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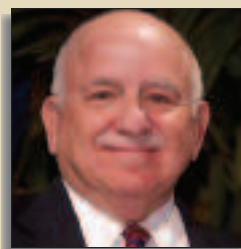
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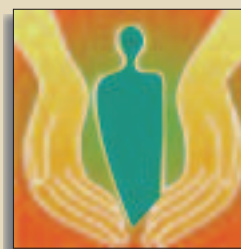
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By Eric Rosenthal

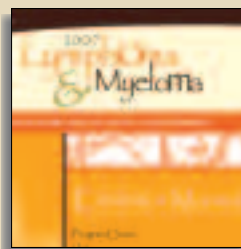
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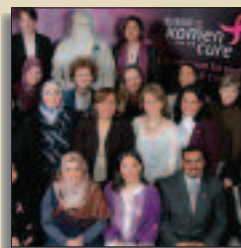
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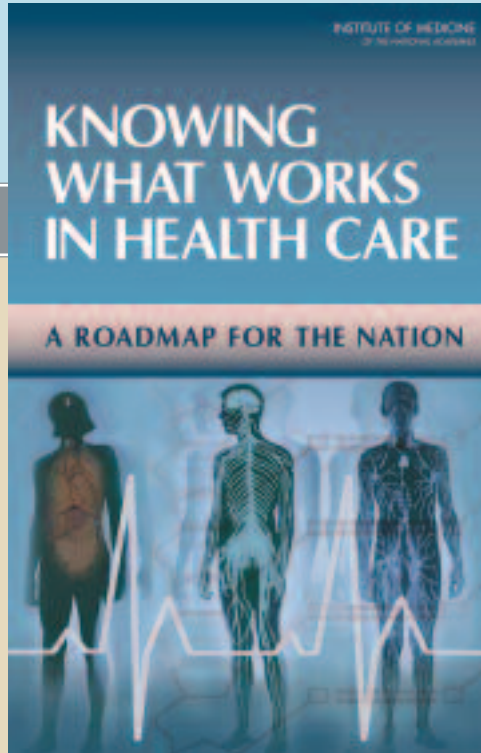
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Chemotherapy Foundation Symposium

'No One Discusses Dying Today, Not Even Health Care Professionals,' Case Manager Complains

By Naomi Pfeiffer

NEW YORK CITY—Dying may be the least discussed major issue in America today, where “60 is the new 40” and “death is the new ‘I am having a really bad day.’” So said Catherine M. Mullahy, RN, CRRN, President of Mullahy & Associates, LLC, a health care case management training and consulting company in Huntington, NY, speaking here at the Chemotherapy Foundation Symposium.

“Our culture dictates that death is not an option. This leads many of us, our families, and physicians to focus on experimental treatments or a cure for a terminally ill loved one rather than a measure of pain-free comfort at the end of life.”

And health care professionals are as culpable as the general public in avoiding discussing end-of-life care, she noted. “Although we learn all the basics, we’re uncomfortable being around dying patients and their families and confronting the impending harsh realities,” she said in her presentation called “Managing End-of-Life Decisions,” which was held during the special all-day session on the last day of the symposium, called “New Perspectives in Oncology Practice,” designed for oncology nurses, nurse practitioners, physician assistants, case managers, and pharmacists.

She noted the difficult situation that physicians are faced with. “On the one hand, their mission is to keep patients alive as long as possible, but on the other hand, they need to communicate openly and honestly with patients regarding their status. Patients need to understand the truth about DNR, CPR, organ transplants, and the like. And the physician should be the one to make

sure that the advance directive forms are explained early on, when the patient is calm, and followed up on in a compassionate way.”

Hospice

Ms. Mullahy noted that in 1982, Medicare pioneered in covering hospice care for the dying, calling for the best possible pain-free comfort for such patients rather than focusing on treatments, cures, medication, or artificial life support. “A patient entering a hospice program agreed to forego further life-extending treatment, and under the 1982 law, a person became eligible for hospice care if a doctor certified that the patient had a terminal illness and was expected to live six months or less.”

Many hospice patients did not live that long, however. In the meantime, new treatments and cures gave patients a new lease on life, so that now the situation is quite different. For example, an updated 1998 ruling was passed by Medicare and Congress stating that a patient may remain in hospice care for unlimited, consecutive six-month periods if the physician continues to certify his/her impending death.

“But this ruling and similar ones have not been honored,” Ms. Mullahy said, noting, for example, that in its recent “End-of-Life Issues Survey,” the Case Management Society of America found that 92% of patients’ advance directives were ignored or delayed more than 50% of the time. In addition, about 75% of patients received no more than about 30 days of the six months of hospice care to which they are entitled—“In fact, more than 50% spent barely 14 days in a hospice.”

Conversely, however, Ms. Mullahy reported current data from the National Hospice and Palliative Care Organi-

zation showing that hospitals offering palliative care are undergoing a construction boom—from 632 in the year 2000 to more than 4,000 today.



Catherine M. Mullahy, RN, CRRN:
“Start by examining your own feelings. Have the conversation regarding your own end of life with family members. By facing your own mortality, you’ll be better equipped to help others do so. Health care professionals also can empower patients by discussing patients’ impending death with them early and often.”

“Further, unlike the bleak wards to which dying patients were once consigned, the new ones are pleasant, natural, caring places for end-of-life patients and their families,” she said.

How to Create a Better Experience

During the question-and-answer period

after her talk, someone asked Ms. Mullahy how health care professionals could help create a more humane end-of-life-experience.

“Start by examining your own feelings,” she replied. “Have the conversation regarding your own end of life with family members. By facing your own mortality, you’ll be better equipped to help others do so.”

Health care professionals also can empower patients by discussing their impending death with them “early and often,” she added.

“Make asking patients about their end-of-life wishes and advance directives a natural part of the patient-professional dialogue, like a routine check-up. Some 80 percent of Americans have not completed an advance directive for their continuing care.”

Also, dying patients can be educated about relevant medical procedures—“Intubation, defibrillation, cardiopulmonary resuscitation, and injection of medication into the heart should become familiar, not terrifying, terms,” she said.

Enhanced Role for Case Managers as Patient Advocates

Additionally, Ms. Mullahy stressed an enhanced role for case managers as patient advocates: “From beginning to end, they should be a constant reassuring presence, assuaging the patient’s fears of diminished mental capacity, monitoring their pain management, and helping patients and their families make the numerous important decisions needed, from power of attorney to transfusions to organ transplant.”

First Colonoscopy with Removal of Polyps Linked to Reduction in Colon Cancer Death

Using a model to predict reductions in death from colorectal cancer, epidemiologists and clinical researchers from Memorial Sloan-Kettering Cancer Center compared the relative effect of an initial screening colonoscopy that clears precancerous polyps from the colon with surveillance follow-up colonoscopy. Ann G. Zauber, PhD, Sidney J. Winawer, MD, and colleagues presented the findings at the Annual Scientific Meeting of the American College of Gastroenterology.

“The model demonstrated a

dramatic reduction in expected colorectal cancer mortality with initial polypectomy with or without surveillance, and suggests that the initial polypectomy accounts for the major component of the mortality reduction,” Dr. Zauber explained in a news release.

The researchers used National Polyp Study data to predict colorectal cancer mortality among three groups of patients: those with no initial removal of polyps or follow-up surveillance by colonoscopy, compared with patients with only initial

polypectomy, and those with both polypectomy and follow-up surveillance. The model predicted mortality of up to 30 years after the initial colorectal exam and removal of precancerous polyps.

Dr. Zauber noted that the major effect on colorectal cancer mortality reduction produced by the initial polypectomy rather than the surveillance colonoscopies is consistent with the low incidence of advanced adenomas observed during follow-up in the National Polyp Study—i.e., precancerous growths in the colon

larger than 1 cm, polyps with a villous component, high-grade dysplasia, or invasive colorectal cancer.

The findings, she said, may support the recommendation to lengthen the interval to six or more years for follow-up surveillance for patients who have polyps removed.

David A. Johnson, ME, President of the American College of Gastroenterology, commented that although there is growing evidence to support the extension of surveillance to longer intervals, prospective studies are still needed.