FDA Approves Novel Smoking Cessation Agent

At 12 weeks, 44% were smoke free.

BY TIMOTHY F. KIRN
Elsevier Global Medical News

The Food and Drug Administration’s approval last month of the drug varenicline may help a significantly greater percentage of patients quit smoking than bupropion, according to federal officials and others. The drug was judged from early trials to show such promise that it was put on the approval fast track 6 months ago. “This is the first time we have had a drug that we can say is better than the other drugs,” said Dr. John R. Hughes, professor of psychiatry at the University of Vermont, Burlington, and a founding member of and spokesperson for the Society for Research on Tobacco and Nicotine. “I think this is a significant advance.” Varenicline tartrate (Chantix, Pfizer Inc.) is approved for use twice a day (1 mg) for 12 weeks, with another 12 weeks for those who are successful in quitting during the first 12 weeks. The drug is not approved for adolescents. In the pivotal trials, varenicline was never used in combination with other smoking-cessation agents, so the label will recommend not combining the drug with bupropion or a nicotine patch.

The FDA had six trials of varenicline to review for approval, five of which were placebo-controlled and randomized, said Dr. Curt Rosebraugh, a deputy director of the Center for Drug Evaluation and Research at FDA, in a press conference. In the two 12-week trials that compared varenicline with bupropion (150 mg twice daily), a combined 44% of subjects taking varenicline were smoke free during the final 4 weeks of the trial, compared with 30% of bupropion-treated subjects and 17% of placebo-treated subjects. Participants in those studies on average had smoked 21 cigarettes a day for 25 years. See FDA Approves • page 4

Complication Rates Reflect Poorly on PAC

BY JANE SALOODOF
Elsevier Global Medical News

SAN DIEGO — The controversial and widely used pulmonary-artery catheter produced no survival benefit but caused more complications than the central venous catheter in a prospective trial that randomized 1,001 patients with acute lung injury. Investigators reported similar mortality, ventilator-free days, and days not spent in the intensive care unit for the two arms of the trial. However, patients given a pulmonary-artery catheter (PAC) had about twice as many catheter-related complications, mostly arrhythmias, during catheter placement. “Even the group of patients who entered the trial in shock did not get benefit of this catheter, which provided more information (than a central venous catheter),” Dr. Arthur P. Wheeler, FCCP, said during a press conference at the International Conference of the American Thoracic Society, where he reported catheter results from the Fluid and Catheter Treatment Trial (FACTT).

And that was a commonly held belief,” added Dr. Wheeler, of Vanderbilt University, Nashville, Tenn., who led the catheter portion of the trial. “If someone was going to benefit, it was going to be the sickest group of patients who had shock, and we didn’t see it.” As a result, investigators from the National Heart, Lung, and Blood Institute’s Acute Respiratory Distress Syndrome Clinical

HRSA Report Projects Gaps In Critical Care Services

BY NANCY NICKELL
Elsevier Global Medical News

The rapid growth of the elderly population in the United States may create a shortage of critical care physicians in the United States—a shortage that could lead to tens of thousands of potentially preventable deaths in the country’s intensive care units, a new federal report warns. The report has prompted critical care societies to outline solutions and press lawmakers and federal health agencies for greater help in boosting the nation’s supply of critical care intensivists. Policy makers can attack the problem three ways: by increasing supply, increasing efficiency, or decreasing the need for intensive care, “said Dr. W. Michael Alberts, FCCP, president of the American College of Chest Physicians. With the nation’s elderly population rising rapidly, “demand for intensivists will continue to exceed available supply through the year 2020 if current supply and demand trends continue,” according to the report, entitled “The Critical Care Workforce: A Study of the Supply and Demand for Critical Care Physicians.” The federal Health Resources and Services Administration (HRSA) produced the report for Congress, which asked the agency in 2003 to examine the adequacy of the critical care workforce. See Critical Care • page 2

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Almost 500,000 people die in ICUs each year, according to the report, and 360,000 of them are not managed by intensivists. If they were, an estimated 54,000 lives could be saved annually according to a study cited by HRSA researchers (Eff. Clin. Pract. 2000;3:284-9).

Although intensivists direct the care of only one-third of critically ill patients, the proportion of patients who are receiving care under the direction of an intensivist has increased dramatically in recent years. Increasing the proportion of ICU patients whose care is directed by an intensivist is expected to retire by age 55, according to a report in 2000 by the Committee on Manpower for the Pulmonary and Critical Care Societies (COPNCCS).

The report stated that 1% of U.S. medical school graduates are expected to choose to practice as intensivists. Medical students find the long, irregular hours and the stress of working in ICUs discouraging, added Dr. Alberts. Although 86% of pulmonologists and critical care physicians are men, a greater proportion of the younger generation of intensivists are women. Because female physicians tend to work fewer hours and retire sooner, the number of hours provided could fall, the report’s authors cautioned.

The large proportion of critical care fellows who are international medical graduates may add to the uncertainty. Those IMGs may face visa restrictions that force them out of the United States. However, data on the actual numbers of IMGs who return to their home countries are unavailable, the report’s authors stated.

Creation of more critical care specialists won’t be easy, the HRSA report acknowledged. “Simple solutions to the critical care workforce shortage are not likely to be found in the near future,” the report’s authors said.

The rise of intensivist-managed ICUs could help meet some of the demand. Encouraging intensivists and pulmonologists trained in critical care to spend more of their work hours in the ICU would increase supply as well. But the report’s authors cautioned that such strategies may require significant financial incentives.

Better management of demand could come as more hospitals use in-house, full-time intensivists to ensure appropriate utilization of critical care services and reduce unnecessary ICU admissions. Improved education regarding end-of-life issues might help physicians and patients make better treatment decisions and potentially reduce the number of days of ICU care.

Organizational changes could improve patient access in a different way, notably in rural areas. “One example is the use of electronic ICUs, where specialist physicians and nurses monitor and help treat critically ill patients in widely scattered hospitals,” the authors stated.

To help close the projected shortfall, four critical care societies have outlined their own proposals to increase the efficient use of current critical care resources and boost the supply of intensivists in the future (see sidebar).

The Critical Care Workforce Partnership—composed of the American College of Chest Physicians, the American Association of Critical-Care Nurses, the American Thoracic Society, and the Society of Critical Care Medicine—also announced plans to work with Sen. Richard J. Durbin (D-Ill.) on legislative and regulatory steps. The looming critical care work force shortage is an issue that affects every one of us and needs to be addressed now,” said Dr. Mark J. Rosen, chief of the division of pulmonary and critical care medicine at Beth Israel Medical Center, New York, and president-elect of the ACCP. “We, or our loved ones, will most probably spend time in an ICU, and we will demand excellent care for ourselves and our families. Without an adequate workforce, that care will simply not be available.”

Drug Boosted Smoking Abstinence

In the follow-up period during one of those trials, 22% of varenicline-treated individuals were still smoking abstinent at a year, compared with 16% of bupropion subjects and 18% of placebo subjects. Smoking abstinence was monitored in the trials by self report and with weekly expired carbon monoxide testing. Northeastern parts of the drug in the trials included nausea (experienced by 30% of patients in one trial), insomnia, and vivid dreams. The nausea was transient and considered mild to moderate. The nausea and other side effects were generally not bothersome enough that subjects quit their regimen. Dr. Hughes noted, and a rate of 50% for nausea is not out of line with what is seen in trials of bupropion and other smoking-cessation agents. Only 10% of subjects quit varenicline because of side effects.

Varenicline is the first drug that was specifically designed for nicotine dependence. Bupropion, though approved for smoking cessation, is an antidepressant. Varenicline is a novel selective nicotinic receptor partial agonist. As such, it not only eases withdrawal craving but also partially blocks the nicotinic effect of smoking. This second property interferes with the reinforcement a smoker receives from lighting up, a benefit that thwarts the potential for relapse. Dr. Hughes and the FDA’s Dr. Rosebraugh noted.

Dr. Susan M. Harding, FCCP, comments: "I am encouraged by preliminary data showing that varenicline has a comparable option for smoking cessation. Varenicline binds to nicotine receptors and also dampens the central effects of nicotine, which is important in patients who have a smoking relapse. Varenicline’s 1-year follow-up data are encouraging—higher than bupropion—" but are still less than optimal with only 22% of treated patients abstinent. Preliminary data show that rimonabant, a selective cannabinoid-1 blocker, improved smoking abstinence rates, compared with placebo; however, it is not FDA approved for smoking cessation, only for obesity therapy (J. Am. Coll. Cardiol. 2006;47:1979-26). Pharmacotherapy is only one tool in our smoking cessation tool box and should be combined with other interventions for successful long-term smoking abstinence.

Pneumococcal Vaccine Cuts Risk of hMPV

Children vaccinated with three doses of pneumococcal conjugate vaccine had a reduced rate of respiratory illness due to human metapneumovirus-associated infections of the lower respiratory tract, as well as a lower rate of clinical pneumonia than did children given placebo, researchers reported. Dr. Shabar A. Madhi of the University of the Witwatersrand, Berkhamp, South Africa, and colleagues performed an analysis of data from nearly 40,000 children—some of whom had been infected with HIV—who had been given three doses of a polysaccharide–protein conjugate vaccine (PCV) or placebo in an ongoing phase III study.

Dr. Madhi and coinvestigators tested nasopharyngeal aspirate samples of the children who had been hospitalized with lower respiratory tract infection (LRTI) for evidence of human metapneumovirus (hMPV), which was discovered only 5 years ago, as well as for HIV and C-reactive protein (J. Infect. Dis. 2006;193:1236-43).

They found that for vaccinated children without HIV, the hospitalization rate was 46% lower than that of children who received placebo. For HIV-infected children, the reduction was 53% versus placebo.

The incidence of clinical pneumonia was also reduced for both HIV-free and HIV-infected children who received vaccine (55% and 65%, respectively).

---John R. Bell
**Statins May Offer Protection During Flu Outbreaks**

A 5-year study in the Netherlands linked statin therapy to a 26% reduction in respiratory disease.

**Pneumonia May Be Tamed by Short-Course Antibiotics**

Zmax, which was approved in the United States in 2005, has a unique microsphere formulation that releases the active drug in the small intestine rather than stomach, reducing gastrointestinal side effects, said Dr. File, who has received honoraria and clinical support from Pfizer Inc., which markets Zmax.

Unpublished pharmacokinetic data suggest that five to eight times more drug is delivered to the site of infection, which maximizes bacterial eradication and thereby helps reduce resistance, he said.

Clinicians should familiarize themselves with the pharmacokinetic and pharmacodynamic parameters of an individual agent and its minimum inhibitory concentration to improve bacterial eradication. Local resistance patterns also should be taken into consideration when choosing an antibiotic.

For example, penicillin resistance in isolates of Streptococcus pneumoniae during 1998-2000 was just 4% in the Netherlands but a staggering 32% in Ireland (J. Antimicrob. Chemother. 2003;52:229-46).

Finally, Dr. File urged physicians to educate their patients about the proper use of antibiotics, not only to reduce patient expectations but also to ease the pressure on physicians to prescribe unwarranted antibiotics, both of which have contributed to overprescribing of these drugs.

"Patient satisfaction is not compromised by the absence of an antibiotic prescription, produced the results that the investigators had anticipated," said Dr. File, professor of internal medicine, Northeastern Ohio Universities College of Medicine, Rootstown, Ohio.

**Maternal Asthma May Increase Risk of Premature Birth**

Maternal asthma was a significant risk factor for premature birth and low birth weight, even if the mother’s asthma was diagnosed years before delivery, Dr. Joel Liem reported at the annual meeting of the American Academy of Allergy, Asthma, and Immunology. Physicians and other health care professionals need to assess present and past asthma, up to 5 years prior, in order to properly assess the risk for premature labor," Dr. Liem told reporters at a press conference at the meeting. The investigators used information from the Manitoba Health Services Insurance Plan database, a population-based health care administrative and prescription database that has records of every child born in Manitoba, Canada, as well as their mothers’ records. Maternal asthma was defined as asthma that has records of every child born in Manitoba, Canada, as well as their mothers’ records. Maternal asthma was defined as asthma that has records of every child born in Manitoba, Canada, as well as their mothers’ records. Maternal asthma was defined as asthma that has records of every child born in Manitoba, Canada, as well as their mothers’ records. Maternal asthma was defined as asthma that has records of every child born in Manitoba, Canada, as well as their mothers’ records.

Using the first definition, the relative risk of asthmatic mothers giving birth at less than 37 weeks and 691 babies (4.9%) had a birth weight of less than 2,500 g. Compared with nonasthmatic mothers, asthmatic mothers were 2.8 times more likely to give birth to a preterm child at less than 28 weeks, and 3 times more likely to give birth at less than 32 weeks. The relative risk of asthmatic mothers giving birth at less than 37 weeks and 691 babies (4.9%) had a birth weight of less than 2,500 g. Compared with nonasthmatic mothers, asthmatic mothers were 2.8 times more likely to give birth to a preterm child at less than 28 weeks, and 3 times more likely to give birth at less than 32 weeks. The relative risk of asthmatic mothers giving birth at less than 37 weeks and 691 babies (4.9%) had a birth weight of less than 2,500 g. Compared with nonasthmatic mothers, asthmatic mothers were 2.8 times more likely to give birth to a preterm child at less than 28 weeks, and 3 times more likely to give birth at less than 32 weeks.

Note: Based on a study of 22,638 patients. Source: Dr. Verheij
Comfort of Dying Patients Enhanced by Order Set

**Intervention stimulated staff to recognize and treat symptoms such as pain and dyspnea more often.**

**BY MITCHEL L. ZOLER**
Elsevier Global Medical News

**NASHVILLE, TENN. — Key elements of palliative care were integrated into the acute and intensive care realms of a hospital by instituting a comfort care order set.** The order set led to significant increases in the use of opioids and do-not-resuscitate orders, as well as greater documentation of pain and dyspnea, Dr. F. Amos Bailey said at the annual meeting of the American Academy of Hospice and Palliative Medicine.

“Increased symptom documentation indicates that the intervention was successful in stimulating staff to recognize symptoms such as pain and dyspnea, and empowering them to order and administer opioids significantly more often,” said Dr. Bailey, director of palliative care at the VA Medical Center in Birmingham, Ala. Dr. Bailey and his associates compared the medical records of 108 terminally ill patients who were treated at the medical center from January to June 2001, before implementation of the new comfort care order set, to the records of 95 patients who were treated during January to June 2003. The order set was implemented during July 2001 to June 2003.

The order set specified the best practices during a patient’s last days and hours of life, based on methods that had been developed in the home hospice setting. These orders included recommendations for managing pain and other symptoms, and discontinuing burdensome interventions and medications. Opioids were highlighted as the medications of choice because of its availability in immediate-release formulations that are liquid, sublingual, or intravenous.

The order set also included psychosocial interventions for patients and their families, and care plans for skin, mouth, eyes, secretions, diet, and the patient’s environment.

The percentage of patients with opioid orders jumped from 57% before implementation of the order set to 83% following implementation. Do-not-resuscitate orders rose from 62% of patients to 85%. Both differences were statistically significant, Dr. Bailey reported at the meeting.

Patients’ pain was documented in their charts 29% of the time before implementation, compared with 58% after the order set was in place. Dyspnea documentation rose from 31% to 78%.

Plans of care for managing pain and dyspnea increased from 10% and 6% of patients, respectively, preimplementation to 54% and 63% after the order set was instituted.

The order set also boosted morphine use, which rose from 49% of patients before the new procedures to 82% 2 years later. Orders for less optimal opioids did not change.

During the final 72 hours of a patient’s life, opioid use jumped from 14% of patients preimplementation to 71% after, a statistically significant difference. The average total opioid dose during this period rose from 31.9 mg before the order set was implemented to 53.1 mg after it was instituted.

**Dr. Paul A. Selecky, FCCP, comments:** This study illustrates the improvement in patient care that can occur at the end of life with the appropriate use of opioids supported by an approved comfort care order set.

### State Program Helps Hospitals Institute Palliative Care

**BY MELINDA TANZOLA**
Elsevier Global Medical News

A California program has helped hospitals establish palliative care services, according to a recent study evaluating the program 1 year after its completion.

Given that more than half of people in the United States die in hospital, end-of-life care is an important part of hospital services. Established palliative care services might help hospitals better provide for these patients and their families.

The California Hospital Initiative in Palliative Services (CHIPS) program was designed to assist hospitals in organizing such programs (Arch. Intern. Med. 2006;166:227-30).

Dr. Steven Z. Pantilat of the University of California at San Francisco and associates recruited all types of hospitals across California for the program. Hospitals interested in joining the program had to demonstrate their readiness, obtain administration approval, and pay a $2,500 fee.

The investigators commented that “it takes time to implement a palliative care consultation service,” suggesting that ongoing mentoring and assistance could be beneficial.

In fact, 60% of the hospitals participating in the program helped other hospitals develop palliative care services.

**Dr. Paul A. Selecky, FCCP, comments:** As a member of one of the hospitals who participated in the CHIPS training program and later received an AHA Circle of Life Award, I can readily attest to the success of this program and our greatly enhanced ability to meet the palliative care needs of our patients.

### Medicare Spending to Increase by 25% in 2006

**DATA WATCH**

Medicare Spending to Increase by 25% in 2006

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*Estimated costs. Source: Health Affairs 2006;25:w61-w73*
Study: Steroids Not Appropriate for Persistent ARDS

BY SHERRY BOSCHERT
Elsivier Global Medical News

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iving methylprednisolone to patients with persistent acute respiratory dis-
tress syndrome did not improve overall survival and increased the risk of death in patients who received the drug more than 14 days after ARDS onset, according to a land-based, randomized, controlled trial in 180 patients.

Sixty days after the start of treatment with moderate-dose methylprednisolone in 89 patients or with placebo in 91 pa-
tients, 26 patients in each group had died, an insignificant difference, reported inves-
tigators in the Acute Respiratory Distress Syndrome (ARDS) Clinical Trials Network of the National Heart, Lung, and Blood In-

At 180 days, 28 patients in the methyl-
prednisolone group and 29 in the placebo group had died. The study enrolled patients from 25 U.S. hospitals 7-28 days after the onset of ARDS. These patients were critically ill, on continuous mechanical ventilation, with persistent bilateral opacities on chest x-rays, and had a ratio of the partial pres-
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Obstructive Sleep Apnea: Stroke and Death

The first study demonstrated that a group of almost 700 patients with sleep apnea had roughly double the risk of stroke or death over about a 3.5-year period than did matched control subjects without sleep apnea after controlling for multiple confounders, including hypertension (Yaggi et al. N Engl J Med 2005; 353:2034). In this study, an increased risk of stroke occurred, despite the fact that all patients with sleep apnea were offered treatment, suggesting that treatment has no effect on stroke risk in patients with sleep apnea.

Are we to conclude from this study that CPAP treatment does not reduce the risk of strokes in those with OSA? Probably not—and this is for several reasons. First, only about half of those with OSA reported using CPAP for 4 or more hours, five or more nights a week. Since self-reported CPAP use is notoriously lower than actual use, the real number using CPAP was probably even lower.

In addition, the subjects in this study had a mean age of about 60 years. The excess mortality and most striking CPAP treatment benefit associated with OSA are for those under the age of 50 years (Marin et al. Lancet 2005; 365:1046; Lavie et al. Eur Respir J 2005; 25:514).

The cohort group in this study may have included too old to demonstrate a benefit from treatment. Further, this relatively old population may have had untreated sleep apnea for years prior to enrollment in this study. In other words, the CPAP treatment may have been too little, too late. Alternatively, it is also possible that the 3.5 years of follow-up was too short a time to show a benefit for stroke reduction with CPAP treatment.

Central Sleep Apnea and Congestive Heart Failure

The second paper was the long-awaited report from the Canadian Positive Airway Pressure trial (CANPAP) on the use of CPAP for patients with central sleep apnea and congestive heart failure (Bradley et al. N Engl J Med 2005; 353:2025). Because this study involved patients with central sleep apnea, it is inappropriate to draw conclusions about the effects of CPAP treatment on patients with obstructive sleep apnea, based on the study results. This study, which was underpowered and terminated early, failed to show that CPAP reduced mortality for those with central sleep apnea and heart failure.

In fact, although there was an early divergence in survival favoring the control group, after 18 months, the divergence favored the CPAP group.

The authors noted, “We cannot exclude the possibility that upward titration of CPAP reduced cardiac output in some patient with low filling pressure, owing to more vigorous diuresis or other medical interventions.” Of note, CPAP was started in an unmonitored sleep laboratory or hospital bed, starting at 5 cm H2O, then increasing over 1 or 2 nights to 10 cm, or “the highest pressure tolerated.”

The senior author of this report pointed out that “CPAP increased exercise capacity” (ie, 6-min walking distance), indicating a clinically beneficial effect. CPAP had no effect on the combined rate of death and cardiac transplantation, and, no, it did not kill people; there were 32 events in each group.

This has to be put into perspective. Drug trials in which mortality is the end point have invariably required at least 2,000 patients to demonstrate a difference between groups. CANPAP had only 258 patients, so it was clearly underpowered to be able to show with certainty that it does or does not improve mortality” (T. D. Bradley, MD; personal communication; March 12, 2006).

Does Treatment Help?

Neither of these studies was designed to assess the effects of CPAP treatment on mortality or stroke in patients with OSA, and they should not be construed to demonstrate that CPAP does not reduce morbidity or mortality from OSA, especially since we have quite a bit of evidence to the contrary. My take on these papers is that they highlight the importance of finding and treating sleep apnea before the damage is done and of working with patients to achieve effective compliance. The ACCP Sleep Institute is addressing both these issues by developing an educational program for primary care physicians and chronic disease management guidelines for care of patients with OSA.

Barbara Phillips, MD, MSPH, FCCP
Division of Pulmonary, Critical Care and Sleep Medicine
University of Kentucky College of Medicine and School of Public Health
Lexington, KY

Editor’s Insight

This Perspective provides an excellent analysis of the significance of two important studies that received considerable attention in the popular press. They are easy studies to misinterpret without an in-depth reading and analysis. In addition to providing this clear analysis, Dr. Phillips also highlights interesting issues and concepts. One important concept is that the “damage is done.” We have perhaps not always thought about how sleep apnea exerts its effects on the cardiovascular system. The idea that recurrent hypoxia may contribute to atherosclerotic cardiovascular disease, as well as hypertension, is important. Another important idea is our need to focus on effective therapies and compliance with them. Dr. Phillips correctly points out that neither study was designed to address the effect of CPAP use on OSA, but the Yaggi study is certainly a reminder of the prevalence of the compliance problem. Innovative technology and effective physician and patient education are clearly needed. An effective therapy is only effective if it is applied. We have a long way to go.

—Editor
Believe it or not, I am actually at my "day job" office at the Moffitt Cancer Center in Tampa while writing this month’s report. After due deliberation, among the myriad of possibilities, I thought I would report some highlights of my presidential report to the Board of Regents at the meeting that was recently held in Tucson.

Before that, and at the risk of straying from my intended subject, let me say the actual meeting was outstanding and extremely productive. Over 400 attendees and their guests attended. In addition to the actual Board of Regents meeting, a number of other groups and committees met, including the Pulmonary and Critical Care Fellowship Training Directors, the Health and Science Policy Committee, the Continuing Education Committee, the Quality Improvement Committee, the Industry Advisory Committee, the Sleep Institute, the Critical Care Institute, the Marketing Committee, and the CHEST Foundation Board of Trustees.

I was especially pleased that the College was able to organize and produce two fellows educational conferences (the 4th Critical Care and Sepsis Conference and the 1st COPD Conference). There was a lot going on that week, and thanks goes to the College staff for skillfully organizing this logistical challenge and producing an "ACCP class event."

Back to my intended topic, it is traditional for the President to provide the Board with a report on what has happened since the last Board meeting. I will be pleased to send you the full text and PowerPoint slides of my report but, in brief, the first 4 months have been a whirlwind. Looking back, I estimate that I spend, on average, 2 to 3 hours per day on College business or planning. I have really enjoyed the first third of the year and feel a real sense of accomplishment. In the first few months, I have worked with the staff and the Executive Committee on finance and budget topics and an international strategy; held a leadership/staff retreat; further developed the ACCP’s Sleep and Critical Care Institutes; fostered inter-society relations; held the ACCP Capitol Hill Caucus; and further developed the goal of “enhancing the value of membership” through efforts of the Practice Management Committee and the Councils of NetWorks and Governors, among many other issues.

I am sure that the upcoming two-thirds of the year will be as challenging but just as rewarding (but more on that in future columns).
In 1956, for the first time, a dedicated team of physicians and nurses came together to care for critically ill patients. It was the beginning of the model of care that is now standard in our modern ICU setting. Since that time, the advances in medical treatment options for critically ill patients have grown in both numbers and sophistication, offering even the most gravely ill an increased chance at survival. What has not changed in the 50 years since the first ICU teams came together is the devastation felt by the families and friends of those critically ill patients who end up in the ICU. The mixture of uncertainty, fear, stress, and confusion is as prevalent today as it was in 1956. The multidisciplinary, multitasking team, operating in a high-tech and fast-paced environment, must seem both chaotic and intimidating to the families of today’s ICU patients. At a time when families are clinging to hope and waiting for news, communication can be both sporadic and hard to understand. Many families are unable or unwilling to ask clarifying questions that allow them to better understand what is happening. An important but undervalued or poorly understood element is the role families or surrogates play in communicating critical information about the patient’s medical history and their preferences concerning treatment. The medical profession has recognized the need for developing and implementing standard protocols that provide health-care delivery teams the guidance they need to provide the best evidence-based care available. These protocols address areas in the ICU setting, such as ventilator-associated pneumonia, glycemic control, and sepsis management. Providing excellent communication to patients and their families should be held to that same standard. Excellent communication cannot mean simply providing more information. Instead, hospitals need to look at providing a safe environment that fosters trust and helps medical professionals recommend treatment options with realistic outcomes, thus allowing families to help determine the direction of their loved one’s care. Understanding the need for a structured and evidence-based approach to family satisfaction and communication led The CHEST Foundation to develop the Critical Care Family Assistance Program (CCFAP). The CCFAP toolkit was developed through an Eli Lilly Foundation grant to increase the scientific evidence between patient/family satisfaction and outcomes, and to shift ICU standards toward a patient- and family-centered model of care. The toolkit was built not from guesswork but from the input and evidence gathered in ICU settings in a variety of health-care settings from academic to community-based institutions. Evidence of the CCFAP effectiveness can be found in the September 2005 supplement to CHEST. To view these articles, go to www.chestjournal.org/content/vol128/3_suppl.

The CHEST Foundation is not the only organization that has recognized the need to change the way information is delivered in today’s health-care system. In 2006, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) added a patient safety goal that states, “Encourage the active involvement of patients and their families in the patient’s own care as a patient safety strategy.” The JCAHO’s rationale was that effective communication with patients and their families about all aspects of their care, treatment, or services is an important characteristic of a culture of safety. The patient safety goals are not the only area in which patient satisfaction is being addressed. The ongoing development of performance measure sets that will be used to evaluate both systems and institutions include measures on the patient’s experience of his or her care. In the future of health care, the perception of care will be as important as the actual care provided. Critics argue that focusing too much on patient and family satisfaction will create a harsh economic burden for the institution. However, in a recently completed study at Barnes-Jewish Hospital in St. Louis, Mo., Dr. Tom Ahrens and his team documented a 1-year savings of $65,000 by helping families better understand the treatment options and prognosis for their loved ones (Ahrens et al., Am J Crit Care 2003; 12:117). A physician-nurse team followed up the attending physician’s status report with a consultation that ensured families truly understood the treatment options available, the recommended care plan, and the likely outcomes. Dr. Ahrens pointed out that without the study protocol in place, the previous ICU communication procedures, once again, become the dominant culture. This observation points to the need for structured approach and involvement outlined in the CCFAP. We have seen in past research from the SUPPORT study that providing clear and more frequent communication is not enough (JAMA 1995; 274:1591). Establishing trust is a crucial element of effective communication. The culture of the institution and the ICU must support a patient- and family-centered philosophy. Part of establishing trust with patients and their families is establishing trusting relationships among the care team. Developing a multidisciplinary team of those affected by changes is the key to a successful cultural transformation. The emergence of leaders within the team is essential to motivate others to set priorities, outline realistic goals, and overcome resistance within the current hospital environment. It is productive to assign a “point person” or project coordinator to take the lead on assembling the core team, assigning roles, and ensuring completion of tasks. The core team members can vary, depending on the design of the hospital environment, but the team most often includes physician and nursing staff from the ICU and surgery departments, as well as pastoral care, social work, diet, environmental management, respiratory care, music, and massage therapy. Patient services, pharmacy, information systems, and facilities management. The process really begins by completing a needs assessment to identify what is working well, along with the gaps in the current communication processes, protocols, and patient care services. Thus, a framework is developed to guide the team in planning interventions that will ultimately help transform the culture of the patient-care environment. Enlisting the full support of the hospital administration by aligning program goals with the hospital mission, outlining the need for change, and asking for required resources is an important aspect to getting started. The team’s initial plan may change along the way, but it has support from the hospital administration and commitment from the team to create a true patient- and family-centered environment, change will occur. At one of the pilot sites where the CCFAP was developed and implemented, it became clear to the team that it had truly arrived at a culture change. A patient in the ICU who had been improving suddenly worsened and, despite the best efforts of the team, the patient was lost. It was a difficult message to communicate to the family, and it involved an attending physician who had fought participating in the program from its inception. Instead of a battle of wills, the physician not only embraced the help of his ICU team but also invited the entire team to his home as a catharsis, allowing the team members to talk through the difficult situation. This story illustrates how working with the tools provided in the CCFAP can help an institution build a culture that supports the patient, the family, and the staff. Even institutions that are doing a good job can improve through having a structured approach to patient- and family-centered care and communication. The CCFAP is a tool that, if implemented, can help a dedicated team build a lasting structure of trust, communication, and cooperative care. Making this a reality at your institution requires some one stepping forward to initiate action. Visit www.chestfoundation.org, or purchase the toolkit at www.chestnet.org.

If you would like more information, contact Michael Bourisaw, Director of ACCP Institutes, at (847) 498-8375 or mbourisaw@chestnet.org.

Michael Bourisaw, Director of ACCP Institutes and Jennifer Pitts, Manager of Institute Development

The Health Affairs Division debuted a new approach to providing ACCP members with valuable practice management information. The inaugural ACCP Webinar (Web-based interactive seminar) was held on April 26, the first in a series of four. Entitled “Revenue Cycle Management—Getting Paid For Your Services,” it provided 45 physicians and practice administrators and managers with the knowledge to assess and diagnose how well they manage their office revenue cycle. This Web-based seminar afforded an unlimited number of registrants the opportunity to register and participate from the comfort of their own offices. Participants received program materials via e-mail prior to the Webinar. During the session, they had the opportunity to take part in a live question and answer session. Polling questions were also used, allowing immediate feedback on how each practice was performing as measured against other participating practices. Everyone received a complimentary CD-ROM as a practice resource for the staff unable to participate. CD-ROMs of all live practice management Webinar events are available at the ACCP Online Store at www.chestnet.org. Upcoming Webinars include:

- Wednesday, June 7, 2006: Operational Overhead: Analysis and Management
- Wednesday, June 14, 2006: Using Nonphysician Providers in Your Practice
- Wednesday, June 28, 2006: Your Patient’s First Impression: Who Greets Them?

Contact Joyce Bruno at the ACCP: jbruno@chestnet.org.

CHEST PHYSICIAN • JUNE 2006

NEWS FROM THE COLLEGE

COMMITTEE COMMENTS

Combating the Communication Crisis in Critical Care

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Practice Management Information You Need to Know

By Marla Brichta
Assistant Vice President, Health Affairs

In an ongoing basis, the Centers for Medicare and Medicaid Services (CMS) forwards information important to you and your practice. Two recently sent notices follow:

1. The new Medicare Enrollment Applications (Form 855) are now available on the CMS Web site. Go to www.cms.hhs.gov/MedicareProviderSupEnroll and click on Enrollment Applications on the left side of the page. All providers and suppliers are encouraged to use the new forms immediately.

2. Beginning May 1, 2003, CMS announces the capability for health industry organizations to submit health care providers’ applications for National Provider Identifiers (NPIs) to the National Plan and Provider Enumeration System (NPPES) via Electronic File Interchange (EFI).

With EFI, a CMS-approved health industry organization can submit a health care provider’s NPI application data, along with the application data of many other health care providers, in a single electronic file in a CMS-specified format. EFI is an alternative to health care providers having to apply for their NPIs via the Web-based or paper application process. After the NPPES processes a file, it makes available to the organization a downloadable file containing the NPIs of the enumerated health care providers.

Interested health industry organizations should apply for a National Plan by going to the CMS Web site (https://nppes.cms.hhs.gov) before downloading and completing the certification statement (available at https://nppes.cms.hhs.gov) and registering as EFI organizations. A completed certification statement must be approved by CMS before an interested health industry organization can participate in EFI.

ACCP Product Highlight: PCCU

Take advantage of this unique ACCP educational program offered on the Web. Each month, a distinguished editorial board of expert clinicians provides two lessons, featuring timely, concise, diagnostic information on current pulmonary and critical care medicine issues.

Earn up to 24 Category 1 continuing medical education (CME) credits. One (1) credit hour will be awarded for each completed lesson. Update your knowledge and understanding of pulmonary and critical care medicine topics, and learn clinically useful practice procedures. Recent lessons have included lung volume reduction surgery; nonobstructive and myopathic pulmonary disease; clinical exercise testing; and informed consent for research in the ICU.

Log on to ACCP today at www.chestnet.org/education/onlinelpcenc/index.php
Managing Depression and Anxiety Is Key in COPD

Understanding the interplay between depression and anxiety and chronic illness is important in the evaluation and treatment of patients with COPD. Plan now to attend this 2-day workshop, September 15 and 16, at the ACCP headquarters in Northbrook, IL. The workshop, supported by a grant from the National Institute of Mental Health, will bring together a multidisciplinary group of investigators and clinicians who will focus on the current best practices and future directions in the detection and depression and anxiety in COPD patients. Physicians, nurses, respiratory therapists, and psychologists are encouraged to attend the workshop.

Janet Maurer, MD, FCCP, is Chair, and Nicola Hanania, MBBS, FCCP, is Co-Chair of the workshop, who, along with leading experts, will explore:

- Epidemiology, disease burden, and economic impact
- Disease burden in special populations
- Screening and screening implications for public policy
- Different management models for the COPD population
- Barriers to diagnosis and management: primary care and patient perspectives

Breakout groups following the presentations offer the opportunity for you to assist in developing recommendations for implementation of current knowledge and suggestions for future research.

This program is a project of the ACCP Clinical Pulmonary Medicine Network.

To register or for more information go to www.chestnet.org/education/courses/dmdaCOPD06/index.php.
Cultural Diversity in Medicine
The population in the United States is diverse in terms of ethnicity, culture, and religion—collectively referred to as “culture.” Within each culture, there are subcultures, so one cannot generalize patients’ practices and beliefs. Black, Hispanic, and Asian patients were more likely than white patients to report they had been treated with disrespect by their health-care providers. The Association of American Medical Colleges recognizes this deficiency in “cultural competence” by physicians and recommends that medical education include training and evaluation. The Liaison Committee on Medical Education mandates, “The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.” Additionally, similar mandates come from the Accreditation Council for Graduate Medical Education and from some states for continuing medical education.

Interstitial and Diffuse Lung Disease
The IDLD NetWork has a project that incorporates pulse oximetry into cardiac stress testing at various participating medical centers. This pilot project is headed by Dr. Imre Noth, FCCP. Patients who present with a complaint of dyspnea are often referred for cardiac stress testing when they may have evolving ILD as the cause of their dyspnea. Diagnosis may be delayed if no cardiac abnormalities are detected and lung disease (which may manifest as exertional desaturation) is not suspected. As effective treatments for pulmonary fibrosis become available, earlier diagnosis and treatment may prevent it from progressing to more severe disease. Members of the IDLD and Transplant NetWorks are serving on the Health and Science Policy Committee panel to draft an evidence-based guideline, “Monitoring of Immunosuppressive Drugs in Patients With Diffuse Lung Disease and/or Transplantation.” This guideline will allow pulmonologists who use immunosuppressive therapies to optimally monitor their patients for untoward drug reactions that may complicate treatment.

Inside NetWorks: e-Advisory NetWork Needs Your Input

- Imagine a vision.
- Inspired by unmet patient needs.
- Fueled by a philanthropic spirit.
- Driven by commitment and belief in the cause.

Advance The CHEST Foundation.

Imagine the power of 10

Join the yearlong celebration as The CHEST Foundation commemorates 10 years of helping you help your patients live and breathe easier.

Watch for more information about local Power of 10 programs and special events throughout the year.

Visit www.chestfoundation.org for updates.

NEWS FROM THE COLLEGE

e-Advisory
The e-Advisory NetWork Steering Committee is working on a Web site development guide, which will provide a standard Web page format for content on the NetWork Web pages. The Executive Committee of the ACCP Board of Regents has provided directives to the committee’s initial draft proposal and is very supportive of this project. The e-Advisory NetWork’s mission is to promote and facilitate pulmonary and critical care medicine education using information technologies and telecommunications. The e-Advisory NetWork welcomes input on what should be included on the NetWork Web pages and suggestions for how the ACCP Web site could be used to enhance ACCP membership, increase involvement, and meet member needs. Suggestions can be e-mailed to the e-Advisory NetWork Chair at networks/chestnet.org.

Interventional Chest/Diagnostic Procedures
The ACCP Interventional Chest/Diagnostic Procedures NetWork Steering Committee is sponsoring a multi-institutional study to better understand the dynamics of fellowship bronchoscopic education/training. The study design is a prospective 2-year protocol evaluating the impact of training modalities for bronchoscopy. The initial cohorts will include first-year fellows from the Carolinas, Virginia, and New York City. The study will begin with baseline testing of first-year fellows at the Carolina Bronchoscopy course hosted at Duke University, July 7, 2006. Subsequent acquisition of cognitive and technical skill sets will be monitored over the course of the academic year.

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Inside the ACCP: Continuing Medical Education

BY ED DELLERT, RN, MBA
ACCP Vice President, Educational Resources

The history of medical education is one of tradition, culture, and prestige in the many organizations and institutions that are the basis for the health-care delivery system that exists today. Murray Kornfeld founded ACCP on the premise of “medical education” for both physicians and the public as it relates to teaching about the clinical effects of tuberculosis. A variable that fluctuates throughout the history of medical education is the amount of time physicians put forth toward enhancing professional education? How much of that “discretionary” time do physicians put forth toward enhancing professional education? Some educational strategies have been employed toward ongoing professional education for both physicians and the educational institution, the ACCP as an educational institution, the ACCP have teamed up with the ACCP to offer discounts and special deals to all members and their families. Recognizing the ACCP as an educational institution, Apple is now offering members 8%-40% off on various items purchased online at the special site: www.apple.com/edu/accp.

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Table 1—ACCP CME Learning and Teaching Portfolio Objectives Over 36 Months

<table>
<thead>
<tr>
<th>Learning Level</th>
<th>Cognitive Domain</th>
<th>Percentage of Portfolio Objectives Over 36 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>I – Expert Interpretation</td>
<td>Recall</td>
<td>5%</td>
</tr>
<tr>
<td>II – Self-Knowledge</td>
<td>Recall</td>
<td>5%</td>
</tr>
<tr>
<td>III – CPG-Based</td>
<td>Interpretation</td>
<td>5%</td>
</tr>
<tr>
<td>IV – Case-Based</td>
<td>Interpretation</td>
<td>5%</td>
</tr>
<tr>
<td>V – Problem-Based</td>
<td>Problem Solving</td>
<td>5%</td>
</tr>
<tr>
<td>VI – QI Improvement</td>
<td>Problem Solving</td>
<td>0%</td>
</tr>
</tbody>
</table>

Total: 25% 30% 45% 100%

Discussion
Accredited CME providers will need to start anticipating what their educational philosophy and culture will need to incorporate over a period of time. ACCP’s curriculum will include not only traditional forms of lecture-based teaching but a more structured delivery of clinical information in multiple learning environments that physicians can utilize in reaching their educational goals.

Accreditation status will most likely favor those programs providing CME that is evidence based, with a major emphasis on the degree to which providers can document changes in physician behavior or patient outcomes. However, documentation of desired outcomes by CME providers will be difficult and expensive (both in time and actual cost) to institute. The key to this effort is to begin and sustain the momentum as expectations of health-care professionals are ever increasing and to sustain a mechanism of long-term viability of ACCP’s educational curriculum.
Relay for Life: Getting Out the Smoke-Free Message

BY DR. DIANE E. STOVER, FCCP
Chair, The CHEST Foundation

Sponsored by the American Cancer Society (ACS), Relay for Life is an overnight community celebration held at schools, fairgrounds, and parks, where people camp out, barbecue, dance, and take turns walking, running, or otherwise moving around a track “relay style” to raise funds to fight cancer.

At nightfall, participants light hundreds of luminaria bags around the track in a moving ceremony to honor cancer survivors, as well as friends, family members, and celebrities who lost loved ones to the disease.

Since 1985, the Relay for Life has spread to over 4,700 communities in the United States and has become a major event, taking place in 20 countries around the world.

What a great opportunity for members and friends of The CHEST Foundation and the ACCP to join this worldwide movement at the grassroots level and do his or her part in the fight against the most common cause of cancer death and the most common cause of preventable death in the world—the use of tobacco.

The 4th Annual NYU Relay for Life was held on April 8, 2006, to support cancer research, education, advocacy, and patient and family services in the community.

CHEST Foundation Love Your Lungs™ wristbands and educational material was available at the ACS table promoting wellness for students.

The ACS, dedicated to eliminating cancer as a major health problem, and The CHEST Foundation, dedicated to eliminating one of the major causes of cancer in the world—TOBACCO USE, share many similar goals, and it seems natural to participate in this event.

As members and friends of the ACCP, and as parents, grandparents, sisters, brothers, and friends of college students, we can take this opportunity in the many communities throughout the world to participate in Relay for Life to help others make the decision not to smoke or to stop smoking.

Call the American Cancer Society at (800) ACS-2345 or visit their Web site, www.cancer.org/relayonline to find out more about Relay for Life and how you can get involved.

Or call Regina T. Limchayeng, ACS Director of Special Events, at (212) 237-3908.

Salt Lake City: The Possibilities Are Endless

Though widely known for its majestic view of the Rocky Mountains, Salt Lake City offers much more than just a breathtaking backdrop for sightseeing.

With endless excitement around every turn, Salt Lake City is the perfect destination for anyone who takes pleasure in the outdoors.

Make your escape to Salt Lake City’s local canyons, which are dotted with crystal clear lakes and streams.

Thanks to the cool, but moderate temperatures of autumn, you can enjoy the vibrant shades of gold, purple, and red splashed across the scenery.

While you’re there, keep your eyes open for wildlife as you hike, bird watch, or mountain bike through the terrain.

Explore a lush forest on horseback, or try your hand at fly-fishing or rafting down a mighty river.

If golf is your game, the nearest course is only a swing away.

Utah parks and monuments envelop Salt Lake City on all sides, with some as close as a 20-minute drive.

Five national parks, belonging to Utah’s neighboring states, are only a road trip away.

A 5-hour drive transports you to the sites and sounds of Yellowstone National Park.

For more information about Salt Lake City, visit www.visitsaltlake.com.

We’re in the News!

BY JENNIFER STAWARZ
Manager, ACCP Public Relations

In early spring, the American College of Chest Physicians gained national and local news coverage with stories related to the recently released cough guidelines, studies published in the journal CHEST, and the untimely death of Dana Reeve.

The ACCP cough guidelines, published early this year as a supplement to CHEST, have been featured in over 1,600 print, broadcast, and Internet stories worldwide.

Coverage continues, and, recently, cough stories have appeared in USA Today (National), Houston Chronicle (Houston, TX), SELF magazine, National Enquirer, and Consumer Reports on Health.

In March, the ACCP distributed a press release highlighting a study from CHEST on the use of antibiotics in infants.

The study showed that children exposed to at least one course of antibiotics in their first year of life may have an increased risk of developing childhood asthma.

Stories related to the study appeared in the Honolulu Star-Bulletin (Honolulu, HI), Seattle Post (Seattle, WA), and The Times-Picayune (New Orleans, LA), among others.

Stories also appeared on television stations in Charlotte, Chicago, New York, and Salt Lake City.

The April press release featured a CHEST study on the hereditary nature of snoring.

Specifically, Cincinnati researchers found that infants who are born to parents who habitually snore are three times as likely as other infants to snore.

The study appeared in several newspapers across the country, including the Arizona Daily Star (Tucson, AZ), New York Times (New York, NY), and Washington Times (Washington, DC).

Stories also appeared on BBC National News and 45 television broadcasts across the United States.

With the announcement of the death of Dana Reeve, the ACCP reached out to national reporters to remind them of the ACCP’s expertise in the diagnosis and management of lung cancer.

As a result, the New York Times interviewed Dr. W. Michael Alberts, FCCP President of the ACCP for a story related to lung cancer in non-smokers.


In addition, syndicated stories have appeared in the Ann Arbor News (Ann Arbor, MI), Fosters Daily Democrat (Dover, NH), The Ledger (Lakeland, FL), Richmond Times (Richmond, VA), and the Star-Banner (Ocala, FL).

Access ACCP press releases at www.chestnet.org/about/press/releases/.

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Questions about CHEST 2006? Visit www.chestnet.org/CHEST.
The ACCP Quality Improvement Committee (QIC) held their inaugural meeting in March 2006 and “hit the ground running.” In addition to developing a manual of policies and procedures, the new committee members had to immediately leap into their main mission of reviewing performance measures. These measure sets had been proposed by the National Quality Forum (NQF), a national coalition charged with validating and endorsing such measures, of which the ACCP is a member organization [http://www.qualityforum.org/].

The committee’s preliminary work included a first draft of criteria for assessing performance measures, as well as the adoption of a mission and vision statement. The QIC continued to develop its process for reviewing measure sets and collaborating with organizations that develop and validate performance measures, eg, the AMA Physician Consortium for Performance Improvement (AMA-PCP) and NQF. The QIC will be working within the context of the ACCP’s global structure, providing for regular interactions with the Executive Committee of the Board of Regents; Health and Science Policy, Continuing Education, Government Relations, and Practice Management Committees; and NetWorks.

These processes and policies of the QIC will be documented on the ACCP Web site in the near future. The NQF performance measures sent to the QIC for review include three sets on the Prevention and Care of Venous Thromboembolism, Ambulatory Care, and Palliative and Hospice Care. The committee members completed online assessments of the three sets and reached a consensus on the final voting. Although some modifications will be made, the process worked, and the QIC is well prepared for the evaluation of future performance measures.
Lung Resection Poses Risk of Aspiration Pneumonia

More than one-fourth of head and neck cancer patients with documented aspiration can develop AP.

BY BRUCE K. DIXON
Elsivier Global Medical News

CHICAGO — Surgical ventricular restoration may be performed safely in a properly selected patients with pulmonary hypertension, according to a study presented at the annual meeting of The Society of Thoracic Surgeons.

“Patients with pulmonary hypertension who underwent surgical ventricular restoration demonstrated significant improvements in cardiac function, as evidenced by a variety of hemodynamic factors,” said Dr. Jason A. Williams. “We also noted significant reductions in cardiac size and New York Heart Association functional class postoperatively,” said Dr. Williams of the Johns Hopkins Medical Institutions in Baltimore.

Surgical ventricular restoration (SVR) is an established therapy for heart failure due to ischemic cardiomyopathy. The purpose of SVR is to counteract the effects of postinfarction ventricular remodeling by reducing ventricle size, restoring elliptical shape, correcting mitral regurgitation, and performing complete revascularization when necessary, Dr. Williams said. However, pulmonary hypertension (PHT) has been considered a contraindication for surgical ventricular restoration because of increased operative risks.

Two previous studies evaluated the effect of PHT on patients undergoing SVR. Investigators in one study reported improved cardiac function in those who underwent SVR even though 40% of the patients had pulmonary hypertension and 25% had preoperative renal insufficiency or moderate to severe mitral regurgitation. NNH for pulmonary artery pressures was 1,865 patients, Dr. Williams noted.

“However, there were no significant differences with regard to the incidence of preoperative renal insufficiency or moderate to severe mitral regurgitation between the two groups. It’s also important to note that in our series, 100% of patients with PHT and 95% of patients in the comparison group were NYHA class III or IV prior to SVR.”

Operative data were also well matched. Of note, there were 7 mitral valve procedures performed concomitantly with SVR in the PHT group, compared with 12 in the comparison cohort.

“It’s important to note that nine patients in our series did not undergo coronary artery bypass grafting concomitantly with SVR, six of those nine received stents prior to SVR surgery, while three patients were not revascularizable due to poor distal targets,” said Dr. Williams.

Postoperative MRI revealed that both groups had significant improvements in mean left ventricular end-systolic and diastolic volume indexes and ejection fractions. Among patients with PHT, the mean left ventricular end-systolic volume index was reduced by 42%, while its diastolic counterpart was lowered by 29%.

Among patients with pulmonary hypertension, the mean left ventricular end-systolic volume index was reduced by 42%, while its diastolic counterpart was lowered by 29%.

The PHT group also showed a significant reduction in the pulmonary vascular resistance index, cardiac index, and right ventricular stroke work index following SVR. Changes in NYHA class were impressive, Dr. Williams said. The number of PHT patients in class III went from 10 preoperatively to 1 postoperatively, and the class IV number dropped from 15 to 6. Among the controls, the number of class III patients dropped from 25 to 5 and class IV went from 17 to 8.

Three-quarters of PHT patients improved to New York Heart Association class II, Dr. Williams noted.

Complication and mortality differences were not significant. The 36-month actuarial survival for the entire SVR cohort was 78%. The PHT group showed a trendward reduced survival, compared with the controls. On Cox regression analysis, the only mortality predictor in the SVR cohort was preoperative renal insufficiency, which the investigators defined as a creatinine level greater than 1.5 mg/dL.

“Pulmonary hypertension was not shown to be a predictor of mortality in our entire cohort, and furthermore, the severity of pulmonary hypertension was not shown to predict mortality in the PHT group,” Dr. Williams said. “In conclusion, we believe that surgical ventricular restoration can be performed safely in appropriately selected patients with PHT. Longer follow-up with more patients should help to validate these early and midterm results.”

The ideal SVR candidate has experienced an anterosetal infarction leading to an enlarged left ventricle, has a large area of akinesia or dyskinesia with preserved or acceptable function of the basal portion of the heart and lateral wall, and is a candidate for revascularization and mitral valve reconstruction if indicated, Dr. Williams said.

“We have not excluded any patient on the basis of pulmonary artery pressure. What we use as an exclusion [criterion] is the evaluation of global cardiac function; patients have to have at least one area of heart that’s alive and contracting fairly normally without global hypokinesia,” he said in an interview.

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Strategies Can Improve Kids’ Acceptance of CPAP

Children don’t like it, but there are things parents can do to help make it more palatable.

BY FRAN LOWRY
Elsevier Global Medical News

SAN JUAN, P. R. — Continuous positive airway pressure (CPAP) can treat OSA. However, “It’s very hard to take. Little kids don’t like it, but there are things parents and physicians can do to help make CPAP more palatable,” said Dr. Hallowber, medical director of the pediatric sleep disorders program at Johns Hopkins University, Baltimore.

Dr. Hallowber said at a meeting sponsored by the American College of Chest Physicians that acceptance of the treatment, Dr. Ann C. Hallowber cautioned.

Obstructive sleep apnea (OSA) is present in 2%-3% of children, and peaks at 3-6 years of age—which is also the peak age for adenotonsillar hypertrophy. The presentation depends on the age of the child. Toddlers with OSA may present with hyperactivity, school-age children will have poor school performance, and adolescents may present with excessive daytime sleepiness and poor school performance.

Adenotonsillectomy is the first-line therapy for children with OSA. When that is not successful, continuous positive airway pressure (CPAP) can treat OSA. CPAP can be problematic in children, however. “It’s very hard to take. Little kids don’t like it, but there are things parents and physicians can do to help make CPAP more palatable,” said Dr. Hallowber, medical director of the pediatric sleep disorders program at Johns Hopkins University, Baltimore.

Dr. Hallowber recommended introducing the device slowly to minimize the fear factor. Put on the mask while the child is awake and doing an activity that is fun and pleasurable, she said.

The worst thing you can do is put the mask on while the child is asleep. “If they wake up and find themselves wearing the mask, they’ll panic,” Dr. Hallowber said. Another trick is to make CPAP part of the child’s normal bedtime routine, along with brushing the teeth and a bedtime story. Other children who use CPAP are wonderful ambassadors for the device and can help relieve anxiety with a show-and-tell. Videos are good for this as well.

Despite these efforts, some children will do everything to resist attempts to put on the mask. Many parents will remove the mask in response to their child’s distress. That is a big mistake, Dr. Hallowber said.

Behavioral training can help parents block or prevent their child’s avoidance behavior by using brief verbal prompting, redirection to a specific task, and if necessary, physically blocking escape while gently guiding the child to remain in the situation. The child’s attempt to remove the mask must be physically interrupted and the mask replaced immediately every time the child removes it.

These behavioral techniques are used in our clinic under the guidance of Dr. Keith Stier, a behavioral psychologist, and they have proved very successful,” Dr. Hallowber said.

Parents should also plan for safety in children who cannot remove the mask during emergencies, Dr. Hallowber cautioned.

Use a nasal mask instead of a full-face mask, or have an emergency pull string that can disengage the mask to prevent aspiration or asphyxiation if the child vomits.

It is important for parents to establish a consistent bedtime routine that lasts about 30 minutes, she explained. Such a routine includes soothing activities, and it always ends with the child putting on the CPAP mask, lying down, and going to sleep.

“Persistence and patience are key,” Dr. Hallowber said.

A consistent, soothing bedtime routine that includes CPAP can improve children’s acceptance of the device.