But the notion of relying exclusively on a nomogram scares some urologists. One reason is that in cases where prostate cancer has invaded the immediately surrounding tissues, patients have been cured by radical prostatectomy, said Peter T. Scardino, M.D., chairman of urology, Baylor College of Medicine, Houston. "If there is microscopic extracapsulary extension the chance the cancer can be cured is still 70%, and if there is seminal vesicle invasion the chance is still 30%," Scardino said.

Even if some cancer cells escape the knife, the operation can increase 5-year survival from 30% to 50%, said Bormes.

"Even if it's only a 10% chance the guy is operable, you will take it," added Lange.

**Trial to Begin**

To improve Urocor’s predictions, a multi-institutional trial is about to begin, with Johns Hopkins, Baylor, and the University of Michigan providing preoperative biopsy samples from patients who had radical prostatectomies.

"We should know its performance characteristics with some degree of accuracy in the next 6 months, and have improvements to the algorithm in the next 12 months," said Veltri.

UroCor has also been developing a nomogram that can predict post-operatively whether cancer is likely to progress. This could help in deciding which patients should have adjuvant therapy following surgery, said Veltri.

The ideal nomogram would make a science of predicting progression of prostate tumors. For the immediate future, at least, this small but critical corner of medicine will remain largely an art.

— David Holzman

**Preparing for Life’s End: Do Health Professionals Need More Training?**

Are health professionals well trained to recognize the end stages of a fatal illness, and to share that awareness sensitively with patients and the people who mean the most to them? Or are many so poorly equipped to deal with these matters — and so uncomfortable with them — that they could profit from clinical guidelines on how to manage care at the end of life with greater compassion and skill?

These are some of the questions that a committee of the National Academy of Sciences’ Institute of Medicine has been grappling with since January 1996. Among the many other questions the 12-person panel has been exploring are the adequacy of the tools available for the assessment and symptom management of dying patients, the strengths and limitations of advance directives, and how better to determine and comply with the wishes of dying patients and their families.

"All these issues have taken on greater urgency as it has become evident that the advances of modern medicine can add to the discomfort of gravely ill patients without significantly prolonging their lives," said Christine Cassel, M.D., who chairs the IOM panel.

"Yet it’s been almost a taboo among physicians to discuss the likely futility of heroic treatment with terminal patients for fear that it will deprive them of hope.

"Since many patients know perfectly well what is going on," she continued, "the effect is to make them feel isolated when they really want is the truth about what they can expect, and reassurance that the physician won’t abandon them at the end. When our report is ready for publication, as it will be next year, it will include a number of recommendations designed to encourage a change of physician behavior in this respect."

But Cassel, who heads the Department of Geriatrics and Adult Development at the Mount Sinai Medical Center in New York, said the panel has also found that physician squeamishness about leveling with dying patients is understandable. For one thing, she noted, palliative care is not generally taught to medical students at either the undergraduate or postgraduate levels.

For another, there has been little systematic study of palliative care, which has given it a low profile in both the practitioner and research communities. Accordingly, Cassel reported, the IOM committee has been looking hard at whether palliative care should be a recognized medical specialty. The Committee will surely recommend that it get more attention from institutions that
Chronic Care Crisis: Escalating Cost and Incidence

The number of people suffering from chronic conditions and the costs of caring for these people are skyrocketing, according to a chart book released recently as a “wake-up call to Americans” by the Institute for Health and Aging at the University of California at San Francisco and the Robert Wood Johnson Foundation, Princeton, N.J., which funded the study.

It is the first study on the prevalence and cost of all chronic health conditions in the United States. The findings were featured in the lead article in the Nov. 13 Journal of the American Medical Association.

Staggering Costs

Using data from the 1987 National Medical Expenditure Survey and 1990 National Health Interview Survey, the report concludes that in 1987, 90 million Americans were living with one or more chronic conditions. In 1995, this number had increased to almost 100 million, costing the nation $470 billion in direct medical costs and more than $230 billion in lost productivity. By 2050, the report estimates that 167 million Americans will be living with chronic conditions, and their direct medical costs alone will reach a staggering $906 billion.

Today, the report stated, chronic conditions are collectively the leading cause of illness, disability, and death in the United States, accounting for three of every four deaths. As the second leading cause of death in 1990, cancer has contributed significantly to the rise in the numbers of individuals suffering from chronic disease.

Correction

In a Dec. 4, 1996, News article, “Cancer Mortality Rates Fall: A Turning Point for the Nation,” it was reported that the mortality rate for Hodgkin's disease is increasing. In fact, from 1973 to 1993 the mortality rate for Hodgkin’s disease declined 58.4% while the mortality rate for non-Hodgkin’s lymphoma increased 36.3%.