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PUGET SOUND ONS
ONCOLOGY NURSING SOCIETY

CHILDREN WITH CANCER

Edited by
Kit Bakke, R.N., M.N.
Barbara Swenson, R.N., M.S., P.N.P.

Children are very special people -- children with cancer are not "little adults." Their diagnoses are usually unique to them. They have unique responses to their diagnoses and treatment. How they need their families, and how they see their deaths or the deaths of their friends, are also unique. Children with cancer need these differences understood, recognized, and valued by the nurses who care for them. The following authors have tried to capture some of the unique and special aspects of caring for children with cancer.

NEXT ISSUE:

Spring Issue The American Cancer Society: Hand in Hand With You.

Guest Editor: Ryan Iwamoto
Article Deadline: 2-26-88
Other Information: 3-4-88

Pediatric Oncology: An Overview

by Jane Brewer Sloan R.N., M.N.
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Pediatric oncology nurses and physicians treat children with a wide range of malignant diseases, most of which share some common characteristics. This article provides a general overview of childhood cancer, and focuses on differences between childhood and adult cancers.

Incidence

Childhood cancers are rare, accounting for only about 1% of all new cancer cases in the United States. Each year in the U.S., approximately 6,100 children under the age of 15 will be diagnosed with a malignant disease. Despite its rarity, cancer remains the leading cause of death due to disease in childhood. Unlike some adult cancers, the number of new cases of childhood cancer per year has remained relatively constant.

Characteristics

Childhood cancers differ from adult malignancies in several respects. Whereas many adult cancers are composed of well-differentiated, slowly-growing cells, childhood cancers are often characterized by immature, poorly-differentiated cells which grow relatively rapidly. These malignant cells are frequently embryonic in origin. Unlike some adult malignancies, such as lung cancer, no common environmental exposures have been clearly identified as causes of childhood cancers.

Leukemias, brain tumors, and lymphomas are the most common pediatric cancers, together accounting for better than 60% of all cases. Following these malignancies, in order of frequency, are neuroblastoma,

The success of marrow transplantation is influenced by age, the availability of an appropriate donor and previous medical history. Children are generally more resilient than adults when recovering from illness; however, the side effects and complications resulting from conventional cancer therapy can limit a child's ability to tolerate the BMT preparative regimen which includes superlethal doses of radio/chemo therapy.(9) Survival rates are significantly increased when children are treated in remission rather than relapse.(10)

Transplants are described by three terms depending on the source of the donor marrow. In syngeneic transplants, marrow is obtained from an identical twin, and is genetically identical to the recipient's marrow. In allogeneic transplants, donor marrow is genetically matched (histocompatible), but not identical to the recipient's. An allogeneic donor may be a sibling, another family member or an unrelated person who has donated to a marrow bank. Donor marrow is obtained through aspirations from the iliac crest and given to the patient in the form of a blood transfusion. In an autologous transplant the recipient's own marrow is removed, stored and reinfused after the preparative regimen. Autologous marrow may be treated to remove any diseased cells.(1,7)

The process of marrow transplantation involves months of medical treatment. Prior to hospitalization the patient undergoes a workup that includes histocompatibility (HLA) typing, bone marrow aspiration, pulmonary function tests, nutritional assessment, a medical history and physical and a social history and assessment of coping skills in order to obtain baseline information. Family members are also tested to determine their suitability as potential marrow or blood product donors.

Intense treatment is started on admission to the hospital. The preparative regimen varies with diagnosis and medical status of the patient. In general, high dose chemotherapy and total body irradiation are used to destroy the cancer cells wherever they are in the body. In the process, the patient's bone marrow is destroyed and the patient is unable to produce any normal blood cells. The child is then "rescued" by an infusion of marrow from a donor. Until that marrow grows in the recipient's marrow space, the child may experience severe toxicity due to pancytopenia (including bleeding disorders and infections), mucositis, nausea and pain.

In addition, graft versus host disease (GVHD) can occur when the donor marrow recognizes the tissues of the host as foreign. GVHD can be mild to severe in intensity. It can involve the skin, liver and gut and may cause extreme pain and discomfort. Acute complications may require intensive nursing care including ventilatory support, hemodynamic monitoring and dialysis. Even without severe complications, the inpatient stay often lasts 6-8 weeks.

Following discharge, patients continue to need close follow-up to monitor for late complications.(11) In Seattle, patients are followed at an outpatient clinic for at least 100 days after the transplant. In some cases complications require readmission during this period.

Families enter marrow transplantation with high hopes that their child will be a survivor. During the course of treatment they are faced with months of risks, unpleasant experiences and uncertainty.

The family is the child's decision-making vehicle and primary source of support.(12) Difficult decisions are continually encountered during the transplantation process. Parents must weigh their hopes of life for their child against the risks associated with treatment. In many cases, marrow transplantation offers hope to an otherwise terminal situation. A 5% chance for survival is viewed as hope for ongoing life, rather than the grim reality that the child has a 95% chance of dying.(12) Once the decision has been made to proceed and the child has received chemotherapy and radiation, there is no turning back. The family is faced with the constant fear of life-threatening complications, graft failure, rejection and relapse. Their ability to cope is influenced by the child's age and developmental stage, and the unique set of circumstances, past experiences, and expectations they bring with them.

Most transplant patients have had previous hospitalizations that influence their response to BMT. In the authors' experience, when past hospital experiences

have been positive, the child and family are more likely to consider the hospital environment a safe place and have a high degree of trust in the members of the treatment team. On the other hand, negative past experiences can evoke a great deal of fear and anxiety. An assessment that includes subjective questions about previous hospitalization will increase understanding of each child's unique physical and psychosocial needs.

The majority of patients must temporarily relocate to another city or state to undergo treatment. This often involves separation from family and friends, and always involves separation from their familiar environment. Children can respond to these losses in a variety of ways. Some become very independent and assume increased respoonsibilities; some become quiet and withdrawn; some experience feelings of fear and abandonment; others become very dependent, demanding constant time and attention from care givers.

A child's behavior can be a reflection of his or her emotional ability to deal with the current situation. For instance, many children develop rituals of refusing to take oral medications or comply with bedtime routines. This is neither unusual nor abnormal. A gentle, but firm and consistent approach generally brings about positive results. Again, keep in mind that children are unique individuals and can be very unpredictable. A child who is usually pleasant and cooperative may suddenly become defiant, angry and uncooperative if his or her "new" environment changes. The arrival of an out-of-town parent or sibling can alter routines and the quantity of time and attention the patient has become accustomed to receiving.

Play is a valuable tool used to assist and encourage children to express themselves. Children will often verbalize their feelings, concerns and needs by projecting onto puppets or other toys.(13) Story telling, drawing and forms of artwork are also effective tools that can be used to facilitate the expression of emotions by children. A child's request to play is often equivalent to an adult's request for someone to talk to or be with to help dispel fear and anxiety.

Intervention may be necessary to facilitate coping within the family unit. The parents and significant others sometimes need assistance and advice in balancing the time and attention given to the patient, with that given to themselves, their spouse, and the other children. Siblings may need assistance to process grief, fear and feelings of rivalry. Donors are in an especially vulnerable situation and often have intensified needs.(14)

Psychosocial problems affecting the entire family may also occur post-transplant. The transition period following the return home can be especially difficult because the support of the transplant team is no longer available.(3) Parents may have anxiety over assuming responsibility for total care of the patient. Reestablishing a "normal" family life and assuming a healthy role for the patient can also be stressful. Sibling rivalry is often exacerbated and parents may struggle with relationship and role changes.

Survivors of marrow transplantation may face longterm complications that significantly impact quality of life. Chronic GVHD is the most prevalent complication, affecting about 30% of longterm survivors.(11) GVHD can affect the skin, liver, oral mucosa, eyes, GI tract, musculoskeletal system, esophagus, vagina, and recovery of the immune system. Immunosupressive therapy is often necessary for one year or more post-transplant.

Other late complications include cataract development, infections, pulmonary disease, and neurological problems. In addition, normal growth and development may be compromised Abnormalities in growth rate, growth hormone production, thyroid and adrenocortical function, and pubertal development have been identified.(15)

Growth rate and growth hormone production is often decreased. Children who have chronic GVHD, a history of cranial radiation, and/or received total body irradiation in one large dose have greater incidence of compromised growth(14). Synthetic growth hormone has recently become available and may be a treatment option for post-transplant patients. Not all children will experience abnormalities, but growth hormone, bone age and growth patterns should be carefully evaluated post-transplant(11,14).

The majority of children experience

delays in pubertal development(14). Most girls transplanted during the prepubertal period do not achieve menarche and most boys have abnormal spermatogenesis. Sex hormone levels can be abnormal and development of secondary sexual characteristics impaired. Children should be evaluated annually, as hormonal supplementation may be necessary to stimulate development of secondary sexual characteristics.

Thyroid function may be abnormal and adrenocortical function subnormal in some children post treatment(14). These conditions are usually asymptomatic, but careful monitoring is recommended and hormonal treatment may be necessary.

The impact of marrow transplantation extends far beyond the acute treatment phase and requires ongoing nursing intervention. When presented with the option of transplantation, families need information about the course of treatment, and longterm effects. Ethical concerns must be addressed to help families identify the best interests of the minor patient. During the acute phase, nursing can provide continuity in a course filled with unknowns. Nursing intervenes to promote comfort, relieve painful and noxious side effects, respond to critical emergencies and facilitate a meaningful death if transplant fails. Nursing care in the post-transplant phase involves careful monitoring and evaluation to promote an optimum quality of life to patients and their families. Care of transplant patients and families requires technical competency and deep human caring. Perhaps the most important role nurses assume is to keep hope alive.

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Curing cancer is not just the killing of malignant cells. It is also the preservation of the quality of a child's life. Children never lose their potential for developing. Involving parents and families in care helps children preserve that potential.

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CHILDREN AND DEATH

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Meeting the needs of the child with late stage cancer who is actively dying is a particularly important nursing role. This emotionally heightened time demands care of oneself to acknowledge one's own grieving. Then the nurse can be available to advocate for the child and his/her family, to be attuned to their grief processes, and to provide support based on their needs and values. With the dynamic relationships that exist within a family system, care of a child who is dying entails a family-centered holistic approach. This article will explore the perceptions and the impact for a child who is dying and the supportive measures to encourage living while dying.

Children's Concept of Death

Late stage pediatric cancer care raises issues of whether, when, by whom and how to discuss death. The choice not to inform a child who is dying may be perpetuated by the belief that children do not understand death. However, Wass and Stillion(1) suggest that children younger than 3 have a concept of death associated with separation. Between the age of 3 and 5, the child thinks of death as a temporary, sleep-like state. "Magical" thinking creates difficulty differentiating fact from fantasy.(2) Between ages 5 and 9, children believe death is distant and after age 9, death is recognized both as the termination of life and as a personal event.(1) Swains' research concludes like Nagy's that the nature of children's concepts of death is influenced by age.(3) Glicken suggests that environmental factors such as previous familiarity with death can accelerate a child's understanding and familiarity with the concept of death.(4)

Other authors contend that very ill children are indeed aware of their impending death. Bluebond-Langer's study of 3 to 9-year-old leukemic children indicated that most children were aware of their impending deaths, were sensitive to the parent's behaviors, and waited for the chance to talk about it.(5) Kubler-Ross reinforces the importance of listening to children and their symbolic meanings. She states that children are less fearful of death(6) than we adults may think. Similarly children's drawings can reflect their intuitive sense of what is happening to them.

Despite these indications of a child's awareness, talking about death often remains a taboo subject. This reflects adults' fears of an uncomfortable situation, and the fear that the child will lose the will to live if death is discussed. Yet to leave these words unsaid can create fantasies, fears, and limitations on the opportunity for family discussions and thus do greater harm. Timing is different for each family. A nurse's ability to sense and promote the right time and tone for these discussions is one of the most valuable interventions the nurse can provide.

Each child's response to dying and loss is reflective of her/his own nature.(6) A child, like an adult, sets his or her own pace and dies in his/her own character. Dying does not mean that children cease to celebrate their infancy, their childhood, or their adolescence. Many variables influence expressions of grief such as past experience with loss, spiritual beliefs, culture, relationships and developmental stage.(8) Gathering this data prompts tailoring interventions appropriately. In addition, Sourkes'(9) framework on loss provides a method of assessing the impact on a child in this transitional time.

Sourkes describes three dimensions of loss that these children and their families face: loss of control, loss of identity, and loss of relationships. Control may be threatened by the recognition of a finite span, changes in physical condition, discomfort from pain and symptoms, and grief. Toddlers and schoolaged children may feel loss of control from changes in their body image, loss of developmental milestones and from fears of being bad.

Control is a crucial developmental issue for all adolescents. To lose all control to a fatal disease is to strip the teenager of what life had explicitly promised him or her. Adolescents may exhibit rage and use denial to maintain that all-important sense of control.

The dying child may perceive himself as

not intact or as different. For infants, parents may react to their baby's changing body. Toddlers and preschoolers, who have immature concepts of causality, may blame themselves for the changes in their bodies. The school age child may feel vulnerable as their attendance at school and interaction with peers changes. The teenager is faced with concerns of disfigurement. Similarly, siblings of children with cancer may fear that they will deteriorate like their sibling.

Parents struggle with the potential loss of their parent role. For example, as a child nears death he/she may begin to let go by not wanting to be held. This physical separation may create frustration and sadness for the parent.

"Whatever the relationship, marital, child/parent, or sibling, the sense of impending absence is pervasive."(9) The child may fear being alone or leaving his parents behind. The fear of abandonment is intense during the age of 2 to 5 years. As a child develops, the loss of peer relationships can create a sense of isolation and rejection. Adolescents become increasingly concerned with their parents' welfare. Siblings (both the child with cancer and the sibling without cancer) face the impending separation of a playmate, a friend, and a role model.

Supportive Measures

One nursing approach to help the child and family maintain control is to provide anticipatory guidance and information to individual family members, or to suggest to parents ways to convey information to their children. Preventing pain also supports a feeling of control. Methods of supporting autonomy include a clear presentation of the options of palliative versus curative care, and dying at home or in a hospital setting. Inclusion of teenagers in decision making supports their independence. Even younger children's perspectives should be taken into account. Focusing on the child's and family's ability for self-care reaffirms control.

Being present to listen and to provide concrete problem-solving information will enhance an individual's self image. To school age children and teenagers, an open manner, not a forced communication, can lead to a mutually supportive environment. For a toddler and a pre-schooler, reinforcement that the changes are no one's fault and that they are loved is imperative to maintaining their sense of self. Encouraging touch reaffirms the worth of the child. Similarly, the clinician's availability conveys the belief that the child and the family members are valuable. Allowing and encouraging a child to be a child and to play, recognizes their inherent worth and supports their living while dying.

Clinicians can validate that relationships are important by encouraging family members, friends, schoolmates, and staff to maintain contact and provide support. We facilitate the final transition in life by supporting the individual "to live and to die in the context of the social relations that are meaningful to him/her."(10) Explanations that individuals express their grief and anger in different styles and paces helps family members anticipate and understand the behaviors and feelings of each other. In addition, allowing individuals the time to express their feelings about changes in relationships (verbally, in action, and with kinetic family drawings) legitimizes the grief process.

Summary

Working effectively with children and their families during the transition of terminal illness demands intelligent assessment, specific knowledge and skilled intervention. Compassionate and supportive nursing measures are directed at promoting a child's and family's control, each individual's identity, and all of the family relationships. This approach supports the child in living while dying.

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Oncology Nursing Society

Coming • Coming Together Home

May 4–7, 1988

Thirteenth Annual Congress
Pittsburgh, Pennsylvania
Home of the ONS National Office

LATE EFFECTS OF CANCER IN CHILDHOOD

Melanie Calderwood, RN, MN
Lead Supervisor
Hematology/Oncology Clinic
Children's Hospital & Medical Center

Due to recent advances in the treatment, a larger percentage of pediatric oncology patients are surviving and becoming adults. However, the treatment for leukemia and solid tumors may extend over several years, and include a variety of toxic therapies. Side effects and long term effects have become a major concern of health providers.

Many chemotherapeutic agents are toxic to the heart, endocrine system, urinary tract, lungs, brain and bone. Adriamycin™, for instance, can cause weakening of the cardiac muscle, leading to congestive heart failure.(1) Children treated with methotrexate and 6-mercaptopurine for leukemia can also exhibit transient liver damage.(2) However, many chronic disorders can be prevented by adjusting chemotherapy dosage. Close monitoring of side effects to determine toxicity is necessary throughout treatment to reduce long term negative effects.

Of great concern is the effect of treatment on the endocrine systems of these growing and developing children. Gonads are at high risk for damage from chemotherapy and radiation. In one study, 68% of long term survivors who had radiation to their ovaries had ovarian failure, and 23% had ovarian failure who received abdominal radiation. However, chemotherapy is not believed to cause ovarian failure, if administered to girls under 17 years of age.(3) Absence of secondary sex characteristics and low hormone concentrations have been reported in girls treated before puberty. Gonad function is usually unaffected by chemotherapy in prepubertal males. In both sexes, the degree and permanence of the gonadal damage from radiation or chemotherapy depends on age, the type of therapy used, and the duration of therapy. Combination therapy can cause greater damage than either chemotherapy or radiation alone.(4)

The effect of cancer therapy on growth patterns is also being studied carefully. Normal growth can be slowed during therapy. Normal growth may or may not resume after therapy is completed. Growth may be affected to a greater extent if chemotherapy is given during a normal growth spurt. Some patients show a deficiency in growth hormone with or without an effect on actual growth. Any long term survivors who do show a growth deficiency are evaluated and given replacement growth hormone as indicated.

Besides treating cancer, chemotherapy and radiation can also be carcinogenic. Long term survivors are clearly at greater risk for another cancer diagnosis (not a relapse) than is the general population. However, it is not known whether this increased risk is due to the previous therapy, a genetic predisposition or an environmental continuity.(5)

Psychological side effects are also documented in some long term survivors. One study found adjustment problems in 57% of childhood cancer survivors. These problems include depression, low self-esteem and anxiety. Cognitive and school performance can also be affected by the long absences or the decreased expectations of teachers. Several studies show IQ losses in children treated with cranial radiation and intrathecal chemotherapy. Deficits have been noticed particularly in arithmetic coding, short term memory and visual motor skills, but not in reading or spelling skills. These drops are more noticeable the younger the child when treated.(6,7) Job and health insurance discrimination is also a common problem reported by childhood cancer survivors.

Late effects of treatment have become more evident as more children survive their cancer. Health professionals are becoming more aware of these potential problems and are planning better therapies to reduce or avoid them. We are also educating families to these risks and to the best known ways to reduce or manage them.

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*** * * * CHANGE OF DUES NOTICE * * * ***

As of January 1, 1988 the PSONS dues schedule will be:

$15.00 renewal fee if paid by 3/1/88*

$20.00 renewal fee if paid after 3/1/88

those who have not paid dues by 5/1/88 will no longer receive chapter mailings.

* Receive a FREE DIRECTORY if paid by January 31st.

PUGET SOUND CHAPTER OF THE ONCOLOGY NURSING SOCIETY

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Oncology Nursing Forum:	Brenda Nevidjon Associate Editor
Research	Betty Gallucci, Member
Resolutions and Legislation	Patricia Mulhern, Committee Chairperson

PSONS Minutes of Business Meeting
November 16, 1987
8:30 p.m. 39 attendees

I. Call to Order - Janet Appelbaum, President

II. Welcome - Janet Appelbaum, President

III. Approval of minutes of September 17, 1987 Business Meeting

IV. Treasurer's Report - Elaine Falangus $8,939 in treasury

V. President's Report - Janet Appelbaum, President

3 paths ahead for PSONS:

1. Transition of leadership to new president. ONS mentorship program will be helpful. Policy & Procedure Manual is typed.

2. Immunology Class project - 100 responses to questionnaires. Community colleges are being approached.

3, Symposium - chance to reflect on last 10 years and talk with Debbie Mayer, President of ONS.

VI. Vice President's report - Joy Miller, Vice President. In January we will vote for new president and new secretary. President would attend ONS mentorship workshop.

VII. Committee Reports:

Newsletter - Janet Appelbaum - need advertising coordinator.

Research - Janet Appelbaum - meets once a month with Mel Habberman. Will conduct study of "PSONS only," "PSONS and ONS," and "ONS only" members.

Legislative - Joy Miller - Educational session - 17 attended session on current issues - Round table is planned for ONS Congress in Pittsburgh - will not do an ONS resolution this year.

Symposium - Brenda Navidjon - Title: Keeping the Promise: Celebrating a Decade of Clinical Excellence and Collegial Support. Six instructional sessions are planned. Debbie Mayer is keynote. Second

annual McCorkle lectureship will be given. Reception will be a celebration of ourselves.

Public Relations - Deb Clark - Sketch for banner presented - ONS logo needs to be added. Poster is planned. Photos are needed - representative of members of PSONS - need negatives or slides - agencies are being approached - will work with membership to get word out better. Will update liaison list.

Program - Gail Bireline - many topics will be covered at the symposium. Spring topic - marketing. Tacoma is requesting a southerly meeting place, i.e., Federal Way.

PSONS Library - growing.

ONF - Jan 15 for Pearl Moore Award - for nurses pursuing a BNS. Make donations collectively as chapter. Scholarships are available.

Historian - photographs are needed.

By-Laws - we are in transition and will probably not need By-laws in future.

Nominating - Carol Mikley will be new chair.

Membership - PSONS dues go from Jan 1 - Jan. 1. Many people have not paid this year. This year you will get a free directory if you pay dues by Jan. 31, 1988. After March 1, you will be assessed a $5 processing fee and your name will be cut from list.

VIII. Old Business: None.

IX. New Business:

1. Committee dinner is scheduled for Jan 8, 1988. Will be held at East/West Conference Room at FHCRC. Annual report will be generated.

2. Sue Baird will be 1/4 time editor of the Forum.

3. Make reservations for Pittsburgh.

4. ONS certification exam will be in Seattle in Oct. 1988.

Adjourn: 9:10 p.m.

NAMES in the NEWS

NEW MEMBERS

Marilyn Gardner - Virginia Mason Hospital
Judy Bests - Riverton Hospital
Ingrid Nielsen - U.W. (Grad Student)
Dionetta Hudzinski - Comm. Home Health
Angela McKeirnan - Providence Medical Ctr
Deana Dahl - University Hospital
Georganne Trandum - St. Joseph (Tacoma)
Kathleen Sullivan - NeoRx Corp.
Terry Lesley - NeoRx Corp.

PUGET SOUND CHAPTER HOTLINE!

PSONS has a telephone answering machine. For questions, concerns and comments regarding Chapter activities, please call:

(206) 329-4411

Mon-Fri 8:00 A.M. - 5:00 P.M. only

Leave your message, name, telephone number and best times to reach you, on the tape recording.

PSONS NEWSLETTER

Published quarterly by the Puget Sound Chapter of the Oncology Nursing Society with the support of the American Cancer Society.
Editor : Kathleen Block

Letters, articles and announcements are requested from all PSONS members and other readers on topics of interest. Neither Puget Sound Chapter of the Oncology Nursing Society, the Oncology Nursing Society, the editorial board of the Quarterly, nor the American Cancer Society assume responsibility for the opinions expressed by authors. Acceptance of advertising does not indicate or imply endorsement by either of the above-stated parties.

Submit materials for publication to Kathleen Block, PSONS Editor, P.O. Box 85058, Seattle, Washington, 98145-1058.

LEGISLATIVE COMMITTEE NEWS

In keeping with the ethics focus of the PSONS, this past fall, the legislative committee sponsored an evening discussion with Jim Speer, a lawyer and ethicist in the UW school of medicine's department of biomedical history and ethics. Dr. Speer spoke to an audience of fourteen and discussed the issues surrounding the Washington Natural Death Act.

Over a three hour period, the concepts of patient autonomy, decision making in medicine, informed consent, living wills and durable power of attorney were developed. Dr. Speer posed several provocative questions about the implications of adding durable power of attorney (endures through patient incompetence) to the existing Washington Natural Death Act. He challenged the belief that families always have their ill family member's best interest at heart when they exercise power of attorney.

If you are interested in learning more about these issues, please feel free to join the legislative committee the third Thursday of each month (Elliott Bay Book Company Cafe, 7 a.m.). We have also established a one year contract with Patty Joynes, director of government relations and nursing practice for WSNA, to help us follow current legislative issues in Washington State.

Nurse Lobby Day in Olympia is scheduled for Monday, February 1, 1988. Scheduled activities include: a legislative update; a PUNCH luncheon; appointments with legislators; observation of committee hearings and an evening reception. For further information contact Ingrid Nielsen (328-1279). Hope to see you there!!

Ingrid Nelson

PUGET SOUND ONS

10TH ANNUAL SYMPOSIUM
FEBRUARY 26 & 27, 1987

MARK YOUR CALENDAR

"Keeping the Promise: Celebrating a Decade of Clinical Excellence and Collegial Support"

Keynote Speaker: Deborah Mayer, MSN, RN, OCN
President, Oncology Nursing Society

Four Seasons Olympic Hotel, Seattle, Washington

KEEPING THE PROMISE: CELEBRATING A DECADE OF CLINICAL EXCELLENCE AND COLLEGIAL SUPPORT

By now you've received the postcard reminding you to reserve February 26 and 27 to attend our 10th Annual Symposium. The Symposium committee has been working diligently to create a symposium which acknowledges the breadth and depth of the talent that is a part of our ten year history. We feel most fortunate that Debbie Mayer, President of the Oncology Nursing Society, will be the keynote speaker. In her busy ONS travel schedule, she did not have obligations for February and accepted our invitation.

To cover a wide scope of topics, the committee has developed six instructional sessions. The speakers are members of our chapter or have been closely affiliated with us in the past. The topics include spirituality, the immune system, oncologic emergencies, emotional well-being, nutrition, and practice in outpatient settings. Sixteen roundtables expand the opportunity for participants to discuss practice, professional, and personal topics. Fran Lewis is this year's McCorkle lecturer. She will be discussing the impact cancer has on the family. The two days will conclude with a panel of people who have survived cancer and are willing to share their experiences with us.

On Friday at 4:30 p.m., the annual wine and cheese reception will be held but will have a more celebratory focus this year. Special guests are being invited to join us and festive catering is planned.

The committee hopes that you will be there.....and that you invite a colleague.

-Brenda Nevidjon
Symposium Chairperson

"I resolved to lose 20 pounds this year . . . I only have 30 more to go."

UPCOMING WORKSHOPS, LECTURES, PRESENTATIONS

Current Issues in Nutrition
Sponsored by: U. W. Continuing Nursing Education
March 24-25
Honolulu, Hawaii
$135.00 10.2 CEUs
Contact: U.W. Continuing Nursing Education
SC-72
Univ. of Washington
Seattle, WA 98195

Bridging the Nation: Managing High Touch in a High Tech World
(1st Annual Conference of Canadian Association of Nurses in Oncology)
Sponsored by: Canadian Association of Nurses in Oncology and The Cancer Control Agency of British Columbia
October 19-22, 1988
Hotel Vancouver; Vancouver, British Columbia, Canada
$225.00 (before 7/31/88; $275.00 after 7/31/88; $325.00 on-site)
Contact: CANO 1988
750 Jervis St., #801
Vancouver, B.C., V6E 2A9
Telex: 04-352848 VCR
(604) 681-5226

Current Trends in Infusion Therapy: 1988 Update
Sponsored by: Innovative Health Care Services
February 19-20
Seattle Airport Hilton
$110.00 12 CEUs
Contact: Innovative Health Care Services
177 Webster Street
Suite A-480
Monterey, California 93940
(408) 372-2848

Pain and Symptom Management In the Terminally Ill: An Educational Seminar
Sponsored by: Hospice Care, Inc.
March 3-5
Hyatt Regency Hotel, Embarcadero Center, San Francisco, California
$485.00 18 CEU's
Contact: Doreen Gonzalez
Hospice Care Inc.
100 N. Biscayne Boulevard
#500
Miami, Florida 33132
(305) 374-4143

Bridging the Gap: Addressing Chemical Dependency in a Family Service Setting
Sponsored by: Lutheran Family Training Institute
February 19-20
Portland, Oregon
$110.00
Contact: Kristen Tooley
(503) 231-7480

Marrow Transplantation: 2nd International Nursing Symposium
Sponsored by: The Seattle Marrow Transplant Nursing Consortium
October 14-15, 1988
Fred Hutchinson Cancer Research Center
For additional information/brochure, please contact:
Corrine Powell
Marrow Transplant Symposium
1124 Columbia St.
Seattle, Washington 98104

Upcoming Spring Courses
Sponsored by: U.W. Continuing Nursing Education:

- Psychosocial Care of the Elderly - April 8
- Closing the Gap: Nursing Management of Dermal Ulcers - April 14
- General Oncology Update for Physicians and Nurses - April 28-29
- Nutrition and Women's Health (Vancouver, B.C.) - May 12-13

For additional information contact:
U.W. Continuing Nursing Education
SC-72
University of Washington
Seattle, Washington 98195

Registered Nurse Refresher Course: An Opportunity to Return to Hospital Nursing
Sponsored by: Swedish Hospital Medical Center
February 16 - April 8
Swedish Hospital
Nursing Staff Development Department
No enrollment fees

Contact: Susan Roth, RN
Nursing Personnel Department
747 Summit Ave.
Seattle, Washington 98104
(206) 386-2141

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Summary

Unlike adult cancer, childhood cancer is rare and occurs at a relatively constant annual rate. Cell growth characteristics of childhood cancers often differ markedly from those of adult malignancies, and childhood cancers tend to be more responsive to therapy. The most common cancers in children are generally uncommon in adults. Many advances in the treatment of cancer have resulted from studies done in children with cancer. ●●

continued from page 3

The vast majority of children with leukemia return to their classrooms. Their friends, school teachers, principals and classmates' parents may need significant education about childhood cancer in general, and its effect on this child in particular to help the child return to as normal a school life as possible.

In conclusion, many differences exist between the adult and child who has ALL. The specific age and development of each individual child can play a vital part in how he or she (and his or her family) is treated. Children need more than medical expertise, they need lots of love and understanding. Having cancer as a child is no fun, but we caregivers can help make it not seem so bad.

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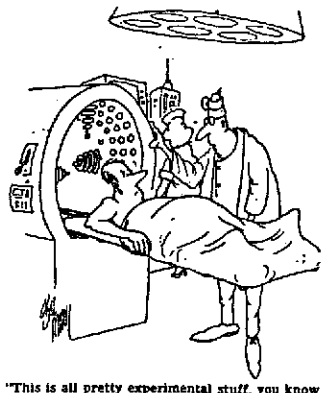

"This is all pretty experimental stuff, you know ... all we're really certain of is that it's going to cost you $2,500..."

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The Oncology Nursing Society,
in cooperation with the Nursing Project
of the
International Union Against Cancer (UICC)

invites ONS members

to participate in the

IN TOUCH Program.

The UICC, a worldwide association of 254 organizations in 84 countries, is dedicated to raising the standards of professional and public education in the field of oncology. The UICC's Nursing Project focuses on preparing nurses, particularly in developing countries, for a more active and effective role in cancer care.

By participating in the IN TOUCH Program, ONS members can reach out and share oncology nursing practice knowledge and skills with nurses from other countries.

ONS members who enroll in the IN TOUCH Program will submit information about their professional interests and practice settings. Through its publication, The International Cancer News, the UICC will invite nurses from around the globe to contact ONS National to be matched with an oncology nurse in the U.S. When the Society is contacted by a nurse from another country, we will review our IN TOUCH file to make a complementary professional match. Both nurses will receive a letter informing them of the match. Once IN TOUCH, the ONS member and their international counterpart can arrange mutual support and information exchanges in writing, by telephone or, perhaps, through visits to each other's countries.

To enroll in the IN TOUCH Program, complete the following information and return to the ONS National Office.

_____ Yes, I would like to enroll in the IN TOUCH Program!

Name_____ ONS Member ID Number_____

Home Address_____
City/State/Zip

Business Address_____

_____
City/State/Zip

Telephone Numbers - Home (____)_____ Work (____)_____

Position_____

Primary Area of Practice_____

Primary Practice Setting_____

ONS members need not have a command of a second language, however, this skill could be helpful in some instances.

Additional Language _____ Can Speak_____ Can Read_____

RETURN TO: IN TOUCH PROGRAM
Oncology Nursing Society
1016 Greentree Road
Pittsburgh, PA 15220-3125
412/921-7373

ONCOLOGY NURSING SOCIETY
1016 GREENTREE ROAD
PITTSBURGH, PA 15220
412-921-7373

For Office Use Only

_____ Member Number

_____ Exp. Date

_____ Fee Rec'd

_____ Cur. Date

_____ Code

PLEASE PRINT AND COMPLETE ALL INFORMATION TO PERMIT PROCESSING OF APPLICATION:

MEMBERSHIP INFORMATION

____ RENEW ____ NEW ____ REJOIN

____ ACTIVE ____ STUDENT

____ MISS ____ MS. ____ MRS. ____ MR. SOCIAL SECURITY # _____

_____ Last Name _____ First Name _____ M.I

Credentials you presently use following your name: _____

HOME ADDRESS:

_____ Street

_____ City State Zip Code

( ) _____ Area Code Phone Number

BUSINESS ADDRESS:

_____ Institution

_____ Address

_____ Address

_____ City State Zip Code

( ) _____ ( ) _____ Area Code Phone Number Ext.

FEDERAL CONGRESSIONAL DISTRICT#_____
(Listed on your voter registration card)

PREFERRED MAILING ADDRESS: ____HOME ____ BUSINESS

ONCOLOGY NURSING SOCIETY INFORMATION

ONS Local Chapter member ____ YES ____ NO If Yes, chapter name _____

Total years: _____In Nursing _____ In Oncology _____ In ONS

_____ Number of previous ONS Congresses attended ONCC Certified _____ YES _____ NO

EDUCATIONAL INFORMATION

Current Education Status:

(Check only one)

____ Full time student

____ Part time student

____ Currently not enrolled

(Check only one)

____ Undergraduate

____ Graduate

____ Post-graduate

Highest Degree Completed: (Check only one in each cagetory.)

(A) Nursing	(B) Other Field
____ Diploma	____ Diploma or Certificate
____ Associate	____ Associate
____ Bachelor	____ Bachelor
____ Masters	____ Masters
____ Doctorate	____ Doctorate
	____ None

(over)

PROFESSIONAL INFORMATION

Employment Status (Check only one):

___ Full time
___ Part time
___ Unemployed

Primary Functional Area (Check only one):

___ Administration
___ Education
___ Research
___ Patient Care
___ Other _____
Please Specify

Primary Position (Check only one):

___ 1 Staff Nurse
___ 4 Head Nurse
___ 7 Clinician
___ 2 Nurse Practitioner
___ 5 Clinical Nurse Specialist
___ 8 Educator
___ 3 Supervisor
___ 6 Director/Assistant Director
___ 10 Researcher
___ 11 Consultant
___ 9 Other _____
Please specify

Primary practice setting (Check only one):

___ Hospital
___ Outpatient/Ambulatory Care Clinic
___ Public Health/Community Nursing
___ Hospice
___ Home Care
___ School of Nursing
___ Private/Group Practice
___ Physician's Office
___ Other _____
Please specify

Primary Area of Practice (Check only one):

___ Chemotherapy
___ Immunotherapy
___ Hematology/Oncology
___ Radiation Oncology
___ Surgical Oncology
___ GYN Oncology
___ Head and Neck Oncology
___ Other _____
Please specify

Patient Population (Check only one):

___ None
___ Adult
___ Pediatric
___ Both

MEMBERSHIP CATEGORIES - Membership extends for one year from the date of receipt of the completed application and payment. As part of your dues, you will receive an annual subscription to the *Oncology Nursing Forum*, the official publication of the Oncology Nursing Society. This subscription is valued at 50% of the regular subscription price to individuals. Dues also include an annual subscription to the *ONS News*.

$_____ $53.00 (U.S. Dollars) - active membership - only registered nurses are eligible.

$_____ $95.00 (U.S. Dollars) - two-year reduced rate - active membership - only registered nurses are eligible

$_____ $26.50 (U.S. Dollars) - student membership - only full time students are eligible.

$_____ $2.00 or $_____ - optional - suggested tax-deductible contribution to support the Oncology Nursing Foundation scholarship, research and public education programs
Designation: ___ Scholarship ___ Research ___ Public Education

METHOD OF PAYMENT - I have enclosed a check or money order in the amount of $_____. Please make check payable to **Oncology Nursing Society.** Non-U.S. residents, please state "U.S. Funds" on your check.

___ VISA ___ MASTERCARD CARD NO._____ _____ _____ _____ CARD EXP. DATE _____

_____ Name as it appears on credit card.

_____
Signature

_____
Date of Application

PSONS MEMBERSHIP

REMINDER

Dear Santa:
Please pay my mom's PSONS dues for X-mas.
Love,
Stephanie
P.S. - I've been a good girl, too.

(for you:)

Membership Application

PUGET SOUND CHAPTER ONCOLOGY NURSING SOCIETY

P.O. Box 85058 • Seattle, Washington 98145-1058

Employment: Full Time____ Part Time____ Unemployed____
Highest Degree: Diploma___ Associate___ Bachelors___ Masters___ Doctorate___
Functional Area: Patient Care___ Administrative___ Research___ Education___
Specialty: Chemo___ Radia___ Surg___ Immuno___ Home care___ Other___
Patient Population: Adult____ Pediatrics____
Total years in Nursing____ in Oncology____

☐ NEW ☐ RENEWAL
☐ ONS Membership Number _____ Expiration Date _____
☐ I give permission to be included in PSONS membership directory.
Credentials _____

Business Address (If different)
Institution _____
Address _____
Address _____
Street _____
City _____ State ____ Zip _____
Phone (H) _____ (W) _____

Last Name _____ First _____ Middle _____
Preferred Mailing Address:
Street _____
City _____
State _____ Zip _____

____ DUES $15.00
____ DONATION ____to PSONS Local Chapter ____to ONF
____ TOTAL SUBMITTED

Dues are $15.00 (in U.S. dollars) per year and must accompany this application. Membership runs from January 1 to December 31. Send your check or money order made payable to PS-ONS to the above address. No partial payments are accepted during the year.

MEMBERSHIP APPLICATION

(for a friend:)

Membership Application

PUGET SOUND CHAPTER ONCOLOGY NURSING SOCIETY

P.O. Box 85058 • Seattle, Washington 98145-1058

Employment: Full Time____ Part Time____ Unemployed____
Highest Degree: Diploma___ Associate___ Bachelors___ Masters___ Doctorate___
Functional Area: Patient Care___ Administrative___ Research___ Education___
Specialty: Chemo___ Radia___ Surg___ Immuno___ Home care___ Other___
Patient Population: Adult____ Pediatrics____
Total years in Nursing____ in Oncology____

☐ NEW ☐ RENEWAL
☐ ONS Membership Number _____ Expiration Date _____
☐ I give permission to be included in PSONS membership directory.
Credentials _____

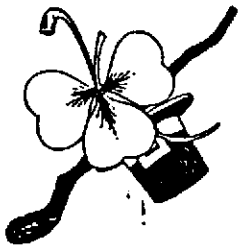
Business Address (If different)
Institution _____
Address _____
Address _____
Street _____
City _____ State ____ Zip _____
Phone (H) _____ (W) _____

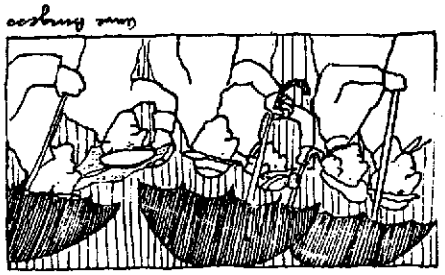
Last Name _____ First _____ Middle _____
Preferred Mailing Address:
Street _____
City _____
State _____ Zip _____

____ DUES $15.00
____ DONATION ____to PSONS Local Chapter ____to ONF
____ TOTAL SUBMITTED

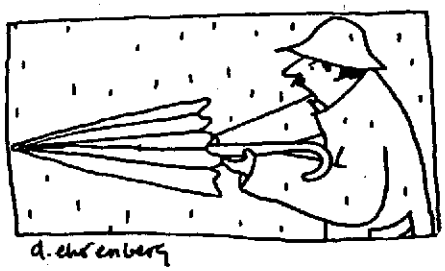
Dues are $15.00 (in U.S. dollars) per year and must accompany this application. Membership runs from January 1 to December 31. Send your check or money order made payable to PS-ONS to the above address. No partial payments are accepted during the year.

MEMBERSHIP APPLICATION





American Cancer Society
Washington Division, Inc.
2120 - First Avenue North
Seattle, Wa 98109



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