According to a new study, patients with locally advanced non-small cell lung cancer live longer if they are treated with radiation therapy and chemotherapy at the same time rather than with chemotherapy followed by radiation therapy.

The research, which involved 592 patients, found a 17.1 month median survival rate for patients treated concurrently, which was significantly better than the 14.6 months for those treated sequentially, says Ritsuko Komaki, MD, of MD Anderson Cancer Center in Houston, TX.

The study consisted of three different treatment groups. Patients in the first group were treated with chemotherapy first followed by daily radiation therapy. Patients in the second group were treated with concurrent chemotherapy and daily radiation therapy. Patients in the third group were treated with concurrent chemotherapy and twice daily radiation therapy. When chemotherapy and twice-a-day radiation therapy were given at the same time, there was better control of the tumor within the treated area compared to patients who were treated by chemotherapy followed by radiation therapy, says Dr. Komaki. Twice daily radiation therapy, however, did cause higher incidence of acute esophagitis, which led to weight loss or dehydration with occasional hospitalization, compared to once daily radiation therapy given concurrently with chemotherapy, says Dr. Komaki.

There was no significant difference in the late toxicities between the three different treatment groups. “We are hopeful that by using new techniques, such as 3D conformal radiation therapy, which allow us to target the radiation more precisely, we will be able to reduce the toxicity levels,” she says. (American Society for Therapeutic Radiology and Oncology)
TB, MAC Decline in HIV Patients

The incidence of TB and Mycobacterium avium complex (MAC) decreased markedly among HIV patients between 1994 and 1999. Researchers who looked at 7,000 individuals during that time frame credit the decrease in TB and part of the reduction in MAC to the impact of highly active antiretroviral therapy, which dramatically changed the clinical prognosis for HIV-infected patients in terms of disease mortality and resulted in less severity of illness and reduced need for hospitalization.

The research team says that after March 1997 TB became the most common mycobacterial disease among those infected with HIV. This was in stark contrast to the pre-antiretroviral era in which MAC was twice as common as TB.

The study involved a large cohort of patients from 51 clinical centers in 17 European countries. (American Journal of Respiratory and Critical Care Medicine, 800).

Better Training, Increased Focus on Patient Needs Required in End-of-Life Conversations

Dying and end-of-life care issues have been the focus of recent media attention, including a PBS documentary and Time magazine report. End-of-life concerns, however, are still uncomfortable topics for many health care providers. A new analysis from researchers at the U.S. Department of Veterans Affairs (VA) suggests that end-of-life issues could be better handled by making such conversations a routine and structured part of care for critically ill patients. Among other measures, the investigators call for the development of a new health care role emphasizing advanced illness care, and physician training and community awareness programs to help doctors, patients, and caregivers cope with end-of-life discussions.

“We need to train all health care practitioners in standard communication models for conversations at the end of life,” says lead author Daniel R. Tobin, MD, of the VA Health Care Network Upstate New York, Albany Division. In the review, Dr. Tobin and co-author Dale G. Larson, PhD, of Santa Clara University, noted recent studies that show patients are dying in unrelieved pain after long hospital stays and intensive care. In addition, patient preferences for life-sustaining treatments are not adequately discussed or documented, and referrals for hospice or home care occur too late or not at all.

Dr. Tobin and Larson identified a combination of barriers (both personal and institutional) that make it difficult for meaningful end-of-life conversations to occur in a health care setting:

• Some patients with an advanced illness avoid end-of-life conversations to conceal their pain and feelings of self-blame, anger, loss, or fear.
• Physicians may avoid end-of-life conversations due to the fear of causing pain and bearing bad news to patients and their families, unfamiliarity with advance directive laws, their view that death is an enemy to be defeated, anticipation of disagreements with the patient, medical or legal concerns, or feeling threatened by such discussions in general.
• Barriers are caused by the health care system in general because end-of-life discussions are not a routine part of care for health care providers; physicians are not compensated for psychosocial conversations, including end-of-life discussions; and patients may receive treatment at a variety of health care delivery sites, where responsibility for end-of-life discussions is not clear.

The authors offer several strategies for improving the quantity and quality of end-of-life conversations, including improving communication skills training for physicians and other health care providers, adopting a patient-centered model of care, increasing focus on remaining quality of life activities, and developing programs to support end-of-life discussions earlier in the health care process.

“Better Training...” continued on page 3
Why Quitters Return to Smoking

Data from a new study that evaluated the maintenance use of ZYBAN (bupropion HCl) Sustained-Release 150 mg tablets among smokers who used some light on the challenges faced by people who try to quit smoking but subsequently return to it—a common problem for the approximately 23 million people who try to quit smoking each year in the U.S. The analysis, presented at the 11th World Congress on Tobacco or Health earlier this year, found that people who used placebo to quit smoking cited "overwhelming cravings" as the most frequent reason for returning to smoking, whereas craving was the sixth most frequent reason cited among people who used Zyban.

"Although some people can successfully quit smoking on their first attempt, understanding the person who returns to smoking has been a challenging issue for researchers and public health advocates," says Michael Durcan, PhD, principal clinical research scientist for the Central Nervous System Clinical Research Group of Glaxo Wellcome, the maker of Zyban, the only non-nicotine pill approved by the FDA as an aid to smoking cessation treatment. On average, smokers attempt to quit five times before succeeding. In acknowledgment of that fact, the U.S. Public Health Service recently issued a definitive guideline advising medical professionals to treat tobacco dependence more like a chronic condition.

In the maintenance use study, 784 smokers were placed on seven weeks of therapy with Zyban and given brief counseling. At week seven, the 432 patients who had not smoked in the past seven days then continued for 45 weeks on either the drug or placebo. At the end of the study, the smokers who returned to smoking (128 in the placebo group and 116 in the group treated with Zyban) were asked to choose factors they felt contributed to their return to smoking. The placebo users most frequently cited "overwhelming craving" (49.2%) as the reason they returned to smoking, followed by "stress" (48.4%), "presence of other smokers" (44.5%), "situation where I normally smoke" (29.7%) and "frustration" (26.6%). However, among the patients treated with Zyban who subsequently returned to smoking, the most frequently cited reason was "presence of other smokers" (44.5%), followed by "stress" (41.4%), "situation where I normally smoke" (26.7%), "frustration" (23.3%) and "anger" (23.3%). "Overwhelming craving" was cited by 22.4% of patients using Zyban, compared to 49.2% of the placebos group.

"These results are a step forward in helping us understand how cravings can affect the smoker beyond the initial cessation phase and throughout the cycle of tobacco dependence," says Dr. Durcan. "This gives medical professionals more knowledge about how to treat smokers, and shows us that some of the hurdles may be best addressed by modifying behavior or changing habits, such as not spending time around other smokers and avoiding smoking situations where they normally smoke."

Acknowledging that older smokers are at greater risk for smoking-related diseases such as cardiovascular disease, stroke, cancer, and respiratory disease, the Centers for Disease Control and Prevention has issued the following facts on smoking among Medicare beneficiaries enrolled in Medicare managed care plans:

• In 1996, the prevalence of daily cigarette smoking was 36.7% among Medicare managed care enrollees aged 55-64, 15.1% among persons aged 65-74, 9.1% among persons aged 75-84, and 4.5% among persons aged 85 and older.
• Medicare managed care enrollees are more likely to visit a physician or health care provider than other smokers; however, only 71% of older smokers receive advice to quit smoking.
• For those enrolled in a Medicare managed care plan who reported any smoking in the past 12 months, the advice to quit increased with the number of visits to physicians or health care providers. An estimated 61.5% who made at least one visit in the past 12 months reported receiving advice to quit, while 76.2% who made five or more visits received advice to quit smoking.
AARC Wants to Know Your Top Five Areas of Concern

Older Americans Seek Quick Dietary Fix

Many chronic lung disease patients need to change their diet to improve their health. But convincing them to alter their eating habits is usually an uphill battle. Now a new survey commissioned by the American Institute for Cancer Research (AICR) may help to explain why. The study, which was undertaken to gauge how seniors deal with dietary changes necessary to lower their cancer risk, shows that as Americans grow older and their metabolism slows, however, they may find it more difficult to effectively manage their weight. They may then become frustrated and give up on healthy diets. Older Americans may also be turning away from healthy diets due to concerns about convenience. They may mistakenly believe that healthy meals require too much time and effort, and instead seek out pills and multi-vitamins as a “quick-fix.”

In the study, respondents to the survey were asked which specific dietary and nutritional supplements, if any, they took to lower their risk of cancer. Vitamin C was the most commonly used supplement, reported by 17% of respondents. Vitamin E came in second, at 16%, and a surprising 9% said they took garlic supplements for lower cancer risk. Folic acid came in fourth, at 8%, and beta-carotene was the fifth most popular dietary supplement used to fight cancer, taken by 7% of Americans. While vitamin C, vitamin E, and beta-carotene are widely known antioxidants, substances that protect the body from the kind of cellular damage that can lead to cancer, researchers don’t know whether or not they are protective against cancer as supplements. Indeed, there is some concern among scientists that very large doses of single antioxidants may have a promotional effect on cancer growth. In a series of studies, for example, beta-carotene supplements were linked to increased lung cancer incidence among smokers.

AARC Wants to Know Your Top Five Areas of Concern

The AARC is currently seeking input from section members regarding the top five areas of concern unique to our specialty area. Please mail, email, or fax your top five concerns related specifically to the specialty (not to the AARC or the practice of respiratory care in general) to Kelli Hagen, 11030 Ables Lane, Dallas, TX 75229, email: hagen@aarc.org, FAX (972) 484-2720 or (972) 484-6010. The Association will utilize our input in determining priorities for the coming year.
The AARC is currently seeking information on JCAHO accreditation site visits. Please use the following form to share information from your latest site visit with your colleagues in the Association. The information will be posted immediately on the AARC website at http://www.aarc.org/members_area/resources/jcaho.html and will also be featured in the Bulletin.

Accreditation visit you are reporting (choose one):

- Home Care
- Hospital
- Long Term Care
- Pathology & Clinical Laboratory Services

Inspection Date: __________________________________________________________________________________
Facility Name: ___________________________________________________________________________________
Contact: _______________________________________________________________________________________
(Please provide name and email address.)

1. What was the surveyors’ focus during your site visit? __________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________

2. What areas were cited as being exemplary? ________________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________

3. What suggestions were made by the surveyors? ______________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________

4. What changes have you made to improve compliance with the guidelines? ______________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________

Additional comments:
Mail or fax your form to:
William Dubbs, RRT
AARC Associate Executive Director
11030 Ables Lane
Dallas, TX 75229
FAX (972) 484-2720