SPEAKER: NTM lung disease is a chronic, indolent infection that can have a variety of clinical presentations from very mild disease to severe cavitary disease. In general, the likelihood of a patient needing to go on treatment is about 50%. In patients that have cavitary disease, bilateral disease, or severe disease, those patients need to be started on antibiotic therapy. And I would not pursue watchful waiting in that group of patients.

The guidelines that were published in 2007 are now under review. The revision will hopefully be available to us all this year. We should manage our patients with bronchiectatic nodule disease with intermittent treatment three times weekly, which will significantly reduce the likelihood of toxicity and will hopefully improve adherence in those patients. But in patients that have bilateral disease, severe disease, or cavitary disease, they need to be managed with daily treatment with a consideration for IV amikacin or intramuscular streptomycin for the initial two to three months.

Unfortunately, the likelihood of cure in this disease is not where it needs to be. Our patients come in and see us, and they say, thank god I don't have tuberculosis. And my first response to them is, you would rather have tuberculosis. We can treat TB. We can cure TB in almost 100% of patients, if they have susceptible TB, with six months of drugs.

In our patients, we're talking about years of therapy, sometimes two years of treatment, with cure rates that are unacceptable, cure rates of 65%, maybe 85% of the time if you have a very adherent patient with mild disease, and even lower in patients that have cavitary disease. So new therapies are desperately needed in this disease state.

And last year, we had a monumental event occur, and that was the approval of the first drug for NTM lung disease. That drug is inhaled liposomal amikacin. And what the sponsors found in their study was that in these treatment-refractory patients who have been treated for an average of four years, 30% of patients just within the first six months were able to convert their cultures. We think that is very important and relevant. And we'll see as the trial is ongoing what the durable conversion rates are in those patients.

In general, this is a well-tolerated medication. A significant amount of patients will have dysphonia or cough, but those side effects are manageable either with interruption or reassurance. And the vast majority of patients were able to stay on the treatment successfully. So I would certainly consider using inhaled liposomal amikacin in patients that have treatment-refractory disease, which is defined as being persistently culture positive after six months of guideline-based treatment. Thank you.