

Puget Sound Quarterly

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Edition

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ONCOLOGY NURSING SOCIETY

Chemotherapy: Nothing New?



NOT!!

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Message From the Board

Susan Ford, Chapter President

This summer with the help of many board, committee members and especially our chapter secretary, Mary Underbrink, I had the opportunity to look at our chapter with much more depth than I ever have before. As your President I have submitted the Puget Sound Chapter for the 1995 ONS/Chiron Therapeutics Oncology Chapter Excellence Award. Yes it is a big title, and it was a lot of work. Yet, I am proud to display to the national organization, what you, the PSONS members do for ourselves, our profession, and our community.

I first would like to thank Ann Reiner, Gloria Winters and Eric Taylor for writing letters of support for our chapter. Ann's letter is in this issue.

I would like to share with you some of the facts I have learned about our chapter during the past two years. Did you know our chapter averages about 250 members who belong to both the local and national organization. As an organization, we average at least 6 free educational offerings every year, this I think is really a kudo, since institutional education budgets are diminishing. And we offer some awesome

programs too! Our annual Symposium is such a class act that we doubled our attendance in a single year, (Don't forget, this year will be our 10th anniversary)

The Quarterly, our chapter newsletter is ineligible to win anymore national awards, why you ask? Because we have won so many already, we are now named in the Hall of Fame. Yes, we do have a large bank roll yet, we invest in our membership. Over the last two years our chapter has funded 5 nurses to go to the National ONS Congress, 5 scholarships to our own symposium, 2 research projects, and has sent the Presidents-elect to the national leadership weekend in Pittsburgh each year. We are one of the few chapters to have developed our strategic plan.

Puget Sound Oncology Nursing is valued by our national peers, at ONS Congress 28 PSONS members presented and 16 did so at the Fall Institute. We are certainly an active chapter on the national level. 15 PSONS members hold national committee positions. Here are a couple of examples of what these people have brought back to our chapter. Gloria Winter's national ethics committee involvement has assisted our chapter members to submit an ethics resolution to the national ONS. And Pat Jordan's involvement in

national government relations has helped chapter members become involved with local political issues such as the chapter sponsorship of issues forums, co-sponsorship of Nurse Lobby Day in Olympia and representation of oncology nursing in state specialty nurses organizations.

We have nominated some outstanding nurses for national awards:

Juanita Madison, ONS Foundation Congress Scholarship, Renee Yanke for OCN of the Year; Ryan Iwamoto for the Schering Clinical Lectureship, and Fran Lewis for the Mara Morgensen Flaherty Lectureship.

We also strive to honor our members locally, the Ruth McCorkle lectureship at the annual Symposium honors one of our chapter founders. We honor current members by selection to speak at the lectureship.

And we do so much more, we actively support and participate in ACS events. We teach and mentor new oncology nurses, we participate in Nurse Lobby Day, our chapter paid for the OCN test in Seattle. I am very honored to be your chapter President when I review these accomplishments. And, no matter what health care reform has in store for us, I'm proud to be a Puget Sound Oncology Nurse.

From the Editor

Dorothy W. Lisk, RN, BSN, OCN
Clinical Trials Nurse
Sacred Heart Cancer and Research Center
Spokane, WA

Hello oncology nurses of the Pacific Northwest! It sure is great to be here - and there - which the power of shared communication allows. That's just my way of saying I think this newsletter is a great idea.

I am a clinical trials nurse at Sacred Heart Cancer and Research Center and also Treasurer of our local ONS Chapter. I've been in Spokane 6 years, having relocated from Philadelphia, PA, where I worked at the Fox Chase Cancer Center (any AOH alumnae out there?). I am pleased to be guest editor of this edition of the newsletter.

While seeking contributors to this newsletter, I was told more than once, "There's nothing new going on in Chemotherapy." Read on and I think you'll find

that statement to be absolutely untrue.

I share with you a new clinical trial in the treatment of breast cancer. I am excited about this study because of its aggressive nature and the important questions it will answer. We owe it to ourselves and to future generations to pursue regimens that may offer long-term, disease-free survival.

Most of you "on the Coast" probably know Wendy Brown. Wendy practices at the University of Washington, Division of GYN Oncology. Her article reviews the development and usage of Taxol, and lets us know where treatment is headed with this drug.

Joan Willis-Bennett is a staff nurse at Holy Family Hospital in Spokane. Joan was primary nurse to Spokane's first peripheral blood stem cell transplant patient and shares that experience with us. While reading Joan's article, you'll note that she reports the physician and two nurses were in attendance during the stem cell infusion. I want you to know that this patient graciously permitted observers and

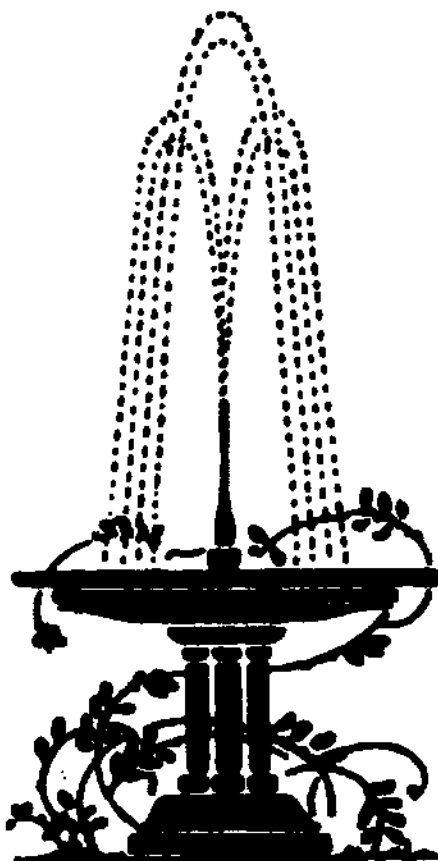
at least six of us watched from the doorway of her room.

Joan G. Craig, M.D. is Medical Director of the Sacred Heart Cancer and Research Center. Dr. Craig reports the results of what has come to be known around Spokane as simply *The Esophageal Protocol*.

Susan Codega is a breast cancer survivor participating in a clinical trial (SWOG 8851). Susan generously relives her chemotherapy experience with us, and once again I am reminded of the courage and strength our patients muster to return again and again for treatment. Susan holds a Master's Degree in Human Development and Family Studies with an emphasis on Family Therapy. Since completing her chemotherapy, Susan has opened her own counselling practice, specializing in patients with illness and their families. Anyone wishing to speak or refer to Susan can call me at the Sacred Heart Cancer and Research Center (509)455-5490.

Keeping the promise

This letter is from a member who's moved away, but wanted to express her thoughts about PSONS, submitted this summer as part of an application for a Chapter Award. Thank you Ann for sharing your thoughts with us.



August 29, 1994

Susan Ford, RN, MN, OCN
President, Puget Sound Chapter
Oncology Nursing Society

Dear Sue,

It is nearly a year to the day since my position was eliminated and I stopped working in Seattle. After 13 years at the same institution and 19 years in the same community, I have relocated to Portland, Oregon. I am confident my position is one that I will enjoy and will provide great opportunity for professional growth, however all this change has not been easy. Living apart from my family and friends for four and one half months was probably the worst part of this transition. I am now very grateful to be in the same house as my family, but many personal and professional friends are still in Seattle. I acutely feel their absence.

The members of the Puget Sound Chapter have been a resource for information and support throughout my long association with the chapter, and even more so in time of change and transition. My first involvement with the group was in the fall of 1981 when the chapter wasn't a chapter, but the Regional Oncology Nurses. I was invited by Janet Schwarz-Applebaum to participate in the planning of the annual cancer nursing symposium. Those weekly meetings culminated in a very compelling conference on grief and support, but it was also the beginning of the forging of powerful professional relationships. I learned many things over the years related to these relationships, but these are at the top of my list:

1. There is strength in numbers. Whether it is a collective voice to the public on cancer pain issues or the boost in self esteem one receives from the understanding there are others who believe that cancer pain can

and should be managed, what I know to be true about cancer nursing was influenced by my colleagues.

2. We are in this together for collective goals. Making a difference in the quality of life in patients and families experiencing cancer is foremost in PSONS' members activities. So many times over the years I have noticed individual member's professional contributions and successes toward this goal be publicly acknowledged. Mention is made at chapter meetings, through the chapter newsletter, and through the McCorkle Lectureship. I truly have never received a greater honor than to be selected by my peers to present my ideas and beliefs about my profession.
3. Oncology nurses are capable of "walking the talk." The grief I have experienced during this past year has been mine to process in my own way, on my own time. Though not life threatening, the loss of my professional role and now my community have been very significant. Chapter members have been sensitive to my process, much like I know they are with patients and families. I received meaningful written and verbal support, as well as job leads. The most reassuring gifts, however, were to know I was being remembered and that my losses were real.

In spite of my sadness of leaving the chapter's fold, I am so proud to have been a part of the development and nurturing of such a fine group of oncology nurses. I am aware that others throughout the US would sometimes marvel at our chapter's unity and purpose. I did not understand that when I was in Seattle; we were just doing what was right. Now that I am outside looking in, I understand.

With Best Wishes for "Keeping the Promise,"

Ann Reiner, RN, MN, OCN

BRING THE NORTHWEST INTO FOCUS

Vote for Pat Buchsel, RN, MSN Director at Large

Pat is a local (NW) expert in bonemarrow transplant and ambulatory care. Her involvement with PSONS and local nursing environment enhances her awareness of NW concerns.

What's new in clinical trials

Dot Lisk, RN, BSN, OCN
Clinical Trials Nurse
Sacred Heart Cancer and Research Center
Spokane, WA

Breast cancer is the most common type of cancer among women in this country, claiming 180,000 women victims annually. The overall five-year survival rate is 75%. The five year survival rate for localized breast cancer has risen to 91% because of advances in early detection, improved surgical procedures, hormonal therapy, and chemotherapy. Scientists all across the country are studying breast cancer and looking for better ways to diagnose and treat the disease, as well as prolong life.

Cancer and Leukemia Group B (CALGB) Protocol 9344 has been activated as an Intergroup Study (INT 0148) to

evaluate the worth of dose-escalating doxorubicin with or without Taxol in the adjuvant setting. Eligible patients are those with node-positive breast cancer who have not been previously treated with chemotherapy or radiation therapy for this disease. Patients will be randomized (see Figure 1) to receive:

- Standard dose cyclophosphamide and doxorubicin, with or without sequential Taxol.
- Standard dose cyclophosphamide and moderate-dose doxorubicin, with or without sequential Taxol.
- Standard dose cyclophosphamide and high dose doxorubicin (with G-CSF support and prophylactic antibiotic therapy), with or without sequential Taxol.

Taxol is supplied by the NCI. G-CSF is supplied for those randomized to arm #3

only.

The study's objectives include improvement in overall survival and disease-free survival, determination if Taxol following standard-dose cyclophosphamide and doxorubicin will be as effective or more effective than standard-dose cyclophosphamide and high dose doxorubicin without Taxol, and to assess the toxicity of different doses of doxorubicin with and without Taxol.

The Southwest Oncology Group participates in this clinical trial under protocol #9410.



Advanced Oncology Nursing Certification Exam: An ARNP Licensure Connection?

Diana J. Wilkie, PhD, RN
Assistant Professor
University of Washington
Seattle, WA

Exciting news! The Oncology Nursing Certification Corporation (ONCC) announced establishment of the

Advanced Oncology Nursing Certification Examination in a July 14, 1994 News Release. The first exam will be administered on April 25, 1995 prior to the ONS Congress in Anaheim, California.

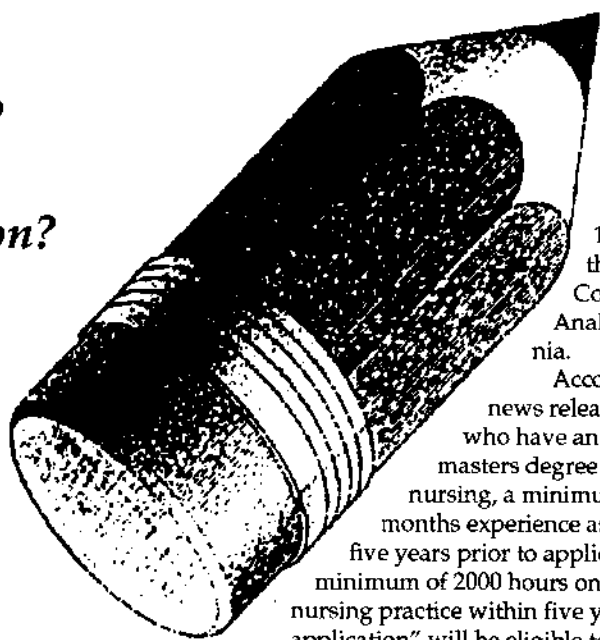
According to the news release, "nurses who have an RN license, a masters degree or higher in nursing, a minimum of 30 months experience as an RN within five years prior to application, and a minimum of 2000 hours oncology nursing practice within five years prior to application" will be eligible to take the exam. It is possible that cancer nurses, who

pass this exam, could be eligible for second licensure in Washington as Advance Registered Nurse Practitioners (ARNP).

Faculty at the University of Washington will submit materials, when they are available from ONCC, and request Washington State Nursing Quality Assurance Commission (formerly, State Board of Nursing) approval of the ONCC exam to qualify advanced practice oncology nurses for ARNP licensure. Results of the approval process will be communicated in a future PSONS Newsletter.

ARNPs, who desire prescriptive authority, are required to complete 30 contact hours of education in pharmacotherapeutics related to the ARNP's scope of specialized and advanced practice. This education must be completed within two years of application for prescriptive authority.

Faculty in the UW School of Nursing are considering development of master's and post-masters programs to prepare Acute Care Nurse Practitioners (ACNP) in the clinical areas of oncology and cardiac/critical care nursing. Oncology ACNPs will be eligible for the ONCC Advance Oncology Nursing Certification Examination. If you are interested in learning more about the ACNP program, contact Sandy Ryan at the Academic Programs Office, SC-72, University of Washington, Seattle, WA 98034.



TAXOL: Past, present and future directions

Wendy S. Brown, RN, OCN
University of Washington
Seattle, WA

The antineoplastic drug taxol* has been commercially available and approved for use in refractory ovarian cancer for nearly two years. Prior to receiving FDA approval, this agent was touted by the press as being the "cure for cancer" that researchers have attempted to find for so long. While this drug has not delivered on the tabloid claims of a cure, it has become an extremely important weapon in our growing armament against various malignancies and the future holds new possibilities for its use.

Development of taxol is interesting in that its antitumor activity was known as early as 1971. However, it wasn't until 1979 that its unique mechanism of action was identified by Horwitz and Schiff, namely as a stabilizer of microtubules which blocks the cells in both G2 and M phases of the cell cycle and prevents mitotic completion. (1,2). From that point on, this drug has been intensively studied and was first entered into NCI clinical trials in 1983. Response rates in patients with refractory ovarian cancer as reported by McGuire et al (3,4) were as high as 30% while Holmes et al reported a 56% (5) response rate in patients with metastatic breast cancer. These numbers generated a great deal of interest in taxol despite toxicities such as cardiac arrhythmias, hypersensitivity reactions, neurological complications, and severe neutropenia. As trials moved forward, pathologic cardiac arrhythmias were found to be rare, effective premedication regimens have controlled most hypersensitivity reactions, neurologic toxicities have been managed by appropriate dosing, and neutropenia, while severe is usually short lived and therefore manageable often without the use of growth factors. Cumulative toxicities have been notably absent, which has allowed patients responding to taxol to continue to receive multiple cycles of this drug. Out of 100 patients who participated in a Phase II NCI sponsored trial at the University of Washington Medical Center, some received as many as 18 doses of this drug before relapsing with no more than grade 3 hematologic or neurologic toxicity noted the entire time.(6)

The latest data from Phase III trials

supports the theory that taxol's effectiveness in ovarian cancer is enhanced when coupled with cisplatin and further suggests this combination may improve response rates when used as first line chemotherapy.(7) Controversy exists however, in the area of infusion times; 3 hour vs. 24 hours vs. 96 hours, and dosing parameters; 135 mg/m² vs. 175 mg/m² vs. 250 mg/m². Statistics are being analyzed at this moment to help define the most effective dose range and infusion schedule. The FDA has given approval for taxol to be infused in both 3 hour and 24 hours time frames. It has also



approved its use in the treatment of breast cancer after failure of combination chemotherapy or relapse within six months of adjuvant chemotherapy. In addition to these two disease sites, taxol's effectiveness is being explored in non-small cell lung cancer, small cell lung cancer, melanoma, colorectal cancer, refractory Hodgkin's disease, tumors of the head and neck, and bladder cancer. In short, there is hardly a tumor type that is not being considered for taxol therapy.

Potential new directions for taxol that have shown promise are in the area of radiation sensitization. A recently published article states, "Combined modality treatment using relatively low concentrations of taxol and ionizing radiation can result in an enhanced response, which could be advantageous in a clinical setting."(8) Oncology nurses who have the

opportunity to monitor patients participating in clinical trials using both taxol and radiation to the pelvic area will need to be especially vigilant for expected severe (grade 4) neutropenia. Growth factors such as filgrastim are currently contraindicated while patients are receiving pelvic radiation, so managing the hematologic toxicity of this combined treatment modality will be especially challenging.

In summary, taxol will continue to be used extensively in neoplasms of many types. Its effectiveness in combination with other drugs such as alkylating agents in achieving longer response times and its potential as a radiation sensitizer, make this drug one that oncology nurses will want to keep abreast of.

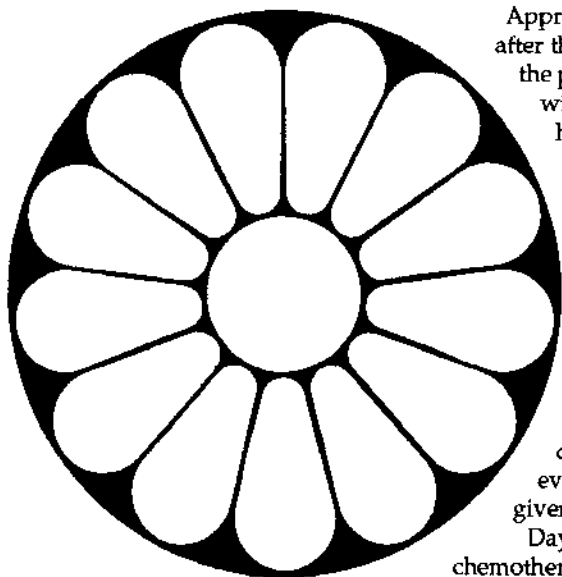
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*Taxol is used to refer to the drug that now has the generic name paclitaxel and the registered trade name Taxol. (Bristol-Myers Squibb Company, New York)

Spokane's first stem cell transplant

Joan Willis-Bennett, RN, BSN, OCN
Holy Family Medical Center
Spokane, WA



July, 1994, Holy Family Oncology Department performed Spokane's first peripheral stem cell transplant for a 42-year-old ovarian cancer patient. She had been treated with conventional chemotherapy treatments and also several Taxol infusions. "Peripheral blood stem cell transplantation is the process of removing circulating stem cells from the peripheral blood through apheresis and returning these cells to the patient after dose intensive chemotherapy."³

When selected for the treatment, the patient had a complete lab work-up and a double-lumen central pheresis catheter placed. High dose chemotherapy was given over several days. Extensive teaching and monitoring by the nursing staff is necessary to avoid complications from toxicities.

After this first chemotherapy regime was completed the patient started on Neupogen injections, a colony stimulating factor to "promote the proliferation of hematopoietic progenitors and stimulate their maturation."³ This patient then traveled to Seattle's Fred Hutchinson Cancer Research Center for the stem cell collection and storage. (Spokane now has the capability to do the stem cell collection). This is done 24 hours after the WBC count is 1000/mm². These cells were treated with a cryoprotectant, demethylsulfoxide (DMSO) and frozen. The stem cell collection for this patient was excellent, so only two collections were necessary.

Approximately 3 weeks after the stem cell collection, the patient was treated with a second regime of high dose chemotherapy. This was done as an outpatient with hydration and utilizing an infusion pump. The patient tolerated the high dose chemotherapy but nausea, vomiting and anorexia were constant problems, even with antiemetics given routinely and prn.

Day 10 after the second chemotherapy regime had been started, the stem cell transplant was scheduled. The patient was admitted to a private room on the oncology unit. Hydration and urine alkalization was necessary to prevent renal complications due to red cell hemolysis which may occur upon thawing of the cells. Hydration was started 12 hours prior to the transplant infusion and

continued for 6 hours post transfusion. 1000cc D5 1/4 N.S. and 50 mEq NaHCO₃ + 20 mEq KCl, was ordered to achieve a urine output of 2-3 ml/kg/hr. and a urine pH of >7. This patient had difficulty maintaining adequate urine output so IV Lasix was given and the IV rate increased. Each void was monitored for pH levels and hematuria. The pH levels remained adequate and slight hematuria was noted.

At 9 a.m. the blood bank personnel arrived with the frozen stem cells, the patient's physician was in attendance, and two nurses were at the bedside, one to give the transfusion and one to monitor vital signs. The patient was premedicated with Mannitol 12.5 gm IV over 15 minutes, Diphenhydramine 50 mg, Epinephrine 1:1000 ml and hydrocortisone 250 mg were available at the bedside. Some patients are sensitive to the DMSO which can cause histamine release and may affect cardiac conduction. Bradycardia and hypotension are potential complications 2-6 hours post transfusion.

Blood bank personnel thawed the 50 ml stem cell collection bag in a special water bath provided by our laboratory department. Infusion must begin immediately to avoid clumping of the cells. Using blood component tubing, the cells were infused slowly for a few moments, then at a wide open rate. The patient's face flushed red, she said she had a "terrible taste in her mouth," and immediately vomited a small amount of bile colored emesis. No other reactions were noted. The facial flushing resolved in 15 minutes. Ativan 2 mg IV was given for the nausea and vomiting.

Vital signs had been taken prior to the infusion and continued to be monitored at least every 30 minutes x 4 hours and every 60 minutes x 4 hours. The patient remained stable. Nausea and vomiting continued and she complained of the pungent odor - strong garlic type odor; both patient and nurses could smell the odor which is due to the DMSO. We had 1:1 RN staff for at least 8 hours for the patient. Slight hematuria, nausea and vomiting continued to be a problem.

This patient was hospitalized for 3 weeks and required antibiotics, a morphine drip, antifungal agents, TPN, blood and platelet transfusions for supportive care until her blood counts increased. She is home, but not back at work. Her primary complaint is fatigue, but is doing well otherwise.

The Fred Hutchinson Cancer Research Center provided us with the protocol and

Continued on Page 13

WHO DECIDED THIS?

Managed care designed by idiots

In case you were focused on the great National Health Care Reform debate in the other Washington, you may have missed the quiet revolution taking place under our noses in our Washington. If you lived in Ellensburg you probably noticed the State's HSC (Health Service Commission) pronouncing its recommendations to our Legislature. Washington state will be facing the debate in early 1995 on who gets how much and from whom. And there's that unresolved question of who pays or who subsidizes or who chooses for themselves or for the rest of us. Few of us are in the policy making business, but all of us are in the health care and wellness industry.

Who is Going to Make it Work?

What is it that has to be made to work, any way? Won't we and our current system of clinics, hospitals and specialty treatment centers still be doing our medical thing? Will it be changed when we are in the managed care business right up to our eyeballs? Perhaps we should take a closer look at who pays for what. And what the HSC will afford to all in the state. Will it be Package A, B or C or perhaps C+? Will the state house choose what's behind door number one?

One day you may report to the same old job only to find it has been redesigned by idiots. Yes, your professional care giving life may be directly affected by the terms of a contract; a contract which defines the scope of work that is to be done (as well as that which is proscribed) for patients presenting with specific set of conditions. You'll have to follow new protocols and treatment regimens and even practice guidelines. There will be gaps and cracks through which patients may fall. You'll be questioning those idiots who created these treatment plans. Chances are you won't recognize the root cause to be a contract; a **contract between your institution and a managed care plan** that is as remote from your work station as a Jovian moon.

We have Met the Enemy and He is Us

As Washington state approaches the implementation phase of HSC certified health plans, there will be a great deal more market positioning on the part of corporate networks and suppliers to prepare for the opening gun of our state's health care reform. The usual collection of generals will be leading the Group Healths, the Blues and the First Choices, but it will be the lieutenants and captains in the trenches who will wage the reform battles. Somewhere between the generals and their trenches are the staff officers in various corporate headquarters, the ones with the MBAs in finance and the MHAs grown in the profit-inspired 80s. These are the contract writers!

Contracts are Not Military Secrets.

Who is best equipped to draft a contract? A contracting specialist you say. And you would be correct. But what if the contracting specialist were a nurse? Can the health care industry invent its own kind of contract specialist? After all, this is the same industry whose interests in QA/Risk Management gave rise to the Certified Case Manager, that growing phalanx of argumentative wizards used by payers and providers to keep money from changing hands.

If you have clinical experience a specialized area, then why not involve yourself in a project to enlighten the idiots at the corporate headquarters? If you have a loyalty to your own institution, then become actively involved in the drafting, modification and creation of contracts. What a way to empower your colleagues at the bedside, by insuring there are marching orders to the right place, all the maps are current and there is plenty of reliable intelligence. Patients face life and death situations and care givers must limit the numbers of casualties especially those which may result from friendly fire.

If the process of health care reform has transformed you into a raging capitalist pig, it may be time to create a business which brings together the brightest clinical minds with the ability to write and review contracts

for any body's corporate headquarters. In a world of quick entries into managed care markets, the contract is king. And the best contracts are those which focus on the client.

Getting Started

Should one read up on contracting or just dive headlong into it? There are books aplenty on contracting, but precious few devoted to the health care industry in general and managed care markets specifically. Recent releases include Making Managed Health Care Work and Health Care Marketing, both from Aspen Publishing in Gaithersburg, Maryland. Specifically needed are objective measurements to determine outcome quality. IOG (Illness Outcome Group) research is largely a shadow activity that should experience explosive growth as buyers and sellers of managed care products attempt to differentiate themselves in the marketplace by pointing out the quality aspects of their services. Quality measurement has a popular component with which we are all familiar: the patient satisfaction survey. These have been good starting points as surrogates for quality, but as HCFA (the Health Care Financing Administration) gathers and releases more and more data on DRG outcomes by hospitals within competing market areas, there will be a surge in outcome research with claims and counter claims. Instead of Pepsi vs. Coke it will be Saint Greeds vs. Saint Mary Euthanasia.

Why not have your institution offer you a course in managed care contracting? Take it as a part of your professional development with or without college level credit. The course may satisfy CHE requirements. Most of all, don't leave that job of contracting to the idiots at the corporate headquarters.



Business Beat

Judy Kornell
Washington State Cancer Pain Initiative
Seattle, WA

Government Relations — *Pat Jordan*. The next meeting will be held on **November 15**, from 5:30—7:00 p.m. at the **Hospice of Seattle office, 425 Pontius Avenue North, Suite 300** in Seattle. call Pat before 5 p.m at 320—4000. The agenda will include review of the Nursing Specialty Meeting, talk about the chapter committee, the role of network nurse and the national office training in California, and how to share the information with PSONS membership.

Education Committee — *Carla Jolley & Kathi White*. The **November 9, 1994** meeting will be held at **Swedish Hospital** (watch your mail for the flyer to verify the location!!), and the topic will be hosted by **Connie Horton** about Cultural Issues and Cancer. **January 11th** meeting will be at **Highline Hospital** with a panel of experts about **New & Investigational Agents in Oncology Care**.

Symposium — *Juanita Madison*. The **17th Annual Cancer Nursing Symposium** sponsored by PSONS will be held **March 10 & 11, 1995** at the **Meydenbauer Convention Center in Bellevue, WA**. This year's theme "Reaching for Hope" reflects the integral role of oncology nursing assisting patients, families, and colleagues to explore and gain personal meaning in hope. Additionally, as oncology nurses, we're experiencing health care in transition — in the location and the ways we provide care. The 1995 symposium will provide an opportunity for professional education and growth as well as developing or refining skills to experience and maintain hope with

the challenges and changes facing us today.

The program will feature **Ronna Fay Jevne, PhD**, program director of the **Hope Foundation of Alberta** as Keynote speaker. The Planning Committee is also very pleased to announce **Betty Galluci, PhD, RN**, as the 1995 **McCorkle** lecturer. Educational programs at the 1995 symposium will spotlight current and topical issues in oncology nursing including care delivery systems, clinical pathways and care maps in the oncology setting and current trends in oncology treatment and care: pain management, new therapies using peripheral blood stem cell rescue, blood product administration, oncologic emergencies, and current trends in lung cancer prevention and care. Roundtables will again be included as a more intimate and informal way to share experience, ideas, and network with colleagues. If you have an idea or are interested in facilitating a roundtable the

committee is looking for volunteers. Contact **Barb Jagels (206)368—9556 (h)** or **(206)667—5858 (w)**.

PSONS will be offering \$100 educational scholarships to assist PSONS members who are not receiving financial assistance to attend. For more information of 1995

PSONS Symposium Scholarships contact **Jean Borth (206)838—0619 (h)**.

Registration at the symposium will again include lunches,

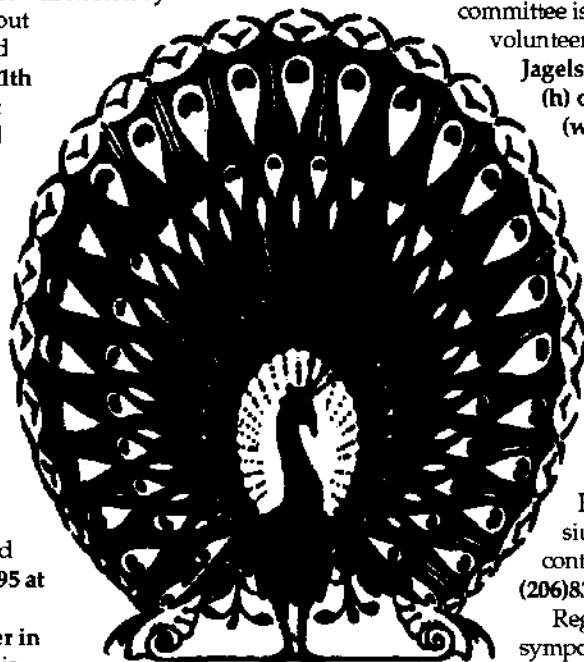
continental breakfast, and a reception Friday evening at the **Meydenbauer Center** where you can meet old friends and make new ones. There will also be plenty of time to meet with exhibitors. The Symposium Planning Committee has been working diligently to keep symposium costs low. If you've wondered exactly what your registration feels pay for: two-thirds of the symposium budget are covered by registration fees and one-third is brought in from

exhibitor and sponsor fees. Over two-thirds of the symposium income goes into facility costs, luncheons, receptions, and coffee breaks to provide a pleasant environment to network, learn and grow. Speaker honorariums, printing and mailing the brochures, and syllabus printing make up the rest of the expenses. To keep expenses low, committee members handle all symposium planning, correspondence, syllabus printing (through Costco!), labeling and mailing brochures, and spend hours putting together the syllabus notebooks. A lot of work but also a fun and rewarding experience.

Planning committee members include: **Juanita Madison** (chair), **Swedish Medical Center**
Meg Lohmann, **Immunex**
Jean Borth, **St. Joseph's Hospital**
Julie Peerboom, **St. Joseph's Hospital**
Aurora Brandvold, **Swedish Medical Center**
Marge Ramsdell, **Madigan Army Medical Center**
Cathy Goetsch, **Virginia Mason**
Mary Underbrink, **Fred Hutchinson Cancer Research Center**
Connie Horton, **Virginia Mason**
Judy Updegraff, **Virginia Mason**
Joanne Iritani, **University of Washington Hospital**
Liz White, **Seattle Veterans Administration**
Barb Jagels, **Fred Hutchinson Cancer Research Center**

Keep your eyes open for more information and brochures on the 1995 PSONS Annual Symposium and mark **March 10 & 11, 1995** on your calendar for attending this excellent educational opportunity for professional growth and networking. Feel free to call me if you have any questions or suggestions. **Juanita Madison**, chair, **PSONS Symposium Planning Committee**, **(206) 386—6211 (w)**, or **(206)432—1117 (h)**.

Clinical Practice — At the last board meeting, there was discussion about where we are headed with this committee. Those of you who informed us of your interest in Clinical Practice on the Symposium Survey last spring will be getting a call about what you envision this committee to be. If you can't wait to tell us, please feel free to call **Sue Ford (206) 752—7804** or **Renee Yanke (206)579—2480!**



Business Beat

Newsletter — *Renee Yanke, editor.*

Since our last visit, I heard from one person with several suggestions...

Conviction
Silver Bullet
White Hope
OncCharts
Magic Bullet
Bulletin for Care
TLC Teaching Learning Caring
Chartwork
Dedicare
Framings
Sharing while Caring
Bright Beginnings
Bright Eyes on the Future
Inside Treatment
InterestCare
Hanging On
Hanging Together
Tenacity
Consensus
Advancing Clinical Practice
Inner Strength: Oncology Nursing
Bedside Charter

*Please drop a line or call me to give me your ideas and feedback! (206)678-5151 (w)
(206)579-2480 (h).*

Research — *Donna Berry.*

A new and inspiring service to the PSONS

membership has begun! The first two research journal club sessions took place in conjunction with the September and October educational meetings. How does it work? Prior to each educational meeting, a member of the research committee chooses two articles relevant to the educational topic. The references are announced with the educational meeting flyer. PSONS members can read the articles and come for a brief discussion of each one in preparation for the educational meeting. It's a great way to brush up on the topic and get in some research reading. Watch for the announcements with each meeting flyer! All interested PSONS members are welcome. AND...It is time to be planning for a PSONS Research Grant in the Spring of 1995. Plant your research bulbs now for beautiful blossoms in April! Please call **Donna Berry** at 782-3433 for more information.

And...A Word from the National Office...

Applications for 1995 Scholarships, Public Education Projects and Career Development Awards — Due December 1st 1994!

Awards range from \$2,000 to \$3,000 for: Doctoral, Master's & Bachelor's Scholarships; Ethnic Minority Scholarships, Congress Scholarships, Public Education Projects and Career Development Awards. For more

information or an application contact:
Oncology Nursing Foundation
501 Holiday Drive
Pittsburgh, PA 15220
(412)921-7373

Applications for 1995 Small Grants Program due December 1, 1994

Grant Periods are for 2 years, ranging from \$4,250 to \$10,000. Funding starts on May 15, 1995. ONS Research Priorities include: Quality of Life, Symptom Management, Outcome Measures for Nursing Interventions, Pain Control & Management, Cancer Survivorship, Cancer Prevention and Early Detection, Research Utilization, Cost Containment & Economic Issues.

For more information contact:

Oncology Nursing Society
Research Department
501 Holiday Drive
Pittsburgh, PA 15220-2749
(412)921-7373.

There are lots of bright and creative nurses throughout the Pacific Northwest — Here's an opportunity to put your heads together and do something either as a chapter /group or individual who is in school and could use some funding!!! Good Luck!

FROM INLAND NORTHWEST CHAPTER

Chapter Meeting — The next meeting will be held on October 20, 1994, with **Johnny Cox PhD, RN** as the speaker. The topic will be *Allocation of Resources and Ethics*, and will be held at the Valley Medical Center in Spokane Valley. Dinner will be at 6:30 p.m. and the speaker at 7:00 p.m.

The meeting on November 17th will be on the Effects of Radiation with a Focus on Research. The meeting will be held at 7:00 p.m. with dinner at 6:30; at the Valley Medical Center in Spokane Valley.

WSCPI — The Washington State Cancer Pain Initiative is planning a Triad Training in Spokane in either April or September 1995. (This is similar to the training held in Seattle @ V.M. in '93 & '94.) Keep your ears open for more information!

FROM COLUMBIA BASIN CHAPTER INTEREST GROUP

"Converting Pain Management Principles into Practice" will be held on **November 5, 1994 from 8:00 to 11:00 a.m.** John Gavrin, MD from the Fred Hutchinson Cancer Research Center, Pain & Toxicity Research will be guest speaking. For more information call **Susan Campbell @ (509)946-4611.**

*****Special Note from another reader:** It's recommended that all RNs get a copy of the November '94 **Good Housekeeping**, and read the article about PAIN! It is well written, discussing the myths & fallacies about pain control, and a great opportunity to be aware of what our patients are reading!!

Correction from the last edition: Betsy Tontini, RN, BSN, OCN is employed at the Central Washington Hospital Cancer Center - Radiation Therapy, and not the Wenatchee Valley Clinic.

A community based protocol treatment of esophageal carcinoma

Joan G. Craig, MD
Medical Director
Sacred Heart Cancer & Research Center

In April 1990, Spokane gastroenterologists, surgeons, medical and radiation oncologists agreed to begin uniform management of patients with localized esophageal cancer. The proposal was made by the Sacred Heart Cancer and Research Center, and was based on the Forastiere protocol first published in the *Journal of Clinical Oncology*, January 1990. Anticipated accrual of patients was 12 annually. **Patient Selection:** Sixty four patients have been diagnosed at Sacred Heart since June 1990 and 47 of them entered onto the program, the last in December 1993. There are 34 cases of adenocarcinoma and 13 of squamous cell carcinoma. Nine cases were in women and 38 in men. The average age was 67.

Clinical staging after biopsy proven cancer was used to select those patients with localized disease, confined to local lymph nodes at designated levels of the esophagus and/or gastro-esophageal junction. Barretts Esophagus was noted in 6 patients. CAT scans, chest x-rays and barium studies were used to ascertain disease stage. Bone scans and brains scans were not done as routine, although one case of brain metastasis and one bone metastases were present at initial workup.

Thirteen of the 64 patients seen at Sacred Heart had advanced disease and 4 were over age 82. These patients were not referred for therapy or refused to participate.

Treatment Plan: Forty seven patients were given simultaneous chemotherapy and

twice daily radiation therapy in a 21 day program, and then at recovery had surgical resection. Surgical and pathological staging were therefore delayed until after completion of treatment.

Staging: At the time of surgery, 6 patients were found to have undetected advanced disease; brain metastasis (1), thyroid invasion (1), liver metastasis (1), lung metastases (1), gastric invasion (1) and widespread metastatic disease in a 32 year old AIDS patient.

Two patients did not undergo surgical resection after completing the initial therapy because of a prior cancer history: one had both gastric and colon resections for separate primaries, and one had had recurrent squamous cell head and neck cancer.

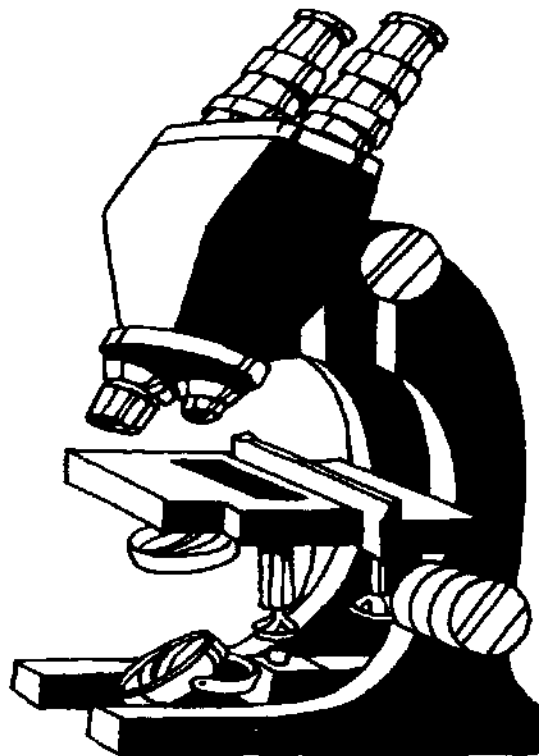
All eight of these above described patients are included in the survival curves of this report. Eighteen (37%) of the 47 patients did not undergo surgical resection after completing the initial chemo-radiation therapy. Reasons for this are multiple, i.e., age, performance status, co-existing disease, and prior abdominal resections. These patients are included in the overall report and are reported separately as a sub-group.

Side Effects: This is a strenuous protocol, with significant side effects. Bone marrow suppression requiring G-CSF was seen in several patients, but only one death attributed to infection. There was a case of ARDS pneumonia with slow but full recovery. One patient could not complete radiation therapy. Parenteral nutrition was needed for all surgical patients (gastrostomy). A single patient with AIDS was treated and survived 9 months with unresponsive, widespread disease.

Follow-up: There is 100% follow-up on all patients accrued over the past 38 months. All have been followed at least 6 months. After completion of the treatment program, patients are cared for by their primary care physician or the medical oncologist. They are seen at regular intervals by radiation oncologists and recurrent or progressive disease is reported to the Cancer Center as it occurs.

Results: Of the 47 patients treated, 23 (49%) are still living from 12-46 months (average 26 mo). Of these 23, 14 were found to be disease free at surgical staging. They have survived an average of 29 months (12-46 mos). (NOTE: 14 patients are 1/3 of the 47 total.)

Of the surviving 23, 8 are living with continuing disease (residual or metastatic from 12-34 months (average 22 mos). One of the surviving 23 has cancer which



Continued on Page 13

My experience with chemotherapy

Susan Codega, MS
Breast Cancer Survivor

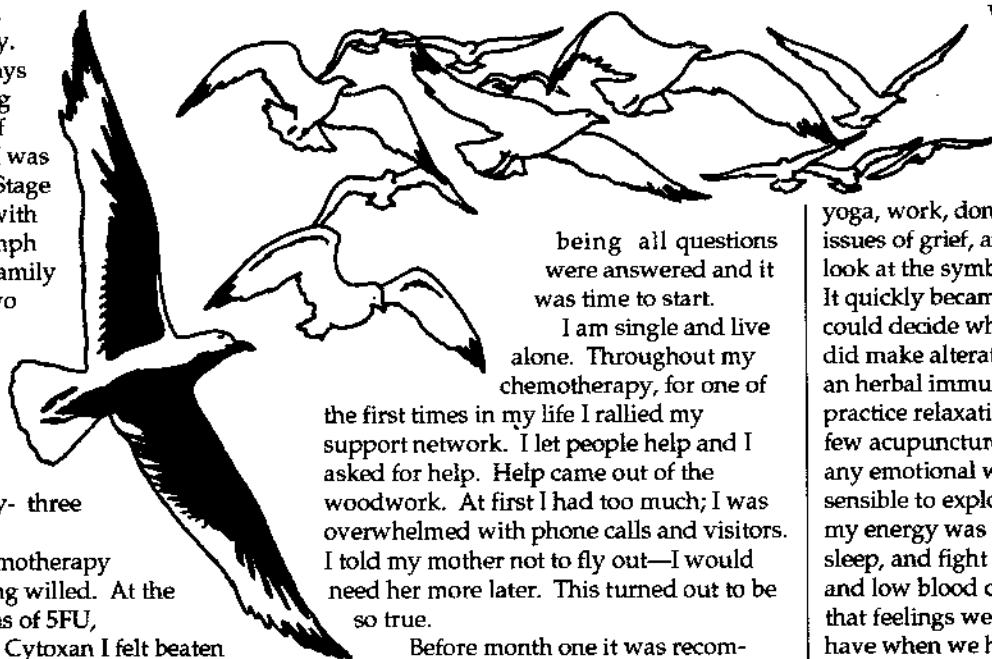
I bought my wig today. It just happened that I was in a bright mood and "Che-Che" (the hair stylist who specializes in cancer patients was great. She assured me she would take care of my hair—or lack thereof and I felt at ease. It seemed like it might be kind of fun to wear a wig for a while, but she warned me not to wear it before I needed it because I would wear it for a long time. She was right." (Journal entry) I wore my wig for about two of the eight or nine months I had no hair, got tired of it, put it away, then gave it away.

I wasn't always so chipper during my six months of chemotherapy. I was diagnosed with Stage II breast cancer with one involved lymph node. I had no family history. I had two tumors in one breast so a mastectomy was recommended. It was three years ago, and I was thirty-three years old.

I started chemotherapy strong, and strong willed. At the end of six months of 5FU, Adriamycin and Cytosan I felt beaten and weak, like they had waged chemical warfare on my body (which they did...if it grows, kill it). I remember saying to myself, if I get sick again I will not go through another round of chemo. But the strength and the strength of will returns and I would do it again (although determined not to need to).

I had IV treatments two successive weeks, took fourteen days of Cytosan, had a two week break, and repeated the schedule. Somewhere in the previous weeks, I had decided to participate in a research study. Throughout the diagnosis and surgery phases I was surprised and disillusioned about how little "they" know. I'm the kind of patient who asks until my questions is answered, so I asked and asked and was frequently told "I don't know". (There's still a lot of comfort in an honest

answer). These interactions served to strengthen my desire to be a research subject. As long as I was getting good treatment, I wanted them to study anything and everything they could think of. If it could possibly save another vital young woman from facing what I was facing, it was well worth the little effort it took for me to be a subject. My only concern was that I got the best treatment for me. All of the subjects in the study went through six months of chemo before the follow-up hormone treatments which varied. I had a little ambivalence about whether or not I would do the chemo, so at least for the time



being all questions were answered and it was time to start.

I am single and live alone. Throughout my chemotherapy, for one of the first times in my life I rallied my support network. I let people help and I asked for help. Help came out of the woodwork. At first I had too much; I was overwhelmed with phone calls and visitors. I told my mother not to fly out—I would need her more later. This turned out to be so true.

Before month one it was recommended that I have a Port-O-Cath placed in my chest. I just didn't want another surgery and decide to see how my IV chemo was without it. The nurse described that I may feel a burning sensation, and if I did, we'd stop and move the IV as to prevent permanent vein damage. Almost immediately I felt it burn, the IV was moved, burned, moved again. The treatment was given and day surgery for the Port-O-Cath was scheduled.

That first month was one thing after another. The chemo, the Port-O-Cath, and then my hair. My hair loss was not slow, not gradual, and began on a Sunday two weeks after my first treatment.

Sunday - My hair has started to fall out.

Tuesday - The first two days were very "creepy".

Friday - By now I'm used to my hair coming out of my head. In fact, it's a pain. Just today my hair is starting to look thin. I might just get rid of the rest of it this weekend.

Saturday - Took back control. Shaved my head! Pretty fun. First look - a monk. Took pictures.

That's the thing - you have so little control. Everything goes so fast. I have always done well under pressure and I was doing marvelously, facing one decision after another. The task was to do everything possible to stay alive. Simple. No ambivalence, no time to worry or whine. I

was barraged by well meaning friends and colleagues. "You need to change your diet, don't do chemo, explore alternatives, herbology, acupuncture, meditation, yoga, work, don't work, do therapy around issues of grief, anger, sadness, resentment, look at the symbolism of your cancer. Stop! It quickly became clear to me that only I could decide what to do and how much. I did make alterations in my diet, I did start an herbal immune system booster, I did practice relaxation and imagery and I did a few acupuncture treatments. I did not do any emotional work. It didn't seem sensible to explore childhood issues while my energy was so needed to feed myself, sleep, and fight the nausea, mouth sores, and low blood counts. I remember thinking that feelings were/are a luxury we get to have when we have enough available energy after basic needs that are met.

Oh yeah—the nausea. I got sick my first treatment, and every one after that. One anti-emetic would work for a short while and we'd try another. I remember thinking to myself that I was getting so sick because my body was healthy enough to recognize the poison (chemo) that it was trying to eliminate. My stomach cells were reproducing so vivaciously that the chemo would understandably kill a lot of them and make me sick. I was actually trying to convince myself that I was doing well, that I wasn't sickly, or weak, or dying.

I got sicker as I went along. Somehow I could brace myself for the IV treatments. The day came, you went. The drugs were in your body, there was a period of no

Continued on Page 13

OCN and proud of it!

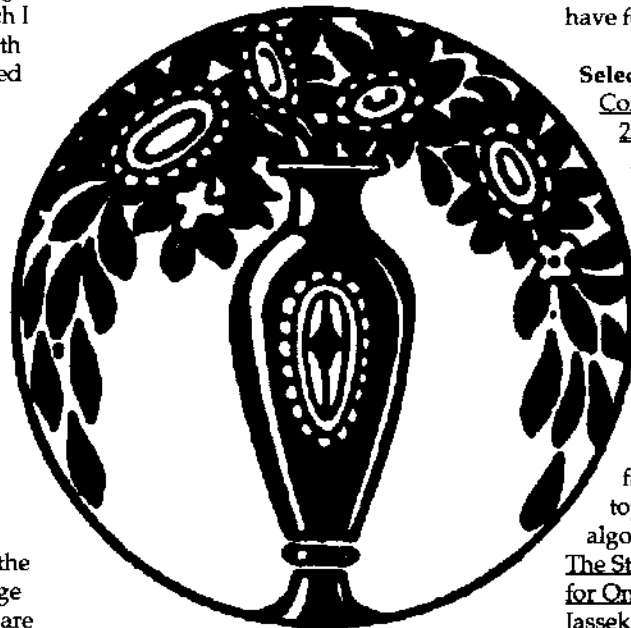
Judy Petersen
Northwest Hospital
Seattle, WA

Are you one of the 13,964 nurses certified in oncology nursing? I am, and I'm proud of it! I wasn't so enthusiastic earlier in September though, as I debated with myself about how much I should be studying for the September 24th exam that I needed to take to be recertified as an OCN. I saw several fellow PSONS members at the September 24th exam on the University of Washington campus, there either to renew as I was or take the exam for the first time. So why bother to take the exam and how do you go about studying for it?

For those not familiar with the certification process, let me briefly give you a few facts. Certification in oncology nursing has been available since 1986. The first exam was taken on April 30, 1986 by 1607 RNs (I remember, I was there!) The Oncology Nursing Certification Corporation (ONCC) definition of the purpose of nursing certification is "to assure the public that the certified nurse has attained the knowledge required to provide competent nursing care in a specialty area of practice, to validate that the certified nurse has completed all eligibility criteria to earn a specific credential, and to promote the development of specialty areas of nursing by establishing minimal competency standards and recognizing those who have met those standards." The exam tests the general oncology nursing knowledge base. The exam is offered twice each year, at the annual Congress in the spring and then again in the fall. Information on eligibility, test description, dates registration and details can be found in the ONCC bulletin and application form. Bulletins are sent to ONS members annually or you can call the ONCC office to have a copy sent to you (412-921-8597).

Starting with the September '94 exam there are 225 test questions (they've thrown in an extra 25 new questions that don't count toward your score). Three and a half hours are allowed for the testing which I've always found to be adequate time. The

testing procedure is generally well organized, and the atmosphere and environment as comfortable as possible. Now I know you'll disagree with this if you took the '94 test at the annual Congress in Cincinnati where the fire alarm rang in the Convention Center requiring that the



building be evacuated just prior to the distribution of test materials!

Why take it?

There are as many good reasons as there are OCN's. It may reflect the commitment you feel to patients, families and your profession. It's an opportunity to demonstrate your competence in your specialty. In these days of competitive job markets, an employer may require oncology nursing certification. It may enhance your career mobility. Some employers provide pay increases or bonuses to certified nurses. Recognition benefits can come in many forms. I've known employers to have special presentations or banquets to honor certified nurses. There are other reasons. What are yours?

How do you study for it?

There are lots of study resources available. First of all, be sure you have a

copy of the test bulletin. Its information includes the Test Blueprint (an outline of test content identifying percentage of questions in each content area). Review of this will help you identify your areas of strength and weakness helping you to focus your study. Following is a list of study resources and tips myself and other OCN's have found helpful.

Selected Book References

Core Curriculum for Oncology Nursing 2nd Edition, by J.C. Clark & R.F. McGee. This covers all the test content areas in outline format.

Cancer Nursing: A Comprehensive Textbook by S.B. Baird, R. McCorkle & M. Grant. Also covers all test areas, but goes into more depth and was easier for me to read than an outline for areas I really needed good review of.

Decision-Making in Oncology Nursing by S.B. Baird. This is a favorite of mine. Key elements of topics are organized into clinical algorithm or decision trees.

The Study Guide for the Core Curriculum for Oncology Nursing by C. Varricchio & P. Jassek. This is very helpful for testing preparation. The chapters and content parallel the Core Curriculum. Each chapter has multiple choice questions with correct answer and rationale provided. Practicing taking a test can be invaluable.

COMPUTER ASSISTED INSTRUCTION Oncology Nursing Review: A Computer Assisted Instruction (CAI) Program. 2nd Edition by ONS. Several colleagues have mentioned this as their study method of choice. It includes test questions.

The test bulletin lists many other excellent books and journal references.

*Form a study group with your co-workers. Decide on a routine meeting time. Assign individuals to review specific content for the groups and quiz each other.

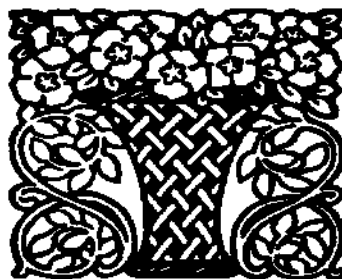
*Look for certification review classes. Area hospitals and our chapter have sponsored such review courses in the past. Perhaps if there is enough interest, the chapter could do this again!

*Design a study plan. Identify your weak areas and focus review on these areas.

My experience with chemotherapy

Continued from Page 11

discomfort, you got (sometimes) violently ill and then you focused on each hour, each day feeling a little better. And you could count. Six months—only twelve times total. Only six times to start over. But the Cytosan was different. The name CELL-KILL. My hand was responsible for opening the bottle—counting three pills each day, placing them in my mouth, knowing I was making myself sick...for fourteen days. The sickness that never



went away, the (14 x 3 x 6) 252! Two hundred and fifty-two pills. The Cytosan was the hardest. One morning I got up, looked at the bottle and threw up.

And the love kept coming too. My mother came, my sister came, my best friend came. They sat with me, laughed, look hairless pictures, cooked, cleaned, planted spring flowers, planted my garden. My mom came for my fourth treatment. I started to throw up and couldn't stop. After two days when I couldn't keep water down I called the doctor. For months I had complained of mouth sores and sickness, with few solutions. When I called this time he had me come in immediately for re-hydration and a new anti-emetic. His response felt assuring. If something was going wrong, he'd take action, otherwise I'd just have to put up with the growing discomforts.

Month five and six I just felt beat down. My blood counts always rose enough that

treatments were not delayed, but they were a little lower each time. I felt myself withdrawing inward, conserving energy and sleeping as much as possible. I was feeling physically defeated.

Yet the day of my last treatment, a burst of energy, giggles with my girlfriend and knowledge that now in a matter of time would feel better. It took a good six weeks to feel decent. It took three months to have enough hair to not look like a cancer patient. And then I felt great, on top of the world, happy and in love with life. The emotional wall hit—who am I, what's important, why me, what did I do... or still doing to get cancer. Am I whole, or am I "damaged goods", as one friend labeled my fears.

I started adjuvant hormone treatments, a shot in the abdomen once a month and two pills every day. More than one person said, "now you can get back to normal," "put this behind you." Are they kidding?

Stem Cell Transplant

Continued from Page 6

orders. Many hours were spent and many phone calls made coordinating the timing and scheduling of all the treatments and obtaining very large amounts of chemotherapy medications.

It was a terrific learning experience for the staff and the patient. When asked how she felt about being our first transplant patient she said she felt very comfortable because we had been involved in her initial chemotherapy treatment and she had the utmost confidence in all of us.

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1. Fred Hutchinson Cancer Research Center Protocol. Seattle, WA
2. Transplanting bone marrow without transplanting marrow. *Quest*, 17 (4), Fall, 1994. 1, 6-7.
3. Walker, F., Roethke, S.K., Marting G. An overview of the rational process and nursing implication of peripheral blood stem cell transplant. *Cancer Nursing*, 17(2), 141-148, 1994.
4. Wodinsky, H.B., Dillmore, R.D., MacDonald S.A. Assessing peripheral blood stem cell Transplant technology. *Journal of Oncology Management*, 3(4), 22-27, 1994.

Community based treatment of esophageal carcinoma

Continued from Page 10

recurred 15 months after being found disease free at surgery.

Fifty one percent of the study patients (24) have died with an average survival of 12 months. Five of the 24 were free of disease at surgery, but dies at 3 to 29 months (average 12 mos) of acute renal failure or recurrent cancer. Two patients previously free of disease had recurrent cancer at 12 and 20 months.

There were 18 of the 47 patients who did not have surgical resection (38%), but did complete the chemo-radiation therapy. Seven of these cases are still living 12-32 months (average 21 months). The eleven who have died survived 2 to 32 months for an average of 9 months. Various reasons are obvious for eliminating surgical treatment: age, performance status, prior abdominal resections, AIDS, or a prior cancer history.

Implications of the Study

Treatment of those clinically staged with limited cancer of the esophagus (local node involvement only) is definitely warranted with up to 13 of patients rendered disease-free by combined chemo-radiation therapy prior to surgery. This group of patients also have a doubling of

life expectancy to at least 29 months (as compared with 12 to 14 months of historical control group). Recurrent disease is usually distant metastatic disease and may occur at intervals up to 24 months after treatment. Local recurrence at the edge of the radiation field was seen in 1 patient.

Future Plans

These patients will continue to be followed at annual intervals to ascertain the average survival times of those patients still living. Recurrent sites and times will be documented.

The protocol itself will be modified according to the abstract by Forastiere published in ASCO, May 1994. The duration of treatment will be extended from 3 to 4 weeks to reduce toxicity and allow for outpatient treatment. Radiation therapy will be given only once daily, thus reducing the need for hospitalization.



PSONS MEMBERSHIP

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Return this form to PSONS, 2611 NE 125th St., Seattle, WA 98125

The Last Word

Sue Ford
Tacoma Community College
Tacoma, WA

So you ask why is this entry so short, It's cuz **Sue Ford** has a new job. No same place, only tenure track at Tacoma Community College. First full-time work in 14 years. No more running around and getting into everyone else's business.

Put your money down and take your test. Who remembers taking the 1st OCN exam in L.A. in 1986, where we had to put our marksense forms on cardboard since the tables were uneven. Well we had our 3rd anniversary party on the campus of the University of Washington in the end of

September as the original group of nurses and many others joined us to complain about test questions one more time. Good luck to every one who was there!!!

Another group of nurses decided after long class and clinical hours to take the now trendy ANA Nurse Practioner Exam. Good luck to you too!

Just quickly —

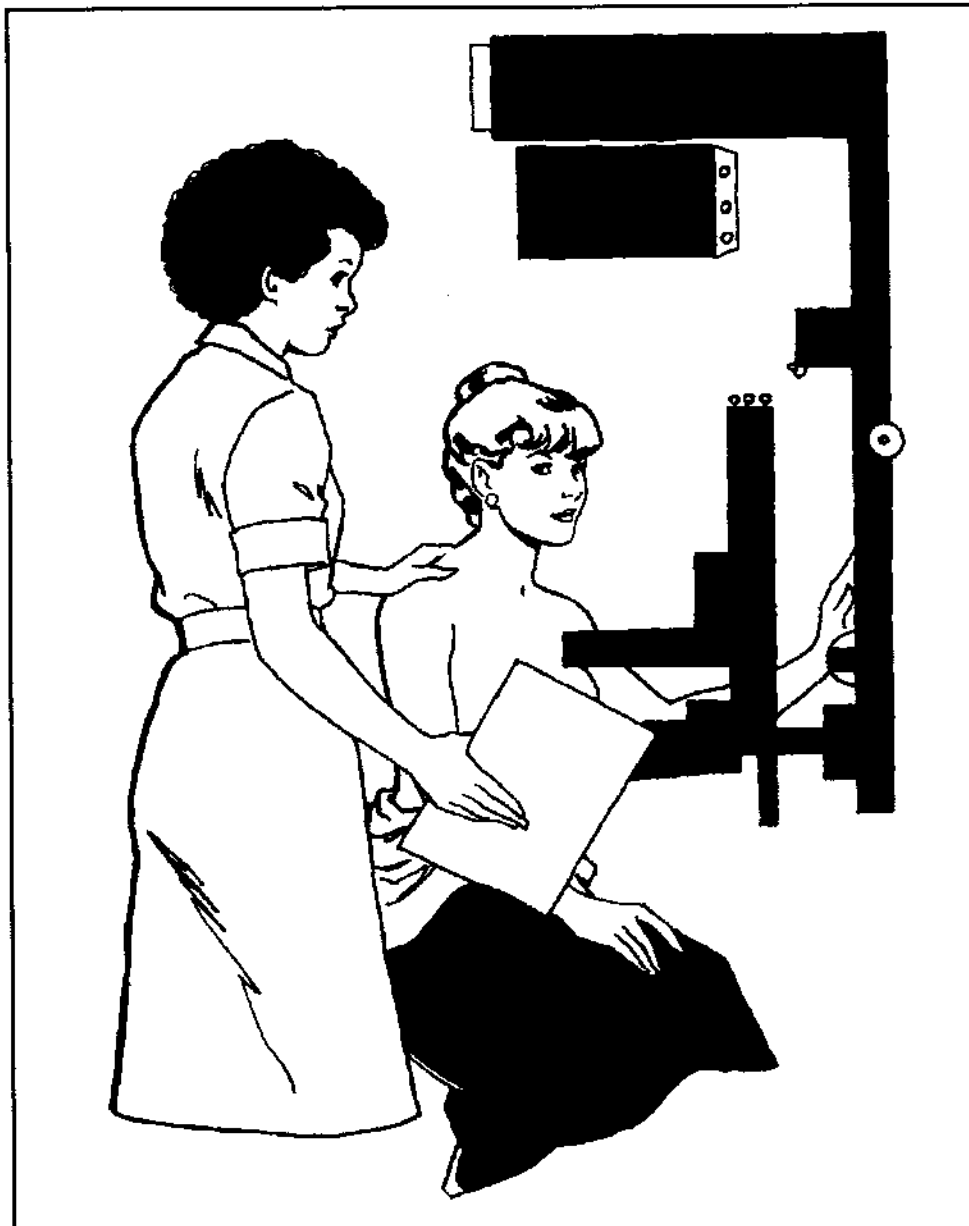
I understand the two Everett hospitals are called Providence General, with all the health care mergers think about these:

Virginia's Group

Multi Swedes

Providence Joe and the two girls (Clare & Francis)

Got anymore, feel free to submit them!!!!?



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Editor: Renee Yanke

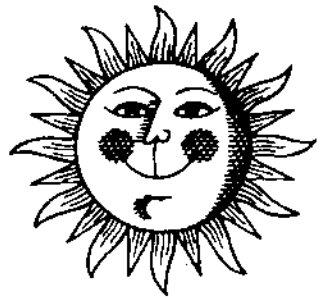
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