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from "ER" to "House," "Emergency!" to "St. Elsewhere," "M.A.S.H." to "Grey's Anatomy," we've all grown up watching dramatic rescues on television medical shows. The patient collapses, the doctor or passerby - always in the right place at the right time - dives in, breathing into the patient's mouth and pumping on their chest.

The fictional patient often recovers fully by the end of the show.

Real life, as we know, isn't so tidy.

Most people whose heart stops beating aren't lucky enough to drop in the vicinity of a (fabulous-looking) emergency room doc. They're more likely to be surrounded by strangers grossed out at the prospect of putting their lips to the unconscious victim or afraid of trying complicated CPR procedures they might have learned years earlier.

And even when everything goes right, the chances of survival have been abysmal - fewer than 4 people in 100 survived such a collapse in 2005, according to one recent study, even if there were witnesses nearby.

To improve those odds, the American Heart Association recently changed its recommendations for how bystanders should handle such medical emergencies. Instead of trying to breathe for the person, as CPR classes have taught for decades, untrained good Samaritans are told now to pump the person's chest at least 100 times a minute until medical help arrives.

"By trying to simplify it and get the message out there . . . we hope that more people will at least do CPR, which will at least keep some blood flowing," said Dr. Monica E. Kleinman, vice chairwoman of the heart association committee that drew up the guidelines, and clinical director of the medical-surgical intensive care unit at Children's Hospital Boston. "It's better to do something than nothing."

Compressing someone's chest pumps blood through the body, including the brain, as the heart would do if it could.

The idea of doing chest compressions without mouth-to-mouth resuscitation arose because so many people were uncomfortable putting their mouth on a stranger's, and because even those who had CPR training were afraid they'd do more harm than good. (Medical professionals emphasize that any attempt at CPR is better than doing nothing. The worst damage that might result is leaving the survivor with broken ribs or a sore chest.)

A study published last month in the Journal of the American Medical Association found that nearly 3,000 out of 4,400 people who collapsed in Arizona over the last five years received no CPR at all. Only 5 percent of the no-CPR group survived long enough to be discharged from a subsequent hospitalization, the study found.

The brain gets damaged very quickly when deprived of blood. "The biggest thing is keeping forward blood flow going," said Dr. Richard D. Zane, vice chairman of emergency medicine at Brigham and Women's Hospital, and an associate professor at Harvard Medical School. (He was not involved in the JAMA study.)

Of those whose chests were compressed by bystanders, 13 percent survived their hospital stay that followed, (though other factors may have contributed to their survival as well, Kleinman said). They were also more likely to have normal brain function than people who didn't get any CPR at all.

The senior author on that study, Dr. Gordon A. Ewy (pronounced AV) said his research suggests that the heart association did not go far enough with its new recommendations. The association still suggests that people who are comfortable doing full CPR continue to do it, though now they are supposed to start with chest compressions and follow with mouth-to-mouth, instead of the other way around.
Any interruption in blood supply to the brain can cause permanent damage, and the time it takes to switch from compression to mouth-to-mouth deprives the brain of too much oxygen, said Ewy, a professor of cardiology and director of the Sarver Heart Center at the University of Arizona College of Medicine. He said the brain gets enough oxygen without mouth-to-mouth.

Ewy said his study suggests that 58,000 more lives could be saved a year by dropping mouth-to-mouth altogether. Kleinman praised Ewy's research, but said it needs to be repeated by others before her committee will consider changing its recommendations again.

Shelley Rhode of Bridgeport, Conn., is a firm believer in chest compressions because she used them this summer to save a stranger's life. On the morning of Aug. 4, a friend sent Rhode a link to a video that Ewy's research group had made, showing how to do chest compressions. She watched it. That night, Rhode went for the first time to a ballroom dancing class in Danbury. Just after the class ended, the teacher, John Vitti, bent down to take off his shoes and collapsed.

Newly confident because she'd seen the video, Rhode and two others pumped on Vitti's chest until paramedics could arrive (Rhode said it took 9 minutes; Vitti said one of the other rescuers, a cardiac nurse, told him it took 20-25)

"I can't say enough about the people who helped me," said Vitti, 63, who had a defibrillator implanted and then a triple bypass, and is now back to teaching dance classes. "If it wasn't for them, that was it, I'd be gone."

Rhode, who works with special education students in Fairfield, said she doesn't think she would have had the courage to get involved if she hadn't watched the video that morning. "I'd never done anything like that before," she said.

"It's just a really wonderful feeling to know that I was capable of saving a life," she said. Rudolph "Rudy" Mosesso, 82, was recently on the receiving end of another good Samaritan's efforts. On Aug. 26, while helping out at a funeral at St. John's Church in Quincy, Mosesso collapsed and stopped breathing.

"They had no heartbeat in the very beginning. They brought me back again," the Holbrook resident said. "I'm a very fortunate man today."

Mosesso, who was treated at Beth Israel Deaconess Medical Center, has recovered extremely well from both the collapse and a valve replacement. He's one of the lucky ones.

Despite improvements in emergency room care, only about one-third of patients like Mosesso who make it to the hospital with a pulse will walk out without some brain damage, according to one of Mosesso's doctors, Michael Donnino, codirector of Beth Israel's cardiac arrest center.

Karen Weintraub can be reached at karen@karenweintraub.com.

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**New CareChex Study Assesses Quality of University Hospital Care in the U.S.**

11/01/2010

**Business Wire**

Business Editors/Healthcare Editors
GREENVILLE, South Carolina--(BUSINESS WIRE)--November 1, 2010--CareChex, a division of The Delta Group specializing in rating the quality of hospital and physician care, today released a new study, An Assessment of the Quality of University Hospital Care in the U.S., that investigates whether or not university hospitals outperform other hospitals on objective measures of quality.

Importantly, to accurately assess the relative quality of care provided by university hospitals, the study removed unusually difficult cases (i.e., outliers) and adjusted for differences in patient risk factors (i.e., clinical and demographic characteristics).

Study results were surprising: While university hospitals do very well as a group in cancer care and in overall medical care, in many clinical categories they either performed the same as non-university
hospitals or sometimes far worse. For example, 89% of university hospitals fall below the national average in orthopedic care, and 85% fall below the national average for general surgery.

CareChex looked across all key components of quality available for comparison – process, outcomes, and patient satisfaction – to form a single composite percentile score and attendant quality ranking. A total of 118 university hospitals were evaluated using The Delta Group’s National Quality Rating Database (NQRD), which includes virtually all general, acute, non-federal U.S. hospitals.

"Most people assume that a university hospital will provide better quality care because these institutions typically conduct cutting-edge academic research, have lofty reputations and adopt the latest treatment protocols and technologies," says Dr. Thane Forthman, Managing Principal of The Delta Group. "We were especially surprised to see the study reveal that some of the nation's best-known university hospitals scored in the bottom quartile of all hospitals nationally for overall quality of hospital care."

"Certainly more research is needed, but at university hospitals you have a large population of interns and residents who are still being trained. While under the supervision of an attending physician, they have the autonomy to make rounds, order lab tests and make clinical decisions, even though they lack time-tested, hands-on experience," says Forthman.

“More importantly, interns and residents often work extended shifts of up to 80 hours per week, which empirical research has shown dramatically increases fatigue-related medical and diagnostic errors, medication errors and other adverse events."

“Regardless of the potential factors contributing to the issue, patients should consider the quality of care provided by all hospitals in their market before making the assumption that a university hospital will provide superior care.”

Among the key CareChex study findings:

University hospitals appeared more frequently in the top 10% of all hospitals nationally in cancer care and overall medical care: 43% of university hospitals studied performed in the top 10% nationally for cancer care, while 17% performed in the top 10% for overall medical care. Surprisingly, many highly-regarded university hospitals performed in the bottom 25% of all hospitals nationally for overall quality of hospital care, including: Emory University Hospital, Dartmouth-Hitchcock Memorial Hospital, George Washington University Hospital, Georgetown University Hospital, Hospital of University of Pennsylvania, Stanford Hospital, Shands Hospital at the University of Florida, The Johns Hopkins Hospital, The University of Chicago Medical Center and University of North Carolina Hospital (Chapel Hill).

Of the 118 university hospitals evaluated, 17 were in the top 10% of all hospitals nationally for overall quality of care in three or more clinical categories:
- Nine Clinical Categories: Ball Memorial Hospital (Indiana University); Gunderson Lutheran Medical Center (University of Wisconsin)
- Six Clinical Categories: Massachusetts General Hospital (Harvard Medical School)
- Five Clinical Categories: Hackensack University Medical Center
- Four Clinical Categories: Baylor University Medical Center; Cedars-Sinai Medical Center (UCLA & USC); Memorial Health University Medical Center (Mercer University); Ohio State University (OSU) Hospitals; Rush University Medical Center; Medical University of South Carolina (MUSC); University of Massachusetts Medical Center
- Three Clinical Categories: Abbott Northwestern (University of Minnesota); Harper University Hospital; Thomas Jefferson University Hospital; Yale-New Haven Hospital; University Medical Center (University of Arizona); University of Wisconsin Hospitals

Of the 118 university hospitals, the following ranked #1 in more than one clinical category:
- Gunderson Lutheran Medical Center (University of Wisconsin) ranked #1 in three clinical categories (overall hospital care, overall surgical care, and major cardiac surgery)
- Massachusetts General Hospital (Harvard Medical School) ranked #1 in two clinical categories (cancer care and general surgery)

University hospitals appeared less frequently in the top 10% of all hospitals nationally in six clinical categories: Orthopedic Care (2% in the nations’ top 10%); Neurological Care (2% in the top 10%); General Surgery (3% in the top 10%); Cardiac Care (6% in the top 10%); Major Orthopedic Care (6% in the top 10%), and Overall Hospital Care (7% in the top 10%).
University hospitals appeared with essentially the same frequency in the top 10% of all hospitals nationally in the following categories: Overall Surgical Care (10% in the nation’s top 10%); Pulmonary Care (11% in the top 10%); Major Cardiac Surgery (11% in the top 10%); Major Neuro-Surgery (11% in the top 10%)

University hospital quality scores fall disproportionally below the national average for the majority of clinical categories: Orthopedic Care (89% fall below the national average); General Surgery (85% fall below); Major Orthopedic Surgery and Neurological Care (78% fall below, respectively); Overall Hospital Care (74% fall below); Overall Surgical Care (73% fall below); Major Neuro-Surgery (67% fall below); Cardiac Care (63% fall below); Major Cardiac Surgery (62% fall below).

A full narrative of the 2010 CareChex study, An Assessment of the Quality of University Hospital Care in the U.S., is available at: http://www.carechex.com/media/univhospstudy.aspx

Also available are graphs of the percent of university hospitals in the nation's top 10% by clinical category: http://www.carechex.com/media/univ10.aspx and of the university hospitals that fall below the national average by clinical category: http://www.carechex.com/media/univ50.aspx

About The Delta Group and CareChex

As the nation’s largest privately-held healthcare information services company, The Delta Group provides an extensive array of products and services designed to measure, manage, and monitor the clinical, financial, and market performance of healthcare organizations. CareChex, a division of The Delta Group, specializes in rating and ranking the quality of hospital and physician care using both public and proprietary measures of performance including process of care, outcomes of care, and patient satisfaction. Learn more at www.carechex.com

More on Study Design, Data Sources and Methods

In November 2010, CareChex released a significant research study relating to the quality of care provided by U.S. university hospitals.

The research project conducted by CareChex was designed as a longitudinal study spanning the most recent three (3) years of federal fiscal year data using all Medicare inpatient discharges from the Center for Medicare and Medicaid Studies (CMS) Medicare Provider Assessment and Review (MedPAR) file as well as the Department of Health and Human Services (DHHS) Hospital Compare database. All CareChex studies utilized both public and proprietary methods validated by third-party organizations for evaluating hospital quality performance. These methods include process of care measures developed by The Joint Commission (TJC) for national accreditation of healthcare organizations, inpatient quality and patient safety measures developed by Stanford University under sub-contract with the federal government's Agency for Health Research and Quality (AHRQ), patient satisfaction measures developed by CMS using a standardized national hospital survey, and proprietary outcome measures developed by The Delta Group for evaluating rates of hospital inpatient mortality, post-surgical complications, and global patient safety events. For more information regarding the construction and validation of the aforementioned methods, please access the following web links:

- Patient Satisfaction Measures: http://www.cms.gov/HospitalQualityInits/30_HospitalHCAHPS.asp

Additionally, specific statistical methods used in the study are provided under separate cover along with the resultant study findings. These methods include statistical significance testing and distribution standardization.

Schwartz Communications
Douglas Russell, 781-684-0770
CareChex@schwartzcomm.com

or

The Delta Group, Inc.
Dr. Thane Forthman, D.H.A., 1-800-711-8363 ext. 318
Managing Principal
Studies from University of Arizona, Department of Physiology provide new data on nephrology
11/01/2010
NewsRx.com

Current study results from the report, 'Vasopressin increases expression of UT-A1, UT-A3, and ER chaperone GRP78 in the renal medulla of mice with a urinary concentrating defect,' have been published. "Activation of V2 receptors (V2R) during antidiuresis increases the permeability of the inner medullary collecting duct to urea and water. Extracellular osmolality is elevated as the concentrating capacity of the kidney increases," scientists writing in the American Journal of Physiology Renal Physiology report (see also ).

"Osmolality is known to contribute to the regulation of collecting duct water (aquaporin-2; AQP2) and urea transporter (UT-A1, UT-A3) regulation. AQP1KO mice are a concentrating mechanism knockout, a defect attributed to the loss of high interstitial osmolality. A V2R-specific agonist, deamino-8-D-arginine vasopressin (dDAVP), was infused into wild-type and AQP1KO mice for 7 days. UT-A1 mRNA and protein abundance were significantly increased in the medullas of wild-type and AQP1KO mice following dDAVP infusion. The mRNA and protein abundance of UT-A3, the basolateral urea transporter, was significantly increased by dDAVP in both wild-type and AQP1KO mice. Semiquantitative immunoblots revealed that dDAVP infusion induced a significant increase in the medullary expression of the endoplasmic reticulum (ER) chaperone GRP78. Immunofluorescence studies demonstrated that GRP78 expression colocalized with AQP2 in principal cells of the papillary tip of the renal medulla. Using immunohistochemistry and immunogold electron microscopy, we demonstrate that vasopressin induced a marked apical targeting of GRP78 in medullary principal cells. Urea-sensitive genes, GADD153 and ATF4 (components of the ER stress pathway), were significantly increased in AQP1KO mice by dDAVP infusion," wrote Q. Cai and colleagues, University of Arizona, Department of Physiology.

The researchers concluded: "These findings strongly support an important role of vasopressin in the activation of an ER stress response in renal collecting duct cells, in addition to its role in activating an increase in UT-A1 and UT-A3 abundance."


Additional information can be obtained by contacting Q. Cai, University of Arizona, Dept. of Physiology, College of Medicine, Tucson, AZ 85724-5218 USA.
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New findings from University of Arizona, College of Pharmacy in the area of multiple sclerosis described
11/01/2010
Pain & Central Nervous System Week
New research, 'Will the newer oral MS agents be welcomed by managed care organizations,' is the subject of a report. "Of the new generation of multiple sclerosis (MS) drugs, 4 oral agents—dalfampridine, laquinimod, cladribine, and fingolimod—could produce significant changes in the treatment landscape for MS. Current first-line treatments, which are administered via injection, are associated with poor treatment adherence, often due to lack of efficacy (perceived and real), adverse drug reactions, cost, and injection anxiety," scientists in the United States report (see also ).

"Although concerns about safety and cost remain, preliminary results indicate that these oral agents are as effective as, or even more effective than, current injectable treatments. Oral MS agents are expected to cost patients less in out-of-pocket expenses, which will likely increase treatment adherence and lead to an overall reduction in medical costs," wrote R.J Lipsy and colleagues, University of Arizona, College of Pharmacy.

The researchers concluded: "While many patients may prefer an oral MS drug, the ultimate choice of therapy will be a shared patient-physician decision based on a multitude of factors, including the efficacy of the current treatment regimen, patient compliance history, and the difference in out-of-pocket expenses."

Lipsy and colleagues published their study in The American Journal of Managed Care (Will the newer oral MS agents be welcomed by managed care organizations? The American Journal of Managed Care, 2010;16(8 Suppl):S227-33).

For more information, contact R.J. Lipsy, University of Arizona, College of Pharmacy, 8530 E Green Acres Dr., Tucson, AZ 85715 USA.

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