A Multidisciplinary Approach

Pulmonary hypertension (PH) is a disease characterized by elevated pulmonary artery pressures and progressive right ventricular failure. It is marked by pulmonary arteriolar vasoconstriction and cellular proliferation and remodeling. At UPMC, we have developed a comprehensive PH clinical program that combines experts in cardiology and pulmonary medicine who work together to diagnose and treat patients with PH. In addition to standard FDA–approved therapies, we provide access to the most recent clinical trials and are supported by one of the largest lung transplant programs in the nation. These resources allow for rapid and effective diagnosis, access to the best new therapies, and the availability of lung transplantations for patients with advanced disease.

Our experts also evaluate patients who develop PH as a result of other advanced lung diseases, such as COPD/emphysema, interstitial lung disease, sarcoidosis, left heart disease, and sickle cell disease, which can greatly impact disease severity and outcomes, and may provide a new avenue for helpful therapy.

We welcome any suggestions or comments on how we might support you in the care of your patients. Please enjoy this issue of the Respiratory Reader.

With great enthusiasm and respect,

Mark T. Gladwin, MD
Professor of Medicine
Chief, Division of Pulmonary, Allergy, and Critical Care Medicine
Director, Vascular Medicine Institute

Michael A. Mathier, MD
Director, Pulmonary Hypertension Program
Medical Director, COACH Program
2013 Pitt Lung Conference Highlights

The 2013 Pittsburgh Lung Conference took place on October 17 and 18, 2013. The topic of this year’s conference was, “Acute and Chronic Lung Infections: Novel Pathogens, Diagnostics, and Therapeutics.” The conference was held at the University Club in Oakland and attracted more than 250 attendees. Chairs Mark Gladwin, MD, Alison Morris, MD, and Karen Norris, PhD, opened the conference, followed by 24 speakers in six symposia:

- Pneumonia: Treatment and diagnosis
- The microbiome and the lung: Does it matter?
- Challenges and the future in vaccine and drug development
- Infections in the immuno-suppressed host
- Infections in “noninfectious” lung diseases
- Emerging and resistant infections

Speakers included MDs and PhDs from academia, governmental organizations, and industry, and highlighted both clinical updates and cutting-edge research. Each symposium concluded with a discussion session with all speakers and the audience. There was also a poster session and reception, followed by a banquet dinner at the Carnegie Museum. This year’s speaker was Donna E. Shalala, PhD, former Secretary of Health and Human Services and president of the University of Miami, who spoke on health care delivery and the challenges it poses to academic medicine. The conference had a broad appeal to clinicians, basic and translational researchers, allied health personnel, public health experts, and industry scientists, all of whom have a major research interest in lung and infectious diseases biology, diagnostics, and therapeutics. Look for summaries of the conference sessions in the *Annals of the American Thoracic Society* later this year. We invite you to join us at the 2014 Pittsburgh Lung Conference: Aging and Lung Disease: Clinical Impact and Cellular and Molecular Pathways, October 23 to 24, 2014, organized by Mauricio Rojas, MD, Ana Mora, MD, and Mark Gladwin, MD.

Save the Date: 2014 Pitt-Munich Lung Conference • Oct. 23 & 24

The 2014 Pittsburgh Lung Conference will be hosted in conjunction with the Comprehensive Pneumology Center, Institute of Lung Biology and Disease, a top–level German institution comprised of the Ludwig-Maximilians University, and Helmholtz Zentrum Munich, Germany.

This year’s conference will focus on, “Aging and Lung Disease: Clinical Impact and Cellular and Molecular Pathways,” and will take place October 23 to 24 at the University Club in Pittsburgh. The purpose of the Pittsburgh-Munich Lung Conference is to present cutting-edge clinical, translational, and basic investigations in an area of lung disease selected each year.

This conference will be exclusively devoted to addressing aging mechanisms of the lung, and will be the first of its kind in the United States.

The 2014 Pittsburgh-Munich Lung Conference will:

- Highlight the clinical aspects of age-related lung diseases, as well as research advances that will drive the development of new therapeutic and diagnostic approaches for this group of patients.
- Focus on the molecular mechanisms of aging, the relevance of advanced age in the pathogenesis and susceptibility to pulmonary diseases, and the impact of aging in the clinical presentation.
- Discuss therapeutic approaches to pulmonary diseases.

Please be sure to check our division website for more information, including a call for abstracts that will go out in late Spring 2014. Visit [www.dept.med.pitt.edu/PACCM/conferences](http://www.dept.med.pitt.edu/PACCM/conferences) for more information.

Join Team PHenomenal Hope as We Race Across the Country in 2014

UPMC pulmonologist Patricia George will be racing her bicycle with teammates Stacie Truszkowski, Anne-Marie Alderson, and Ryanne Palermo on a four-woman team in the Race Across America, one of the toughest endurance races in the world. This bicycle race starts on June 14 in Oceanside, Calif., and goes nonstop approximately 3,000 miles to the finish line in Annapolis, Md., in less than nine days. The team has partnered with the Pulmonary Hypertension Association (PHA) and presenting sponsor UPMC in an effort to raise awareness and funds to find a cure.

In partnership with PHA, this effort has grown from a Pittsburgh-based team into a national campaign called Race of Our Lives, inspiring patients to organize and participate in Unity Miles events all over the country.

How can you get involved?

Make a tax-deductible donation to the team to support PHA funds for research and patient services.

For more information, check out the team website at [TeamPhenomenalHope.org](http://TeamPhenomenalHope.org).

Please help spread the word!
When to Refer for Lung Transplantation in Pulmonary Hypertension

By Patty George, MD

Although many new therapeutic discoveries have been made, pulmonary hypertension remains a chronic and progressive disease for most patients. As such, we believe that early discussion of lung transplantation is important in the management of patients with this disease. While physicians often refer patients who are on IV prostacyclins, there are many other cases when earlier referral may be beneficial. When medical treatment does not improve a patient’s World Health Organization (WHO) functional class, or when treatments are escalated, surgical treatment of pulmonary hypertension — i.e., lung transplant — should be considered. In addition, if the patient has scleroderma-associated pulmonary arterial hypertension (PAH), or lung disease complicated by PAH, earlier referral is often best.

Early referral for transplantation does not automatically mean patients will be listed too soon, but allows transplant physicians to consider the patient’s candidacy and work with referring physicians to optimize any risk factors to work towards the best outcomes. We believe it is always better for patients to be referred when they are relatively healthy rather than when it is too late, so that they may be monitored and then listed when they are in the “transplant window” for double lung transplant and before the right ventricle fails. In cases of right ventricular failure, patients may receive heart-lung transplant or, depending on their condition, they may no longer be a candidate for lung transplantation. Importantly, early referral is beneficial to the patient and caregivers, especially if they are from out of town. As patients get sicker, the week of testing becomes more difficult, and when oxygen needs increase, it can be less safe for patients to travel. Also, when sick patients and caregivers are more anxious, they are less likely to comprehend the magnitude of transplant decision making, often not fully grasping the potential complications. Hence, for a whole host of reasons, early referral for transplant is preferred.

UPMC is one of the most active transplant centers in the world, having performed more than 100 transplants per year for the last eight years, and has much experience in transplanting patients with idiopathic and associated PAH. Between 1994 and 2012, UPMC transplanted 44 patients with idiopathic pulmonary arterial hypertension, with one-, five-, and 10-year survival rates of 86 percent, 64 percent, and 55 percent. We are one of few centers to consider and transplant patients with scleroderma, and we also consider patients over the age of 65 who would be turned down at many other centers.

To expedite the evaluation process, patients who are considered for transplant may be seen in the Comprehensive Pulmonary Hypertension Clinic on their first or early follow-up visit. Alternatively, they also can be referred for full transplant evaluation through our lung transplant office, which includes testing and consultation with our transplant pulmonologists. As transplant pulmonologists, our job is to perform an evaluation and help expedite the process of full lung transplant evaluation. We work to identify areas that may need to be evaluated more fully when the patient returns for full outpatient evaluation. In the initial visit, we help educate patients about the evaluation process as well as lung transplantation. In the pulmonary hypertension clinic with patients who are less ill and not quite ready for full evaluation or near listing, I function more in the role of pulmonologist, providing a diagnostic and therapeutic opinion regarding potential parenchymal disease, in addition to introducing the idea of lung transplant. When considering the life-altering therapy of lung transplantation, we prioritize establishing rapport with patients and their referring physicians, so that we can work together to ensure the utmost patient health and satisfaction.

What to expect when you refer for lung transplant

When a referral is made for full transplant evaluation, you can expect we will do our best to complete it in the time frame that best meets the patient’s needs. If a patient is sick and needs to be evaluated urgently, please let us know. The first step after taking the patient’s information is to obtain insurance authorization for testing and evaluation. A checklist is also sent for health screening and vaccines to be performed by the patient’s primary care or referring physician. Once obtained, the five days of outpatient evaluation are set up for the patient at UPMC. If some of the testing has been completed within the last three to six months, we often do not need to repeat these tests in the initial evaluation, and the evaluation may be shorter. After the week of testing, each patient is discussed in our multidisciplinary meeting, and the recommendations are communicated to the patient and referring physician. It is important to know that early referral does not mean we will automatically push people to list too early. If the patient is not yet in the transplant window, we will follow along with the referring physician, and will be available should their disease progress.

For more information on how to refer a patient for lung transplantation, see page 7.

Suggested reading:

For a list of the Division of PACCM’s recent publications and suggested reading for this issue, visit UPMCPhysicianResources.com/Pulmonology.
CASE PRESENTATION:
Pulmonary Veno-Occlusive Disease: The Other Pulmonary Arterial Hypertension

A 64-year old African-American female with progressive dyspnea had a right heart-catheterization (RHC) in June 2013 consistent with pulmonary arterial hypertension (PAH) (Table 1). She also endorsed a history of Raynaud’s phenomenon. An ANA titer was positive (>1:1280) with an anti-centromeric pattern, and limited cutaneous systemic sclerosis with associated PAH was suspected. She was started on sildenafil 20 mg three times daily while awaiting insurance approval of inhaled treprostinil, but over the course of a week felt worsened dyspnea.

Due to the worsened dyspnea, she stopped taking the sildenafil, and over the next few days felt better. However, her dyspnea worsened again so she was admitted for further evaluation. A repeat RHC was performed, demonstrating similar hemodynamics, but now the pulmonary vascular resistance (PVR) was higher and the cardiac output (CO) was lower (Table 1). A noncontrast, high-resolution chest CT demonstrated numerous mediastinal lymph nodes without enlargement, diffuse centrilobular emphysema with scattered septal thickening, and minimal ground-glass opacities (Figure 1).

Based on her history and CT findings, there was concern that she had postcapillary disease or pulmonary veno-occlusive disease (PVOD). Because the PVR and CO had worsened, it was decided to try a pulmonary vasodilator that could be easily titrated in the hopes that she had a greater degree of precapillary pulmonary vascular disease, and might benefit from vasodilation. Because of its short half-life, IV epoprostenol was selected; however, this would be performed under close hemodynamic monitoring in the ICU. She initially tolerated IV infusion doses of two ng/kg/min and 4 ng/kg/min, with modest hemodynamic improvement (Table 1). When the epoprostenol dose was increased to six ng/kg/min, the patient (Continued on Page 7)

Table 1: Hemodynamic Data

<table>
<thead>
<tr>
<th></th>
<th>June 2013</th>
<th>September 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>No epoprostenol</td>
<td>IV Epoprostenol at 4 ng/kg/min</td>
<td>IV Epoprostenol at 6 ng/kg/min</td>
</tr>
<tr>
<td>Right atrium</td>
<td>5 mm Hg</td>
<td>8 mm Hg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 mm Hg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 mm Hg</td>
</tr>
<tr>
<td>Right ventricle</td>
<td>70/8 mm Hg</td>
<td>83/9 mm Hg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/D</td>
</tr>
<tr>
<td>Pulmonary artery</td>
<td>79/24 mm Hg</td>
<td>83/30 mm Hg</td>
</tr>
<tr>
<td>(mean 50 mm Hg)</td>
<td></td>
<td>76/34 mm Hg</td>
</tr>
<tr>
<td>(mean 52 mm Hg)</td>
<td></td>
<td>72/45 mm Hg</td>
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<tr>
<td>(mean 51 mm Hg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(mean 57 mm Hg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary capillary wedge</td>
<td>10 mm Hg</td>
<td>8 mm Hg</td>
</tr>
<tr>
<td>Transpulmonary gradient</td>
<td>40 mm Hg</td>
<td>44 mm Hg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40 mm Hg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>38 mm Hg</td>
</tr>
<tr>
<td>Cardiac output</td>
<td>5.5 L/min</td>
<td>4.1 L/min</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.7 L/min</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.6 L/min</td>
</tr>
<tr>
<td>Cardiac index</td>
<td>2.6 L/min/m²</td>
<td>2.0 L/min/m²</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.6 L/min/m²</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.7 L/min/m²</td>
</tr>
<tr>
<td>Pulmonary vascular resistance</td>
<td>7.7 Wood units</td>
<td>10.7 Wood units</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8.5 Wood units</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6.8 Wood units</td>
</tr>
</tbody>
</table>

Figure 1: A noncontrast, high-resolution chest CT demonstrated interlobular septal thickening at the periphery (arrows) and minimal ground-glass opacities. There was also evidence of centrilobular emphysema and numerous mediastinal lymph nodes not seen in this view.

Figure 2: Histopathology of pulmonary veno-occlusive disease. A) Hematoxylin and eosin stain of lung tissue at 4x magnification demonstrating diffuse septal thickening. B) Hematoxylin and eosin stain of lung tissue at 20x magnification demonstrating lymphocytic inflammation of a small pulmonary vein with perivascular fibrosis (black arrow) and progressive luminal obliteration characteristic of pulmonary veno-occlusive disease (white arrow).
Pulmonary hypertension is divided into five categories according to the classification system endorsed by the World Health Organization (WHO). Pulmonary arterial hypertension (PAH) belongs to Group I, which is a progressive proliferative vasculopathy in pulmonary arterioles that results in right heart dysfunction. Patients experience progressive dyspnea, right heart failure, syncope, and ultimately death. Since PAH is associated with reduced bioavailability of nitric oxide (NO), a number of approaches enhancing NO generation and bioactivity have been proposed over the past decade, including administration of nitrite.

In 2004, Dr. Gladwin’s research team first reported that inhaled nitrite could be a treatment for PAH. They demonstrated that inhalation of nitrite produced pulmonary vasodilation and reduced pulmonary arterial pressures in an ovine hypoxia model. The nitrite effect appears to be mediated by the slow conversion of nitrite to NO, because higher levels of exhaled NO gas were measured. More recently, Dr. Zuckerbraun’s research group at UPMC showed that repeated inhalation of nebulized nitrite could reverse or prevent established PAH in two different rodent models. In the mouse hypoxia-induced pulmonary hypertension model, nitrite halted the progression and reversed the increase of the right ventricular pressures. In the rat model of PAH induced by monocrotaline, nebulized nitrite was also able to decrease the muscularization and hyperplasia of the small pulmonary arteries. This study also suggests that the nitrite effect is mediated by NO-cGMP signaling and downstream induction of the cell cycle check-point inhibitor p21, which inhibits smooth muscle cell proliferation.

Pulmonary venous hypertension (PVH) belongs to Group II, which is a common cause of pulmonary hypertension resulting from left heart diastolic or systolic dysfunction. Chronic elevation in left ventricular (LV) filling pressure causes a backward transmission of the pressure to the pulmonary venous system, which has been proposed to mediate vasoconstriction, pulmonary vascular remodeling, and secondary right ventricular (RV) failure. Because impaired LV diastolic function is common in patients with hypertension, diabetes, obesity, and coronary artery disease (CAD), PVH is frequently associated with metabolic syndrome. According to Robbins et al., more than 90 percent of patients with PVH in their study were found to have multiple features of metabolic syndrome.

In order to study PVH, we established a “two-hit” model of PVH, based on combining pulmonary endothelial injury in the background of severe metabolic syndrome. A single dose of SU5416, a VEGF inhibitor that induces endothelial injury and apoptosis, was injected to obese ZSF1 rats. This model links severe metabolic syndrome to the progression of PVH and provides a novel tool to explore potential treatment for PVH. Using this model, we showed that chronic nitrite therapy improved hyperglycemia and attenuated PVH.

The clinical characteristics of PVH, dyspnea, elevated pulmonary arterial pressure, and eventually right heart dysfunction are similar to PAH. PVH is therefore often misclassified and mistreated as PAH. The utilization of therapies for PAH, such as pulmonary vasodilators, with PVH patients has been shown to worsen symptoms or cause adverse effects. Thus, our identification of nitrite as a therapy to reduce the development of both PAH and PVH is a new and potentially important finding, which also may provide an appropriate treatment strategy for clinicians to consider.

Inhaled nitrite is now given at our UPMC Pulmonary Hypertension Clinic for patients with PAH, as part of a multinational phase II proof of concept clinical trial. To date, nine patients have been enrolled in this trial at UPMC.

Acknowledgment:
We are grateful to Elfy Chiang for the graphic assistance.

Suggested reading:
For a list of the Division of PACCM’s recent publications and suggested reading for this issue, visit UPMCPHysicianResources.com/Pulmonology.
Comprehensive Pulmonary Hypertension Clinic at UPMC

By Michael Risbano, MD

In 2009, UPMC launched the Comprehensive Pulmonary Hypertension Clinic under the direction of Michael Mathier, MD, and Mark Gladwin, MD. The clinic utilizes a multidisciplinary approach in the evaluation and management of patients with pulmonary vascular disease. Led by co-directors David Ishizawar, MD (cardiology), and Michael Risbano, MD (pulmonology), the clinic combines the expertise of cardiologists, pulmonologists, and specialists in sleep and pulmonary transplant medicine in the evaluation and treatment of pulmonary hypertension (PH).

Pulmonary Hypertension Groups:
The types of conditions we help manage

**Group I**
- Idiopathic PAH
- Drug-induced PAH
- PAH associated with connective tissue disease
- HIV-associated PAH
- Congenital heart disease
- Sickle cell disease

**Group II**
- Pulmonary hypertension due to diastolic dysfunction and left heart disease

**Group III**
- Pulmonary hypertension due to parenchymal lung disease (emphysema, interstitial lung disease)

**Group IV**
- Chronic thromboembolic PAH

**Group V**
- Pulmonary hypertension associated with other diagnoses (e.g., sarcoidosis and thyroid disease)

Our patients

We see patients referred by primary care physicians, pulmonologists, or cardiologists for the evaluation and management of pulmonary hypertension. Due to the diverse etiologies of pulmonary hypertension, the Comprehensive Pulmonary Hypertension Clinic at UPMC is well-suited to help manage these complex patients. When people think of pulmonary hypertension, Group I PAH comes to mind. As a group, we are interested in both the evaluation and management of PH related to heart and lung disease and pulmonary embolism. These groups of patients are as challenging to manage as the IPAH population. We have enjoyed seeing patients with a wide variety of pulmonary vascular conditions.

Early referral

Patients who are evaluated and treated for PH early in the disease process have improved outcomes. We are eager to see patients early in their diagnosis, in which there is a suspicion of pulmonary hypertension (PH) based upon transthoracic echocardiogram. We are also excited to see patients with a long-standing diagnosis of PH who already are on therapy, but whose physicians are seeking another opinion in the next step in management, and/or evaluation for lung transplantation.

Comprehensive clinical approach

All referred patients will be evaluated by either a pulmonologist/pulmonary transplant physician or a cardiologist. All previously obtained records and images are reviewed. A significant amount of time is spent with the patient gathering history as well as providing education about the diagnosis and treatment of pulmonary hypertension. We complete any remaining serologic testing, pulmonary function testing, six-minute walk test, radiologic and echocardiographic imaging and/or hemodynamic evaluation, which may include resting or exercise right heart catheterizations.

Each PH clinic physician will gladly see and evaluate patients with all forms of PH (Group I-V). It may be preferential, however, for referred patients to be directed to either clinic based upon underlying comorbidities. Those patients with underlying lung disease could be directed to the Pulmonary PH Clinic and those with underlying heart disease could be directed to the Cardiology PH Clinic. Patients seen at the Comprehensive Pulmonary Hypertension Clinic at UPMC will be discussed at our weekly conference. At this conference, the accuracy of the PH diagnosis, diagnostic testing, potential medical therapy, and eligibility for clinical trials will be discussed in detail among the attending physicians. Longitudinal follow-up will occur with the initial evaluating physician.

Rapid diagnostic evaluation

Our goal is to provide comprehensive and expedited patient care to the highest level of patient and referring physician satisfaction. We strive to complete all testing within one to two weeks of the initial visit, and for patients who are more symptomatic or traveling from a distance, we can often accommodate a clinic visit with remaining tests and right heart catheterization on the same day, or within a two-day period.

Initiating or modifying therapy

One of the clinic’s strengths is the close relationship between patient care and clinical/translational research. UPMC is currently involved in a multitude of clinical treatment trials, and can offer many patients novel therapies through these trials. In addition to enrollment in clinical trials, our nurses, nurse practitioners, social workers, and case managers help navigate the path to implementation of FDA-approved therapies.

Follow-up care

We are happy to follow up with patients after their initial visit to our clinic. In addition, should we identify other conditions related to a patient’s pulmonary hypertension, such as connective tissue disease, liver disease, or other conditions, we can easily refer them for further clinical evaluation, because we work closely with many specialists throughout UPMC.

How to refer

To refer a patient to the Pulmonary Hypertension Clinic at UPMC, call 1-877-PH4-UPMC (8762) or email PHprogram@upmc.edu. Although we take a multidisciplinary approach, we recognize that patients may already have a pulmonologist or cardiologist involved in their care. We will work closely with referring physicians to maintain an overall continuum of care. We look forward to working with referring physicians to help serve the needs of patients with pulmonary hypertension.
Pulmonary Veno-Occlusive Disease (Continued from Page 4)

developed increased dyspnea and the PCW pressure rose from 10 mm Hg to 19 mm Hg despite diuresis (Table 1). A chest x-ray demonstrated acute pulmonary edema. The epoprostenol dose was decreased, and her pulmonary edema improved. At this point, the patient decided to take a palliative course with comfort measures only. A postmortem examination of her lung tissue did confirm the presence of PVOD (Figure 2) with very minimal, if any, precapillary disease.

PVOD is a rare, though fatal disease which is classified as a Group 1 PAH disease and differentiated from Group 1 PAH diseases in its postcapillary rather than precapillary involvement. Thus, unlike PAH, which affects pulmonary arteriolar vessels, PVOD affects small pulmonary veins. Most cases of scleroderma-related PVOD in the existing literature are presented as case reports or case series. This particular case highlights the need to consider PVOD when pulmonary vasodilator therapies cause worsened dyspnea or hypoxemia with pulmonary edema. Though the radiologic triad of patchy ground-glass opacities, lymphadenopathy, and septal thickening is suggestive of PVOD, these findings are neither sensitive nor specific. Because tissue diagnosis requires adequate amounts of peripheral lung tissue, a wedge resection is necessary instead of bronchoscopy. Because the surgical risks are high, wedge resections should be undertaken only when the diagnosis of PVOD is reasonably certain and the diagnosis will make a difference in management. At best, pulmonary vasodilators, if tolerated, are only temporarily effective. The only known effective treatment is lung transplant; therefore, when PVOD is diagnosed, patients should be referred to a lung transplant center. Unfortunately, the prognosis is poor and the diagnosis is often made in autopsies.  

Suggested reading: For a list of the Division of PACCM’s recent publications and suggested reading for this issue, visit UPMCPhysicianResources.com/Pulmonology.

Educational Opportunities

The Division of Pulmonary, Allergy, and Critical Care Medicine is deeply committed to a mission that includes:

- Providing the highest-quality, compassionate patient care for patients with lung disease.
- Mentoring and training medical students, residents, fellows, and young faculty.
- Research and scientific discovery.

To foster an educational and collaborative environment, the division offers the following weekly conferences throughout the academic year:

Basic and Translational Research in Lung Disease Conference is held every Tuesday from noon to 1 p.m. in the Biomedical Science Tower, Conference Room 1295. This conference provides pulmonary faculty and staff an opportunity to hear speakers from throughout the University environment outline their current biomedical research efforts in order to facilitate expanded collaborations.

Pulmonary Case Conference is held every Thursday from noon to 1 p.m. in the Biomedical Science Tower, Conference Room 1295.

Pulmonary Grand Rounds is held each Friday from noon to 1 p.m. in UPMC Montefiore, Conference Room NW628. It consists of lectures by external and internal speakers and is designed to bring forth the latest scientific and clinical developments in pulmonary and allergic disease and in critical care.

If you wish to be placed on our email distribution list, please contact Theresa Dobransky at dobranskyta@upmc.edu.

To learn more about our additional educational resources, including free CME videos and podcasts, visit UPMCPhysicianResources.com/Pulmonology.

How to Refer a Patient for Lung Transplant

To refer a patient for lung transplant evaluation, the following information is needed:

- Patient’s name and contact information
- Date of birth
- Medical records, including an H&P, PFTs, CT scan, and CXR reports from the last two years, routine blood work results, current medication list, and any cardiac testing that has been done, such as an echo and/or left- and right-heart catheterization.

The information can be faxed or mailed to the attention of Nancy Pepke, BSN, RN, CCTC, intake coordinator:

Fax: 412-648-6369
Mailing address: UPMC Presbyterian Lung Transplant Program 200 Lothrop St., Suite C-900 Pittsburgh, PA 15213

Insurance clearance can take up to two to three weeks. Once insurance authorization is received and medical records have been reviewed, the patient will be contacted for a phone interview/history. Once deemed acceptable for evaluation, the patient will be asked to provide a date when he or she AND a family member can come in for three to five days of testing. Referring physicians can request an expedited schedule for a patient based on their assessment. If you have questions, please call the pretransplant office at 412-648-6202.
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A world-renowned health care provider and insurer, Pittsburgh-based UPMC is inventing new models of accountable, cost-effective, patient-centered care. It provides more than $887 million a year in benefits to its communities, including more care to the region’s most vulnerable citizens than any other health care institution. The largest nongovernmental employer in Pennsylvania, UPMC integrates more than 62,000 employees, 22 hospitals, 400 doctors’ offices and outpatient sites, a nearly 2.3-million-member health insurance division, and international and commercial operations. Affiliated with the University of Pittsburgh Schools of the Health Sciences, UPMC ranks No. 10 in the prestigious U.S. News & World Report annual Honor Roll of America’s Best Hospitals — and No. 1 in Pennsylvania. For more information, go to UPMC.com.