Title
Older adults and smoking: A match made by the tobacco industry.

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MATERIALS AND METHODS

We performed an evaluation of 49 MM patients transplanted at Inova Fairfax Hospital from 1997-2006 to examine outcomes in the context of age. MM treatment was either Vincristine, Doxorubicin, and Dexamethasone (VAD) or Thalidomide Dexamethasone. Patients were apheresed with goal of attaining 5x106/kg CD34 cells prior to receiving 200 mg/m2 of Melphalan. Transfusions were given to maintain hgb > 8gm/dl and plts >10,000/mm3. Continuous variables were analyzed as means and 95% CI, but p-values were produced using a Wilcoxon Rank Sum Test for non-normally distributed data. Categorical variables were analyzed using Fisher's Exact Test. RESULTS are found in the Table below.

DISCUSSION

In MM patients with comparable performance status, there were no differences in complications, engraftment, cell viability, days of apheresis, or transfusion use in older versus younger patients. Younger patients appeared to achieve higher CD34 yields (p=0.05). Our data support the concept that older MM patients with good performance status can be treated with stem cell strategies comparable to those developed for younger patients.

Variables/Age Group	<60 (N=28)	60+ (N=21)	p value
Age (years)	49.5 {47.1, 51.9}	67.7 {65.3, 70.0}	<.0001
Karnofsky Score	94.4	95.3	1.00
MM Treatment: VAD (%)	82.1	71.4	0.49
MM Treatment: ThalDex (%)	17.9	28.6	
Days of apheresis	1.96 {1.64, 2.29}	2.14 {1.60, 2.69}	0.76
CD34 yield	9.03 {6.85, 11.2}	6.26 {5.10, 7.43}	0.05
Viability: Day 1	81.4 {74.5, 88.4}	81.8 {71.7, 92.0}	0.86
Viability: Day 2	91.2 {88.4, 94.0}	85.6 {80.2, 90.9}	0.06
Viability: Day 3	81.7 {69.2, 94.2}	84.9 {77.1, 92.6}	0.49
Days to engraftment: Neutrophils	13.7 {13.1, 14.4}	13.8 {13.1, 14.5}	0.90
engraftment: PLT	19.2 {16.0, 22.5}	19.8 {17.8, 21.6}	0.72
# PLT Transfusions	3.96 {2.40, 5.53}	3.52 {2.44, 4.61}	0.81
# RBC Transfusions	3.00 {2.28, 3.72}	3.81 {2.80, 4.82}	0.20
Mobilization regimen (%G)	79	86	0.71
Transplant Associated Complications (%)			
Death <100 days	0	0	1.00
Mucositis II-IV <30 days	21.4	9.5	0.40
Sepsis <30 days	10.7	0	0.25
Pneumonia <30 days	3.6	4.8	1.00

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A Comparison of Methods of Estimating Glomerular Filtration Rates in Elders with Multiple Comorbidities.

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Mildred Wyatt and Ivor P. Wold Center for Geriatric Care

Purpose: To compare methods of estimating glomerular filtration rates (GFR) among an elderly indigent population with multiple co-morbidities.

Methods: A retrospective chart review collected laboratory data, co-morbid diagnoses, medications, and recall of dietary protein intake from patients who had been referred for dietary counseling in a publicly funded geriatric clinic. Concurrent functional status, demographics as well as blood pressure, height and weight were also determined. GFRs were estimated using the MDRD and CG formulas.

Results: Data were available on 171 patients. Most (68%) were African American women. Subjects ages ranged from 58 to 91 with a mean of 73, SD of 7.5. Average BMI was 29 (SD 7.7). Protein intake retrieved from dietary recall (crude estimate) ranged from 0-99 grams per day with a mean and median of 48, SD 24. Two-thirds of subjects reported independence in cooking, shopping and medications. On average systolic blood pressure was 145 mm Hg and diastolic blood pressure was 74 mm Hg.

The CG formula identified more subjects with GFR <90 (132) than did the MDRD formula (70). The mean GFR of 171 subjects estimated by the CG formula was 56 (SD 19) and the mean GFR of the 171 subjects estimated by the MDRD formula was 72 (SD 14).

Conclusions: In this elderly population the CG tended to identify lower GFRs than the MDRD, which does not include a weight parameter. Clinicians should be aware of the marked discrepancy between these two widely used estimating equations in elderly minority patients like those in this study. GFRs estimated using the CG formula placed these ambulatory patients in CKD stage 3, a classification that requires further evaluation and treatment for kidney disease-related conditions,

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Age is inversely correlated with apolipoprotein C-III levels in elderly men at risk for type 2 diabetes.

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Supported By: American Heart Association

Apolipoprotein C-III (apoC-III) is a useful marker of triglyceride-rich lipoprotein metabolism and an indicator of higher risk for cardiovascular disease (CVD). Apo C-III levels are lower in centenarian offspring compared to age-matched controls, suggesting that this could be an indicator/predictor of longevity which may be related to a favorable pattern of lipoprotein levels and sizes. Centenarian offspring also exhibit higher levels of HDL-cholesterol. In order to assess the relationship of age with apo C-III and HDL-cholesterol levels, we evaluated cross-sectionally 312 subjects participating in a screening program for diabetes (fasting blood glucose = 113 ± 44.8 mg/dl and body mass index= 30.92 ± 6.1 kg/m^2). We found that age was inversely related to apo C-III levels in elderly men (61-94 years, r=-0.34, p=0.035), while no significant relationship was observed in elderly women (61-83 years, r=-0.057, p=0.7). In contrast, we found a positive relationship between age and apo C-III levels in younger women (23-60 years, r=0.26, p=0.0023), but observed no significant relationship in younger men (18-60 years, r=0.005, p=0.9). The inverse relationship between age and apo C-III in elderly men remained statistically significant after adjusting for HDL-cholesterol and glucose values (R^2=0.28, p=0.0105). HDL-cholesterol level was directly associated with age in women (r=0.22, p=0.002), but not in men (r=0.10, p=0.23). In summary, age is inversely correlated with apo C-III levels in elderly men but not in older women, which suggests that apo C-III may be a predictor of longevity in men but not in women. In contrast, apo C-III increase with age in younger women implying that sex modifies the relationship between age and apo C-III levels. Since longevity is associated with a favorable lipoprotein profile, further studies to evaluate the potential role of low apo C-III on longevity-associated phenotypes are warranted.

A118

Older Adults and Smoking: A match made by the tobacco industry.

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Tobacco use is the most prevalent substance abuse disorder in older adults. Older smokers are more likely to: be successful at smok-

ing cessation and gain significant benefits. However, they blame themselves for their smoking behaviors and are less likely to see a connection between their health and tobacco use. After seven years of litigation the tobacco companies were convicted of racketeering: "they knew for fifty years or more that cigarette smoking caused disease, that filter and low tar cigarettes increased rates of smoking and were not "more healthy" (Kessler, 2006). In addition to individual behavior change strategies, public health efforts must focus on changing the cultural and policy contexts of tobacco use. Intervention strategies, which hold the tobacco industry accountable for its behavior, are effective in changing views of tobacco use (Balbach & Glantz, 1998). There are no previous studies on tobacco industry impact on older smokers. This study will focus attention on what the documents reveal about industry targeting of seniors and on exploring how information from document analysis may inform tobacco control efforts. Documents were retrieved from several industry document websites and analyzed using a case study approach. When the search term "senior citizen" was entered it revealed 10,183 documents, for the term "elderly" there were 25,780 documents, and for the term "50+" the yield was 1,127,144 documents with a range from 1935 to 1995. We present evidence from over 500 documents showing that the tobacco industry did extensive psychographic research and cohort analyses on current and future mature smokers. The low tar cigarette was developed in response to the "needs and wants" of older smokers. In a 1977 RJR Memo stamped "Secret", "we know from other tests that low tar - while important to all groups - is more important to older smokers". American Tobacco memo, 1994: "As smokers age, they tend to migrate to Ultra Low Tar….As the Boomers age, they will want to reduce their tar level (we need) to be firmly positioned and visible when they "awaken". All our resources should be concentrated against the "Graying Boomer". The tobacco industry had a significant role in the initiation and maintenance of smoking behaviors in older adults. This information can be useful in removing the culture of shame that overshadows older smokers and results in more effective tobacco control policies and intervention strategies.

A119

Colon Cancer Screening: A Retrospective Study of Compliance With Guidelines.

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Background: Colon cancer is the third commonest cancer in the US. Randomized trials have demonstrated the efficacy of screening. To our knowledge, compliance with screening guidelines in elderly population has not ever been reported in the US.

Objective: Determine the compliance among primary care physicians with the American Cancer Society screening guidelines for colorectal cancer in elderly population. Secondarily, determine the difference in compliance based on gender, ethnicity and the reasons for noncompliance.

Design and Setting: Retrospective Cohort; Internal medicine practice of 8 full-time physicians at an academic center.

Methods: We randomly selected 221 charts for review. Selection was determined by inclusion criterion: All patients born 1950 or prior, first visit to clinic in 2000, most recent visit after December 2003, to exclude dropped out or dead patients. The charts were examined to answer the following: 1. Was screening offered when indicated? It should have been offered at age 50. A 2-year period was permitted to complete screening. 2. Was screening completed by any of the approved methods either late or on time? 3 FOBT cards per year for 3 consecutive years, flexible sigmoidoscopy or barium enema every 5 or colonoscopy every 10 years. 3. Were abnormal/normal results followed per guidelines? A 2-year period was allowed to complete the work up. If the answer to any of the above was "No" or if it was late, noncompliance was recorded and reasons for same searched in the chart.

Results: Screening was offered when it was indicated in 55.6%, 66.5% completed screening either late or on time (66.4% men vs. 66.7% women & 67.1% White vs. 60% Non-whites), abnormal/normal results were followed per ACS guidelines in 59.2% and 33% had documented compliance (Men 37.2% vs. women 28.8%, white 32.8% vs non-white 34.7%). The most common explanation for non-adherence was "unknown", i.e. the chart did not provide an explanation (79 %); 19.6% declined screening and 1.4% were non-compliant because of lack of insurance or presence of co-morbid conditions.

Conclusions: The compliance rate in this primary care practice was 33%. There was no significant difference in the compliance based on gender & ethnicity. The reasons for non-compliance for the most part remain unknown, but there was substantial patient refusal to be screened suggesting room for improvement either in patient or physician education or in documentation.

A120

The Use of Facilitation Processes for Quality of Life among Nursing Home Residents.

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Background: Growing interest in quality of life within long-term care settings has been motivated by both legislative demand for improvements and grassroots movements for nursing home reform. Research has focused primarily on outcome measures of satisfaction. These study designs, while important, do not allow for an evaluation of process.

Purpose: To investigate quality of life processes through an ethnographic analysis of nursing home residents' daily lives and activities participation.

Methods: Prospective, qualitative study of residents at a 430-bed skilled nursing facility in San Francisco. Data includes 150 hours of participation in and observations of resident involvement in daily activities. 30 interviews with residents, staff and administrators were included. Interviews and observations were recorded through written field notes, which were analyzed iteratively throughout data collection. As themes emerged, results were validated through triangulation, the process of verifying results with participants and archival data. When thematic saturation was reached, the data were reanalyzed to develop a more nuanced understanding of the theme's significance.

Results: Early in the research, residents and staff attributed an excellent quality of life at the nursing home to the number and variety of scheduled activities offered. They also noted the importance of "dignity" as an ideal. Over time, a theme of "facilitation" emerged which incorporated both the activities and ideals. Participants recognized facilitation as a process through which quality of life improvements were made and dignity was maintained. Facilitation encompasses a variety of actions through which staff members assist residents in their attempts to remain creative and productive. It involves the use of staff time and skills to enable residents to complete tasks that they can no longer do independently, and results in expressions of satisfaction by residents and caregivers alike. Facilitation took the form of physical assistance, of reminiscence through verbal and musical memory cues, and of organization and structuring of activities.

Conclusion: Members of this small society identify facilitation as an essential process through which residents can enhance their quality of life and their maintain their "dignity." By examining processes rather than outcomes, one can uncover ways in which elders participate in the creation of meaningful lives within institutional settings.

A121 Encore Presentation

Increasing Patient Satisfaction through the Dining Experience.

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Increasing Patient Satisfaction through the Dining Experience