

## Distribution of Flu Vaccine Begins

GlaxoSmithKline (GSK) announced in early August that the U.S. Food and Drug Administration's (FDA) Center for Biologics Evaluation and Research (CBER) has released the first lots of FluLaval® [Influenza Virus Vaccine] allowing distribution in the U.S. to begin for the 2010–11 flu season. GSK anticipates distribution of Fluarix® [Influenza Virus Vaccine] to follow in the next several weeks. FLULAVAL is approved for use in adults (18 years of age and older) to help protect against influenza disease. FLUARIX is approved for use in adults and children (3 years of age and older).

Earlier this year, vaccine experts at the Centers for Disease Control and Prevention (CDC) recommended that individuals six months and older should get a flu vaccine each year. The 2010–11 flu vaccine will offer protection against the 2009 H1N1 pandemic virus and two other flu viruses.

According to the CDC, annual flu vaccination is the most effective method for preventing flu virus infection and its complications. CDC's Advisory Committee on Immunization Practices (ACIP) voted for "universal" flu vaccination in the U.S. to expand protection against the flu to more people.

Important Safety Information for FLUARIX/FLULAVAL

- Do not administer FLUARIX/FLULAVAL to anyone with known systemic hypersensitivity reactions to egg proteins (a vaccine component) or a life-threatening reaction to previous administration of any influenza vaccine.
- If FLUARIX/FLULAVAL is administered to immune-suppressed persons, including individuals receiving immunosuppressive therapy, the immune response may be lower than in immune-competent persons.
- If Guillain-Barre syndrome has occurred within six weeks of receipt of prior influenza vaccine, the decision to give FLUARIX/FLULAVAL should be based on careful consideration of the potential benefits and risks.
- Vaccination with FLUARIX/FLULAVAL may not protect 100% of susceptible individuals.
- In clinical trials with FLUARIX/FLULAVAL, the most common adverse events in adults included injection site pain and redness, muscle aches, fatigue and headache. Most adverse events in adult clinical trials were mild and self-limited. (See adverse reactions section of the Prescribing Information for FLUARIX for other potential adverse events.)

- The tip caps of the prefilled FLUARIX syringes contain natural rubber latex which may cause allergic reactions in latex sensitive individuals.

## COPD and Your Heart

Researchers have long known that severe COPD can have harmful effects on the heart, decreasing its ability to pump blood effectively. To see if mild and even symptomless COPD might also be linked to reduced heart function, a team of scientists led by Dr. Graham Barr of Columbia University Medical Center studied 2,816 generally healthy adults ages 45 and older.

The researchers used breathing tests and imaging studies of the chest to assess the structure and function of each person's heart and lungs. None of the participants had severe COPD or heart disease, but many were found to have mild abnormalities in heart and lung function. All were participants in the Multi-Ethnic Study of Atherosclerosis (MESA), a large study designed to detect early signs of heart, lung and blood diseases before symptoms appear. MESA is supported by NIH's National Heart, Lung, and Blood Institute (NHLBI).

The scientists observed that as lung function and structure became increasingly impaired, so did the heart's ability to fill with oxygen-rich blood. The volume of blood pumped per minute also dropped as lung function declined. The link between lung and heart function was strongest in the 370 participants who were current smokers, but it was also seen in people with mild COPD who had never smoked.

The new results suggest that these changes in heart function occur much earlier than previously realized, when COPD is mild or even before symptoms appear. Because the study population was ethnically mixed and covered a broad age range of apparently healthy people, the findings may be widely applicable to the general U.S. population. These results raise the intriguing possibility that treating lung disease may, in the future, improve heart function.

### Phone Home on Us

To sign up for the program cosponsored by A1AA and Coram Healthcare, go to

[http://www.alpha1advocacy.org/a1aa\\_phonocard\\_program.htm](http://www.alpha1advocacy.org/a1aa_phonocard_program.htm)

or call us toll free at 1-866-367-2122.

### Alpha-1 Advocacy Alliance

"Our mission is to improve the health and well being of those affected by Alpha-1 through support to patients, educating healthcare professionals, and advancing public policy for the Alpha-1 Community."

## How Alpha-1 Has Changed My Life (cont.)

Now I had two things wrong with me and no insurance to cover the cost. The fear was almost too much. I decided to take a job as a surveyor. I knew the job was way beyond my schooling and physical capabilities, but they had great insurance to help pay for the medical expenses. Each time I went out into the field and pounded that rebar into the ground, I felt like I was going to die. I couldn't breathe, my lungs felt like they were lead weights, but I knew I needed this job so I didn't quit. After a year of abusing myself, I was laid off due to the inability to fulfill the job requirements. Once again my life was spiraling out of control. This disease had its grasp on me once again. I took the first job I could get. The job was so stressful I became severely ill and lost 20 lbs. in a month. My wife was so scared. She thought she was going to lose me. Finally I found a new job as a cook for a restaurant called Jakes. We continued to pay the cobra from the surveying job while I worked as a cook. The job is physically hard for me, but I know I can't stop now. The medical bills are still piling up but I try to be like that little bird refusing to feel sorry for myself. To my own surprise, I even entered the 2009 Heart and Soul run in Billings, Montana with my wife who had been training for the race for five months. I was just going to walk the 6.2 miles but something inside me said try to run what you can. I finished that race in 1 hr and 18 min, just 10 minutes after my wife. I knew in that moment I could achieve anything I set my mind to even with Alpha-1. I am still young and life isn't over yet. I thank my wife and my family every day for their support. I couldn't imagine what it would be like to have to face an illness all alone. I am no 36 years old and I believe I still have many things to share with this world. College is my second chance to a better life. I want to find a job that will allow me to be successful and healthy at the same time. College is my next mountain and I hope there will be many more mountains to climb.

## CMS Finalizes Manufacturer Agreements for Coverage Gap

In 2011, only drugs with a signed manufacturer agreement will be covered under Part D. CMS has issued the final model agreements that drug manufacturers must sign to participate in the Medicare Coverage Gap Discount Program in 2011. Furthermore, unless manufacturers agree to the discount program, their products will not be covered under Medicare Part D, CMS said.

In a memo accompanying the manufacturer and third-party administrator model agreements, CMS told drug manufacturers that beginning in 2011, only applicable drugs with a signed manufacturer agreement with CMS will be covered under Part D. In addition, the manufacturer must also sign an agreement with a third-party administrator contracted with CMS. The deadline for returning the agreements is September 1 at 11:59 pm EDT.

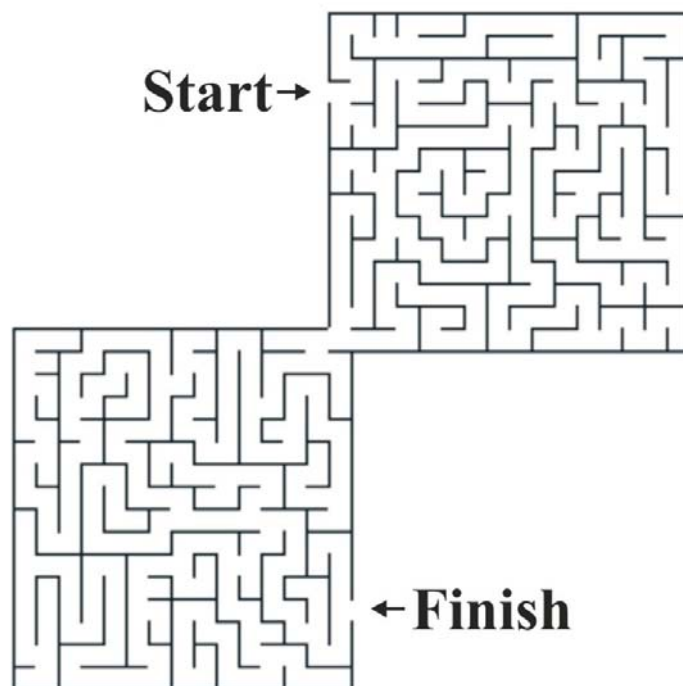
Starting in 2011, beneficiaries in the Part D coverage gap who are not eligible for Medicare Extra Help (a program for low-income beneficiaries) will see a 50% discount when they pick up their medications at their local pharmacy. This is the second step in closing the doughnut hole by 2020 under the Affordable Care Act.

As the first step, beneficiaries who have entered the coverage gap in 2010 and are not eligible for Medicare Extra Help are receiving one-time, \$250 checks from the federal government. More than 750,000 Medicare patients have received these payments as of August 10, according to CMS.

According to the discount program's final guidance that CMS issued on May 21, at the point of sale in the pharmacy, Medicare Part D plan sponsors will be responsible for determining if beneficiaries are eligible for a discount and if the drugs are discountable drugs, calculate the discount amounts on doughnut-hole claims, and include that information in adjudicated-claims response messages back to the pharmacies. Plans must reimburse pharmacies for the discounts within the same timeframe as Part D claims—14 days if submitted electronically, or 30 days if submitted otherwise.

As described in the model agreement, drug manufacturers will have 38 days to reimburse the plans for the discounts. Related resources on [www.pharmacist.com](http://www.pharmacist.com).

Can you find the way to the finish?



Solve the cryptogram—substitute letters to form a familiar phrase.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z							
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## Complications and Dealing

by Ann Marie Benzinger



My transplant journey will never end because I am a two-time lung transplant recipient due to Alpha-1 antitrypsin deficiency. I have walked you through my wait for the second transplant, the surgery and long recovery and now the issues of rejection, infection and the unknown factors that make transplantation a journey rather than an event. This column will end my “telling of the tale” though you can be sure my life will go on, issues will come up

and I will deal with them and move on. The original intent was to tell my view, thoughts and events as they happened so that future recipients, caregivers and family members would at least have one person’s real experience as a reference.

I left off in April exiting the hospital for treatment for mild rejection. This was my second biopsy showing rejection, listed as A1B1. The solumedrol doses give you a warped sense of well-being and energy. Once the treatment began to wear off, my energy levels declined and the wheezing, which never left, increased. By the middle of May, the wheezing was keeping me from sleeping and I was exhausted all the time. I could breathe fine, deep breaths that I haven’t had for many years. Overall, I felt bad, but not sick. Hard to explain to a doctor with words other than, “I breathe well, but feel like crap”. My sternum also hurt and moved, more than it did in the beginning. I sent off an email to my doctor and was scheduled for another bronchoscopy and hopefully a consult with the surgeon about my chest.

I arrived at the hospital in the middle of May for my bronc and had my usual chest xray and lung function tests before I headed for the bronchoscopy suite. I was gowned, IV started and blood drawn and took my gurney ride over to the bronc room. The doctor had decided that I needed to be admitted for a day or two so they could find out what was making me ill, so I knew then I would be staying at least overnight. The bronc was uneventful but the bronchial lavage didn’t give me the relief from the wheezing that I usually experienced. I was told the surgeon was out of town but would see me later in the week when he returned. In the hospital room, another IV was started along with antibiotics to cover any infections that could be going on. I was told to rest and a chest CT was ordered.

The CT revealed nothing abnormal with my lungs, but it did expose a cyst in the head of the pancreas. I was scheduled for an endoscopy on Wednesday morning to try to biopsy the cyst and remove it, if possible and if deemed necessary. Another IV was started as the ones I had were no longer usable (one had fallen out and the other one leaked all the meds). Getting an IV going has become a real pain, in every sense. Once I was sedated, the gastroenterologist inserted the endoscope through my mouth down to the location of the cyst. He could not aspirate the cyst due to the positioning of the scope. We knew nothing more from the procedure. The doctor recommended blood work and based on those results, further exam in six months. No one ordered the blood work.

Later that day a group of four white coats entered my room and told me they were from plastic surgery to discuss my chest.

One did all the talking, most to his colleagues I assumed were younger residents and interns, and explained that I was complaining about the sternum moving. After a minimal exam, he informed me that they could insert a metal plate with four bolts to make my chest stationary. I asked if it was broken or separated and he said he couldn’t tell from the xray. I asked if the surgery would correct the problem and he said he couldn’t say for sure. When he asked me what I thought, I re-counted what he had told me—the sternum might be broken, but he wasn’t sure; they might be able to fix it, but he wasn’t sure. He recommended that I see the attending.

The next morning I asked the nurse for copies of my blood work and I was told I couldn’t have them until I left the hospital. The nurse coordinator told me the same thing offering to go over the results verbally. I explained my wish to have them in my hand so I could better formulate any questions. It was a no.

I decided that I needed to go home. I asked the nurse’s aide to ask the nurse for the appropriate papers to leave AMA (against medical advice) as I was going home. I had nothing to pack because I wasn’t prepared to be admitted when I came for the bronc. I paced the floor and waited for the paperwork. I was gaining nothing by being in the hospital, leaky IV’s went unattended, communication from one person to the next was slow or didn’t happen at all, and I was given no information without getting angry. I didn’t want to be angry and certainly did not want to be in a hospital 150 miles from home. The nurse practitioner got my papers together, advised me of what I needed to do to follow up, I signed the discharge (not AMA) papers and left the hospital. I took a shuttle over to the bus station and made a ten-hour bus ride home.

While I do not recommend my behavior to anyone, you must look out for yourself and decide what needs to be done. Transplantation is not a game of chance. Communication between you and your team must be open and honest and consistent. I had a fantastic pre-transplant coordinator, pulmonologist and surgical team and ICU nursing staff who saved my life. I am forever thankful they were there for me. I am now under the care of my former transplant center in Richmond, Virginia.

The journey goes on. August 5, 2010 marked 13 years since my first single-lung transplant. Thank you to my angel donors and their families.

### Thank you

Thank you to those of you who have answered our request for donations. Your generosity is most appreciated, not only by us, but by those who ask for assistance and need our help. It is both sad and alarming to have to tell someone that we are temporarily out of financial assistance when they need help with a medical bill, co-pay or a utility bill. Your checks mean a lot to this community, many of whom have families to support and rely on disability income to support them. Many thanks to Baxter who continues to support us especially in times of immediate need. If you would like to make a tax deductible donation, please mail it to A1AA PO Box 202 Wolfstown, VA 22748. Again, thank you for sharing with us so we can share with those in need.

## Controversy over Augmentation Therapy

### Cochrane Review

#### Intravenous Alpha-1 Antitrypsin Augmentation Therapy for Treating Patients with Alpha-1 Antitrypsin Deficiency and Lung Disease

Gøtzsche PC, Johansen HK

#### Summary

Alpha-1 antitrypsin deficiency is an inherited disorder that can cause lung disease. It affects about 1 in 1600 to 5000 people. Those with lung disease suffer from shortness of breath, reduced ability to exercise and wheezing. People who smoke are more seriously affected and have a greater risk of dying from the disease. We reviewed the benefits and harms of treating patients who have the form of the disease that affects the lungs with alpha-1 antitrypsin extracted from human plasma. We found two randomised trials (total 140 patients) comparing this treatment with placebo for two to three years. All patients were ex-smokers or had never smoked but had the genetic problem that carried a high risk of developing lung problems. **Neither trial reported on the number of lung infections, hospital admissions or death from the disease.** The studies found no difference between the two groups in quality of life or in number of exacerbations of the disease. The lung function deteriorated slightly less measured by CT scan, but slightly more measured by forced expiratory volume in one second. Therapy with alpha-1 antitrypsin cannot be recommended, in view of the lack of evidence of clinical benefit and the high cost of treatment.

*This is a Cochrane review abstract and plain language summary, prepared and maintained by The Cochrane Collaboration (<http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD007851/frame.html>), currently published in The Cochrane Database of Systematic Reviews 2010 Issue 7, Art. No.: CD007851. DOI: 10.1002/14651858.CD007851.pub2. The full text of the review is available in The Cochrane Library.*

#### Abstract

**Background:** Alpha-1 antitrypsin deficiency is an inherited disorder that can cause lung disease. People who smoke are more seriously affected and have a greater risk of dying from the disease.

**Objectives:** To review the benefits and harms of augmentation therapy with alpha-1 antitrypsin in patients with alpha-1 antitrypsin deficiency and lung disease.

**Search strategy:** PubMed, the Cochrane Trials Register and **ClinicalTrials.gov** (7 January 2010), and the Cochrane Cystic Fibrosis & Genetic Disorders Group's Trials Register (13 March 2009).

**Selection criteria:** Randomised trials of augmentation therapy with alpha-1 antitrypsin compared with placebo or no treatment.

**Data collection and analysis:** The two authors independently selected trials, extracted outcome data and assessed the risk of bias.

**Main results:** Two trials were included (total 140 patients) that ran for two to three years. All patients were ex- or never-smokers and had genetic variants that carried a very high

risk of developing chronic obstructive pulmonary disease. Mortality data were not reported. There was no information on harms in the first trial; in the second trial, serious adverse events were reported to have occurred in 10 patients in the active group and in 18 patients in the placebo group. Annual number of exacerbations and quality of life were similar in the two groups; **none of the trials reported on average number of lung infections or hospital admissions.** Forced expiratory volume in one second deteriorated a little more in the active group than in the placebo group (difference was -20 ml per year; 95% confidence interval -41 to 1;  $p = 0.06$ ). For carbon monoxide diffusion, the difference was -0.06 mmol/min/kPa per year (95% confidence interval -0.17 to 0.05;  $p = 0.31$ ). Lung density measured by CT scan deteriorated a little less in the active group than in the placebo group (difference 1.14 g/l; 95% confidence interval 0.14 to 2.14;  $p = 0.03$ ) over the total course of the trials.

**Authors' conclusions:** Augmentation therapy with alpha-1 antitrypsin cannot be recommended, in view of the lack of evidence of clinical benefit and the cost of treatment.

*We copied reports from the Cochrane review of the study done by Peter C. Gøtzsche and Helle Krogh Johansen. The major problem we see with the study is that neither trial the authors used reported on the number of lung infections, hospital admissions or deaths from the disease. The most frequent comment we have seen on the international support group list (email address: ALPHA-1@HOME.EASE.LSOFT.COM) is that there have been significantly fewer exacerbations and hospitalization when on the therapy. This we feel is important enough to warrant making the therapy available. Opinions by the Alpha-1 Foundation may be seen at <http://www.alpha-1foundation.org/news/cochrane-study-poorly-designed-ignores-wealth-of-data-does-disservice-to-rare-disease-patients-says-alpha-1-foundation>.*

## Q & A about Liver Biopsy

### What Is a Liver Biopsy?

A liver biopsy is a procedure to remove a small piece of the liver so it can be examined with a microscope for signs of damage or disease. The three main types of liver biopsy are percutaneous, transvenous, and laparoscopic.

### When Is a Liver Biopsy Performed?

A liver biopsy is performed when a liver problem is difficult to diagnose with blood tests or imaging techniques, such as ultrasound and x ray. More often, a liver biopsy is performed to

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estimate the degree of liver damage—a process called staging. Staging helps guide treatment.

### How Does a Person Prepare for a Liver Biopsy?

At least 1 week before a scheduled liver biopsy, patients should inform their doctor of all medications they are taking. Patients may be asked to temporarily stop taking medications that affect blood clotting or interact with sedatives, which are sometimes given during a liver biopsy. Medications that may be restricted before and after a liver biopsy include: nonsteroidal anti-inflammatory drugs, such as aspirin, ibuprofen, and naproxen; blood thinners; high blood pressure medication; diabetes medications; antidepressants; antibiotics; asthma medications; and dietary supplements.

Prior to liver biopsy, blood will be drawn to determine its ability to clot. People with severe liver disease often have blood clotting problems that can increase the risk of bleeding after the procedure. A medicine given just before a liver biopsy, called clotting factor concentrates, reduces the risk of bleeding in patients with blood clotting abnormalities.

Patients who will be sedated should not eat or drink for 8 hours before the liver biopsy and should arrange a ride home, as driving is prohibited for 12 hours after the procedure. Mild sedation is sometimes used during liver biopsy to help patients stay relaxed. Unlike general anesthesia where patients are unconscious, patients can communicate while sedated but then often have no memory of the procedure. Sedatives are often given through an intravenous (IV) tube placed in a vein. The IV can also be used to give pain medication, if necessary, after the procedure.

### How Is a Liver Biopsy Performed?

All three main types of liver biopsy remove liver tissue with a needle; however, each takes a different approach to needle insertion. A liver biopsy may be performed at a hospital or outpatient center.

**Percutaneous Liver Biopsy:** The most commonly used technique for collecting a liver sample is percutaneous liver biopsy. For this method, a hollow needle is inserted through the abdomen into the liver to remove a small piece of tissue. To help find the liver and avoid sticking other organs with the biopsy needle, doctors often use ultrasound, computerized tomography (CT), or other imaging techniques. Ultrasound is an imaging technique that uses sound waves to create images of the body's internal tissues and organs. Ultrasound images are displayed on a video monitor. The doctor chooses the best spot on the abdomen for inserting the biopsy needle and then marks the spot with ink. In other cases, ultrasound is used during a biopsy to safely guide the needle through the abdomen and into the liver. CT is an imaging technique that takes hundreds of cross-sectional x rays in a few seconds. Putting together the cross-sectional x-ray pictures—like lining up slices of a loaf of bread—a computer forms a whole image of the internal organ. Some doctors do not use an imaging technique and instead locate the liver by tapping on the abdomen. During the procedure, patients lie on their back on a table with their right hand resting above their head. A local anesthetic is applied to the area where the biopsy needle will be inserted. If needed, an IV tube is used to give sedatives and pain medication. The doctor makes a small incision in the abdomen, either toward the bottom of the rib cage or just below it, and

inserts the biopsy needle. Patients will be asked to exhale and hold their breath while the needle is inserted and a liver sample is quickly withdrawn. Several samples may be collected, requiring multiple needle insertions. After the biopsy, patients must lie on their right side for up to 2 hours to reduce the risk of bleeding. Patients are then monitored an additional 2 to 4 hours after the biopsy before being sent home.

**Transvenous Liver Biopsy:** Transvenous liver biopsy is used when a person's blood clots slowly or when excess fluid is present in the abdomen, a condition called ascites. During the procedure, patients lie on their back on an x-ray table and a local anesthetic is applied to one side of the neck. If needed, an IV tube is used to give sedatives and pain medication. A small incision is made in the neck and a specially designed hollow tube called a sheath is inserted into the jugular vein. The doctor threads the sheath down the jugular vein, along the side of the heart, and into one of the hepatic veins, which are located in the liver. To see the veins, the doctor injects liquid contrast material into the sheath. The contrast material lights up when x rayed, highlighting the blood vessels and showing the location of the sheath. The doctor threads a biopsy needle through the sheath and into the liver and a liver sample is quickly withdrawn. Several samples may be collected, requiring multiple needle insertions. The sheath is carefully withdrawn and the incision is closed with a bandage. Patients are monitored for 4 to 6 hours for signs of bleeding.

**Laparoscopic Liver Biopsy:** Doctors use laparoscopic liver biopsy to obtain a tissue sample from a specific area or from multiple areas of the liver or when the risk of spreading cancer or infection exists. Laparoscopic surgery is a technique that avoids making a large incision by instead making one or a few small incisions. The doctor works with special tools—including a

## Choosing Coram as your alpha-1 provider is a breeze

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small, lighted video camera—passed through the incisions. A doctor may take a liver sample during laparoscopic surgery performed for other reasons, including liver surgery. During laparoscopy, patients lie on their back on an operating table. An IV is inserted in a vein to give sedatives and pain medication. A small incision is made in the abdomen, usually just below the rib cage. A plastic, tubelike instrument, called a cannula, is inserted in the incision and the abdomen is inflated with gas. Inflation allows the doctor space to work inside the abdominal cavity. A biopsy needle is inserted through the cannula and into the abdomen. The needle is inserted into the liver and a tissue sample is quickly withdrawn. Several samples may be collected, requiring multiple needle insertions. Any excessive bleeding because of the surgery is easily spotted with the camera and treated using an electric probe. After liver samples are collected, the cannula is removed and the incision is closed with dissolvable stitches. Patients will need to remain at the hospital or outpatient center for a few hours while the sedatives wear off.

### How Soon Do Results Come Back from a Liver Biopsy?

Results from a liver biopsy take a few days to come back. The liver sample goes to a pathology laboratory where the tissue is stained. Staining highlights important details within the liver tissue and helps the pathologist—a doctor who specializes in diagnosing disease—identify signs of liver disease. The pathologist looks at the tissue with a microscope and sends a report to the patient's doctor.

### How Long Does It Take to Recover from a Liver Biopsy?

Most patients fully recover from a liver biopsy in 1 to 2 days. Patients should avoid intense activity, exercise, or heavy lifting during this time. Soreness around the incision site may persist for about a week. Acetaminophen (Tylenol) or other pain medications that do not interfere with blood clotting may help. Patients should check with their doctor before taking any pain medications.

### What Are the Risks of Liver Biopsy?

Pain at the biopsy site is the most frequent risk of percutaneous liver biopsy, occurring in about 20 percent of patients. The risk of excessive bleeding, called hemorrhage, is about 1 in 500 to 1 in 1,000.<sup>3</sup> Risk of death is about 1 in 10,000 to 1 in 12,000.<sup>4</sup> If hemorrhage occurs, a procedure called embolization, assisted by an x-ray procedure used to visualize blood vessels called angiography, can be used to stop the bleeding. In some cases, a blood transfusion is necessary. Surgery can also be used to stop a hemorrhage. Other risks include puncture of other internal organs, infection, and spread of cancer cells, called cancer seeding. Transvenous liver biopsy carries an additional risk of adverse reaction to the contrast material.

Source: Internet: [www.digestive.niddk.nih.gov](http://www.digestive.niddk.nih.gov).

## Baxter Announces Definitive Agreement with Kamada

Baxter International Inc. announced a definitive agreement with Kamada Ltd. August 24 for exclusive commercial rights to GLASSIA™ [Alpha 1-Proteinase Inhibitor (Human)], the first and only liquid alpha1-proteinase inhibitor, in the United States, Australia, New Zealand and Canada. GLASSIA™,

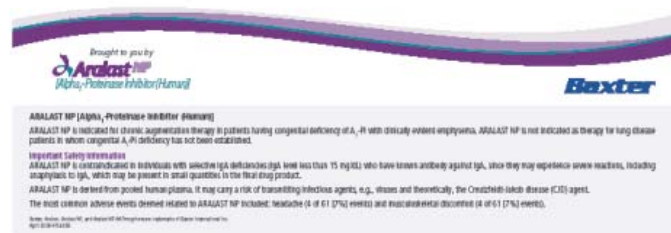


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To learn more, visit [www.aatmosphere.com](http://www.aatmosphere.com) or call 1-866-ARALAST (1-866-272-5278).



which was approved by the FDA on July 1, 2010, is indicated for chronic augmentation and maintenance therapy in individuals with emphysema due to congenital deficiency of alpha1-proteinase inhibitor (Alpha1-Pi), also known as alpha1-antitrypsin (AAT) deficiency. Baxter expects to introduce GLASSIA™ in the United States during the fourth quarter of 2010 and will pursue distribution licenses for GLASSIA™ in the other countries for which it has obtained rights.

“The agreement with Kamada underscores Baxter’s commitment to expanding the diagnosis of alpha1-antitrypsin deficiency by bringing new and innovative therapeutic options to Alpha-1 patients and their treating physicians,” said Larry Guiheen, president of Global BioPharmaceuticals, Baxter BioScience. The distribution agreement includes an upfront cash payment by Baxter of \$20 million. The agreement also includes a provision under which Kamada has agreed, for a limited period of time, not to initiate or enter any discussions or agreements relating to the commercialization of GLASSIA™ in certain other geographies and for Kamada’s investigational next-generation inhaled therapy. Under a separate license agreement, Baxter has been granted the right to process GLASSIA™ and will seek necessary regulatory approvals to enable it to do so. Also under this agreement, Baxter may make additional payments of up to \$25 million related to the achievement of certain commercial milestones and the execution of a technology transfer related to the production of the therapy by Baxter, as well as royalties on product sales.

## New Development in Artificial Lungs

Two research teams, from Harvard Medical School in Boston and Yale University, have grown artificial lungs that function in rats. The artificial lungs have the same alveolar structure, size and function as native lungs. The regenerated lungs oxygenated the recipient's blood for up to six hours, after which edema—accumulation of fluid within the lung—and capillary leakage occurred. For more information about this development which might alleviate the shortage of donor lungs in the future, see

<http://www.newscientist.com/article/dn19173-artificial-lungs-breathe-new-hope-for-transplants.html?DCMP=OTC-rss&nsref=health>.

## Help Alhapatamus:

Find the words, which are forward, backwards, up, down, or diagonal.

AIR CONDITIONER	C I N Z M P I N P
BACKPACKING	C Z O H D D Q R
BASEBALL	R H L Y H V M K W
BATHING SUIT	L N J H Y G E G
BEACH	V O L E Q O A A S
BERRIES	E A S O N N N F
CAMP	G U A B G R T C C
CAP	R L Y F O I X P
DAISY	D T B N A E C O A
DIVING	I E C I V K A L
FAN	T D E V R T B A G
FLOWERS	T I T I D C L R
FRISBEE	R O S P D H H H E
GARDENING	N I D A S A E V
GRASS	U O A A E U T I C
HEAT	D F O S W P R U
HIKING	N R B Q N N G I N
HOT	A I R N I K O H
ICECREAM	K S A H I D P O D
JOURNEY	G E S I M C H P
LIGHTNING	S U N N N E C A M
OCEAN	W S B T S A S O
OUTDOORS	Y N G O G R I A O
OUTINGS	X X U O U B A B
OUTSIDE	D F M A I S E H S
PARK	S T W I I O E N
PICNIC	K L Y A Y T S S W
PLAY	T Y A O T R S E
POPSICLE	H O N V E O A I T
RECREATION	V L X H R M V C
RELAX	V W A T E R M E L
REST	O N E I N H R X
ROSE	Z E F V G M C W R
SANDCASTLE	J Y E N R U O J
SEASHORE	L R C P I N E E R
SEASON	C S N U S T S N
SHOWERS	K S G N I T U O C
SUMMER	R E M M U S E I
SUN	X N G N I K I H L
SUNFLOWER	I T R A V E L H
SUNHAT	
SUNSCREEN	
SWIMMING	
SWIM SUIT	
THUNDER STORM	
TRAVEL	
TRUNKS	
VACATION	
VOYAGE	
WATERMELON	
WATER PARK	
WATER SKI	



## Prevention of Skin Cancer

By the Mayo Clinic staff

Most skin cancers are preventable. To protect yourself, follow these skin cancer prevention tips:

- Avoid the sun during the middle of the day. For many people in North America, the sun's rays are strongest between about 10 a.m. and 4 p.m. Schedule outdoor activities for other times of the day, even in winter or when the sky is cloudy. You absorb ultraviolet (UV) radiation year-round, and clouds offer little protection from damaging rays. Remember, sunburns and suntans cause skin damage that can increase your risk of developing skin cancer. Sun exposure accumulated over time also may cause skin cancer.
- Wear sunscreen year-round. Sunscreens don't filter out all harmful UV radiation, especially the radiation that can lead to melanoma. But they play a major role in an overall sun-protection program. Choose a broad-spectrum sunscreen that has a sun protection factor (SPF) of at least 15. Use a generous amount of sunscreen on all exposed skin, including your lips, the tips of your ears, and the backs of your hands and neck.
- Wear protective clothing. Sunscreens don't provide complete protection from UV rays. So cover your skin with dark, tightly woven clothing that covers your arms and legs, and a broad-brimmed hat, which provides more protection than a baseball cap or visor does. Some companies also sell photoprotective clothing. A dermatologist can recommend an appropriate brand. Don't forget sunglasses. Look for those that block both types of UV radiation—UVA and UVB rays.
- Avoid tanning beds. Tanning beds emit UV rays and can increase your risk of skin cancer.
- Be aware of sun-sensitizing medications. Some common prescription and over-the-counter drugs—including antibiotics; certain cholesterol, high blood pressure and diabetes medications; and nonsteroidal anti-inflammatory drugs such as ibuprofen (Advil, Motrin, others)—can make your skin more sensitive to sunlight. Ask your doctor or pharmacist about the side effects of any medications you take. If they increase your sensitivity to sunlight, take extra precautions to stay out of the sun in order to protect your skin.
- Check your skin regularly and report changes to your doctor. Examine your skin often for new skin growths or changes in existing moles, freckles, bumps and birthmarks. With the help of mirrors, check your face, neck, ears and scalp. Examine your chest and trunk, and the tops and undersides of your arms and hands. Examine both the front and back of your legs, and your feet, including the soles and the spaces between your toes. Also check your genital area and between your buttocks.



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Wolfstown, VA 22748

**Address Service Requested**

**FOR INFO CALL: 540-948-6777**  
**Toll Free: 1-866-FOR-A1AA**  
**Fax #: 540-948-6763**  
**<http://www.alpha1advocacy.org>**

## **Inside: Controversy over Effectiveness of Augmentation Therapy**

**THE ALPHA-1 FAMILY PROVIDING INFORMATION AND EDUCATION TO THE COMMUNITY.**

### **Alphapotamus**

Alphapotamus is proud to announce the William H. Poplett Memorial Scholarship recipients for 2010. There were many moving essays submitted and we wish we could have awarded one to each deserving applicant. The funds reflect donations made in memory or in honor of Alpha-1 patients. Named after one of our co-founders, Bill Poplett, the scholarships are given in \$500.00 increments to help defray the costs of college and to encourage the student to aspire to succeed. The 2010 scholarships were awarded to Mark Fowler, Jr from Billings, Montana, attending Montana State University; Jason Roundtree from Richmond, Va, attending Virginia Commonwealth University and Richard Fauci of Mckinney, TX, attending Prairieview A&M. Congratulations to all of our fellow Alphas and we wish you continued success.

#### **How Alpha-1 Has Changed My Life**

*by Mark Fowler*

In 2004 I was first diagnosed with A1AD. I thought my life was over. The only thing I heard was the doctor saying you only have 48% of your lungs left at 29 years old. I remember blowing into that breathing machine with all my might hoping to prove them wrong. The machine told the ugly truth, I did have Alpha-1. I didn't really understand the diagnosis. Many questions were running through my mind. What do you mean something is eating my lung tissue? How is that possible? How could someone live with only half of their lungs? What did I do to deserve a terminal disease? The same question kept ringing

through my head. Why me? I couldn't even hear my wife telling me I was still young and life wasn't over yet. I went into a deep depression. My life began spiraling out of control. I started to drink heavily and almost ruined my marriage. People from the support groups were calling me, but I couldn't talk to them. Talking about the disease made it real. I just could not let it be real. The thought of dying was destroying my life, but something in my heart said I could not live this way anymore. I started working out and even hiked up a mountain to prove to myself I was not going to quit living. I decided to fight Alpha-1 no matter what it took. I wanted my life to mean something. I began the treatments, but again was in a panic about the cost. How was I going to pay over \$13,000.00 a month and still take care of my family? I was also diagnosed with bipolar disorder.

**Continued  
on page 2.**

