Puget Sound Quarterly

Vol. 13, No. 4
Autumn, 1990

PUGET SOUND ONS

ONCOLOGY NURSING SOCIETY

Enterostomal Therapy and Oncology Nursing:

Collaborative Practice

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President's Message

Joy Miller Knopp, R.N., M.N., O.C.N
Overlake Hospital Medical Center

I first want to update you on some ONS highlights.

The 1991 Congress to be held in San Antonio will be four days in length with opening ceremonies on Wednesday morning (Theme: Common Heritage - Frontier Spirit). The Oncology Nursing Forum will increase frequency to 8 issues in 1990, and 10 in 1992. Also the ONF will now be in the Index Medicus and on Medline! There are now 16,867 ONS members. The "average" nurse member is a hospital staff nurse, working full time, with 7 to 15 years oncology experience, and a BSN.

At our June PSONS Board retreat, Patty, Barb, Betty, and myself reviewed PSONS activities and budget for 89-90. As you may remember, we raised our dues from $15 to $20 last year, an increase felt necessary to maintain a strong financial standing and quality services for our members. This continued the precedent of raising our dues instead of using our reserves to balance the budget.

While a full report of this year's (90-91) budget will be published in the next Quarterly, the board was pleased to find that projected expenses easily balanced projected revenues. The committees are attempting to make their programs more self-sufficient and our membership has remained strong. To guide us in this next year, the board developed these goals:

1. Continue to provide quality education offerings to our membership.
2. Assure financial "health" of PSONS.
3. Maintain stable leadership with renewal.
4. Assess the needs of the membership particularly in areas of high population growth and rural areas.
5. Improve the orientation process for new members.
6. Support a visionary approach to health care.
7. Support membership involvement in ONS.

From the Editor

Linda Brubacher, ARNP, ET
Virginia Mason Medical Center
Guest Editor

"Embrace the Scope" was the title of the 22nd annual conference of the International Association for Enterostomal Therapy. ET nurses are viewed by many health care professionals as nurse specialists primarily involved with the acute and rehabilitative care of people with stomas and draining wounds. The expanded scope of practice includes nursing interventions related to dermal ulcers, pressure sores, and incontinence. Practice settings and personal preference frequently determine the extent of the expanded scope of practice. ET nurse educational programs, the board certification exam, and the educational offerings provided at the annual IAET conference reflect the expectation and support for an expanded role. As ET nurses see a greater variety of patients, it becomes evident that we need to collaborate with more nurses in various areas.

Wound care in the oncology setting could involve nursing management strategies associated with complications of malignant fungating lesions. These include infection, necrosis, drainage, odor, bleeding, and pain. The ET nurse could be consulted regarding the most effective wound irrigation, topical treatment such as a nonadherant dressing, and the most current strategies for odor control. This year at the IAET conference we learned about the use of topical metronidazole in malodorous, ulcerating skin lesions.

Altered skin integrity as the result of radiation therapy could result in a joint consult between a radiation oncology clinical nurse specialist and a ET nurse. New surgical procedures for cancer patients could be another area where ET nurses are utilized.

This issue of PSONS Quarterly will focus on areas related to oncology patients, nurses, and ET nurses at Mountain States Tumor Institute in Boise, Idaho, Assured Home Health and Hospice of Chehalis, Washington, and Virginia Mason Medical Center in Seattle, Washington.

ATTENTION
All PSONS Members
(Especially Board members & Committee Chairpersons)

The deadlines for items to be included in the Newsletter issues are as follows:

1990 Special Year-End Issue • *September 28*
Winter, 1991 • *December 10*
Spring, 1991 • *February 28*

Please submit your calendar of meetings as soon as possible and all committee reports throughout the year by the above dates.
Thanks!

The E.T. Nurse Role in the Special Needs of the Oncology Patient

Vicki Mueller, R.N., C.E.T.N.
Denise Murray, R.N., C.E.T.N.
Enterostomal Therapy
Mountain States Tumor Institute
Boise, Idaho

Mountain States Tumor Institute is a multi-disciplinary cancer treatment center which offers outpatient oncology services in chemotherapy, radiation therapy, hospice, family counseling and enterostomal therapy services. It is a regional diagnostic, treatment, education and research center. Approximately 49,700 procedures are performed annually.

The role of the E.T. Nurse has been demanding in not only working with patients with stomas, but has provided an opportunity for tremendously expanded services over the past 13 years. Exteriorized tumor and odor management presents a great challenge to the client, family, and nursing staff. If the tumor location, drainage, or odor interferes with daily activities and personal comforts, then more than a standard gauze dressing is required. Externalized tumors are often friable and dressing removal or rubbing due to clothing may cause potential for hemorrhaging. Non-adherant dressings, such as Adaptic, Lyofoam, or Elastogel will prevent trauma when removing the dressing. Net dressings replace tape to secure dressings when possible. If tumor bleeding is noted Gelfoam acts to stop bleeding and may be needed in the home setting.

Odor control may be achieved by gentle cleansing in a shower or using a spray cleanser such as Carrington's Cara-Klenz or other commercial skin cleanser (Uniwash, Peri Wash, Constant Care). Puriclens (Sween Co.) is a cleansing and deodorizing gel, Malodex Spray (Kaylen Co.) or Ostozyme (Shelton Co.) may be sprayed or squeezed directly on the odor source and or dressings. Charcoal impregnated dressings, as exterior dressings, filter odor.

Drainage containment may be achieved through the use of pouching systems, dressings, and exudate absorbing products. The new calcium alginate dressings (i.e. Kaltostat, by Calgon Vestal) form a gel which is painless to remove. They may be pre-moistened to increase adherance due to body contour or minimal exudate.

Skin and tissue damage following drug extravasation may require surgical reconstruction. Immediate wound care involves support of damaged tissues through gentle cleansing and moist dressings. Our current wound treatment generally is b.i.d. cleansing with Carrington Cara-Klenz and application of Carrington gel covered with normal saline moistened gauze. Use of a hydrophyllic dressing on a clean, shallow wound may be utilized to enhance wound healing. If necrotic tissue is visible, debridement through dressing, autolysis, surgery, or enzymatic debridement may be indicated.

Routine stomal evaluation at the beginning of chemotherapy and radiation therapy is performed to establish a baseline and to educate the patient regarding special needs while on chemotherapy or radiation therapy. The patient is encouraged to discontinue irrigation if diarrhea ensues during chemotherapy or radiation therapy to the G.I. tract or if the patient becomes immunosuppressed. The patient can develop mucositis on the stoma, as well as orally. If the patient is anemic they may have a very pale stoma. Patients are evaluated for stomal tumors and parastomal tumors.

The patient may be required to change the current pouching system to minimize skin problems during radiation treatment. Reusable appliances are discouraged if the patient becomes leukopenic to decrease the potential of infection. Additionally, we alert the patient and staff to chemotherapy drugs that are excreted via the G.U. or G.I. tract so that safety precautions may be used (such as gloves) when emptying appliances and replacing them.

Altered skin integrity as a result of radiation therapy is a concern to our patients and our practice. We have developed a close working relationship with our radiation oncologists and radiation therapists. In fact, we will soon design a study to see if we can systematically effect a decrease in expected skin reaction.

Radiation disturbs the balance between basal cell production and surface cell destruction. As a result, skin reaction can include erythema, peeling, moist desquamation, pruritis, alopecia, and increased pigmentation. We note surfaces at risk to include boney prominences, surgical wounds, and skin folds (under breast, axillae, groin, and perineum). Fortunately, these reactions are temporary and resolve after therapy is completed within days to weeks.

Factors that affect the degree of reaction are dependent on total dose, size of the treatment field and time interval between surgery, radiation, and chemotherapy, a patient's age, nutrition, skin type and general health status.

General guidelines for skin care while on radiation therapy are given to our patients as indicated.

1. Do not remove ink marks. They must be kept during the treatment course. Do not scrub the treatment areas. Let lukewarm water run over the area. Avoid hot water. If using soap, use one without deodorants, perfumes or dyes. (Oatmeal based soaps, i.e. Aveeno may be helpful.)
2. For general dryness and itching check with therapist or physician. We use Nivea or Sween cream after treatment and at hour of sleep. Do not use before treatment.
3. Do not use powder with cornstarch if skin folds are moist or skin is broken. Do not use powder with talcum or zinc oxide products.
4. Do not wear tight fitting clothing that rub or constrict area of treatment. Cotton undergarments allow for absorption of perspiration. Use mild detergent in washing clothing.
5. Do not use a heating pad or hot water bottle.
6. Do not shave treatment areas without checking with therapist (can trim hairs close to skin surface).
7. Do not expose treatment area to the sun during and after treatment.
8. Do ask questions.

In the acute care, outpatient and home settings the oncology patient may experience a variety of cutaneous problems. The enterostomal therapy nurse is trained and experienced in consulting and management of the variety of special needs.

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Rodriguez, D. "Special Considerations: Care of the Ostomy Patient Receiving Cancer Therapy" in *Principles of Ostomy*. Mosby; St. Louis, 1982, 381-389.

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Nursing Interventions With the Continent Urinary Kock Pouch Patient

Lynda L. Brubacher, ARNP, ET
Enterostomal Therapy
Virginia Mason Medical Center

A continent urinary diversion stores urine internally, enabling patients to be free of an external collecting device. Recently, many forms of continent intestinal urinary diversions have been described. These include the Kock pouch (pronounced "coke"), the Indiana pouch, the Mainz pouch, and others. The Kock pouch continent urinary diversion has been done in the United States since 1982 and has the longest follow up and largest patient series, with excellent long term results. This procedure was developed in the 1970's by a Swedish surgeon, Dr. Nils Kock. A newer procedure, the Kock pouch to the urethra, has been done since 1986 and is available for a select group of male patients. These procedures are not simple to surgically construct and the urological surgeon may refer these patients to a facility where they are performed more frequently.

Dr. T. R. Pritchett has performed a number of both procedures before arriving at Virginia Mason Medical Center, and over the past two years at VMMC. Patients are referred from various parts of the United States for these procedures.

The Koch pouch cutaneous continent urinary deversion

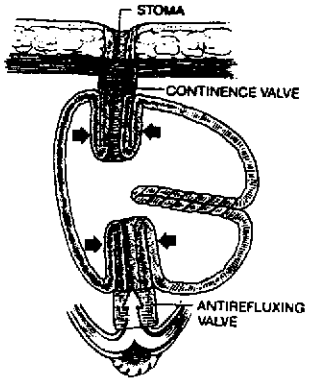

Figure 1
Cross-section of the Kock pouch. The one-way valves of intussuscepted ileum collapse as the pouch fills (solid arrows). The pressure on these nipple valves maintains continence and prevents reflux while allowing the urine to enter the pouch via the afferent valve (open arrow).

* All figures reprinted with permission from Pritchett, T.R., "Bladder Replacement with the Kock Pouch: A Continent Urinary Diversion," **Virginia Mason Clinic Bulletin** 1989; 43:73-81.

The Kock pouch cutaneous continent urinary diversion: Patients with malignancies of the genitourinary tract, congenital anomalies or problems related to neurogenic bladder, may be candidates for this type of surgical procedure. Patients with a traditional ileal conduit urinary diversion have been successfully converted to the Kock pouch.

The body of the pouch and two nipples valves are constructed from a 21/2 to a 3 foot segment of ileum. The proximal, or afferent, nipple valve is constructed to allow filling of the Kock pouch from the upper urinary tracts. As the pouch fills, the pressure on the nipple valve causes it to collapse, creating a one way valve constructed by a technique of intussusception. This prevents reflux of urine in the Kock pouch up into the ureters and kidneys (Figure 1). The other nipple valve, which is the distal or efferent nipple valve, allows for catheterization through a small abdominal stoma into the internal pouch for drainage (Figure 2). As the pouch fills, pressure is applied on the efferent nipple valve so that it collapses, preventing leakage of urine from the stoma. Pouch capacities can eventually average up to 1000 cc.

This procedure satisfies many of the requirements of the ideal continent urinary diversion. Reflux is prevented (the incidence being less than 1%), continence is achieved (efferent nipple valve leakage occurs in 10% to 15% of the cases), it is a low pressure reservoir and easy for the patient to empty. It is not recommended for all cystectomy patients. Carefully selected and motivated patients are crucial. It should not be performed on patients with a short life expectancy, since it has a 10% to 15% risk of revisional surgery. Other contraindications for this procedure include:

- patients with renal insufficiency and a serum creatinine of 2.5 or greater. They are at risk for chronic metabolic acidosis problems because the intestinal mucosa absorbs chloride and excretes bicarbonate. It is controlled with the oral administration of sodium bicarbonate, or sodium-potassium citrate.
- patients who have inflammatory bowel disease or short bowel syndrome are not good candidates.
- caution needs to be exercised in patients who have undergone prior abdominal or pelvic irradiation, since they have an increased risk of problems with urine leakage and diarrhea.
- patients with multiple abdominal surgeries before high dose irradiation therapy should not have the Kock pouch procedure.

Kock pouch continent urinary diversion to the urethra: If the bladder neck, urethra and prostate are free of cancer or carcinoma-in-situ, and external sphincter function is intact, it is possible to construct a continent intestinal diversion and connect it to the urethra. Since the urethra and sphincter are removed in women during a cystectomy, it is not a surgical option for women.

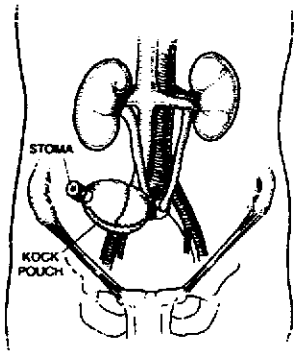

Figure 2
The pouch is located in the pelvis. The catheterizable stoma is usually in the right lower quadrant of the abdomen.

The Kock pouch to urethra is constructed from the terminal ileum. The nipple valve prevents reflux or urine to the ureters and kidneys. The edge of the Kock pouch reservoir is anastomosed to the urethra. These patients void by relaxing their external sphincter and allowing their internal bladder replacement to empty by gravity or gentle Valsalva maneuvers (Figure 3). If they experience the uncommon problem of difficulty voiding due to mucus plugging, they will need to pass a urethral catheter to drain the pouch. They usually have day time continence after a period of time, but up to 30% will have night time incontinence. Awakening every two to three hours at night to urinate can help patients maintain dryness. Some choose to wear a condom catheter or pads at night.

The ET nurse provides pre and post-operative patients instruction and support. Pre-operative preparation includes reviewing a video tape on Kock pouch anatomy and function, stoma site marking, and reviewing the purpose of the various drainage tubes. Assessing the patient's ability to learn self-care, identifying support systems, and

Kouch pouch continent urinary diversion to the urethra.

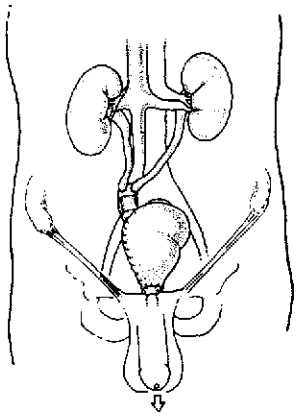

Figure 3
The pouch is located in the pelvis. Urination occurs through the penis without the use of a catheter.

emotional needs, are other areas that are addressed.

Post-operative care includes irrigation of the Medina catheter. This is a clear plastic catheter sutured in the stoma and connected to gravity drainage. Before the patient is discharged it is connected to a leg bag. This catheter enables the newly created reservoir to remain undistended so all suture lines heal properly. A Penrose drain will be placed in the left lower quadrant and will function like a safety valve to remove fluid that may develop during the healing process. It will be covered with an external urostomy collecting device. Nurses need to observe for the complication of reservoir leakage which is demonstrated by increased output from the Penrose drain site. Ureteral stents, which protect the anastomosis, will usually be visible in the right lower quadrant and be connected to a leg bag before the patient is discharged. Patients are taught to irrigate the Medina tube every four hours during the day because it exudes a large amount of mucus. They measure drainage from the Penrose drain site, reporting significant increased drainage to the M.D. These tubes remain in place for three weeks after surgery, and sometimes longer, if patency of the reservoir is a problem. Patients are given written instructions regarding home care of the drainage tubes and steps to take if they should become dislodged. They are also given an application for a Medic Alert bracelet. Approximately 21 days after surgery, the patient is readmitted to the hospital for a one night stay to learn Kock pouch care. An intravenous antibiotic injection will be administered the morning of the admission and the patient will go to the x-ray department for a Kockogram and an IVP. If the x-rays show no leakage of urine from the pouch, the Medina tube and stents will be removed. If Penrose drain leakage has not increased by the next morning, it is removed before the patient is discharged. The ET nurse instructs the patient in self-catheterization after the Medina catheter is removed, reviewing care of the catheter and potential problems. The catheterization schedule is every two hours during the day and every three hours during the night. After they are discharged, the time between catheterization will increase by one hour each week until the patient is catheterizing every six to seven hours during the day and not at all during sleeping hours. The patient uses a 20 or 22 French Coude catheter and cleans it with soap and water. A small amount of povidone-iodine solution is poured over the lumen of the catheter and the outside is washed with the same solution. The catheters air dry and are stored in a covered tray. Dressings for the stoma are female mini sanitary pads cut in thirds.

Patients need to expect some discomfort if the pouch becomes distended. They may experience pain in the back, cramping, nausea or a feeling of indigestion or fullness. This can result in nipple valve leakage requiring revisional surgery. They need to report problems of incontinence, symptoms of a urinary tract infection or pouchitis to their M.D. Pouchitis could be manifested by malaise, elevated temperature, back pain, increased mucus, strong odiferous urine or urine leakage from the stoma. If an established Kock pouch patient is admitted to the hospital, it is important for the nursing staff to be aware of some of the basic information regarding catheterization if the patient is being diuresed, or if they are unable to be responsible for their own Kock pouch care.

- Tape in place a 20 French Coude catheter to straight drainage bag if the patient is being diuresed or if they require every one hour output. **Never use a Foley.** This could permanently damage the valve.
- Catheterize every four hours. If urine output is less than 300 cc. urine, catheterize every six. Note: This could vary according to the length of time the patient has had the Medina tube removed. Inquire about their catheterization schedule at home.
- Use a 20 or 22 French Coude catheter and clean them as previously described or check with the ET nurse.

Pre and post-operative care for the Kock pouch to the urethra patient is similiar to the Kock pouch cutaneous continent urinary diversion patient. Since they do not have a stoma, the urethral catheter drains urine from the Kock pouch. They are taught pre-operative self-catheterization in the event they experience mucus plugging after the urethral catheter is removed three weeks after surgery. On the second admission, 21 days after surgery, they receive written instruction regarding Kegel exercises and management of urinary incontinence.

The surgical options available to patients today create a new challenge for nurses during pre-operative education. Time must be devoted to being clear regarding each procedure. They need to have the option of talking to other individuals who have experienced the various surgical procedures. The value of a well prepared patient is frequently reflected during their post-operative rehabilitation.

References:

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Pritchett, T.R. "Bladder Replacement with a Kock Pouch: A Continent Urinary Diversion", *Virginia Mason Clinic Bulletin*, 1989, 43:73-81.

E.T. Nursing in Hospice, Oncology, and Home Care

Annette Yanisch Hayden,
RN, BSN, OCN, ET
Hospice Coordinator
Assured Home Health and Hospice
Chehalis, Washington

"You can put a man on the moon, but you can't get a bag to stick without leaking". Such was the lament that followed me for weeks as I struggled to find a pouching system for a 74 year old woman with multiple abdominal fistulas dying of colon cancer. After months in the hospital, she was sent home to die after her fistulas "miraculously closed". Within 24 hours at home, however, one fistula after another opened and "the battle of the bag" was on.

Thanks to our agency E.T. nurse we were able to develop a plan of care and, with trial and error, finally found a pouching system that 1) adhered for 2-3 days without leaking and 2) the daughter was able to change. Originally sent home with a prognosis of 2 weeks to 2 months, this patient lived an additional 8 months. My skills as an oncology nurse helped with the multiplicity of other problems this patient had, but in relation to her fistulas, I was helpless without my E.T. nurse. I wish I could find this daughter and tell her that I am now an E.T. nurse - in large part because of her mother.

I moved from homecare in Seattle to Lewis County about 1 1/2 years ago. I had always had an E.T. nurse consultant available in any work setting prior to this move and was surprised to find there was no E.T. nurse in all of Lewis County. Wound care was greatly compromised with unsuccessful treatments continued for lack of knowledge of alternatives. Stoma patients struggled with their lifestyle changes as well as practical matters of appliance leakage and proper-fitting. I have had patients prefer Glad sandwich bags to the leaking, poorly fitting appliances they tried. Many people isolated themselves rather than try to attempt an outing in public that would end in embarrassment. Seeing an opportunity for career diversification, as well as feeling that education in this area complements my oncology specialization, I completed the 2 month E.T. nursing education course at Abbott-Northwestern Hospital in Minneapolis, Minnesota. The knowledge that I have as an E.T. nurse has greatly enhanced my nursing practice and interacts well with my oncology/hospice/homecare background.

As the only E.T. nurse in Lewis County, I act more as a consultant than a primary nurse. I make joint visits with other nurses who listen and learn along with the patient; and then are more prepared for the next similar situation. With my oncology background, I am a resource for staff and patients as they have multiple post-op concerns, as well as

Continued on Page 10

Business Beat

Judy Kornell, R.N., M.N.
Fred Hutchinson Cancer Center

Education Committee

Betty Gallucci notes that the October 10th meeting will be held at the University of Washington's Urban Horticulture Center from 6-9 PM. The November meeting will feature on-site telecasting!

Clinical Practice Committee

Joanne Iritani, Annemarie Maguire, and Company are planning 2 educational offerings in the coming year. Their committee has compiled a resource list for the membership so we will know who to call when we have questions regarding pain and symptom management, or how to manage a cancer unit, and everything in between! These will be available at the next meeting and are to be included in the new member packets being designed for orientation to PSONS. At the October gathering a question box will be avilable for those who submit a written description of a clinical problem. Please leave a contact person's phone number for a response. The Clinical Practice Committee is open to new members at this time and meetings are scheduled to suit the geography of those attending. The past year they have been in the southcenter and downtown areas. "Corresponding" members are welcome too!

Membership Committee

HELP! Sue Ford asks anyone knowing the address of a Marilyn Taylor please call the hotline. She is a missing person - we have no mailing address for this member. We also need to know if you Canadian colleagues are receiving mailings as the postal rates for bulk are different between Washington and B.C.

American Cancer Society

This summer the American Cancer Society Oncology Nursing Colloquium had 6 participants for their 2 week session, Fran Lewis, our ACS Professor of Oncology Nursing reported. The women are from around the state and will return to their agencies/hospitals with a variety of information to further oncology nursing practice. The attendees were:

Jennifer Lee of Bothell (Northwest Hospital)
Rae Jean McPhillips of Oroville
Lynn Perry Borden of Shelton (Mason General)
Catherine Slawson of Olympia (Black Hills)
Jan Imas of Olympia (St. Peters)
Linda Wills of Yakima

ATTENTION:
New Mailing Address!

Puget Sound Chapter
Lake City Professional Center
2611 N.E. 125th St., Suite 305
Seattle, WA 98125-4357

Results of 1990 PSONS Membership Survey

— 54 respondents —

Average Length of PSONS Membership = 4.72 years

Common Reasons for PSONS Membership =
Networking, newsletter, professional contacts, symposium, link to ONS

Common Reasons for ONS Membership (National) =
Committee membership, receive the Forum, SIGs, Yearly Congress

Members that are affiliated with a Special Interest Group (SIG) = 46% of respondents

Members with O.C.N. = 40% of respondents
Members planning to get O.C.N. = 50%
Members requesting a review course = 57%

PSONS Committee Activity Most Valued
1. Newsletter, Clinical Practice, Education, Symposium
2. Government Relations
3. Membership/PR
4. Historian

Level of Membership Involvement
If not involved, why not? =
Live too far away, not interested, new and unaware of committees

What would make you want to get involved?
Personal invitation, know more about activities, commitment to 2 years

The meetings should be held in:
a) a consistent location = 46%
b) a rotation of locations = 54%

Should we offer CERPs at the educational offerings?
Yes = 38%
No = 62%

How many PSONS Symposiums have you attended?
Most have attended 2 or 3

Should travel awards be offered?
Yes = 91%
No = 9%

Is the PSONS directory helpful?
Yes = 89%
No = 11%

PSONS Profile

Judy Petersen, R.N., M.N., O.C.N. is what is affectionately known as an "old timer". She has been around and involved with ONS, ACS, and the UW Nursing School for a long time. A B.S.N. graduate of the University of Wisconsin at Madison in 1977, Judy went on to get her M.N. from the University of Washington in 1981. After working for awhile in Bellingham, she settled in as the Oncology Clinical Nurse Specialist at Northwest Hospital in 1983 where she has made her presence known through nursing and patient education, writing policies and procedures, consulting, and sharing her expertise with colleagues in a true team model. Judy was involved with Vicky Whipple (Providence - Everett) and Anna Quincy (Sacred Heart - Spokane) in the development of the highly acclaimed Chemotherapy Workshop developed under the auspices of the American Cancer Society. She has also been state chair for the Service and Rehabilitation Committee of ACS for the past 3 years.

Judy feels that the most pressing issue in oncology nursing today is maintaining enough nurses at the bedside with specialty training in oncology. The challenge is to keep continuing education programs at a level consistent with meeting the rapidly changing field of cancer care - but that's what makes it exciting! Judy would like to do some work in the area of early detection, screening, and risk assessment in the future.

Judy says her motto is "work hard, play hard". She enjoys her time off with husband Rick Taber (Fred Hutchinson), when hiking, biking, and gardening are a priority. The two plan to take a trip in the fall to Southeast Asia where they will spend two months touring Hong Kong, Indonesia, and Thailand. Judy says this is strictly pleasure - they don't intend to look up any medical professionals or investigate differences in health whatsoever - good for you! We look forward to hearing about this "vacation to die for" at a future PSONS meeting. Thanks Judy, for all your hard work!

PSONS NEWSLETTER
Published quarterly by the Puget Sound Chapter of the Oncology Nursing Society with the support of the American Cancer Society.
Editor: Anna Williams

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 Anna Williams, PSONS Editor, Lake City Professional Center, 2611 N.E. 125th St., Suite 305, Seattle, Washington, 98125-4357. (206) 386-2013

PUGET SOUND CHAPTER HOTLINE!
PSONS has a telephone answering machine. For questions, concerns and comments regarding Chapter activities, please call:
(206) 462-5385
24 Hours
Leave your message, name, telephone number and best times to reach you, on the tape recording.

Clinical Practice Review

Joanne Iritani, RN, MN, OCN
Nurse Manager
University of Washington
Medical Center

The Clinical Practice Committee surveyed the membership on current practices in the care of vascular access devices at the February PSONS Symposium. The results of this survey were presented at the April educational offering; results will be briefly reviewed here for those who were unable to attend the April meeting.

A total of 64 surveys were completed; 47 (73%) were from nurses in inpatient settings, 13 (20%) from outpatient settings, 3 (4%) from physician offices, 8 (12%) from home care agencies and 1 (1%) "other".

The most frequently used type of VAD in order of decreasing frequency: Hickman lines, implanted ports, Groshongs, and PICCs. All respondents stated their institutions had written policies for the care of patients with VADs.

Flush Procedure

The flush procedure for VADs varied by frequency, concentration, and solution of flush solution. Some consistencies were reported i.e. Hickman lines appeared to be flushed with Heparin 10 units/ml 2.5 cc. qd by the majority of respondents. There was a range however, with some respondents flushing with Heparin 10 units/ml 2.5 cc q8h, to those flushing with Heparin 100 units/ml 2.5 cc every five days.

The majority of respondents caring for patients with Groshong catheters reported flushing with normal saline, again with varying frequency and volume. There were some reports of flushing Groshong catheters with Heparin (10 units/ml and 100 units/ml) as frequently as every 8 hours, to an infrequently as once a week.

There appeared to be more consistency with implanted port flushing; most people indicated they flushed with Heparin 100 units/ml, with frequencies varying from daily, every two weeks, to every month.

PICC lines were flushed with Heparin 10 units/ml or 100 units/ml, again with varying volume (1 cc to 5 cc) and frequency (BID to once a month).

Frequency of Dressing Change

There was a range of responses to the frequency of dressing change for all VADs; responses ranged from every day to 2-3 times a week, to prn.

Most Frustrating Problem with VAD

The majority of respondents indicated that "no blood return" was the most frustrating problem with VADs. Other answers included: fibrin sheath formation, cracked hubs of Groshong catheters, inability to infuse fluids/blood, and length of time required to draw blood from PICCs.

Problems/Comments on Port Needles

The comments on implanted ports focused primarily on difficulty infusing high volume fluids, and drawing blood. Trouble shooting interventions ranging from position changes, to dye studies, and less frequently, urokinase administration. Urokinase concentrations commonly used were either 5000 units or 10,000 units. Several respondents also reported using 100,000 units, and 25,000 units.

The difficulty accessing and maintaining venous access was another difficulty mentioned by respondents. Many mentioned difficulty with catheter dislodgement, especially with peritoneally implanted ports.

Patient Education

The majority of respondents (62%) indicated that staff nurses are responsible for patient education on newly placed VAD's. Clinical nurse specialist (37%) and, in order of decreasing frequency, IV therapy, home infusion agency, nurse educator, pharmacist, and physician were responsible for patient teaching.

In summary, the survey results indicated all institutions had written policies/procedures for care of patients with VAD's. There appeared to be much variation in flush solution and frequency of flushing for patients with Hickman lines, implanted ports, Groshongs, and PICC's. There was also variation in Urokinase concentrations, with concentrations ranging from 5000 to 100,000 units. Because of the nature of this survey it was difficult to ascertain the specific conditions under which these variations in practice were occurring. The survey results presented above are not intended as recommendations for practice, but rather to provide clinicians with information regarding the variances in practice which exist in this community.

The Last Word

Renee Yanke, R.N., M.N
Whidbey General Hospital

Summer is almost over and everyone's been on vacation, so the news is a bit thin. The big event this summer has been the Goodwill Games which many of us attended. Some people took the extra step and participated in the Goodwill Games Marathon. Joy Miller Knopp came in 26th out of 750 runners on July 21st!! GOOD RUN JOY! (She told me she left her dog at home.)

In case any of you missed the news, Ryan Iwamoto, R.N., M.N. (Virginia Mason) was awarded the Lane W. Adams Award from the American Cancer Society. This is an award given by ACS nationally, based upon staff and patient recommendations. Congratulations Ryan!

On the ONS front, Janet Schwarz-Appelbaum, R.N., M.N. (NeoRx) has been named the chairperson of the Biological Response Modifier SIG (Special Interest Group). Congratulations!

Speaking of Biological Response Modifiers, the grapevine told me that Kathleen Block, R.N., M.A. (formerly Editor of PSQ) changed jobs in April. She is now working at Immunex as a Clinical Research Associate. Her work involves monitoring clinical trials of colony stimulating factors in Phase I - III trials, before the drug hits the marketplace. At Immunex, one of her assignments is working with "compassionate studies". A physician calls with a request for medication (usually for a patient with life-threatening neutropenia), and the drug is released to the physician if the patient meets criteria. Kathleen says the new work is very interesting, and working in private industry is a "new experience" from her former research position at Virginia Mason.

There are some of our local membership going "on vacation" to Colorado for the Pain Seminar sponsored by a Public Health grant. There were 500 applications returned to ONS and 75 selected from those. Betty Gallucci reports that a geographical distribution was a primary method of selection and that at least one applicant from 49 states was chosen. The more applications per state - the more participants that got in from those states - which means that even if you didn't get selected to go, your application may have made it possible for someone else from your state to get in! Washington had three applicants selected to attend and although Betty wouldn't spill the beans on who they were she did say they represented a geographical distribution from the state; Seattle, Tacoma, and Spokane. We do know that Anna Williams, R.N., M.N. (Swedish Hospital - Pain Service) will be facilitating one of the laboratory sessions on high-tech pain management. Have a great "vacation" and we're looking forward to future workshops!

Judy Moore, R.N., M.N. (HHC of Whidbey General) reports that she had a great time on vacation in Wyoming in July - and is now energized in looking for a new clinical supervisor as well as a full time nurse. Good luck Judy!

Dionetta Hudzinski, R.N., M.N. (St. Elizabeth HHC) reports that nurses in Yakima are getting ready for the OCN exam in September. Linda Belsky, the Clinical Specialist at "St. E's" has developed a review course using the ONS Core Curriculum to help prep the nurses. Good luck to everyone getting ready for the exam!

Interested in a short term project compiling the membership directory and developing a resource list? Call Patty Jordan on the hotline. Note - New date for the November meeting to be the week of the 26th (exact date undetermined yet). This will be an ONS teleconference with Seattle being the host and linkups with our fellow chapters in California. The topic - Supportive Care of the Chemotherapy Patient. Don't miss it. Are you looking for a new project to start this Fall? How about joining some of us in developing the new Pain Management Curriculum in association with the American Cancer Socicty. We are working on a program similar to the Chemotherapy Workshop that was created a few years ago. Please call Renee Yanke if you are interested in working on this at 1-678-7624. How about any of you Colorado participants? As always send all the scoop on what's happening in you part of the world to:

The Last Word
c/o Renee Yanke, RN, MN
Whidbey General Hospital
101 North Main Street
Coupeville, WA 98239-0400
or FAX (206) 678-7623

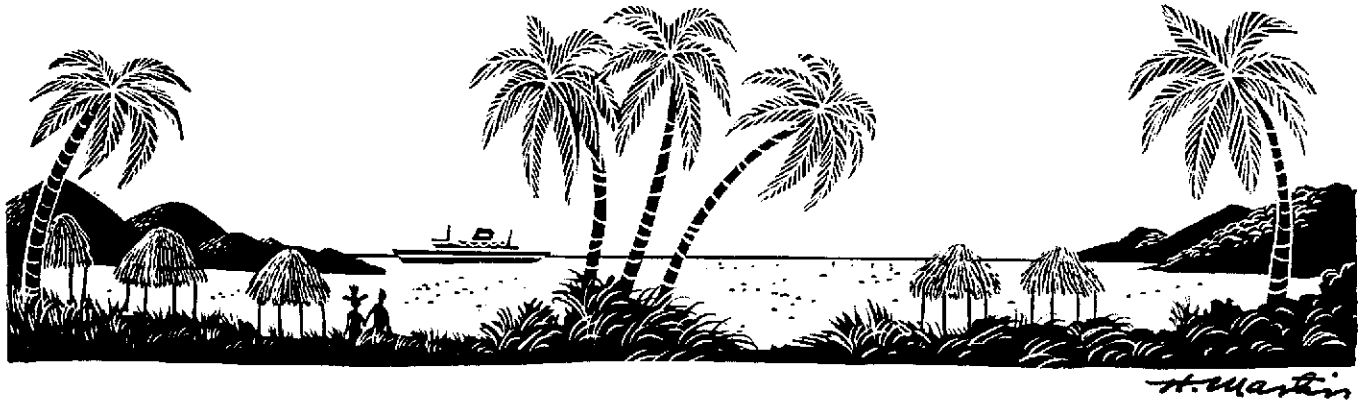
Hospice, Oncology and Home Care

Continued from Page 6

with their cancer diagnosis, treatment, and implications. Knowledge of wound healing processes and product options has been extremely helpful in treating cancer-related wounds. I now have some "tools" for dealing with the next fungating breast wound or fistula patient I see.

I would encourage all homecare agencies to have an E.T. nurse as a consultant in some form. Recommendations regarding mattress overlays for high risk patients to prevent pressure sore formation or for pressure reduction is important. All foam mattresses are not of equal quality. Inservicing of wound healing, products, and pouching systems can be useful to all homecare nurses as they need to be "jacks of all trades". For hospice benefit patients, supply costs and knowledge of cost-effective treatment alternatives can be very helpful. If in a rural area like Lewis County where E.T. nurses are few and far between, consider contracting with an E.T. nurse in creative ways. One idea would be to send photographs of wounds to the E.T. nurse who could make recommendations based on visual as well as telephone descriptions. Although not an ideal situation, this would give the agency access to the knowledge and expertise of another specialist.

The value of an E.T. nurse in homecare should not be underestimated. Home is where most people want to be - to live and die - and the development of a wound, a pressure sore, or the process of adapting to a new stoma can be overwhelming and necessitate nursing home placement if there is inadequate support at home. In terminal care where patient comfort is of paramount importance, prevention of pressure sores and/or minimizing odor and containing drainage of wounds, can be the difference between home as a place to die and home as a place to die with dignity and in comfort.



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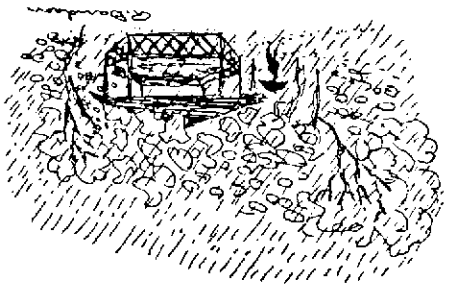

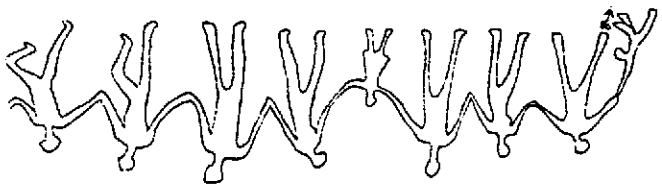

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