truthful prognostic information will dash a patient's hopes, so they withhold information. However, a number of patients we talked to said they found confronting the reality of their situation very helpful." Even when there is nothing more a physician can do to prolong life, continuity of their expertise and the doctor-patient relationship is vital to non-abandonment.

To learn more, the investigators recruited 31 physicians who identified 55 patients with incurable cancer or advanced COPD, as well as 36 family caregivers and 25 nurses. They then conducted "qualitative and semi-structured" interviews at the beginning, middle and end of the year-long study.

They found that patients who were asked to talk about hope and their views of the future independently brought up the subject of abandonment. Physicians and nurses, on the other hand, did not talk about abandonment, but instead reported experiencing a lack of closure.

This led the researchers to understand that patients, families and clinicians experienced this phenomenon in different ways: patients and families experienced abandonment as worries related to a loss of continuity with their clinicians, while families often felt abandoned after the patient's death. Clinicians, on the other hand, experienced this as a lack of closure with patients and families.

"The way that we have structured hospice and end-of-life care in this country can encourage the feeling of abandonment and disconnection," said Dr. Curtis. "The clinicians who have been providing care for a long period of time often simply turn care over to hospice providers. While hospice does a great job of stepping in to provide end-of-life care, we must develop systematic ways that physicians and nurses involved in patient care can stay involved in caring for patients at the end of life, even in very small ways."

Dr. Curtis hopes that individual physicians or nurses will recognize that if they are feeling a vague sense of lack of closure, their patients and families are at risk for abandonment. "There are simple steps they can take—sending a card, making a phone call," said Dr. Curtis. "So many physicians we talked to said they thought about doing these things, but didn't want to be intrusive. While clinicians are giving voice to this concern, they are often not taking action."

Going forward, Dr. Curtis and his colleagues will focus on developing interdisciplinary interventions that can help physicians, nurses and other healthcare professionals prevent or address abandonment. ■

ATS TO AWARD CME CREDIT THROUGH AJRCCM AND PATS

This year, the ATS will launch a new program through which physicians can earn continuing medical education credit based on select articles published in the *American Journal of Respiratory and Critical Care Medicine* and *Proceedings of the American Thoracic Society*.

"For many members, it is difficult to find the time and resources to attend CME courses, which is why the Society developed this new online program," said John Balmes, M.D., chair of the ATS Publications Policy Committee. "Not only will readers learn about the latest advances in pulmonary, critical care and sleep medicine, they will also be able to more conveniently fulfill their CME requirements from the comfort of their homes or offices."

By the end of the year, a total of 20 articles published in the *AJRCCM* and *PATS* will be accompanied by a Web-based CME exam and evaluation. Readers will be able to earn up to one American Medical Association Physician Recognition Award Category 1 credit for each test they successfully complete. While this program will be free to ATS members, non-members and subscribers will be required to pay a fee.



Through a section of the Web site called "My CME," users will be able to view the status of the exams they have completed. The system also will allow users to begin a test and save it so that they can return to complete it at a later date.

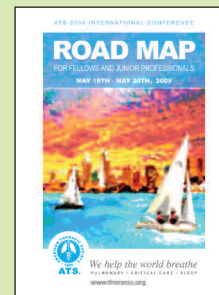
"The Society is now in the process of finalizing the specifics of this new program," explained Dr. Balmes. "Once we work out these details and the CME site goes live, we will provide ATS members with a more comprehensive overview of this extraordinary new membership benefit."

The ATS is already working to expand the program to include articles published in the *American Journal of Cell and Molecular Biology*, he added, a portion of the site that will likely go live next year. ■

NEWS BRIEFS

'ROAD MAP' FOR FELLOWS HIGHLIGHTS BEST OF ATS 2009

To help individuals at the beginning of their careers navigate the 2009 ATS International Conference, the Society's Members In Transition and Training Committee, or MITT, is again publishing the *Road Map for Fellows & Junior Professionals*.



The *Road Map* mini-program, which highlights sessions and other events of interest at ATS 2009, aims to ensure new members and first-time conference attendees get the most out of the meeting's 400 sessions, 800 speakers and 5,300 original research abstracts.

Attendees can download the *Road Map* from the ATS Web site at www.thoracic.org/go/conference-roadmap or pick up a copy onsite during the meeting at the ATS Center or the Center for Fellows and Junior Professionals, both of which will be located in the San Diego Convention Center.

PILOT PROJECT IN EDUCATIONAL OUTCOMES MEASUREMENT

Attendees at four postgraduate courses during ATS 2009 in San Diego will be asked to participate in a pilot project directed by Tao T. Le, M.D., M.H.S., assistant clinical professor at the University of Louisville. The initiative is sponsored by the ATS Education Committee, which is co-chaired by Atul Malhotra, M.D., and James M. Beck, M.D.

- PG 3 "Chronic Obstructive Pulmonary Disease: Progress in 2009"
- PG 6 "Mechanical Ventilation: State of the Art"
- PG 17 "Interventional Pulmonology with Practical Demonstration: Something for Every Pulmonologist"
- PG 18 "Nuts and Bolts of Management of Interstitial Lung Disease"

A number of faculty members scheduled to present at these courses have prepared pre- and post-course tests in case vignette formats. When properly constructed, case vignettes can measure increased competence to manage patients. Outcomes also help course faculty improve their instructional strategy. Dr. Le will report on the pilot's results this summer. This project is part of an overall ATS initiative to measure and improve educational quality.

CALL FOR PROPOSALS: ATS 2010 • NEW ORLEANS

The ATS is now accepting proposals for the scientific and medical program for the 2010 International Conference, which will be held May 14 to 19, in New Orleans. Proposals for sessions covering all areas of pulmonary, critical care and sleep medicine are encouraged.



Submission formats include scientific symposia, seminars, workshops and postgraduate courses. All proposals must be submitted through the ATS Web site by **June 30, 2009**. To submit a proposal, visit <http://conference.thoracic.org>.

RESEARCH IN BRIEF

SUMMARIES OF RESEARCH FINDINGS IN PULMONARY, CRITICAL CARE, AND SLEEP MEDICINE FROM AROUND THE WORLD

LUNG TRANSPLANT CONTRAINDICATED FOR PATIENTS 70 YEARS OR OLDER

NEW YORK (Reuters Health) - A retrospective review of United Network for Organ Sharing (UNOS) data has led reviewers to conclude that lung transplantation may be used "with caution" in patients older than age 60, but "should not be used for patients older than age 70."

"From current guidelines, there exists no definitive recommendation regarding the maximum age that is safe for lung transplantation," Dr. Eric S. Weiss from The Johns Hopkins Hospital in Baltimore, Maryland, who led the effort, told Reuters Health.

He and colleagues analyzed the impact of advanced age on short- and intermediate-term outcomes for 8,363 adults who had a lung transplant between 1999 and 2006. Patients were stratified by age into four quartiles: (Q1) 18 to 45 years (n=2,192); (Q2) 46 to 55 (n=2,160); (Q3) 56 to 60 years (2,000); and (Q4) 61 years to 79 years (2,011).

"The findings of this study show that patients age 60 to 69 can be transplanted safely with acceptable short- and long-term results," Dr. Weiss told Reuters Health. Patients in all four age quartiles had similar 30-day and 90-day mortality rates, the investigators found. Thirty-day mortality rates for Q1, Q2, Q3 and Q4 were 5.5%, 5.3%, 5.4% and 4.6%, respectively, while 90-day mortality rates were 9.5%, 9.5%, 8.9% and 9.3%, respectively.

"Importantly," Dr. Weiss said, "although I think some clinicians are reticent to transplant older patients due to fear of operative and short-term mortality, our study shows that short-term survival is no different in older patients relative to young patients."

At one year, patients in Q4 (age 61-79) had mortality rates of 21.4%. One-year mortality rates for the other groups were 17.3%, 17.2% and 18.7% in Q1, Q2 and Q3, respectively.

According to Dr. Weiss, patients age 70 and older had "exceedingly high mortality rates." Of the 57 patients identified as 70 or older, 34% of the patients died during the study period. These patients had a 30-day mortality rate of 7% and one-year mortality rate of 42%.

"We did not expect to see such a strikingly high mortality rate for the 57 patients age 70 and older in this study," Dr. Weiss admitted. "I think the findings of this study support transplantation for patients younger than age 70 only," he concluded. ■

Last Updated: 2009-03-20 16:56:18 -0400

J Am Coll Surg 2009; 208:400-409.

TOO TIGHT GLUCOSE CONTROL IN ICU MAY RAISE MORTALITY RISK

NEW YORK (Reuters Health) - Attempts to maintain euglycemia in critically ill adults may do more harm than good, according to a large, international trial published in the *New England Journal of Medicine* for March 26.

Based on early trials showing tight glucose control reduced ICU mortality, many professional organizations support this strategy for ICU patients, the authors report. However, more recent data have called into question the safety of this approach.

In the largest such trial to date, the NICE-SUGAR (Normoglycemia in Intensive Care Evaluation-Survival Using Glucose Algorithm Regulation) trial involved more than 6,000 patients treated in the ICUs of 42 hospitals in Australia, New Zealand and Canada. Subjects were randomly assigned to glucose control within the target range of 81 to 108 mg/dL (intensive control, n=3,016), or 144 to 180 mg/dL (conventional control, n=3,014).

Ninety-day mortality was 27.5% in the intensive control group and 24.9% in the conventional-control group (odds ratio 1.14, p=0.02). "This represents a number needed to harm of 38," Dr. Simon Finfer at the George Institute for International Health in Sydney, Australia, and co-authors report.

Severe hypoglycemia affected more patients in the intensive control group (6.8% versus 0.5%, p<0.001), and involved a higher number of episodes (272 versus 16).

"On the basis of our results," Dr. Finfer's team concludes, "we do not recommend use of the lower target in critically ill adults."

However, the NICESUGAR trial results may not be definitive, suggest editorialists at Yale University in New Haven, Connecticut. They call for post-hoc analyses exploring precise causes of death, as well as per-protocol and subgroup analyses.

In the meantime, Drs. Silvio E. Inzucchi and Mark D. Siegel write, "It would seem reasonable to continue our attempts to optimize the management of blood glucose in our hospitalized patients, especially to avert the extremes of hyperglycemia (which have acute effects on renal function, hemodynamics and immune defenses) and also hypoglycemia (with its own, often more immediate and serious, consequences)."

Still, they caution against "neglectful glycemic control involving haphazard therapeutic approaches (e.g., use of insulin 'sliding scales')—all too common a decade ago." ■

Last Updated: 2009-03-24 17:15:52 -0400

NEJM 2009; 360:1283-1297, 1346-1349.

ABDOMINAL OBESITY MAY IMPAIR LUNG FUNCTION

NEW YORK (Reuters) - New research suggests that metabolic syndrome, primarily the abdominal obesity component, is associated with lung function impairment. Moreover, the degree of obesity need not be severe to increase the risk.

The findings showed that "mild abdominal adiposity, even with a normal body mass index, is associated with lower forced vital capacity (FVC)," lead author Dr. Nathalie Leone, from Universite Denis Diderot in Paris, said in a statement.

"The association," Dr. Leone explained, "may result from the mechanical effects of truncal obesity and/or the metabolic effects of adipose tissue. Abdominal obesity may mechanically affect the diaphragm and chest wall compliance with decreased lung volumes."

The findings come from a cross-sectional study of 121,965 men and women seen at the Paris Investigations Preventives et Cliniques Center from 1999 to 2006. Lung function impairment was defined as a forced expiratory volume in one second (FEV₁) or forced vital capacity (FVC) below the lower limit of normal.

After adjusting for age, gender, smoking status, alcohol use, educational level, body mass index, leisure-time activity and cardiovascular disease history, metabolic syndrome was still linked to lung function impairment, according to the report in the *American Journal of Respiratory and Critical Care Medicine* for March.

In addition to abdominal obesity, other metabolic syndrome components tied to lung dysfunction were abnormalities in lipid levels and in glucose/blood pressure. Still, abdominal obesity showed the strongest association, raising the risk of abnormal FEV₁ and FVC by 1.94- and 2.11-fold, respectively.

In a related editorial, Dr. Paul Enright, from the University of Arizona in Tucson, writes that "there is now enough evidence to recommend that waist circumference always be measured before spirometry tests. Abdominal obesity could then be highlighted on the printed report so that the physician interpreting the report could take the effect of obesity into account." ■

Last Updated: 2009-03-11 8:00:59 -0400

Am J Respir Crit Care Med 2009; 179: 432-433, 509-516.

INDETERMINATE RESULTS FOR LATENT TB COMMON IN YOUNGER CHILDREN

NEW YORK (Reuters Health) - Commercial blood tests for latent tuberculosis infection (LTBI) yield indeterminate results more commonly for children under four years of age than for older children, according to a report from Italy in the March issue of *Pediatrics*.

Interferon-gamma release assays (IGRAs) appear to be more accurate than the skin test for diagnosing LTBI, the authors explain, but the performance of IGRAs for diagnosis in children has not been studied extensively.

Dr. Luca Richeldi, from the University of Modena and Reggio Emilia, and colleagues analyzed the performance of IGRAs under routine conditions in a large pediatric population to investigate the frequency of indeterminate results and the potential effect of age on these diagnostic tests.

Positive IGRA results were obtained in 18.8% of children tested with QuantiFERON- TB Gold (QFT-G), 17.1% of children tested with QuantiFERON- TB In-Tube (QFT-IT), and 14.3% of children tested with both a QFT and TSPOT.TB, the authors report.

For children under age four years, indeterminate IGRA results were significantly more common with QFT-G and QFT-IT than with TSPOT.TB, but this difference was not apparent for children four years and older. Mitogen responses were significantly lower in younger children than in older children, the researchers note.

"Our findings, based on the retrospective evaluation of a large cohort of children, lend support to the notion that different IGRAs for the diagnosis of LTBI may produce significant-

ly different rates of indeterminate results in young children," the investigators say.

"TSPOT.TB-positive controls seemed to be equally efficient at any age," the authors conclude. "Because young children are a high-risk group and a main target for preventive LTBI treatment, these results may have an impact on the strategies aimed at TB control." ■

Last Updated: 2009-03-26 16:13:43 -0400

Pediatrics 2009;123: e419-e424.

TREATMENT OF OSA REDUCES CARDIAC DYSFUNCTION RISK IN CHILDREN

NEW YORK (Reuters Health) - Obstructive sleep apnea (OSA) in children is associated with an increased risk of subclinical ventricular dysfunction, according to a report in the March issue of *Thorax*. Successful treatment of OSA, however, can restore normal function, the investigators found.

Severe OSA has previously been linked to congestive heart failure in childhood, the authors explain, but the effect of intervention for OSA on cardiac dysfunction has not been well-characterized.

Dr. J. Y. S. Chan and colleagues from The Chinese University of Hong Kong assessed cardiac structure and function in 101 children aged six to 13 years with OSA and measured the degree of reversibility after various treatments including nasal steroids and adenotonsillectomy.

Apnea-hypopnea index and oxygen desaturation index were significantly associated with abnormal right ventricular geometry and function, the authors report, and the severity of OSA was significantly associated with abnormal left ventricular geometry.

Although none of the children opted to receive non-invasive positive pressure ventilation, several underwent adenotonsillectomy or received nasal steroid therapy.

Seventeen of the 36 children available for follow-up at six months had improved OSA, the researchers note, and only those children showing improvements in OSA also had significant improvements in cardiac geometry and dysfunction.

"Childhood OSA is associated with right and left ventricular remodeling and dysfunction," the investigators conclude. "Community-based screening programs may allow early detection and treatment of OSA that could potentially reverse myocardial dysfunction, remodeling and lessen the risk for future cardiovascular disease." ■

Last Updated: 2009-03-20 14:04:17 -0400

Thorax 2009; 64:233-239.

PREOPERATIVE PROGRAM PROMOTES LONG-TERM SMOKING ABSTINENCE

NEW YORK (Reuters Health) - Surgical patients who attended a smoking cessation program before their procedure were significantly more likely to be abstinent at one year than their peers who received usual care, new research shows.

The results, which appear in the March issue of *Anaesthesia*, also indicate that the smoking cessation intervention reduced postoperative complications from 41% to 21% (p=0.03).

The study featured 117 patients, scheduled for elective general or orthopedic procedures, who were

randomized to participate in the intervention, initiated four weeks before surgery and continued for four weeks afterward, or to receive usual care.

"The intervention group," lead author Dr. Omid Sadr Azodi explained in a statement, "attended weekly meetings or received telephone support and were provided with free nicotine replacement therapy, while the control group just received standard pre-operative care."

One interesting finding, according to Dr. Sadr Azodi, who is with the Karolinska Institute in Stockholm, was the high study refusal rate. Many patients, he noted, simply refused to take part in the study because they did not want to give up smoking or were stressed by their upcoming operation.

Throughout the perioperative period, 36% of intervention patients completely refrained from smoking, compared with just 2% of control patients ($p<0.001$). At one year, the abstinence rate in the intervention group was more than double that of the control group: 33% versus 15% ($p=0.03$).

A low level of nicotine dependence and a body mass index of 30 or higher both increased the odds of one-year smoking abstinence by roughly 3.3-fold.

"Our intervention was for a fairly intense eight-week period, but we recognize that people with higher levels of dependency may need longer to help them stop smoking before surgery," Dr. Sadr Azodi noted. ■

Last Updated: 2009-03-19 10:29:08 -0400

Anaesthesia 2009; 64:259-265.

HIGH-DOSE CAROTENOID SUPPLEMENTS TIED TO LUNG CANCER RISK

NEW YORK (Reuters Health) - Extended use of individual beta-carotene, retinol and lutein supplements, at doses higher than in multivitamins, increases lung cancer risk, according to data from the Vitamins and Lifestyle (VITAL) prospective cohort study.

High-dose beta-carotene supplements increase lung cancer rates in high-risk individuals, even though carotenoids from dietary sources tend to lower risk, Dr. Jessie A. Satia and co-researchers note in the April 1 issue of the *American Journal of Epidemiology*. "Whether effects are similar in the general population is unclear."

The researchers analyzed data from 77,126 subjects ages 50 to 76 who filled out questionnaires in 2000-2002 regarding supplement use over the previous decade. The cohort was predominantly white and generally healthy, the authors note, and while there were few never-smokers among the lung cancer cases, there were fewer current smokers in the overall cohort than in the general population.

By linking to the SEER cancer registry, Dr. Satia, at the University of North Carolina at Chapel Hill, and her team identified 521 incident lung cancer cases. They estimated hazard ratios (HRs) for individual supplements after adjusting for age, gender and smoking history.

For beta-carotene used for at least four years, the HRs for total lung cancer and for small-cell lung cancer were 1.18 ($p=NS$) and 3.22 ($p=0.01$).

For retinol, the HR for total lung cancer was 1.53 ($p=0.02$). For non-small-cell lung cancer, it was 1.80 ($p=0.002$). For lutein, corresponding HRs were 2.02 ($p=0.006$) and 2.48 ($p=0.01$).

The researchers speculate that "1) these nutrients from supplements may be more bioavailable than those from dietary sources; 2) large intakes may interfere with absorption, transport and distribution and/or metabolism of other carotenoids or micronutrients that could have offered significant protection; and 3) too high a dose of an antioxidant vitamin may interfere with generation of reactive oxygen species needed for beneficial processes, such as normal immune response and apoptosis."

They conclude: "Long-term use of individual beta-carotene, retinol and lutein supplements should not be recommended for lung cancer prevention, particularly among smokers." ■

Last Updated: 2009-03-26 8:00:41 -0400

Am J Epidemiol 2009; 169:815-828.

HFA INHALERS RAISE BREATH ALCOHOL

By David Douglas

NEW YORK (Reuters Health) - Replacement of chlorofluorocarbons (CFCs) as propellants may mean that certain hydrofluoroalkane (HFA) powered asthma inhalers could cause interference with breath analyzer readings, according to Australian researchers.

"In order to decrease greenhouse emissions, the propellant in metered dose inhalers used for asthma treatment has been changed," senior investigator Dr. Deborah Y. Yates pointed out in remarks to Reuters Health.

"The new propellant," she added, "consists of HFAs, with some also containing alcohol-ethanol. In theory, this might give a high reading on a breath test for alcohol if an asthmatic patient has just used such an inhaler. However, until recently, no one had studied this issue."

In the January issue of *Respirology*, Dr. Yates of St. Vincent's College in Darlinghurst, and colleagues report that they conducted a randomized trial involving 16 asthmatics and 15 normal controls.

The researchers studied the effect on breath ethanol concentrations (BEC) at two, five and 15 minutes after use of an HFA-ethanol inhaler, a CFC inhaler and a placebo inhaler. The effect of ingesting a standard amount of alcohol was also investigated.

There was a significant but transient increase in BEC after use of the HFA-ethanol inhaler, but this returned to baseline within five minutes. Thus, continued Dr. Yates, "we measured the effect of one such inhaler on breath alcohol levels both before and after a glass of white wine."

"We showed that such an effect did occur," she concluded, "but it was short-lived and small in comparison with the effect of having a drink. Both patients and clinicians enjoyed participating in the study!" ■

Last Updated: 2009-03-03 17:21:25 -0400

Respirology 2009; 14:112-116.

BRONCHODILATOR THERAPY MAY HELP IN MILD COPD

NEW YORK (Reuters Health) - Patients with GOLD (Global Initiative on Obstructive Lung Disease) stage 1 COPD may benefit from use of an anticholinergic inhaler, Canadian researchers report in the March issue of *Thorax*.

Most such patients remain undiagnosed, lead investigator Dr. Denis E. O'Donnell told Reuters Health. Nonetheless, he noted, "the study shows that even patients with mild airway obstruction, as measured by a traditional breathing test—spirometry—may have extensive disease of their smaller airways."

Dr. O'Donnell of Queen's University in Kingston and colleagues conducted a randomized double-blind crossover trial of 16 patients with COPD who had a lung function (FEV1) that was 90% of predicted.

They underwent exercise testing on two separate occasions during which they were given either nebulized ipratropium bromide or placebo.

"When challenged with physical exertion," Dr. O'Donnell continued, "these patients demonstrate air trapping and lung over-inflation which contribute to breathlessness and exercise intolerance."

Compared to use of placebo, ipratropium prompted a 5% increase in FEV1 predicted, a 12% decrease in residual volume predicted and a decrease in specific airway resistance of 81% predicted. There was also a significant increase in dynamic inspiratory capacity sampled during exercise and in tidal volume, and a reduction in dyspnea.

"The current study shows consistent improvements in airway function with reduced air trapping and breathlessness after short term treatment with an inhaled anticholinergic agent compared with placebo," Dr. O'Donnell concluded. "This study provides a solid physiological rationale for consideration of a trial of an anticholinergic inhaler in patients with mild COPD who experience persistent breathlessness on activity." ■

Last Updated: 2009-03-26 16:06:13 -0400

Thorax 2008; 64:216-223.

PATIENT-PHYSICIAN CONNECTION RESULTS IN CLOSER ADHERENCE

By Martha Kerr

NEW YORK (Reuters Health) - Patients who feel a connectedness with their personal physician feel they are receiving a higher quality of care and that the medical care is more consistent with approved guidelines than patients who feel like a "number" in the healthcare system.

A study of nine primary care practices and four community health centers connected with Massachusetts General Hospital, involving a total of 181 physicians in the Boston area, was conducted by Dr. Steven J. Atlas and colleagues "to determine whether patient-physician connectedness affects measures of clinical performance."

The study involved 155,590 adults who made one or more visits to one of the practices between 2003 and 2005. Dr. Atlas' team looked at screening for breast, cervical and colorectal cancer in eligible patients; hemoglobin A1c measurement in patients with diabetes; and low-density lipoprotein (LDL) cholesterol measurement in patients with or at risk of coronary artery disease.

The researchers found that 59.3% of the patients were connected to a specific physician, 34.5% were connected only to a specific practice and 6.2% could not be connected to a physician or a practice.

The researchers report in the March issue of the *Annals of Internal Medicine* that "physician-connected patients were significantly more likely than practice-connected patients to receive guideline-consistent care."

Mammography rates were 78.1% for physician-connected patients and 65.9% for practice-connected patients. Hemoglobin A1c measurement rate was 90.3% for physician-connected diabetics and 74.9% for practice-connected diabetics. "Receipt of preventive care varied more by whether patients were more or less connected to a physician than by race or ethnicity," they found.

"We try to connect a patient with a primary care physician, but the medical education system is not sufficient to sustain this. The number of primary care physicians is at an all-time low and unless the pipeline changes, the situation is not going to change," Dr. Atlas said in an interview with Reuters Health.

"We need to change the locus from the office-based visit to something else, such as by phone or email...The whole reimbursement system is based on the office visit," Dr. Atlas said.

"We need to change our outreach, by having more early morning or late evening hours and more weekend hours," he added. "We need a patient-centered home model, where the system makes it easier for the patient than for the physician."

In an accompanying editorial, Dr. Andrew B. Bindman of the University of California at San Francisco echoed Dr. Atlas' point about the medical education system. "Although there are demonstrable benefits associated with patients having a personal physician, this goal has been undermined in recent years by the shrinking number of physicians entering into practice in one of the primary care specialties of family medicine, general internal medicine or pediatrics," Dr. Bindman told Reuters Health.

"Several steps are needed to reverse this trend, beginning with a reform of the payment formulas in Medicare and other health insurance plans that reward specialists and the performance of procedures to a disproportionate degree over the diagnostic, education

and coordination functions of primary care physicians in their roles as communicators with patients." ■

Last Updated: 2009-03-03 15:42:54 -400

Ann Intern Med 2009; 150: 325-335.

ASTHMA 'COACHES' CUT REHOSPITALIZATION AMONG POOR CHILDREN

By Martha Kerr

NEW YORK (Reuters Health) - Community health workers acting as asthma coaches are able to reduce the need for re-hospitalization for asthma among children in low-income families, researchers report in the March issue of the *Archives of Pediatrics and Adolescent Medicine*.

A population-based study of 191 African-American children between two and eight years of age covered by Medicaid who were hospitalized for asthma was conducted by Dr. Edwin B. Fisher of the University of North Carolina at Chapel Hill and colleagues. The children were randomized to usual care or to two years with an asthma coach.

Coaches reinforced basic asthma education and positive behaviors in disease management on home visits and by phone calls. Teaching was tailored to the parents' "readiness to adopt management practices." Coaches used a "non-directive supportive style."

"The coach offers help in figuring out how to implement in daily life the action plan developed in the physician's office," Dr. Fisher explained in an interview with Reuters Health. "In this sense, the fact that the coach is familiar with the neighborhood and circumstances of the parent and child and has time to 'brainstorm' with the parent about how to implement the plan is a great advantage."

He added, "The coach doesn't need expertise, just basic familiarity with the terms of an action plan and the time and good communication skills to work effectively with the parent."

There were an average of 21.1 contacts per parent over the 24 months of the intervention. During the first three months after randomization, 89.6% of parents had at least one contact with the coach.

Thirty-five of 96 children (36.5%) assigned an asthma coach were re-hospitalized with asthma, compared with 55 of 93 children (59.1%) who received usual care.

"The 52% reduction in hospitalization (mean admissions per child, 0.73 in the coached and 1.52 in usual care group) is comparable with the effect of interventions implemented by professionals," the investigators report.

While there was no reduction in visits to the emergency department (ED) in this study, there was a reduction in the need for hospitalization following an ED visit in the coached group, suggesting "acuity at arrival for emergency care may be reduced by having learned to initiate treatment before emergency care or to seek emergency care earlier." ■

Last Updated: 2009-03-12 16:20:10 -0400

Arch Pediatr Adolesc Med 2009; 163:225-232.

RESEARCH IN BRIEF

These research summaries were selected by *American Journal of Respiratory and Critical Care Medicine* editorial board members Drs. Michael P. Keane, Geraldo Lorenzi Filho and Toru Oga, who reviewed approximately 60 stories recently published by Reuters Health in the fields of pulmonary, critical care and sleep medicine.



GO ONLINE Additional research summaries, also selected by members of the *AJRCCM* editorial board, are published each month at www.thoracic.org/go/research-in-brief.

WHO'S WHO at ATS

SERPIL ERZURUM'S PERSEVERANCE IS PAYING OFF

The best advice Serpil C. Erzurum, M.D., can give to investigators at the beginning of their careers is this: a passion for discovery is a prerequisite, but clinical research is mostly about perseverance.

"Translational research is a cumulative process that advances little-by-little until you finally can see your destination," said Dr. Erzurum, who is professor and chair of the Pathobiology Department at the Cleveland Clinic's Lerner Research Institute. "After many years, my team is now at the point where we can see how cellular mechanisms and pathways that we have identified might lead to benefits for patients. To be able to apply our work to the patient and feel like we have contributed, even in a small way, is immensely gratifying."

Equally gratifying has been the rapid growth of her department at Lerner Research Institute. When it was first created in 2004, the department had only three staff members. Today, Dr. Erzurum oversees 21 researchers and more than 100 support personnel. "We do the entire spectrum of research—from basic science to clinical studies—and our department members are unified by their common goal of discovering disease processes," she explained.

Which leads her to another piece of advice for fellows: clinical research is by no means a solitary endeavor. "To borrow Hillary Clinton's phrase, it takes a village," said Dr. Erzurum, who credits her excellent staff of Ph.D.s, M.D.s, R.N.s—who collectively secure more than \$20 million in grants each year—with all of the advances they have made since she became the department's inaugural chair.

As a translational researcher, Dr. Erzurum works at both the bench and bedside. "Our focus is to understand the molecular and biochemical events in the asthmatic airway so that we can develop better diagnostic tools and therapies," she said. "In the last several years, we have also been studying pulmonary endothelium and how abnormalities in metabolic pathways in endothelial cells contribute to pulmonary vascular and airway diseases."

When she is not in the lab, she teaches and sees patients in the outpatient clinic or during hospital consult rounds. She also dedicates much of her time to mentoring fellows and trainees. "Knowing how much my own career was shaped by the people who guided and encouraged me along the way, I know how important it is to be mentored," said Dr. Erzurum, who credits her own mentors with sparking her interest in pulmonary and critical care medicine during her internship and residency at Baylor College of Medicine in Houston.

This interest only grew after she completed her residency and began working as a staff physician at the Indian Health Service's 30-bed Sioux San Hospital and the VA Medical Center in Sturgis, South Dakota. "This experience taught me a lot about practical patient care and the value of personal contact, history and physical examination in general medical practice," Dr. Erzurum explained.



"Translational research is a cumulative process that advances little-by-little until you finally can see your destination. After many years, my team is now at the point where we can see how cellular mechanisms and pathways that we have identified might lead to benefits for patients."

She put these clinical skills to use when she began her pulmonary and critical care fellowship at the University of Colorado Health Sciences Center in 1987. She quickly realized just how much she enjoyed bench research while working with Scott Worthen, M.D., who was studying how inflammatory cells are retained in the lung. She later discovered her passion for clinical research while working on an asthma clinical trial with Richard Martin, M.D.

"I knew then that I wanted to apply basic science research to clinical practice," said Dr. Erzurum. She entered postdoctoral fellowship at the National Heart, Lung, and Blood Institute's pulmonary branch with Ronald Crystal, M.D. "The NIH was, and is, one of the most exciting places for cutting-edge science and human studies. The environment really promotes application of research discoveries to patient care," she said.

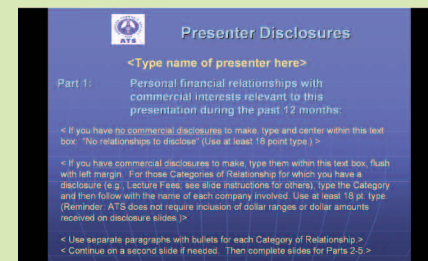
In 1993, she moved to the Cleveland Clinic where she developed her translational research program.

Since joining the ATS as a fellow, Dr. Erzurum has been active in the Assembly on Allergy, Immunology and Inflammation. She chairs the ATS Membership Committee and will be installed as the assembly's new chair this month at the Society's 2009 International Conference.

Dr. Erzurum lives in Cleveland—"possibly the best city in the world"—with her daughters, Claudia, 16, and, Ayla, 19. ■

NEWS BRIEFS

REMINDER FOR CHAIRS AND PRESENTERS AT ATS 2009: COI DISCLOSURE



ATS members who will be chairing or presenting at the Society's 2009 International Conference in San Diego are reminded of the importance of onsite faculty disclosure and conflict-of-interest (COI) management.

The ATS now requires moderators and presenters to prepare and display disclosure slides at the beginning of conference presentations, in conformance with the Accreditation Council for Continuing Medical Education's disclosure-to-learner requirements and the ATS's policies on disclosure of COI and tobacco industry relationships.

PowerPoint disclosure slide templates that satisfy ATS requirements can be downloaded from the ATS Web site at www.thoracic.org/go/international-conference in the section called "Presenter and Chair Resources." Other slide formats may be used, as long as they include the required information. Moderators and presenters can retrieve their conference faculty disclosure form for use in preparing these slides by visiting <http://conference.thoracic.org>.

Session chairs/moderators are also reminded to look for the COI documentation form on the podium at their sessions. They must complete the form by the end of each session they moderate, in order for the ATS to meet ACCME requirements for written attestation that all speakers disclosed all COI issues and any conflicts were resolved.

FREE ACCESS TO ATS • 2009 WEBCASTS

As a benefit of your 2009 International Conference registration,* the ATS is again offering 12 months of free access to 2009 conference Webcasts. Full conference paid registrants will have post-meeting access to more than 200 hours of ATS 2009 presentations, reflecting the diverse topic areas of the conference—including major symposia in clinical, basic, translational and behavioral science, all Year in Review sessions and evening postgraduate seminars—at no extra charge.



The "Best of ATS Conferences" Webcasts provide full audio and slides, synchronized and searchable. More details will be provided onsite during the meeting and will be available on the Society's Web site afterward. Visit www.thoracic.org and visit "Best of ATS Conferences."

*Free access is limited to paid conference registrants in full conference categories (including in-training). One-day registrants, other attendees and non-attendees may pay for this 12-month access by placing orders at designated pricing levels to be announced in the final program onsite.



ATS PRESIDENT-ELECT MEETS WITH OBAMA'S TEAM ON HEALTHCARE REFORM IN D.C.

On March 25, President Barack Obama's health policy advisors invited approximately 40 physicians to meet with them at the White House to discuss the President's "vision" for healthcare reform, including reducing the cost of healthcare, preserving patient/consumer choice and increasing quality of care.

"The goal of the meeting was primarily to get input from clinicians, representatives of leading professional societies and the deans and vice-chancellors from major medical schools about what they believe are the most important issues a reformed healthcare system should address," said ATS President-Elect J. Randall Curtis, M.D., M.P.H., who attended the meeting as a representative of the ATS and a critical care specialist.

Obama advisors Ezekiel J. Emanuel, MD, PhD, Robert Kocher, M.D., and Dora Hughes, M.D., M.P.H., first presented the key components of the new system the President hopes to introduce this year. They then asked for feedback on a range of issues, including physician reimbursement, quality and performance metrics, use of technology, medical malpractice reform, coordi-



nation of care across subspecialties and the medical education system.

Among the issues that Dr. Curtis and his colleagues identified as most critical were tying physician reimbursement to quality metrics other than volume of care delivered; changing the Anti-Kickback and Stark Laws to allow for better coordination of care; reforming medical malpractice to discourage "defensive medicine;" increasing support for primary care providers; endorsing the concept of the patient-centered medical home; modernizing the medical education system so that it supports reform efforts; and promoting research

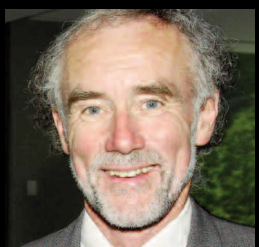
on comparative effectiveness.

Through healthcare summits like this one, the Obama advisors said, the administration is getting the information it needs to fine-tune its plan for reform, which is expected to be unveiled in late May. "By inviting representatives from such a broad range of adult and pediatric specialties—including primary care, surgery, psychiatry, gynecology, cardiology, and pulmonary, critical, and sleep medicine—the administration appears to be incorporating the viewpoints of a broad range of physicians and other clinicians," said Dr. Curtis. ■

Obituary

Professor Robert J. Pierce

January 15, 1947-February 7, 2009



Robert John Pierce, M.D., died tragically on February 7, 2009, defending his home in St Andrews, Victoria, Australia, against the Black Saturday firestorm. His sudden death has shocked his many friends in the sleep and pulmonary medicine communities in Australia and around the world.

A native of Melbourne, Dr. Pierce completed his undergraduate medical degree at the University of Melbourne in 1970. After doing his residency at Melbourne's St. Vincent's Hospital and Repatriation General Hospital, he headed to the United Kingdom to complete his training at Royal Brompton Hospital in London.

Dr. Pierce later returned to Heidelberg to develop his clinical and research skills under the guidance of Dr. Colin Barter and the late Dr. Alistair Campbell. His colleagues there remember him as an "excellent clinician and teacher whose inquiring and incisive mind and capacity for hard work" led to research publications in the fields of pulmonary physiology, asthma, chronic obstructive pulmonary disease and lung cancer.

"Rob was one of the handful of clinicians in Australia who recognized the importance of the burgeoning field of sleep medicine at an early stage and established sleep investigative facilities at Heidelberg, which rapidly became the premier site for sleep medicine training in Victoria," said Peter Holmes, M.B.B.S., deputy director of adult respiratory and sleep medicine at Monash Medical Centre in Melbourne, who trained with Dr. Pierce. "Although initially, there were some doubters of the importance of sleep measurement and disorders in pulmonary departments in Australia, he maintained strong advocacy in this area and participated enthusiastically in the often laborious task of developing professional standards and fostering sleep training within pulmonary physician certification in Australia."

While overseeing the amalgamation of the Austin and Heidelberg Repatriation Respiratory Units in Melbourne when the two hospitals united in 1995, Dr. Pierce further expanded the department's

large clinical sleep disorders unit, with its associated strong research arm. He also established the Victorian Respiratory Support Service, which supports the needs of patients throughout Victoria who require chronic ventilatory support.

An ATS member since 1990, Dr. Pierce forged strong collaborations and enduring friendships with colleagues in many different parts of the world. In 2000, he founded the Institute for Breathing and Sleep to promote research, education and public advocacy. He was also a founding investigator of the Australasian Sleep Trials Network.

He made several sabbatical visits to Harvard to establish collaborative studies in upper airway physiology with David P. White, M.D., Atul Malhotra, M.D., and other colleagues. This year, he led an international group that secured funding from the Victorian Neurotrauma Initiative to further the understanding of sleep disorders in patients with quadriplegia and translate this knowledge into improved treatment for these patients.

"Rob always maintained his clinical skills and was loved by his patients, many of whom became his friends," said Christine McDonald, M.D., Ph.D., who worked with Dr. Pierce at the Austin and Repatriation Medical Centre. "He was an extremely popular member of the sleep and pulmonary medicine communities in Australia and beyond. It will be hard to imagine a conference in either of these fields without his laconic sense of humour and permanently windswept hairstyle."

He was also well-known for his abiding interest in respiratory and sleep health in indigenous Australians. During a sabbatical in 2006, he saw firsthand the prevalence of respiratory and sleep health problems in remote aboriginal communities in Northern Australia. Until his sudden death, he was actively pursuing an advocacy role, as well as developing educational materials to address some of these issues. He was also working towards establishing a sustainable respiratory health service in this region.

Despite his many achievements, it was Rob's personal qualities that his colleagues and friends found most endearing and memorable. "He was extraordinarily kind and generous with his time, and his door was unfailingly open to patients, students, colleagues and friends," said Ron Grunstein, M.D., Ph.D., of Royal Prince Alfred Hospital in Sydney. "He was friendly, encouraging, supportive and helpful to young investigators, whether they were local, national and international. For someone so prominent in academic medicine, he was an extremely humble person, apparently unburdened by ego."

Dr. Pierce is survived by his parents; his wife, Jan; and their children, Chris, Lucy, Nick and Tristan.

ATS PARTICIPATES IN WORKSHOP TO ADAPT *ISTC* TO CHALLENGES IN SOUTHEAST ASIA



Attendees at the "National Workshop on Adapting the *ISTC* to the Myanmar Context." Front row, center: Professor Adike Wibowo, WHO representative to Myanmar, with Dr. Hopewell (left) and Fran Du Melle, M.S., senior director of ATS international programs and activities.

In March, ATS members and staff participated in a national workshop to adapt the principles set forth in the *International Standards for Tuberculosis Care* to the unique set of challenges that practitioners providing TB services in Myanmar face.

Developed in 2006 by the Tuberculosis Coalition for Technical Assistance (TBCTA) in a process led jointly by the ATS and World Health Organization (WHO), the *ISTC* presents a set of widely accepted, evidence-based standards for the diagnosis and treatment of TB, as well as the public health responsibilities associated with preventing and curing the disease.

"It is widely recognized that, in many countries, involvement of the private sec-

tor is crucial to bringing about effective TB care and control," said former ATS president Philip C. Hopewell, M.D., who co-chaired the committee that produced the *ISTC* with Mario Raviglione, M.D., from the WHO. "To address specific limitations in South East Asia, this workshop focused on encouraging all care providers to develop public-private partnerships for the delivery of TB care."

Promoting such partnerships is a major component of the *ISTC*, which was launched in Myanmar on World TB Day 2009. With an estimated population of 55.4 million, Myanmar is among the 22 countries with the highest burdens of TB, according to the WHO.

ATS/ALAT TO HOST 15TH ANNUAL MECOR COURSE IN LATIN AMERICA

The 15th annual Methods in Epidemiology, Clinical and Operations Research (MECOR) in Latin America will take place October 19 to 24, 2009, in Botucatu, Brazil.

Jointly sponsored by the ATS and the Asociación Latinoamericana del Tórax (ALAT), the MECOR program encourages physicians and other healthcare workers to develop research projects around their patients that will improve their practices and public health programs.

The ATS and ALAT will offer the following courses:

- Level 1: "Introduction to Clinical Research Methods"
- Level 2: "Advanced Clinical Methods"
- Level 3: "Advanced Clinical Research Methods: Protocol Development"
- Level 4: "Applied Clinical Research Methods: Data Analysis and Scientific Writing"

Who Should Apply?

Doctors with an interest in respiratory medicine who wish to improve their skills in clinical research and investigation. No prior experience with research is needed for the level-one course, but applicants for the level-two course should have research experience or have attended the introductory MECOR course.

Since all four courses emphasize methods for quantifying the burden of respiratory disease in Latin America, preference in selecting applicants and providing travel awards will be given to individuals with a specific interest in this area of research.

Why Should I Attend?

MECOR is much more than an annual training course. It allows attendees to form ongoing relationships with mentors and provides a forum in which graduates are able to present their research findings.

How Do I Apply?

Please send initial inquiries to Gaby Patino, at gpatinoire@yahoo.com. Application forms will be sent to qualified individuals.



At the annual MECOR program in Latin America, students learn to formulate a research question, develop a research paper, analyze data and write a paper.

NEW TB VACCINE CLEARS IMPORTANT HURDLE (continued from page 1)

consequence and represents a great hope for the future fight against global TB. We are looking forward to the next phase of research that will continue to assess the safety, while further evaluating its efficacy in preventing new infections."

"The results of this trial are very important, as they suggest MVA85A is safe and highly immunogenic in people who are infected with *M. tuberculosis*," she concluded. "Further, larger trials are needed in TB endemic areas to assess the efficacy of this vaccine against the development of TB disease, but these results are very encouraging and justify the further development of this vaccine." ■

Pick Up Complimentary Journals & Magazines at ATS • 2009



Pick up copies of these leading medical journals and news magazines, free-of-charge, during the 2009 ATS International Conference this month.

The following periodicals will be available at the ATS 2009 Journal and Magazine Annexes, both of which will be located outside of the Exhibit Hall in the San Diego Convention Center.

JOURNAL ANNEX:

- *American Journal of Respiratory and Critical Care Medicine*
- *American Journal of Respiratory Cell and Molecular Biology*
- *Canadian Respiratory Journal*
- *Clinical Respiratory Journal*
- *Journal of Physiology*
- *Journal of the American Medical Association*
- *Journal of Sleep Research*
- *New England Journal of Medicine*
- *Proceedings of the American Thoracic Society*
- *Science*
- *The Lancet*
- *Thorax*

MAGAZINE ANNEX:

- *Advance for Managers of Respiratory Care*
- *Advance for Respiratory Care Practitioners*
- *Pulmonary Reviews*
- *RT for Decision Makers in Respiratory Care*

CONFERENCES, COURSES & MEETINGS

Activities sponsored or endorsed by the ATS and its chapters are listed in **bold**.

DATE & PLACE	TITLE	CONTACT
May 8 to 12 Seattle, Washington	"Immunology 2009: The 96 th American Association of Immunologists (AAI) Annual Meeting"	www.aai.org
May 12 to 15 Minneapolis, Minnesota	"North American Research Conference on Complementary & Integrative Medicine: Collaboration to Promote Scientific Discovery & Health," sponsored by the Consortium of Academic Centers for Integrative Medicine	www.imconsortium-conference.org
May 15 to 20 San Diego, California	"2009 ATS International Conference," sponsored by the American Thoracic Society	ats2009@thoracic.org www.thoracic.org
June 4 to 5 Washington, DC	"2009 National Asthma Forum," sponsored by the Environmental Protection Agency	www.epaasthmaforum.com
June 10 to 13 Aspen, Colorado	"52 nd Annual Thomas L. Petty Aspen Lung Conference: The Environment and the Lung—Detection, Prevention and Mechanisms of Disease"	Jeanne Cleary Phone: (303) 724-6038 aspenlungconference@comcast.net www.aspenlungconference.org
June 19 to 25 Philadelphia, Pennsylvania	"AAI Introductory Course in Immunology," sponsored by the American Association of Immunologists	www.aai.org
June 25 to 26 Bournemouth, United Kingdom	"2009 Summer Meeting of the British Thoracic Society"	bts@brit-thoracic.org.uk www.brit-thoracic.org.uk
July 7 to 10 Dublin, Ireland	"Main Meeting of the Physiological Society, United Kingdom"	www.physiology2009.org
July 26 to 31 Minneapolis, Minnesota	"AAI Advanced Course in Immunology," sponsored by the American Association of Immunologists	www.aai.org
July 31 to August 4 San Francisco, California	"13 th World Conference on Lung Cancer," sponsored by the International Association for the Study of Lung Cancer	www.2009worldlungcancer.org
August 21 to 25 Phoenix, Arizona	"ACCP Critical Care Medicine Board Review 2009," sponsored by the American College of Chest Physicians	www.chestnet.org
August 26 to 30 Phoenix, Arizona	"ACCP Pulmonary Medicine Board Review 2009," sponsored by the American College of Chest Physicians	www.chestnet.org
October 3 Orlando, Florida	"The American Society of Emergency Radiology 2009 Annual Meeting and Postgraduate Course in Trauma and Emergency Radiology"	Phone: (713) 965-0566 asermeeingsdept@meetingmanagers.com www.erad.org
October 22 to 24 Torrance, California	"Harbor-UCLA Practicum in Cardiopulmonary Exercise Testing and Interpretation," sponsored by Harbor-UCLA Medical Center	Phone: (310) 222-3801 szagala@LABiomed.org
October 25 to 28 Toronto, Canada	"The Critical Care Forum"	info@criticalcarecanada.com www.criticalcarecanada.com
October 29 to November 1 Philadelphia, Pennsylvania	"47 th Annual Meeting of the Infectious Diseases Society of America"	jmills@idsociety.org www.idsociety.org

Research Program

NEW GRANT OPPORTUNITY

THE ATS/PFIZER RESEARCH GRANT IN PULMONARY ARTERIAL HYPERTENSION

This research grant has been made possible by an educational grant from Pfizer, Inc.

DEADLINE: July 1, 2009

For more information, please visit
www.thoracic.org/sections/research/new-research-program.html