

MEDICAL

Officials expect West Nile cases to be down this year

From staff reports

The mosquito-borne illness typically peaks in September and ends with the first freeze.

As of August 19, 28 states have reported 236 cases of human West Nile virus to the CDC, including two deaths, yet Georgia has recorded only one human case of the potentially fatal disease so far this year in Fulton County. Health officials were investigating a possible case of the virus in Floyd County last week.

"We can't predict how much mosquito-borne disease we'll see this year in the state or Northwest Georgia," says Northwest Georgia Public Health's Dr. Wade Sellers. "We wish we could, but we do know that preventing mosquitoes from breeding and protecting yourself from mosquito bites are the best ways to avoid West Nile virus. It's important that people practice both methods of prevention. We know that West Nile virus is here to stay in the U.S. as well as in Georgia."

Sellers urges people to eliminate the stagnant water where mosquitoes breed. "Mosquitoes lay their eggs in standing water. Limit the number of places around your home for mosquitoes to breed by getting rid of items that hold water," he said. "Mosquitoes can lay hundreds of eggs in just a tablespoon full of water."

He also recommends using mosquito repellent containing DEET if you have to be outside. "While DEET isn't safe for infants, mosquito repellent contain-

ing DEET is highly effective and safe for both adults and children, when used according to the manufacturers' instructions," says Sellers.

So, why are we not seeing much WNV this year in Georgia? "It's been fairly rainy this season considering that we're technically still in a drought," says Northwest Georgia Public Health Environmental Health Director Tim Allee, "and the strange weather actually seems to be reducing the mosquito numbers, and that's certainly helped to keep our WNV human cases to just one."

He said rainstorms have helped by flushing containers and reservoirs where the Southern house mosquito, Georgia's primary West Nile-carrying insect, lay its eggs.

Northwest Georgia Public Health Public Information Officer Logan Boss said the numbers don't mean that people can quit taking action against the virus.

Mosquito control helps by reducing adult mosquito numbers, according to Boss. Although the mosquito populations will rebound, Boss says, "the constant reduction in population will keep mosquito numbers low enough to lessen transmission rates to birds, reduce the amount of circulating virus and lower the risk to people."

According to Northwest Georgia Public Health epidemiologist Debra Abercrombie most mosquitoes do not carry West Nile or other viruses or cause illness in people and that most people who

YEAR-BY-YEAR

Year-by-year summary of human West Nile cases in Northwest Georgia and statewide:

2002: 1 case in Bartow County, no deaths; 36 cases statewide with 7 deaths

2003: 6 cases (Bartow 1, Catoosa 1, Polk 2, Walker 2) and no deaths. Georgia had 55 human cases and 4 deaths.

2004: No cases in Northwest Georgia. Georgia had 22 human cases and one death.

2005: 1 case in Northwest Georgia in Paulding County. Georgia had 24 human cases and two deaths.

2006: No cases in Northwest Georgia. Georgia had 8 human cases and one death.

2007: No cases in Northwest Georgia. Georgia had 55 human cases and one death.

2008 so far: One human WNV case recorded in Georgia so far this year in Fulton County.

Source: Northwest Georgia Public Health

are bitten by infected mosquitoes will not become sick. However, she emphasizes that anyone who experiences flu-like symptoms after being bitten by a mosquito should consult a physician, especially individuals older than 50.

Please see WEST NILE 5

Study: Drugs as good as stents in some cases

By Marilyn Marchione
Associated Press Medical Writer

People with chronic chest pain who are not in big danger of a heart attack now may have even less reason to rush into an artery-opening angioplasty: There's more evidence drugs should be tried first and often are just as effective.

The slim early advantage for angioplasty at relieving pain in these non-emergency cases starts to fade within six months and vanishes after three years, according to a new report from a landmark heart study.

That is sooner than the five years doctors estimated last year after their first analysis of the study. The new information comes from patients' own reports of how they fared after treatment. Results are published in the New England Journal of Medicine.

"This study should be enlightening and practice-changing for doctors and patients alike," and should lead more to try drugs before resorting to the \$40,000 heart procedure, said Duke University's Dr. Eric Peterson, who co-authored an editorial in the medical journal.

The number of angioplasties has been falling since the first results from this big study came out in 2007, according to new figures requested by The Associated Press from an American College of Cardiology database.

Angioplasty remains the top treatment for people having a heart attack or hospitalized with worsening symptoms. It involves using a tiny balloon to flatten a clog and propping the artery open with a mesh tube called a stent.

However, at least a third of angioplasties are done on people not in imminent danger, to relieve chest pain. These patients are no more likely to die or suffer a heart attack if initially treated with drugs alone, the big 2,287-patient study revealed.

Still, angioplasty's fans tout it as a quick fix that improves quality of life. That benefit is fairly small and short-lived, compared to good medication use alone, the new report found.

Researchers did followup health surveys of about 70 percent of the study's participants. At the start, 78 percent had chest pain.

Three months after treatment, 53 percent of patients who had angioplasties plus drug treatment and 42 percent of the drugs-alone patients were free of chest pain. Both groups continued to improve, and the gap started to narrow within six months. After three years, their scores on chest pain, quality-of-life and treatment satisfaction did not significantly differ.

"Patients get better," regardless of which initial treatment they have, said study leader Dr. William Weintraub of Christiana Care Health System in Newark, Del.

One exception: Those who started out with more severe chest pain fared better with angioplasty. And not everyone did well on drugs alone — about one-third ultimately needed an angioplasty or heart bypass surgery.

The study was funded by the U.S. Department of Veterans Affairs, the Medical Research Council of Canada and a host of drug companies. Many of the researchers have consulted for drug makers, and many of the study's critics have consulted for stent makers.

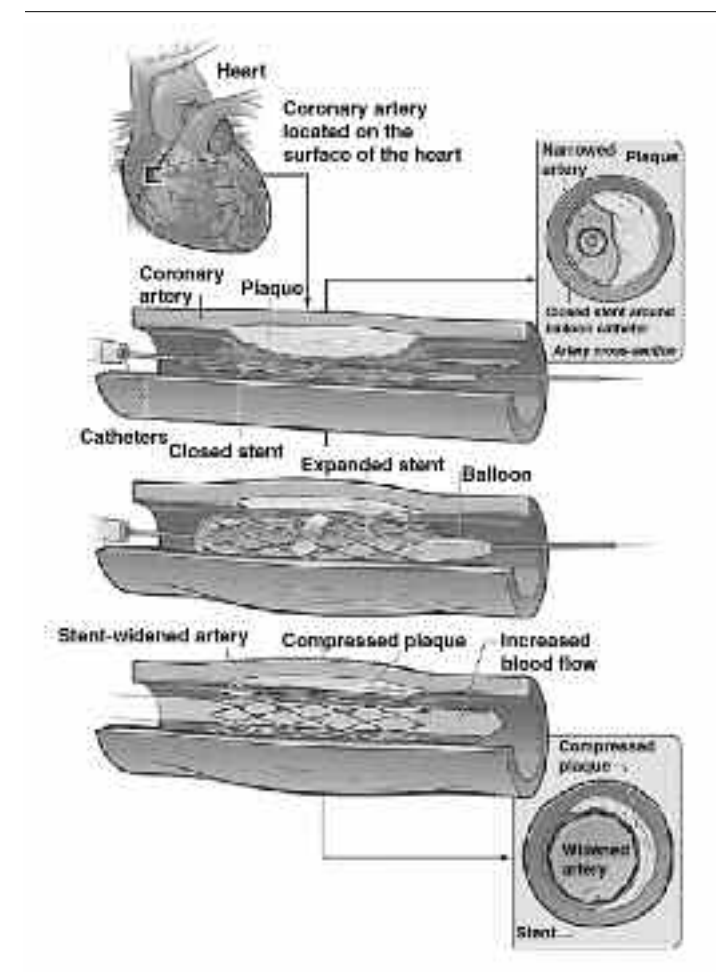
People in the study were properly tested to ensure they were medically stable, said Dr. Spencer King, a cardiologist at St. Joseph's Heart and Vascular Institute in Atlanta and past president of the cardiology college.

"My greatest fear" is that some patients now may be given medications without adequate testing to show angioplasty can safely be delayed, he said.

The study patients also received an ideal mix of medicines, potentially including aspirin, cholesterol-lowering statins, nitrates, ACE inhibitors, beta-blockers and calcium channel blockers.

Not all patients do, especially when doctors are paid more to do an angioplasty than for the many office visits needed to get the meds right.

"It's a tricky business and it requires a lot of close follow-



Source: www.nhlbi.nih.gov

up," said Dr. W. Douglas Weaver, a heart specialist at Henry Ford Health System in Detroit and president of the cardiology college.

About 1 million angioplasties are done in the United States each year.

The number started to decline before the study came out because of safety worries about certain stents and continued to fall after it, said Dr. Ralph Brindis, a California

heart specialist who heads the cardiology college's cardiovascular data registry.

The proportion of angioplasties done on people with chronic but stable chest pain dropped from 18 percent in early 2005 to just more than 15 percent by March 2008, the registry shows. Started 10 years ago, it now includes information on about 530,000 angioplasties per year — roughly 60 percent of the national total.

METHOD from 3

But it might become an additional tool for higher risk women with a lot of dense tissue that makes tumors hard to spot on mammograms, and it could be done at less cost than an MRI, or magnetic resonance imaging. About one-fourth of women 40 and older have dense breasts.

"MBI is a promising technology" that is already in advanced testing, said Carrie Hruska, a biomedical engineer at the Mayo Clinic in Rochester, Minnesota, which has been working on it for six years.

She gave results in a telephone news briefing Wednesday and will present them later this week at an American Society of Clinical Oncology conference in Washington, D.C.

Mammograms — a type of X-ray — are the chief way now to check for breast cancer. MBI uses radiation, too, but in a different way.

Women are given an intravenous dose of a short-acting tracer that is absorbed more by abnormal cells than healthy ones. Special cameras collect the "glow" these cells give off, and doctors look at the picture to spot tumors.

Researchers tried both methods on 940 women who had dense breasts and a high risk of cancer because of family history, bad genes or other reasons.

Thirteen tumors were found in 12 women — eight by MBI alone, one by mammography alone, two by both methods and two by neither. (The two missed cancers were found on subsequent annual mammograms, physical exams or other imaging tests.)

Looked at another way, MBI found 10 out of 13 tumors, missing three; mammograms detected three out of 13 tumors and missed 10. Using both methods, 11 out of 13 tumors would have been detected.

"These images are quite striking. You can see how the cancers would be hidden on

ON THE WEB

Visit these Web sites for more information about the study:

www.asco.org

www.cancer.net

www.mayoclinic.com/health/breast-cancer/DS00328/DSECTION=tests-and-diagnosis

the mammograms," Hruska said.

Mammograms gave false alarms — led doctors to conclude that cancer was present when it was not — in about 9 percent of patients, compared to only 7 percent for MBI. The MBI tests led to more biopsies than mammograms did, but they more often revealed cancer.

The Susan G. Komen for the Cure foundation and Bristol-Myers Squibb, which makes the imaging agent used in the study, paid for the work.

The next test will be to see how MBI stacks up against MRI. The federal government is paying for a new study Mayo is leading that compares the two in 120 high-risk women with dense breasts.

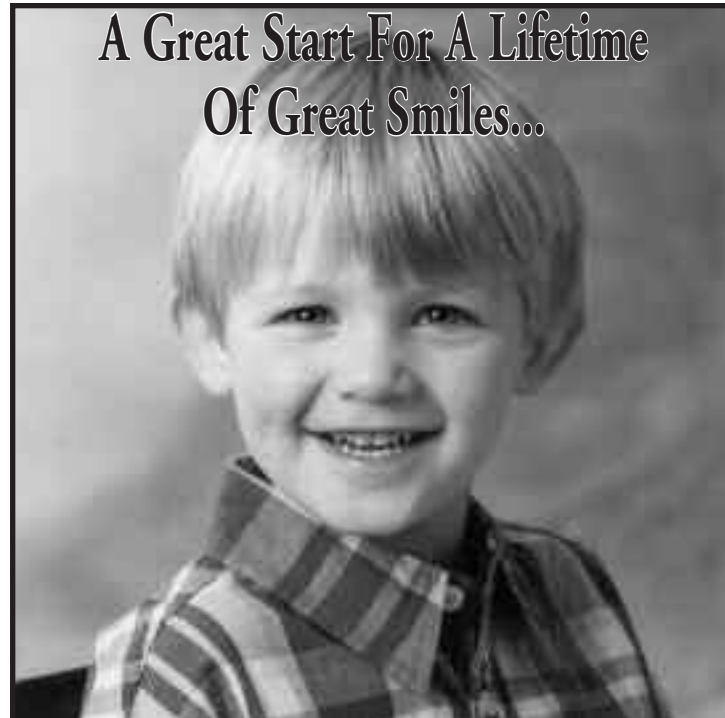
MRI is often used now for women with dense breasts, but it gives many false alarms that lead to unnecessary biopsies. Doctors hope MBI will prove more accurate and cost less — under \$500 versus more than \$1,000 for an MRI.

"We all know that mammography is, in and of itself, an imperfect tool, and we clearly need to do better in the future," said Dr. Eric Winer of the Dana-Farber Cancer Center in Boston, a spokesman for the oncology group. "It is fair to say that MRI will not solve all problems either."

One drawback of MBI: It uses about 8 to 10 times the radiation of mammograms, a dose that engineers like Hruska are trying to lower with newer technology. Other medical centers also are testing MBI.

"We're just beginning to see what this technology can do," she said.

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