S P R I N G  2 0 0 7

The Spirogram

Spring is here at last!

Now is the time that one’s nose and lungs turn to spring cleaning, pollen and the start of allergy season. So what’s causing the problem?

The plants all around us are producing pollen – tiny grains that are used by the plant to reproduce - but sometimes people get in the way. Most of the pollens that cause allergic reactions are produced by grasses, trees and weeds. These plants produce pollen that gets carried in the wind. Each plant can produce millions of grains of pollen a day and these grains may be carried for miles. People then breathe in the air containing these grains of pollen. When these grains get trapped in the nose or throats of people with allergies, they trigger sneezing, itchy eyes and coughing. They will also lead to symptoms of asthma with coughing, wheezing, chest tightness and shortness of breath.

Different people are allergic to different plants. They get symptoms when plants to which they are allergic start producing pollen. This will be at the same time for a particular plant each year. As different plants produce pollen at different times, people may have slightly different allergy seasons, depending on to what they are allergic. Allergy season will also vary in different parts of the country. In Vermont our allergy season typically starts in May. Further south, in Florida for example, allergy season may start in late January.

You may hear the pollen report on the local news. This is a measure of how many grains of pollen are in the air. Pollen counts are often highest early in the morning on warm, dry, breezy days and lower when it is wet and chilly.

So let’s finish with a few lung health tips:

◊ If you allergies are bad, stay indoors and run the air conditioner even on mild days to keep the pollen down.

◊ Avoid outdoor activities at peak pollen times—generally late afternoon.

◊ Take a shower after spending time outside to wash off the pollen.

We hope you have a lung healthy spring!

- Anne E. Dixon, MD -
IDIOPATHIC PULMONARY FIBROSIS: What’s New in Diagnosis and Treatment

Idiopathic pulmonary fibrosis (IPF) is a chronic disease of the lungs (pulmonary) that results in slowly progressive scarring (fibrosis), and the cause is not known (idiopathic). IPF typically strikes patients who are older than 50 years of age. In the United States the rate of new cases (incidence) is about 50 – 100 new patients per year for every million people.

The symptoms of IPF at the onset are usually mild shortness of breath with exertion such as hurrying on the level or carrying packages. Most patients experience a dry cough without producing any sputum. The average time of survival from the time a physician makes the diagnosis of IPF is quite variable, but half will have died within 3 – 5 years; some patients survive for decades while others deteriorate quite rapidly.

A confident diagnosis of IPF can be made in most patients based on their physical signs and symptoms, their pulmonary function test results, and the pattern of lung disease seen on a high-resolution computed tomography (CT) scan. Known environmental causes of lung scarring (such as heavy exposure to asbestos) and other diseases associated with lung scarring (such as rheumatoid arthritis) must be excluded. For some patients, a surgical lung biopsy is needed to make a diagnosis, particularly those with early or mild disease. The lung tissue reveals characteristic features with patchy areas of scarring near the edges of the lungs.

There is no known clearly effective treatment for IPF, and good therapy is needed badly. Supportive care with oxygen, exercise, cough suppressants, and similar measures is often helpful in relieving symptoms but does not reverse the scarring process. Well-designed clinical trials are needed to determine whether treatments for IPF are beneficial, and these trials should involve large numbers of patients at many research centers. Treatments should be compared without the patients or the doctors knowing exactly which drugs they are receiving: randomized placebo-controlled double-blind multi-center trials.

The therapy that is usually recommended for IPF involves low-to-moderate doses of cortisone-like medications (steroids) such as azathioprine (Imuran®) or cyclophosphamide (Cytoxan®). Although used for decades, this treatment has not been truly tested in rigorous clinical trials. One such trial is just beginning under the sponsorship of the National Institutes of Health. A recent report from Europe suggests that the addition of an anti-oxidant amino acid, N-acetyl cysteine (NAC) to this therapy may improve its effectiveness.

Two new drugs to treat IPF are being tested at the Vermont Lung Center as part of multi-center trials. Both drugs are tablets taken by mouth, and both have shown some favorable results in smaller preliminary studies. The CAPACITY trial tests the effectiveness of pirfenidone, while the BUILD-3 trial tests bosentan. Both trials are currently available for enrollment for patients with proven IPF. There is great hope that new treatments and combinations of drugs will offer real improvement for patients with this serious and usually progressive lung disease.

- Gerald S. Davis, MD -

Ask Dr. Charlie

Does the quality of the indoor environment affect my asthma?
Yes, it does. We know that cigarette smoke, even if the patient wasn’t the smoker, can cause asthma. Indoor air contains a wealth of asthma triggers including pet dander, insects, cooking gas and mold just to name a few. These triggers cause asthma attacks if not kept under control.

Does the outdoor environment affect asthma?
It is unclear how important the environment outdoors is to asthma because it has been difficult to prove that any of the common pollutants do much. However, small particles and diesel exhaust have been shown to be associated with asthma in children and, of course, pollen is a big problem. Thus is why it is always better to breathe clean air.

- Charles G. Irvin, PhD -
ASTHMA

The Study of Acid Reflux in Asthma (SARA)
Primary Investigator: Charles Irvin, Ph.D.; Director, Vermont Lung Center
Coordinator: Stephanie Burns

Gastroesophageal Reflux Disease (GERD) is frequent in people with asthma who have poor asthma control. GERD can occur without symptoms, and may be why some asthmatics cannot control their asthma despite being on a controller medication. Nexium® (the purple pill on TV) is a proton pump inhibitor that reduces the amount of acid in the stomach, which is what causes GERD. This trial is looking at whether giving Nexium® to patients who have poor asthma control despite being on inhaled corticosteroids (controller medication) will help improve their asthma.

Minimum Qualifications: Age 18 years or older with a diagnosis of asthma; On daily inhaled asthma medication

The Study of Acid Reflux in Children with Asthma (SARCA)
Primary Investigator: Charles Irvin, Ph.D.; Director, Vermont Lung Center
Coordinator: Stephanie Burns

The purpose of this study is to see if adding a drug (lansoprazole) that decreases the amount of stomach acid will help children with asthma.

Minimum Qualifications: Age 6 to 17 years of age with a diagnosis of asthma; On daily inhaled steroid medication

Weight Loss and Asthma
Primary Investigator: Anne Dixon, M.D.; Director, Clinical Research
Coordinator: Lorraine Bourassa, R.N.

This study is being done to assess the effect of weight reduction on markers of inflammation, lung function and asthma symptoms following gastric bypass surgery. We are trying to understand why some overweight people have asthma, whereas other people do not. Study involvement lasts approximately 1 year.

Minimum Qualifications: Age 18 years or older with a diagnosis of asthma; Morbidly Obese; Planned bariatric surgery; No smoking in the last 6 months

Study of the Impact of Body Mass Index on Asthma (SIBA)
Primary Investigator: Anne Dixon, M.D.; Director, Clinical Research
Coordinator: Lorraine Bourassa, R.N.

This is a 1 to 2 visit study looking at obesity which has been identified as a major risk factor for asthma, especially in adult women. We want to understand why some women develop asthma when they are obese but others do not, and if this is related to inflammation originating in adipose cells.

Minimum Qualifications: Female between ages of 18 to 45; Body Mass Index between 35 to 45; No smoking within the last 6 months

The Effect of CPAP on Asthma Control
Primary Investigator: Laeeq Shamsuddin, M.D.; Anne Dixon, M.D.; Director, Clinical Research
Coordinator: Lorraine Bourassa R.N.

This study involves 4 visits, 2 prior to CPAP treatment and 2 visits after receiving 4 weeks of CPAP treatment. We are evaluating whether treatment of a person’s sleep apnea will help their asthma.

Minimum Qualifications: Diagnosis of asthma; Symptoms of obstructive sleep apnea; Sleep study scheduled

Asthma Exacerbations: Physiology, Upper Airway and Fibrin
Principal Investigator: Charles G. Irvin, Ph.D.; Director, Vermont Lung Center
Coordinator: Sherburn Lang

This National Institutes of Health (NIH) funded study is looking at possible mechanisms that may cause a worsening of your asthma (asthma exacerbations). The recruiting for this study is done in the Emergency Department when patients are seen for an asthma exacerbation. For those who are eligible and choose to participate, we perform some non-invasive testing of their breathing and ask a few questions. Once they are stabilized we repeat that testing, as well as obtaining a blood and sputum sample and having a CT scan done. We then have them come back in 2 weeks once their asthma has stabilized for repeated testing.

We are also comparing the patients to normal controls and stable asthmatics. This is done by age, sex, and race matching. If you are interested in participating, please forward your information.

Forced Oscillation Mechanics in Mild Asthmatics
Primary Investigator: Lennart K.A. Lundblad, Ph.D.
Coordinator: Sherburn Lang

This research study is designed to look at the lung mechanics in people with and without asthma using a method known as the Forced Oscillation Technique (FOT). During the FOT test, a flow signal oscillation is delivered (“forced”) into the airways via a mouthpiece. You will feel this as gentle puffs of air similar to breathing in front of a desk fan. We will compare how your posture (sitting or lying down) affects the results of these tests, as well as comparing two different machines that are commercially available.

This study involves 2 study visits, each of which lasts approximately 2.5 hours. For some asthmatics, we may conduct a third test to determine the severity of your asthma using more sensitive breathing tests.

Circulating CD34 Progenitor Cells in Asthma and Emphysema
Primary Investigator: Daniel Weiss, M.D.
Coordinator: Stephanie Burns

A scientific research study to help determine if adult stem cells are involved in either asthma or emphysema. If so, this would provide a basis for utilizing adult stem cells for regenerating normal lung and be a new potential therapeutic approach for either asthma or emphysema. We are looking for participants who have either asthma or emphysema or you who serve as an age and sex matched normal control for a patient with severe asthma or emphysema. This study involves 1 study visit which consists of a blood drawing.

COPD/EMPHYSEMA

Circulating CD34 Progenitor Cells in Asthma and Emphysema
Primary Investigator: Daniel Weiss, M.D.
Coordinator: Stephanie Burns

[See description above]

CYSTIC FIBROSIS

Comparison of Standard Tobramycin Inhalation Solution to the new Experimental Tobramycin Inhalation Powder
Primary Investigator: Thomas Lahiri, M.D.; Laurie Whittaker, M.D.
Coordinator: Lorraine Bourassa, R.N

This study is for people who have Cystic Fibrosis and a lung infection cause by the bacteria, Pseudomonas aeruginosa. The Novartis study is to determine if a dry powder version of Tobramycin, that can be more rapidly administered using an inhaler, is as safe as standard Tobramycin solution administered with a nebulizer.

Minimum Qualifications: Age 6 years or older; Positive sputum for pseudomonas

IDIOPATHIC PULMONARY FIBROSIS

Research Trial for Patients with Idiopathic Pulmonary Fibrosis
Primary Investigator: Gerald Davis, M.D.
Coordinator: Stephanie Burns

A Randomized, Double-Blind, Placebo-Controlled, Phase 3 Study of the Safety and Efficacy of Pirfenidone in Patients with Idiopathic Pulmonary Fibrosis. The InterMune, trial is an investigational trial looking at the efficacy of treatment with pirfenidone compared with placebo in patients with idiopathic pulmonary fibrosis (IPF).

Minimum Qualifications: Age 40 to 80 Years of age; Diagnosis of IPF with in last 48 months

Research Trial for Patients with Idiopathic Pulmonary Fibrosis
Primary Investigator: Gerald Davis, M.D.
Coordinator: Lorraine Bourassa, R.N.

The main purpose of this clinical study is to demonstrate that bosentan delays the time to worsening of the lung function test in patients with Idiopathic Pulmonary Fibrosis.

Minimum Qualifications: Age 18 or older; Diagnosis of IPF with in last 36 months
New Study Beginning at the VLC

This spring we will be starting a new asthma study in children between the ages 6 and 17 years. This study, the “SARCA Study” (Study of Acid Reflux in Children with Asthma) is sponsored by the National Institutes of Health, and we will be participating as part of the American Lung Association-Asthma Clinical Research Centers network. The study is similar to the “SARA” study, with which you may familiar, and in which some of you may have even participated. We are trying to determine whether treatment of gastro-esophageal reflux disease in children can improve control of their asthma. Many may think that gastro-esophageal reflux disease simply affects adults, but pediatricians have long realized that reflux is common in children, may cause chronic cough, and maybe even aggravate asthma. Children may not have any obvious symptoms of reflux, and so it may be hard to pinpoint the cause of the cough or worsening asthma.

Similar to the SARA study, we will enroll children with symptoms of poorly controlled asthma. The children will perform lung function tests (blowing into a machine), and with the help of their parents answer questions about their asthma symptoms. Some children will receive treatment for reflux. The treatment (Prevacid®, generic name lanzoprazole) is very commonly used, FDA-approved drug, to treat children with acid reflux. Other children will receive a placebo (a pill that looks the same, but doesn’t contain any medication). Neither the study coordinators, nor the child (or their parents) will know which treatment the child receives.

Nationwide we hope to recruit about 400 children to this important study. Poorly controlled asthma is a major cause of illness and hospitalization in young children, so this is a particularly important study of which we are excited to be a participant.

-Anne E. Dixon, M.D -
complete the planned studies for the therapies currently under development. While it is very exciting to have new treatments to combat this devastating disease, successful clinical trials are essential to determine if therapies will be of benefit. To increase participation in research studies, the CF Foundation has begun offering grants to facilitate clinical research. We are proud to announce that the FAHC/UVM center was recently awarded this grant. The grant will be used to support an additional research coordinator which will allow additional research studies to be performed. Dr. Tom Lahiri and Dr. Laurie Whittaker are the two primary investigators involved in CF research. At present there are four active clinical trials and a 5th is about to begin. Several of the studies involve drugs that are in the CF drug development pipeline. We are excited to participate in the development of new therapies which will hopefully one day improve and prolong the lives of patients with CF. For more information about these studies contact the VLC.

-Laurie Whittaker, MD-

Diesel Exhaust and Asthma

Governor Douglas recently signed a bill to ban school bus idling in Vermont. This is an important new law that should improve the lung health of children in Vermont. Asthma is a leading cause of illness in children in the United States; for some children this is a minor inconvenience, but asthma is also a major cause of hospitalization in children, and 5,000 people per year die of asthma in the United States.

Asthma has steadily been increasing over the last 20 years; one reason for this is air-pollution. Pollution-related to diesel emissions is particularly problematic. Diesel particles (particulate matter) are small enough to penetrate deep into the airway and can cause direct irritation. The particles also bind to allergens such as pollen to improve the efficiency with which these are transmitted to the airway and cause asthma. Diesel exhaust also contains gaseous compounds (such as carbon monoxide, nitrogen dioxides and sulfur dioxides) which cause airway inflammation.

• Diesel particles can penetrate easily into the airways
• Diesel particles can cause direct irritation
• Diesel particles can exacerbate reactions to other irritants and allergens
• Gases in diesel exhaust cause airway inflammation

Continued on Page 2
Stem Cells for Lung Diseases: Promise of Future Therapies

- Daniel Weiss, MD, PhD

Stem cells have been in the news lately as a potential treatment for many diseases including lung diseases. Able to endlessly copy themselves and grow into any type of cell in the body, they function as the body’s cellular repair shop. While embryonic stem cells have been the focus of heated debate since 1998, many scientists have been quietly examining the potential of two controversy-free and very promising alternatives – adult stem cells and umbilical cord blood stem cells.

For the past several years, a group of researchers in the Vermont Lung Center have been gaining momentum, as well as international recognition, for their work in the area of adult stem cells and their potential role in treating lung diseases. Benjamin Suratt, M.D., Assistant Professor of Medicine, and his colleagues were the first to find evidence that adult human stem cell transplantation resulted in cell regeneration in damaged lung tissue. Suratt and colleague Daniel J. Weiss, M.D. Ph.D., Associate Professor of Medicine, are working to understand how adult stem cells might offer a treatment for several lung diseases. “A number of studies show that adult bone marrow-derived stem cells and stem cells obtained from cord blood can be induced to turn into heart, liver or brain or, more importantly for us, the lung,” says Weiss. “We’ve been able to follow the lead of these studies and do some pretty amazing things.”

However, despite the promise for stem cell therapies, Weiss cautions that practical use is still many years away. There is still a great deal about stem cells that needs to be understood before they can be safely used in lung diseases. While this is frustrating to patients with severe lung disease, and we receive several phone calls a week from patients, it is critically important to realize that there are no approved uses or clinical trials for use of stem cells in the treatment of asthma or emphysema in the US. There are some illegal and unstudied uses of stem cells for treatment of emphysema originating from Brazil. Please DO NOT participate in this or any other trial that has not been approved by the FDA and National Institutes of Health. We will keep you informed about legitimate trials using stem cells when they occur.

Ask Dr. Charlie

- Charles G. Irvin, PhD

Do children grow out of asthma?
This is a yes and no answer. Asthma symptoms appear in children typically before two years of age where on the order of 20% of children wheeze. Most “grow out” of asthma but of those children still wheezing at the age of 6, most will have persistent asthma.

What effect does adult smoking have on childhood asthma?
This is a very bad thing for children because environmental tobacco smoke (ETS) is the one clearly known cause of asthma. For this and other obvious reasons children should not be exposed to cigarette smoke.
List of Current VLC Studies

**Asthma**

**Study of Acid Reflux in Asthma (SARA)**
Primary Investigator: Charles Irvin, Ph.D., Director, Vermont Lung Center
Coordinator: Stephanie Burns
Who: People with asthma who do not have heartburn
What: 9 visits over 7 months
Compensation: up to $450

**Study of Acid Reflux in Children with Asthma (SARCA)**
Primary Investigator: Charles Irvin, Ph.D., Director, Vermont Lung Center
Coordinator: Stephanie Burns
Who: Children age 6-17 with asthma who do not have heartburn
What: 9 visits over 7 months
Compensation: up to $550

**Study of the Impact of Body Mass Index on Asthma**
Primary Investigator: Anne Dixon, M.D., Director of Clinical Research
Coordinator: Lorraine Bourassa, R.N.
Who: People with asthma and also people without asthma who have Body Mass Index of 35 to 50
What: 1 to 2 visits
Compensation: up to $75

**Weight Loss and Asthma**
Primary Investigator: Anne Dixon, M.D., Director of Clinical Research
Coordinator: Lorraine Bourassa, R.N.
Who: People with asthma and also people without asthma undergoing gastric bypass surgery
What: 10 visits over 12 months
Compensation: up to $775 for asthmatics, up to $250 for people without asthma

**The Effect of CPAP on Asthma Control**
Primary Investigator: Laeeq Shamsuddin, M.D.; Anne Dixon, M.D., Director of Clinical Research
Coordinator: Lorraine Bourassa, R.N.
Who: People with asthma and untreated sleep apnea
What: 4 visits, 2 before CPAP treatment and 2 after CPAP treatment
Compensation: Up to $100

**Asthma Exacerbations: Physiology, Upper Airway and Fibrin**
Primary Investigator: Charles Irvin, Ph.D., Director, Vermont Lung Center
Coordinator: Sherburn Lang
Who: Looking at possible mechanisms that may cause a worsening of asthma
What: 4 visits, the first one in the ER with an asthma exacerbation
Compensation: up to $275

**Forced Oscillation Mechanics in Mild Asthmatics**
Primary Investigator: Lennart K.A. Lundblad, Ph.D.
Coordinator: Sherburn Lang
Who: People with mild asthma and people without asthma
What: 3 visits
Compensation: up to $150

**Cystic Fibrosis**

**Comparison of Standard Tobramycin Inhalation Solution to the new Experimental Tobramycin Inhalation Powder in Cystic Fibrosis**
Primary Investigator: Thomas Lahiri, M.D.; Laurie Whittaker, M.D.
Coordinator: Lorraine Bourassa, R.N.
Who: People with Cystic Fibrosis
What: 9 visits
Compensation: up to $340

**An open-label study looking at the long-term safety of ALTU-135 for the treatment of patients with Cystic Fibrosis-related exocrine pancreatic insufficiency**
Primary Investigator: Laurie Whittaker, M.D.; Thomas Lahiri, M.D.
Coordinator: Lorraine Bourassa, R.N.
Who: People with Cystic Fibrosis who have pancreatic insufficiency
What: 14 visits
Compensation: up to $640

**Idiopathic Pulmonary Fibrosis**

**Investigational trial looking at the effects of treatment with Bosentan compared with placebo in patients with Idiopathic Pulmonary Fibrosis**
Primary Investigator: Gerald Davis, M.D.
Coordinator: Stephanie Burns
Who: People with Idiopathic Pulmonary Fibrosis
What: 18 to 32 months depending on time point enrolled
Compensation: none

**Chronic Obstructive Pulmonary Disease**

**Investigational study looking at the effects of treatment in people with chronic obstructive pulmonary disease comparing two different doses of Indacaterol (study drug) to tiotropium and placebo.**
Primary Investigator: Anne Dixon, M.D. Director of Clinical Research
Coordinator: Sherburn Lang
Who: People with Chronic Obstructive Pulmonary Disease (COPD)
What: A 26 week treatment with 14 visits
Compensation: $30 for each study visit completed

For more information on these studies, please visit our website @ www.vermontlung.org
Nocturnal Asthma

Do you have shortness of breath, coughing, and wheezing at night? Then you may have nocturnal asthma. It is common for asthma symptoms to worsen at night. In fact, 7 out of 10 asthmatics have asthma symptoms at least one night a week.

There are many possibilities as to why a person's asthma may be worse at night. Exposure to allergens in the bedroom, such as dust mites, is one cause of nighttime asthma. Certain allergens that you may be exposed to in the middle of the day, can stick around the airway and then cause an asthma attack while you are sleeping. Chronic sinus problems with post nasal drip which are often worse when lying down can cause asthma at night. Also, heartburn which is often worse laying down flat can cause asthma at night. Your body temperature drops by almost 2 degrees while you sleep. This can lead to an asthma attack. Even sleep apnea—brief pauses in breathing—can possibly worsen asthma.

It is important to inform your doctor if your asthma symptoms worsen at night. You may be asked to monitor your lung function using a peak flow meter. This is a portable device that measures the lung volume and how quickly air can be expelled from the lungs. Nocturnal asthma can be documented by recording peak flow rates at bedtime, during any awakening at night and in the morning.

The medications you take while you are awake may not last long enough by the early morning hours, so your doctor may switch you to longer acting medications, or suggest you alter the timing of your medications. Treatments aimed at specific causes such as antacids for heartburn, decongestants for sinusitis, CPAP machine for sleep apnea have also shown to help.

If you have asthma symptoms at night, remember that you are not alone, and that there are many possible causes. Most severe asthma attacks, the type that can land you in the hospital occur at night!
cause these studies also showed that large fat cells are a predictor of who will develop diabetes. Further studies by Dr. Pratley's group have demonstrated that fat cells from obese individuals produce a large number of factors that promote inflammation. Many of these factors are predictors of diabetes and may be related to the other complications of obesity.

A large number of population studies have shown that obesity is a risk factor for developing asthma. A current study that is being conducted in collaboration with Dr. Anne Dixon and other members of the Pulmonary section examines whether factors secreted by fat cells link obesity and asthma. Fat cells from subjects with asthma are being compared to those of patients without asthma to see whether the characteristics of the fat cells differ. An additional important question that will be addressed in this study is whether weight loss will improve asthma.

These studies could suggest new approaches to treatment even prevention of complications of obesity, such as diabetes and/or asthma. For further information, you can call the Diabetes Research Center at 802-857-8903 or email us at diabetes.research@uvm.edu.

For many years, I've been interested in supportive care in the medical ICU. Much of the “treatment” we provide to critically ill patients is actually just good, solid supportive care while they heal. We know some information about these processes. For example, we have learned how to partially prevent unwanted infections in the ICU, how to prevent clots from developing in patient's large veins, and how to control blood sugar. However, nutrition in the ICU remains an area where we continue to lack good evidence to guide clinical practice. We don’t know nearly enough about when, how, and what to feed our patients.

It is clear now that feeding into the gut is better than through the veins. And, it appears that feeding patients early in their critical illness is also helpful. However, we still don’t really understand the importance of caloric intake early in critical illness; i.e. how many calories do really sick patients really need? We also don’t understand how to best provide nutrition to obese patients in the ICU. Similarly, we have very few data guiding us about the types of nutrients we should give. How much protein should patients really receive? How much fat? Does it even matter? And do nutrients like selenium, glutamine, arginine, and omega-3 fatty acids help? These are all research questions that my group is interested in working to answer.
New Faces in Pulmonary & Critical Care Medicine

Renee Stapleton, MD, MSc

When did you move to Vermont?
September, just in time to see our first New England autumn.

Where did you go to School?
I grew up in Helena, Montana; went to college at Rice University in Houston, Texas; and then went to medical school at the University of Washington in Seattle.

Why did you choose Vermont?
Both my husband and I grew up in small communities, and we have always known that we didn’t want to raise our family in an urban area. Then, when a job opened up here, we came and visited and fell in love with everything about Vermont -- the culture, the geography, the people, and the job here at UVM/FAHC. It’s perfect!

What are your research interests?
My interest surrounds building a research program that focuses on nutritional support and pharmaco-nutrient interventions in critically ill patients. I am also interested in end-of-life care, communication in the ICU, and treatment preferences at the end of life.

What is your favorite thing about working in research?
I love working with bright, funny, and energetic colleagues who always keep me on my toes. I love that each day brings something different; that I can write, teach, read, take care of patients, and travel all as aspects of my work; and that research contributes to the greater good.

Yolanda Mageto, MD, MPH

When did you move to Vermont?
I moved to Vermont in August.

Where did you go to School?
I got my medical degree Washington University in St. Louis, Missouri and my master’s degree in public health from The University of Washington in Seattle.

Why did you choose Vermont?
It wasn’t even on my radar screen until this friend of mine sent me an email asking if I would be interested in interviewing for a possible job. I came up here in April and June and the rest is history … it is beautiful with a great quality of life and a great place to raise my three kids. (Of course I have yet to experience a Vermont winter…). I

What are your research interests?
My interests are interstitial lung disease, particularly idiopathic pulmonary fibrosis and sarcoidosis.

What is your favorite thing about working in research?
My favorite thing about research is the most challenging - finding something that makes the lives of my patients better and puts a smile on their faces, finding out new things that will make someone’s life better. I like challenges and research provides room for challenge and change.

Ask Dr. Charlie

Who gets asthma?
Asthma often runs in families but that is not as important of a factor as having allergies. Environmental tobacco is another known cause.

Can a person die from asthma?
Yes you can die from asthma but fortunately it is a rare event. About 4-5 people a year die of asthma in the state of Vermont but these deaths can often be prevented.
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Coordinator: Stephanie Burns
Who: Children age 6-17 with asthma who do not have heartburn
What: 9 visits over 7 months
Compensation: up to $350

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Primary Investigator: Anne Dixon, M.D., Director of Clinical Research
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Who: People with asthma and also people without asthma who have Body Mass Index of 35 to 50
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Coordinator: Sherburn Lang
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Investigational study looking at the effects of treatment in people with chronic obstructive pulmonary disease comparing two different doses of Indacaterol (study drug) to tiotropium and placebo.
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Coordinator: Laurianne Griffes
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What: A 26 week treatment with 14 visits
Compensation: $30 for each study visit completed
Compensation: $30 for each study visit completed

For more information on these studies, please visit our website @ www.vermontlung.org

The Saint Michael’s Experience

I have been interested in the medical profession since I was a young child. No one in my immediate family is in the medical field although my 90 year old paternal great-grandmother and 70 year old paternal aunt were nurses. I watched Rescue 911 on CBS on Tuesdays when I was in primary school, and I thought being an emergency medical technician would be an exciting career. By the time I graduated high school I would be certified as an EMT, and I had a new career goal.

Flash forward to the last week of August 2003 and I began my life at Saint Michael’s College, or simply Saint Mikes. The school was recommended as a “good fit” for me by my high school college advisor.

After visiting the campus twice, I knew it would be a great school for higher education. More importantly, I knew it would be a change from what I had been accustomed to. I am from Brooklyn, New York and I went to a NYC public high school in Manhattan that had large class sizes and a very diverse group of students. Neither were found at Saint Mikes!

I found the teaching and residence life staffs particularly skilled in their jobs. I am by nature inquisitive and most, if not all of my questions were answered by the professors there. The residence life staff was particularly helpful in developing my social and leadership skills. I served the College twice as a resident assistant – including once during the summer.

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Another facet of the Saint Mikes culture that aided my personal and professional growth was its rescue service, “Saint Michael’s Rescue”. I entered the organization my first semester very shy and unconfident. My senior year, I was appointed to be the Training Officer, responsible for the competency and continuing education for the members of the organization. It is through numerous rescue calls at all times of the day and night as well as the repetition of skills that I learned the basics of patient care. Many of the calls I received were for respiratory distress. Some of these patients seemed anxious and a great deal of them seemed to be in despair. In senior year, I decided to pursue a career in medicine as a physician because of my exposure to patient care and my interest in treating the cause of illnesses.

In addition to being interested in medicine, I also developed a passion for understanding human behavior. Psychology was my major at Saint Mikes. I have a particular interest in psychiatry and its subspecialty of psychosomatic medicine, particularly asthma. It is through my interest in asthma that led me to Dr. Charles Irvin and his research. I am thankful for this opportunity and I look forward to working with the Vermont Lung Center on the Asthma Exacerbation study and other projects. I also look forward to meeting most if not all patients involved with these studies.