

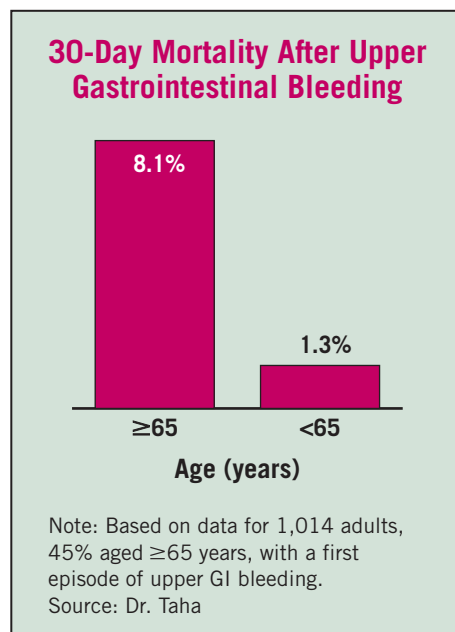
Age Predicts Early Mortality After GI Bleeding

BY HEIDI SPLETE
Senior Writer

SAN DIEGO — Older age was the strongest predictor of early mortality in adults with gastrointestinal bleeding after investigators controlled for medications and comorbidities, according to data from more than 1,000 adults treated at a single medical center.

In recent years, more clinicians have turned to low-dose aspirin and antithrombotic agents for the prevention of cardiovascular disease, but the interaction of these products with other risk factors for GI bleeding has not been studied thoroughly.

"We aimed to assess the 30-day mortality after upper gastrointestinal bleeding in association with the use of NSAIDs, low-dose aspirin, and other antithrombotic drugs," Dr. Ali S. Taha of Crosshouse Hospital and the University of Glasgow, Scotland, and associates wrote in a poster presented at the annual Digestive Disease Week.



The investigators analyzed data from 1,014 adults who presented with a first episode of upper GI bleeding. A total of 45% of the patients were aged 65 years

and older, and 8.1% of these patients died within 30 days of bleeding, compared with 1.3% of the younger patients.

After adjustment for multiple variables, patients who were aged 65 years and older had a significantly greater risk of 30-day mortality, compared with their younger counterparts.

In a univariate analysis, cerebrovascular disease, cardiovascular disease, and the use of diuretics, digoxin, and either low-dose aspirin or other antithrombotic drugs were significantly associated with an increased risk of 30-day mortality.

Low-dose aspirin was defined as 75 mg/day, and the antithrombotic drugs included clopidogrel, dipyridamole, and warfarin.

Use of NSAIDs had no significant impact on 30-day mortality, and the specific withdrawal of rofecoxib (Vioxx) had no apparent effect on 30-day mortality rates in this population.

The Blatchford score (an accepted measure of risk in patients with upper GI bleeding) was calculated using both clinical

and laboratory data at each patient's presentation.

Patients scoring higher than 10 on this measure had five times the risk of early death, compared with patients who scored 0-2.

Despite the importance of comorbidities and medication use, the results suggest that age is a strong and independent predictor of early mortality in patients with upper GI bleeding. However, more studies are needed to determine the clinical implications for treatment, Dr. Taha said in an interview.

"Ulcer prevention should be considered seriously in elderly patients, particularly in the presence of other comorbid conditions and use of ulcerogenic drugs," Dr. Taha said. "And once bleeding has taken place, such patients should be targeted for intensive management."

Dr. Taha stated that he has received grants and research support from Astellas Pharma Inc., AstraZeneca Pharmaceuticals, Merck & Co., and Yamanouchi Pharmaceutical Co.

NCI Centers Yield Best Colorectal Cancer Surgery Outcomes

BY BRUCE JANCIN
Denver Bureau

NEW YORK — Colorectal cancer patients who undergo tumor resection at a National Cancer Institute–designated cancer center have markedly lower 30-day mortality and superior long-term survival than do those treated at other hospitals, according to a review of more than 42,000 Medicare patients with colon or rectal cancer.

Of note, hospitals earn their NCI cancer center designation not on the basis of clinical outcomes or quality-of-care measures—which don't figure in the NCI's decision-making—but through demonstrated excellence in basic science and clinical research.

What is it about the nation's 62 NCI cancer centers that results in better outcomes?

"Possible explanations for this observed benefit include surgeon, oncologist, and pathologist specialization and volume; a multidisciplinary team approach to cancer care; or adherence to the most current cancer surveillance and treatment guidelines," Dr. Emily C. Paulson reported at the annual meeting of the American Surgical Association.

She presented a retrospective cohort study of 33,970 Medicare patients with colon cancer and 8,591 with rectal cancer in the NCI Surveillance, Epidemiology and End Results database. The patients underwent radical tumor resection in 1996-2003.

In all, 3.0% of those with colon cancer and 4.3% of rectal cancer patients had their surgery at an NCI-designated center,

said Dr. Paulson, a surgery resident at the Hospital of the University of Pennsylvania, Philadelphia.

Unadjusted 30-day mortality was 3.2% in colon cancer patients who were treated at an NCI cancer center and 6.7% in those who were treated elsewhere. Among rectal cancer patients, 30-day mortality was 1.9% in those who were treated at an NCI center, compared with 5.0% in those who were treated elsewhere.

In a multivariate logistic regression that was adjusted for patient demographics, cancer stage, acuity of admission, hospital bed size, case-specific surgical volume, and teaching status, colon cancer patients treated at an NCI-designated cancer center had a highly significant 42% reduction in relative risk of 30-day mortality, compared with those treated in other hospitals.

Similarly, rectal cancer patients treated at an NCI center had an adjusted 50% reduction in 30-day mortality.

Patients were followed through 2005. The adjusted long-term mortality risk was 17% less for colon cancer patients who underwent resection at NCI cancer centers than for those who underwent resection elsewhere, while for rectal cancer patients it was 16% less.

Median survival was significantly longer for patients in all four cancer stages if they were operated on at an NCI center.

For example, stage III colon cancer patients whose tumor resection took place at an NCI center had a median survival of 4.7 years, compared with 3.2 years for those treated at a non-NCI center.

Patients with stage II rectal cancer treated at an NCI center had a median survival of 6.7 years, while for those treated elsewhere it was 4.7 years, Dr. Paulson continued.

Dr. Frederick L. Greene said that he was "saddened and concerned" by the findings. As chairman of the American College of Surgeons Commission on Cancer for the past 5 years, he has overseen the hospital approvals program that was created in an effort to raise practice standards through benchmarking and constructive feedback to the 1,460 participating hospitals.

What is the message for small community hospitals that participate in the approvals program?

These small hospitals have been trying to improve the quality of their cancer care, but they will never have all the multidisciplinary resources that are available in an NCI cancer center, said Dr. Greene, who is chairman of the surgery department at Carolinas Medical Center in Charlotte, N.C.

Dr. Najjia Mahmoud, senior author of the study, said that referring all of the 150,000 patients who are newly diagnosed with colorectal cancer each year to the nation's 62 NCI-designated centers would create "an impossible scenario" both for those hospitals and for patients, who in many cases would have to travel burdensome distances.

She and her coworkers intend to use their study as a starting point to identify the specific elements of care provided at NCI centers that lead to the superior outcomes.

The ultimate goal is to develop ways of improving care that are achievable at many hospitals.

"We suspect, but we don't know, that these outcomes are not confined just to NCI centers. We suspect that NCI-like centers with high surgeon volume—not hospital volume, but surgeon volume—and specialization without the basic science research component of NCI centers may have similar outcomes," said Dr. Mahmoud, a colorectal surgeon.

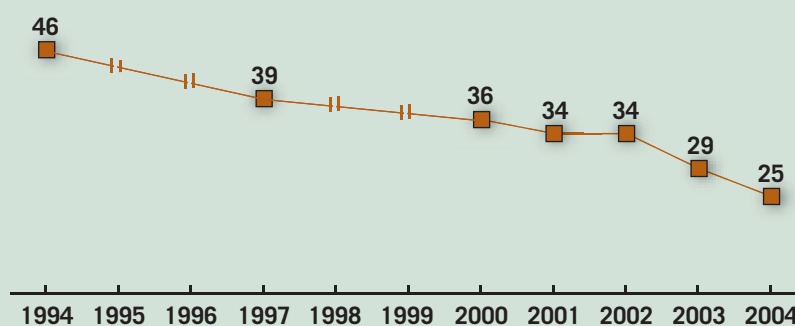


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DR. MAHMOUD

DATA WATCH

Inpatient Mortality From Gastrointestinal Hemorrhage Declining (per 1,000 admissions)



Source: Healthcare Cost and Utilization Project