

OND/DOL group (P = 0.01). Fewer PALO-treated pts experienced the most common adverse events of constipation (9.8% vs 13.5%) and headache (6.1% vs 12.4%) compared with OND/DOL-treated pts; cardiac adverse events were similar and infrequent (<3%) in both groups. The adverse event profile was similar to that seen in the pts < 65 yrs.

Conclusions

A single dose of PALO was more effective than OND/DOL in preventing CINV over 5 days post-CT in elderly patients. PALO's longer half-life and improved control make it a more convenient and appropriate 5-HT₃ receptor antagonist for use in elderly cancer patients receiving emetogenic CT. ■

dose of 0.25 mg PALO or 32 mg OND (study 1) or 100 mg DOL (study 2). Two methods for evaluating the carryover effect were conducted: evaluating control of D-CINV in

all patients with or without A-CINV (Grunberg, ASCO '03) and hierarchical models evaluating treatment effects adjusting for risk factors over time.

Results

Of the 500 pts across all groups with no A-CINV, 376 (75%) had no D-CINV. Of these pts controlled for A-CINV, more pts (218/272; 80%) receiving PALO had no D-CINV compared with those receiving OND or DOL (158/228; 69%) [P = 0.005]. A similar benefit was also seen among the 254 pts who did have A-CINV. 24/106 (23%) receiving PALO had no D-CINV while 18/148 (12%) receiving OND or DOL had no D-CINV [P = 0.027].

Conclusions

The same magnitude of improved prevention of D-CINV with PALO in patients with or without A-CINV provides evidence that this greater efficacy in preventing D-CINV is a true pharmacologic effect rather than carryover from better prevention of A-CINV. Complete results utilizing a hierarchical (random-effects) model accounting for risk factors and trial heterogeneity will also be presented. ■

I might be able to assist other folks.

OA: Tell us about your practice and patient base.

DS: One third of my patients are physicians, the remainder are patients facing a variety of medical ailments.

OA: What do you see as the next leap in the psychological treatment of cancer patients and physicians?

DS: I think the entire system is readying for a massive change. Health care costs too much and it has become a drag on the economy as small businesses (and some large ones) stagger to keep their employees covered. When the implosion comes I think we're going to see more specialization units – places where people go just to get their heart disease addressed, or cancer, or diabetes. Keep in mind that alternative medicine is a multi-billion dollar industry – partially because people want holistic care. Those programs that incorporate the human element are likely to garner greater market share, thus I see psychological treatment built far more into the health care of the future than now. But I don't think it's going

to be through therapy. I foresee mental health "coaches" or "tour guides" who help orient newly diagnosed patients to the psychological challenges they face.

On the physician side, there is a movement to help physicians live more balanced lives, starting in medical school. The movement has stalled and failed to break into residencies where some of the worst habits are learned, but it's only a matter of time.

OA: How has your outlook on life changed since you were first diagnosed?

DS: I wrote *Mom's Marijuana* specifically to talk about that massive perspective shift. Now I enjoy trivial worries – if you can obsess about a flat tire or overdue bill, your life must be pretty good. Humor and relationships are more important to me now.

OA: Are you currently involved with any oncology related organizations/societies?

DS: I give quite a few talks to oncology organizations and am especially assisting a non-for-profit known as FERTILE HOPE (www.fertilehope.org). OA

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