



THE TRIBUNE'S VIEW

Eased worries

Airport and NSEI

By HENRY J. WATERS III

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Legislative approval for expanded airport authority options was urged in part as a way to "help finance improvements," leading to skepticism in this column. I predicted scant chances of getting funding for our airport from surrounding counties and cities and said that if funding did come, shared management demands could be trouble.

Now airport promoters tell me no such intent or plan is in the offing. The new allowance to include entities other than counties will be used to encourage more involvement of area representatives and greater outreach to potential users of the airport. Several Jefferson City businesses are helping underwrite the escrow fund being built to ensure start-up ticket sales levels, for instance.

The airport might be renamed to reflect a more regional focus, they say, but there will be absolutely no handing-over of management authority.

Obviously, increased efforts to get traffic from a wider region make sense. At the moment, surprisingly small percentages of regional air travelers fly from Columbia. More than 90 percent from places as close as Jefferson City and Fulton drive to St. Louis or Kansas City. Some officials in the capital city actually regard the Columbia airport as competition.

Coupled with anticipated improvements in service, increased outreach to area officials and residents can help. Until we hear something more about promoting funding from those surrounding cities and counties, our skepticism can go back in the box.

The other worry recently expressed in this column had to do with the proposed reorganization of nuclear science education and research on the University of Missouri campus.

Chancellor Brady Deaton and Provost Brian Foster had announced closure of the graduate-level Nuclear Science Engineering Institute and transfer of its students and faculty to a more integrated arrangement in the School of Engineering. After current NSEI denizens complained, Jesse Hall

announced it would not close the program until all students currently enrolled and those coming this fall have graduated.

During the debate, some in the program worried that closure of NSEI would damage the growing nuclear science reputation of MU. In this column I focused more narrowly, hoping the on-campus to-do would not damage chances for the university to collaborate with Ameren Missouri and Westinghouse Electric Co. in competing for some \$452 million in federal funding to develop a new type of small nuclear reactor said to be the best answer to future nuclear power generation.

I was happy to see the report Friday of a letter sent by Ameren CEO Warren Baxter to UM System Chief of Staff Bob Schwartz in which Baxter praised moves by MU to "strengthen its overall nuclear engineering program for students" and pledged MU would be an "important strategic partner" with Ameren and Westinghouse.

Deaton and Foster contend the newly organized program will be an improvement, and apparently Ameren and Westinghouse are happy. Engineering Dean James Thompson is asking NSEI faculty to help design new engineering degrees in the school, and UM Chief Schwartz assured NSEI faculty their research and teaching would receive continued support.

Reorganization of this type is hard on a university campus, but if nuclear engineering education and research on campus can be strengthened and key partners like Ameren and Westinghouse agree, whoopee! NSEI faculty and future students will benefit, and the rough start can be overcome.

HJW III

Friendship is like a bank account. You can't continue to draw on it without making deposits.

COLUMBIA MISSOURIAN

Adult ICU to close at Women's and Children's Hospital

By Janelle Pfeifer

May 22, 2012 | 1:33 p.m. CDT

COLUMBIA — The adult intensive care unit at the MU Health Care's Women's and Children's Hospital will close in early June.

Spokeswoman Mary Jenkins said the last day the unit is scheduled to be open is June 8, but this could change to ensure a seamless transition for those involved.

Jenkins said that new technology has shortened the length of time many patients stay and that fewer obstetrics and gynecology patients are needing critical care.

"The number of patients anticipated to need the ICU is only a handful," Jenkins said. "Only one-fourth of 1 percent of patients (at Women's and Children's Hospital) will require intensive care."

Patients in need of intensive care will be taken to University Hospital, which is also a part of MU Health Care. Jenkins said the average number of patients in intensive care units at University Hospital on a daily basis is 51.

"University Hospital is going to be the best place for those patients to receive critical care because we have multiple ICUs and specialists," she said.

The 11 nurses employed in the intensive care unit at Women's and Children's Hospital have been assigned recruiters to help transition to other departments throughout the system, Jenkins said.

"These are nurses that we want to retain, so we are doing everything we can to help them transition to jobs within MU Health Care," she said.

Supervising editor is Elizabeth Brixey.



ST. LOUIS POST-DISPATCH

Columbia hospital closing adult intensive care

A Columbia hospital says it will close its adult intensive care unit next month because it is not being used enough.

Patients who need critical care at Women's and Children's Hospital will be taken by ambulance to University Hospital.

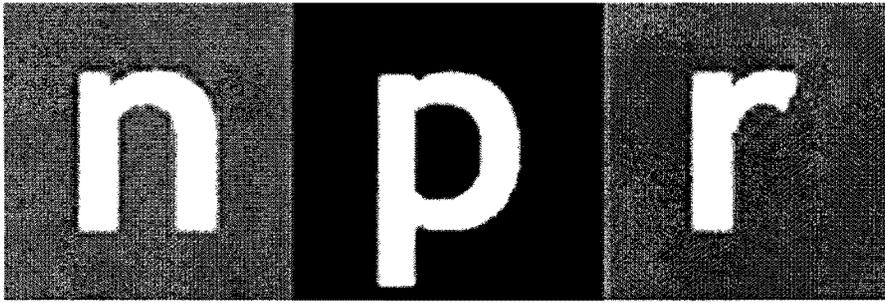
The closing is scheduled for June 8.

The decision also displaces 11 nurses. **But University of Missouri Health Care officials say they help the nurses find jobs in other parts of the health system.**

Missouri Health spokeswoman Mary Jenkins says the Women's and Children's adult ICU had an average daily patient census was 1.5.

The Columbia Tribune reports the hospital's pediatric and neonatal ICUs will remain open.

Jenkins says less than one-quarter of 1 percent of the hospital's patients require critical care, which will be provided at University Hospital.



Easier Colon Cancer Test Works Well, But Colonoscopy's Still King

MU MENTION PAGE 2

A big study of a colon cancer test called flexible sigmoidoscopy may provide a good example of how a cheaper, easier-on-the-patient and possibly better technology isn't always the one American doctors choose to use.

Over the past decade or so, sigmoidoscopy has been largely abandoned by the doctors in the U.S. in favor of colonoscopy to detect and prevent colon cancer. Indeed, colonoscopy largely gets the credit for a 30 percent drop in colon cancer incidence since the 1980s, much of it the past decade.

But a lot of Americans over 50 — about 40 percent — aren't getting colonoscopy exams, which require an unpleasant colon-purging ordeal beforehand and light anesthesia while the gastroenterologist snakes a tube through the 6-foot length of the colon.

By comparison, sigmoidoscopy examines only the last two feet of colon. It doesn't require such rigorous prep or anesthesia. It takes less time and costs hundreds of dollars less. And it has a lower risk of side effects, such as perforation of the colon.

The new study of sigmoidoscopy versus "usual care" in 155,000 Americans shows that those in the "scope" group had 21 percent fewer diagnoses of colorectal cancer and were 29 percent less likely to die of it.

(In absolute terms, there were 12 colorectal cancer cases in the screened group versus 15 who got usual care per 10,000 people followed for a year. The cancer death rate was 3 per 10,000 person-years among those who were scoped, versus 4 in the comparison group.)

In fact, the benefits of sigmoidoscopy were probably bigger than that because nearly half of the "usual care" group also got scoped. That diluted the difference between the two groups.

The study, paid for by the National Cancer Institute, was unveiled on Monday at the Digestive Disease Week conference in San Francisco and published online by the *New England Journal of Medicine*.

Now that there's gold-plated evidence that a cheaper, easier colon cancer screening test prevents cancer and saves lives, you might expect the balance might shift away from colonoscopy, at least a little bit. After all, "no randomized clinical trial proving that colonoscopy can reduce cancer mortality has yet been published," as Dr. John Inadomi of the University of Washington notes in an accompanying editorial.

But it's not that simple. Gastroenterologists in the U.S. already have a substantial investment (in all senses) in colonoscopy. Some say that scoping only the left side of the colon, as sigmoidoscopy does, is like doing mammography on only one breast. You might be missing something important.

On the other hand, 2 of 3 precancerous colon polyps arise on the left side. And it's not clear how good colonoscopy is in identifying and removing right-sided polyps, which are flatter.

These right-sided polyps might be biologically different too, perhaps giving rise to cancers that are more aggressive and less amenable to cure. That could undercut the effectiveness of colonoscopy — even if they're found and removed, it might make less difference than removing left-sided polyps.

Still, many doctors would be nervous about sigmoidoscopy's inability to find deeper polyps. Authors of the new study estimate that sigmoidoscopy found more than 1,000 tumors but missed 97.

"We missed some tumors, so I think that having colonoscopy is probably the better first test," study leader Christine Berg told Shots. "But if you don't want to have a colonoscopy and would feel more comfortable having a flexible sigmoidoscopy, you should have it."

Dr. Michael LeFevre, a professor of family practice and community medicine at the University of Missouri, thinks many people would prefer it.

"The prep is dramatically different," LeFevre says. "Compared to that gallon of liquid you have to drink the night before your colonoscopy that makes you feel like you're about to explode, with sigmoidoscopy it's typically a laxative the night before and a couple of enemas in the morning and you're ready."

And as Dr. Inadomi of the University of Washington says: "The best test is the one that gets done."



Panel's PSA test recommendations spark debate among doctors, cancer survivors

MU MENTION PAGE 2

The United States Preventive Services Task Force announced in its final recommendation Monday that healthy men should no longer get screened for prostate cancer with a prostate-specific antigen (PSA) test because a resulting diagnosis may do more harm than good.

The panel said with a positive PSA test, risks of harmful side effects from treating prostate tumors that may be too slow-growing to ever cause a problem were more likely for men than the risk of dying from prostate cancer.

Evidence cited by the panel includes an 11-year study of 180,000 men that found more than 1,000 had to be screened with a PSA test to prevent a single prostate cancer death. The panel also found in another study for every 1,000 men who get a PSA test, 30 to 40 will develop erectile dysfunction or urinary incontinence, two men will experience a major cardiovascular event such as a heart attack caused by treatment, and one man will develop a potentially deadly blood clot in his leg or lungs from treatment. The guidelines were published in the May 21 issue of the *Annals of Internal Medicine*.

The recommendations aren't mandated, and the Obama administration said Monday that Medicare will continue to pay for the simple blood test, the Associated Press reported. Other insurers tend to follow Medicare's lead.

Reaction following the announcement has been mixed among the medical community and patients.

CBS News medical correspondent Dr. Jon LaPook reported on the CBS Evening News on Monday that yesterday's announcement sparked fury at the American Urological Association (AUA) annual meeting in Atlanta.

"The AUA is outraged and believes that the Task Force is doing men a great disservice by disparaging what is now the only widely available test for prostate cancer, a potentially devastating disease," the association said in a written statement. Its position is that, "when interpreted appropriately, the PSA test provides important information in the diagnosis, pre-treatment staging or risk assessment and monitoring of prostate cancer patients."

The decision should be one that men discuss in detail with their urologists, the AUA said.

Dr. Peter Shlegel, chairman of urology at New York-Presbyterian/Weill Cornell Medical Center in New York City who attended the meeting, told HealthPop, "Death rates from prostate cancer have dropped dramatically in the U.S. despite an aging population, which suggests evaluation and early treatment of prostate cancer is valuable in saving lives." Referencing high-risk patients, such as African Americans who face a higher prostate cancer risk, Shlegel added, "There will be more people who die of prostate cancer because of the application of these study results," he said.

Task Force Chair Dr. Virginia Moyer, a professor of pediatrics at Baylor College of Medicine in Houston, told the AP of her group's guidelines, "We don't want this to be the answer. We want to screen for the ones that are going to be aggressive, manage those early - and leave everyone else alone," she said.

Dr. Michael Lefevre, a member of the task force who is associate chair in the department of **family and community medicine at the University of Missouri School of Medicine, told CBS News of the backlash, "We have been taught for years to fear cancer and that only hope is early detection and treatment," Lefevre said. "And so for both doctors and patients alike, it's difficult to accept that some cancers don't need to be discovered and don't need to be treated."**

Dr. Lee Green, a primary care physician at the University of Michigan also thought fear played a role.

"Cancer is a fear word," Lee told MedPage Today. "People have a need to believe, a need to feel that we have some power over this terrible disease," he said. "Admitting the truth, that PSA screening doesn't really save lives, is unacceptable because it takes that away."

In a CNN editorial, Dr. Otis W. Brawley, chief medical and scientific officer of the American Cancer Society, wrote that over the past two decades, more than 1 million American men have received unnecessary treatments causing side effects - some life-threatening - because of mass prostate cancer screening with a PSA test. He called screening a "lucrative business," alluding to financial benefits for hospitals because positive tests lead to more hospital visits and treatments, and resulting side effects may too lead to more visits and treatments.

"While I hope that this new recommendation will put an end to mass screening, I am not optimistic," said Brawley. "As Upton Sinclair once said, 'It is difficult to get a man to understand something, when his salary depends on his not understanding it.'"

Brawley, who was not on the task force, also went on CBS This Morning Tuesday to discuss his thoughts on the guidelines. He said he would prefer to see selective-screening within a physician-patient relationship in which men are told the risks and benefits of a PSA test and are free to decide.

"We need to not dupe men into thinking that there's always benefit with this and everyone's going to get help. Some people are going to get killed because they get the test," he said.

What do prostate cancer survivors think?

Dr. Bruce Chabner, a physician at the Massachusetts General Hospital Cancer Center in Boston who survived prostate cancer told MedPage Today, "Would I still be alive and free of disease without PSA testing and treatment?" he asked. "I don't know, but I suspect that at the very least I would not be free of metastatic disease, as the PSA was going up, and the tumor was growing."

ESPN analyst Digger Phelps, former basketball coach at Notre and a man who was diagnosed with prostate cancer two years ago, described on CBS This Morning the "living hell" of the unknowns he felt when doctors discovered cancer after a PSA test.

He said the panel's recommendation is a "a step backward and you're going to see more guys putting off the awareness of check yourself out," Phelps said. "I disagree because I'm a survivor."

The heated debate continued into the commercial break, with cameras still rolling. Watch more from CBS This Morning: