

## Measuring the movie gore that youngsters see

Should a 10-year-old watch *Scary Movie*'s villain pull a young woman out of a car and stab her to death? Or see Mel Gibson's character in *Payback* undergo a gory interrogation?

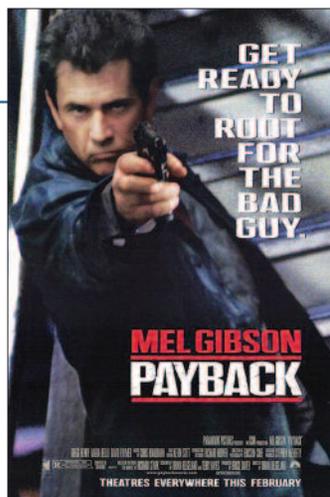
Not many people would think so. Yet a recent study led by DMS pediatrics fellow Keilah Worth, Ph.D., shows that millions of preteens and young teens are watching violent movies—despite their R rating. More than 1,000 studies have documented a link between exposure to violent media and aggression in children, but the Dartmouth study was the first one to examine the actual exposure of young adolescents around the country to violent R-rated movies.

**Scary:** The researchers conducted a national telephone survey of 6,522 children between the ages of 10 and 14 and asked if they'd seen any of 40 R-rated films released from 1998 to 2003. The study's 10 most popular films were each seen by more than 23% of the study participants. Nearly 50% of the youngsters, including 27% of the 10-year-olds, had seen *Scary Movie*, for example. "It's really disturbing" that children that young are seeing such films, says Worth, since many "10-year-olds just stopped believing in Santa Claus."

Though some may dismiss the comedic violence of *Scary Movie* as harmlessly funny, pediatrician James Sargent, M.D., begs to differ. "Laughing at violence is a cardinal sign that the adolescent has been desensitized to violence," says Sargent, a senior scientist on the study. "Violence desensitization is how the military prepares soldiers for war. Little kids should not be prepared for war."

**Sadistic:** In the paper, which was published in the August issue of *Pediatrics*, several factors—being male, an older teen, and nonwhite; performing poorly in school; and having less-educated parents—were associated with higher exposure to violent movies. In addition to comedic violence, four other types of movie violence were identified: horror with gore, sadistic violence, sexualized violence, and extreme interpersonal violence.

The paper, funded by the National Institutes of Health and the American Legacy Foundation, is one of Sargent's many studies examining the influence of media on adolescent behavior. Now that the researchers have quantified youngsters' exposure to movie violence, they're analyzing the effects of that exposure on behavior. In the meantime, Sargent urges parents to always say no to young adolescents who want to watch R-rated movies. KATHERINE VONDERHAAR



A DMS study quantified how many 10- to 14-year-olds see movies like this.

## Study puts stents on their mettle

"Stent" may not be quite a household word, but more than a million of the tiny mesh tubes are used annually in the United States. Stenting—the insertion of one of the little tubes in a blocked blood vessel, to prop it open—has become a common way to treat a variety of coronary diseases. But for the past five years, ever since the development of a new kind of stent, there's been debate over whether the old kind or the new kind is better. A recent study from Dartmouth has brought some solid data to bear on the matter.

**Vessel:** A major problem associated with stenting is restenosis—the reblockage of the stented vessel. Restenosis occurs because the body sees the stent as a foreign object and initiates a healing response, which results in a buildup of smooth muscle cells around the stent. This narrows the vessel again and often requires the insertion of another stent—a process known as subsequent revascularization.

So scientists developed drugs that prevent the proliferation of smooth muscle cells. Since 2003, there has been a choice between using a stent coated with these drugs—known as a drug-eluting stent (DES)—or an older, bare-metal stent (BMS). After DESs were shown to reduce the rate of restenosis by 50%, their use took off. About 60% of patients were receiving them within a matter of months.

"That's revolutionary," says Dartmouth cardiologist David Malenka, M.D., of how fast the new technology was adopted. He led the recent study, which compared DESs to BMSs. It was prompted by the fact that although DESs reduce restenosis, patients with a DES had an increased rate of blood clots in the stent—a phenomenon known as stent thrombosis. Were BMSs perhaps better after all?

**Claims:** To answer that question, Malenka looked at Medicare claims data for patients with coronary stents—38,917 who got BMSs before the introduction of the DES, and 28,086 from the post-DES era; more than 61% of the latter got a DES. The finding—published in the *Journal of the American Medical Association*—was that post-DES patients had a lower incidence of subsequent interventions. The authors concluded that DESs' "decreased rate of restenosis and subsequent revascularization, with their attendant risks, could more than compensate for a small increased risk of stent thrombosis from drug-eluting stents."

But even though the study—which was funded by the National Institute on Aging and the Robert Wood Johnson Foundation—showed a net benefit from DESs, Malenka says "we still need to learn more about how to minimize the risk of late stent thrombosis."

To do that, patients can stay on anticlotting drugs longer, use a BMS instead of a DES, or choose an alternative treatment. The bottom line, says Malenka, is that patients and physicians should weigh patient-specific risks and benefits. "Nothing is risk-free," he notes. "People have options; people have choices." TINA TING-LAN CHANG

**The bottom line, says Malenka, is that . . . "nothing is risk-free."**