

Lung Ca Diagnoses Down, Hospitalizations Steady

BY DIANA MAHONEY
New England Bureau

Fewer Americans are being diagnosed with lung cancer, yet more are being hospitalized for it.

The federal government's Agency for Healthcare Research and Quality has released new data showing that the number of hospital admissions associated with a principal diagnosis of lung cancer remained stable between 1995 and 2006, while the number of hospitalizations with lung cancer as a secondary diagnosis increased 15%—despite a steady decline in the number of Americans diagnosed with the disease during the same period.

The discrepancy can be largely attributed to the fact that patients with lung cancer are living longer thanks to therapeutic advances and are receiving more in-hospital treatments, including surgery and chemotherapy, according to the report (www.ahrq.gov/news/nn/nn111208.htm).

A statistical analysis of hospital stays for lung cancer, using the 2006 Nationwide Inpatient sample database, showed that of the 535,700 hospitalizations citing a lung cancer diagnosis in 2006, 149,900 were principally for lung cancer and 386,000 had lung cancer as a secondary diagnosis.

"Overall, the total number of lung cancer-related hospitalizations has increased 10% since 1995, ranging from 475,600 stays in 1999 to a high of 542,200 stays in 2005," according to the report. The aggregate cost for all lung cancer-related hospitalizations was more than \$6 billion, the authors noted.

Approximately 63% of hospitalized lung cancer patients in 2006 were 65 years or older, and only 2.4% were younger than 44 years. When patients younger than 45 years were hospitalized, twice as many stays involved a secondary diagnosis of lung cancer, "potentially indicating follow-up hospitalizations for sequelae of lung cancer," the authors wrote.

With respect to gender, men were hospitalized for lung cancer overall more frequently than were women, and men older than 65 years had the highest rates of hospitalization for all lung cancer patients.

The highest rate of hospitalizations with lung cancer as a primary diagnosis was observed in the South, with 89 admissions per 100,000 persons, compared with approximately 30, 55, and 34 per 100,000, respectively, in the Northeast, Midwest, and West. In contrast, the highest rate of lung cancer stays overall was seen in the Northeast, with 178 stays per 100,000 persons, compared with 137, 109, and 81 in the Midwest, South, and West, respectively.

Medicare was the most common payer both for principal and secondary stays, and private insurance was the second most common. Uninsured patients accounted for 3.6% of principal lung cancer admissions and 1.8% of secondary admissions, both of which are less than the 5.8% average rate of uninsured nonmaternal, non-neonatal hospitalizations, the authors said.

The rates of in-hospital deaths associated with lung cancer hospitalization in 2006 were 13% of patients with a principal lung cancer diagnosis and 8.6% of pa-

tients with a secondary diagnosis—both of which are substantially higher than the 2.6% observed for the average nonmaternal, nonneonatal hospitalization.

An evaluation of common procedures associated with lung cancer-related hospitalizations showed that cancer (lung cancer, other cancer, secondary malignancies) or some type of maintenance therapy (radiology, chemotherapy) accounted for approximately 40% of all hospital stays. Respiratory diagnoses—such as pneumo-

nia, chronic obstructive pulmonary disease, respiratory failure, and pulmonary heart disease, among others—were also common reasons for lung cancer-associated hospital stays, the authors wrote.

When procedures were performed during lung cancer stays, the four most common among patients hospitalized primarily for lung cancer were diagnostic bronchoscopy and biopsy of the bronchus (49%); lobectomy or pneumonectomy (31%); incision of pleura, thoracentesis,

chest drainage (16%); and blood transfusion (11%). The four most common procedures when lung cancer was the secondary diagnosis were blood transfusion (15%); respiratory intubation and mechanical ventilation (10%); incision of pleura, thoracentesis, chest drainage (9%); and diagnostic bronchoscopy and biopsy of the bronchus (8%).

Procedures common to all hospitalizations included therapeutic radiology, cancer chemotherapy, and upper gastrointestinal endoscopies and biopsies, they wrote. ■



The power of negative thinking

In treatment of gram-negative infections caused by susceptible gram-negative microorganisms

AZACTAM is indicated for

- Complicated and uncomplicated urinary tract infections, lower respiratory tract infections, septicemia, skin and skin-structure infections, intra-abdominal infections, and gynecologic infections
- Adjunctive therapy to surgery in the management of infections caused by susceptible organisms. Effective against most commonly encountered gram-negative aerobic pathogens seen in general surgery

Important Safety Information: AZACTAM is contraindicated in patients with known hypersensitivity to aztreonam or any other component in the formulation.

While cross reactivity of aztreonam with other beta-lactam antibiotics is rare, this drug should be administered with caution to any patient with a history of hypersensitivity to beta-lactams.

Clostridium difficile-associated diarrhea (CDAD) occurs with use of nearly all antibacterial agents, including AZACTAM, and severity ranges from mild diarrhea to fatal colitis. Antibacterial agent use alters the normal flora of the colon leading to overgrowth of *C difficile*. Consider CDAD in all patients presenting with diarrhea following antibiotic use. If CDAD is suspected or confirmed, ongoing antibiotic use not directed against *C difficile* may need to be discontinued.

In patients with impaired hepatic or renal function, appropriate monitoring is recommended during therapy.

Please see brief summary of prescribing information on adjacent page.

think negative.

Azactam®
aztreonam IV/IM 1g/2g

élan © 2008 Elan Pharmaceuticals, Inc. AZL1470608