

ONCOLOGY

Lung Cancer Gender Gap

Women diagnosed with lung cancer actually may have normal pulmonary function tests prior to diagnosis, according to findings from a study of 294 patients at Memorial Sloan-Kettering Cancer Center (MSKCC), New York, NY. The results suggest that women with lung cancer may be less likely than men to present with chronic obstructive pulmonary disease (COPD)—a condition often found in previous studies to be an independent risk factor for lung cancer.

Investigators from MSKCC and Lincoln Medical and Mental Health Center, Pomona, NY included in their study all patients who had been diagnosed with primary lung cancer at MSKCC between March 1995 and January 1997 and were given pulmonary function tests prior to treatment. They found that 110 (73%) of 151 men had COPD, compared with 75 (53%) of 143 women. When the data were adjusted for smoking status and age, the lower prevalence of COPD in women persisted (odds ratio, 0.44; 95% CI, 0.26 to 0.74; $P = .002$). The lower prevalence was sustained even when the researchers adjusted for number of pack-years of smoking.

Histology findings were similar in both genders, though women had a higher proportion of bronchoalveolar carcinoma than men (10.5% versus 4%, respectively), and men had a higher proportion of squamous cell carcinoma than women (31.8% versus 22.4%, respectively).

The data not only provide further evidence of gender-based differences associated with lung cancer risk factors, the researchers say, but also sug-

gest that using COPD as a criterion for high risk might miss a number of women. That can be critical, they point out, given that the rate of lung cancer deaths among women jumped 550% between 1950 and 1991 and that lung cancer is now the most common cause of cancer death among women.

Source: *Chest*. 2006;129:1305-1312.

ENDOCRINOLOGY

Type 2 Diabetes or LADA?

No one clinical feature reliably differentiates latent autoimmune diabetes in adults (LADA) from type 2 diabetes. Having at least two of five distinguishing clinical features, however, can help diagnose LADA, say Australian researchers from The Walter and Eliza Institute of Medical Research and The Royal Melbourne Hospital, both in Parkville, Victoria, who conducted a retrospective study of 213 patients.

The investigators interviewed 102 patients with LADA and 111 patients with type 2 diabetes, recruiting the study participants by referral through diabetes educators, physicians, and a diabetes clinic. They found that the following criteria were significantly more frequent in the LADA group: age younger than 50 at diabetes onset; acute symptoms of polydipsia or polyuria, with possible unintentional weight loss before diagnosis; body mass index less than 25 kg/m²; and a personal or family history of DR3- or DR4-related autoimmune disease, such as autoimmune thyroid disease, celiac disease, rheumatoid arthritis, and autoimmune hepatitis. Multivariate analysis verified that all but one criterion (family history of DR3- or DR4-related autoimmune disease) were associated independently with a LADA diagnosis.

Approximately three quarters of the patients with LADA—versus only one quarter of the patients with type 2 diabetes—had at least two of the clinical features. Therefore, the presence of at least two features (or a LADA clinical risk score of ≥ 2) justifies testing for glutamic acid decarboxylase antibodies (GADA), the researchers theorized.

To validate their clinical screening tool, the researchers prospectively interviewed and measured the GADA assay in 130 patients aged 30 to 75 who had been diagnosed recently with diabetes and did not require insulin treatment. They found that the LADA clinical risk score of ≥ 2 had a 90% sensitivity and a 71% specificity for identifying patients with LADA. Moreover, the researchers say, using a LADA score of ≤ 1 was a highly reliable method for excluding LADA.

Source: *Diabetes Care*. 2006;29:970-975.

LONG-TERM CARE

The Benefits of Family-Style Dining

A tablecloth, porcelain plates, full cutlery, napkins, flower arrangements, meal choices, conversation, and a lack of outside distractions are all characteristics of the ideal (if not always the real) family dinner. Adding these elements into the nursing home setting can help residents stay healthy and can improve their quality of life, say researchers from Wageningen University, Wageningen, Netherlands. They conducted a six-month intervention study involving 178 residents of five nursing homes who had chronic somatic diseases but no dementia. Each nursing home had one intervention ward and one control ward, each

with separate dining areas and serving staff.

In addition to the provision of real table settings, the study group (95 residents) decided when the food was to be served, and served themselves—or received help from a nurse or table companion. Before eating, there was a moment for reflection or prayer. No other activities, such as cleaning or visits from the doctor, were allowed during mealtime. The dining room was tidied immediately after the meal was finished.

By contrast, a control group of 83 residents continued with “preplated” service, had sectioned plates and plastic cups, and wore bibs. The control residents had to choose their meals two weeks ahead of time. Their mealtimes were interrupted with comings and goings, and mealtime began when the trays arrived.

At six months, the researchers measured individual outcomes for several areas of quality of life, (including sensory, physical, and psychosocial functioning; perceived safety; and perceived autonomy), physical performance (including gross and fine motor movement), body weight, and energy intake. They adjusted for residents’ age, length of stay, and gender.

The intervention group remained stable in the quality of life measures, while the control group declined. Similarly, scores for physical performance were stable in the intervention group but declined significantly in the control patients, with the change occurring mainly in the subscale of fine motor function. Mean body weight remained relatively stable in the intervention group, but declined significantly (by 1.1 kg) in the control patients. Mean energy intake increased significantly in the intervention group but dropped significantly in the control group. With the exceptions of sensory functioning, perceived autonomy, and gross motor function, the difference in changes in all areas of outcome

measure between the two groups was significant.

The researchers, acknowledging the reality that nursing homes are usually limited in staff and budgets, designed their intervention protocol to require no extra work or expense. Costs did include the one-time buying of materials, such as tablecloths. With motivated staff, however, they conclude the program is easy to achieve on a low budget. In their own case, the researchers say, the enthusiasm of residents and nursing staff convinced the management teams and nursing home boards to implement the family-style mealtimes program in other wards of the nursing homes studied.

Source: *BMJ*, doi:10.1136/bmj.38825.401181.7C (published May 5, 2006).

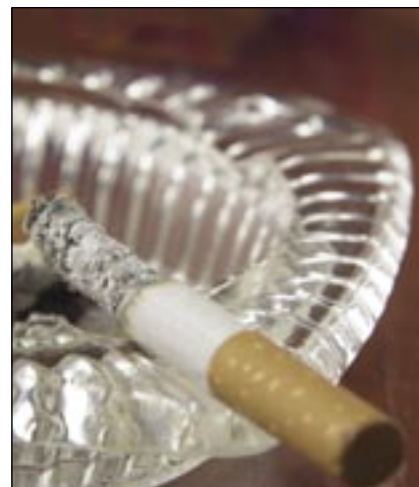
PREVENTIVE MEDICINE

Smoking Now, Nursing Home Later?

Primary care physicians can help keep their patients who have not yet reached retirement age out of nursing homes (NHs) by encouraging them to change modifiable lifestyle factors now, say researchers from Rutgers University, New Brunswick and Piscataway, NJ and Birmingham VA Medical Center and University of Alabama, both in Birmingham.

The researchers performed Cox proportional hazards regressions on data from the National Health and Nutrition Examination Survey Epidemiologic Follow-up Study (NHEFS), which tracked two age groups of respondents to the original survey for nearly 20 years. As NH admissions were tracked in NHEFS, the investigators examined the association of six risk factors—smoking, lack of exercise, obesity, systolic blood pressure (BP), total cholesterol level, and diabetes—at baseline with long-term risk of NH admission.

Of 3,526 respondents aged 45 to 64 (the middle-aged group), 6.5% had at least one risk factor, compared with 25% of 2,936 respondents aged 65 to 74 (the elderly group). In the middle-aged group at baseline, diabetes more than tripled the risk of NH admission; smoking, inactivity, and elevated systolic BP were associated with rela-



tive risks of 1.56, 1.4, and 1.35, respectively. Obesity was a risk factor for the elderly group at baseline.

The risk associated with each factor was greater for the middle-aged group than for the elderly group. A combination of two lifestyle-related factors greatly increased the risk of NH admission, particularly if one of the factors was diabetes. Diabetes combined with smoking raised the risk of NH admission by five times for people with no other risk factors. Diabetes combined with other risk factors was associated with a fourfold higher risk. The most common pairing of factors, smoking and inactivity, doubled the risk.

The researchers note that risk factors were measured only at baseline, so they could not examine how risk changed as risk factors changed. Nevertheless, they say their findings suggest that prevention is more effective earlier, not only to help more people survive to old age, but to help them do it outside of an NH. ●

Source: *Arch Intern Med.* 2006;166:985–990.