**ACIP: Give Flu Shot to Kids Up to 5 Years Old**

**BY MIRIAM E. TUCKER**

*Elsevier Global Medical News*

**ATLANTA — All children aged 6-59 months should be immunized annually against influenza, the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices recommended unanimously at its winter meeting.**

The new recommendation, which is expected to be approved and published by the CDC prior to the next flu season, expands the age group to be targeted for routine influenza immunization beyond the current 6-23 months to include all children aged 6-59 months, as well as their household contacts. The committee also voted to add coverage of influenza vaccine for 24- to 59-month-olds in the Vaccines for Children Program. The American Academy of Pediatrics’ Committee on Infectious Disease is expected to endorse the recommendation later this year, Dr. Carol J. Baker, the AAP coliasion to ACIP, said in an interview.

Among the data leading to the ACIP vote were those presented by Dr. Katherine A. Poehling, of Vanderbilt University, Nashville, Tenn., showing that during two recent influenza seasons, rates of outpatient and emergency room visits for children aged 2-5 years were nearly identical to those for children aged 6-23 months. Indeed, during 2002-2003, the number of natural killer T cells exist abundantly in the lungs of people with asthma and could be a new target for asthma therapies, according to a group of asthma researchers. According to Omid Akbari, Ph.D., of Harvard Medical School, Boston, and colleagues, “invariant natural killer T cells are virtually absent from the lungs of controls and patients with sarcoidosis but are present in high numbers in the lungs of patients with asthma” (N. Engl. J. Med. 2006;354:1117-29).

These T cells, when activated, can lead to airway inflammation and asthma, they reported. “Therapies for asthma that target pulmonay invariant natural killer T cells may be highly effective.”

The findings come from a study of 25 subjects, 14 of whom had moderate-to-severe persistent asthma. Six healthy asymptomatic volunteers served as controls, and five other subjects had stage II sarcoidosis, a respiratory inflammatory disease. All study subjects underwent blood drawing, bronchoalveolar lavage fluid was examined, it revealed a high proportion of natural killer T cells in the asthma patients, but not in the controls or in those with sarcoidosis.

In addition, the predominance of natural killer T cells in asthma patients are found in their lungs, with only low levels in their peripheral blood, noted the authors. “Our study indicates that the immunology of asthma must be studied not by the examination of peripheral blood but, rather, by the evaluation of cells from within the lungs,” they wrote.

The number of natural killer T cells did not appear to be significantly reduced with inhaled corticosteroid therapy, they reported. "These T cells, when activated, can lead to airway inflammation and asthma, they reported. "Therapies for asthma that target pulmonary invariant natural killer T cells may be highly effective.

**T Cell Type Could Be New Target for Asthma Treatment**

**BY KATE JOHNSON**

*Elsevier Global Medical News*

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**MedPAC Calls for More Medicare Pay**

**BY TODD ZWILLICH**

*Elsevier Global Medical News*

The American Academy of Pediatrics criticized MedPAC’s call for higher physician payments. “If enacted by Congress, this new MedPAC recommendation will help physicians continue to treat Medicare patients,” AMA board member Dr. Duane Gady said in a statement. "But the group is likely to be less impressed by a renewed MedPAC recommendation that calls for a new committee to advise Medicare on the resource-based relative value scale (RBRVS) that sets reimbursement for medical services. An AMA panel, called the RVS update committee (RUC), currently makes recommendations on payment updates for hundreds of treatment and diagnostic codes. But MedPAC chair Glenn Hackethal told the AMA's annual convention in June that it was ‘not clear’ the current RUC system is adequate.”

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More T Cell Research Needed

**MedPAC • from page 1**

In a recent news conference, the MedPAC reported that hospitals get a 2.95% increase for treating Medicare’s 42 million beneficiaries. That would pare back the projected growth in hospital payments by nearly half a percent. The commission noted that a slowdown was needed to help control the program’s rising costs.

The proposal is in line with the White House fiscal 2007 budget, which calls for $480 million in hospital payment cuts for 2007 as part of efforts to control entitlement spending. Hospitals have complained bitterly that they already lose money on Medicare, and that further cuts could drive some of them out of business.

**Payment Proposals, Political Realities**

Physicians and hospitals may have little to fear—or to hope—for this year, according to several key members of Congress. At a Capitol Hill hearing, Rep. Nancy L. Johnson (R-Conn.) said that half of hospitals already operate in the red on money from Medicare patients. In an earlier interview, Rep. Johnson, who chairs the House Ways and Means subcommittee on health, said that President Bush’s budget is likely to be “substantially rewritten” by Congress.

California Rep. F. Pete Stark, Rep. Johnson’s democratic counterpart, suggested that Congress will be unwilling to back any more significant changes to Medicare in an election year. “They’re not going to give the raises the doctors want, and the hospitals aren’t going to get cut as much as they think,” he said in an interview.

Sen. Gordon H. Smith (R-Ore.) agreed. “It’s very bleak for doing anything. In sessions that precede elections, it’s all politics all the time,” he said. Mr. Smith, a member of the Senate Finance Committee.
Panel Expands Vaccination Ages

ACIP • from page 1

Influenza vaccine manufacturers have indicated that they plan to produce between 100 million and 120 million doses for the 2006-2007 flu season, which should be enough to cover the additional 5-3 million healthy children aged 2-5 years in the United States. In a separate vote, ACIP also advised against mandating of influenza vaccination in the absence of a supply decrease or delay, as has been done in previous seasons in anticipation of such problems.

Dr. Baker pointed out that expanding the age of universal influenza immunization up to age 5 years will reduce rates in the overall population, given recent evidence that these children are the vectors of influenza transmission to their contacts. While the ACIP did include household contacts in their recommendation, their immunization rates are typically far lower than for other groups designated as high risk.

This new recommendation should promote protecting our patients and has the potential for protecting their parents and their older siblings. Immunizing contacts often doesn't happen. This recommendation provides

Dr. DeRoy M. Graham, FCP: comments:

Universal influenza vaccination for children aged 6-59 months and their household contacts is clearly supported by health resource utilization data. Adding coverage of influenza vaccine for 24-59-month-olds under the Vaccines for Children Program is essential to make this recommendation a reality. This policy would also reduce influenza rates among adults, in that the preschool child serves as an important vector of transmission.
Panel: Give Pertussis Shot to Health Care Workers

B Y M I R I A N E . T U C K E R  Elsevier Global Medical News

ATLANTA — Health care workers in hospitals or ambulatory care settings and those who have direct patient contact should receive the adolescent/adult formulation of the tetanus-diphtheria-acellular pertussis vaccine, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention voted at its winter meeting.

The new recommendation is aimed at protecting health care workers as well as their patients. “Preventing pertussis among health care workers will decrease exposures and secondary cases in both pediatric and adult care settings,” said Dr. Trudy Murphy of the CDC’s National Immunization Program.

Like the tetanus-diphtheria (Td) vaccine that it replaces, the tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine, adsorbed (Tdap) is routinely recommended at intervals of 10 years for all adults. But an interval as short as 2 years is now advised for the Tdap dose among health care workers in ambulatory and acute care settings, including physicians, nurses, aides, respiratory therapists, medical and other students, social workers, and clerical workers, among others.

Priority should be given to vaccination of health care workers who have direct contact with infants and are less than 12 months of age and have not yet received all three doses of the infant formulation diphtheria-tetanus-acellular pertussis vaccine (DTaP). Hospitals and ambulatory facilities are strongly encouraged to provide Tdap for health care workers and to use approaches that maximize vaccination rates, according to the draft document that the committee unanimously approved. The document must be adopted by the director of Centers for Disease Control and Prevention before it becomes official.

The move follows ACIP’s October 2005 vote to replace the old 10-year Td booster with Tdap (marketed by Sanofi Pasteur as Adacel) as a routine adult immunization and the committee’s June 2005 recommendation to use Tdap among 11- to 12-year-olds at the routine adolescent visit (using either Adacel, which is licensed for use in persons aged 11-64 years, or GlaxoSmithKline’s Tdap, Boostrix, which is licensed for ages 10-18 years).

The routine childhood immunization wears off after about 10 years, so nearly all adults are currently susceptible to pertussis. Although the disease is rarely fatal in adults (as it can be in infants), it does cause prolonged cough lasting for 3 or more weeks in 80%-100% of adults, and post-tussive vomiting in 50%. Missed work for illness or medical care occurs in 78% of adults for a mean of 9.8 days. Dr. Tejpratap Tiwari of the CDC’s National Immunization Program reported at the meeting.

In one previous study, 80% of 62 pediatric hospitals that responded to a survey mailed to 93 hospitals reported having identified pertussis cases within the past 5 years. In 11% of the hospitals, a physician had contracted the disease after exposure to a patient (Infec. Control Hosp. Epidemiol. 1997;18:400-4). And a survey of 143 health care workers conducted at a tertiary care hospital between 1992 and 1994 identified infection in 7.6% of 39 emergency department employees and in 2% of 106 resident physicians (Infec. Control Hosp. Epidemiol. 1999;20:120-3).

In a third study, health care workers made up 8% of 384 adults with pertussis from a total of 664 adolescent and adult pertussis cases that occurred in Quebec in 1998 (J. Infect. Dis. 2000;182:174-9). In that setting, the risk of pertussis among health care workers was 1.7 times greater than the risk among the general adult population.

“Limited data suggest a substantial rate among health care workers, higher than the general population,” Dr. Tiwari said.

Often, the disease is passed between patients, hospital visitors, health care workers, ancillary staff, and their outside contacts in the community before it is detected, resulting in late diagnosis, delayed treatment, and late implementation of control measures.

And once a pertussis outbreak is detected, the process of identifying contacts, providing postexposure prophylaxis, testing and treating symptomatic patients and employees, and furloughing symptomatic employees during the first 5 days of treatment becomes “very labor intensive, destructive, and costly,” Dr. Tiwari said.

In a separate vote, the committee rejected a proposal from its pertussis working group to recommend off-label use of Adacel in adults over 64 years of age, despite limited data suggesting high rates of infection in that age group, as well as no evidence of increased adverse events in a study from Australia in which a similar vaccine containing the same Tdap composition was given to 252 healthy adults aged 59-91 years.

Still, some ACIP members expressed discomfort about making a recommendation for off-label use without more specific data. Sanofi-Aventis expects to provide that data within 2-3 years.

Bosentan Labeling Adds Liver Warning

Reported cases of hepatotoxicity associated with bosentan therapy have prompted changes to the pulmonary arterial hypertension drug’s prescribing information.

Actelion Pharmaceuticals US Inc., which manufactures bosentan (Tracleer), made the changes to highlight the importance of monthly liver function monitoring for the duration of bosentan treatment and the need to adhere to the new recommended dosage adjustment and monitoring guidelines. The new treatment and monitoring recommendations include:

► For alanine aminotransferase/aspartate aminotransferase (ALT/AST) levels greater than three and up to five times the upper limit of normal, confirm by another aminotransferase test. If confirmed, reduce the daily dose or interrupt treatment and monitor aminotransferase levels at least every 2 weeks.

► For ALT/AST levels greater than five and up to eight times the upper limit of normal, confirm by another aminotransferase test. If confirmed, stop treatment and monitor aminotransferase levels at least every 2 weeks.

► For ALT/AST levels greater than eight times the upper limit of normal, treatment should be stopped and reintroduction of the drug should not be considered.

For more information, contact the company by calling 888-835-5445.

—Kerry Wachter

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Omalizumab Cut Steroid Use For Severe Allergic Asthma

BY PATRICIE WENDLING
Elsevier Global Medical News

MIAMI — Omalizumab maintained control of severe allergic asthma and reduced the need for inhaled corticosteroids during 3 years of treatment in an analysis of data from a 52-week open-label extension study.

The findings extend the results of previous studies by showing that asthma control and a favorable safety and tolerability profile were maintained during long-term treatment with the anti-IgE monoclonal antibody, Dr. Jacques Hébert and associates reported in a poster at the annual meeting of the American Academy of Allergy, Asthma, and Immunology.

The study was supported by Genentech Inc. and Novartis Pharmaceuticals Corp., which co-market omalizumab (Xolair). The drug gained federal approval in June 2003 for the treatment of moderate to severe asthma in patients 12 years and older.

In the core 32-week study of 341 patients, omalizumab significantly reduced the use of inhaled corticosteroids and rescue medications while improving symptoms and quality of life, compared with placebo. A first extension to this trial showed that these favorable efficacy and safety findings were sustained for a further 96 weeks of treatment.

In a second extension of the trial, researchers enrolled 178 patients, of whom 149 (84%) completed the study. Patients underwent a washout period of 12 weeks or more before receiving omalizumab subcutaneously at a dose of 0.016 mg/kg or more per IU/mL of IgE every 2 weeks or 4 weeks for up to 52 weeks.

Mean forced expiratory volume in 1 second (FEV1) showed no decline between the start of the first extension (baseline) and week 52 of the second extension (2.24 L vs. 2.26 L). Good or excellent asthma control based on the physician’s overall assessment, was sustained from baseline to week 52 in 121 of the 149 (81%) patients.

During the same period, inhaled corticosteroid doses decreased about 20% among 96 patients who received the same inhaled corticosteroid throughout the first and second extensions and were not taking oral corticosteroids, reported Dr. Hébert, director of the Centre de Recherche Appliquée en Allergie, Quebec City. He has no financial interest in either of the study’s sponsors.

Of the 178 patients who enrolled in the second extension, 134 (75%) had at least one adverse event, generally of mild or moderate severity. The incidence was similar to that reported during the core study (80%) and the first extension (88%). Respiratory events were the most frequent adverse events: asthma not otherwise specified in 49 patients (27.5%), rhinitis in 41 (23%). No drug-related deaths and no new safety issues were identified during the study.
Infusion Protocol Cuts Time To Target Glucose Levels

The Yale protocol, which includes drip rate and blood glucose change velocity, is being increasingly adopted.

BY MIRIAM E. TUCKER
Elsivier Global Medical News

WASHINGTON — More hospitals are implementing standardized insulin infusion protocols, many of which emulate the Yale protocol. Dr. Philip A. Goldberg, said at a consensus conference sponsored by the American Association of Clinical Endocrinologists, American College of Endocrinology, and the American Diabetes Association.

Dr. Goldberg, a postdoctoral fellow at Yale University, New Haven, Conn., said the protocol was introduced in 2001 after the publication of a study from Amdagrim Leuven, Belgium study (N. Engl. J. Med. 2001; 345:1339-67). Until then, the “state of the art” unit had been to tolerate blood glucose levels as long as they did not exceed 200 mg/dL, and to rarely institute or adjust insulin or sulfonylurea therapy. In 2004, the Yale group updated its protocol following the publication of the first American Association of Clinical Endocrinologists’ national guideline on inpatient diabetes and metabolic control (Endocr Pract. 2004;10:77-82) and the American Diabetes Association’s technical review (Diabetes Care 2004;27:S539-91). The blood glucose targets were lowered to 90-119 mg/dL, and the IV bolus was increased by about 40% to gain more rapid control. Also, the terminology was modified to conform to the standards of the Joint Commission on Accreditation of Healthcare Organizations (Diabetes Spec. Suppl. 2005;8:188-99).

In 54 consecutive cardiothoracic ICU patients, mean blood glucose levels were another 12-13 mg/dL lower on average with the new protocol and with no concomitant increases in hypoglycemia. Similarly, mean glucose level was 118 mg/dL among 47 consecutive medical ICU patients。

With the old protocol, levels averaged 123 mg/dL. The new protocol halved to 4.5 hours the median time to reach a glucose level below 140 mg/dL (the old target).

These results would have been impossible without “buy in” from the nursing staff, Dr. Goldberg emphasized. “The ICU nurses are the ones who are doing this. You have to recognize that up front.”

A major barrier still to be overcome is the long-held fear of hypoglycemia. Many hospital personnel believe that levels of 150-200 mg/dL are “normal” and that anything below 100 mg/dL is cause for concern. “There is a culture of hyperglycemia, with a fear of hypoglycemia, or even of low normal,” he said.

To address these concerns, inservice training at Yale consists of 35 minutes addressing the “why” of the protocol and just 10 minutes for the “how.” The trainers review the published data and reinforce the message that most hypoglycemic episodes are benign and treatable.

It’s also important to acknowledge to the nursing staff that if they will follow the protocol, they will not cause harm. “Every body’s institution has different local climates and need different things,” he said. “It’s nice to see that people are taking our drip, adapting it to their local environment, and having some success with it,” Dr. Goldberg noted.

And in 2004, the Yale group again updated its protocol following the publication of the first American Association of Clinical Endocrinologists’ national guideline on inpatient diabetes and metabolic control (Endocr Pract. 2004;10:77-82) and the American Diabetes Association’s technical review (Diabetes Care 2004;27:S539-91). The blood glucose targets were lowered to 90-119 mg/dL, and the IV bolus was increased by about 40% to gain more rapid control. Also, the terminology was modified to conform to the standards of the Joint Commission on Accreditation of Healthcare Organizations (Diabetes Spec. Suppl. 2005;8:188-99).

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Medication Errors in ICU Stem From Communication Gaps

M edication errors in the intensive care unit are most often due to communication failures and improper use of intravenous pumps, according to a report compiled by the U.S. Pharmacopoeia.

The USP analyzed records from 503 hospitals, and likely just touched on the more frequent use of accessory devices for successful intubation. With the increased prevalence of obesity in our society, we need to ensure that intubation kits in our practicing hospitals have access to emergency intubation devices, including bougies and laryngeal mask airways.

Dr. Susan M. Harding, FCCP, comments: Although this is a retrospective study, it shows that morbidity obese individuals (BMI of greater than 40 kg/m2) are more likely to require multiple intubation attempts and a laryngeal mask airway device for successful intubation. With the increased prevalence of obesity in our society, we need to ensure that intubation kits in our practicing hospitals have access to emergency intubation devices, including bougies and laryngeal mask airways.

Communications problems included verbal orders that were misinterpreted, incomplete or poor transcription, illegible handwriting, wrong or unreadable abbreviations, and inappropriate use of decimal points in written orders, said Mr. Santell.

In the intensive care unit, errors of omission are the most frequently reported and were committed by nurses, physicians, and pharmacists, said Mr. Santell. Patients were also administered the wrong dose of the wrong drug. These two errors plus the omissions accounted for 72% of errors in the ICU, he said.

Intravenous pump problems—usually tubing mix-ups or improper programming—were the second largest area of errors.

Insulin, heparin, and albuterol were most often involved in ICU errors.

Surgical ICUs had the most errors in invasive procedures in ICU stem from communication gaps. Medication errors in the intensive care unit are most often due to communication failures and improper use of intravenous pumps, according to a report compiled by the U.S. Pharmacopoeia.

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More Pediatric Status Asthmaticus Cases Visit PICU

‘We need to ask ourselves if we’re prepared for the increase in admissions that is certainly ahead.’

BY ROBERT FINN
Elsevier Global Medical News

SAN FRANCISCO — The number of hospital admissions for pediatric status asthmaticus seems to be decreasing, but at the same time both the number and the proportion of patients with status asthmaticus who are admitted to the ICU appear to be increasing, Dr. Mary E. Hartman said at the annual congress of the Society of Critical Care Medicine.

In New Jersey over the 10-year period from 1992 to 2001, ICU admissions for status asthmaticus increased from 10 per 100,000 children to 18 per 100,000, an increase of 80%, said Dr. Hartman of the University of Pittsburgh. Dr. Hartman and her colleagues examined an administrative database from New Jersey that tabulated every pediatric hospitalization in the state’s hospitals. For the years 1992, 1995, 1999, 2000, and 2001, the investigators identified all admissions with the ICD-9 codes for status asthmaticus. The database included demographic information as well as information on admission characteristics such as length of stay and whether the child was admitted to an ICU.

The investigators were also able to determine which of the 108 hospitals had a pediatric ICU (PICU) and which had only an adult ICU or no ICU at all. During the 10-year period, there were 17,066 pediatric status asthmaticus admissions. Fifty-nine percent of the children were male, and 70% were less than 10 years old. The proportion of uninsured children was 8.1%. These demographic characteristics did not change appreciably over the study period. Overall, 9.3% of status asthmaticus admissions involved an ICU stay. But that increased from 4.4% in 1992 to 17.7% in 2001.

This pattern of increased ICU use did not reflect overall trends in hospitalization during that period. When all hospitalizations and all ICU admissions were considered, total pediatric hospitalizations decreased just 9%, compared with 43% for status asthmaticus. Likewise, total pediatric ICU cases increased by 51%, compared with 127% for status asthmaticus.

Deaths were infrequent during the study period and remained stable over time. A total of eight children died during the 5 years studied. On the other hand, the number of children who required mechanical ventilation declined steadily from 1995 to 2001. “The drop in ventilated cases corresponds to an increase in ICU admissions during that time, and we believe that these data represent a trend in increased vigilance . . . toward more aggressive management of status asthmaticus patients in the ICU,” Dr. Hartman said.

Dr. Mary E. Hartman, University of Pittsburgh.}

“We believe that these data represent a trend ... toward more aggressive management of status asthmaticus patients in the ICU.”

Dr. LeRoy M. Graham, FCCP, comments: Severe pediatric status asthmaticus requiring PICU admission is unfortunately increasing while overall hospitalization for pediatric asthma is decreasing. Increased PICU capacity as well as support for children’s hospitals with unique pediatric expertise and effective triage practices are critical issues in health care planning.
**Maternal Vitamin D Intake May Cut Kids’ Asthma Risk**

**BY PATRICE WENDLING**

**Elsevier Global Medical News**

**MIAMI BEACH —** High maternal vitamin D intake in pregnancy may help protect children from asthma and wheezing illnesses during early childhood, results of a large, prospective study suggest.

In multivariate analyses, every 100 IU increase in maternal vitamin D intake was associated with about a 10% lower risk for any wheeze (an odds ratio of 0.90) and with nearly a 20% lower risk of having a child at high risk for asthma (an odds ratio of 0.82).

This inverse association between vitamin D intake and asthma risk was present whether vitamin D came from diet or nutritional supplements and remained after controlling for 10 confounding factors, Dr. Carlos A. Camargo Jr., FCCP, reported at the annual meeting of the American Academy of Allergy, Asthma and Immunology.

“This is a new hypothesis, but the vitamin D story is going to be one that you’re going to hear more and more about in the years ahead,” Dr. Camargo told reporters at the meeting.

“Already this year there is a lot of discussion going on about vitamin D and cancer. But to link this to asthma and allergic diseases is very exciting,” Dr. Camargo explained.

The best explanation for the observed protective effect is that vitamin D, which is known to have some immunologic effects, influences IL-10 secretion by regulatory T cells, explained Dr. Camargo, who is with the department of epidemiology at Harvard Medical School in Boston.

The findings suggest that vitamin D insufficiency is a reality, particularly in northern parts of the country.

Exactly what the correct amount of daily vitamin D intake is remains unclear, in part because of emerging data from this and studies in other specialties, Dr. Camargo said.

“Most people in the field would recommend 800-1,000 IU/day, and yet you’ll see recommendations of 200-400 IU in the literature,” he said.

Dr. Camargo added that the Institute of Medicine’s recommendations should be revisited.

The mean vitamin D intake by mothers during pregnancy was 548 IU/day in the study, which included 1,194 mother-child pairs in Project Viva. Project Viva is a prospective prepartum cohort study in Massachusetts.

Maternal intake of vitamin D was assessed by study researchers using a validated food questionnaire in the first and second trimesters and was averaged for analyses.

*Statements are based on observations reported from in vitro or animal trials.*
Montreal — Lung cancer patients should be assessed for their surgical suitability using algorithms rather than absolute values of forced expiratory volume in 1 second, according to a study conducted at the University of Texas Health Science Center in Houston.

‘Algorithms … that use values of FEV1, [forced expiratory volume in 1 second] greater than 80% for pneumoectomy or predicted postoperative FEV1 of 35% or greater are more consistent than predictions for resection using absolute values of FEV1, in liters,’ Dr. M. Yessim Ersoy told the CHEST 2005 annual meeting of the American College of Chest Physicians.

Explaining the “apparent lack of congruency” among methods for preoperative patient selection, Dr. Ersoy and her colleagues cited previously published studies and British Thoracic Society guidelines, which state that an FEV1 of 2 L or greater is a safer lower limit for pneumoectomy in patients with lung cancer. Others have utilized FEV1, based on percent of predicted normal—ranging between 60% or higher and 80% or higher—to indicate a patient suitable for resection.

“The British Thoracic Society [Thorax 2001;56:89-108] says no further respiratory function tests are required for pneumoectomy if FEV1 is 2 L or higher.” Otherwise, based on radionuclide studies, an estimated postoperative FEV1, greater than 40% predicted is okay; otherwise, consider exercise testing,” said Dr. Ersoy of the University of Texas Health Science Center (UTHSC) in Houston.

There are difficulties with recommendations that use percentage of predicted or estimated postoperative FEV1. “The literature is heavily biased on making predictions for resection using absolute values of FEV1, in liters, but this approach creates a big bias against women, females, and patients of small stature who might tolerate lower levels of lung function,” she said.

Dr. Ersoy and her associates conducted a study that included all patients with unilateral lung cancer referred to the UTHSC pulmonary laboratory for preoperative evaluation between January 2002 and May 2005. The investigators reviewed clinical characteristics, results of pulmonary function tests, and quantitative regional ventilation-perfusion lung studies. “Tests included spirometry before and after bronchodilators, measurement of lung volumes by body box plethysmography, and single-breath diffusing capacity.”

Dr. Ersoy explained. Quantitative radionuclide studies of regional lung ventilation and perfusion in the sitting position were performed the same day. A total of 1,334 patients were studied.

The researchers found that 47% of patients had PPO FEV1, under 40%, and only 2% of those had a reading under 35%. “We also looked at patients with FEV1, over 60% and under 80%, and this was even worse: 41% of them had predicted postoperative FEV1, less than 40%, and 26% had PPO FEV1, less than 35%,” she said. “About one-third of patients with an FEV1, higher than 2 L would have been deemed ineligible for pneumoectomy based on PPO FEV1, less than 40%,” Dr. Ersoy said.

“Tolerances for resection using absolute values of ventilation and perfusion in the sitting position are inconsistent,” Dr. Ersoy explained. Quantitative radionuclide studies of regional lung ventilation and perfusion in the sitting position were performed the same day. A total of 1,334 patients were studied.

The researchers found that 47% of patients had PPO FEV1, greater than 2 L (mean 2.64 L). But 49% of those who had FEV1, greater than 2 L had an FEV1, less than 80%.

Another interesting thing was that of those patients who had PPO FEV1, greater than 2 L, 30% had a predicted postoperative (PPO) FEV1, of less than 40% and 13% had a… PPO less than 35%,” Dr. Ersoy said.

“I agree completely that we need to get away from absolute values, and we need to get away from this preoperative percent of normal and really go through a predicted postoperative value as the cutoff,” said discussant rather than Dr. Detterbeck, FCPP, chief of thoracic surgery at the Yale University Cancer Center in New Haven, Conn. Regarding mortality figures, he said that the “numbers we have for a predicted postoperative FEV1, of less than 40% pertain to an open lobectomy or an open pneumoectomy. If you look at data from series that used open segmentectomies or open wedge resections in patients with very limited pulmonary function, mortality results are consistently below 5%.

“So we have to be careful about using these numbers to say that patients will not tolerate a segmentectomy or wedge resection,” Dr. Detterbeck said. He also noted that there is no good definition of exactly how high the risk is for patients below a particular level. “So a 15% operative mortality might be appropriate in some patients who have a very curable cancer.”

Study Clarifies Algorithms for Preop Cancer Assessment

Montreal — Lung cancer patients should be assessed for their surgical suitability using algorithms rather than absolute values of forced expiratory volume in 1 second, according to a study conducted at the University of Texas Health Science Center in Houston.

“Algorithms … that use values of FEV1, [forced expiratory volume in 1 second] greater than 80% for pneumoectomy or predicted postoperative FEV1 of 35% or greater are more consistent than predictions for resection using absolute values of FEV1, in liters,” Dr. M. Yessim Ersoy told the CHEST 2005 annual meeting of the American College of Chest Physicians.

Explaining the “apparent lack of congruency” among methods for preoperative patient selection, Dr. Ersoy and her colleagues cited previously published studies and British Thoracic Society guidelines, which state that an FEV1 of 2 L or greater is a safer lower limit for pneumoectomy in patients with lung cancer. Others have utilized FEV1, based on percent of predicted normal—ranging between 60% or higher and 80% or higher—to indicate a patient suitable for resection.

“The British Thoracic Society [Thorax 2001;56:89-108] says no further respiratory function tests are required for pneumoectomy if FEV1 is 2 L or higher. Otherwise, based on radionuclide studies, an estimated postoperative FEV1, greater than 40% predicted is okay; otherwise, consider exercise testing,” said Dr. Ersoy of the University of Texas Health Science Center (UTHSC) in Houston.

There are difficulties with recommendations that use percentage of predicted or estimated postoperative FEV1. “The literature is heavily biased on making predictions for resection using absolute values of FEV1, in liters, but this approach creates a big bias against women, females, and patients of small stature who might tolerate lower levels of lung function,” she said.

Dr. Ersoy and her associates conducted a study that included all patients with unilateral lung cancer referred to the UTHSC pulmonary laboratory for preoperative evaluation between January 2002 and May 2005. The investigators reviewed clinical characteristics, results of pulmonary function tests, and quantitative regional ventilation-perfusion lung studies. “Tests included spirometry before and after bronchodilators, measurement of lung volumes by body box plethysmography, and single-breath diffusing capacity.”

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Understanding nicotine addiction

Most experts agree at this point that smoking is a chronic, relapsing condition, an addiction similar in nature to that seen in cocaine and heroin users.1-4 Following are 4 criteria the Surgeon General has used to define addiction, along with an explanation of how nicotine—specifically smoking—meets these criteria.

1. Addiction leads to compulsive use, despite adverse consequences

According to a 1988 Surgeon General’s report, “highly controlled or compulsive use indicates that drug-seeking and drug-taking behavior is driven by strong, often irresistible urges. It can persist despite a desire to quit or even repeated attempts to quit.”

Smoking statistics show that approximately 70% of current smokers report that they want to quit; however, only about 5% of smokers who try to quit without medical aid succeed.14 For those who finally do quit, it is usually only after 6 to 9 failed attempts.15 It is common for people to continue smoking despite known negative health consequences. In fact, smoking behavior often persists even after the presentation of comorbid conditions.16

2. Addiction involves a psychoactive substance with reinforcing properties

The psychoactive (mood-altering) properties of nicotine are substantially related to its effect on the mesolimbic dopaminergic system. For delivery of nicotine, smoking is the most efficient mechanism. In a matter of seconds, nicotine from inhaled smoke crosses the blood-brain barrier and begins altering brain chemistry through binding to cholinergic receptors normally activated by acetylcholine. Dopamine is released in the nucleus accumbens, triggering central nervous system effects such as pleasure, relief of anxiety, better task performance, and improved memory. These rewards serve to reinforce smoking behavior.5,6,9,10

Complicating this effect is that the routines associated with smoking, such as smoking in social environments, can also come to be reinforced through the pleasure response. Eventually, the pleasure associated with smoking in these settings acts as a subconscious trigger, making it hard for the smoker to dissociate the behavior from the addiction. This explains why successful quit attempts often require some degree of behavioral modification.5,6,11

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3. The addicted subject develops tolerance

Nicotine initiates its action by competitively binding at the nicotinic acetylcholine receptors (nAChRs), ligand-gated ion channels on the cell membrane. Compared with the endogenous agonist acetylcholine, nicotine causes a prolonged activation of nAChRs. The activation is followed by a desensitized state in which the receptors are unresponsive to agonists. This process has been compared to tripping a circuit breaker.15,19

Chronic use of nicotine leads to chronic desensitization of nAChRs. As more nicotine is consumed, and more receptors become desensitized, the user experiences a diminished pleasure effect with each subsequent cigarette smoked. As the response decreases, increasing levels of nicotine are required to achieve a consistent, desired effect.15,19 These are defining characteristics of tolerance.
‘New Era’ of Drugs Approaching for Atrial Fibrillation

BY MITCHEL L. ZOLER
Elsevier Global Medical News

Boston — Two drugs for preventing atrial fibrillation that were being considered for approval by the Food and Drug Administration in early 2006 headed the list of new antiarrhythmia agents that could change atrial fibrillation treatment over the next few years. A “new era” of drug treatment is approaching, Dr. Peter Kowey said at an international symposium on atrial fibrillation that was sponsored by Massachusetts General Hospital.

Drugs that may be part of that era include:

► Azimilide. This agent blocks both rapid and slow potassium channels in the heart and is one of the drugs under FDA review. Azimilide is being considered as a way to prevent shocks from an implanted cardiac defibrillator.

► Dronedarone. Also before the FDA, dronedarone is an amiodarone congener and the first from a line of amiodarone-like compounds that are under development. These agents are attracting interest because amiodarone is the most effective antiarrhythmic medication that is currently available but it is also associated with adverse effects and weaknesses.

Dr. Kowey said at the symposium, also sponsored by the Academy of Health Care Education.

Dronedarone avoids the thyroid and pulmonary toxicity that is seen with amiodarone. The two agents have not been compared with each other in a head-to-head study, but if dronedarone were to be approved, it would be “extraordinarily useful” for relatively young patients who are being considered for amiodarone treatment, perhaps because they have already failed treatment with a class 1C drug such as flecainide or propafenone, he said.

Dronedarone should not be used in patients who have severe heart failure because of a suggestion of safety problems in the clinical trials so far. The drug also should be avoided in patients who are suffering from severe renal dysfunction. For patients with severe left ventricular hypertrophy, amiodarone remains the best drug.

► RSD-1235. Some phase III testing has been completed for this atrial-selective drug, but other studies are still in progress.

The drug’s manufacturer says that it plans to apply for FDA licensing early this year with an intravenous formulation for termination of acute arrhythmia. An oral form is still in clinical trials.

Atrial-selective agents are a major area of development because adverse electrical effects on ventricles are the biggest reason for toxicity of existing drugs for atrial arrhythmia, said Dr. Kowey. Another atrial-selective drug, AVE-0118, is just starting clinical studies.

Atrial repolarizing delaying agents also are just entering clinical studies and must show their potential in proof-of-concept tests. Gap junction modulators are in preclinical development, although the main focus now for these drugs is ventricular arrhythmias. Stretch-activated channel blockers also are being studied.

Some drugs already on the market have also shown signs of possible efficacy for atrial fibrillation. β-Blockers are a promising class. Carvedilol in particular showed signs of efficacy for preventing atrial arrhythmia in patients with ischemic heart disease in the CardiRVolod Postinfarct Survival Control in Left Ventricular Dysfunction (CAPRICORN) trial. Certain ACE inhibitors and angiotensin-receptor blockers have also shown signs of efficacy for preventing fibrillation in completed trials, and the efficacy of some angiotensin-active drugs as primary therapy for atrial fibrillation is now being tested in randomized controlled trials.

Other agents that have shown hints of efficacy include antiplatelet agents and some antibiotics, especially statins, which significantly reduced the incidence of atrial fibrillation episodes in two retrospective studies.

References:
5. Dr. Kowey said at the symposium, also sponsored by the Academy of Health Care Education.

The αβ* receptor

Recent evidence suggests that scientists have now identified specific nAChRs in the brain that is believed to act as a primary mediator of the addictive properties of nicotine—the αβ* receptor.1-4 The isolation and characterization of this receptor is a significant advancement in the understanding of the neurobiology of smoking addiction.

Conclusion

Smoking is a chronic, relapsing condition. For most smokers, the compounding effects of behavioral, psychological, and physical triggers make overcoming their addiction extremely difficult. However, given the high morbidity and mortality related to smoking,5-6 getting smokers to quit is important. Proactive medical intervention for smokers may be beneficial.1 Recent advancements in the study of nAChRs—specifically the identification and characterization of the αβ* receptor—represent a significant advancement in the understanding of the nature of nicotine addiction.

References:
### Pulmonary Perspectives

#### The World Health Organization Framework Convention on Tobacco Control: Where Are We Now?

In this one bowl, there is rice from a thousand households.” The saying of Zen poet Ryokan (1758–1831) well describes the contribution of many parties toward the Framework Convention on Tobacco Control (FCTC): the World Health Organization (WHO), other United Nations agencies, member states, nongovernmental organizations (NGOs), academia, the media, and even the tobacco industry.

The FCTC came into effect on February 27, 2005. It was signed by 168 countries and has now been ratified by 116. This makes it one of fastest track international treaties of all time, enjoying widespread support around the world. This new treaty is the first international legal instrument designed to promote national action to reduce the growth and spread of the global tobacco epidemic. It will place countries under international legal obligation to curb tobacco use by implementing tobacco control laws, taxation policies, and programs. The treaty provisions are outlined in the table below.

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<th>At-a-Glance: FCTC Main Provisions</th>
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<td><strong>Regulation of:</strong></td>
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<tr>
<td>▶ Contents, packaging, and labeling of tobacco products</td>
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<td>▶ Prohibition of sales to and by minors</td>
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<td>▶ Illicit trade in tobacco products</td>
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<td>▶ Smoking in work and public places</td>
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<td><strong>Reduction in consumer demand by:</strong></td>
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<td>▶ Price and tax measures</td>
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<td>▶ Comprehensive ban on tobacco advertising, promotion, and sponsorship</td>
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<td>▶ Education, training, raising public awareness, and assistance with quitting</td>
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<td>▶ Protection of the environment and the health of tobacco workers</td>
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<td>▶ Support for economically viable alternative activities</td>
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<td>▶ Research, surveillance, and exchange of information</td>
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There is no disagreement on the health evidence that led to the treaty. The main concern of countries has been economic—whether or not the FCTC would have an effect on their tobacco farmers and other tobacco workers and tax revenues. Reassuringly, analysis of economics and trade by the World Bank, the Food and Agriculture Organization of the United Nations, and other health economists concludes that neither the FCTC nor any tobacco control measures will harm economies, even those of major tobacco-growing countries, such as China or Brazil. With the number of smokers predicted to rise from the current 1.3 billion to 1.6 billion by 2020 (principally due to increases in global population), no tobacco farmers will be out of work for decades to come.

Economists have pointed out that many tobacco control measures cost nothing. For example, these include legislation requiring warning labels on cigarette packets, the creation of smoke-free areas, or simple advice on quitting from a health professional. Other actions may have some cost, but are cost-effective, such as bans on advertising and promotion and the provision of quitting services, including nicotine replacement treatment. Price measures, such as increased tobacco tax and a crackdown on smuggling, will actually increase government tax revenue, while reducing the numbers of young smokers and encouraging adults to quit.

The FCTC is, as its name suggests, an initial framework. Over time, countries will negotiate and conclude more specific protocol agreements designed to implement the goals of the framework convention. The late Paul Szasz, a United Nations mental health expert, said, “Expect a convention to please no one, but hope it will be acceptable to everyone,” and that is what we got. The lengthy process and the interminable discussions at many meetings were often wearisome but had the advantage of gradually emerging with a consensus and buy-in from the key players, especially the member states.

Even before it was adopted by the World Health Assembly in May 2003, the process itself had mobilized technical and financial resources for tobacco control, encouraged governments to take action ahead of the finalization of the convention, and raised awareness among other government ministries.

Because the convention is ratified by national governments, an important result of the FCTC is that it has “kicked tobacco upstairs” in governments, requiring an ongoing commitment from all government departments, not just ministries of health, but also those of economics and trade, development and planning, foreign affairs, law, and customs. This widespread involvement was evident even in the negotiating process. China’s team, for example, included members from a wide range of government departments. Similarly, the convention expanded responsibility for tobacco issues from WHO to other United Nations agencies, some of which had hitherto been minimally involved with tobacco.

The FCTC has had a major impact on national and international tobacco control action. For example, in India, the FCTC has led to the creation of a health ministry and the Department of International Affairs.

The FCTC has a major impact on NGOs, as well. Prior to 1993, there were only a handful of international and regional NGOs devoted solely to tobacco issues, and most of them functioned independently of one another. The FCTC changed this isolation, giving birth to alliances and coalitions throughout the NGO community. NGOs attended all the working group and intergovernmental negotiating body meetings, some as members of government delegations. They were highly creative in their lobbying, supported or criticized governments with daily “ordeal” or “dirty ashtray” awards to the best or worst performance of the day and ran an effective media campaign. The Death Clock (see photo), run by the NGOs, was one example of their constant efforts. The published comments on the Chair’s text were used extensively by delegates. NGOs will be crucial in the implementation stage ahead.

Not surprisingly, the tobacco industry was not in favor of a strong, legally binding FCTC and, instead, sought to promote self-regulating marketing mechanisms and voluntary agreements. The industry complained it was not invited to be an integral part of the negotiations, but there have been many avenues for it to make its views known, i.e., directly to governments, as members of delegations, at the public hearings on the FCTC in Geneva in October 2000, and through its public relations machinery.

The FCTC now makes it more difficult for the tobacco industry and its allies to try to derail national tobacco control legislation, as the convention indicates that the tide of tobacco control action is international, unstoppable, and a necessary public health measure, good for the wealth and health of nations.

There are lengthy procedures ahead, involving further ratifications by remaining countries, establishment of a Conference of the Parties, development of protocols, and creation of a reporting mechanism.

The first session of the Conference of the Parties to the FCTC took place from February 6–17, 2006, in Geneva, between ratifying states. Other states, for example those who had signed but not ratified the FCTC (such as the United States), participated as observers. NGOs in official relations with WHO and international intergovernmental organizations also participated as observers.

During this first session of the Conference of the Parties, parties decisions were taken in technical, procedural, and financial matters relating to the implementation of the treaty, such as the establishment of the permanent secretariat, funding and financial support, monitoring and reporting on implementation progress, and protocols.

Ongoing information on the process can be found at the following sites: WHO, www.who.int/tobacco/framework/en; and the Framework Convention Alliance, fcta.org.

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**Editor’s Insight**

Professor Judith L. Mackay
Director, Asian Consultancy on Tobacco Control
Hong Kong SAR, China

Dr. Mackay provides an important and timely update on the status of the FCTC. The convention is the result of untiring work and perseverance by many, including Dr. Mackay. Since the ACCP and the CHEST Foundation have played a major role in tobacco control in the United States and have a strong international interest in tobacco control, this reminder of the status of the FCTC is particularly relevant. That the US government has not ratified the convention is a sign of the power and ongoing influence of the tobacco industry and a strong reminder of our need for continued work in this area. The fight is not over. The FCTC is, however, an extraordinary measure in the ongoing fight.

—Editor
Pulmonary Vascular Disease
Interest in pulmonary vascular disease continues to grow among members of the ACCP. This was clearly reflected by the record attendance at the NetWork Open Meeting at CHEST 2005. We invite you to www.chestnet.org/networks/pvd/index.php, our NetWork Web page that features a curriculum with links to selected abstracts. We continue to update the curriculum, and add new material. The NetWork will conduct a survey to assess the training provided in pulmonary vascular disease during fellowship programs in pulmonary and critical care medicine. The findings of this survey will enable us to identify and address specific levels of need within the field of pulmonary vascular disease.

We continue to explore ways to facilitate communication and discussion among NetWork members through clinical roundtables and other means. To contact us regarding new projects, e-mail the NetWork chair at Namita.Sood@osumc.edu.

Respiratory Care
The Respiratory Care NetWork serves to connect the ACCP with other professional organizations that focus on respiratory care. These include the National Board for Respiratory Care (NBRC), the Committee on Accreditation of Respiratory Care (CoARC), the AARC Board of Medical Directors (BOMD), and NAM-DRG. The liaisons, as well as leaders from these organizations, meet with the Respiratory Care NetWork Steering Committee at the annual CHEST meeting to review and report on the current activities of that organization.

An important group that is missing from this list of liaisons comprises the physicians who are the Medical Directors of the nearly 400 respiratory care training programs throughout the country. A forum is needed for these Medical Directors to share their ideas, successes, and failures.

We hope to meet this need by inviting Medical Directors, who also are ACCP members, to participate in roundtable discussions during CHEST 2006. If you are a Medical Director of a respiratory care training program, please submit your name, e-mail address, and other contact information to Lee Ann Fulton at flulton@chestnet.org.

Sleep Medicine
More than 50 members of the Sleep Medicine NetWork participated in the NetWork’s open meeting at CHEST 2005 in Montreal. A presentation by Dr. Bela Patel on “The Nose and Sleep-Disordered Breathing” was followed by discussions on the activities of the NetWork during the past year, which included an educational slide set project; an update on certifications by the American Board of Sleep Medicine (ABSM) and the American Board of Medical Specialties (ABMS); the change in fellowship accreditation by the American Academy of Sleep Medicine (AASM) to the Accreditation Council for Graduate Medical Education (ACGME); a report on the activities of the Board of Registered Polysomnographic Technologists; and an update on joint activities between the Sleep Medicine NetWork and the ACCP. SleepNet, the sleep network of the ACCP, edited by Dr. Scott Manaker, FCCP.

Thoracic Oncology
The Thoracic Oncology NetWork has sent a survey to ACCP member pulmonologists and thoracic surgeons in the United States. This survey is a Time II assessment of lung cancer diagnosis and treatment practices and beliefs. The original survey results were summarized in an article in CHEST (Schroen et al. Chest 2000; 118:129), before the publication and dissemination of the Diagnosis and Management of Lung Cancer: ACCP Evidence-Based Guidelines in January 2003. Pulmonologists and thoracic surgeons are the primary point of care for patients with lung cancer. They have significant influence over the subsequent care pathways that receive and the patient’s attitude toward his or her disease. In addition to assessing changes in attitude since the previous survey, this project seeks to gauge current beliefs regarding the treatment of patients with lung cancer. They have significant influence over the subsequent care pathways that receive and the patient’s attitude toward his or her disease. In addition to assessing changes in attitude since the previous survey, this project seeks to gauge current beliefs regarding the treatment of patients with lung cancer. They have significant influence over the subsequent care pathways that receive and the patient’s attitude toward his or her disease. In addition to assessing changes in attitude since the previous survey, this project seeks to gauge current beliefs regarding the treatment of patients with lung cancer. They have significant influence over the subsequent care pathways that receive and the patient’s attitude toward his or her disease. In addition to assessing changes in attitude since the previous survey, this project seeks to gauge current beliefs regarding the treatment of patients with lung cancer. They have significant influence over the subsequent care pathways that receive and the patient’s attitude toward his or her disease. In addition to assessing changes in attitude since the previous survey, this project seeks to gauge current beliefs regarding the treatment of patients with lung cancer.
INSIDE THE ACCP

The CHEST Foundation: Helping Your Patients Live and Breathe Easier

For over 10 years, The Foundation has provided funding to reach thousands of patients and communities.

By Marilyn Lederer
Vice President and COO, The CHEST Foundation

Ten years ago, a committed group of ACCP members, led by ACCP Past President Dr. Bart Chernow, Master FCCP, had a vision to create a philanthropic arm of the College to address the needs of patients and their communities in the area of cardiopulmonary and critical care medicine. In 1996, The CHEST Foundation was created as ACCP’s supporting foundation. For the past decade, with the assistance of ACCP members, donors, staff, and strategic partners, The Foundation has made a significant impact in improving patient care and lung health for the College’s global membership.

Unlike other foundations that focus on specific diseases or public health issues, The CHEST Foundation solely exists to support the College and its members. Its mission and programs derive from the expressed needs of ACCP members who serve on The Foundation’s Board of Trustees and working committees. The Foundation concentrates its efforts in four key areas—critical care, tobacco prevention, humanitarian services, and clinical research—to develop programs and resources that help you promote better health for your patients and their families. Over the past 10 years, The Foundation has provided funding to reach thousands of patients and communities.

What kind of resources is The Foundation providing for ACCP members?

► The Critical Care Family Assistance Program (CCFAP) is designed and implemented in nine hospitals across the United States and is changing the way care is delivered to ICU patients and their families. With the CCFAP toolkit, promotional video, and the September 2005 supplement to CHEST, any ACCP member can replicate this important program in his or her hospital.

► Lung Lessons™ and the Speakers Kit on Women & Girls, Tobacco & Lung Cancer reflect The Foundation’s knowledge that smoking kills and its commitment to tobacco prevention for children and adults. With these ready-to-use resources, any ACCP member can use the materials for grand rounds or to make a presentation in a child’s classroom.

► The Humanitarian Awards Program annually provides grants to organizations in which ACCP members volunteer their time and expertise to provide care to those who otherwise could not afford their services. Over the past 6 years, The Foundation conferred almost $600,000 in grants to organizations around the world.

► Beyond the First Response provides disaster relief in times of manmade and natural disaster. In the past year, with support from ACCP members and staff, The Foundation has provided assistance in the aftermath of the Asian tsunami and Hurricanes Katrina and Rita on the Gulf Coast of the United States.

The CHEST Foundation has provided over $3 million in clinical research awards since 1997 and annually grants almost $500,000 in awards to ACCP members to promote turning research into practice. To ensure that its valuable programs are implemented, The CHEST Foundation works through the College’s Networks and committees. In addition, for the past 5 years, The Ambassadors Group, made up of ACCP members’ spouses and family members, has been educating, networking, and volunteering on behalf of The CHEST Foundation. The Ambassadors Group has completed projects, such as Stories at the End of Life and the Love Your Lungs™ wristbands, and uses The CHEST Foundation tobacco prevention materials to make presentations to elementary and high school students around the world.

This year commemorates The CHEST Foundation’s 10th anniversary. The impact that its founders envisioned a decade ago has been realized. The Foundation’s 10th anniversary theme is “Imagine the Power of 10.” I hope that we can count on ACCP members to help The CHEST Foundation multiply its impact exponentially in the next 10 years.

For more information about The CHEST Foundation, or to make a charitable contribution, please go to www.chestfoundation.org.
Ultrasonography has important applications in pulmonary and critical care medicine (PCCM). In the United States, ultrasonography is still considered to be the province of the radiologist, particularly by medical subspecialists, such as the PCCM clinician. This essay will present a basic overview of ultrasound concepts and discuss an alternative approach to ultrasonography—that the proper place of ultrasonography is at the bedside of the patient and in the hands of the PCCM clinician.

Bedside ultrasonography is a powerful clinical tool that has many different uses for the PCCM clinician. The availability of high quality, portable ultrasonography machines now allows the PCCM clinician to use this method at the bedside for immediate diagnosis, to guide treatment, and to better perform a wide variety of invasive procedures. Using the ultrasonography transducer, the bedside clinician can obtain accurate, real-time images in order to assess the anatomy and function of many critical organ systems, while the use of Doppler assesses cardiovascular function. Thoracic ultrasonography includes the pleural space, the mediastinum, and the lung (Beck et al. Chest 2002; 122:1759-1773). Pleural ultrasonography has importance for the diagnosis of pleural disease and for ultrasonography guidance of device insertion. Lung ultrasonography has exceptional utility in management of the critically ill (Lichtenstein. General ultrason in the critically ill. Berlin: Springer-Verlag, 2005). For example, it allows immediate diagnosis of pneumothorax and is superior to standard supine chest radiography in assessing the critically ill patient with ARDS (Lichtenstein et al, eds. Atlas of chest fluoroscopy and Kopman-Feller et al, eds. Ultrasound-guided procedures and investigations; New York: Marcel Dekker, 2005). PCCM journals have published comprehensive guide to training strategy for pulmonology residents (Beaulieu et al. Chest 2005; 128:881-895, 1766-1781).

How can the clinician obtain adequate training in this important discipline? The following is a summary of some principles in planning training strategy.

1. Ultrasonography is a valuable tool for all PCCM clinicians. PCCM clinicians are able to achieve a high level of competence with proper training in ultrasonography. However, there is no requirement that a PCCM clinician learn any particular aspect of ultrasonography. The clinician should only pursue training if he / she would find clinical utility in the skill.

2. The clinician should pursue a modular approach to training. The modules of ultrasonography that are relevant to PCCM practice include the following:
   - Transcardiac and transesophageal echocardiography: the basic and advanced levels
   - Abdominal ultrasonography: basic and advanced levels, including ultrasonography-assisted interventions
   - Vascular ultrasonography: ultrasonography-assisted vascular access
   - Thoracic ultrasonography: ultrasonography examination for pleural, lung, and mediastinum, including ultrasonography-assisted interventions
   - Endobronchial ultrasonography: advanced level

Adequate training is the key to safe application of bedside ultrasonography. How can the PCCM clinician obtain adequate training in this important discipline? The following is a summary of some principles in planning training strategy.

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   - Endobronchial ultrasonography: advanced level

This essay serves to outline the justification for ultrasonography training by the PCCM clinician, as well as reviews some general principles of training to guide the interested physician.
How Important Is Continuing Medical Education?

A successful CME educational activity will no longer be defined in terms of participants’ satisfaction.

By Ed Dellert, RN, MBA
Vice President, Educational Resources,
American College of Chest Physicians

H ow important is CME to physicians? Does CME really support professional development? Can CME be linked to improved patient outcomes?

Continuing medical education (CME), by definition, consists of educational activities that serve to maintain, develop, and increase a physician’s knowledge throughout his or her entire career.

The American Medical Association (AMA) defines the content of CME as being the body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public. The real question becomes, “Does our current CME structure really make a difference?” Could a new and more qualified CME system affect the driving change correlated with improved outcomes?

To address the use of structured time for education, some CME providers have proposed and implemented self-directed learning tools to develop educational programs into learning portfolios, designed to capture learning whenever and wherever it can occur. Learning portfolios can document, describe, and assess learning events, such as answering important clinical questions in order to maintain competence. Strategies such as these are, in part, due to address the seven recommendations to improve physician “life-long learning,” as suggested by the Council of Medical Specialty Societies (CMSS) (www.cmss.org/index.cfm?p=display&detail=Conjoint%20Committee%20on%20CME).

The ACCP Continuing Education Committee (CEC) has had many discussions using the seven recommendations outlined by the CMSS as a benchmark to what ACCP’s educational future would look like.

The foundation of ACCP’s educational future, however, has indirectly affected the driving change correlated with improved outcomes. The ACCP Continuing Education Committee (CEC) has had many discussions using the seven recommendations outlined by the CMSS as a benchmark to what ACCP’s educational future would look like.

The question for the CEC is to determine what experiential learning concepts they will want to advocate to ACCP membership. Professional societies, such as the ACCP, need to seriously assess the strategies being used in their educational curricula and begin to assess the desired knowledge, skills, behaviors, and patient outcomes that measure attainment of these outcomes. A successful CME educational activity will no longer be defined in terms of participants’ satisfaction but rather in terms of clinical performance improvement, improved patient satisfaction, and other desirable implications from these types of educational efforts. The ultimate question is, “Will you be ready to embrace this type of change in CME?”

What is your vision of tomorrow’s CME? Let me know via e-mail at eddellert@chestnet.org.
Position Statement: Medical Director of Sleep Disorders Center

Definition:
The Medical Director of a sleep center or laboratory shall be a licensed physician who has special interest and knowledge in the diagnosis and treatment of sleep disorders. The Medical Director should be qualified by training and/or experience in the management of sleep disorders and possess an in-depth knowledge of diagnostic equipment, procedures, and techniques. This physician should be responsible for the quality, safety, and appropriateness of the sleep center and/or laboratory services.

Duties:
1. The Medical Director is responsible for the delivery of sleep center and/or laboratory services and is accountable to the medical staff for the quality of patient services delivered by the sleep center staff and all other health professionals providing such care and for diagnostic testing. As a result, sleep technologists should work under the direction of a qualified Medical Director at all times in order to assure their competency and to maximize their capabilities as described in their scope of practice.
2. The Medical Director provides 24-hour availability, including, where necessary, an appropriately qualified designee(s) to share these responsibilities or assume them in the Director’s absence.
3. The Medical Director is readily available and interacts regularly with sleep laboratory personnel, promoting bedside and laboratory problem-solving and guidance.
4. The Medical Director positions the sleep center and/or laboratory to be successful in the changing health-care environment by championing cost-effective policies and procedures, while assuring optimal delivery of sleep diagnostic and therapeutic services in a continuum, inside and outside of the hospital.
5. The Medical Director participates in the quality improvement program of the sleep center/laboratory and the hospital, assuring proper allocation of sleep disorder therapies and diagnostic services through appropriate audit techniques.
6. The Medical Director participates in the development and introduction of new sleep medicine services, equipment, and procedures and also monitors current sleep medicine services for their continued medical usefulness.
7. The Medical Director facilitates continuing education in the diagnosis and treatment of sleep disorders for physicians, sleep technologists, sleep technology students, registered nurses, respiratory therapists, administrators, patients, and the community.
8. The Medical Director coordinates and facilitates professional relationships between the sleep center/laboratory and hospital administration, the medical staff, nursing, respiratory care, pharmacy, emergency care unit, critical care units, post-anesthesia recovery rooms, home health agencies, and other departments and agencies that utilize sleep medicine services.
9. The Medical Director audits physician performance in prescribing sleep disorder therapies in conjunction with the appropriate governing body of the medical staff.
10. The Medical Director provides consultation to physicians with respect to available and appropriate treatment of requested sleep diagnostic and therapeutic services.
11. The Medical Director shares responsibility with and provides medical expertise to the administrative/technical director of the sleep center/laboratory in matters regarding equipment, space, personnel, discharge planning, safety, policies and procedures, supplies, patient care protocols, budget, case management, record keeping, preventive maintenance, infection control, fiscal and regulatory agencies.
12. The Medical Director, as the agent of the medical staff, is responsible for seeing that the sleep medicine services are in compliance with federal and state laws and regulations, as well as the requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Academy of Sleep Medicine (AASM).
13. The Medical Director assures the quality and safety of the sleep studies, including:
   a. Ensuring the quality of the testing performed in the sleep laboratory.
   b. Deciding what types of testing will be performed in the laboratory and what equipment will be used.
   c. Selecting the normal reference values appropriate for the patient population studied in the laboratory.
   d. Being responsible for the review and interpretation of test results.
   e. Deciding the training and/or credential requirements and evaluating the performance of the technical personnel of the laboratory.
   f. Minimizing any risks to and managing any complications in the patients tested in the laboratory and ensuring the safe performance of sleep diagnostic and administration of therapies.
   g. Developing written protocols for all testing procedures.
   h. Being a consultant to other physicians to offer advice on appropriate tests to order in a given clinical situation and appropriate use of the laboratory facilities.
   i. Developing and implementing procedures to prevent the transmission of infection by the laboratory equipment and personnel and to prevent other hazards to patients and staff.

Adapted from ACCP Position Statement: “Medical Director of Respiratory Care Department and Pulmonary Function Laboratory: Definition and Duties,” revised 2005; www.chestnet.org/institutes/si/index.php.

Salt Lake City: Experience the City, Experience the Rockies

Experience all that is Salt Lake City, Utah, this year during CHEST 2006, October 21-26. Salt Lake City is an extraordinary place in the United States that combines all the action and ambiance of the city with the high adventure and breathtaking scenery of the mountains. Downtown Salt Lake City offers over 100 restaurants, 65 bars, the opera, museums, shopping, and a wealth of other attractions—most within walking distance of the Salt Palace Convention Center, site of CHEST 2006. When you’re ready for outdoor adventure, experience the best—hiking, mountain biking, fishing, and skiing in the Rockies.

It’s easy to get to Salt Lake City and even easier to get around. The airport is a major transportation hub. You’ll be able to walk to many attractions, and the TRAX light-rail service is an easy-to-use option. International travelers may need a visa to enter the US and should contact the US Immigration Department (www.usimmigrationsupport.org) or the US Customs & Border Protection (www.cbp.gov) for details. For more information about Salt Lake City, visit www.visitsaltlake.com.
Treatable Coexisting Rhinitis Is Common in Sleep Apnea

**Intranasal corticosteroid use may result in marked improvement in sleep-disordered breathing.**

**BY BRUCE JANIN
Elsevier Global Medical News**

**KEYSTONE, COLO.** — All patients with obstructive sleep apnea should be evaluated and treated for rhinitis, an extremely common coexisting condition, Dr. Robert Ballard said at a meeting sponsored by the National Jewish Medical and Research Center.

Several recent studies indicate that intranasal corticosteroids, perhaps in combination with an oral leukotriene modifier, result in marked improvement in sleep-disordered breathing in children. Indeed, in many cases the youths are essentially cured of their sleep apnea. Adults seem less responsive but do experience worthwhile partial improvement, according to Dr. Ballard, director of the sleep disorders program at the Denver center.

Epidemiologic studies indicate the vast majority of patients with obstructive sleep apnea (OSA) have symptoms characteristic of rhinitis: nasal dryness, congestion, postnasal drip, runny nose. That has been Dr. Ballard’s clinical experience as well.

As a result, nearly all National Jewish Medical and Research Center patients on nasal continuous positive airway pressure (CPAP) therapy for OSA are on intranasal steroids. It lessens OSA severity, renders the CPAP more tolerable, and improves compliance.

The therapeutic rationale for identifying and treating rhinitis in patients with OSA lies in the notion that the nasal disorder may contribute to the pathophysiology of the sleep disorder. The idea here is that the nasopharynx functions as a Starling resistor. Increased nasal airflow resistance due to rhinitis leads to exaggerated intrapharyngeal pressure during inspiration, which may in turn result in oropharyngeal collapse, much like when one sucks too hard on a straw, Dr. Ballard explained.

There are a couple of published studies demonstrating marked benefit from intranasal steroids in children with OSA, one of which was placebo controlled.

Even more recently, investigators at the University of Louisville (Ky.) reported on 22 children aged 2-10 years with residual mild sleep-disordered breathing at overnight polysomnography 10-14 weeks following tonsillectomy and adenoidectomy performed as treatment for their OSA. The children were placed on the oral leukotriene modifier montelukast plus intranasal beclomethasone for 12 weeks, at which point they underwent overnight polysomnography again. Fourteen other children with residual sleep-disordered breathing after tonsillectomy and adenoidectomy whose physicians elected not to resort to medication served as controls.

The mean baseline postnatal apnea-hypopnea index (AHI) in children in the montelukast/beclomethasone group was 3.9 events per hour. Although that wouldn’t even qualify as mild OSA in adults, in children it does, Dr. Ballard explained. After 12 weeks of montelukast and intranasal beclomethasone, their AHI had dropped to 0.3 per hour, considered normal. In contrast, there was no significant improvement with intranasal steroids alone.

**Risk of Sleep Apnea Is High in Polycystic Ovary Syndrome**

**BY ROBERT FINN
Elsevier Global Medical News**

**SAN FRANCISCO** — A high risk for sleep apnea was common in women with polycystic ovary syndrome and was linked to high fasting insulin levels, Dr. Estra Tasali reported at a conference sponsored by the American Diabetes Association.

Among the women with normal glucose tolerance, insulin levels in response to oral glucose were twice as high in women at high risk for sleep apnea, compared with those at low risk. This finding suggests that sleep apnea might worsen the metabolic consequences of insulin resistance, accelerating the conversion from normal to impaired glucose tolerance, Dr. Tasali said.

Although the study does not establish causation, Dr. Tasali recommended that women with polycystic ovary syndrome (PCOS) be systematically evaluated for sleep apnea, as its treatment might improve glucose metabolism. A high risk for sleep apnea was observed in 30 of 40 women with PCOS, and 92% of the women had sleep problems, according to Dr. Tasali and her colleagues at the University of Chicago (J. Clin. Endocrinol. Metab. 2006;91:46-42).

Of the 40 women, 32 had previously been given an oral glucose tolerance test. Glucose tolerance was normal in 19 women. In 22 women at high sleep apnea risk, average fasting insulin levels were significantly higher (168 pmol/L) than they were in the 10 women at low apnea risk (97 pmol/L). Among the 13 women with impaired glucose tolerance, glucose and insulin levels did not differ depending on the level of apnea risk.

A cohort of eight women with PCOS underwent overnight polysomnography for symptoms suggestive of obstructive sleep apnea. Mean sleep efficiency was 80% in the women with PCOS, compared with 92% in a control group of age-matched, nonobese women. The women with PCOS also had significantly longer mean sleep latency (41 minutes vs. 10 minutes), and significantly shorter total sleep time (323 minutes vs. 442 minutes, a difference of almost 2 hours).

“Sleep apnea might be an intrinsic component of the metabolic disturbances that appear with polycystic ovary syndrome,” Dr. Tasali said.

Furthermore, severity of sleep apnea as measured by the apnea-hypopnea index, and the degree of oxygen desaturations during rapid-eye-movement sleep, accounted for more than 90% of the variability in measures of glucose tolerance including hemoglobin A1c levels.

Together, these findings could mean that both glucose tolerance and sleep apnea are strongly influenced by a common mechanism in women with PCOS.

Dr. Tasali disclosed that she had no conflict of interest related to her presentation.
AMA-Congress Pact Pushes Pay for Performance Ahead

BY JENNIFER LUBELL
Elsevier Global Medical News

S
pecialty organizations are concerned that the Amer-
can Medical Association is unilaterally setting per-
formance goals that doctors won’t be able to meet.
A recent agreement between the AMA and leaders in
Congress outlines an ambitious 2-year time line for
establishing performance measures, “to improve volun-
tary quality reporting to congressional leadership,” AMA
Chair Duane M. Cady said in a statement.
Dr. Cady signed the pact at the end of last year, although
the details weren’t publicly disclosed until several months
later. The terms were outlined in a Feb. 7 memorandum
from AMA Vice President Michael Maves to the state med-
ical associations and national specialty societies.
The agreement was cosigned by Sen. Charles E. Grass-
ley (R-Iowa), chair of the Senate Finance Committee;
Rep. Nathan Deal (R-Ga.), chair of the House Ways and
Means Committee; and Rep. Bill Thomas (R-Calif.), chair
of the House Energy and Commerce subcommittee on
health.
The plan calls for physician groups to work with the
Centers for Medicare and Medicaid Services (CMS) to
agree on a starter set of evidence-based quality measures
for a broad group of specialties, with a goal of develop-
ing approximately 140 physician measures covering
for health.

The alliance is receiving funding from the Agency
for Health Research and Quality and CMS to test
26 measures at six clinical sites, beginning May 1.
Those measures include some developed by the
centrum, among others. The pilot is crucial,
Dr. Nielsen said.
In 2007, doctors who report on three to five
quality measures would see increased payments
from Medicare. By the end of next year, physician
groups should have developed performance mea-

sures “to cover a majority of Medicare spending
for physician services,” the agreement said.
Other initiatives, such as working on methods
to report quality data and implementing addi-
tional reforms to address payment and quality
objectives, also were outlined in the agreement.
Nothing in the agreement with the congressional lead-
ers should be a surprise, Dr. Cady said. “It involved only
[those] commitments we had previously outlined to our
specialty society colleagues.”
Yet some members of the consortium said they had no
advance notice of the AMA’s plans to sign this pact. “Some
groups feel they should have been a part of it,” Cynthia
A. Brown, director of advocacy and health policy at the
American College of Surgeons, said in an interview.
Surgery. “While those concerns are valid, it isn’t going to
come to that.” These groups need to remember that the
AMA’s consortium is run by the specialty societies, a
process that’s consensus based, he said.

At the press briefing, Dr. Nielsen said the initial mea-
sures won’t cover all the specialties, but it was necessary
to show Congress that the profession was serious about
quality improvement, she said.
“There’s an assumption that the AMA will be responsible
for doing all the specialty measures, said Dr. David Nielsen,
executive vice president and chief executive officer of the
American Academy of Otolaryngology-Head and Neck
Surgery. “While those concerns are valid, it isn’t going to
come to that.” These groups need to remember that the
AMA’s consortium is run by the specialty societies, a
process that’s consensus based, he said.

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