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[TUESDAY, JULY 22, 2008]

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## Congress to turn focus to education, health care

The Times-Picayune | 07.22.08

By David Hammer  
Staff writer



Ted Jackson / Times-Picayune

**Dr. Dale Betterton guides the congressional delegation through the LSU Health Care Services Community Clinic in eastern New Orleans during a bus tour of New Orleans and coastal Mississippi.**

Eleven months after Valerie Schexnayder rushed up to U.S. House Speaker Nancy Pelosi in the middle of a 9th Ward street and begged her to listen, Pelosi was back in New Orleans on Monday, standing with Schexnayder in her brand new home.

Schexnayder told Pelosi her struggles with the Road Home had turned desperate: She wasn't getting housing aid because the state was running out of money. A few weeks after the Pelosi visit, the 61-year-old got a \$124,000 check from Louisiana's federally financed program. Two months after that, Congress sent the cash-strapped program an additional \$3 billion.

"What an inspiration she is to all of us," Pelosi said as she toured the home that replaced the one that floated down Reynes Street during Katrina.

Now, nearly three years after Hurricanes Katrina and Rita, local leaders are again trying to show why Washington should send more help to Louisiana. Pelosi and other congressional leaders promised to turn their focus to health care and education needs.

But they continue to deal with other state requests. Gov. Bobby Jindal said Monday that his top priority is to persuade his former congressional colleagues to give the state 30 years to pay its \$1.8 billion share of levee construction costs, rather than the three years signed into law last month.

The congressional group also met over the weekend with New Orleans criminal justice officials, some of whom were disappointed when the House removed from the Senate version of the emergency war spending bill \$300 million in hurricane recovery money, including, \$17.7 million to double the size of city drug courts, add drug rehabilitation beds, build detention centers for nonviolent juveniles, expand the district attorney's staff and improve the Police Department's technological capabilities.

Majority Whip James Clyburn, D-S.C., said the Democratic leadership agreed to remove the provisions when the White House threatened a veto.

Clyburn said the Democrats will work to restore the aid in an economic stimulus package working its way through Congress now. Gregory Rusovich, chairman of the New Orleans Crime Coalition and an architect of the criminal justice financing package, cheered that commitment Monday.

"We are very hopeful now, with Speaker Pelosi and Majority Whip Clyburn once again committing to the region, that they will take steps to put money back into the new plan," Rusovich said.

--- State: Need time to pay ---

As for the Army Corps of Engineers' \$14.7 billion project to build 100-year storm protection by 2011, Jindal said the requirement that Louisiana pay its \$1.8 billion share over three years would undercut critical work on coastal wetlands restoration, something for which the state already has dedicated \$500 million.

Jindal said he also is lobbying President Bush, a fellow Republican who could solve the issue with a simple executive order, as he presses Pelosi and other Democratic leaders for a legislative fix. He said Pelosi expressed her support Sunday at dinner.

"If ever there was a time to use the provisions in the law (to extend the payment schedule), you'd think this would be the time," Jindal said in an interview Monday. "We're willing to offer up our future OCS (off-shore oil and gas drilling) revenues: They could subtract our payments out of our royalty payments. That would secure a funding source, so there's no impact on the federal budget."

Under Jindal's proposal, Washington would keep Louisiana's revenue from Outer Continental Shelf oil and gas revenues until the \$1.8 billion was paid off. Such an arrangement would help Louisiana avoid the need to borrow money, although it would result in the state forfeiting about \$20 million a year until 2017, and about \$600 million or more each year after 2017 -- until the bill is paid -- as production from new offshore finds increases the state's share of the revenue.

New Orleans Mayor Ray Nagin hoped for a more generous arrangement, arguing that the state and local governments shouldn't have to pay anything for the levee work.

"While I support the governor's compromise position on federal funding for this protection and appreciate his advocacy, I believe that this city and this region deserve 100 percent federal funding for this flood protection system," Nagin said.

Rep. William Jefferson, D-New Orleans, said Monday that he believes that when all negotiations are complete, Louisiana will be absolved from any cost-share obligations.

--- Education needs outlined ---

Members of the congressional delegation visited Xavier University on Monday and pledged to help the leaders of nine local institutions of higher learning.

Xavier is looking for a flood insurance waiver that was already extended to the state's K-12 schools. Pelosi committed to creating a nationwide higher-education disaster loan fund, similar to one created for historically black colleges after the 2005 storms.

Speaking for his counterparts, Xavier President Norman Francis told the delegation that universities still need help to overcome Hurricane Katrina's devastation. The nine local institutions suffered a combined \$700 million in damage and \$300 million in lost revenue in the first year after the storm.

Xavier's enrollment is recovering slowly. It had 900 students in its freshman class in the fall of 2005 and that fell to 450 in the year after Katrina struck. The freshman count went back to 670 in the fall of 2007 and is expected to reach 800 this fall, Francis said.

--- Clinics praised ---

The delegation also braved the midday heat at a Louisiana State University community health clinic in eastern New Orleans. The modular facility was built with federal aid, and clinic officials thanked Congress. But that section of the city is still 10 miles from the nearest hospital.

"If you're out here having a cardiac situation, you'll probably be dead by the time you get to the emergency room," City Councilwoman Cynthia Willard-Lewis told the congressional representatives.

While New Orleans has far to go in restoring its downtown hospital corridor, local leaders said community clinics represent a post-Katrina success, helping bring better care to traditionally underserved groups.

Clayton Williams, director of health systems development for the Louisiana Public Health Institute, said a \$100 million grant helped launch the initiative. It features 70 sites run by 25 organizations in an effort to bring primary care to low-income populations.

Rep. Donna Christensen, a physician who represents the Virgin Islands, said New Orleans could become a model for bridging the gap in care, but expressed concern about improving electronic medical records.

Williams said Bush's Office of Management and Budget stepped in and prohibited the \$100 million grant from being used for improving health technology. Clyburn said a new provision is being considered in Washington specifically to finance health technology improvements.

Jefferson said he'll push to restore \$500 million for affordable housing in the stimulus package being debated in Congress.

<http://www.nola.com/news/t-p/washington/index.ssf?/base/news-2/1216705813288820.xml&coll=1>

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## **Epilepsy center reopens on West Bank**

**The Times-Picayune | 07.22.08**

By Jennifer Evans  
Staff writer

In another step toward recovery for a regional health-care system splintered by Hurricane Katrina, adult patients suffering from epilepsy can once again receive services at the state's Epilepsy Center of Excellence, reopened at a new West Bank location.

Advertisement

The Louisiana State University Health Sciences Center and West Jefferson Medical Center on Monday announced a partnership that will offer patients seizure monitoring and surgical options at the Marrero hospital. Prior to Hurricane Katrina, such services were offered by LSU at Memorial Baptist Hospital in Uptown.

"For the first time since the disaster, we can now offer the full range of services to diagnose, treat and even cure epilepsy," said Dr. Larry Hollier, chancellor of the LSU Health Sciences Center.

According to the Centers for Disease Control and Prevention, about 3 percent of Americans will be diagnosed with epilepsy by age 80.

Although medications are available to treat epilepsy, Dr. Erich Richter, associate director of the reopened center, said some patients experience seizures that can't be controlled by medication alone.

Seizures are caused when "irritable" cells in the brain become overactive, setting off an uncontrolled electrical firing of neurons throughout the brain, according to Richter, a neurosurgeon. The goal during surgery is to find the spots in the brain that trigger the seizures and take them out, he said.

In February, West Jefferson Medical Center began admitting epilepsy patients for scheduled monitoring periods averaging five days. Since that time, four or five patients have been monitored, and one patient has undergone surgery, according to Dr. Peter Olejniczak, the center's director.

The two hospitals developed a partnership after West Jefferson committed \$400,000 to buying new monitoring equipment and to covering the costs of nurses and some other support staff. LSU is providing the center's physicians and technicians.

The West Jefferson center has two epilepsy monitoring beds and one surgeon specializing in the condition. The center accepts private and public health insurance, which in many cases covers needs of indigent patients suffering from epilepsy.

While the two-bed monitoring capacity is half the capacity at Baptist prior to Hurricane Katrina, Olejniczak said the center's reopening is a critical step.

"For us, this is a breakthrough. . . . Through this collaboration, we can offer patients an interactive team," he said.

Both Tulane Medical Center and LSU's medical center in Shreveport offer seizure-monitoring procedures for adults. Tulane resumed surgery for epilepsy patients in 2006, according to Dr. John Walsh, professor of neurosurgery at Tulane.

Children's Hospital resumed seizure monitoring and epilepsy surgery in November 2005.

<http://www.nola.com/news/t-p/index.ssf?/base/news-0/1216704825226900.xml&coll=1>

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## **Epilepsy clinic finds home at West Jeff Medical Center**

**WWLTV.com | 07.21.08**

Meg Farris / Eyewitness News Medical Reporter

Nearly three years ago, local people with epilepsy lost the doctors and the clinic that gave them "quality of life" and even cured them of seizures.

Now, with a new partnership, the doctors and patients are back together as a local hospital gives them a clinical home.

Elmo Boudreaux of Marrero goes there to find out why he passes out and gets pain in his brain.

"I've been married 23 years and the strain that it puts on the family and just on everyday life, if they could find out what's wrong with me and take care of it, it would be a miracle for me," he said.

"Sometimes it's really tough," added his wife Tammy. "Elmo was the one who did everything - went to work everyday, planned everything, took care of his own family and now a couple days a week he can't even function. And we don't really know what's going on and it's scary."

So in hopes of a diagnosis and treatment they have come to West Jefferson Medical Center where the newly opened Epilepsy Center of Excellence is run by neurosurgeons from LSU Health Sciences Center. It's a new partnership that doctors say is critical.

"For the first time since the disaster we can now offer the full range of services to diagnose, treat and even cure epilepsy," says Dr. Larry Hollier, LSUHSC Chancellor. "In partnership with West Jefferson Medical Center we are reestablishing the only level-4 epilepsy center along the Gulf Coast."

"In the post Katrina world this is a demand that is absolutely something that we had to respond to," says West Jefferson Medical Center CEO, Nancy Cassagne.

The former Epilepsy Center was in Memorial Medical Center uptown on Napoleon Avenue, and there has been no place to treat, diagnose, monitor or perform epilepsy brain surgery since Katrina flooded the area.

"For two and a half years we have been unable to monitor our patients and provide surgical services," said Dr. Piotr Olejniczak, the Director of the Epilepsy Center of Excellence for the LSU Health Sciences Center.

"Epilepsy is a major problem in our society and almost four percent of the population has recurrent problems with seizures and that translates into almost 90,000 people in the state of Louisiana," says Dr. Erich Richter, Associate Director of the Epilepsy Center of Excellence at the LSU Health Sciences Center. Some of the patients who used the center before the storm said the treatment and brain surgery there changed their lives. Now they are now seizure-free.

"The surgery was a great success," said patient Chris Willig, who said he got into a wreck in 1984 that nearly killed two friends of his.

"It's been six years," said epilepsy patient Barbara McGowan. "I've had absolutely no seizures, so now I can drive, I can cook on a stove, and I can use power tools."

<http://www.wwltv.com/topstories/stories/wwl072108tpepilepsy.7b1b5eca.html#>

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## **LSUHSC Epilepsy Center Back Up And Running**

**995 WRNO | 07.21.08**

By Richard Hunter

The LSU Health Sciences Center lost its epilepsy treatment center because of Hurricane Katrina. But now, the center is back under one roof as a result of a partnership between LSUHSC and West Jefferson Medical Center.

Officials with the two medical complexes have announced the re-establishment of the Epilepsy Center of Excellence, now located at West Jefferson.

"For the first time since the disaster, we can now offer the full range of services to diagnose, treat and even cure epilepsy," said Dr. Larry Hollier, Chancellor of LSU Health Sciences Center New Orleans.

Dr. Peter Olejniczak, Director of the Epilepsy Center of Excellence, said Katrina severely disrupted the operations of the center by depriving it of its home. The center lost its monitoring unit which was housed at Baptist Hospital, and for 2 and a half years, says Olejniczak, they'd been unable to monitor their patients and provide surgical services.

"Through this wonderful collaboration, we can put everything under the same roof and have a real Level 4 epilepsy center," Olejniczak said.

<http://995fm.com/cc-common/news/sections/newsarticle.html?feed=135361&article=3983555>

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**Treating Disease in the Big Easy**  
**Discover Magazine.com | 07.09.08**  
 by H. Lee Kagan



iStockphoto

The case was straightforward, exactly what we needed on a busy morning. A 40-year-old construction worker had given me a history that sounded as if he had reviewed the signs of acute appendicitis just before walking into the clinic. He'd had two days of central abdominal pain that had now migrated into his right lower quadrant, mild nausea, no appetite, no vomiting, and no diarrhea. "A slam dunk," I thought. "Appendicitis until proven otherwise." I asked him to lie down on the exam table, but my mind had already begun to move to the next question: Where could I send him for surgery?

My wife and I were volunteering in New Orleans East, just north of the devastated lower Ninth Ward. Nine months earlier, Hurricane Katrina had tried to wash away the Big Easy, and almost everything, including the health-care system, was still broken. In a parking lot across from a flooded-out high school, a charitable group had set up a cluster of trailers to serve as a clinic. A hundred people were being treated daily, many lining up in the predawn hours hoping to be seen.

At the city's few functioning emergency rooms, the waiting time was up to two hours. And that was just to get a patient out of the ambulance. Once inside the ER, it was another 6 to 12 hours to get seen. "Unless you are bleeding or having chest pain, it's a long wait wher-ever you go in this city," the paramedics told me.

I continued with the exam. Placing my hands on the patient's belly, I began exploring for the tenderness that I knew I would find on the lower right side. I pressed down gently and looked for any sign of pain. His face, however, remained impassive. When I asked him if it hurt, he said no. I pushed systematically all over his abdomen. No tenderness anywhere.

"Does this hurt?" I asked again, pressing once more on the right lower quadrant. His answer was unchanged: "No."

I almost asked him, "Are you sure?" but refrained. Twenty years of practice had taught me to recognize when I had stumbled down the wrong diagnostic path. My slam-dunk case had just gotten interesting.

What could cause these symptoms yet produce no abdominal tenderness? My number one guess was a kidney stone, a mass that can form from minerals such as calcium in the urine. When stones migrate down the ureter—the channel linking the kidney to the bladder—they can cause trivial pain or induce

sheer agony. But in either case, unless there are complications, there should be no abdominal tenderness.

The clincher would be blood in my patient's urine. Stones in transit scratch the ureter as they travel and thus almost always cause microscopic amounts of blood to appear. We had a rudimentary lab at the clinic, so I had the patient give me a urine specimen. I dipped a plastic strip loaded with 10 different chemical spot tests into the urine, laid the strip on a paper towel, and then watched. Over the next 60 seconds I observed each of the spots for a color change. Sure enough, the one for blood turned blue-green—positive. "Yes, indeed," I smiled to myself, "you almost fooled me." But then I stopped short. My eye had just caught the spot for glucose. It was rapidly turning orange-brown—strongly positive for sugar. +++

He'd been so thirsty, he was drinking water every hour.

I asked the nurse to check the patient's blood sugar. As she pricked his finger, I asked him if he'd ever been told he had diabetes. He said no. On further questioning, he said that for the past six months, since returning from Houston, to which he had fled with his wife and daughter just before the storm, he'd been excessively thirsty, drinking water nearly every hour. And he'd been urinating almost as frequently. Polydipsia (excessive thirst) and polyuria (excessive urination) are classic symptoms of diabetes.

The nurse pointed at the glucose meter. Instead of a number, the machine's digital readout showed the word high, meaning the result was above the meter's upper limit of 600. (Normal fasting blood sugar ranges from 70 to 99.) My patient had developed diabetes, and it was now wildly out of control.

The pieces of the puzzle began fitting together. The kidneys normally filter blood to make urine, but the high amount of sugar in my patient's blood had caused his kidneys to draw off an abnormally large amount of water to dilute the sugar load. (That is why excessive thirst can be a sign of diabetes.) The ensuing dehydration had led to his developing a stone, though kidney stones are not a common complication of diabetes. The passage of my patient's stone from the kidney toward his bladder had triggered the pain that brought him to the clinic. At least that's how I put it together. My patient didn't need an operation; what he needed now was insulin.

Ordinarily I would have transferred this patient to the ER or hospitalized him directly. But rather than try to send him to another overburdened facility, I did a quick assessment. His vital signs were stable, and the urine spot test for acid accumulation (a dangerous complication of uncontrolled diabetes) had been negative. I decided that we could treat him.

After explaining the situation, I started an intravenous drip of fluids and injected a dose of insulin under his skin. The nurse and I then took turns checking his blood sugar every hour. With periodic small doses of insulin, his glucose level gradually dropped. Our goal was to get it down to below 300. Seven hours later, after we'd given him one and a half liters of fluid (about a half gallon) and a sizable load of insulin, he was feeling "the best I've felt in many months." His blood sugar was 230.

The nurse gave him a crash course in diabetes management, including general information about the disease as well as techniques of self-monitoring and self-injecting. He was a quick learner.

Toward the end of the day, we removed the IV. Our pharmacy gave him insulin and pills to improve his glucose metabolism. They also gave him supplies for testing and injecting himself.

Two days later he was back for a follow-up appointment. He looked and felt great. All the pain was gone. He smiled as he proudly showed us his log of blood sugar readings. They were all well below 200.

"You used to be too sweet, but we've fixed that," I joked.

He also gave us the tiny stone that he had passed in his urine. Patients passing a stone are normally given a urine screen to take home, but we'd had none. So we had given him a few coffee filters that we'd purloined from the break room to strain his urine at home. He'd caught the little bugger, and we sent it to the lab for analysis.

Absent that stone and the pain it created, my patient would soon have ended up in one of New Orleans's beleaguered ERs in a life-threatening diabetic coma. Instead, with treatment he was back to work in a few days, helping to rebuild his beloved hometown.

H. Lee Kagan is an internist in Los Angeles. The cases described in Vital Signs are real, but names and other details have been changed.

<http://discovermagazine.com/2008/aug/09-treating-disease-in-the-big-easy>

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**Quest: Repairing more hearts with implanted pumps****The Times-Picayune | 07.21.08**

By LAURAN NEERGAARD

The Associated Press

WASHINGTON (AP) — When it comes to hearts, Taneal Wilson won the lottery. A small pump implanted to keep the 31-year-old alive long enough for a heart transplant somehow helped Wilson's ravaged heart completely recover instead.

Only a lucky few are ever weaned off those implants, their rested hearts able to work on their own again. How to duplicate those successes is one of cardiology's biggest questions — as a new generation of the heart pumps begins U.S. testing.

"Why his heart recovered and the next person's heart does not recover, we don't know," said Dr. Steven Boyce, Wilson's surgeon at Washington Hospital Center in the nation's capital. "We're waiting for the science to catch up to the art."

That science is beginning. Doctors have begun pairing heart pumps with high doses of cardiac medication in hopes that more aggressive therapy will shrink flabby enlarged hearts enough to avoid a transplant, or at least enable patients to survive longer without one. At a few hospitals in the U.S. and Britain, they're also testing an experimental steroid-like drug on pump recipients that might spur heart muscle to rebuild.

Experts gathered by the National Institutes of Health recently urged testing heart pumps on patients who aren't quite as sick, instead of reserving them for the near-dead like doctors do today.

By that time, "we probably have lost our window of opportunity," said Dr. Lyle Joyce of the University of Minnesota — part of the first study to see if the slightly less sick fare better using Ventracor's next-generation VentrAssist pump.

It's much-needed work. Heart failure is on the rise, with 5.3 million Americans and 20 million people worldwide whose hearts become weak and unable to pump properly due to age, damage from a survived heart attack or other problems. In half of all cases, doctors can't even find a cause — like Wilson, who went from healthy to near comatose in a matter of weeks.

Medications and certain pacemakers help, yet heart failure kills 57,000 Americans a year and contributes to many more deaths. Only about 2,100 patients a year receive a heart transplant. A few thousand more try to buy time with "left ventricular assist devices" or LVADs, that take over the left ventricle's job of pumping blood through the body, powered by special batteries worn in a fanny pack.

Early pumps were too big for many patients and wore out quickly, the longest lasting just over a year. Last spring, the Food and Drug Administration approved a mini-LVAD, Thoratec Corp.'s HeartMate II, deemed safer and, with fewer moving parts, expected to last longer.

Now comes a third generation of LVADs that doctors hope will last five years or longer because they have just one moving part. Among them: VentrAssist, which has begun U.S. testing, and a pump by HeartWare Ltd. — to begin testing soon — designed to be even smaller and easier to implant.

Resting the heart can prove remarkably rejuvenating. About a third of LVAD patients have significant improvement in heart muscle function, making them better transplant candidates, says Dr. Simon Maybaum of New York's Montefiore Medical Center, who led the best study to date of recovery.

But rarely do patients fare as well as Taneal Wilson — whose pump was surgically removed June 17, 10 months after its implant, because his heart is functioning like a normal 30-something's again.

Between 5 percent and 9 percent of LVAD recipients have been weaned off, some only to quickly relapse. Boyce postponed Wilson's explant for months to be as sure as possible that his heart would beat unaided.

"This is a second chance God gave me," says Wilson. "I told the doctors every day, 'I got two sons. I need to go home to them.'"

Wilson was a school maintenance crew supervisor, used to physical labor, when he suddenly found it difficult to breathe. He spent weeks in intensive care before Boyce could implant the then-experimental HeartMate II, the only LVAD small enough to fit his chest.

Looking back, Wilson laughs about adapting to life sustained by a battery change every three to four hours. He initially made friends carry a heavy bag of eight extra batteries whenever he walked along Washington's streets. Then one day Wilson went to a grocery store for cake mix and carried just two extra batteries inside — only to worry the whole time that someone would steal his truck where he'd left the rest.

But he got confident enough to venture out to his former hangouts: "My buddies got the batteries. ... I'd just sit back and enjoy myself like everybody else."

Doctors can't yet predict which LVAD recipients will be lucky like Wilson, although so-called acute patients with abruptly damaged hearts have a better shot. More hospitals are learning how to dial back the pumps to test for recovery.

"If you don't look for it, you can't find it," says Maybaum, whose own hospital had two explants in the last year.

EDITOR'S NOTE — Lauran Neergaard covers health and medical issues for The Associated Press in Washington.

<http://www.nola.com/newsflash/index.ssf?/base/politics-4/1216667349272400.xml&storylist=health>

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## Health officials tout computer prescribing

**The Times-Picayune | 07.21.08**

By KEVIN FREKING  
The Associated Press

WASHINGTON (AP) — Those hard-to-read scribbled prescriptions from doctors could soon become a rarity.

Beginning Jan. 1, the federal government will boost Medicare's payments to doctors that send prescriptions electronically to a pharmacy rather than writing them out on paper and handing them to the patient. The widespread adoption of electronic prescribing is expected to save taxpayers as much as \$156 million over the next five years and save lives, Health and Human Services Secretary Michael Leavitt said Monday.

Currently, about 10 percent of family physicians use computers to transmit prescriptions to pharmacies. The software can ensure that all necessary information is filled out and legible and also allows doctors to keep better tabs on their patients. They can check for the possibility of an allergic reaction or whether a prescription may conflict with another medicine. They can also see if patients are taking their medication as directed.

Congress approved the higher payments last week as part of a bill that voided a 10.6 percent cut in reimbursement rates for doctors who treat Medicare patients. President Bush had vetoed the bill because of other provisions that lowered payments to health insurers. But on the issue of electronic prescriptions, lawmakers and the administration were in broad agreement. In the end, Congress ended up overriding Bush's veto.

In a conference call with reporters, Leavitt said the provisions for electronic prescriptions should cut down on an estimated 1.5 million injuries each year caused by drug-related errors. He noted that pharmacies also make more than 150 million telephone calls each year to clarify what was written on a prescription pad.

"That's a lot of people needlessly hurt and a lot of time spent trying to sort out bad handwriting," Leavitt said.

The biggest barrier to electronic prescribing has been the expense of buying and setting up the necessary equipment and software — an estimated \$3,000 per prescribing doctor. So Congress agreed to pay doctors slightly more over the next five years when they use such systems. They would get an extra 2 percent in their reimbursement rates when treating Medicare patients during 2009 and 2010, 1 percent more in 2011 and 2012 and 0.5 percent more in the final year.

"It is fairly costly for a small practice to begin the change-over to e-prescribings so the incentives in this particular bill will help," said Dr. James King, president of the American Academy of Family Physicians.

Congress also put in place financial penalties for those physicians who decline to use electronic prescribing, dropping their Medicare reimbursements by 1 percent in 2012, 1.5 percent in 2013 and 2 percent in 2014. Some exceptions will be allowed for hardship cases.

Leavitt said Medicare officials will hold a conference in the fall to help doctors work through some of the technical issues involved in setting up electronic prescribing.

<http://www.nola.com/newsflash/index.ssf?/base/politics-4/1216676347274520.xml&storylist=health>

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## Hoping Two Drugs Carry a Side Effect: Longer Life

The New York Times | 07.22.08

By NICHOLAS WADE

CAMBRIDGE, Mass. — One day last month, clad in white plastic garments from head to toe, Dr. David Sinclair showed a visitor around his germ-free mouse room here at Harvard Medical School.

The mice, subjects in studies of health and longevity, are kept in wire baskets under intensive nursing care. A mouse gym holds a miniature exercise machine that tests the rodents' ability to balance on a rotating bar. In a nearby water maze, mice must recall visual cues to swim to safety on a hidden platform, a test of their powers of memory. Those that forget their lessons are rescued as they start to submerge and humanely dried out under a heat lamp, Dr. Sinclair assured his visitor.

Dr. Sinclair is a co-founder of Sirtris, a company that itself has been swimming in uncharted waters as it works to develop drugs that may extend the human life span. But it seemed to have found a safe platform last month when it was bought last month by the pharmaceutical giant GlaxoSmithKline for \$720 million.

Sirtris has two drugs in clinical trials. One is being tested against Type 2 diabetes, one of the many diseases of aging that the company's scientists hope the drugs will avert. With success against just one such disease, the impact on health "could be possibly transformational," said Dr. Patrick Vallance, head of drug discovery at GlaxoSmithKline.

The new drugs are called sirtuin activators, meaning that they activate an enzyme called sirtuin. The basic theory is that all or most species have an ancient strategy for riding out famines: switch resources from reproduction to tissue maintenance. A healthy diet but with 30 percent fewer calories than usual triggers this reaction in mice and is the one intervention that reliably increases their life span. The mice seem to live longer because they are somehow protected from the usual diseases that kill them.

But most people cannot keep to a diet with a 30 percent cut in calories, so a drug that could activate the famine reflex might be highly desirable. Dr. Leonard Guarente, an M.I.T. biologist who founded the field of sirtuin biology, thinks the famine reflex is mediated through the sirtuin enzymes. Dr. Sinclair, his former student, discovered that sirtuins could be activated by drugs. The most potent activator that emerged from his screens was resveratrol, a natural substance found in red wine, though in amounts probably too low to be significant for health.

The Sirtris drug being tested in diabetic patients is a special formulation of resveratrol that delivers a bloodstream dose five times as high as the chemical alone. This drug, called SRT501, has passed safety tests and, at least in small-scale trials, has reduced the patients' glucose levels.

The other drug is a small synthetic chemical that is a thousand times as potent as resveratrol in activating sirtuin and can be given at a much smaller dose. Safety tests in people have just started, with no adverse effects so far.

The hope is that activating sirtuins in people would, like a calorically restricted diet in mice, avert degenerative diseases of aging like diabetes, heart disease, cancer and Alzheimer's. There is no Food and Drug Administration category for longevity drugs, so if the company is to submit a drug for approval, it needs to be for a specific disease.

Nonetheless, longevity is what has motivated the researchers and what makes the drugs potentially so appealing.

Dr. Christoph Westphal, the chief executive of Sirtris, said of the potential of the drugs, "I think that if we are right, this could extend life span by 5 or 10 percent." He added that his goal was to develop drugs against specific diseases, with the extension of life being "almost a side effect of our medicine."

Sirtris was founded in 2004 after Dr. Westphal, then working at a Boston venture capital firm, approached Dr. Sinclair. Because of widespread interest in the sirtuin activation idea, Dr. Westphal had little difficulty raising money and recruiting distinguished scientists to Sirtris's advisory board.

He later decided to sell the company to GlaxoSmithKline, he said, because it was getting harder to raise money and clinical trials could proceed faster with the larger company's resources. Sirtris was acquired at an 84 percent premium, better than the 50 percent at which most companies are bought, Dr. Westphal said.

The impact of Sirtris's drugs, if successful, could extend beyond the drug industry. Dr. Guarente believes that many people might start taking them in middle age, though after having started a family because they may suppress fertility.

Mice on the drugs generally remain healthy right until the end of their lives and then just drop dead. "If they work in people that way, one would look to an extension of health span, with an extension of life as a possible side effect," Dr. Guarente said. "It would necessitate changing ideas about when people retire and when they stop paying into the system."

GlaxoSmithKline could put SRT501, its resveratrol formulation, on the market right away, selling it as a natural compound and nutritional pharmaceutical that does not require approval by the F.D.A. "We haven't made any decisions, but that clearly is an option," Dr. Vallance said.

If GlaxoSmithKline decides instead to seek F.D.A. approval, it will need to prove that resveratrol is safe in the large doses required for efficacy. Resveratrol seems to exert many influences on the body, some of which are not exerted through sirtuin. "None of us should be naïve enough to think resveratrol won't have multiple effects, including some you don't want," Dr. Vallance said.

GlaxoSmithKline's purchase of Sirtris has pushed the optimism of sirtuin researchers and others to new heights. "We are all holding our breath," said Dr. Huber Warner, editor of the *Journals of Gerontology*. But the success of the drugs is far from assured.

Most potential drugs fail to make it past clinical trials, and the same may prove true for Sirtris's candidates. The sirtuin-activating chemicals the company has designed could turn out to be toxic. Another uncertainty is that the underlying science is still in flux and debate rages among academic researchers over many details of how caloric restriction works.

Some biologists think that sirtuin is not the only mediator of the famine reflex, and that resveratrol may not work through sirtuin at all in exerting its beneficial effects on mice. "There are data both for and against that hypothesis, though that doesn't dissuade one from pursuing it as a potential benefit," said Dr. Thomas Rando, who studies aging in stem cells at Stanford University.

In initial tests in mice, resveratrol has doubled muscular endurance, lowered the bad form of cholesterol, protected against various bad effects of a high-fat diet and suppressed colon cancer. New reports are confirming some of these benefits, but others are ambiguous or puzzling.

According to a study published on July 3 in the journal *Cell Metabolism* by Dr. Sinclair and Dr. Rafael de Cabo of the National Institute on Aging, resveratrol given to aging mice reduced their cataracts, strengthened their bones, improved coordination and enhanced their health in several other ways. Yet despite their better health, the mice lived no longer than usual.

"Minimally this calls into question one pillar of the GSK investment," said Dr. Ronald Evans, a leading expert on hormonal responses at the Salk Institute. Dr. Evans said that sirtuin research was promising but unproved, and that he did not agree that sirtuin was the probable mediator of the famine reflex, a concern that "calls into question the second pillar of the GSK investment."

The frontiers of science are often turbulent, and it can take years for clarity to emerge from confusion. Dr. Westphal said the decision to ignore the academic debate about exactly how resveratrol may work was one of two principal reasons for Sirtris's quick success. The other was to focus the company's limited resources on developing just two drugs.

The researchers at Sirtris are no strangers to skepticism. Dr. Guarente and Dr. Sinclair were ridiculed when they first started looking for longevity genes more than 15 years ago, because aging was then considered to be an intractable problem. His colleagues, Dr. Guarente said, "thought I was nuts."

Dr. Sinclair, when he first arrived as a young postdoctoral student in Dr. Guarente's lab to work on longevity, was downcast to learn of the other students' severe doubts. "The view even in Lenny's lab was that this problem was going nowhere, it was a house of cards that would fall down any month now." He called his parents in Australia to tell them he may have made a big mistake. But the research led eventually to the discovery of the sirtuinlike proteins and their role in extending the life span of yeast, worms and flies.

He and Dr. Guarente developed the sirtuin field with the hope of increasing longevity. But because of Sirtris's focus on developing drugs that have the F.D.A.'s approval for specific diseases, both are being less explicit about their hopes of reversing aging. "There's a much greater chance of a drug that can treat disease than of extending life span," Dr. Sinclair said.

"I'm becoming more boring in my old age," he added apologetically.

GlaxoSmithKline's press releases refer to the sirtuins as "enzymes that the company believes control the aging process." But Dr. Vallance is more guarded, saying aging is too hard to measure. The goal is not the extension of human life span; rather, "The prolongation of health is the aim," Dr. Vallance said.

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## Russia Scorns Methadone for Heroin Addiction

The New York Times | 07.22.08

By MICHAEL SCHWIRTZ



Brendan Hoffman

**DRUG PROBLEM** Patients in a program for heroin addiction in Yekaterinburg, Russia, run by a nongovernmental group.

MOSCOW — The conference seemed innocuous enough: a Moscow hotel, slide shows and several dozen doctors and specialists gathered to discuss how to treat heroin addiction. But then members of a Kremlin youth group called the Young Guard arrived, crowding the hotel's entrance and denouncing the participants as criminals and paid agents of the West.

The focus of their outrage was methadone, a drug prescribed by doctors around the world to wean addicts from heroin. A synthetic form of opium, methadone is central to a therapy endorsed by the United Nations and 55 countries, including the United States.

But not Russia. Though heroin abuse is widely linked to the country's H.I.V. epidemic and the spread of criminality, the issue of methadone treatment is all but taboo here.

Methadone, typically taken by mouth in liquid form, blocks addicts' cravings for heroin by binding to the brain's opioid receptors. Methadone has critics in many countries, who argue that it replaces one form of opiate addiction with another; in Russia even talking about it can provoke legal sanction.

"There is no possibility to have a normal discussion about this issue," said Dr. Vladimir D. Mendelevich, director of the Institute for Research Into Psychological Health, in Kazan, 500 miles east of Moscow.

After the conference in February, which Dr. Mendelevich helped organize, Moscow's legislature began an inquiry into whether he had engaged in "drug propaganda," and it called on prosecutors to open a case against him, he said.

Several years ago, prosecutors filed administrative charges against him after he posted reports on methadone treatment to his Web site. The charges were eventually dropped, but he was forced to take down the site. "If I revive it," he said, "another case of narco-propaganda will be opened, and there would likely be some kind of verdict."

While Dr. Mendelevich struggles with his opponents, Russia continues to suffer a steady increase in intravenous drug use. Drug addiction was nearly unheard of until the Soviet Union fell. But as borders opened and the economy collapsed, illicit narcotics gushed in.

Estimates on the number of drug addicts in Russia range from three million to six million. Most use intravenous drugs like heroin and other opium-based narcotics that largely originate in Afghanistan and easily flow across the country's porous southern borders.

The epidemic has put added strain on Russia's struggling health care system and has posed a serious challenge to law enforcement.

Intravenous drug use is also the leading cause of H.I.V. and AIDS in Russia. It accounted for about 66 percent of new cases in 2006, and the epidemic continues to grow, though not as quickly as in the past, according to the United Nations' AIDS agency. The Russian government estimated that as of 2007 more than 400,000 people were living with H.I.V., out of a population of about 142 million. (The United Nations' estimate from 2005 was 940,000; by comparison, 1.2 million Americans, out of a total of 300 million, were living with H.I.V.)

Many international experts say methadone treatment is critical to controlling the epidemic. Coupled with needle exchange (already in use in some Russian cities), the therapy could "largely stop the spread of H.I.V. among injecting drug users," Peter Piot, the executive director of Unaid, the United Nations agency, said in May.

Without methadone, he said, the epidemic is not likely to be stopped. "I may be wrong, but I don't see it happening."

Russia's health establishment is not impressed.

At the same AIDS conference, Dr. Gennady G. Onishchenko, the country's chief sanitary doctor, the equivalent of surgeon general, said health officials "are not convinced that this is effective," and added, "There is little optimism for legalizing methadone therapy in the near future."

Dr. Onishchenko declined to be interviewed on this issue, as did Dr. Nikolai N. Ivanets, Russia's top narcotics specialist.

Dr. Ivanets, an aggressive opponent of methadone, who gave opening remarks at Dr. Mendelevich's conference, attacked the professional credentials of the conference participants and singled out Dr. Mendelevich for special scorn.

"Everyone has become so annoyed with methadone, with the exception of a few groups of people who call themselves specialists," Dr. Ivanets said at the conference. "This is a group of dissenters."

Methadone opponents in Russia say the therapy entraps patients in lifelong addiction; others accuse Western countries of pushing the treatment on Russia for commercial gain. There are also fears that methadone could seep into the black market, given the high level of corruption at many Russian clinics.

Russia's own treatment methods, though not perfect, they argue, sufficiently address the needs of addicts.

Then there are the pro-Kremlin youths from groups like Young Guard — the youth wing of the dominant United Russia party — whom the government routinely mobilizes to harass high-profile dissenters. At their demonstration outside the methadone conference, protesters held placards and waved flags, calling methadone "a dead end."

But some Russian specialists, along with current and former addicts, have begun to challenge the official line.

"Scientific arguments, evidence-based data, are not convincing them," said Evgeny M. Krupitsky, the head of a laboratory that conducts research on drug addiction at St. Petersburg State Pavlov Medical University. Russian methodology regarding opiate addiction "is not evidence-based," but relies on "subjective opinions of major leaders in this field."

Though not every addict would benefit from methadone substitution therapy, more than 60 percent of Russian users would, Dr. Krupitsky said.

Many researchers on both sides of the methadone debate agree that only a small fraction of the heroin users in Russia seek treatment at detoxification centers and that most who do — some say more than 90 percent — relapse into drug use shortly after leaving.

At such clinics, doctors encourage immediate abstinence from drug use, rather than the gradual process that methadone substitution therapy entails. Patients are often given sedatives and painkillers to cope with withdrawal symptoms. Many are then released after a month or two with the expectation that they will remain clean. They rarely do.

“You only have a chance to stay sober for one month,” said Masha A. Ovchinnikova, a former heroin addict from St. Petersburg, who said she quit largely with willpower (and anti-withdrawal drugs provided by “contacts”), while friends remained mired in addiction or died.

“If you go on detox once and then twice and then three times, you realize that it doesn’t work for you,” Ms. Ovchinnikova said. “You don’t want to ask for help from the medical system; you don’t believe in it.”

Supporters of methadone treatment or other opiate substitution therapies argue that if properly administered by medical professionals, the treatment method breaks addicts’ dependence on illegal narcotics, acting as a surrogate to ease withdrawal symptoms, while decreasing the risk of overdose, criminality and H.I.V. transmission.

“I am for any scientific, medical approach to treatment,” said Albert Y. Zaripov, a former heroin addict who counsels users in Kazan.

He began shooting heroin more than a decade ago with a group of 10 friends. Four are in jail, another four remain chained to their addictions, and two died. He alone quit, but after he had contracted H.I.V.

“If there is another treatment besides substitution therapy, there’s no problem,” he said. “But I haven’t heard of anything else that has helped or that is more effective.”

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## Cases Slowing Down to Let the Moment Sink In

The New York Times | 07.22.08

By JESSICA L. ISRAEL, M.D



Tim Laing

It's Monday morning and I meet my new medical student, Nelson, on the hospice unit. I am there to sign a death certificate for a man who died the night before. Nelson is flipping through the patient's chart, and he asks me, "What are we going to do for this patient today?"

I wonder if he's kidding, and I say: "Nothing. He's dead." Later, recalling this conversation, I still cannot believe I said it so matter-of-factly.

Nelson is still holding the chart and I think I see his hands shake.

"Hey, are you O.K.?" I ask. "You do know what you signed up for, don't you? It is a palliative-care and hospice elective. People are going to die every day."

"I know, I know," he says. "I've just never been near anyone who has died before." Then he says, "Wow, it's really a big deal." And he sits down — because he needs to, I think; he needs to respect the moment.

In this moment I learn something from Nelson, a lesson I thought I already knew. I learn to slow down, to feel the gravity of the moment, the power of time and the depth of this important work. Nelson is right. It is a big deal.

Nelson's "wow" makes me think back to my first death. I was a third-year medical student at Mount Sinai. It was a big day for me because my resident was going to let me do a paracentesis.

Patients with advanced liver disease can have something called ascites — too much fluid in the abdominal cavity, which can be uncomfortable and can make it hard to breathe. A paracentesis is a way to remove that extra fluid. You place a needle, and then a catheter, through the skin and muscle under the navel. Then you let it drain into bottles lined up on the floor.

As I was about to start, my patient became unconscious. Someone called a code and what seemed like a million doctors and nurses ran into the room. They did CPR, pushed meds, used the paddles. I had my sterile gloves on, but I was pushed to one side. I heard my patient's ribs crack under the weight of the compressions. I watched residents bag his mouth until the anesthesiologist intubated him and hooked up the ventilator. Electrocardiogram strips littered the bedside; an intern tried to place a central line in his groin. After 20 minutes the lead resident said: "That's it. Thank you all very much. Time of death 3:15."

Everyone left just as quickly as they had arrived, and for a moment, my moment, I was alone with this dead man. Me with my sterile gloves, and him — naked with his mouth open. My eyes filled with tears, and I hoped nobody noticed. I had been so preoccupied by the opportunity to stick a needle into a belly that I overlooked the seriousness of his disease.

I covered him with a sheet crumpled at the foot of his bed. I learned that day that I needed to slow myself down, to appreciate the gravity of the moment, the power of time and the depth and proximity of my work. It was a very big deal.

Nelson comes and goes, and I have a new student. Again, I'm rushing to get everything done. This time I am on the hospice unit and I go in to see a patient I haven't seen since before the weekend. She is sleeping, and her hair is brushed back from her face. I introduce myself to her son. He tells me he thinks she is comfortable, but had a rough night. I decide not to wake her, because I figure rest is more important than agitating her out of her sleep. I am on my way off the unit when her son calls after me: "Can you come back? My mom wants to tell you something."

I am back at the bedside. This time her eyes are open. I touch her cool hands. "Do you want to tell me something?"

She holds my hand to her face and pulls me close. "I wanted to thank you for this. Thank you."

There it is again — another moment, another near miss. I was rushing to get the day started. I would not have awakened her. I would have just moved on to the next thing I had to do. I would have missed the chance to feel the "wow." It is a very big deal. How quickly we forget, and how lucky we are to be reminded, before it's too late.

Jessica L. Israel is chief of geriatrics and palliative medicine at Monmouth Medical Center in Long Branch, N.J.

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## Questions About Sunscreen Safety

New York Times | 07.22.08

Tara Parker-Pope



Soaking up sun at Orchard Beach in the Bronx. (Ozier Muhammad/The New York Times)

After the Environmental Working Group put out its list of best and worst sunscreens, many loyal sunscreen users began to worry. Many of the top-selling brands don't make the best list, and the group claims four out of five sunscreens it reviewed aren't effective.

"A lot of people are concerned," said Dr. Darrell S. Rigel, clinical professor of dermatology at New York University's Langone Medical Center. "I've spent a lot of time talking to people about it."

As my Well column in Tuesday's Science Times explains, many scientists say the concerns about sunscreens are overblown and they question the methodology used by the Environmental Working Group. However, others agree that better labeling of sunscreens is needed and have called for more study of how sunscreen ingredients interact with skin, sun and the human body.

The bottom line: the best sunscreen is the one that you use. Pick a sunscreen you like — either from the list provided by the Environmental Working Group or among the best-selling brands — and use a lot of it, often.

<http://well.blogs.nytimes.com/2008/07/21/questions-about-sunscreen-safety/>

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## Asthma Medications: Not a Clear Advantage

The New York Times | 07.22.08

By GINA KOLATA



Frederic J. Brown/Agence France-Presse — Getty Images

**Athletes who have asthma have been accused of receiving an advantage from medication.**

In 1992, just after she had returned from winning a gold medal in the Barcelona Olympics, the swimmer Dara Torres was running with a friend on a hot, humid day in Gainesville, Fla. She was wheezing, she said, which was nothing new. She had always had breathing problems and thought nothing of it.

But her friend, a hand surgeon, told Torres that she sounded like someone who had asthma. Torres's father has asthma, but it had never occurred to her that she might have it, too. She did, and as soon as she started taking asthma medication, she realized how much, and how needlessly, she had been suffering.

"I was always coughing," she said in a telephone interview last week. "And my breathing was horrible. I really had a hard time."

Now, at 41, Torres has returned to competitive swimming and earned a place on the United States Olympic team. And she is outraged by those who say that she only recently declared she had asthma and that taking asthma drugs was the secret to her astounding success. The drugs, it is often claimed, are performance enhancers.

That is not, however, what asthma and doping experts say. Inhaled asthma drugs, according to medical consensus, allow athletes with asthma to breathe normally but do not make them better than normal. And they do nothing for athletes who do not have asthma.

Elite-level athletes with documented proof that they have asthma are allowed to take certain inhaled corticosteroids, which prevent inflammation of airways and can hold asthma symptoms at bay.

And they are allowed to take other inhaled drugs, beta-2 agonists, which relax the smooth muscle cells of airways, relieving symptoms. A few of the beta-2 agonists can increase muscle and decrease body fat if they are injected or taken orally.

But when they are inhaled, in doses used to control asthma, beta-2 agonists do not improve performance, asthma and doping experts say. And neither do corticosteroids.

"A lot of people believe they are performance enhancers," Dr. Gary I. Wadler said about inhaled asthma drugs. But, added Wadler, who is chairman of the World Anti-Doping Agency's prohibited list and methods subcommittee, "there is no evidence for that at all."

Dr. Kenneth Fitch, a member of the International Olympic Committee's medical commission, has provided some of that evidence. A professor at the School of Sport, Exercise and Health at the University of Western Australia, he conducted three double-blind studies of asthma drugs and concluded that they did not enhance performance. In the studies, neither the participants nor the researchers knew who was receiving asthma drugs or who was receiving a dummy substance.

Some, like Paula Radcliffe, who has asthma, have heard other explanations for why the drugs are banned. Radcliffe is the women's world record holder in the marathon. The drugs, she believes, are banned for those without the condition because they can mask the presence of other performance-enhancing drugs.

"That's what I've been told," Radcliffe said in a telephone interview from her home in Britain.

But that is not true, according to Dr. Patrick Schamasch, the medical and scientific director for the I.O.C.

Wadler explained that a drug "doesn't have to work to be on the list" of the World Anti-Doping Agency's prohibited substances.

To be banned, a drug has to meet two of three criteria: Taking it must enhance or potentially enhance performance, place an athlete's health at risk, or violate the spirit of sport.

In a person who does not have asthma, the drugs have no benefits, only the risk of side effects that can place an athlete's health at risk. An athlete taking them in an attempt to gain a competitive advantage would then be violating the spirit of sport. Therefore, Wadler said, inhaled asthma drugs can be banned.

Yet there is no doubt that many elite athletes have asthma, or that asthma symptoms can be brought on by intense exercise.

That is what happened to Radcliffe. She said she learned that she had asthma at 14, when she passed out while training because she could not breathe. Running, she said, and especially running when the air is cold or polluted, brings on her symptoms. It is hard for her to train without the drugs. She said that in order to receive permission to take asthma drugs in competition, she had to stop taking drugs for 10 days before being tested for asthma.

"I struggled," Radcliffe said. "I wheezed and my voice got creaky. And I had a dry, tickly cough that lasted for five or six hours after hard workouts."

One indication of the prevalence of asthma among elite athletes came when researchers tested every athlete in seven sports on the 1998 United States Winter Olympic team — biathlon, cross-country skiing, figure skating, ice hockey, Nordic combined, long-track speedskating and short-track speedskating. Nearly a quarter of the athletes, including half of the cross-country skiers, had asthma. In comparison, about 5 percent of the general population has asthma.

The percentage of all United States Olympians with asthma increased from 1996, when it was 12.4 percent, until 2000, when it was 18.9 percent, according to Fitch. But in 2002, when testing became more stringent, the percentage dropped to 12.9 percent. It was 9.1 percent in 2004 and 12.1 percent in 2006, Fitch said.

Asthma is especially prevalent in swimming, distance running, cycling and skiing. That may be because those athletes are exposed to pollutants and dry air, said Dr. Thomas Casale, the chief of allergy and immunology at Creighton University in Omaha. Those who are prone to asthma, he said, can have airways that are especially sensitive to irritants.

For swimmers, the irritants may be trichloramines used to disinfect the water, said Kenneth Rundell, the director of the Human Performance Laboratory at Marywood University in Scranton, Pa. Ice skaters may

be affected by pollutants released by ice-cleaning machines, which are often powered by natural gas or propane, he said. Skiers breathe Teflon when they go in and out of the wax room.

As for distance runners and cyclists, Rundell said, they can be affected by air pollution, especially fine and ultrafine particles, and by the drying effect of breathing rapidly for long periods of time.

Pollen can make symptoms even worse for those who are allergic to it, which includes the majority of athletes with asthma, as it turns out.

None of this bodes well for the Beijing Olympics, asthma researchers say. The Chinese government has said it will reduce the air pollution, but it also warned that the Olympics will be held during pollen season.

One approach the United States has taken has been to fly its athletes to Beijing to have them tested for asthma while they exercise there.

“Our concern is that many who are asymptomatic in a place like Colorado Springs run into problems in Beijing,” said Randall Wilber, a sports physiologist at the United States Olympic Training Center in Colorado Springs. Although he said he could not reveal how many athletes were now documented asthmatics, “that certainly is being considered by many athletes as a strategy.”

<http://www.nytimes.com/2008/07/22/sports/olympics/22asthma.html>

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**Basics Mirrors Don't Lie. Mislead? Oh, Yes.****The New York Times | 07.22.08**

By NATALIE ANGIER



Vivienne Flesher

For the bubbleheaded young Narcissus of myth, the mirror spun a fatal fantasy, and the beautiful boy chose to die by the side of a reflecting pond rather than leave his “beloved” behind. For the aging narcissist of Shakespeare’s 62nd sonnet, the mirror delivered a much-needed whack to his vanity, the sight of a face “beated and chopp’d with tann’d antiquity” underscoring the limits of self-love.

Whether made of highly polished metal or of glass with a coating of metal on the back, mirrors have fascinated people for millennia: ancient Egyptians were often depicted holding hand mirrors. With their capacity to reflect back nearly all incident light upon them and so recapitulate the scene they face, mirrors are like pieces of dreams, their images hyper-real and profoundly fake. Mirrors reveal truths you may not want to see. Give them a little smoke and a house to call their own, and mirrors will tell you nothing but lies.

To scientists, the simultaneous simplicity and complexity of mirrors make them powerful tools for exploring questions about perception and cognition in humans and other neuronally gifted species, and how the brain interprets and acts upon the great tides of sensory information from the external world. They are using mirrors to study how the brain decides what is self and what is other, how it judges distances and trajectories of objects, and how it reconstructs the richly three-dimensional quality of the outside world from what is essentially a two-dimensional snapshot taken by the retina’s flat sheet of receptor cells. They are applying mirrors in medicine, to create reflected images of patients’ limbs or other body parts and thus trick the brain into healing itself. Mirror therapy has been successful in treating disorders like phantom limb syndrome, chronic pain and post-stroke paralysis.

“In a sense, mirrors are the best ‘virtual reality’ system that we can build,” said Marco Bertamini of the University of Liverpool. “The object ‘inside’ the mirror is virtual, but as far as our eyes are concerned it exists as much as any other object.” Dr. Bertamini and his colleagues have also studied what people believe about the nature of mirrors and mirror images, and have found nearly everybody, even students of physics and math, to be shockingly off the mark.

Other researchers have determined that mirrors can subtly affect human behavior, often in surprisingly positive ways. Subjects tested in a room with a mirror have been found to work harder, to be more helpful and to be less inclined to cheat, compared with control groups performing the same exercises in nonmirrored settings. Reporting in the *Journal of Personality and Social Psychology*, C. Neil Macrae, Galen V. Bodenhausen and Alan B. Milne found that people in a room with a mirror were comparatively less likely to judge others based on social stereotypes about, for example, sex, race or religion.

“When people are made to be self-aware, they are likelier to stop and think about what they are doing,” Dr. Bodenhausen said. “A byproduct of that awareness may be a shift away from acting on autopilot toward more desirable ways of behaving.” Physical self-reflection, in other words, encourages philosophical self-reflection, a crash course in the Socratic notion that you cannot know or appreciate others until you know yourself.

The mirror technique does not always keep knees from jerking. When it comes to socially acceptable forms of stereotyping, said Dr. Bodenhausen, like branding all politicians liars or all lawyers crooks, the presence of a mirror may end up augmenting rather than curbing the willingness to pigeonhole.

The link between self-awareness and elaborate sociality may help explain why the few nonhuman species that have been found to recognize themselves in a mirror are those with sophisticated social lives. Our gregarious great ape cousins — chimpanzees, bonobos, orangutans and gorillas — along with dolphins and Asian elephants, have passed the famed mirror self-recognition test, which means they will, when given a mirror, scrutinize marks that had been applied to their faces or bodies. The animals also will check up on personal hygiene, inspecting their mouths, nostrils and genitals.

Yet not all members of a certifiably self-reflective species will pass the mirror test. Tellingly, said Diana Reiss, a professor of psychology at Hunter College who has studied mirror self-recognition in elephants and dolphins, “animals raised in isolation do not seem to show mirror self-recognition.”

For that matter, humans do not necessarily see the face in the mirror either. In a report titled “Mirror, Mirror on the Wall: Enhancement in Self-Recognition,” which appears online in *The Personality and Social Psychology Bulletin*, Nicholas Epley and Erin Whitchurch described experiments in which people were asked to identify pictures of themselves amid a lineup of distracter faces. Participants identified their personal portraits significantly quicker when their faces were computer enhanced to be 20 percent more attractive. They were also likelier, when presented with images of themselves made prettier, homelier or left untouched, to call the enhanced image their genuine, unairbrushed face. Such internalized photoshoppiness is not simply the result of an all-purpose preference for prettiness: when asked to identify images of strangers in subsequent rounds of testing, participants were best at spotting the unenhanced faces.

How can we be so self-delusional when the truth stares back at us? “Although we do indeed see ourselves in the mirror every day, we don’t look exactly the same every time,” explained Dr. Epley, a professor of behavioral science at the University of Chicago Graduate School of Business. There is the scruffy-morning you, the assembled-for-work you, the dressed-for-an-elegant-dinner you. “Which image is you?” he said. “Our research shows that people, on average, resolve that ambiguity in their favor, forming a representation of their image that is more attractive than they actually are.”

When we look in the mirror, our relative beauty is not the only thing we misjudge. In a series of studies, Dr. Bertamini and his colleagues have interviewed scores of people about what they think the mirror shows them. They have asked questions like, Imagine you are standing in front of a bathroom mirror; how big do you think the image of your face is on the surface? And what would happen to the size of that image if you were to step steadily backward, away from the glass?

People overwhelmingly give the same answers. To the first question they say, well, the outline of my face on the mirror would be pretty much the size of my face. As for the second question, that’s obvious: if I move away from the mirror, the size of my image will shrink with each step.

Both answers, it turns out, are wrong. Outline your face on a mirror, and you will find it to be exactly half the size of your real face. Step back as much as you please, and the size of that outlined oval will not change: it will remain half the size of your face (or half the size of whatever part of your body you are looking at), even as the background scene reflected in the mirror steadily changes. Importantly, this half-size rule does not apply to the image of someone else moving about the room. If you sit still by the mirror, and a friend approaches or moves away, the size of the person’s image in the mirror will grow or shrink as our innate sense says it should.

What is it about our reflected self that it plays by such counterintuitive rules? The important point is that no matter how close or far we are from the looking glass, the mirror is always halfway between our

physical selves and our projected selves in the virtual world inside the mirror, and so the captured image in the mirror is half our true size.

Rebecca Lawson, who collaborates with Dr. Bertamini at the University of Liverpool, suggests imagining that you had an identical twin, that you were both six feet tall and that you were standing in a room with a movable partition between you. How tall would a window in the partition have to be to allow you to see all six feet of your twin?

The window needs to allow light from the top of your twin's head and from the bottom of your twin's feet to reach you, Dr. Lawson said. These two light sources start six feet apart and converge at your eye. If the partition is close to your twin, the upper and lower light points have just begun to converge, so the opening has to be nearly six feet tall to allow you a full-body view. If the partition is close to you, the light has nearly finished converging, so the window can be quite small. If the partition were halfway between you and your twin, the aperture would have to be — three feet tall. Optically, a mirror is similar, Dr. Lawson said, "except that instead of lighting coming from your twin directly through a window, you see yourself in the mirror with light from your head and your feet being reflected off the mirror into your eye."

This is one partition whose position we cannot change. When we gaze into a mirror, we are all of us Narcissus, tethered eternally to our doppelgänger on the other side.

<http://www.nytimes.com/2008/07/22/science/22angi.html>

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## **HHS awards \$49 million for state high-risk insurance pools** **AHA News | 07.22.08**

The Department of Health and Human Services today announced \$49.1 million in grants to 30 states that provide health insurance to residents who cannot get conventional health coverage because of their health status.

The grants will support high-risk pools that offer health coverage to individuals with serious medical conditions.

The states are Alabama, Alaska, Arkansas, Colorado, Connecticut, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin and Wyoming.

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## Medicare Moves To Limit Costs In Drug Plans

The Wall Street Journal | 07.22.08

By SARAH RUBENSTEIN

Medicare is trying to curb an opaque industry practice that inflates what some older and disabled people pay for medicines under the federal insurance program's prescription-drug plan.

Medicare Part D, introduced in 2006 to extend drug coverage to beneficiaries, is provided through private health-insurance companies. Many insurers in turn contract with so-called pharmacy-benefit managers to administer their plans. Among other functions, these PBMs negotiate lower drug prices with pharmacies. But some companies, under a practice allowed by Medicare, then charge a higher price to health insurers and, ultimately, the government.

This approach is called "lock-in pricing" because the insurers pay the PBMs a set amount for the drugs, even if that differs from what the drugs really cost at the pharmacy. Lock-in-pricing can boost costs for Medicare beneficiaries because they pay a percentage of their drug costs. Also, the practice can more quickly drive consumers into the notorious gap in coverage known as the doughnut hole, where they generally must begin paying the full cost of their medicines. The doughnut hole kicks in when total drug expenditures by the beneficiary and the plan reach \$2,510. Medicare drug plans start paying again once total expenditures reach \$5,726.

Lock-in pricing "has a detrimental effect on the beneficiary because it pushes him into the coverage gap faster," says Abby Block, director of the arm of the government's Centers for Medicare and Medicaid Services (CMS) that runs the drug benefit. Under a current Medicare proposal, PBMs would be allowed to continue claiming the higher prices for reimbursement. But beneficiaries' own drug costs would be calculated without the extra amounts included.

Pharmacy-benefit managers -- including Express Scripts Inc., Medco Health Solutions Inc., and units of CVS Caremark Corp. and UnitedHealth Group Inc. -- carry out their functions behind the scenes, including developing lists of covered drugs, maintaining networks of participating pharmacies and paying the pharmacies when beneficiaries buy drugs.

CMS figures that 19% of the hundreds of Medicare drug plans are using lock-in pricing this year, affecting 14% of the 25.8 million enrollees in the Medicare drug program. Other plans use what is known as pass-through pricing, in which PBMs charge insurers the same prices they pay the pharmacies.

Patients who take lots of drugs are most affected by lock-in pricing. For example, one female patient who last year regularly took six generics and two branded drugs had average monthly costs of about \$256, according to the patient's explanation of benefits. At that rate, the patient was on track to reach the doughnut hole in October. But without the PBM's higher charge based on lock-in pricing, the patient would have paid \$215 a month on average for the same drugs -- and she wouldn't have hit the doughnut hole until December, according to an analysis of data provided by the patient's pharmacist.

The price spreads tend to be much greater for generics than for branded drugs. That's because generics are much cheaper for pharmacies to acquire, making it easier for PBMs to negotiate down the prices they pay and less noticeable to patients and insurers when the extra costs are included.

PBMs that administer lock-in pricing plans argue that the method is common in the private insurance market and should be available for Medicare as well. Some PBMs say the extra money they make under the pricing method provides funds to encourage more consumers to use lower-cost generic drugs. Express Scripts, for instance, says it analyzes beneficiaries' drug-purchasing habits and sends patients letters to explain how changes in their purchasing habits could lower their costs. And some companies, including UnitedHealth and CVS Caremark, which operate both as PBMs and insurers, have warned that if those extra amounts aren't included in drugs' costs, insurance plans that would be affected by any change may have to increase premiums, the monthly price that seniors pay for the plans.

To be sure, a large majority of older people are satisfied with their Medicare drug-benefit plan and say they are paying less for drugs than they were before the benefit existed, when seniors relied on a hodgepodge of private and public drug benefits, or made do without coverage. In a Wall Street Journal Online/Harris Interactive survey over the Internet of 571 U.S. adults age 65 or older, published in

December, some 75% of respondents said their plan had saved them money and 83% said their plan was easy to use. Some 12% said they had to pay the full price for medicines because they had hit the doughnut hole.

The Kaiser Family Foundation projected this spring that the average premium for most Medicare Part D plans would rise nearly 17% to \$31.99 a month in 2008 from \$27.39 a month last year. That follows an average premium increase of 5.6% in 2007 from a year earlier.

The difference between what PBMs pay pharmacies and what they are reimbursed by insurers under lock-in pricing is generally a secret. Medicare itself doesn't have this information and therefore doesn't estimate the total cost of the practice.

For consumers it may be possible to determine the size of the price differences under lock-in pricing by looking at the full cost of your drug listed on your explanation of benefits, and asking your pharmacy how much it was paid. But many pharmacists are prohibited from disclosing pricing information under terms of their contracts with PBMs.

"It is absolutely unacceptable for any government benefit program to be based on questionable [numbers] or numbers that aren't transparent or easily understood by a beneficiary," says Michael Burgess, director of the New York State Office for the Aging, who says he was unaware of the issue until recently.

An analysis of explanation-of-benefits documents from consumers and payment data from pharmacies shows that the size of the price differences varies widely from as low as just a few dollars to well over \$100. In one case, a patient filled a prescription for a 90-day supply, or 270 pills, of the generic anti-nausea medication prochlorperazine. The difference between what the PBM, Express Scripts, paid the pharmacy and the price that showed up on the patient's explanation of benefits was \$146.53.

Express Scripts spokesman Steve Littlejohn said it is "extremely rare" for price differences to get above \$100, and it occurred in this case because the patient purchased the drug at a quantity greater than is typically prescribed. Broadly, Mr. Littlejohn said that PBM pricing on generics "is very competitive, and is generally far better than [uninsured] cash-paying customers obtain on their own." He added that the differences on costs of branded drugs are much slimmer and that overall the company's per-prescription profit margin is a "single digit" percentage.

Medicare has been battling lock-in pricing almost since the inception of the drug-benefit program. But efforts to curtail or stop the practice have faced numerous delays, amid intense lobbying on the subject.

"We thought we had a clear policy" barring lock-in pricing when the drug benefit was created, says Ms. Block of CMS. "We learned that there were different ways of interpreting a policy statement," she adds.

Under Medicare's current proposal, PBMs wouldn't be able to hide the extra costs of drugs. Instead, they would have to declare the extra amounts as "administrative" costs that an insurance plan pays the PBM. Patients' own drug costs would be calculated without the extra amount included, thereby easing the burden on consumers.

Although the proposal wouldn't prohibit lock-in pricing, health-cost experts say the transparency and accounting that would be needed to include the extra costs as a separate "administrative" item could effectively curb the practice. CMS hopes to finalize its proposed regulation late this summer to go into effect in 2010.

The PBM trade group, the Pharmaceutical Care Management Association, opposes the CMS proposal because it says insurers should be able to choose what type of pricing they want. The drug benefit "program is working," says Mark Merritt, the group's chief executive. "Unless it can be decisively shown that one model offers more end savings for consumers or is decisively able to manage drug [costs] better for the program, we think there ought to be flexibility and choices."

A spokeswoman for CVS Caremark, which administers Medicare drug plans as a PBM and also sponsors plans through its SilverScript Insurance Co. subsidiary, says lock-in pricing is used in its SilverScript plans and is also common in other Medicare plans for which CVS Caremark serves as the PBM. UnitedHealth says it uses lock-in pricing on United Rx Basic and United Rx Value Medicare plans.

Not all major PBMs use lock-in pricing in Medicare, including Medco Health and Humana Inc., an insurer that acts as its own PBM for its Medicare plans. Humana spokesman Tom Noland says pass-through pricing, the alternative to lock-in pricing, gives patients "the full benefit of our negotiated discounted rates with network pharmacies and also promotes transparency of pricing."

In the meantime, Medicare drug-benefit participants buying drugs should consider checking low-price sellers of generic medications, such as Costco Wholesale Corp. and Wal-Mart Stores Inc., to see if their retail prices are lower than those in the insurance plan.

That is what Len Steinberg of Scottsdale, Ariz., did, and he found that Costco's retail price for his generic nasal spray was about half of the drug's total cost under his plan.

Mr. Steinberg, a 73-year-old retired employee-benefits consultant, says he now pays cash for certain cheap generics at Sam's Club and Costco, rather than using his drug coverage. That allows him to avoid the doughnut hole and continue receiving coverage for his more expensive branded medications, he says.

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**LETTER: Cancer project a sound investment for state**  
**The Shreveport Times | 07.22.08**

Frances Gilcrease

I want to thank the Louisiana Legislature and Gov. Bobby Jindal for their approval of the Colorectal Cancer Screening Demonstration Project, which was supported by the American Cancer Society, LSU and a number of health organizations in our state.

This project will save lives and save the state on costs related to colorectal cancer treatment. Everyone eligible for colorectal cancer screening in Louisiana deserves access to these life-saving tests.

The Louisiana Colorectal Cancer Screening Demonstration Project will help low-income, uninsured and underserved residents aged 50-64 across the state gain access to life-saving screening programs for early detection of colorectal cancer. The demonstration project has been allocated \$1.5 million in the state budget. This is a sound investment for a healthier Louisiana.

Early estimates are that the demonstration project will save more than \$7.4 million over three years in initial colorectal cancer treatment costs and more than \$2.7 million in ongoing treatment costs.

Additionally, by building capacity for screening and treatment, Louisiana will be in the position to access federal Centers for Disease Control and Prevention dollars once approved by Congress. These dollars will most likely go first to states with a proven track record for successful, population-based colorectal cancer screening.

This project is a huge victory for our state, and I applaud our elected leaders for sharing in the vision.

Frances Gilcrease  
Cancer survivor  
Natchitoches

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