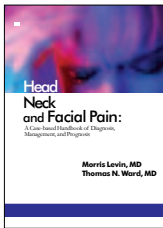


**New on the bookshelf:
Recent releases by
DMS faculty authors**

Renal Physiology. Edited by Bruce M. Koeppen, M.D., Ph.D.; and Bruce Stanton, Ph.D., professor of physiology. Mosby; 2007. The fourth edition of this book, part of Mosby's Physiology Monograph Series, covers the fundamental concepts of normal renal function. It highlights cellular and molecular detail in supplementary boxes, incorporates updated clinical material, and includes self-study problems. Among the kidney functions covered are the regulation of body fluid, the excretion of metabolic products, and the production of hormones.



Head, Neck, and Facial Pain: A Case-based Handbook of Diagnosis, Management, and Prognosis. Edited by Morris Levin, M.D., associate professor of medicine; and Thomas N. Ward, M.D., professor of medicine. Anadem; 2006. This book brings together the perspectives of diverse pain specialists in a unified approach to the management of conditions that produce chronic pain in the head, neck, and face. It covers over 20 categories of such pain, including migraine, temporomandibular joint disease, and carotid artery pain.



MEDIA MENTIONS: DMS

Among the people and programs coming in for prominent media coverage in recent months was a surgeon who is leading a major back-surgery study known as SPORT (Spine Patient Outcomes Research Trial). In May, results comparing surgical and nonsurgical treatment of spinal stenosis were released. “A team led by **James Weinstein** of Dartmouth Medical School in New Hampshire found that fusing the bones to treat this degenerative spondylolisthesis typically works better than nonsurgical treatment,” CNN.com reported. The *Los Angeles Times* wrote, “‘With the results of this study, we can now discuss much more fully the surgical and nonsurgical options available to our patients so that they can make an informed choice,’ Weinstein said.” CBS News commented on the first SPORT study, released last year, saying that “Weinstein’s previous research on another common back problem—the herniated disc—showed surgery is not necessarily better than other therapy. ‘The question we have to ask is are we actually making those patients better?’ Weinstein asks. ‘And is spending more money for all of these spine operations making a difference in our health of our country? I’m not convinced it is.’” (For more on the latest SPORT study, see page 5.)



In a CBS *Morning News* story on Medicare’s plan to “begin posting hospital scorecards on the web,” reporter Wyatt Andrews talked to an orthopaedic surgeon at DHMC, where surgery results have been posted on the institution’s website for some time. “Dr. **William Abdu** says the information has led to fewer back surgeries,” said Andrews. “Because we’re basing our decisions on patient preference, not on surgeon preference,” Abdu commented. “The patients are educated about their options and their outcomes based on those options.”



Presidential candidate Hillary Clinton’s visit to DHMC in August attracted media attention from all over the country. “Almost 15 years ago, First Lady Hillary Clinton came to Dartmouth-Hitch-

cock Medical Center to help launch the push for universal health-care coverage,” wrote the *Chicago Tribune*. “Now years later, the former first lady is running for president and it was déjà vu all over again as she returned to this state’s premiere teaching hospital Thursday in her continued quest for a system of universal health care.” The *Wall Street Journal* noted that “the New York Senator addressed about 200 health professionals, many of them in their white coats.”

The Associated Press reported in June that a study that found “high doses of folic acid do not prevent precancerous colon polyps in people prone to them and may actually increase the risk of developing the growths . . . surprised scientists. Previous studies showed diets low in folic acid led to a higher risk of colon cancer. . . . ‘You really should not take folic acid to prevent colorectal adenomas. It’s ineffective for that purpose,’ said study coauthor **Bernard Cole** of Dartmouth-Hitchcock Medical Center.” See page 6 for more on the study.



“Diabetics who are frustrated by clunky needles and syringes are getting an injection of sleek new devices called insulin pens,” according to an article in the *Wall Street Journal*. But the new-fangled gadget hasn’t won over everyone. “Some doctors say they still prefer syringes because they’re used to them and don’t know much about the pens,” observed the article, which then quoted “**Joel Lazar**, a family doctor and assistant professor of community medicine at Dartmouth Medical School in New Hampshire. ‘In primary care, we have our antenna up that when something is repackaged, it’s a marketing gimmick,’” Lazar said.



The *Dartmouth Atlas of Health Care*, created by Dr. **John Wennberg**, got described in rather glowing terms recently. In an article on health-care costs, the *New York Times* explained that to get the statistics for the “wonderful *Dartmouth Atlas*, . . . researchers adjust the numbers to take into account

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age, race and sex, which is another way of saying that there is no good explanation for the huge variations they find.” And the *Atlas’s* website was recommended in a *Wall Street Journal* story on hospital selection as “a gold mine of information comparing hospital practices across regions and states.”

In an Associated Press piece on recruiting, training, and retaining rural doctors, “Dr.



Donald Kollisch of the Rural Health Scholars program at Dartmouth College in New Hampshire said the ratio of patients to doctors is about twice as high in rural areas as it is in urban areas nationwide. He said

rural areas account for about 20 percent of the country’s populations but only have 10 percent of the nation’s doctors.”

A *Discover* magazine article on the spontaneous remission of cancer included the story of a Dartmouth patient—John, a 30-year-old with cancer that had spread to his lung.

“His oncologist, **Joseph O’Donnell**, . . . urged him to undergo immediate treatment.” But John “didn’t follow his doctor’s recommendation. Instead, he took a month off to strengthen his body for the treatment that he knew



would most likely be a grueling ordeal. He went on long hikes in the mountains, he ate healthy foods, and he meditated.” When “O’Donnell repeated the chest x-ray . . . instead of the large cancerous lesion

in [the] lung, he saw . . . nothing. O’Donnell recalls, ‘When John came back a month later, it was remarkable—the tumor on his chest x-ray was gone. Gone, gone, gone.’”

The *Chicago Tribune* reported on a new web site developed by the National Cancer Institute “to help you sort through all the confusing information out there about what causes cancer and what you can do to pro-

tect yourself (maybe). Essentially a primer on risk and risk factors, it explains basic concepts that science writers tend to gloss over,



as if everyone is born knowing what it means to have a ‘17 percent lifetime risk [1 in 6]’ of developing, say, prostate cancer. The concept of lifetime risk is hard even for physicians to wrap their heads around.

Medical risk experts Drs. **Steven Woloshin** [pictured above] and **Lisa Schwartz** [pictured below] of Dartmouth Medical School say it’s easier to grasp the risk in well-defined chunks of time, as in, ‘The average



50-year-old man has a 2 percent chance of being diagnosed with prostate cancer before his 60th birthday.’ (Another way of expressing that 2 percent risk is 1 in 43, although

Woloshin and Schwartz say ‘23 out of 1,000’ is more readily understood.)”

A “phenomenon known as medical tourism” is on the rise, according to an article in the *Oregonian*. Increasing numbers of Americans are traveling to other countries, “saving money on procedures costing far more in the U.S.” But some doctors urge caution. “Dr.

Aaron Kaplan, director of device development at Dartmouth-Hitchcock Medical Center,



has written about the differing medical regulatory environments of the U.S. and Europe. European officials are concerned more with the safety of medical devices than with their effectiveness, he reports. But

the [U.S.] FDA requires studies that demonstrate devices are both safe and effective—a regulatory hurdle that takes more time. In Europe, . . . the reviewing is not extensive. ‘The device you’ll be getting, by its nature, is new and not well evaluated—and that has its risks,’ says Dartmouth’s Kaplan.”

“A grocery store chain based in Maine declared success yesterday for a



year-old experiment in using a rating system to direct customers to healthier food items,” the *New York Times* reported. The Hannaford Brothers Company developed a system “called Guiding Stars [that] rated the nutritional value of the grocery items in the store on a



scale of zero to three stars, with three representing the most nutritional products. After analyzing a year’s worth of sales data, Hannaford found that customers tended to buy leaner cuts of meat” and other healthy items.

Sales of products with stars increased, while sales of items with no stars declined. “‘I have to say, I’m thrilled,’ said **Lisa Sutherland**, assistant professor of pediatrics and a nutrition scientist at Dartmouth Medical School, who was part of an advisory panel that devised Hannaford’s system. ‘They were pretty much what I would have expected with an objective system that wasn’t designed to promote or negate one food or another.’”

The Associated Press, reporting on a debate over resources, wrote that “medical imaging equipment makers are lobbying to overturn Medicare cutbacks after weathering some of the worst sales numbers in recent memory. . . . [But] health-care experts that advise lawmakers are not convinced that more medical technology translates into better health



care. ‘We have communities with half as many scanners as those in other parts of the country and their outcomes are just as good, and in some cases better, than communities spending twice as much on

imaging,’ said **Elliott Fisher**, a professor at Dartmouth Medical School, who consulted for government advisors on the imaging issue.”