AMERICAN THORACIC SOCIETY

ATS NEWS

ONLINE EACH MONTH http://www.thoracic.org/news

IN THIS ISSUE

ON THE ATS web

Clinicians can now download a two-page flyer on lymphangioleiomyomatosis (LAM), the newest addition to the ATS Patient Information Series, in both color and black and white at **www.thoracic.org/sections/education/patient-education/patient-education-materials**. The flyer serves as a resource for pulmonary and critical care physicians in discussing with their patients diagnoses, medical procedures and disease management strategies related to LAM, a rare lung disease that affects women almost exclusively, usually during their childbearing years.

NEW STATEMENT ON HEPATOTOXICITY OF ANTITUBERCULOSIS THERAPY

This month, the ATS published a new statement on the pathogenesis, prevention and treatment of liver damage caused by anti-tuberculosis (TB) medications.

The statement, which appears in the October 15 issue of the *American Journal of Respiratory and Critical Care Medicine*, gives a review of current literature on drug-induced liver injury (DILI) or hepatotoxicity, a potential side effect of more than 700 drugs approved for use in the United States. The document also provides recommendations for minimizing a patient's risk of developing liver damage and identifies directions for future research.

"Hepatotoxicity has been a long-standing and often treatment-limiting concern for physicians caring for patients infected with active and latent TB," said Jussi J. Saukkonen, M.D., who chaired the statement writing committee, which included 12 members of the Assembly on Microbiology, Tuberculosis and Pulmonary Infections. "Historically, TB physicians have accumulated a unique body of experience with DILI caused by a relatively small number of medications, while doctors treating other illnesses have had more isolated and sporadic encounters with only a smattering of hepatotoxic drugs."

The multi-disciplinary writing committee looked carefully at this issue in the new guidelines, which provide clinicians with all of the current evidence-based and clinical information available on identifying risk factors, recognizing symptoms, weighing the benefits with the risks and developing safe treatment programs. "The document also shows that although progress has been made in some areas, we still have much more to learn," Dr. Saukkonen added.

As noted in "Treatment of Tuberculosis," a 2003 statement published by the ATS, Centers for Disease Control and Prevention and Infectious Diseases Society of America, some TB treatment regimens can infrequently cause serious damage to the liver, especially in people who chronically consume alcohol, have preexisting liver disease, are pregnant or who take other hepatotoxic medications.


StopTB Partnership

Unlike the 2003 guidelines, which were much broader in scope, the new statement focuses solely on DILI related to TB medications. "To help clinicians understand and recognize DILI, we documented the metabolism of these drugs, mechanisms of injury and clinical signals," explained writing committee member Charles A. Peloquin, Pharm.D. "The document aims to provide clinicians with the education and resources needed to optimize patient care."

The final document is proof that the committee—which included specialists in TB, pharmacology and hepatology—accomplished this goal by outlining strategies for optimal clinical management.

Questions and Answers

As TB medications were developed and introduced in the U.S. during the 20th century, physicians found reason to be concerned about the hepatotoxicity of several of these agents. Although the benefits of anti-TB medications were increasingly clear, doctors searched for ways to reduce the toxicity of multi-drug regimens used for prolonged treatment courses.

(continue on page 6)

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Boehringer Ingelheim

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MESSAGE FROM THE PRESIDENT

John E. Heffner, M.D.

A fundamental truth about good ideas is that they become even better over time. And such is the case with the American Thoracic Society's Public Advisory Roundtable.

Five years ago, then ATS President William J. Martin II conceived the idea of developing an organization of patient-interest groups that would enrich the Society with patients' perspectives. ATS PAR has now grown to 15 organizations and assumed an expanding role in ATS affairs. This increasing importance demonstrates not only that ATS PAR was a very good idea, but also underscores the strength of its leadership.

Paula Polite, head of the Sarcoidosis Research Institute, was the first Chair of ATS PAR and developed its original charter, which called for a mutually beneficial relationship between patient-interest groups and the Society to promote research, advocacy and patient care. Paula's advocacy skills earned her an invitation to become the inaugural co-chair of the ATS Workforce Congressional Action Team (W-CAT).

ATS PAR leaders like Paula help bring the patient voice to our advocacy efforts and remind Congress that we promote an expanded physician and nurse workforce in order to help patients. Each year, ATS PAR members also accompany members of the ATS Research Advocacy Committee to Washington, D.C. for joint research lobbying. This joint advocacy effort has also been successful in expanding air travel options for patients needing supplemental oxygen.

As the second ATS PAR chair, John Walsh, head of the Alpha-1 Foundation, redefined the meaning of high energy, tireless devotion and organizational commitment. Through John's efforts, it became clear that ATS PAR is one of the most effective consultative resources available to ATS leadership on health policy and research advocacy. John also effectively reminded us that ATS PAR is not a separate organization, but "PAR is us." To distribute ATS PAR resources throughout the Society, its members now serve on multiple committees and task forces.

During the tenure of Judy Simpson, head of the Pulmonary Hypertension Association, as current ATS PAR Chair, the growing success of ATS PAR has required some organizational restructuring to maintain its effectiveness. An ATS PAR Executive Committee is being established to coordinate the activities of the broader ATS PAR membership, which is now called the Council of Public Representatives. The mutual commitment of ATS and PAR is best stated by ATS PAR in the introduction of its policy document:

> "The ATS Public Advisory Roundtable (ATS PAR) is a core component of the American Thoracic Society and a mutually beneficial partnership wherein organizations that represent persons affected by respiratory diseases, sleep-related conditions, or related critical illnesses collaborate with the American Thoracic Society to advance their shared educational, research, patient care, and advocacy goals. ATS PAR bridges the patient's perspective to the Society and provides the Board of Directors with strategic guidance to keep patients and families as a central focus of all ATS activities and programs."

The direct funding of the Society's research grants by ATS PAR members clearly demonstrates this collaboration. As does the annual PAR Symposium at the International Conference, where scientists, clinicians and patients convene to highlight the importance of rapidly finding and translating new scientific discoveries into improved patient care. ATS PAR is now planning a larger event at the conference, which will be open to general members of the public. Moreover, during the last three years, ATS PAR has doubled to 16 the number of sessions at the International Conference that host patient speakers. We can also thank ATS PAR for assisting Mairanna Sockrider, ATS Associate Web Editor for Patient Education, in developing patient education resources posted on our Web site.

ATS PAR continues to grow as an integral component of the ATS. In future issues of the *American Journal of Respiratory and Critical Care Medicine*, we will highlight individual patient-interest groups within ATS PAR. Earlier this year, I appointed Bill Martin to serve as the first liaison between ATS PAR members and ATS leadership to ensure that we continue this productive and creative exchange of ideas.

How best to summarize the contributions of ATS PAR? The introduction of the new ATS PAR Policy and Procedures, I believe, eloquently expresses its role in accomplishing our deeply shared missions:

> "The ATS PAR has created unparalleled synergy with the ATS by involving patients in providing support, shaping policy and stimulating research. Objectives are accomplished through ATS PAR representation on standing ATS Committees and joint programs and activities that will ultimately improve the lives of individuals affected by respiratory diseases, sleep-related conditions, or related critical illnesses."

We thank ATS PAR for this synergy and their contributions to the Society and the patients we serve.

Current ATS PAR Members

1. Judy Simpson, *Pulmonary Hypertension Association, Inc.* (Chair)
2. John W. Walsh, *Alpha-1 Foundation*
3. Karen Fulton, *ALA of the Greater Bay Area*
4. Willard A. Fry, M.D., *ALA of Metro Chicago*
5. Eileen Rubin Zacharias, *ARDS Foundation*
6. Bill McLin, *Asthma and Allergy Foundation of America*
7. Pamela S. DeNardo, *COPD International,COPD Council*
8. Suzanne Pattee, *Cystic Fibrosis Foundation*
9. Donna Appell, *Hermansky-Pudlak Syndrome Network*
10. Laurie Fenton, *The Lung Cancer Alliance*
11. Richard Gelula, *National Sleep Foundation*
12. Paula Y. Polite, previous head of *Sarcoidosis Research Institute*
13. Gregory R. Porta, *Children's Interstitial Lung Disease Foundation, Inc.**
14. Teresa Richardson Geiger, *Coalition for Pulmonary Fibrosis (CPF)**
15. Vicky Holets Whittemore, *Tuberous Sclerosis Alliance**

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* Pending appointment

NEWS BRIEFS

JOIN THE ATS IN SAN FRANCISCO IN 2007

Mark your calendars to attend the 2007 ATS International Conference in San Francisco, **May 18 to May 23, 2007**.

Attendees will be able to choose from among scores of sessions on the diagnosis and treatment of chronic obstructive pulmonary disease, cystic fibrosis, asthma, sarcoidosis, lung cancer and pulmonary hypertension. There will also be sessions on acute respiratory distress syndrome, ventilator-induced lung injury, controversies in critical care, obstructive sleep apnea and night-time hypoxia.

Need another reason to attend? San Francisco is the ideal host city for combining business with pleasure. Famous for its scenic beauty, cultural attractions, diverse communities and world-class cuisine, it is a walkable city dotted with landmarks such as the Golden Gate Bridge, cable cars, Fisherman's Wharf, Alcatraz and the largest Chinatown in the US. For more information about the Conference, visit the ATS website at **www.thoracic.org**.

SUBMIT NOMINATIONS FOR SECRETARY-TREASURER

To submit your nominations for ATS Secretary-Treasurer for 2007 to 2008, please complete the following steps:

1) Get permission from the candidate to submit his/her name. (Self nominations are also encouraged).

2) Write a nominating letter addressing the qualifications and experience of the nominee in terms of leadership style and skills, scientific and clinical reputation, administrative ability, diplomacy and service to the ATS.

3) Obtain the promise of additional letters of support from two ATS members. Attach their names to your letter.

4) Send these materials to the attention of the "ATS Nominating Committee" by fax at (212) 315-8630 or by regular mail at 61 Broadway, 4th Floor, New York , NY 10006.

All nominations must be submitted by Wednesday, **November 15**.

RESEARCH GRANTS FOR STUDENTS, RESIDENTS AND FELLOWS

The American Medical Association (AMA) Foundation is announcing a call for proposals for the **Seed Grant Research Program** for medical students, residents and fellows. Grants of $2,500 will help young physician scientists conduct basic science, applied or clinical research projects. Grants will be awarded in five research categories: Cardiovascular/Pulmonary Diseases, HIV/AIDS, Leukemia, Neoplastic Diseases and Secondhand Smoke. Applications are due by December 1, 2006. Recipients will be announced in March 2007.

RENEW YOUR ATS MEMBERSHIP TODAY

All ATS members will receive a mailed membership renewal invoice this month. To ensure your membership benefits continue uninterrupted into 2007, simply update and return the invoice, or visit the ATS Web site at www.thoracic.org/sections/membership to renew your membership electronically by clicking on the "Pay Your Dues Online" link.

What are the benefits of ATS membership?

- **Subscriptions** to the *American Journal of Respiratory and Critical Care Medicine*, the *American Journal of Respiratory Cell and Molecular Biology* and *Proceedings of the American Thoracic Society*. Standard dues-paying Full Members receive both online and print subscriptions to all current issues of the three journals. Reduced Dues Program Full Members and Guest Subscription Program participants receive online subscriptions only. Affiliate members may subscribe to the journals at a reduced rate.

- Membership in interest-specific **assemblies and sections**. ATS assemblies produce globally recognized position statements, state-of-the- art clinical standards and guidelines, professional education workshops and other special projects. Assemblies offer ATS members unique opportunities to share work, exchange ideas, pool resources and ultimately advance respiratory, sleep and critical care medicine.

- Recognized as an accredited provider of **continuing medical education** (CME) by the Accreditation Council for Continuing Medical Education, the ATS meets the highest standards in medical education and provides a variety of opportunities to its members in a number of teaching modalities. These include events like the annual International Conference and State of the Art Course, monographs, audiocassettes, CDs and online learning.

- **Advocacy** for National Institutes of Health and Veterans Administration research funding; patient rights; global disease prevention; Medicare reimbursement and a variety of other issues affecting physicians, scientists, patients and others in the pulmonary, critical care and sleep communities.

- Viewed by physicians, scientists, nurses and other healthcare professionals as the largest global exchange of the latest discoveries and standards of care in respiratory, critical care and sleep medicine, the **ATS International Conference** is one of the Society's most important undertakings. ATS members pay significantly discounted registration fees and are given the first opportunity to participate by submitting abstracts, working through assemblies on programming and attending the many sessions, symposia, postgraduate courses and workshops.

For more information about membership or billing, contact us at membership@thoracic.org or +1 (212) 315-8685.

ATS membership categories and standard dues* are as follows:

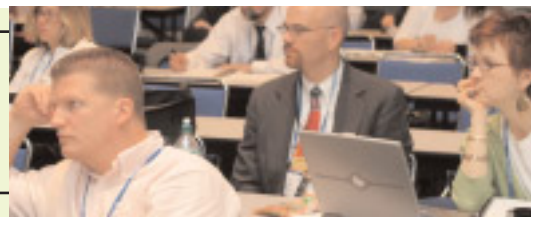
- Full Member (Doctoral): $350 (with a doctoral degree or equivalent)
- Full Member (Non-doctoral): $250 (with a graduate degree and three years' professional experience)
- In-Training Member: $75 (Open to graduate students, medical students, interns, residents and fellows during their formal, documented periods of training)
- In-Transition Member: $150 for year 1 and $250 for year 2 (During these two years, In-Transition Members will have all the privileges of Full Members)
- Affiliate Member: $130 (Must have a demonstrated interest in the activities of the ATS, but not qualify for membership in the Society in any of the Full or In-Training membership categories)
- Senior Member: $100 (Full Members who attest that they are fully retired, or that they have an income-limiting permanent disability)
- Emeritus Member: $0 (Full Members who are professionally active and reach the age of 75 may apply for the status of emeritus membership. Emeritus Members shall have all the privileges of Full Members)

*Full Members residing in countries with annual Gross National Income (GNI) per capita of $7,500 or less as reported by the World Bank or in countries designated by the World Health Organization (WHO) as being high-TB burdened, may participate in the ATS Reduced Dues Program (RDP), the ATS-ALAT Membership Program, or the ATS Guest Subscription Program (GSP) accordingly:

- **RDP Level A**: Full Members in countries with annual GNI per capita of $3,000 or less and in high-TB burdened countries are eligible to pay ATS reduced dues of $75. RDP Level A members have all the benefits of Full Members with online-only access to the ATS journals.
- **RDP Level B**: Full Members in countries with annual GNI per capita between $3,001 and $7,500 and in high-TB burdened countries are eligible to pay ATS reduced member dues of $175. RDP Level B members have all the rights and privileges of Full Members with online-only access to the ATS journals.
- **ATS-ALAT Membership Program**: Members of the Asociación Latinoamericana del Tórax (ALAT) who reside in Central and South America and the Caribbean are eligible to become ATS members at no charge for the first year, and with minimal incremental charges in subsequent years. ATS-ALAT members have all the benefits of Full Members with online-only access to the ATS journals.
- **GSP Individual or Institutional**: Individuals and institutions in countries with annual GNI per capita of $3,000 or less and in high-TB burdened countries may apply for complimentary online access to the ATS journals. Participants do not receive any of the other benefits of membership.

To learn more about the benefits and eligibility criteria of these programs, please visit www.thoracic.org and click on International Low Cost Options in the Membership area or e-mail membership@thoracic.org.

COPD AND TRANSPLANTATION AMONG ATS 2007 POSTGRADUATE COURSES



The ATS has planned an exciting and informative program for the 2007 International Conference, which will be held May 18 to 23 in San Francisco.

Over 200 symposia, track sessions, seminars and workshops are being developed and speakers secured. In addition to these clinical and scientific sessions, the ATS is sponsoring 26 postgraduate courses on **Friday and Saturday (May 18 and 19)** before the official start of the Conference. The 2007 postgraduate courses being offered are:

FRIDAY, MAY 18

PG1 - Tools of the Trade for Translational Research
PG2 - Practical Chest Imaging for the Pulmonologist
PG3 - COPD: Update for the Clinician and Researcher
PG4 - Diagnostic and Management Dilemmas in Diffuse Interstitial Lung Disease
PG5 - Point of Care Ultrasonography for the Intensivists
PG6 - Current Methods for the Respiratory and Environmental Researcher: A Toolkit for Clinical Investigation
PG7 - Pulmonary Rehabilitation and the Flight of the Bumblebee – "Refining the Process and Expanding the Scope"
PG8 - Lung Function Testing in Young Children: Clinical and Research Applications
PG9 - Pulmonary Embolism Diagnosis and Treatment: State-of-the-Art 2007
PG10 Grant Fundamentals
PG11 - Non-Pulmonary Sleep Medicine for the Pulmonary Physician
PG12 - Essential Respiratory Physiology During Mechanical Ventilation
PG13 - Correct CPT Coding, Billing and Documentation for Pulmonary, Critical Care and Sleep Medicine

SATURDAY, MAY 19

PG14 - Therapeutic Targets of Airway Inflammation
PG15 - Advances in Pharmacogenetics
PG16 - Scientific Writing: How to Publish for Academic Success
PG17 - Interventional Pulmonology with Practical Demonstration: Something for Every Pulmonologist
PG18 - Current Concepts in Lung Transplantation
PG19 - Clinical Controversies: A Physiological Approach to Patient Care
PG20 - Critical Care Nephrology for the Intensivist: Fluid Management, Acid-Base and Electrolytes, Renal Failure and Renal Replacement Therapy
PG21 - Critical Care Review: Built Around ABIM CCM Module
PG22 - Lung Innate Immunity: The Frontlines of Host Defense
PG23 - New Insights Into the Pathophysiology and Consequences of Obstructive Sleep Apnea in Children
PG24 - How to Manage Patients with Pulmonary Hypertension: A Course for Clinicians and Scientists
PG25 - Lung Cancer: From Cell to Cure
PG26 - Clinical Applications of Classical Physiology in Pulmonary Function Testing

For more information on each of these courses, visit the ATS Web site at www.thoracic.org/go/pg-courses.

Registration forms for the ATS Conference and these postgraduate courses will be available in **January 2007** in the Advance Program and online at www.thoracic.org.

Postgraduate courses require an additional registration fee and seating is limited, so plan to register early to ensure attendance at the postgraduate course of your choice.

WHO'S WHO at ATS

POLLY E. PARSONS
DIRT ROADS, CITY MEDICINE

To Polly E. Parsons, M.D., practicing medicine means balancing administration, program development, clinical work, research, teaching and family.

As Director of Pulmonary and Critical Care Medicine at the University of Vermont (UVM), Dr. Parsons oversees 15 faculty members, attends in the MICU and heads critical care services at the University's hospital, Fletcher Allen Health Care. Since July 2005, she has also served as the Interim Chair of the Department of Medicine.

"My job really gives me the best of all worlds," she said. "The medical school and hospital have everything you would expect to find in a city environment in terms of grant funding, research, clinical expertise and spectrum of disease states. That means that I work at an academic tertiary care medical center, but get to live in the country on a dirt road."

A native of Vermont, Dr. Parsons has spent the last six years building UVM's pulmonary and critical care program, which has doubled in size under her leadership. "When I moved back to Vermont, I never set out to build a large division, but we were incredibly fortunate to have an excellent existing core faculty and attract amazing candidates."

Not only has the number of faculty increased, she added, but the key components of the division's mission—clinical care, research and education—have also grown dramatically.

To date, Dr. Parsons has published more than 100 articles, editorials and reviews on the pathogenesis of acute lung injury and acute respiratory distress syndrome (ARDS). Despite her multiple administrative roles, she has continued to be actively involved in research, most recently as a member of the ARDS Clinical Trials Network

From Bioresearch to Pulmonary and Critical Care

After earning her medical degree from the University of Arizona in 1978, Dr. Parsons completed an internship and residency in internal medicine at the University of Colorado Medical Center. The "exceptionally strong" program there sparked her interest in respiratory medicine as a subspecialty. "Every time I needed help, I called a pulmonary fellow," she explained. "It was a very collegial group that was very excited about what was going on in the field."

Dr. Parsons found this enthusiasm contagious. In 1981, to gain more experience, she began a research fellowship at National Jewish Hospital and Research Center. She credits mentors Tom Hyers, M.D., and Peter Henson, Ph.D., with introducing her to basic science research and the links between biomarkers and acute lung injury.

"That year of research was an invaluable experience that really kick-started my career as a bioresearcher and cemented my decision to become a pulmonologist," she said.

A year later, Dr. Parsons continued her fellowship training in pulmonary medicine at the University of Colorado Health Sciences Center (UCHSC). She joined the faculty in 1985 and, over the next 15 years, focused her research on NIH-funded translational studies in the pathogenesis of acute lung injury.

"When I was starting out, there was a lot of basic science research in inflammation and ARDS, but the translational piece wasn't there yet," she said. "The recognition of the importance of patient heterogeneity and the advancement in the clinical care of the patients have changed the face of the field, but there is still a lot of room to redefine our understanding of the pathogenesis of the syndrome and develop targeted interventions."

"I am amazed by the variety pulmonary and critical care medicine offers."

Coming Home

In 2000, Dr. Parsons, then Professor of Medicine at the UCHSC, was invited to become a Visiting Professor at the University of Vermont. When colleagues there suggested she consider joining the UVM faculty fulltime, she wasn't even thinking of leaving Colorado. "However, since the program had so many terrific people, and I had family ties in the area, it was hard to say no," she said.

Six years later, as Director of Pulmonary and Critical Care Medicine, Chief of Critical Care Services and Interim Chair of the Department of Medicine, Dr. Parsons says things undoubtedly "worked out for the best."

"I am still amazed by the variety that pulmonary and critical care medicine offers," she said. "That's the best part of the field—you can go back and forth between teaching, patient care, research and administration with relative ease."

Until last year, Dr. Parsons directed UVM's Pulmonary and Critical Care Medicine Fellowship Training Program. "Because of the enormous challenges students face today in terms of debt-burden, funding shortages and lifestyle issues, mentoring is now more important than ever," she said.

ATS Involvement

Since joining the ATS in 1989, Dr. Parsons has been a member Membership Committee and the Assembly on Critical Care's Nominating and Planning Committees. She currently chairs the Training Committee and serves on the Clinicians' Advisory Committee and Task Force on Critical Care Medicine.

As Chair of the Training Committee, Dr. Parsons addresses some of the "greatest obstacles" to young people, particularly women, who are now entering the field. The ATS recognized her efforts in this area by awarding her the Elizabeth A. Rich Award at the 2006 International Conference in San Diego.

On a Personal Note

Dr. Parsons lives in Williston, Vermont with her husband, Jim Jacobson M.D., a psychiatrist at UVM, and their sons, Alec and Chandler. In their free time, they enjoy traveling, biking, swimming, skiing, hiking and reading.

NEWS BRIEFS

NEW TRAVEL REQUIREMENTS: ATS 2008 TORONTO, MAY 16-21

New travel regulations to be implemented early next year will require all individuals planning on attending the 2008 ATS International Conference in Toronto, Canada, to present a valid passport to enter the country (and to re-enter the United States).

As of January 8, 2007, all passengers, including U.S. citizens, traveling by air or sea to and from Canada, Mexico, Central or South America, the Caribbean and Bermuda must have a passport. This is a change from prior travel requirements, which allowed travelers to cross these borders with only a driver's license or a birth certificate.

For more information on the new requirements and instructions on how to apply for or renew a U.S. passport, visit http://travel.state.gov/.

NSF ANNOUNCES PICKWICK POSTDOCTORAL FELLOWSHIP

The National Sleep Foundation (NSF) is now offering the Pickwick Postdoctoral Fellowship to persons interested in pursuing basic, clinical and applied sleep research.

Pickwick Postdoctoral Fellows receive funding based on National Institute of Health guidelines from $36,996 to $45,048, plus a benefits allowance for two years, with the second year being contingent upon satisfactory progress.

The application deadline is December 1, 2006. Applicants may be non-U.S. citizens, but to qualify, research must be conducted under the tutelage of a sleep mentor at an established American or Canadian laboratory.

For more information, visit www.sleepfoundation.org/pickwick or contact Maria Butler at (202) 347-3471 or mbutler@sleepfoundation.org.

SAVE THE DATE: SOTA 2007

Mark your calendars: The 12th annual ATS State of the Art Course in pulmonary and critical care medicine will be held at the Westin Copley Place in Boston, **Thursday, March 1**, to **Sunday, March 4**, 2007.

Course directors Drs. Jesse Hall and Gregory Schmidt once again expect to provide more than 25 lectures and seven "Meet the Professor" sessions over three-and-a-half days. For more information, please contact Miriam Rodriguez, Manager of ATS Education and Training Programs, at mrodriguez@thoracic.org or (212) 315-8639.

the ADVOCATE

TIME IS RUNNING OUT ON MEDICARE PHYSICIAN PAYMENT FIX

ATS URGES IMMEDIATE CONGRESSIONAL ACTION

Last month, Congress returned to work after its summer recess with a long list of important legislative issues and limited time to address them.

The physician community's top priority in September was for Congress to pass legislation averting the 5.1 percent cut in Medicare physician reimbursement scheduled to begin January 1, 2007. Unless Congress acts, the medical community anticipates these cuts will steadily decrease Medicare payments by nearly 40 percent over the next nine years.

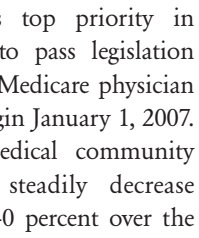
The U.S. House of Representatives and Senate are well aware of the impending problem. To date, 80 senators and more than 200 representatives have signed letters urging Congressional leadership to act immediately to stop the cuts. However, such efforts will be hindered by time limitations, the several billion dollar cost of preventing the cuts, partisan positioning and the upcoming Congressional elections in November.

In a recent letter to Congress, ATS President John E. Heffner M.D., urged legislators to take decisive action against the "draconian cuts" before the October recess. The ATS Washington Office is working closely with the American Medical Association and other organizations to pressure Congress to pass such legislation.

CLEAN AIR

ATS Comments on EPA Ozone Standard

In August, ATS Environmental Health Policy Committee member Kent E. Pinkerton, Ph.D., appeared before the Environmental Protection Agency (EPA) Clean Air Scientific Advisory Committee (CASAC) to present the Society's views on the need for stricter standards on ozone exposure.



Kent E. Pinkerton, PhD

The EPA is reviewing its current standards to ensure public health is adequately protected. As part of this process, the CASAC held a hearing to collect public input. By court order, the EPA must issue a proposed rule by March 2007.

In his comments, Dr. Pinkerton outlined the growing body of scientific evidence that even ozone exposure below the current EPA standards can cause adverse health effects. He also noted that the EPA review process does not adequately consider how ozone affects inner-city children. Based on the weight of the available evidence, it is the ATS's position that the EPA needs to issue a stricter standard for ozone exposure.

TOBACCO

District Judge Rules Against Tobacco Industry

In August, U.S. District Court Judge Gladys Kessler ruled against the tobacco industry in a civil racketeering suit. The ruling, brought under the Racketeering Influenced and Corrupt Organizations (RICO) statute, marks the first time that the courts have issued broad injunctive relief against the tobacco industry.

After hearing the evidence, she found that the Department of Justice had overwhelming proven that the tobacco industry had engaged in a decades long campaign of deceptive practices to sell tobacco products, including hiding the known health effects of tobacco from the public; deliberately manipulating nicotine content to enhance the addictive powers of tobacco products; and intentionally marketed tobacco products to children.

In the ruling, the judge outlined a series of "corrective measures" to prevent the tobacco industry from engaging in future fraudulent behavior, including:

- Banning the use of "light," "mild," "low-tar," "natural" and any other term that implies a health claim
- Place "corrective statements" in major media
- Publicly disclose tobacco industry documents
- Publicly release marketing data for the next 10 years

When the case was initiated under the Clinton administration, the Department of Justice had sought $280 billion in disgorgement of illegal profits from the tobacco industry. Under the Bush administration, the U.S. Department of Justice significantly scaled back the monetary damages to $14 billion to fund tobacco cessation and education campaigns. A previous appellate court decision prohibited Judge Kessler from issuing other corrective actions, such as financial fines.

Earlier this year, the ATS joined other medical organizations in filing an "amicus curiae" or friend of the court brief that detailed a range of corrective options Judge Kessler could implement in constructing her decision.

The tobacco industry has already filed motion requesting that the ban of deceptive practices only apply to the United States, an indication that it plans to continue these marketing techniques overseas.

Nicotine Levels in Cigarettes on the Rise

In related news, the Massachusetts Department of Public Health released a study showing that nicotine levels in most cigarettes have increased around 10 percent from 1998 to 2004.

ATS Joins Amicus Brief in Tobacco Case

The ATS joined several other health groups in filing an amicus brief in the Supreme Court case *Philip Morris USA Inc. v. Williams*.

When smoker Jessie Williams died of lung cancer in the late 1990s, his family sued Philip Morris. An Oregon court awarded the plaintiff $821,000 in compensatory damages and $79.5 million in punitive damages.

Philip Morris is asking the Supreme Court to overturn the punitive award, claiming that it is excessive and, therefore, unconstitutional and in violation of the company's right to due process.

Generally, U.S. courts base such decisions on the degree of reprehensibility of the defendant's misconduct. In previous cases, the Supreme Court affirmed that "reprehensibility" is the most important factor, but also stated that "in practice, few awards exceeding a single-digit ratio between punitive and compensatory damages, to a significant degree, will satisfy due process."

The ATS and others in the health community believe the punitive award is justified because Philip Morris engaged in uniquely egregious wrongful behavior and caused an extraordinary amount of harm. The amicus brief recounts the history of how the company's actions adversely affected public health.

The Advocate has been prepared by the ATS Washington Office to educate and update ATS members on pertinent legislative and regulatory issues. The ATS Washington Office is the hub of a nationwide Legislative Network that enables state and local ATS and ALA volunteers, members and staff to participate in grass roots advocacy or public policy initiatives. The Washington Office maintains an advocacy Web site at www.thoracic.org/advocacy and can be contacted at (202) 785-3355.

ATS PUBLISHES STATEMENT ON HEPATOTOXICITY OF ANTITUBERCULOSIS THERAPY

(continued from page 1)

"In some instances, lower doses reduced the toxicity of these drugs," said Dr. Saukkonen. "Physicians also learned that some individuals may be predisposed to TB DILI and that other medical illnesses or social habits like alcoholism and drug use could confound the issue."

Although clinicians have found combining patient education with clinical and biochemical monitoring to be effective in reducing the risk of developing hepatotoxicity, some questions remain about predisposing factors, the mechanisms of TB DILI, the toxicity of specific regimens—such as the combination of the drugs rifampin (RIF) and pyrazinamide (PZA) in treating latent TB infection—and the influence of preexisting liver diseases like viral hepatitis.

These questions are compounded by the fact that the incidence of DILI from non-tuberculous medications is on the rise. In recent years, it has become so prevalent that it has replaced viral hepatitis as the most apparent cause of liver failure.

At the same time, however, the safety of taking isoniazid (INH) for latent TB infection (LTBI) has improved, in part due to advances in practice and experience. Likewise, a series of recent studies have further advanced the field by identifying the hepatotoxicity of RIF and PZA for LTBI.

"The statement answers questions that were not addressed in the 2003 guidelines, provides significant updates and fleshes out some areas that were touched on briefly in the past," said Dr. Saukkonen. "The benefits of treating TB are unequivocal. Ultimately, the goal is to make TB treatment even safer by developing guidelines and standardized methods for limiting toxicity."

"While we pursue the objective of shorter TB treatments, we should be cognisant of the lessons of the past."

Most notably, it confirms that while treatment of LTBI with INH or RIF is generally safe, DILI "may occur with all currently recommended regimens for treating TB."

"Each TB medication has its own risk for toxicity, but despite these risks, combining up to four drugs significantly shortens the treatment period for active TB," said Dr. Peloquin. "The ultimate goal is to cure active TB cases and prevent latent TB from becoming active, all the while minimizing the risks for individual patients."

When physicians detect hepatotoxicity, the statement recommends TB therapy be interrupted, modified or stopped, depending on the severity of hepatotoxicity, the patient's co-morbidities and response to treatment. Although some individuals may resume treatment—perhaps with a different regimen—the risk of reintroducing specific drugs may in some instances be "hazardous" and "should be considered relative to potential benefit."

Readers should keep in mind, however, that the statement makes an important distinction between active and latent TB, added Timothy R. Sterling, M.D. "For patients with active disease, which can be fatal if untreated, the benefits of anti-TB medications outweigh the risks," he said. "The risk of disease and TB-associated mortality is much lower in persons with latent infection, however, so the toxicity risk that's considered acceptable is much lower."

The U.S. and Beyond

Although the writing committee was entirely U.S.-based, the new document reflects current national and international literature on the topic.

The writing committee first met at a multidisciplinary symposium in November 2002 to determine the breadth of the new statement through open discussions. This information was then supplemented by an extensive literature review. "We tried to be as comprehensive as possible," said Dr. Peloquin.

At the same time, it is important to note that the new guidelines "can only summarize what's known about the risk of hepatotoxicity in anti-TB therapy" and provide suggestions for minimizing the risk of developing it, added Dr. Sterling.

"Because of differences in patient populations, definitions and monitoring practices, our knowledge is still incomplete," he said. "To better understand mechanisms and factors of DILI, more research must be done."

"While we aggressively pursue the objective of shorter TB treatments with new agents and drug combinations, we should be cognizant of the lessons of the past," said Dr. Saukkonen. "This means finding new drugs that are even safer than those we are currently using and testing them carefully in a variety of patient populations."

Areas in need of further investigation include the role of genetic influences, optimal monitoring strategies and newer, less toxic regimens. The writing committee members believe a large, controlled study on the hepatotoxicity of anti-TB medications could provide answers to the many lingering questions about DILI. To read the document in full, visit the ATS Web site at **www.thoracic.org/sections/publications**.

CONFERENCES, COURSES AND MEETINGS

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

DATE & PLACE	TITLE	CONTACT
Oct 31 to Nov 4 Paris, France	**"37th Union World Conference on Lung Health Update," sponsored by the International Union Against Tuberculosis and Lung Disease"**	**E: paris2006@iuatld.org www.worldlunghealth.org**
Nov 13 to 14 Bethesda, Maryland	**"Fourth Symposium on the Functional Genomics of Critical Illness and Injury: Surviving Stress," sponsored by the National Institutes of Health**	**Phone: (410) 377-0110 E: Anne@strategicresults.com www.strategicresults.com/fg4/**
Nov 16 to 17 Brussels, Belguim	"Run of Echocardiographie-Doppler in Intensive Care and Reanimation," sponsored by Erasme University Hospital	Phone: +32 2 555 36 31 E: sympicu@ulb.ac.be www.intensive.org
Nov 19 to 22 Kyoto, Japan	**"11th Congress of the Asian Pacific Society of Respiratory (APSR)"**	**Phone: + 8175 751 3832 E: apsr2006@kuhp.kyoto-u.ac.jp| www.apsr2006.org**
Nov 30 to Dec 2 Sydney, Australia	"Asia-Pacific Interventional Advances Conference (APIA)," sponsored by the Society for Cardiovascular Angiography and Interventions	E: info@apia.org.au www.apia.org.au
Dec 5 to 7 Brussels, Belgium	"12th Postgraduate Refresher Course," sponsored by Erasme University Hospital	Phone: +32 2 555 36 31 E: sympicu@ulb.ac.be www.intensive.org
Jan 21 to 24, 2007 Maui, Hawaii	**"Hawaii Thoracic Society Seventh Annual Symposium"**	**Phone: (808) 537-5966, ext. 312 E: healthed@ala-hawaii.org www.ala-hawaii.org/2007-symposium.asp**
Feb 2 to 3, 2007 Carmel, California	**"Current Controversies in Pulmonary and Critical Care Medicine," sponsored by the California Thoracic Society**	**Phone: (714) 730-1944 E: ctslung@aol.com www.thoracic.org/ca.html**
Mar 1 to 4, 2007 Boston, Massachusetts	**"The ATS State of the Art Course in Pulmonary Medicine and Critical Care"**	**Miriam Rodriguez Phone: (212) 315-8639 E: mrodriguez@thoracic.org www.thoracic.org**

Slurping Around with P.D.W.

In this column, ATS Immediate Past-President Peter D. Wagner, M.D., reports on his search for a great bottle of wine at a reasonable price.

WHITE

Concannon 2004 Chardonnay "Central Coast" $6. This wine is very enjoyable and easy to drink. Flavors of lime and stone fruit, good acidity and restrained oak give this a clean crispness that is very attractive. While not very complex, it is a great value.

RED

Here is my first annual Yellowtail red wines issue, the 2005 vintage. All are available at Trader Joes for $5 each; some can be found elsewhere. All are made in a similar style— straightforward, simple, lots of fruit, good acid, not too tannic or oaky, but clearly not meant for aging. All are drinkable, but I thought some much better than others.

The best was the Shiraz 60%/Cabernet 40%. Deep garnet, needs to air to swirl off touch of sulfur, but lovely dark berry fruit improves over 30 minutes in the glass. Fruit has richness, while acid, oak, tannin are all light and in balance. Highly recommended. Next was Cabernet 70%/Merlot 30%. Very similar to the above at first, but after about 30 minutes, the fruit started to subside a bit. Still a nice wine and good value. Third was the Shiraz 100%. A bit briary and stemmy with slightly higher acid, and less rich, but worth the price. Fourth was Merlot 100%, which had some sulfur and was very generic with floral/grapey fruit. Given the above choices, I would not buy it again. Fifth was the Cabernet 100% that was again very generic and smelled and tasted of sulfur that persisted.