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Is it necessary for physicians to contact all HRT patients?

Patients and physicians chart new HRT strategies

If all one had to go by was the news reports, one might think that hormone replacement therapy (HRT) was going the way of the dodo. But the news about the Women's Health Initiative study on HRT that was halted due to higher-than-expected adverse effects among some participants isn't all bad. After the initial shock of the trial results, the other side of the story is beginning to gain ground.

True, among women taking both estrogen and progestin, there is an increased risk of heart disease, pulmonary embolism, and invasive breast cancer. Those risk increases are high in percentage terms, but low in numeric terms. For heart disease, there are an extra seven events (non-fatal myocardial infarction or death from heart disease) per 10,000 person years, as well as eight more each of strokes, pulmonary embolisms, and invasive breast cancers per 10,000 person years. However, there were also six fewer colorectal cancers and five fewer hip fractures per 10,000 person years. It adds up to 19 more cases of adverse events (see **Figure 1** on page 114).

The increased risk led the data and safety monitoring board to halt the part of the study that included combination therapy. Women without uteri who are taking estrogen alone continue to receive study medication or placebo for the remaining three years of the Women's Health Initiative (WHI).

INSIDE . . .

Charting a course

But when the news broke, most news outlets only reported the percentage increase in risk and didn't note that the study involved testing HRT for positive health effects related to heart disease, stroke, breast and colon cancer, and fracture risk -- nor whether HRT was helping women cope with some of the more troublesome symptoms of menopause.

For physicians who work with older women who have been on HRT for some time, the news does create something of a dilemma. Do you contact all the older women you see who are on HRT and ask them to contact you about their regimen? Do you wait for them to call you -- something

many women are doing since the news reports hit the airwaves? Or do you simply wait for them to come in for their annual check-ups? And when you do see the patient, what should you tell her?

Some physicians who work for large health plans, like Kaiser or Group Health, can search internal databases for patients on combination HRT. For other physicians, however, it would involve a difficult search through paper charts, points out **Deborah Grady**, MD, MPH, director of the University of California San Francisco/Mt. Zion Women's Health Clinic Research Center.

"Kaiser sent out a letter to all 100,000 women in California who are on HRT," she notes. Grady's office is contacting patients taking the estrogen/progestin combination.

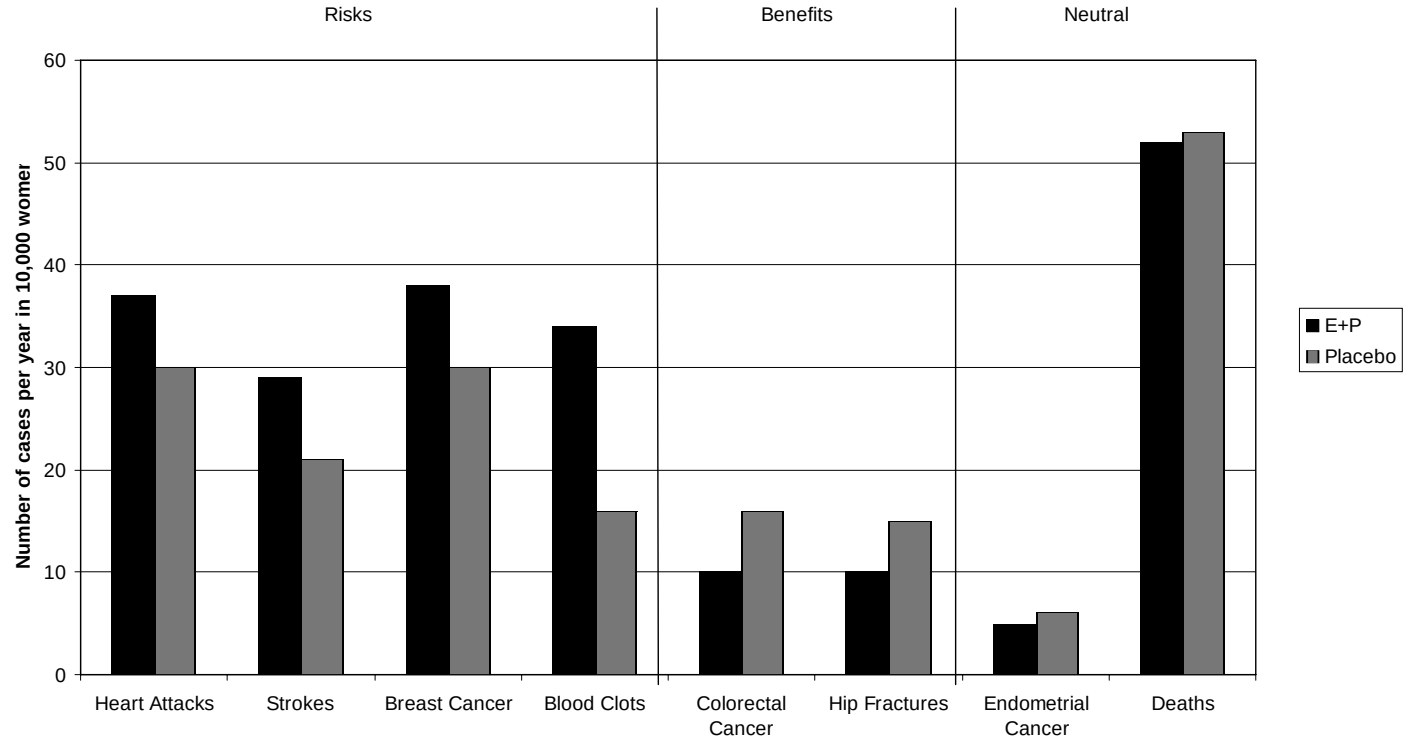
She feels strongly that she should do that for her patients, but admits she's "not sure there is any urgency requiring physicians to paw through all their records." Still, she finds the results of the study worrisome.

"It does reduce the risk of fractures, but it's not the best drug for that," she says. "If patients are having very troublesome symptoms of menopause, that's one thing. But when you ask many patients why they are on HRT, you often hear, 'I don't know.' If that's the case, I think they should stop."

For many women, a short course of HRT is enough to help them deal with menopause symptoms. "Some women only have symptoms for a few months," Grady says. "Others, it seems to persist forever."

But in most cases, no matter how terrible, symptoms generally improve and eventually cease. For patients on HRT for menopausal symptoms, Grady says a shorter or tapered course of HRT would do the trick. "I've cut the dose from 0.65 mg to 0.3 mg, or I've had women stop on the weekends. Then after a couple months, I have them drop Friday dosing, and so on, until they are off it."

Figure 1: Disease Rates for Women on Estrogen Plus Progestin or Placebo



Source: Women's Health Intitative.

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When is it worth the risk?

Certainly the news has changed the way both physicians and patients will look at menopause and the hot flashes and mood swings that women so hate. "In the old days, there was no reason seen to tolerate the symptoms," Grady says. Indeed, there was indication that HRT would not only help the symptoms, but also protect women from heart disease, stroke, and perhaps even cancer. "It's all different now, though. The bar is higher. If all you have is minor symptoms, you have to wonder if it's worth the risk."

For a 50-year-old woman, it might be, she says. But for an older woman, perhaps not. "If you have an increase of 20 bad events per 10,000 women per year, that doesn't sound bad. But after five years, that's an increase of 1%. Is that okay? For some women who are very risk averse, it isn't. Others just don't care."

As a physician, Grady says she has to take the woman's opinion into account, as well as any additional risk factors she may have that make the additional risk worrisome.

Get the message right

HRT is the most prescribed medication in the country -- some 46 million prescriptions per year, says Grady, which suggests how huge and complex the recent news is for patients and physicians. One undisputed message from the early halt to the trial is simple: HRT should no longer be used to prevent disease, but rather to combat troublesome menopause symptoms.

"If I knew a woman well enough to know her symptoms and her values, I would probably counsel her to find a way to stop," says **Garnet Anderson**, PhD, one of the principal investigators for the WHI and a member of the biostatistics program at Fred Hutchinson Cancer Research Center in Seattle. "I might suggest she try a hormone holiday to see if symptoms recur, or try tapering her dose off. If this wasn't possible now, I would ask her in another six to 12 months to try again."

Anderson says many women are on the drugs to prevent fractures, or they may not be aware that they don't need the hormones any more for menopause symptoms. In both cases, Anderson says, physicians should talk to patients about stopping HRT and pursuing other strategies to deal with medical conditions.

While the number of women who might experience adverse effects seems low, the risks of continuing HRT clearly outweigh any benefits, Anderson says. "In 10,000 women taking hormones for 5 years, there would be 35 more heart attacks, 40 more strokes, 40 more breast cancers, and 40 more pulmonary embolisms plus assorted other cardiovascular conditions. There would be 30 fewer colorectal cancers and 25 fewer hip fractures. Adding this up, there would be 100 more women with one of these serious events because of estrogen and progestin. Sure, these are small risks, but until a couple weeks ago, women were being told to take this medicine to prevent some of these diseases. Our data do not support that practice."

Limited duration probably OK

Short-term use of HRT isn't the problem, says **Jacques Rossouw**, MD, acting director of the WHI at the National Heart, Lung, and Blood Institute, and neither patients nor physicians should panic. "The point is that while we want to get the word out to women and their doctors that long-term use of this therapy could be harmful, women should not conclude that they will develop breast cancer, or have a heart attack or stroke if they've taken this medication. Even in those who do suffer one of these diseases, the condition may not be due to the therapy."

There are better, safer ways to prevent heart disease, and better ways to prevent osteoporosis, too, he says. Though the study didn't look at the use of HRT to treat menopausal symptoms, Rossouw says he and his colleagues "think that the benefits for this may outweigh the risks. [However], we recommend that women consult their doctor about their individual benefits and risks from such use. If they decide to take the therapy, they should do so for a short period."

The WHI trial was the first randomized study to look at whether hormones could have a positive impact on heart disease rates. Earlier studies had suggested positive effects from HRT, says **Marcia Stefanick**, PhD, principal investigator of the WHI and a professor of medicine at Stanford University in Palo Alto, CA. "The bottom line is that none of these earlier studies was able to provide the definitive answers about the overall balance of risks and benefits that we now have in the WHI study," she says.

Editor's Note: The Women's Health Initiative website is www.whi.org. *The site has a link to the JAMA article, as well as other information that could assist physicians. Other information is available from:*

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• Garnet Anderson, PhD, WHI Clinical Coordinating Center, Fred Hutchinson Cancer Research

Center, 1100 Fairview Ave N. MP-1002, Seattle, WA 98109-1024. Telephone: (206) 667-4699.

Reference

1. Writing Group for the Women's Health Initiative Investigators. Risks and benefits of estrogen plus progestin in healthy postmenopausal women: Principal results from the Women's Health Initiative Randomized Controlled Trial. *JAMA* 2002; 288:321-333.

Media reports overblown

Over-diagnosis common with PSAs, but less common than once believed

Ever since a study in the *Journal of the National Cancer Institute* suggesting prostate-specific antigen (PSA) screening for prostate cancer leads to over-diagnosis rates of 30% to 45%, newspaper headlines have reduced the study to single statements equating PSA tests with risk.[1] Not accurate, says study author **David F. Penson**, MD, MPH, an assistant professor of urology at the University of Washington and staff urologist at the VA Medical Center in Seattle.

"It's easy to look at the findings and say there is over-diagnosis of prostate cancer due to the test, and therefore, the test is bad," he says. "But that's not what we found."

Part of the problem is that the definition of over-diagnosis the researchers used is different than what others have used in the past. "Our definition was a cancer that was identified by the test but would not have presented in the lifetime of the patients," explains **Ruth Etzioni**, PhD, another study author and an associate member of the Fred Hutchinson Cancer Research Center in Seattle. "Surgeons define cancers based on whether it is clinically significant, the size, stage, and histology of the cancer. To them, clinically insignificant cancers are over-diagnosis. If an 85-year-old man presented with a moderately differentiated tumor with some local extension, that's clinically significant. But in our book, it's an over-diagnosis because of the short life expectancy of that man. Our definition gives a higher over-diagnosis rate -- particularly in older men."

High 'over-diagnosis' rate no surprise

In many older men, the patient dies with prostate cancer, not of it, says Penson. "There are a lot of indolent cancers that just don't matter to the patient. We knew that we would pick these up." Penson tells *SCM* the rate of over-diagnosis was actually lower than researchers expected to find.

The study looked at 2 million men from 60 to 84 years of age and, using data from the National Cancer Institute's Surveillance, Epidemiology, and End Results registry, found over-diagnosis among white men of 29% and about 44% for black men.

Penson isn't sure the racial distinction is important. The difference in rates could stem from differences in the prostate tissue of African-American men, or it may relate to something inherent in the statistical model that the researchers used. In the end, it doesn't change the message of the study, he says.

The only time the different rates come into play is when physicians and patients discuss treatment options, Etzioni explains. "When you have a biopsy result, you have to determine whether it is a cancer that is going to impact the quality of life of the patient and his survival, or whether it should be left alone," she says. "For that, you should look at co-morbidities, how old the patient is, his life expectancy, and if there are any clinically alarming characteristics of the cancer." Race may play a role in that discussion, she says.

Better than expected

Etzioni, like Penson, says she thought the study would find more over-diagnosis than the researchers uncovered. "We were trying to compare lifetime probability of a diagnosed prostate cancer with a lifetime probability of latent prostate cancer. We had this information from different sources. We looked and there was a huge difference. Before PSAs became common, only about 25% of cancers were diagnosed in the lifetime of patients. So that leaves a huge potential for over-diagnosis."

Indeed, the potential for over-diagnosis was so large that Etzioni calls the study results "encouraging. There had been a great deal of alarm about over-diagnosis, but it hadn't been quantified. But what we found certainly wasn't as great as some of the speculation that was out there. We think that 30% or less is encouraging, particularly since we were looking at older men, and our over-diagnosis definition takes into account life expectancy."

Maybe the problem is that the press focuses too greatly on the number, she says. "We all knew that over-diagnosis is a real problem," says Etzioni. "It is with any cancer test. The number is going to be greater than zero. Maybe we have to

work on finding a different benchmark. You just aren't going to have zero percent over-diagnosis when you do a screening test."

The take-home message for physicians is that it is particularly important to keep in mind the age of the patient, says Penson. "If you have a 50-year-old with a moderately differentiated prostate cancer, even though it is a slow-growing cancer, at that age the operative word is growing, not slow." For older men, though, it may not matter. "I think some of these facts have been lost on the media."

The study did not address the whether "testing is a good or a bad thing," Penson says. "This isn't about screening or not. For physicians with patients diagnosed with prostate cancer after a PSA test, you have to have a frank discussion about the cancer itself, the patient's co-morbidities, and estimate if you have to treat this or not."

Many such cancers don't have to be treated, he adds. "It is reminder for us that not all cancers are spelled with a capital 'c'. But you also have to keep in mind that 40,000 men die of prostate cancer every year."

> 'Before PSAs became common, only about 25% of cancers were diagnosed in the lifetime of patients. So that leaves a huge potential for over-diagnosis.'
>
> Ruth Etzioni, PhD
> Fred Hutchinson Cancer Research Center
> Seattle

Further, physicians need to remember that not all elevated PSA levels indicate cancer. "It could be an infection or some other temporary issue," he says.

What Penson would like physicians to take home from his work is that perhaps patients with 10 years or less of life expectancy should forego PSA testing. For them, a finding of prostate cancer could lead to biopsies or treatments that may have no impact on longevity.

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Reference

1. Etzioni R, Pension DF, Legler JM, et al. Overdiagnosis due to prostate-specific antigen screening: lessons from U.S. prostate cancer incidence trends. *J Natl Cancer Inst* 2002; 94:981-990.

Already popular among older patients, house calls gain favor among physicians

It's easy to romanticize the days of the Old West, when a physician would travel from patient to patient on horseback. Overhead was minimal, patients were grateful, and appointments weren't tracked by an unseen gatekeeper worried about throughput. Change the horse to a pick-up truck, though, and you have an idea of what one Colorado geriatrician has created for himself. For more than 18 months, **Roger Bermingham**, MD, has run his Fort Collins, CO, practice in just that way, devoting his time almost totally to making house calls for his elderly patients.

Not only does Bermingham say this route is better for his psyche and his patients' well-being than an office-based practice, but also that it makes more sense financially than seeing Medicare patients in an office where he would have to pay rent and hire staff.

Indeed, as reimbursement for a typical visit is squeezed, house calls by physicians have actually seen a significant bump in reimbursement -- from as low as $40 a couple of years ago to between $58 and $209 for each call depending on the complexity of the visit and the region in which the physician works, says **Constance Row**, executive director of the American Academy of Home Care Physicians (AAHCP).

There are more than 30 million senior citizens in our country, and that number is expected to double by 2020. At the same time, the number of chronically homebound also is rising. These figures, according to the AAHCP, combined with strong patient preference to be treated at home whenever possible, are leading to a resurgence of the old-fashioned house call.

Leaving middle management behind

Bermingham, who practiced in a small town in Colorado for seven years, moved to Fort Collins to teach and direct a resident family practice program. He joined an established practice

and became board-certified in geriatrics.

"I went from doing pretty much everything to having more and more of a geriatric practice," he notes. But as his role in the residency program grew, Bermingham says he became something of a middle manager. After a year and a half, he decided to get back to clinical practice, specifically solo practice. "I loved teaching, but I was doing more administrative stuff -- hiring, firing, budgets, and meetings."

Bermingham had seen the only other Fort Collins-based geriatrician try a regular office-based practice and fail. "She had an office, paid rent, had office hours, paid a nurse. But if you have 95% Medicare practice, it's tough to break even, let alone make a profit," he says.

His answer was to combine a nursing home practice with home care visits. "I don't have a full-time office, but I rent space two half-days a month so that those who are well enough to come in for annual visits can come in. I can also do some procedures I can't do in the home."

Aside from those two half-days, Bermingham works out of his truck, from a desk at home, and by making assiduous use of his handheld computer. His wife, a nurse, provides some record keeping for him, and he has computer programs with templates that allow him to complete some of his own paperwork. He does his own coding, for instance, but sends his bills out to a service.

"It is a combination of satisfying a need in the community plus reimbursement issues," he says of his decision to create this non-traditional practice. So far, it's working: Bermingham's voice mail message tells callers he regrets his practice is full and he is currently not accepting new patients.

Financial benefits

While there is certainly a financial incentive to doing business this way, Bermingham says he has found other reasons why home visits make sense. "You find out a lot more about people in their own homes," he says. "It's also more enjoyable to practice medicine this way."

Physicians who make house calls have more flexibility than do home health agencies in the range of patients for whom Medicare will reimburse. "I have to justify it in my notes why someone can't get out to the doctor," Bermingham says, noting that in home care, a patient has to be truly homebound. "With my patients, maybe the week before they were getting out to the store, but now they have a new illness and for three or four days, it's hard to get out. That's justification enough."

Bermingham concedes he is working more hours than he might if he had an office-based practice, "but it's a different type of work," he says. Unlike traditional office-based practitioners, Bermingham has a lot of flexibility in taking time off. If he doesn't have any pressing patient issues, he can take a three-day weekend on short notice. He works with a nurse practitioner who shares night and weekend coverage with him, an arrangement that provides for more rest than a typical solo-practitioner might otherwise get with an elderly and sometimes sickly patient base.

While he is very busy, Bermingham sees fewer patients than he did when he was in an office-based practice. "Then, I saw maybe 28 patients a day. Now, on a busy day, I see something in the high teens. I've actually hit the low 20s, but that was really pushing it."

Home visits are scheduled by appointment, and Bermingham sees nursing home patients on specific days. He also schedules particular times when he'll hit assisted living facilities. Visits usually last longer than a typical office visit, but that's partly due to the complexity of many of his cases.

"Part of the length of a visit is because I don't have the same pressures I would in an office. If I saw a patient in my office and he wanted to sit and talk, then my nurse would be sticking around and I'd be thinking about the overtime I was paying, or she'd be knocking on the door to tell me the next patient was waiting. So part of it is logistical."

However, Bermingham acknowledges that part of the attraction of his practice style is "the Gestalt of the home visit. When I'm in that patient's home, I see his bookshelf. I have a deeper sense of who he is as a person. I get to see his aide from the home care agency who might not come to an office appointment. The whole visit just has a different flavor."

Good for the doctor, good for the patient

Along with providing the physician with a good professional life, home-based medicine can provide better and more compassionate care for the elderly, particularly those at the end of their lives. Bermingham says his most memorable house call involved a 94-year-old woman with end-stage congestive heart failure complicated by renal failure and anemia. "The family wanted confirmation about what was going on. They wanted to talk to a doctor. But they didn't want to have to pack her up and send her to a doctor's office." The patient was still "with it," he says, just very weak.

"I gave her a prognosis and talked to her

family. She squeezed my left hand. Three hours later, she died. I used to tell my residents that when you are dealing with geriatrics, you have to think like a pediatrician, because there is always a third party involved -- a daughter, a niece, a daughter-in-law. I was able in this case to provide closure not just for the patient, but for the family as well."

Continuing a tradition

Natalie Mariano, MD, is an internist in Falmouth, MA, in solo practice. About 60% of her practice is Medicare, and she makes house calls to all of her dying patients.

"I've been doing it since day one," she says. When she first moved to the town in 1982, the retiring physician whose place she was taking had been providing house calls, as had his father before him. "A lot of those patients came to me and said the doc came to see them once a month … would I do the same?" she recalls. "At first, a lot of them were kind of social calls where you sit and talk to the person. I was new, so my practice had the time available for me to do that."

Now, 20 years later, most of her house calls are to homebound patients, most of whom are at the end of their lives. "It's not really a cost-effective or time-effective way to practice medicine for regular patients," she says. "I can't do as much for them at home. But when you are talking about comfort care and the terminal stages of a disease, it really works."

Through her house calls, Mariano says she gets to know her patients better. "I am a guest in their home. I see how they live, how the family functions," she says, adding that she views it as an extension of her role as a primary care giver who has been part of the community for decades. "I've known these people for so long, it seems a very natural thing to go into their homes at the end."

Given Mariano's office-based practice, the home visits can be difficult to fit in to her schedule. She tends to make those calls on her day off, on weekends, or when she is otherwise not in her office. "Usually, these aren't emergency calls. Frankly, I would do more of it if it didn't break up my day. It is one of the aspects of practicing medicine that I love most, and I would love to do more of it."

She says that she could see 20 patients during the day in her office and perhaps remember one single interaction out of all of that. "But I remember every house call, every time. It is as if you have been given this remarkable gift, to share in their lives. It really is a tremendous honor to come into their homes."

House calls make for better physicians

It takes a humble person, adds Bermingham, to go into another person's territory, to remember you are a guest in the home, and to act accordingly. "It's not for every physician," he notes.

But for physicians who can take off the hat of authority, it can make work life more enjoyable, and at the same time, Mariano says it can make one a better physician. "It has given me a much better understanding about what goes on in the homes of sick people," she notes. "In training, you see people in the hospital alone. That is just one facet of a sick person's life. Then you see them in the office when you are in practice. But you are still missing part of the picture."

One of Mariano's patients was "kind of a pain," she says. "He was a nasty guy. But I went to his home, and he had this panoramic view from his house. I never would have thought he was one to even care about beauty." Another patient dying of cancer was fond of doing needlepoint. "Her husband took me room to room and showed me what she had done. That kind of thing gives me a sense that they are complete people, more than just their illness. It gives me more respect for them, their talents, and their pasts. I can see if they live in a situation where they might not be able to afford the medications I prescribe for them. I know what in the home impacts their health. I think that the more you know about someone, the better you can treat them."

Bermingham thinks house calls will increase in popularity, primarily among Medicare patients. "It's hard to get things done for non-Medicare patients. You have to get pre-authorizations." There are also liability issues, for a male physician going into a woman's home to treat her alone, for example.

"But my wishful thinking is that more physicians will be drawn to this kind of practice," he says. "There is a great deal of job satisfaction and a lot less stress than a typical office-based practice. Managed care organizations stress 'throughput.' The whole Marcus Welby image was changed to the evil gatekeeper, and that's not why people get into medicine."

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California surgeon promotes anterior hip replacement

For a typical hip replacement patient, recovery can be as tedious and painful as the arthritis that precipitated the replacement in the first place. Patients are limited in activities for as long as two months after traditional surgery. For older people whose fragility makes being in a hospital downright dangerous and staying in bed a poor idea at best, a new approach would be better.

Or perhaps an old one that is making its presence felt in this country for the first time? Very few surgeons do it in this country, but in France, an anterior approach to hip replacement surgery has been fairly common. No muscles have to be split or detached from the bone, as is common with posterior or antero-lateral approaches. The result to patients: immediate unrestricted hip flexion with less potential for painful dislocations, as well as rapid functional recovery.

Good Samaritan Hospital in Los Angeles is one facility that is doing anterior hip replacements. "I first came upon this in France where it has been used for some time," explains **Joel Matta**, MD, an orthopedic surgeon who has been doing the surgery for several years. "But here, it isn't done much, in part because the best way to perform it is on a special operating table that can manipulate the leg and put it in positions that it is hard to achieve on a standard table."

Matta says that because no muscle is detached from bone during the procedure, patients can start walking sooner with crutches or a walker, and physical therapy can start almost immediately. Hospital stays can be as short as two days, he says, and most patients are out within five days. In addition, because the muscle is left intact, there is less likely to be any dislocation. Patients who undergo the anterior surgery don't have to limit their movement after getting out of the hospital -- they can sit on a regular chair or toilet seat or get into a car. There are also fewer instructions for them to follow. And the cost? The same as a traditional surgery.

For the 35 years that hip replacement surgery has been done, Matta says that the only focus of researchers has been trying to improve the longevity of the prosthesis. "But we've gone as far as we can on that. Now we have to look at ways to improve the surgical approach and minimize muscle damage."

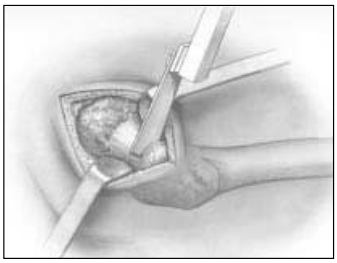
Along with Good Samaritan, there are a few other places around the country that have the special table necessary for this surgical approach. Yet another reason it might not be as popular here is that it is easier to get to the femur to attach the prosthesis using the posterior approach, says **Kritaps Keggi**, MD, who has been doing a version of the anterior approach using a traditional operating table since the 1970s. To

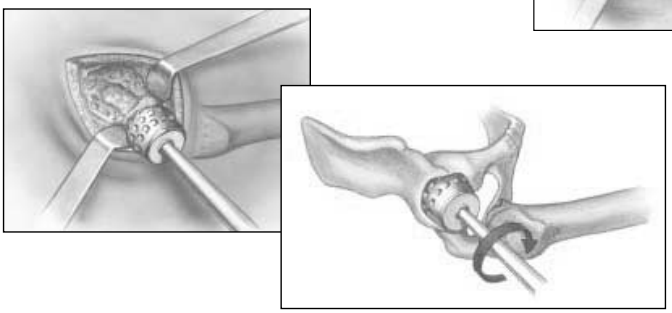
Figure 1: Anterior Hip Replacement Techniques

TOTAL HIP REPLACEMENT | JOEL M. MATTA,M.D.

The Approach

The hip is exposed by following a natural plane between muscles and without detachment of muscle or tendons from the bone. The femoral neck is cut and the arthritic femoral head and neck removed.



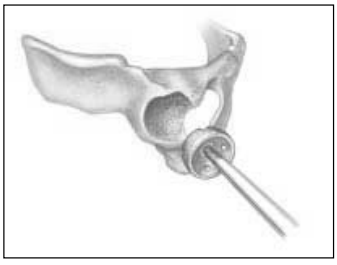


Acetabular Preparation

The arthritic acetabulum undergoes a procedure called reaming. A hemispherical shaped reamer rotates on the end of a shaft. Reamers of gradually increasing diameter accurately shape the bone of the acetabulum to accept the acetabular prosthesis.

The Acetabular Prosthesis

An acetabular prosthesis slightly larger in diameter than the prepared acetabular cavity is inserted with a "jam" fit that produces initial stability. During insertion active x-ray control with the fluoroscope is used to position the prosthesis accurately. One or more screws can also enhance initial stability. Later stability relies on the biologic process of growth of the bone onto the prosthetic acetabular surface. Following insertion of this titanium acetabular "shell", the bearing surface (usually of ultra high density polyethylene) is inserted.



Source: Joel M. Matta, MD.

date, he says he has done over 4,500 total hip replacements using this method.

Keggi, who hopes to have an English-language study on this approach in print "before too long," admits that there are concerns with the anterior approach, such as the potential for bleeding deep in the femur. He has created some special instruments designed to make that aspect less of a concern.

Maybe someday, but not yet

The fact that there has been no English-language, peer-reviewed study in a major journal on this approach may be an even bigger reason why it hasn't taken off, says **Seth Leopold**, MD, an associate professor in the department of orthopedics at the University of Washington.

"In the absence of a study, any claims made aren't worth very much, are they?" Leopold notes. While the anecdotal evidence from a physician about the lack of dislocations is important, it is only an untested hypothesis until a peer-reviewed study is done. "We don't know what the unintended consequences are. Unless there is long-term follow-up of the patients, we don't know whether there is, indeed, a better-than-expected dislocation or complication rate. Patients who have bad results won't necessarily go back to the same surgeon. What proportion of patients have they contacted and do they have follow-up data on?"

Not that Leopold wants to be totally negative. He knows Matta's work in particular and says that he would willingly attend one of his talks on virtually any orthopedic subject. "When [Matta] has a study to present that shows scientifically that this is the way of the future, I'll be the first one on the plane to L.A. to learn the procedure," Leopold says.

Meanwhile, he suggests, be as skeptical as you would be of any new procedure claiming better results than a traditional approach that has yet to be published in a peer-reviewed journal.

In the last few months, Matta has made some presentations on his technique that generated interest among other orthopedic surgeons. He is also working with a company to design a new table since the original French models are no longer produced.

"I think it is only going to increase in the future," he says. "It is a way to replace hips while preserving muscle. I've been doing this for six years. Usually, about 2% to 5% of patients experience dislocations after replacement. I've had none. I've done 15 years of surgery the traditional way, and six years like this. I'm much more pleased with this technique."

Keggi agrees, saying he can't imagine doing it from behind anymore because the advantages are "so great with this approach. It doesn't matter if the case is a complex revision or involves bone grafting. In the front, you go in and the hip is right there. From behind, you have to go through all that fat."

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'Stunning' study results

Placebo trial questions value of arthroscopic knee surgery

Pity the poor arthritis sufferers of the country: a study that included a rare instance of placebo surgery has found that arthroscopic knee surgery isn't any better than placebo in alleviating pain or improving function in osteoarthritic knees.

"The head of orthopedic surgery [at the Houston VA Medical Center] here wasn't sure that the procedure worked at all," explains **Nelda Wray**, MD, MPH, chief of general medicine at the hospital. The study suggests he's right, and since knee pain is the most common cause of functional limitation among people over 65, the news is "stunning," she says.

The study in *The New England Journal of Medicine* looked at 165 patients with osteoarthritis in the knee.[1] In a double-blind study, patients were assigned to one of three groups: arthroscopic debridement, arthroscopic lavage, or placebo surgery. Those in the latter group received skin incisions and underwent a simulated debridement without insertion of the scope.

Patients were assessed based on three scales for pain and two for function. They also performed one objective walking and stair-climbing test.

At no time was there any difference between the intervention and placebo groups. The scores were all similar -- 48.9 out of 100 on the pain scale for the placebo group, 54.8 for the lavage group, and 51.7 for the debridement group after a year. At two years, the results were even more similar, with the three groups between 51.4 and 53.7. The differences, says Wray, aren't clinically meaningful.

Data tell the story

"We looked at 48 different data points," she says. "You would have figured that placebo would have been better in two or three of those just by chance alone. But the placebo surgery was never better. And the interventions were never better. The differences are so close we can say that not only is the procedure not better than placebo, but it is equivalent. The data [are] just that strong."

Two types of patients typically undergo this type of surgery, Wray explains: those with an acute injury, such as a professional sports player; and "a second group who have it because they say their knee hurts." For the former group, the surgery has been revolutionary. "There is less trauma to the knee and they are back on the field faster," she says. "But for osteoarthritis, we weren't sure it worked."

One challenge to the findings might be that the surgery could be helpful for a smaller, more tightly defined group of patients than was analyzed in the study, Wray concedes.

"But we did our analysis on several subgroups," she says. "It didn't matter what the alignment of the knee was. It didn't matter how bad the arthritis was. Some surgeons say it only works on those patients with mechanical symptoms. But of the 180 patients we initially looked at, 176 had the mechanical symptoms."

The message Wray has for surgeons is that they should think strongly about continuing this procedure and putting patients through that risk. "The billions of dollars a year we spend on this surgery could be better spent somewhere else."

Seth Leopold, MD, an associate professor in the department of orthopedics at the University of Washington in Seattle says he believes the study was well done and confirms the suspicions that many orthopedists had about using arthroscopy for osteoarthritic patients. However, he would like to underscore that arthroscopy still is useful for a large number of patients.

The study findings leave two choices to patients with arthritic knees: replacement surgery or medical management. Wray suggests a strategy for surgeons contemplating a surgical intervention for osteoarthritis: do a placebo trial first. "I hear doctors talking about doing spacer surgery, but since we know you can do placebo surgery safely and ethically, do that first before you allow some new procedure to disseminate."

Editor's Note: For more information on this topic, contact Nelda Wray, MD, MPH, chief of general medicine, Houston VA Medical Center, 2002 Holcombe Blvd. (M.R. 152), Houston, TX 77030. Telephone: (713) 794-8681.

Reference

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Study documents alarming suicide rate among elderly

Access to handguns, poor sleep, limited social contacts, and depression are all risk factors for suicide among the elderly, according to new research that cites an alarming rate of self-inflicted deaths in this age group. In fact, every 95 minutes, an elderly person kills him or herself. The risks are greatest among white men. Indeed, support from community, family, and religion may explain why older African-Americans are an exception to this phenomenon and are much less likely to die by suicide than elderly whites.

The findings were reported in the *American Journal of Geriatric Psychiatry*, which had five separate research articles devoted to exploring what prompts so many older Americans to contemplate suicide and take their own lives or, in the case of many African-Americans -- particularly African-American women -- to avoid such thoughts and actions.

While they represent only about 13% of the population, in 1999 Americans 65 years of age and older accounted for almost 19% of all suicides. A closer look at the statistics finds the higher rates mainly due to an age-associated spike in suicides among older white men, who are about three times more likely to kill themselves than elderly African-American men and about seven times more likely to commit suicide than older white women. Suicide incidence is so low for older African-American women -- for example, in 1998, there were less than 20 nationwide -- it is difficult to even compute a rate.

Demographics portend higher suicide rates

Suicide rates among the elderly deserve increased attention for a variety of reasons, not the least of which is the fact that older adults are the fastest growing segment of our population, says an editorial accompanying the articles by **Yeates Conwell**, MD, of the University of Rochester Medical Center, and **Jane Pearson**, PhD, of the National Institute of Mental Health.

"In coming decades, as increasing numbers of people age into the stage of life that carries the greatest risk for suicide, the absolute number of seniors that take their own lives may expand dramatically," they write. But they note that scientists are responding to the challenge by pursuing research into social, psychological, and physiological risk factors specific to older adults. Because suicide is rarely related to a single cause, it is important to consider multiple risks simultaneously.

Conwell was the lead investigator of a study that identifies access to handguns as a risk factor for suicide in elderly men.[1] This analysis of 83 suicides in western New York revealed that firearms and, in particular, handguns were much more likely to be available in the homes of older suicide victims than in the homes of a control group, which was selected to match the victims in age, sex, race, and county of residence. In fact, 41 of the 52 suicide victims who kept firearms in their house used a gun to end their lives.

"One implication of these findings is that, were it possible, restriction of access to handguns may be an effective, universal preventive intervention for reducing rates of suicide later in life," the authors conclude.

The study appears to reinforce research that found firearm suicide rates for elderly citizens declined significantly in states that instituted waiting periods or background checks, or both, for handgun purchases in response to the 1994 federal Handgun Violence Prevention Act. Conwell and his colleagues speculate that while possession of a rifle or shotgun "may indicate no more than a historical interest in sport," the purchase of handgun by an older person "may be a critical signal of suicide intent."

Identifying risk factors

Preventing suicide in older people involves more than removing the means of accomplishing it, the researchers readily acknowledge. It's also necessary to look for additional signs an individual is at risk, e.g., access to firearms by elders who are depressed. In addition, lack of social interaction and poor sleep quality appear to be indications that a senior may end up committing suicide, suggests a study led by **Carolyn Turvey**, PhD, of the University of Iowa College of Medicine.[2]

The work by Turvey and her colleagues is the second study of its type to examine suicide in a large community of older adults. They looked at 15,000 elderly subjects whose health status, including mental health, had been tracked for ten years as part of the Established Populations for Epidemiologic Studies of the Elderly. They culled from that group 21 people who died by suicide and compared their various health issues with a group who did not.

> It appears that depression, poor sleep quality, and limited social support 'erode a will to live that affects mortality even in the absence of suicidal tendencies.'
>
> Carolyn Turvey, PhD
> College of Medicine
> University of Iowa

The three key risk factors for suicide identified in the study -- depression, poor sleep quality, and limited social support -- also crop up as general indicators of mortality. In other words, as the authors note, these are symptoms that "predict both death by natural causes and suicide.... It appears these variables erode a will to live that affects mortality even in the absence of suicidal tendencies," they write.

People who did not die by suicide had stronger ties to a community beyond their family, the authors also found. This finding figures prominently in another study, headed by **Joan Cook**, PhD, of the University of Pennsylvania and the Philadelphia VA Medical Center that examines suicide from the African-American perspective.[3]

Perhaps because they so rarely take their own lives, there has been little attention given to suicide risk among older African-Americans, Cook and her colleagues note. Her study analyzed suicidal thoughts, and the lack thereof, among a group of 835 older African-Americans residing in urban public housing developments.

The investigators found that only 27 or 3.2% of the subjects reported having suicidal thoughts. Those contemplating suicide were more likely to be experiencing depression and anxiety while feeling detached from social, religious, and spiritual connections. For subjects who were not thinking about suicide, strong ties to social and religious support networks were common

themes. For example, 90% of those studied said they had "received a great deal of support and comfort from religion."

Overall, the authors found "preliminary evidence" to validate theories that social support networks and religion are "protective factors" that make suicide less common in older African-American communities. However, Cook and her colleagues said more research is needed into both suicidal risks and protective factors that might be more pronounced in African-American communities "to determine their actual potency for" spawning treatments.

The study finds that while suicide rates may be comparatively low for older African-Americans, there still is a need for effective clinical interventions.

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NEWS BRIEFS

Researchers document power of positive thinking

Positive thinking truly is powerful, according to a study from Yale University which found that thinking positively about aging can extend life by as much as 7 ½ years. That's more than longevity gained from low blood pressure or low cholesterol, maintaining a healthy weight, abstaining from smoking, or exercising regularly.

The study in the August issue of the *Journal of Personality and Social Psychology* found that those who reported more positive self perceptions of aging demonstrated significantly longer survival than those who reported more negative self perceptions of aging.[1]

Depending on whether elderly persons are prompted to see themselves as "wise" or "senile," they will experience enhanced or compromised memory performance, will to live, cardiovascular response to stress, mathematical performance, and views of other older people, says lead author **Becca Levy**, PhD, assistant professor in the Yale's department of epidemiology and public health. She notes stereotypes about aging are acquired long before one becomes old and are therefore rarely questioned. "Once individuals become older, they may lack the defenses of other groups to ward off the impact of negative stereotypes on self perceptions," she says.

The findings about attitude and survival rates were made by analyzing and matching data collected in a small town in Ohio with data from the National Death Index. Researchers looked at how 338 men and 322 women 50 years old and older responded to several statements about aging in 1975, and then examined how their responses predicted their survival up to 23 years later. An example of one of the self-perception of aging statements was: "As you get older, you are less useful."

Those respondents with more positive views on aging live longer -- up to 7.6 years longer -- even after taking into account factors such as age, gender, socioeconomic status, functional health, self-reported health, and loneliness.

The effects of attitudes about aging had a greater impact on survival than low blood pressure and cholesterol, each of which is associated with a longer life span of about four years. The attitudes about aging also had a greater impact on longevity than lower body mass index, not smoking and regular exercise -- each of which extends life by one to three years.

"Our study carries two messages," the authors note in the study. "The discouraging one is that negative self-perceptions can diminish life expectancy; the encouraging one is that positive self-perceptions can prolong life expectancy."

Reference

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Depressed patients less likely to take antihypertensives

Physicians know many patients are noncompliant with medications -- for reasons ranging from the inability to pay for their medications to lack of understanding the importance of continuing with a medication regimen after

symptoms ease. Indeed, many physicians seem to think they can pick out their noncompliant patients.

"We doctors are often armchair prognosticators and think we can look at which patients know about their disease and which don't and figure out who won't take all their medications," says **Philip Wang**, MD, DrPH, an instructor of medicine at Harvard Medical School.

A recent study by Wang and colleagues at the division of pharmacoepidemiology and pharmacoeconomics at Harvard challenges that assertion.[1] They found, with the exception of depression, there was no single issue among patients that led to noncompliance with an antihypertensive regimen.

The study looked at nearly 500 hypertensive patients from a large HMO and a VA medical center. Researchers developed a survey to assess patients' psychosocial and behavioral characteristics, including health beliefs, knowledge, and social support regarding blood pressure medications, satisfaction with health care, depression symptom severity, alcohol consumption, and tobacco use. Using prescription-filling data, they then calculated actual adherence to prescription drug regimens over a one-year period.

Health beliefs, social supports, and patient satisfaction had no impact on compliance, but depression did.

The results were adjusted for demographics, so Wang is confident that age isn't a confounding characteristic. "In fact, when we adjusted for age, the depression effect got stronger."

The message to physicians is clear, says Wang. "If you know someone is depressed and if you are treating that patient for hypertension, you should be more vigilant with compliance and have a high index of suspicion with their answers."

Another, more indirect message is that primary care providers "should be vigilant for depression, period," says Wang. He said that although this study looked only at hypertension medications, it could be extrapolated to other medications. "I'm comfortable making the leap that depression might impact any other medication regimen, too," he says.

Editor's Note: Contact Philip Wang, MD, DrPH, instructor in medicine, Harvard Medical School, division of pharmacoepidemiology and pharmacoeconomics, at (617) 278-0929 or via e-mail at pswang@partners.org.

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Beta blockers better than expected; adverse side effects prove rare

It's long been thought that beta blocker therapy can lead to depression, fatigue, and sexual dysfunction. But a study in the *Journal of the American Medical Association* has debunked that as myth.[1]

"For a long time there has been conventional wisdom that beta blockers are associated with substantial adverse non-cardiac symptoms," says senior investigator **Harlan Krumholz**, MD, an associate professor of internal medicine and cardiology at Yale. "But most of the conventional wisdom was anecdotal. There was no systematic review of this association."

To determine whether beta blockers are associated with depression, fatigue, and sexual dysfunction, the Yale group looked at 15 clinical trials involving more than 35,000 subjects who were prescribed beta blockers for the treatment of heart attack, heart failure, or hypertension.

"What we found is there is no clear evidence that use of beta blockers causes depression," Krumholz says. "There was a slight association between use of beta blockers and resulting fatigue and sexual dysfunction." The risk of fatigue was the equivalent of one additional report for every 57 patients treated. The risk of sexual dysfunction was one additional report of sexual dysfunction for every 199 patients treated with beta blockers.

"We also found that these symptoms were common among patients taking placebo," he adds. "Therefore, given the survival benefit associated with beta blocker therapy for patients who have had a heart attack, concerns about the development of these adverse effects should not deter physicians and their patients from initiating long term treatment when indicated, although surveillance for adverse effects remains prudent."

Reference

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Animal therapy can ease loneliness, says study

For perhaps the first time, animal-assisted therapy has been proved by scientific study to

have positive results. According to research published in *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, loneliness among nursing home patients can be alleviated through pet therapy, and the lead author of the study thinks it's possible that the results can be extrapolated to the community-dwelling population.[1]

The study looked at 45 residents of long term care at a VA facility in St. Louis. The residents were given standardized tests for loneliness and demographic and pet histories. They were then randomized in to three groups -- no animal therapy, weekly therapy, and visits with pets three times a week. After six weeks, the residents were given the loneliness test for a second time.

The results showed significant reduction in loneliness scores among those patients who had animal therapy, says **William A. Banks**, MD, professor of internal medicine and geriatrics at St. Louis University Medical School. He notes that while the study didn't directly address the community-dwelling elderly, "it seems logical that if the person in question has had pets in the past, if they have the physical, financial, and emotional resources that pet care demands, and -- most importantly -- [if] they have the desire to share their lives with a pet, then the right animal could become an immensely important aspect of their lives."

Given other recent studies that indicated the importance of mood and attitude in staying healthy and living longer, pet therapy could be one way to help alleviate debilitating loneliness.

Editor's Note: For more information on this topic, contact William A. Banks, MD, professor of internal medicine/geriatrics, St. Louis University Medical School, VAMC (151), 915 N. Grand Blvd., St. Louis, MO 63106. E-mail: bankswa@slu.edu. Telephone: (314) 289-7084 4590.

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Depression often persists for years among seniors

Health care providers increasingly recognize depression as an illness that can be treated. However, along with that recognition comes an assumption that it can be cured. A recent study in the *Archives of General Psychiatry*, however, indicates that among older people, cures may be rare.[1]

Researchers in Amsterdam looked at more than 275 depressed elderly people and followed them for six years. They looked at self reported measurements of depression, and also conducted diagnostic interviews. The natural history of their disease was assessed for symptom severity using the Center for Epidemiological Studies Depression Scale score.

The average symptom severity for the study participants remained above the 85th percentile for the entire course of the study. Only 14% of the patients had short-lived symptoms. Almost a quarter of the patients had remissions, and 44% had unfavorable but fluctuating disease courses. Nearly a third of patients had a severe chronic disease course for the entire duration of the study.

The authors note that while depression that meets diagnostic thresholds is relatively rare among the elderly, those who meet DSM thresholds often have the worst prognosis. Even patients with sub-threshold disorders -- a group that had the best outcomes among the group studied -- are still at high risk of developing DSM affective disorders, the authors note.

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NYU hopes to bridge skill gap with course for geriatric nurses

Nurses interested in upgrading their skills with geriatric patients have a new tool: an on-line, free Internet-based review course set up by the John A. Hartford Foundation Institute for Geriatric Nursing in the Division of Nursing at New York University's Steinhardt School of Education.

"Nearly half of the hospital beds in the United States are occupied by adults ages 65 and older, yet fewer than 1% of the practicing registered nurses are certified in geriatrics," says **Mathy Mezzy**, EdD, RN, FAAN, director of the Hartford Institute. "This problem is compounded by the general nursing shortage we are experiencing in this country."

The on-line course, which prepares registered nurses to become certified as gerontological nurses by the American Nurses Credentialing

Center of the American Nurses Association, reviews and summarizes key clinical information for the care of older adults, from the causes of aging, to pain management, to nursing home protocols. It also reviews the many financial, social, political, and cultural issues that affect nursing care for elders.

The course is available free-of-charge on the Internet at the institute's website, *www.hartfordign.org*. The course takes six to eight hours to complete.

The course is organized around four common older patient types nurses encounter in their practice: healthy, frail, institutionalized, and dying adults. Each module includes a case study of a typical patient in the population being reviewed.

Practice questions in each module and a final review test set assist in examination preparation, and the course is designed for individual study at a flexible pace. The program is recommended for practicing nurses, nurse educators, or nursing students who want to acquire fundamental knowledge of geriatric nursing care. Individuals completing the course may earn 9.6 contact hours of continuing education credit through the Center for Continuing Education in Nursing at NYU's Division of Nursing.

For more information about the on-line geriatric nursing review course, e-mail the Hartford Institute at hartford.ign@nyu.edu; or call Elaine Gould at (212) 998-5568.

Drops delay, may prevent glaucoma in some patients

Researchers have discovered that eye drops used to treat elevated pressure inside the eye can be effective in delaying the onset of glaucoma and may even prevent the disease. According to a study in the *Archives of Ophthalmology*, scientists found that pressure-lowering eye drops reduced by more than 50% the development of primary open-angle glaucoma, the most common form of glaucoma and one of the nation's leading causes of vision loss.[1]

Researchers noted that 4.4% of the study participants who received the eye drops developed glaucoma within five years. By comparison, 9.5% of the study participants who did not receive the eye drops developed glaucoma.

The study also found several significant risk factors that were associated with the development of glaucoma in study participants. These included personal risk factors, such as older age and African descent, as well as ocular risk factors, such as higher eye pressure, certain characteristics in the anatomy of the optic nerve, and thinness of the cornea.

It is estimated that between 3 and 6 million people in the United States -- including between 4% and 7% of those over 40 -- have elevated eye pressure and are at increased risk for developing open-angle glaucoma. Until now, doctors did not know if treating elevated eye pressure -- before glaucoma developed -- could delay the onset of the disease. Some doctors treat people with elevated eye pressure, others do not. This study provides some important information to consider in reaching a decision about treatment.

"This study showed that treating elevated eye pressure delays or prevents the onset of glaucoma in some people," says **Paul A. Sieving**, MD, PhD, director of the National Eye Institute (NEI). "The study clearly makes a connection between elevated eye pressure and the onset of glaucoma. However, not all people with elevated eye pressure should be treated with the eye drops."

The study examined 1636 people 40 to 80 years of age who had elevated eye pressure but no signs of glaucoma. Half were assigned daily eye drops, and the other half was assigned to observation and no medication. In the medication group, treatment reduced eye pressure by approximately one-fifth.

"It is significant that this modest 20% reduction in eye pressure had such an important protective effect in the development of glaucoma," says study chairman **Michael Kass**, MD, of the Washington University Department of Ophthalmology and Visual Sciences. However, Kass sounded a cautionary note: "Eye care professionals should not prescribe eye drops for all people who have elevated eye pressure with no sign of glaucoma. Doctors should take into account several factors, including the simple fact that 90% of participants in the observation group did not develop glaucoma within the five-year study period. Individuals' risk of developing glaucoma, along with their health status and life expectancy, should be considered. The burden of daily treatment, including cost, inconvenience, and possible side effects, are other factors that the doctor and patient should discuss."

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Report on disease management for frail elderly available

A practical resource for senior care professional focused on disease management strategies for frail-elderly patients in now available. One of seven new special reports in National Health Information's popular Disease Management Series, *Frail Elderly: Disease Management Strategies & Programs* contains all-new programs, strategies, decision-making tools and case studies in care management for frail seniors. This 54-page all-new volume includes these articles:

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