

**IN THE NEWS**

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## **Chabert recognized for superior respiratory care**

**Houma Today | 07.03.08**

NIKKI BUSKEY, Staff Writer

Leonard J. Chabert Medical Center has earned recognition from the American Association for Respiratory Care for its quality respiratory care.

"The entire Respiratory Department needs to be commended on receiving this honor" said Chabert CEO Rhonda Green.

About 700 U.S. hospitals have received the Quality Respiratory Care Recognition, Chabert officials said. Chabert is the only one in the Houma-Thibodaux area to earn the distinction.

"This is quite an honor, given that only 15 percent of respiratory departments across the country ever achieve this level of recognition," said Michelle Maize, director of Respiratory Care Services at Chabert.

The American Association for Respiratory Care began awarding the honor in 2003 to help consumers identify facilities using qualified respiratory therapists.

Hospitals earning the designation ensure patient safety by agreeing to adhere to a strict set of standards governing their respiratory-care services.

Criteria include requiring that all respiratory therapists in the hospital:

Hold certain licensed credentials or are legally recognized by the state as competent to provide respiratory services.

Are available round-the clock.

Have a doctor designated as medical director of respiratory care.

[http://www.houmatoday.com/article/20080703/ARTICLES/807030327/1211/NEWS01&title=Chabert\\_recognized\\_for\\_superior\\_respiratory\\_care](http://www.houmatoday.com/article/20080703/ARTICLES/807030327/1211/NEWS01&title=Chabert_recognized_for_superior_respiratory_care)

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## Still feeling the ill effects of Katrina

**Napa Valley Register | 07.07.08**

By Michaela Lambert

Ever since I returned from New Orleans this spring break, I have not been able to forget what I saw and experienced in Louisiana. One of the most vivid pictures etched in my memory is that of a homeless encampment of nearly 100 tents seen under a highway overpass. As I drove past this startling reminder of the destruction and displacement of people after Hurricane Katrina, I couldn't help but wonder how many people living in these homeless communities are mentally ill and not able to receive medical care because of the economic strain on New Orleans following Hurricane Katrina. I have discovered that not only is mental illness prevalent in New Orleans, but there is little to no mental health care available for the common, mentally ill patient. Since the storm, psychiatric beds available to adults have dwindled to an all-time low as the number of adults displaying signs of mental illness has significantly increased.

Before Hurricane Katrina the World Health Organization performed a survey between February 2001 and 2003 and interviewed 826 adults who would later be affected by Hurricane Katrina (Kessler, 2006). After Katrina, the survey interviewed a new sample of 1,043 adults living in the same area and asked the same questions regarding mental illness and suicidality. The results were astounding. Between this time, mental illness did not rise by a diminutive amount. It doubled! This survey is noteworthy in itself, yet it does not take into consideration the population of people in New Orleans that are homeless and therefore could not be reached through a phone survey. Studies have shown that the homeless population in New Orleans has more than doubled since Hurricane Katrina (Jervis, 2008). In addition to this, according to the National Coalition for the Homeless, 20-25 percent of homeless adults show some signs of mental illness (Mental Illness and Homelessness, 2006). Therefore, it can be concluded that mental illness has more than doubled since Hurricane Katrina.

Prior to Hurricane Katrina there were 240 adult psychiatric beds in New Orleans Parish, for a population of 300,000 people. This number was considered low for a population of this size. Today, there are only 20 beds in service in the whole city of New Orleans (McCulley, 2007). Many of the hospitals that once provided support for the mentally ill have not been reopened. One example of this is Charity Hospital. Before Katrina half of the psychiatric beds in New Orleans were located in Charity Hospital. But since Hurricane Katrina, Charity has not been reopened despite the efforts of many doctors. The loss of public hospitals such as Charity has put all private hospitals into a crisis. Private hospitals have been forced into taking on large numbers of uninsured patients, something they cannot afford. While private hospitals get reimbursements for the core medical services the hospital provides for the poor, neither the federal, nor the state government gives reimbursements to hospitals for adult psychiatric beds. Therefore, private hospitals in New Orleans are not able to reopen these services.

As the availability of psychiatric beds has dwindled to an all-time low in New Orleans, people have started to take desperate measures. In New Orleans, jail has started to be used as a psychiatric facility. According to Judge Calvin Johnson, who works at a court specifically for mental health patients who have gotten caught up in the justice system in New Orleans, family members have begun to call asking that their mentally ill relatives be placed in jail. But because people cannot be admitted to the jail mental facility without being arrested, family members have resorted to calling in fake crimes to get their relatives the mental health care they need (New Orleans, Mental, 2007).

Three years after Hurricane Katrina, the mental health care system in New Orleans is close to nonexistent. The little that is available in terms of mental health care is not substantial enough to supply resources for a fraction of New Orleans' population displaying signs of mental illness. Despite the fact that New Orleans is still in such an obvious state of despair, the rest of the nation has turned a blind eye to the apparent shortcomings of the mental health care system after Katrina. While some aid has been sent to Louisiana in the form of bricks and mortar and other building supplies, Louisiana has received a minuscule amount of aid in regard to mental health care. While the United States celebrates the rebirth of New Orleans during Mardi Gras and the prosperity and rejuvenation displayed in the French Quarter and on televisions across the nation, the common citizens of New Orleans are still trapped in an inadequate governmental system where they are receiving little assistance.

(Lambert lives in Napa.)

[http://www.napavalleyregister.com/articles/2008/07/07/opinion/letters\\_to\\_the\\_editor/doc4871ac2512949520489325.txt](http://www.napavalleyregister.com/articles/2008/07/07/opinion/letters_to_the_editor/doc4871ac2512949520489325.txt)

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## **Glenn Guilbeau: LSU board will miss Weems Shreveport Times | 07.07.08**

BATON ROUGE - I thought Gov. Bobby Jindal was an LSU fan.

Could he have been just pretending to be one last fall in an election year that happened to fall in a national championship year?

Jindal, or his people, even went as far as trying to circulate purple and gold bumper stickers with the words, "Tigers for Jindal." LSU had those discontinued as it did not want to appear to be supporting a particular candidate.

Jindal did grow up in Baton Rouge, and it is not a reach to assume he is an LSU fan. But if he truly cared about LSU athletics he would veto something he did last week. He removed attorney Charles Weems from the LSU Board of Supervisors. He should not have done this.

Most LSU Board of Supervisors members are replaceable - very replaceable. In the past, some remained with their hands close to the football for far too long. There needs to be a steady flow of attrition on this board. It tends to be more like a sewing circle than a leader of a great institution.

Weems was always a solid voice among, at times, crazies. He had been on the board since 1991 and leaves with the most continuous seniority. New blood is always good, but it's also good to keep some of the vintage around. LSU is suddenly full of new blood.

Skip Bertman, probably the greatest athletic director LSU has ever had, just retired and was replaced by former Duke athletic director Joe Alleva, who knows very little about LSU or major football schools. LSU president John Lombardi has only been on the job for about a year. A new chancellor, Michael Martin, takes over next month.

Things could not be much better at LSU athletically at the moment, and Weems is a major reason for that. Weems was part of the push for better facilities and premium ticket pricing that really began in the late 1990s when he was chairman of the Board of Supervisors.

Weems was instrumental in the hiring of Dr. William Jenkins as LSU president and Mark Emmert as chancellor in the spring of 1999. Weems was with Emmert and others from LSU on a visit to the Memphis home of sports agent Jimmy Sexton in late November of 1999 to hire Michigan State football coach Nick Saban. Saban won LSU's first football national championship in 45 years in 2003.

Weems was also heavily involved with Bertman in the hiring of Les Miles from Oklahoma State after the 2004 season when Saban went to the Miami Dolphins. Miles won another national championship for LSU last season. Unlike some on the board and others throughout the media and fan base, Weems has never been bitter toward Saban nor delved into revisionist history concerning Saban's stay at LSU. He remains friendly with Saban as several other LSU power brokers do. Weems is not prone to silly emotion, which can often be seen on the board. During controversial times, he was always a level head.

"I think what I'm most proud of is being a part of a new commitment to excellence at LSU," said Weems, a graduate of the LSU law school. "We were able to get out of the old mindset and move forward. I think LSU has made enormous strides in the last 10 years, and not only in athletics. We've gotten to a great plateau, but to sustain that takes good maintenance. I would have liked to continue to be a part of that."

Weems was given virtually no notice of his removal by Jindal or any of his people, who have consistently proven to be communicatively dyslexic. Weems was given no explanation. But then, not even Dale Brown got a call back from any one in Jindal's administration after several recent calls and letters.

"That is Governor Jindal's prerogative and his right," said Weems, who like Jindal is a Republican. "I guess what I'll miss most is the opportunity to make LSU better."

Weems could one day return to the board. This has happened with other members. Should LSU stumble in the near future, Weems should be on speed dial whether he is on the board or not.

<http://www.shreveporttimes.com/apps/pbcs.dll/article?AID=/20080707/SPORTS0402/807070334/1034/SPORTS04>

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## **Opinion: U.S. Health Care System Overhaul Needed To Reduce Costs, Columnist Writes Kaiser Network | 07.03.08**

"Health care will become one of the most onerous personal finance issues in coming years unless the system is changed to ensure universal access, cost control and long-term financing," Bloomberg columnist John Wasik writes in the Bloomberg/Boston Globe. He writes that the establishment of an "entirely government-run program may be untenable and politically unacceptable," and that the "road to a solution can merge both private and public interest." According to Wasik, such a "hybrid" health care system would use audit firms to determine areas to reduce costs, negotiate lower prices for services, base payments for services on performance and outcomes, and increase use of efficient technologies.

He writes, "Massive buying power through consolidation of separate programs and a public-private partnership" would "make health care available to more than 47 million who don't have coverage." Wasik writes, "The health care picture of the future isn't cloudy," adding, "There will be devastating financial consequences if we don't hunker down and prepare for a much more severe fiscal storm" (Wasik, Bloomberg/Boston Globe, 7/2).

[http://www.kaisernetwork.org/daily\\_reports/rep\\_hpolicy.cfm#53118](http://www.kaisernetwork.org/daily_reports/rep_hpolicy.cfm#53118)

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## Doctors Press Senate to Undo Medicare Cuts

The New York Times | 07.07.08

By ROBERT PEAR

WASHINGTON — Congress returns to work this week with Medicare high on the agenda and Senate Republicans under pressure after a barrage of radio and television advertisements blamed them for a 10.6 percent cut in payments to doctors who care for millions of older Americans.

The advertisements, by the American Medical Association, urge Senate Republicans to reverse themselves and help pass legislation to fend off the cut.

How to pay doctors through the federal health insurance program is an issue that lawmakers are forced to confront every year because of what is widely agreed to be an outdated reimbursement formula. But the dispute, which showcases the continued potency of health care issues, has reached a new level of urgency this year. Some doctors are reassessing their participation in the program and powerful interests on all sides are in a lobbying frenzy.

Just before the Fourth of July recess, the House passed a bill to prevent the Medicare pay cut by a vote of 355 to 59. In the Senate, Republicans blocked efforts to take up the bill, so the cut took effect on July 1, as required by the formula. But the Bush administration has delayed processing of new claims to give Congress time to come up with a compromise.

Senator Harry Reid of Nevada, the majority leader, said he planned to force another vote this week, and Democrats pressed their case over the weekend in their national radio address.

Democrats need just one more vote to pass the bill, and they hope to win over Republicans who were hit by advertisements over the recess. The advertisements assert that Republicans have been protecting “powerful insurance companies at the expense of Medicare patients’ access to doctors.” The commercials were aimed at 10 Republican senators, including seven up for election this fall.

But President Bush has vowed to veto the bill, so the fight — and the uncertainty — could continue for weeks.

Mr. Bush and many Republicans oppose the bill because it would finance an increase in doctors’ fees by reducing federal payments to insurance companies that offer private Medicare Advantage plans as an alternative to the traditional government-run Medicare program.

Insurance companies and the White House argue that the bill would hurt beneficiaries who rely on private Medicare plans. America’s Health Insurance Plans, a trade group, ran television advertisements last week, urging Congress to “stop cuts to Medicare Advantage.”

Medicare is just one issue on which Congress is stalled. The Senate has yet to finish work on a bipartisan bill to help homeowners facing foreclosure. Lawmakers are also struggling with legislation to regulate electronic surveillance and deal with soaring gasoline prices.

But the Medicare issue has been a sticking point for years. The question is how to rein in the rapidly rising cost of the federal health program. Members of both parties say they want to change the formula, which defines a “sustainable growth rate” for spending on doctors. But Congress is nowhere near agreement.

The pending bill offers a short-term fix. It would reverse the 10.6 percent cut and increase Medicare payments to doctors by 1.1 percent in January. Under the current formula, doctors would still face cuts of more than 5 percent a year from 2010 to 2012.

Despite the president’s veto threat, many House Republicans bolted and voted for the bill, putting added pressure on their colleagues in the Senate.

As the maneuvering goes on in Washington, doctors around the country have begun to reassess their participation in Medicare.

Dr. David D. Richardson, 40, an ophthalmologist in Los Angeles County, closed his practice last week to all but emergency patients and those needing surgery.

"I love practicing medicine," Dr. Richardson said, "but I would lose more money by keeping my office open than by pulling it back to a skeleton crew. Just like a physician in the emergency room, I try to reduce the hemorrhaging."

In Topeka, Kan., Dr. Kent E. Palmberg, senior vice president and chief medical officer of the Stormont-Vail HealthCare system, said its 70 primary care doctors were "no longer accepting new Medicare patients as of July 1 because of the draconian cut in Medicare reimbursement."

Dr. Gerald E. Harmon, a family doctor in Pawleys Island, S.C., said he decided last week that he would not take new Medicare patients "until further notice."

"This is not what we enjoy doing," says a notice in his waiting room. "It is what we must do to maintain financial viability."

Dr. Harmon said that Democrats had been more helpful on Medicare legislation, but that the two parties shared responsibility for the impasse.

"Rome is burning, and Nero is fiddling away, trying to get re-elected," Dr. Harmon said.

Doctors have also entered the political arena. One made a direct appeal to Mr. Bush at a fund-raiser last week in Jackson, Miss. Dr. J. Patrick Barrett, a spine surgeon and president of the Mississippi State Medical Association, said he had told Mr. Bush that the Medicare pay cut would be "extremely detrimental to the health and welfare of the elderly population."

In an interview, Dr. Barrett said: "I lose money whenever I operate on a Medicare patient. In the last week, a number of doctors have told me they will quit seeing new Medicare patients or will cut back on the amount of Medicare work they do."

The A.M.A.'s advertisements focus on Senators John Cornyn of Texas, John E. Sununu of New Hampshire and Roger Wicker of Mississippi, among others.

Republicans defend their position in various ways. Mr. Cornyn said the bill provided only "a patchwork fix." Senator Charles E. Grassley of Iowa said Democrats were playing "partisan games."

Senator Jon Kyl of Arizona, the Republican whip, said, "Nobody wants to cut physicians' pay." But lawmakers disagree over how to cover the cost of remedial legislation.

More than 10 million of the 44 million Medicare beneficiaries are in private Medicare Advantage plans offered by companies like Humana, UnitedHealth and Coventry Health Care. Many of these plans offer extra benefits like vision and dental care. But independent studies have repeatedly found that the private plans cost the government more per person than traditional Medicare.

Expecting the battle to resume this week, Coventry Health Care, in an e-mail message dated July 3, asked insurance agents across the country to call Congress and oppose the pending Medicare bill, saying that it would be "harmful to beneficiaries."

On the other side of the issue, military families have joined doctors and AARP, the advocacy group for older Americans, in lobbying for the bill.

Relatives of active-duty military personnel, military retirees and their dependents receive care under a federal program known as Tricare, which uses the Medicare fee schedule to pay doctors.

When Medicare reduces payments to doctors, fees under the military program are also reduced, and it becomes more difficult for military families to find doctors.

Congress is "playing chicken with your health care," the Military Officers Association of America told its members in a bulletin last week.

Medicare receives 15 million claims a week for services paid under the physician fee schedule, so any change in payment rates has big implications.

Michael O. Leavitt, the secretary of health and human services, said he would try to “minimize the impact” of the cut by instructing Medicare contractors to hold claims for 10 business days.

Kerry N. Weems, the acting administrator of the Centers for Medicare and Medicaid Services, said doctors would not be paid at the lower rates “before July 15 at the earliest.”

However, Medicare officials said, that is simply what the law requires. Under existing law, claims cannot be paid sooner than 14 days after they are received. And if claims are filed on paper, rather than electronically, they cannot be paid sooner than 29 days after they are received.

[http://www.nytimes.com/2008/07/07/health/policy/07medicare.html?\\_r=1&hp&oref=slogin](http://www.nytimes.com/2008/07/07/health/policy/07medicare.html?_r=1&hp&oref=slogin)

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## **CMS releases proposed 2009 outpatient/ASC rule AHA News | 07.03.08**

The Centers for Medicare & Medicaid Services today released a proposed rule updating Medicare payment rates for hospital outpatient and ambulatory surgery center services for calendar year 2009.

According to the rule, CMS would continue to transition to the new ASC payment rates, with ASC services paid at a 50/50 blend of the 2007 ASC payment and the 2009 ASC payment, which are 65% of the hospital outpatient rate.

Hospitals reporting seven outpatient quality measures in 2009 would receive a 3.0% inflation update, while eligible hospitals not submitting data would receive a 1.0% update.

The proposed rule outlines the process for validating hospitals' quality data; proposes adding four new imaging efficiency quality measures for public reporting in order to receive a full update in CY 2010; and seeks comment on 18 other quality measures for potential inclusion at a future date.

It also would alter how CMS pays for imaging services when multiple services are provided in one session, by creating a single payment for certain multiple imaging services such as ultrasound, computed tomography and magnetic resonance imaging.

The rule also changes the way partial hospitalization services are paid, reduces payments for separately payable drugs, and proposes changes to the hospital Medicare cost report for drugs and biologicals.

The rule will appear in the July 18 Federal Register, with comments accepted until Sept. 2.

AHA staff is analyzing the rule, and a Special Bulletin with further details will be sent to AHA members on Monday.

[http://www.ahanews.com/ahanews\\_app/jsp/display.jsp?dcrpath=AHANEWS/AHANewsNowArticle/data/ann\\_080703\\_OPPTS&domain=AHANEWS](http://www.ahanews.com/ahanews_app/jsp/display.jsp?dcrpath=AHANEWS/AHANewsNowArticle/data/ann_080703_OPPTS&domain=AHANEWS)

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## **Democrats hit GOP on support for Medicare cuts**

### **The Advocate | 07.06.08**

By JULIE HIRSCHFELD DAVIS  
Associated Press Writer

WASHINGTON (AP) -- Sen. Dick Durbin, the No. 2 Democrat, accused Republicans of putting seniors and military families at risk by siding with President Bush against a measure to prevent Medicare cuts.

Durbin, D-Ill., used a Saturday national radio address to call on Republicans to back the bill to stave off a 10.6 percent cut in Medicare payments to doctors.

It passed the House overwhelmingly last week in defiance of Bush's threat to veto it, but it fell just one vote short of the 60 it needed to advance in the Senate, with most Republicans voting "no."

"It's time for the Republican senators who are filibustering this measure to put our seniors and our military families ahead of private insurance companies and let the Senate pass this bill as soon as possible," Durbin said.

Bush and Senate Republicans don't like the bill because it includes offsetting cuts to insurance companies that use Medicare money to offer private health care coverage to about 20 percent of seniors.

The lower fees to doctors went into effect July 1, but Medicare officials are holding off processing new claims, hoping that Congress will act within the next few weeks to restore the higher payments. Many health plans, including the government program covering military personnel, tie their payment rates to Medicare's.

In a letter to Democratic leaders on Thursday, Republicans called for a monthlong extension to buy time to write a bill Bush would sign.

"The millions of beneficiaries who depend on Medicare and the providers who treat them are not political pawns in a partisan game, and Congress should not treat them that way," said the letter, signed by Sen. Mitch McConnell, R-Ky., the minority leader.

Democratic leaders intend to use the impending deadline to pressure Republicans, particularly those facing steep re-election challenges, to switch their votes or be accused of hurting seniors and others. Senate Majority Leader Harry Reid, D-Nev., plans a second vote on the measure as early as next week.

The Medicare bill is just one area in which Republicans and Democrats are battling over spending offsets. Democrats insist on pairing legislation to extend expiring tax cuts with tax increases elsewhere to prevent a rise in the deficit, and Republicans have steadfastly opposed such hikes.

McConnell offered to accept some tax increases if Democrats would agree to reduce spending on domestic programs.

Reid quickly rejected the proposal. In a statement, he said Republicans were choosing to "cut programs to help working families, seniors and veterans in need of health care" to protect multinational companies that would benefit from extending the tax cuts.

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## Cooling May Not Help Injured Brains in Children

**WLOX 13 | 07.04.08**

By Serena Gordon, HealthDay Reporter

WEDNESDAY, June 4 (HealthDay News) -- Cooling the brain after a traumatic brain injury may not help improve neurological outcomes and might even increase mortality.

That's the conclusion of a randomized trial of 225 children with brain injuries, but the authors and other experts suspect that by changing the cooling and re-warming protocol, other researchers may have more success with this therapy.

"Our hypothesis was that hypothermia would improve the outcome," said study author Dr. Jamie Hutchison, a critical care physician and director of the acute care research unit at the Hospital for Sick Children in Toronto.

"Children were randomized to receive 24 hours of cooling, to 32 degrees Celsius. They had to be enrolled within eight hours of their injury and, after cooling, we re-warmed an average of 0.5 degree Celsius every two hours. To our surprise, we didn't see any benefit," said Hutchison.

He said the study was designed to assess neurological outcomes, and that there was no difference between those who were cooled and those who received standard treatment. Additionally, the researchers saw a trend toward increased mortality in the cooled group. But, Hutchison said, the study wasn't designed to assess mortality and that those findings were not statistically significant.

Results of the study are in the June 5 issue of the New England Journal of Medicine.

Youngsters up to age 4 are among those most likely to suffer a traumatic brain injury, according to the U.S. Centers for Disease Control and Prevention. About 435,000 American children visit emergency rooms with traumatic brain injuries each year, and as many as 2,685 children die from traumatic brain injuries in the United States annually, according to the CDC.

Common causes of traumatic brain injuries are motor vehicle accidents, falls, assaults and collisions, like those that might occur during sports, reports the CDC. About 75 percent of traumatic brain injuries are mild, but more serious injuries can cause lifelong disability, creating problems with thinking, reasoning, the senses, language and emotions.

Hutchison said there may be a number of reasons why they didn't see an effect from cooling in the current trial. "Possibly, we may need to keep it going longer after a brain injury, because the brain keeps swelling for days after an injury. Perhaps 24 hours is too short a duration," he theorized.

Also, he said that there was a significantly higher incidence of low blood pressure during re-warming, and that the re-warming period may have been too quick.

The bottom line, said Hutchison, is that cooling for brain injury in children should not be used in the same context it was for this trial: 24 hours of cooling with re-warming occurring over 18 hours.

He said that several other studies of hypothermia for pediatric brain injury are already under way, but they're cooling for longer periods and re-warming more slowly.

Dr. P. David Adelson, director of neurotrauma at Children's Hospital of Pittsburgh, is leading one of the newer trials. He said this was a well-done study, and that other researchers have learned from it, but that "the jury is still out" on hypothermia for brain injury.

In his current study, Adelson said they are starting the cooling sooner, cooling for a longer period of time and re-warming at a far slower pace.

"This is a promising therapy that's going through an evolution. I think this study shows the difficulty of looking at complex disease processes [like traumatic brain injury], and trying to look at interventions. No one therapy will be the end-all treatment for brain trauma," said Adelson.

<http://www.wlox.com/global/story.asp?s=8434472&ClientType=Printable>

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## **Cholesterol Screening Is Urged for Young**

**The New York Times | 07.07.08**

By TARA PARKER-POPE

The nation's pediatricians are recommending wider cholesterol screening for children and more aggressive use of cholesterol-lowering drugs starting as early as the age of 8 in hopes of preventing adult heart problems.

The new guidelines were to be issued by the American Academy of Pediatrics on Monday.

The push to aggressively screen and medicate for high cholesterol in children is certain to create controversy amid a continuing debate about the use of prescription drugs in children as well as the best approaches to ward off heart disease in adults.

But proponents say there is growing evidence that the first signs of heart disease show up in childhood, and with 30 percent of the nation's children overweight or obese, many doctors fear that a rash of early heart attacks and diabetes is on the horizon as these children grow up.

Previously, the academy had said cholesterol drugs should be considered in children older than 10 if they fail to lose weight after a 6- to 12-month effort. The academy estimated that under the current guidelines, 30 percent to 60 percent of children with high cholesterol were being missed. And for some children, cholesterol-lowering drugs, called statins, may be their best hope of lowering their risk of early heart attack, proponents said.

"We are in an epidemic," said Dr. Jatinder Bhatia, a member of the academy's nutrition committee who is a professor and chief of neonatology at the Medical College of Georgia in Augusta. "The risk of giving statins at a lower age is less than the benefit you're going to get out of it."

Dr. Bhatia said that although there was not "a whole lot" of data on pediatric use of cholesterol-lowering drugs, recent research showed that the drugs were generally safe for children.

Surprisingly, the paper published in the medical journal *Pediatrics* that explains the new guidelines notes that among adolescents, average total cholesterol levels as well as LDL and HDL cholesterol have remained stable, while triglyceride levels have dropped, based on data collected from 1988 to 2000.

It is not clear how many children would be affected by the new guidelines. The recommendations call for cholesterol screening of children and adolescents, starting as early as the age of 2 and no later than the age of 10, if they come from families with a history of high cholesterol or heart attacks before 55 for men and 65 for women.

Screening is also recommended for children when family history is unknown, or if they have other risk factors, like being at or above the 85th percentile for weight, or have diabetes.

If the child's cholesterol level is normal, retesting is suggested in three to five years. Although lifestyle changes are still recommended as the first course of action, drug treatment should be considered for children 8 years and older who have bad cholesterol of 190 milligrams per deciliter and who also have a family history of early heart disease or two additional risk factors, the new recommendations say.

The guidelines give no guidance on how long a child should stay on drug treatment.

But they do say the first goal should be to lower bad cholesterol levels to less than 160 milligrams or possibly as low as 110 milligrams in children with a strong family history of heart disease or other risk factors like obesity.

Because statins have been around since only the mid-1980s, there is no evidence to show whether giving statins to a child will lower the risk for heart attack in middle age.

The academy also now recommends giving children low-fat milk after 12 months if a doctor is concerned about future weight problems. Although children need fat for brain development, the group says that because children often consume so much fat, low-fat milk is now appropriate.

<http://www.nytimes.com/2008/07/07/health/07cholesterol.html?ref=health>

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## Costly Cancer Drug Offers Hope, but Also a Dilemma

The New York Times | 07.06.08

By GINA KOLATA and ANDREW POLLACK

It took only an instant for 58-year-old Gailanne Reeh to go from the picture of health to death's door. By chance, her doctor noticed a lump under her arm during a routine exam. It turned out to be advanced breast cancer.

Soon she was having tests to reveal the extent of the cancer and hearing the grim results.

The surgeon, she recalled, "looked at me and said: 'This is not a conversation I like to have. But I can't do anything for you. You can't be cured. You can't be treated. All we can do is manage your cancer.'" On scans to detect tumors, the doctor told Ms. Reeh, "you light up like a Christmas tree."

And so, like many others in that situation, Ms. Reeh, the vivacious owner of a staffing agency in Boston, was given bevacizumab, also known as Avastin, a drug that signifies both the hopes and dilemmas of modern medicine.

Looked at one way, Avastin, made by Genentech, is a wonder drug. Approved for patients with advanced lung, colon or breast cancer, it cuts off tumors' blood supply, an idea that has tantalized science for decades. And despite its price, which can reach \$100,000 a year, Avastin has become one of the most popular cancer drugs in the world, with sales last year of about \$3.5 billion, \$2.3 billion of that in the United States.

But there is another side to Avastin. Studies show the drug prolongs life by only a few months, if that. And some newer studies suggest the drug might be less effective against cancer than the Food and Drug Administration had understood when the agency approved its uses.

While many patients and their doctors say the drug can improve the quality of life — like a sense of well-being and an ability to carry out daily tasks without exhaustion or pain — such effects can be hard to document. Meanwhile, many patients with cancers other than those of the colon, lung or breast are taking the drug, even in cases where there is no compelling evidence that it can help.

Avastin also has serious, if infrequent, side effects, some of which can be lethal. And because it is almost always used with standard chemotherapy — it did not work as well when researchers tried it alone — patients on Avastin do not escape chemotherapy's side effects.

"I still use Avastin routinely, but it's sobering," Dr. Leonard Saltz, a colon cancer specialist at Memorial Sloan-Kettering Cancer Center in New York, said of the new data. "It's not a slam dunk and, in fact, the incremental benefit may be more modest than we want to admit."

If Avastin were inexpensive or if it cured cancer or even held it at bay, as the drug Gleevec does for blood cancer, few might care. But like a half-dozen or so new biotechnology drugs with a similar combination — alluring promise, high price and only arguable benefits — Avastin raises troubling questions:

What does it mean to say an expensive drug works? Is slowing the growth of tumors enough if life is not significantly prolonged or improved? How much evidence must there be before billions of dollars are spent on a drug? Who decides? When, if ever, should cost come into the equation?

For a patient like Ms. Reeh, fighting for her life, the cost is not the main concern. If her insurer did not pay, she said, she would go into debt, find a way to raise the money.

But some in the pharmaceutical industry worry that such prices will raise concerns about whether the drugs are worth it, leading to a backlash like price controls or restrictions on use.

Roy Vagelos, a former chief executive of Merck who is considered an elder statesman of the industry, said in a recent speech that he was troubled by a drug, which he would not name but which was a clear reference to Avastin, that costs \$50,000 a year and adds four months of life. "There is a shocking disparity between value and price," he said, "and it's not sustainable."

Some patient advocates are also troubled by very expensive treatments like Avastin coming into routine use on what they see as little more than a hope and an expensive prayer.

"It's absolutely critical that we start having a public discussion," said Barbara Brenner, executive director of Breast Cancer Action, an advocacy group. "I think of Avastin as a model that is showing us where the problem is."

### The Rising Cost

The problem is largely one of cost.

Cancer drugs constitute the second biggest category of drugs in the United States behind cholesterol-lowering medicines, and accounted for \$17.8 billion of total prescription drug sales of \$286.5 billion in 2007, according to IMS Health, a health care information company. Spending on drugs for cancer grew 14 percent last year, faster than for all but three other diseases.

About 100,000 Americans take Avastin, according to Genentech's data. The drug is being formally tested in as many as 450 clinical trials for about 30 types of cancer. And Genentech, its partner Roche and the National Cancer Institute are now starting studies that will include more than 26,000 people with lung, colon or breast cancer at earlier stages of the disease than were studied initially. If Avastin is approved for those earlier-stage patient groups, it could have a major impact in delaying the return of their cancer, but hundreds of thousands of additional people could end up taking it, possibly for years.

And that, insurers and patient advocates say, could impose a considerable financial burden.

The drug's price, as charged by Genentech, can be \$4,000 to more than \$9,000 a month, depending on a patient's weight and the type of cancer. Avastin's cost to patients and insurers can be much higher, though, because doctors and hospitals buy the drug and then sell it to patients or their insurers, often marking up the price. So the \$2.3 billion that Genentech recorded in sales of Avastin represents only part of what Americans spent on the drug last year.

And while doctors typically want the best for their patients, there also are other factors that may push them to prescribe Avastin.

"Think about where the interests are aligned," said Dr. Deborah Schrag, a colon cancer specialist at the Dana-Farber Cancer Institute in Boston. "Patients who seek out cancer care are often quite willing to try all kinds of things. Doctors want to help them and may be financially incentivized. And it is often quite hard for insurance companies to intervene."

Medicare requires that the doctor or hospital buying Avastin be paid an amount equal to Genentech's average selling price plus a markup of 5 to 6 percent. Of that amount, Medicare pays 80 percent and the patient pays 20 percent. Doctors and hospitals typically do not make much money on Avastin for Medicare patients, and can even lose money if they buy the drug at a price that is higher than average. But patients can end up paying thousands of dollars a month. Some have supplemental insurance to take care of it; others do not.

But private insurers sometimes pay several times as much as Medicare pays for Avastin. Doctors and hospitals have at times charged as much as \$35,000 a month for the drug, said Dr. Peter Dumich, who reviews claims for cancer patients for AWAC, a company that helps employers contain health care costs. The insurers have little choice, Dr. Dumich says, when their contracts say they must pay a portion, like 80 percent of the charge, whatever the charge actually is. "Providers have them over a barrel," he said.

And, like Medicare, private insurers may in turn require patients to pay a percentage of what can be hefty bills.

That has happened to Jim Lemieux, a colon cancer patient at Dana-Farber. His private insurance requires that he pay 25 percent of the cost of his treatment, which includes Avastin. His insurer, he said, is charged \$6,000 a month for the drug, making his share \$1,500.

Mr. Lemieux, who was a sales manager at a car dealership, says he cannot bear to look at his medical bills. They include bills for hospitalizations and surgery and co-payments for standard chemotherapy, as well as Avastin.

To try to make ends meet, he and his wife just sold their house and are moving into their son's basement. Even so, he says, he expects he will have to file for bankruptcy.

"You figure you've got insurance," Mr. Lemieux said. "I paid 30 years and never got sick. I should have just paid the money to myself."

But he is not planning to give up Avastin.

"I'm trying to stay alive," Mr. Lemieux said. "I decided I'm not going to die from Stage 4 colon cancer."

### A Promising Dream

When Napoleone Ferrara was hired by Genentech in 1988, he was assigned to work on a drug to ease labor during childbirth. But he could not get cow pituitary glands out of his mind.

Dr. Ferrara had noticed in his previous academic job that when he mixed extracts from the glands with cells from blood vessels, the vessel cells started to grow rapidly. Something made by those glands, he reasoned, could spur vessel growth. He found that substance in 1989 and called it vascular endothelial growth factor, or VEGF (pronounced VEJ-eff). He even isolated its gene. And that led to a new idea for a cancer drug.

It drew from a hypothesis for a sort of universal cancer treatment, advanced by the late Dr. Judah Folkman of Harvard. Dr. Folkman had argued, starting in 1971, that tumors must grow their own blood vessels to bring them nourishment and oxygen. If you could choke off those vessels, Dr. Folkman said, you could halt cancers.

Dr. Ferrara and his colleagues realized that if they could block VEGF, cancer cells might not be able to grow blood vessels. So Genentech developed a monoclonal antibody, a type of protein, that would bind to VEGF and disable it. In 1997, the company began testing its antibody, which became Avastin, in cancer patients.

There were some setbacks. Avastin failed in its first big clinical trial, against very advanced breast cancer. Genentech's stock dropped 10 percent in one day, and some analysts questioned whether the company's investment would ever pay off.

Meanwhile, the company was well into a trial of Avastin for colorectal cancer. Patients got chemotherapy plus either Avastin or a placebo. The Avastin patients lived more than four months longer, a median of 20.3 months, compared with 15.6 months for the other group. "We were excited," Dr. Schrag said. "Four months is big."

In February 2004, 15 years after Dr. Ferrara's initial discovery, the Food and Drug Administration approved Avastin for patients with advanced colon cancer. A blockbuster was born.

But now there is a question mark over that evidence. That first exciting result compared Avastin with a type of chemotherapy that has since been widely replaced by a more effective regimen.

In a later, larger study comparing Avastin with current chemotherapy, Avastin slowed the growth of tumors but did not extend life by an amount considered statistically significant.

Dr. Schrag said she would continue to give the drug to her colon cancer patients. But when she talks to patients about Avastin now, she said, she will add a few more caveats.

She believes that some patients are helped — that they may feel better and, she hopes, may even, in some cases, live longer. She says a few of her Avastin patients lived several years and some are still alive. Of course, she acknowledges, there is no proof that Avastin was responsible, but it is stories like those that give her, and patients, hope.

“All patients want to be the tail end of the survival curve,” Dr. Schrag said.

When Avastin was approved for colon cancer, Genentech decided to charge \$2,200 for an average dose, taken every two weeks. That was a reflection of the research and development it had put into the drug as well as continuing research, said Walter Moore, the company’s director of government relations.

Genentech, which has never before revealed what it spent to develop Avastin, now says that it and its partner Roche have spent more than \$2.25 billion starting with Dr. Ferrara’s original work. The figure includes research, clinical trials and filing for regulatory approval and is well beyond what was spent by the federal government, which conducted important clinical trials of Avastin. Through May 2006, the government had spent \$44.6 million on Avastin trials and related laboratory work, according to figures obtained from the National Cancer Institute by Consumer Watchdog, an advocacy group.

While it is impossible to compare directly the company’s investment to the costs of developing other cancer drugs, the amount Genentech says it spent is “on the high side” of the industry average, said Henry Grabowski, a professor of economics at Duke University who has analyzed drug development costs.

Genentech says it and Roche — which owns a majority of Genentech and markets Avastin outside the United States — will spend an additional \$1 billion testing Avastin as a treatment for early-stage cancers.

The price also reflected Genentech’s perceived value of the drug compared with other cancer treatments. The price was half that of Erbitux, a colon cancer drug from ImClone Systems and Bristol-Myers Squibb that was approved the same month as Avastin and had not been shown to prolong life.

But Avastin is typically used for a longer time and by more patients than Erbitux. And the Avastin dose for lung and breast cancer is twice that for colon cancer, doubling the price.

Eric Schmidt, an analyst at Cowen and Company, said pharmaceutical companies typically based drug prices on what the market could bear.

“It’s high because Genentech can price it high,” he said, noting that Avastin’s price was in line with that of some other cancer drugs. Despite the company’s research and development costs, Mr. Schmidt said, Genentech is one of the most profitable of pharmaceutical and biotechnology companies.

Other countries have different views about whether Avastin is worth its price. An institute that advises the British government on which drugs to pay for recommended against it, saying that the drug was not cost effective based on its cost per year of life extended.

In the United States, Genentech argues that it puts patients first, with free drugs for those who have no way to pay for them and donations to charities that can help with payments. It also capped the price for a year’s supply of Avastin at \$55,000 (not counting markups by doctors and hospitals) for patients with incomes of less than \$100,000 a year.

But progress against cancer has a price, the company says.

“The quest is to eliminate the disease,” Arthur D. Levinson, Genentech’s chief executive, said at an annual investor meeting. “And, yes, there is going to be a cost to that.”

#### Of Dubious Benefit

After colon cancer, the next target was lung cancer.

Dr. Bruce Johnson of Dana-Farber knew the difficulties well. He had been at the National Cancer Institute, where he reviewed 25 years’ worth of clinical trials, 30 studies that started with high hopes and ended with little progress. He used to give talks quoting a World War I general: “Ground gain minimal. Casualties huge. Conclusion — press on.”

Avastin, in that context, looked like something of a triumph. Patients who took it along with standard chemotherapy survived for a median of 12.3 months, compared with 10.3 months for those getting only chemotherapy. The results were announced in 2005. “Finally,” Dr. Johnson said, “something worked.”

But as with colon cancer, a newer study adding Avastin to a different chemotherapy regimen has raised questions about its effectiveness against lung cancer. The study’s Avastin patients lived no longer than those who got the chemotherapy plus placebo. Although the drug did slow the median time until progression of tumors, the difference was less than a month.

The third approval for Avastin, for advanced breast cancer, came in February of this year. The clinical trial found it significantly slowed the progression of cancer but did not significantly extend life. The F.D.A. went against its own panel of outside experts, who had voted 5 to 4 against approval.

The agency’s action has not sat well. Senator Charles E. Grassley, Republican of Iowa, asked the Government Accountability Office to look into the F.D.A.’s approval of Avastin and some other drugs that “appear to have little to no effect in protecting lives and increasing health.”

Dr. Lee Newcomer, an oncologist and executive at the insurer United HealthCare, said patients were not well served, and neither were insurers, nor the public, which ultimately foots the bill. If a drug just stops tumor progression, without the woman’s living longer or feeling better, without her noticing anything different, Dr. Newcomer said, “you’re treating an X-ray.”

Patient advocacy groups were split.

“Even when these drugs ‘work,’ what kind of impact are you talking about?” said Fran Visco, president of the National Breast Cancer Coalition, which opposed approval. “But we market them and give them to everybody.”

Yet other doctors and advocates for patients say that when tumors grow, patients can notice new or worsening symptoms. And they certainly experience greater anxiety.

Dr. Kathy Albain, a breast cancer specialist at Loyola University Medical Center in Maywood, Ill., polled colleagues and patients and found overwhelming support for approving drugs based on delaying tumor progression. It would be ideal to show that a drug also prolongs life, but that may not be realistic, she said. The reason is that when a woman’s cancer progresses, doctors change the drugs they use, hoping to slow the cancer. That dilutes any impact of the first drug — in this case Avastin.

Kay Wissmann, director for government relations at the Breast Cancer Network of Strength, a patient advocacy group, said women should have a choice to use Avastin.

“We’ve got some good evidence about this particular drug,” she said, “so maybe we should let the people with metastatic disease have the option of using it.”

#### Unapproved Uses

Then there are patients who cannot wait for evidence that a drug works for their cancer.

One patient’s husband had no medical training. But he determined through his own literature search that his wife’s form of brain cancer produced a lot of VEGF, the very substance Avastin neutralized. So the couple wanted to try Avastin, even though it had never been tested for brain cancer. It was 2004, when the only Avastin approval was for colon cancer.

They asked the woman’s doctor, Dr. Virginia Stark-Vance, to give them the drug.

Dr. Stark-Vance, a solo practitioner in Dallas and Fort Worth, was reluctant, worried that Avastin could cause bleeding in the brain. That had happened in one of the earliest clinical trials, when a 29-year-old woman whose liver cancer had spread to her brain collapsed from a hemorrhage while riding her bicycle.

Finally, Dr. Stark-Vance agreed on the condition that the woman be hospitalized to receive Avastin, in case there was a brain hemorrhage. Had there been one, Dr. Stark-Vance “could have lost her license,” said Dr. Henry Friedman, a brain cancer specialist at Duke.

Like many others taking Avastin, this woman plunged into the unknown, without the assurance of a clinical trial studying whether the drug worked for her type of cancer.

Doctors are free to prescribe Avastin, or any other drug on the market, for unapproved uses, at their discretion. As much as 75 percent of cancer drug use is of this “off label” variety, according to an estimate by the National Comprehensive Cancer Network, a group of big cancer centers. And some doctors say that with patients dying, they simply cannot wait for airtight evidence.

“Of course we want everything to be evidence-based,” said Dr. Yashar Hirshaut, an oncologist in Manhattan. “I also like the American flag and apple pie.”

But, he explained, “You say, ‘This person is dying right here and I need something that will help, and there’s a logical construct that I can see how it will help.’ ”

One of his patients, Alice Lichter, has had gastric cancer since 2006. Dr. Hirshaut is throwing the whole arsenal at it, giving her gemcitabine, a drug used for pancreatic cancer, plus virtually every drug approved for colon cancer: Avastin, Erbitux, Eloxatin, irinotecan, 5-FU and leucovorin. Most are not approved for gastric cancer.

Once every two to four weeks, Ms. Lichter, 72, flies from her home in Miami and checks into Lenox Hill Hospital in Manhattan, where she undergoes four days of intravenous infusions.

“I call Lenox Hill my second home,” she said.

‘You Name It, It Got Tried’

Ms. Lichter, whose cancer appears to have receded, said she never questioned Dr. Hirshaut’s judgment. And she has no idea how much her drugs cost because Medicare is paying for them and her supplemental insurance covers her co-payment. Insurers say they are often forced by state laws to pay for cancer drugs not approved by the Food and Drug Administration, and Medicare must pay if the drug’s use is listed in a compendium, a reference compiled by cancer specialists, whose standards are looser than the F.D.A.’s.

Such requirements are one reason about 12 percent of United HealthCare’s Avastin patients have cancers other than colon, breast and lung. “Brain, stomach, pancreas, primary cancers of the liver, bladder, small bowel, larynx, prostate — you name it, it got tried,” Dr. Newcomer said.

But the anecdotes and evidence from small trials that may seem to justify off-label use sometimes turn out to be misleading. That happened with pancreatic cancer. After patients and doctors decided Avastin had to be helping, cancer researchers themselves conducted a large study. So did Roche. Avastin, both studies concluded, did not prolong life for people with cancer of the pancreas.

For brain cancer, doctors are encouraged, although they do not really know for sure whether Avastin helps. The brain tumor in Dr. Stark-Vance’s patient shrank so much after two infusions of Avastin that the radiologist who performed the brain scans called Dr. Stark-Vance in wonderment.

Dr. Stark-Vance began treating more patients. Some insurers paid for the drug. Others, including Medicare and Medicaid, did not. But Dr. Stark-Vance said Genentech agreed to provide the drug free for her patients who could not otherwise pay.

As word spread, Dr. Friedman at Duke and Genentech organized studies of a type generally considered less than definitive. There was no control group that took another drug or got a placebo. Everyone got Avastin. Otherwise, no one would enroll in the study, doctors argued.

Then the investigators compared the results with what they thought would have happened without Avastin. The patients lived a median of about nine months, about three months longer than the researchers estimate would have been expected.

But such comparisons have led scientists seriously astray in the past because the people being treated with a new drug often are very different from previous patients who did not take it and because overall medical care steadily improves. Nonetheless, Genentech has said it planned to apply this year to the F.D.A. for approval for Avastin to treat glioblastoma, the deadliest form of brain cancer.

Dr. Stark-Vance said her initial Avastin brain cancer patient broke her hip and had to be taken off the drug because it interfered with wound healing. She eventually died.

But by now, even without an F.D.A. approval, “the whole country” is using Avastin for glioblastoma, Dr. Friedman said.

### Better Than Nothing?

Gailanne Reeh remembers what life was like within a few months of those initial scans, when her cancer began causing terrible symptoms.

Her abdomen grew so full of fluid that it was hard to bend to tie her shoes. Bowel movements were difficult, and even lying down was uncomfortable with that huge mass in her abdomen.

She says she was chilled by what she recalls her doctor saying: “There was so much growing so fast in my abdomen and so much in my bowel, it was not a matter of maybe I would get a bowel obstruction. It was when I would get a bowel obstruction,” Ms. Reeh said. “And when I got it, there would be nothing anyone could do. I would die.”

To try to stave off such a horrible outcome, her oncologist, Dr. Eric Winer of Dana-Farber, offered to enroll her in a clinical trial comparing Avastin with another new biotech drug. Ms. Reeh was assigned to the group that got Avastin in combination with the chemotherapy drug paclitaxel, also known as Taxol.

The study closed after six months, but Ms. Reeh continued with her drug regimen, and her insurer is paying. After six months of treatment the fluid in her abdomen was down to just a trace, her tumors were stable or smaller and she felt like her former self again.

“I’m really, really excited,” she said.

### Was it the Avastin?

Dr. Winer said he did not know, since Taxol can also shrink tumors. It is impossible to draw conclusions from individual patients, he said. Still, he said, “I think it is quite likely that the combination of Taxol and Avastin improved her odds of having a better quality of life.”

Dr. Winer says that when he is not sitting in front of a patient, he thinks about whether drugs like Avastin are worth it to society. But when facing a seriously ill patient, who, based on clinical trial results, might benefit — even if only a little — from Avastin along with chemotherapy, he has to think about his patient’s needs.

“I can’t say, ‘Let’s not use Avastin; it’s a very expensive drug and I am worried about the cost to society,’ ” Dr. Winer said.

And so, Dr. Winer said, the answer you get when you ask whether drugs like Avastin are worth it very much depends on whom you ask.

“A person who hasn’t been affected by cancer will say, ‘Gee, why should we pay for an expensive treatment that doesn’t extend life when we have other needs?’ ” Dr. Winer said.

A person like Ms. Reeh will have a different response. She does not want to give up Avastin.

Last month, she reluctantly stopped taking her drugs for a while because Taxol was injuring the nerves in her feet. But later this month she hopes to resume taking both drugs, or at least Avastin.

Ms. Reeh says she knows her cancer may very well kill her eventually. But what is it worth to feel better again?

"It's really about living and not waiting to die," she said.

And what if 5 percent of Avastin patients live a lot longer than they would have without the drug?

"I might be in that 5 percent," she said.

<http://www.nytimes.com/2008/07/06/health/06avastin.html?ref=health>

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## Uncommonly Big Hearts May Not Harm Athletes

The New York Times | 07.07.08

By GINA KOLATA

WEST WINDSOR, N.J. — The three young men, tall, lean and tanned, had just been named to the United States Olympic rowing team. They showed up at Mercer County Park recently to meet the public and bask in their achievement. But their most amazing physical feature was inside their bodies, researchers say.

These athletes have hearts that make cardiologists gasp in awe, hearts that are among the biggest ever seen in healthy people. They are enormous, elongated, torpedo-shaped hearts, twice the mass of a normal heart, that draw blood in like a suction pump and push it out like a piston.

Ordinarily, of course, no one would know how big and powerful an athlete's heart might be. But these men — 29-year-old Wyatt Allen, 28-year-old Chris Liwski, and 31-year-old Bryan Volpenhein — were taking part in a research project that involved regular echocardiograms. Its goal is to find simple ways of deciding whether an athlete whose heart is huge has a dangerous condition that can lead to sudden death or whether the enlarged heart is a normal adaptation to strenuous, demanding exercise that allows people to perform at elite levels.

The so-called athlete's heart has been something of an obsession with doctors and researchers for more than 100 years. Athletes like marathon runners and Tour de France cyclists had enlarged hearts, doctors reported, and there were fears that the enlargement was not good — that it could lead to untimely death.

Now, said Dr. Paul Thompson, a cardiologist at Hartford Hospital, it is known that if the heart is healthy, there is never a point at which it is too big.

And, said Dr. Benjamin Levine, a cardiologist at the University of Texas Southwestern Medical Center in Dallas, it is also known that the heart can grow or shrink by a third, depending on the demands it must meet.

But a condition called hypertrophic cardiomyopathy afflicts 1 in 1,500 people, leads to a huge heart and is a leading cause of sudden death in athletes. That is what led Dr. Malissa Wood, a cardiologist at Massachusetts General Hospital in Boston, and a colleague, Dr. Aaron Baggish, to do their study to try to tell whether an athlete has that condition or is simply adapting to the stress of training.

Wood and Baggish, who are marathon runners, began looking at athletes' hearts a few years ago with studies of Olympic speedskaters. Skaters do not have hearts the size of rowers — few athletes do — but the right side of their hearts, which pumps blood, is enlarged, Wood said. The skaters also had a surprising ability to conserve energy. When they were at rest, their hearts were very relaxed, beating far less vigorously than the hearts of sedentary people.

"It was almost as if they were hibernating," Wood said. "But when they raced, their hearts really kicked in."

Last summer, the investigators took their portable echocardiograms to the skaters and studied their hearts again, asking what had happened now that the skaters had taken a break from intense training and competition. Their hearts, it turned out, had shrunk and were no longer so extraordinary.

In another study, the investigators compared Harvard football players to rowers. Both groups of athletes had enlarged hearts compared with what would be expected among inactive people the same size and age. But in a comparison with the rowers, the hearts of football players looked different, and acted differently. The football players had hearts that were thicker and stiffer. The rowers' hearts were bigger, more efficient, more relaxed.

Then the investigators became interested in Olympic rowers, reasoning that rowers were known to have big hearts. The reason is that rowers use all the big muscles of their body, repetitively contracting and relaxing them, which puts a huge demand on the heart to supply those muscles with blood.

In fact, Levine said, rowing puts such strains on the heart that astronauts use rowing machines during space flights to try to maintain their cardiovascular fitness.

Another reason for the big hearts is that rowers tend to be big people, and bigger people have bigger hearts. Allen is 6 feet 4 inches and 210 pounds, Liwski is 6-7 and 220 pounds, and Volpenhein is 6-3 and 215 pounds. The researchers, though, accounted for the men's size when assessing the size of their hearts, reporting that their hearts were still huge, twice the normal size.

But how big did the rowers' hearts actually grow? Wood and Baggish asked. And did their hearts continue to grow as they trained more intensely for the Beijing Olympics?

Wood and Baggish took their first look at the rowers' hearts in December, selecting the top three contenders for the United States team.

"Their hearts were incredible," Wood said. "Their masses were some of the biggest we have ever seen." Then they checked the rowers again in March. Their hearts had grown even larger.

The torpedo shape probably reflects a natural constraint on the heart's growth, Wood said. The heart is surrounded by a membrane, the pericardium, that, Wood suspects, constrains its growth along its middle. As the heart grows, it can push out along either end. (In fact, Levine said, dog trainers have snipped the pericardium of racing dogs, allowing their hearts to expand. The dogs, he says, then ran faster.)

But athletes with hypertrophic cardiomyopathy can also have huge, torpedo-shaped hearts. Wood said she thought she now knew how to distinguish them from healthy athletes' hearts.

The key, she said, is the high-velocity pumping and the powerful suctioning of blood back into the heart. An ill heart, she says, can never suction like that.

As for the rowers, they say they are happy to know their hearts are big, happy to see their hearts on the echocardiograms. It actually gives them confidence.

"You learn what your heart can handle," Volpenhein said. "Seeing it, knowing what it's capable of, you realize you can train harder."

<http://www.nytimes.com/2008/07/07/health/07hearts.html?ref=health>

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## **Department offers grants to expand**

### **The Advertiser | 07.04.08**

From staff reports

The state Department of Health and Hospitals' Bureau of Primary Care and Rural Health is now accepting applications for its \$1 million Community-Based Rural Health Program grant.

The grants are directed to rural and urban medically underserved areas to expand access to primary care services.

Up to \$75,000 individual awards are available to public and nonprofit groups located in rural areas, health professional shortage areas or areas identified in Act 162 from the 2002 first session of the Louisiana Legislature.

Proposed projects should expand, enhance or strengthen access to quality primary care services or School-Based Health Centers. Priority will be given to projects that demonstrate components of the medical home system of care, such as evidence-based, patient-centered care, coordination of care across multiple providers, disease management, quality improvement initiatives and health information technology.

"Putting these funds in the hands of local health care providers will allow them to make their own vital improvements, like implementing electronic health records," stated DHH Secretary Alan Levine in a news release.

Other eligible projects include information system technology for interoperability, referral systems and data collection relative to quality improvement and patient safety; chronic disease management and care coordination; pharmacy services and management; and the addition or integration of mental, dental or preventive health services.

<http://www.theadvertiser.com/apps/pbcs.dll/article?AID=2008807040307>

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## **Area technologists needed**

### **The Advertiser | 07.06.08**

Marsha Sills

In the next six years, the state estimates that the Lafayette region will need 30 percent more surgical technologists.

These allied health professionals ensure the sterile environment of a surgery room and handle the instruments needed for the procedure.

Three associate of applied science degree programs offer surgical technology training within the Louisiana Community and Technical College System.

The only program in this region is offered at Louisiana Technical College Lafayette campus.

Since 1992, the Lafayette campus has offered a technical diploma in surgical technology, but as the field is starting to demand an associate's degree, in 2006, the college received conditional approval to create an associate's program.

Last week, the program received full approval from the Louisiana Board of Regents.

At the Lafayette campus, three classes of students have graduated in the field with their associate's degrees. Another class will graduate this December.

"Within the region, we are the main supplier for surgical technologists," said Lori Lavergne, a certified surgical technologist who is the Lafayette surgical technology program director. "We have eight students who will graduate this December and we have more than eight positions open at local hospitals. Industry will have to wait until the following December until we get another graduating class."

While before only technical diplomas were required to work in the field, the demands are changing, said Amy Broussard, an instructor in the program at the Lafayette campus. Broussard is also the program's clinical coordinator.

"The Association of Surgical Technologists, our professional association, has been saying the associate degree is the recommended standard of education for the field. It's a new standard and it's taken time for us to catch up," Broussard said.

Right now, it's not a mandate of the certifying board, so those with the technical diploma can still sit for certification. But the field is expecting the change in time as more schools begin transforming their technical diploma programs into associate's programs.

Health professionals are in demand now across the state, but so are instructors, Lavergne said.

"We're constantly looking for instructors. It's hard to compete with industry," she said. "It's hard for people to come from industry into teaching because of the cut in pay that they take."

With the talk of changing the way that technical college programs within the Louisiana Community and Technical College System are funded to align more dollars with high-demand programs.

As of now, the technical colleges receive cookie-cutter funding to apply to all programs, regardless of the cost of instruction per student.

The current funding formula has meant that some programs were capped because of costs to hire instructors.

Lavergne said the surgical technology program is capped at 40 students.

"Hopefully, they will want to increase the numbers if we would have the monies available to find adequate instruction," Lavergne said.

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