days). Also, people in the intervention group were much less likely to be hospitalized than people in the control group.

In general, Casarett said, people who are in hospice care have decided they do not want to be in a hospital setting—although, of course, they are free to change their minds and get hospital care if it is needed.

Another important finding from the study is that families of people in the intervention group were more satisfied with the end-of-life care their loved one received than families of people in the control group. That was true even though people in the intervention group were no more likely to be enrolled in hospice at the time of their death, nor to die in the nursing home rather than an acute care setting.

“But the main difference is that they spent more time in hospice. So even if this intervention doesn’t result in more people dying in hospice, they spend more time in hospice. Who’s enrolled at the time they die may not mean as much as the care they got the previous week or previous month,” explained Casarett. “Hospice does a lot to prepare patients and also families for death, both in terms of focusing on pain and symptom management, and emotional and spiritual support,” said Casarett. “But we don’t know what hospice did to make people more satisfied. Was it better pain management? Was it better emotional support? We just know hospice is very important in improving satisfaction with care.”

Casarett said his group is doing other studies to determine exactly what it is about hospice that helps families feel better about the care their loved ones get.

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**SWITCH TO AROMATASE INHIBITOR BETTER THAN CONTINUING TAMOXIFEN**

Breast cancer patients who switch to the aromatase inhibitor, anastrozole, after 2 years on tamoxifen do better than women who continue taking the full 5-year course of the older drug, results of a new analysis indicate. Writing in *The Lancet* (2005;366:455–462), researchers from Austria and Germany report the combined findings of the Austrian Breast and Colorectal Cancer Study Group trial 8 (ABCSG trial 8) and the Arimidex/Nolvadex 95 trial (ARNO 95).

The trials involved more than 3,000 women who received standard treatment for early-stage breast cancer (lumpectomy plus radiation or mastectomy) followed by tamoxifen. After 2 years on the drug, 1,608 women were randomized to continue tamoxifen, and 1,618 were assigned to switch to anastrozole.

After median follow up of 28 months, the researchers reported a 40% decrease in risk of local or distant metastasis or contralateral breast cancer in the women who took anastrozole compared with the tamoxifen group. In absolute terms, anastrozole conferred a 3.1% event-free survival benefit over tamoxifen (95.8% versus 92.7%).

There was no significant difference in overall survival between the groups after 3 years. As expected, however, the drugs did have different side effects. Women on anastrozole experienced significantly more bone fractures (odds ratio [OR] 2.14) and significantly fewer thromboses (OR 0.25) than women on tamoxifen. Women on anastrozole also reported more bone pain and nausea.

Lead author Raimund Jakesz, MD, of the Vienna Medical University, says the findings support those of earlier trials—in particular the Arimidex, Tamoxifen, Alone or in Combination (ATAC) trial—that found aromatase inhibitors superior to tamoxifen for preventing recurrences, particularly in the first 2 years of therapy. They also suggest that women who have taken 2 to 3 years of tamoxifen therapy should be switched to an aromatase inhibitor for their remaining years of hormonal treatment.

That group of patients is likely getting smaller, said Christy Russell, MD, of the University of Southern California’s Norris Comprehensive Cancer Center. Russell was not involved in the new research. She serves as...
chair of the ACS’s Breast Cancer Advisory Group.

“I’d say since the ATAC data came out—the head-to-head comparison of tamoxifen and anastrozole—that any newly diagnosed post-menopausal woman with breast cancer has for the most part been started on anastrozole as her initial therapy,” she said. “So the question would be, is there a group of women who should absolutely start on tamoxifen and then switch over? There’s no reported trial that has answered that question.”

The ongoing Breast International Group 1–98 (BIG1–98) trial may provide some clarification, however. That study includes both a head-to-head comparison of the aromatase inhibitor letrozole and tamoxifen, as well as a comparison of women who take one of the drugs then switch to the other.

Jakesz and his colleagues say their results do not apply to newly diagnosed patients and “should not be used to support a treatment strategy of starting with tamoxifen with the intention of changing to an aromatase inhibitor after 2 or more years.”

Russell noted, though, that premenopausal women who become menopausal from breast cancer chemotherapy might be candidates for such a treatment strategy. Many physicians would begin such a woman on tamoxifen, then switch her to an aromatase inhibitor once it is clear that her menopausal status has become permanent.

The question of side effects also causes some physicians to start women on tamoxifen rather than an aromatase inhibitor, Russell said.

“The concerns being raised by physicians are for women with severe osteoporosis or who have already had fractures because we know there are more fractures on aromatase inhibitors,” she explained.

Russell, however, thinks the benefits of aromatase inhibitors are greater than the risks to bone health, even in women at high risk for bone problems, such as the elderly.

“There are so many good drugs available to build back bone—all of the bisphosphonates, for instance—that it would be preferable to use a drug that is better [than tamoxifen] for improving bone health and a drug which is better for reducing the risk of breast cancer recurring,” she said. “I don’t believe that tamoxifen is such a strong estrogen-like compound for the bones that it is to be used preferentially over one of the bisphosphonates.”

Moreover, she noted, elderly women, who are at greatest risk for fractures, are also at higher risk for blood clots and strokes—and tamoxifen can increase this risk even more.

Questions remain about the effect of aromatase inhibitors on lipid levels and myocardial infarction. Many studies have shown higher cholesterol levels in women on aromatase inhibitors, but it is not clear whether aromatase inhibitors actually raise cholesterol levels, or whether the difference is merely a result of tamoxifen lowering them. Likewise, rates of myocardial infarction in some trials have been higher (although not by a statistically significant amount) among women on aromatase inhibitors, but it is uncertain whether that is due to a protective effect of tamoxifen or a risk of the aromatase inhibitors.

SMOKING CESSATION: TWO OUT OF “5A’S” AREN’T ENOUGH

A recent survey of participants in nine different health maintenance organizations (HMOs) suggests health care providers are doing well at encouraging smokers to kick the habit, but could do better at helping them get cessation tools, and much better at following up to track their progress in quitting.

Researchers led by Virginia P. Quinn, PhD, of Kaiser Permanente Southern California, were looking to measure physician compliance with the “5A’s” of tobacco cessation treatment promoted by the U.S. Public Health Service: Asking patients about tobacco use, Advising smokers to quit, Assessing smokers’ willingness to try quitting, Assisting smokers with cessation treatment and referrals, and Arranging follow-up contacts. They published their findings in the