Puget Sound Quarterly

Northwest Regional Edition

Vol. 19, No. 4, 1996

PUGET SOUND ONS

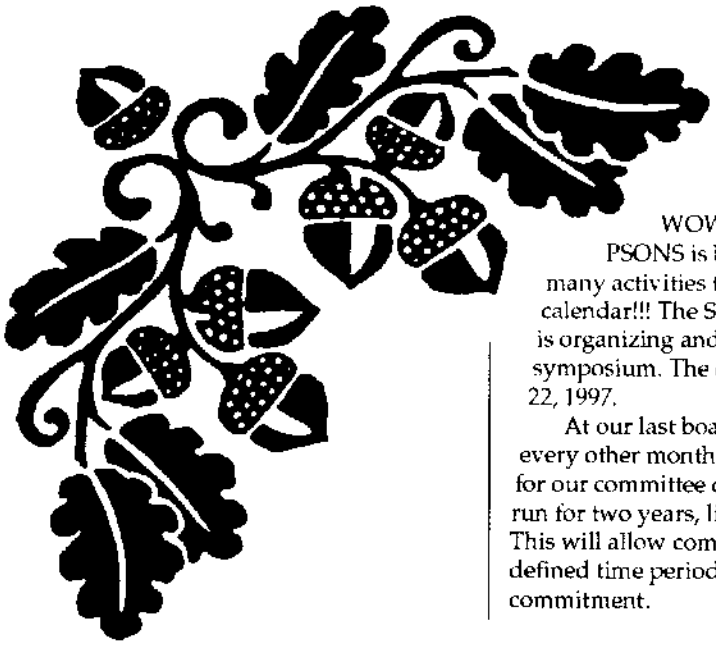
ONCOLOGY NURSING SOCIETY

CANCER PREVENTION: A powerful approach

Inside:

This issue of the Quarterly is underwritten, in part, by the generous support of Zeneca Pharmaceuticals (see page 4).

From the President



Irene J. Karlsen Thompson RN, MSN, ARNP, OCN

I am writing this message at the end of October. WOW! Fall sure came fast! PSONS is busy as usual with many activities taking place. Mark your calendar!!! The Symposium Committee is organizing and planning our next symposium. The dates are March 21 and 22, 1997.

At our last board meeting (we meet every other month), we voted in "terms" for our committee chairs. The terms will run for two years, like the board officers. This will allow committee chairs to have a defined time period of responsibility and commitment.

Speaking of committee chairs... big WELCOME to **Barbara Chasan** the new chair of the Research Committee!!!!!! Barbara has been an active member of the Research Committee. We're excited to have her join our leadership team.

We are still seeking someone for the position of Historian. It's a fun position and a great way to be involved. Anyone interested????

A big THANK YOU to **Ian Anderson**, **Liz White** and **Cathy Goetsch** for helping with the ONS booth at the recently held "Association of Pediatric Oncology Nurses" conference. The conference was held at the Seattle Convention Center for two days. Ian, Liz and Cathy volunteered at the booth and helped to introduce participants to ONS and PSONS.

Well... that's the news for now. Have a great Fall!!!

From the Guest Editor

Cancer Prevention: What we should all know and live

Cathy Goetsch, RN, BSN, OCN
Cancer Prevention Project Coordinator
Virginia Mason Research Center

Cancer is predicted to have the dubious honor of passing heart disease as the number one killer of Americans by the year 2000. It currently affects one in three people. If not diagnosed with cancer themselves, they have a friend, co-worker, or family member who is. While advances in cancer treatment continue to be made, the long term survival after a cancer diagnosis is still just over 50 per cent: This figure is an average which includes the notoriously poor prognosis sites such as ovarian and small cell lung as well as the very curable basal cell skin cancers (American Cancer Society, [ACS], 1996).

Prevention is clearly an avenue of opportunity. Cancer prevention has several components. Primary prevention is actions taken to keep a cancer from occurring. Secondary prevention is the detection of cancer in asymptomatic individuals. Tertiary prevention is aimed at minimizing the morbidity of the disease. All of these areas are receiving deserved attention from lay and professional publications, and research is ongoing to find evidence regarding effective strategies.

Primary prevention has its most notable potential in the area of smoking cessation. It is estimated that 35% or cancer incidence and at least 30% of cancer mortality is related to use of tobacco products (Meyskens, 1995). Not many people, except maybe those who work for the tobacco industry, would disagree with the statement that lung cancer can be caused by

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From the Editor

You may notice a few "differences" in this issue. First, we've let the sponsor tell you a little more about what specific products they offer and phone numbers of the reps that serve all of our areas. They would be happy to answer questions or provide education materials. You may notice some missing columns. The NLN has the last word (they are coming to the institution that **Sue Ford** teaches at next week and consequently, Sue was unable to do her usual column, but I'm sure she's not forever silenced). **Karen Black** came up with quite an excuse for why she didn't get the PSONS Profile written. Apparently, she was on the way to interview **Bethany Campbell** and went into labor.

Congratulations, Karen, you're excused.

Also, for those from the Seattle area, Cancer Lifeline is looking for volunteers and the training starts in January. Some folks from Montana have always written a short article about their Wilderness experience. We'd encourage you to write for a brochure.

My best wishes to all of you as we celebrate the holidays...

— Connie Horton

Prevention

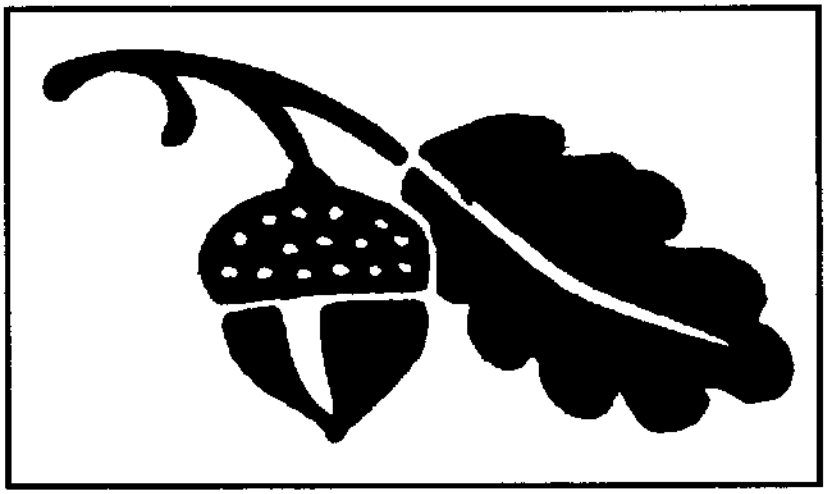
smoking. There is strong evidence linking tobacco use with several other sites as well, including oropharynx, bladder, cervix, pancreas, esophagus, kidney, stomach, and 15-25% of adult leukemias (Meyskens, 1995). **Katy Duggan, RN** gives us strategies to help us help those who need to quit smoking.

Another focus of primary prevention is diet. This is an area of interest to everyone, and as a result, much unsubstantiated and contradictory information bombards the public. Up to 30% of excess cancer mortality is estimated to be related to diet (Meyskens, 1995). **Annie Birgenheier, RD**, a clinical dietitian working with inpatient and outpatient populations at Virginia Mason Medical Center, provides us with a review of the American Cancer Society diet recommendations.

Chemoprevention is a third strategy for primary prevention of cancer. Taking a chemical to block or reverse the development of disease has been modeled for us in cardiology since the early 1970's (Meyskens, 1995). Many dietary components and pharmacological agents have been suggested for possible use in cancer prevention. Large national placebo controlled studies are underway looking at various strategies: vitamin A analogues alone or in combination with other agents for prevention of second primaries or adjuvant therapy for cancers of various epithilial cell origins; calcium carbonate, aspirin, and other non-steroidal anti-inflammatory drugs for effect in colo-rectal cancer; tamoxifen for prevention of breast cancer in asymptomatic, high risk women; and finasteride for prevention of prostate cancer which will be closing to accrual in early December (Goetsch, 1996). Information regarding these and other prevention trials is available from the Cancer Information Service: 1(800)4CANCER. Several of the cancer centers in the northwest are participating in these studies. You can call me at 223-6742 from in King County; toll free in Washington 1(800)542-0872 ext. 6742? from outside Washington 1(800)354-9527 ext. 6742.

An upcoming area of primary prevention will undoubtedly be interventions with individuals at high risk to develop cancer based on their pedigree or on positive results of gene testing. With the rapid advances in molecular genetics enabling the identification of cancer associated gene defects, strategies to mitigate or reduce the risk of these individuals will be developed. Studies to document the success of prophylactic treatments need to be done. Gene therapy, though in its infancy will not be long in coming (Sporn, 1996).

The second arm of prevention available to us is screening for early detection of cancer in asymptomatic individuals. Effective screening has several criteria: (a) The disease has to be an important health problem, usually with high incidence and high morbidity. (b) Case finding must result in treatment options which decrease morbidity. (c) Tests done should be acceptable to those being screened (i.e.. safe, non-invasive, affordable). (d) Test done should be easy for the provider to perform and interpret. And (e) tests done should be valid and reliable with both sensitivity and specificity (Mokulis & Thompson, 1995). Our notable successes have been with cervical and breast cancer. We know from the model of cervical cancer that effective screening for detection of early stage disease can result in marked reduction in mortality (Meyskers, 1995). Since the widespread use of pap smears cervical cancer has become a rare cause of cancer death. Unfortunately with the spread of the AIDS epidemic there is now a resurgence of incidence in HIV infected women (Aboulafia, 1994). The recent use of screening mammograms has shown the ability to detect early stage disease and positively impact mortality rates, but with unfortunate trends toward under use by minority women (Burns, et al., 1996). There is still debate about what age to start mammogram screening and how often screening should be done.



Another controversial topic is female hormone replacement therapy and its relationship to breast cancer. There is little consensus in the scientific community. What should you tell your patients and their family members? **Barb Fristoe, ARNP**, Oncology Nurse Practitioner in the outpatient Hematology Oncology Section at Virginia Mason Medical Center, reviews current information on breast cancer risk as it relates to hormonal replacement therapy.

The American Cancer Society (ACS) screening guidelines for early detection of cancers are introduced by **Judy Peterson, RN**, Oncology Clinical Nurse Specialist, and IV Therapy Supervisor at Northwest Hospital. Currently no effective method of early detection exists for lung cancer, the second most frequently occurring cancer in men and women, and the most frequent cause of cancer death in both (Richert-Boe & Humphrey, 1992). The other top causes of cancer morbidity and mortality are prostate cancer, the most common cause of cancer in males, and the second most common cause of cancer death in men, and colon cancer, the third most common cause of cancer in both sexes (ACS, 1996). Both colorectal and prostate cancer have ACS guidelines for screening, but controversy exists as to their cost effectiveness. There is no doubt that yearly digital rectal exams (DRE) combined with prostate specific antigen (PSA) blood tests are effective at finding early stage prostate cancers. What is less clear is whether the early case finding results in a reduction in mortality, although evidence exists that quality of life is improved (Mokulis & Thompson, 1995). Studies have shown that fecal occult blood tests in combination with sigmoidoscopy as recommended by the ACS can be effective at reducing colon cancer mortality. Cost effectiveness had improved with improvement in occult blood tests but some insurance carriers, including Medicare, do not cover this screening (Levin, 1996).

Tertiary measures of prevention are also controversial. Cost versus efficacy of palliative treatments is now being questioned by insurers. Without data to support our interventions we may be denied their use. A symptom many patients

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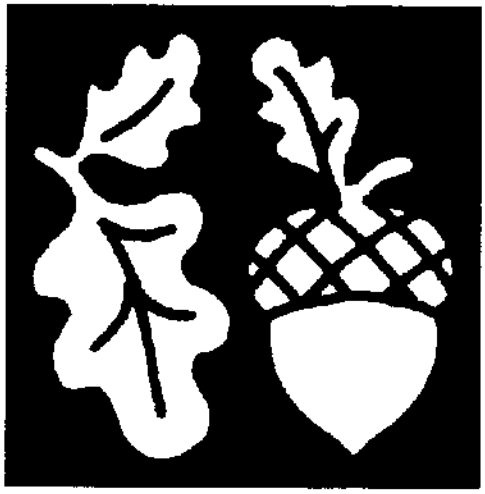
and families focus on is weight loss. Studies to gain evidence to support various interventions are available. An example is the South-West Oncology Group (SWOG) trial (9327) to see if pentoxifylline is effective at combating the anorexia and cachexia of metastatic disease. This is a placebo controlled study with free drug available to patients. These types of trials also provide an opportunity for patients to feel they are contributing to the good of others who come after them.

Though the traditional focus of oncology nurses has been caring for individuals and groups who are impacted by cancer diagnoses, plainly there is a role for us in cancer prevention. PSONS president, **Irene Karlsen Thompson, ARNP**, shares with us some of her strategies and experiences since changing from a tertiary to a primary care focus. We as oncology nurses, have the strengths of access to and credibility with our established patient. We are already known and are trusted by those we serve and their support systems. We know how to provide effective education; we need only ask if interest exists, or if information is desired about prevention topics. Asking takes only a moment. Having prevention information available in our lobbies takes even less time. Health care professional reinforcement of any positive expressions of desire to change lifestyle risks or engage in prevention focused behaviors has been shown to be helpful in assisting people to follow through on their intentions (Meyskens, 1995) .

Taking action to reduce tobacco use is one of the priorities of the Oncology Nursing Society. The October issue of the Oncology Nursing Forum includes the U.S. Department of Health and Human Services Clinical Practice Guideline for Smoking Cessation which covers prescribing strategies for nicotine replacement. Let us affirm our commitment to anti-tobacco action and cancer prevention in general, enacting these principles in our own practices and in our own lives.



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Tobacco Cessation: The Questions We Think About — The Answers We Need

Katy Duggan, RN, MEd
Health Education Specialist
Virginia Mason Medical Center

Questions:

What do we know about nicotine, about smokeless tobacco, about passive smoke, about snuff??

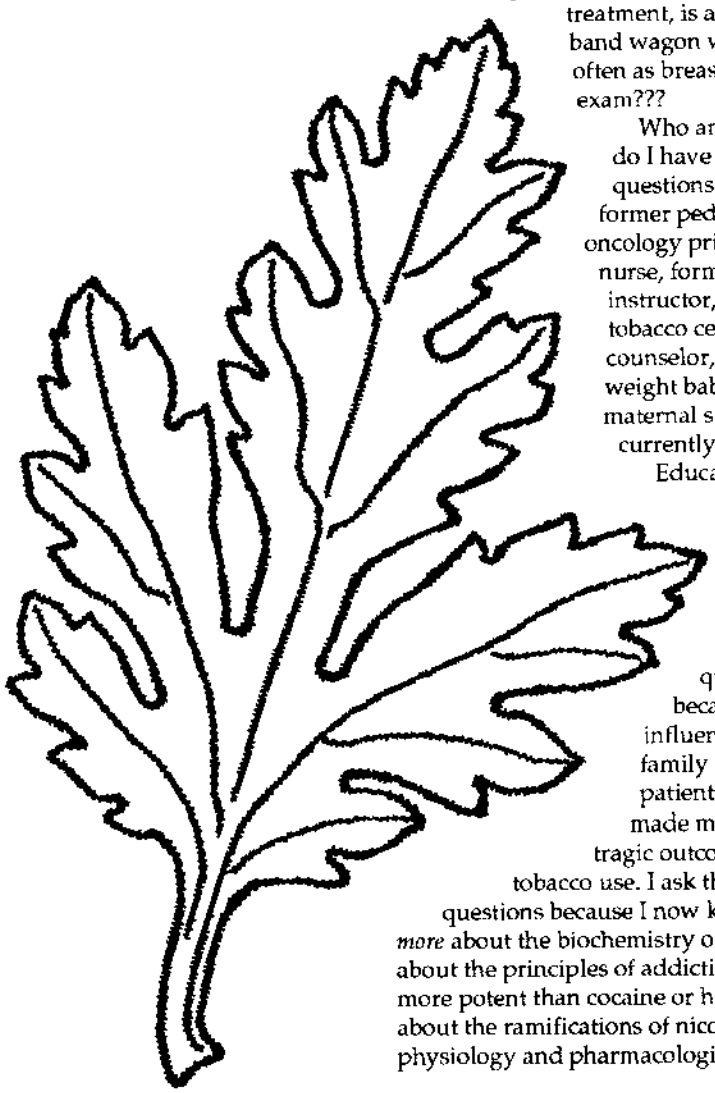
What do we know about the bad effects tobacco use has on a person's body, their immune system, those who live around them??

What do we know about metabolism of nicotine in the liver, the negative impact on platelets, the lowered absorption of pain medications?

How do we talk with our patients about the benefits of stopping tobacco use, about addiction to a very potent drug, about changing lifelong behaviors that encompass every aspect of their life??

What do we know about "readiness to change" theory and the "4 A Model (Ask, Advise, Assist, Arrange)?" What do we know about applying it to our patient populations in oncology?

How do we establish tobacco cessation as a value our oncology healthcare teams believe is an important care principle, is a priority for identification and treatment, is a prevention band wagon we ride as often as breast self exam???



Who am I and why do I have so many questions?? I am a former pediatric oncology primary care nurse, former nursing instructor, former tobacco cessation counselor, a low birth weight baby due to maternal smoking, and, currently, the Health Education Specialist for a Seattle hospital.

I ask these questions because of the influences on my family and my patients which have made me face the tragic outcomes of tobacco use. I ask these questions because I now know *so much more* about the biochemistry of tobacco, about the principles of addiction to a drug more potent than cocaine or heroin, and about the ramifications of nicotine on body physiology and pharmacological efficacy.

Currently, most of my time on tobacco related issues is split between prevention and education — education of our inpatient and outpatient staffs and those individuals who wish to stop using tobacco.

Facts:

- Tobacco is the only legal substance that is harmful even when used as directed.
- It is highly addictive.
- It kills more Americans each year than alcohol, heroin, AIDS, fires, cocaine, car accidents, suicides, and homicides *combined*.
- Passive (secondhand) tobacco smoke kills 53,000 people per year or the equivalent of the city of Yakima, Washington being wiped off the map annually!
- Tobacco contains 4,000 different chemical compounds. Just a few may be familiar to you:
  - ammonia — household cleaner
  - arsenic — rat poison ingredient
  - butane — lighter fluid
  - cadmium — batteries
  - cyanide — deadly poison
  - formaldehyde — preservative for bodies
  - methoprene — insecticide
  - methyl isocyanate — accidental release killed 2,000 in Bhopal, India
  - napthalene — mothball chemical
  - polonium — cancer causing radioactive element
- Nicotine causes increased platelet adhesiveness and aggregation — the probable link to strokes.
- Individuals exposed to extended periods of passive smoke show elevations in platelet aggregation.
- Smoking increases hemoglobin due to binding of carbon monoxide to oxygen molecules.
- Tobacco use lowers plasma levels of tricyclic antidepressants, accelerates metabolism of theophylline, enhances elimination of caffeine, lowers B12 levels, and decreases the efficacy of pain by accelerating their metabolism.
- Nicotine was once used as an insecticide for crops in the U.S. but was banned because of its "toxic effects."
- New research demonstrates macular degeneration gradually occurs in people who use tobacco over time.
- Nationally, 100% of U.S. HMO's pay for treating lung cancer but only 67% pay for tobacco cessation

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Nutrition and Cancer Prevention — *What role does it play?*

Annie Birgenheier, RD
Clinical Dietitian
Virginia Mason Medical Center

We "buckle up" to reduce our risk of death in motor vehicle accidents. We exercise and limit dietary cholesterol and salt to reduce our risk of death from heart disease and stroke. But cancer is a random killer, right? There is no controlling our risk of death from cancer, right? WRONG. Diet is one of several factors that may strongly affect cancer risk and is one that can be controlled.

Nutrition is a first-line effort toward primary cancer prevention. If the American population would adopt a healthy style of eating, reducing fat intake to 25% of total calories and increasing fruit, vegetable and grain intake to supply 25 - 35 grams fiber per day, studies estimate that the cancer mortality rate could decrease by 8% just by the year 2000. Foods contain thousands of chemical components, stimulating an almost infinite number of chemical combinations and physiologic interactions. As we eat, exposure to dietary contributors to cancer affects everyone. Since food components variably inhibit and promote carcinogenesis, present research does not allow clear cut cause-effect conclusions that can be used by the general population to guarantee cancer prevention. Strong research-based recommendations show positive correlation cancer risk reduction.

American Cancer Society Recommendations

- **Maintain Desirable Body Weight.** Cancer Prevention Study 1, conducted prospectively from 1960 - 1972, clearly showed obesity increased the risk of death from certain cancers. Women 40% above desirable weight had up to 55% greater mortality from cancer than women of normal weight, while obese men had up to 33% greater mortality. Obesity and abdominal adiposity in women increases endogenous estrogen/estrone production by adipose tissue and increases risk of post-menopausal breast tumors and possibly endometrial cancer. In the U.S., rates of obesity are rising among adults and youths. Weight loss and long term maintenance are complex behavioral challenges with long reaching positive effects on disease prevention. Reducing intake of total energy (calories) and increasing expenditure of total energy by physical activity is easier said than done.

- **Eat a Varied Diet.** Variety, balance and moderation is the mantra of nutrition professionals as a way to achieve an optimum nutritional state. They apply as well to cancer risk reduction.

  The Food Guide Pyramid recommends both the number of servings and the variety of foods to eat every day, as well as eating in moderation those foods whose nutrients that in excess may contribute to disease risk. The base of the Pyramid — whole grains, fruits and vegetables — recommends a level of daily intake which approximately doubles current national consumption, while keeping animal-based foods, such as milk and meat, at present consumption levels. A recent study undertaken to assess foods currently contributing to the American diet showed an average intake per day of 3.5 servings fats/oils/sweets, 1.3 servings dairy, 2.2 servings meat/protein, 2 servings vegetables, 1 serving fruit and 5 servings grains. Current recommendations are to decrease fat intake to 25 - 30% of total calories, increase fruits/vegetables to 5 or more per day and increase grains up to 11 servings per day. Trends in food consumption indicate that there is little progress toward achieving these nutrition goals.

- **Include A Variety of Both Fruits and Vegetables in the Daily Diet.** There is a strong association between increased fruit and vegetable consumption and decreased risk of cancer in several sites, including lung, colon, prostate, bladder, esophagus and stomach. Current recommendations are for 5 - 9 servings every day, which again is double the actual intake of American adults. Fruits and vegetables are also rich in antioxidants and phytochemicals, which show very strong evidence toward reducing cancer risk. (More on these substances further in the article.)

- **Eat More High Fiber Foods, Such as Whole Grains, Legumes, Vegetables, Fruit.** Dietary fiber consists of complex plant carbohydrate components, some of which are not digestible by the human intestinal tract. There is a high correlation between high fiber, 20 - 35 grams per day, and decreased risk of colon cancer. A fiber rich diet appears to influence estrogen metabolism by inhibiting the re-absorption of biliary estrogens through larger fecal volume excretions. A recent study showed 30 - 50% of colon tumors had estrogen receptors. Fiber's role as a possible inhibitor of carcinogenesis results from increased stool bulk and hydration capacity which may decrease the concentration of fecal carcinogens interacting with colonic mucosa. Fiber may bind fatty acids, bile acids and metabolites which can act as cancer promoters. Specific components of fiber — digestibility, fermentability, bulk density, binding capacity, hydration — rather than total fiber, may be ultimately responsible for the protective effects seen.

  Another question for researchers is whether fiber provides a direct protective effect or whether the benefit comes from fiber foods providing nutritious substitutes for high calorie or high fat foods, which more easily lead to obesity. Much public education is needed to promote 6 - 11 servings per day of whole grains and cereals when these complex carbohydrate foods have been negatively associated with labels of "starchy" and "fattening".

- **Cut Down on Total Fat Intake.** There is substantial evidence indicating that excessive fat intake increases the risk of developing breast, prostate and pancreas cancer. The controversy is whether the increased risk comes from the fatty acid content itself or from the excess total energy (calories) those foods provide. A high fat diet may also

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Questions

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interventions!

- It is estimated 25% of the population of Washington State uses tobacco products.
- Fewer than 60% of smokers report they have *ever* been advised to quit by their health care team.
- Hydrogen cyanide is a poison that attacks necessary respiratory enzymes. It is not found in ordinary air pollution. Long term exposure above 10 ppm (parts per million) is considered *dangerous*. Cigarette smoke contains 1600 ppm!
- Nicotine is a stimulant. f tobacco users go an hour or more without smoking, their nicotine level drops. When the person smokes, the level goes back up and there is a perceived sensation of relaxation or stress relief. In reality, it is just maintaining the "fix."

Answers:

Tobacco related illnesses are preventable! Each of you as a healthcare provider, in whatever capacity, is obligated to assess your patients for use and advise them of the implications to their general health and their healing process.

There are two keys premises to remember about counseling related to tobacco cessation.

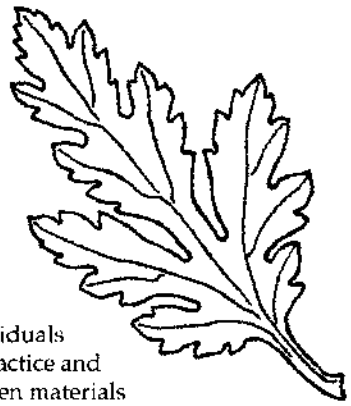
1) When we talk to people about tobacco, this is not a *moral issue* this is a *healthcare issue*. Often the healthcare provider is a tobacco user but as a professional they must separate their use from their role as a provider.
2) Quitting is a *process not an event!* The average tobacco user has seven quit attempts before becoming "quit for life."

As professionals we must learn more about the nicotine's relationship to illness beyond the respiratory system. We need to follow recent research published on its link to interfering with the P450 system in the liver where many medications are metabolized.

Many clients I worked with only understood it was "bad" for them. They were not able to correlate their tobacco use as the cause of their emphysema or their renal cell carcinoma diagnosis to the two pack/day addiction's influence on the kidney.

We must share our knowledge in a consistent, non-judgmental interaction at *every* encounter with individuals in our practice. That seems a lot! Studies have shown tobacco users are more likely to quit when told to stop by their healthcare providers — doctors, nurses, medical assistants.

We must learn to use the "4A" approach : Ask, Advise, Assist, and Arrange. We must learn the stages of "readiness to change" model: Precontemplative, Contemplative, Preparation, Action, Maintenance, and Relapse. We need to apply these in our daily practices.



Watch for those "teachable moments" with individuals in your practice and have written materials available to start the process of dialog.

Discuss with your those you work with what will be the "philosophy" of the healthcare team towards addiction to tobacco. It helps to have a united message so clients perceive it as a "value" in your healthcare delivery system.

Learn more about nicotine replacement therapies. Better to have *one chemical*, nicotine, going into the body than 4,000 chemicals inhaled or absorbed through tobacco.

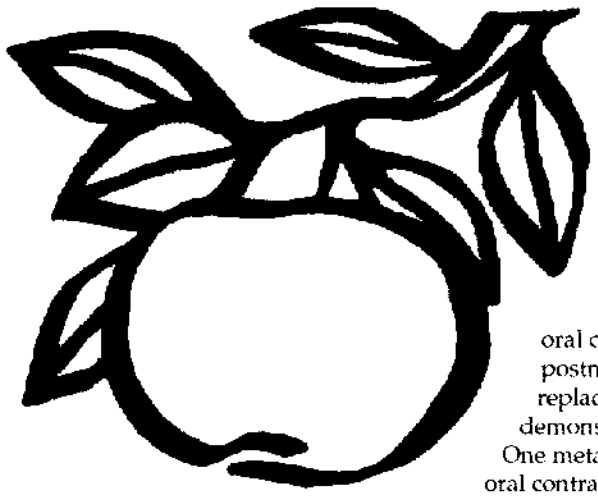
We know nicotine interferes with healing by decreasing blood flow and platelet aggregation. We are also learning more about its negative effects on the immune system. Watch for articles in your journals related to tobacco use.

Finally, if we could save a city the size of Yakima each year just by eliminating secondhand smoke exposure — think what the impact from our interventions with actual tobacco users becoming "quit for life."

Breast Cancer and Hormone Therapy

Barbara Fristoe, MN, ARNP
Virginia Mason Medical Center

The relationship between hormones and the development of breast cancer is unclear. Risk factors attributed to the development of breast cancer that implicate hormonal influence include nulliparity, later age at first birth, early menarche and late menopause. Theories of hormonal risk include long-term exposure of breast tissue to estrogen which increases cell division and proliferation, therefore increasing the chance of genetic changes. Another explanation is that breast tissue exposed to multiple ovulatory cycles faces increased risk of carcinogensis from environmental factors such as chemicals including pesticides, DDT and polychlorinated biphenyls (PCBs).



Role of Exogenous Hormones in Breast Cancer

Studies including use of oral contraceptives as well as postmenopausal hormone replacement therapy have demonstrated conflicting results. One meta-analysis of studies of oral contraceptives conducted between 1966-1989 showed an increased risk of premenopausal breast cancer in women who had used oral contraceptives for several years before their first pregnancy. Confounding factors include changes in the doses of hormones in oral contraceptives over these years as well as changes in women's reproductive patterns over the past 20 + years. Other studies have shown no association between oral contraceptive use and breast cancer.

Data have also been conflicting in associating hormone replacement therapy (HRT) with breast cancer risk. Early use of hormone therapy involved estrogen only. Progestins were added to decrease the risk of endometrial cancer and the role of combined hormonal therapy on breast cancer risk is uncertain. Most studies have shown little or no risk with five years or less of hormone therapy. Both the Nurses Health Study and the Breast Cancer Detection and Demonstration Program showed increased risk with current use of hormones, but not for use in the past. In some meta-analyses, risk is increased in women using HRT for 10-15 years or more. Other studies have shown an increased risk in women with a family history of breast cancer. These studies indicate that specific groups of women may be at increased risk with exogenous hormone use.

From recent studies, there is some evidence that there is improved survival in women who were taking hormone replacement at the time of diagnosis of breast cancer or in the previous year. This effect may be due to better health surveillance in women receiving hormone therapy resulting in early detection. Hormone therapy may also be more likely to produce estrogen receptor positive tumors which have a better prognosis.

Pregnancy and Breast Cancer

Another indication of the complexity of the role of hormones in breast cancer is how pregnancy, with elevated hormone levels, affects women with breast cancer. Studies of women who were pregnant at the time of diagnosis of breast cancer, as well as women who have become pregnant after breast cancer treatment have shown little effect on prognosis, although the numbers of women studied have been small. Women who desire to become pregnant after having breast cancer are generally advised to wait at least two years before becoming pregnant.

Hormone Replacement Therapy

Many women are concerned about the relationship between use of hormone replacement therapy and breast cancer risk. This influences their personal decisions about post-menopausal hormone replacement therapy. The benefits of hormone replacement are well known.

After menopause, the risk of heart disease in women approaches that of men and is the leading cause of death in older women. The use of estrogen replacement may decrease heart disease risk by as much as 50%. Estrogen is effective in increasing high- density lipoproteins and in lowering low-density lipoproteins. Hormone replacement therapy is also effective in preventing osteoporosis by maintaining bone mass. Osteoporosis may lead to hip and wrist fractures with falls as well as painful spontaneous vertebral compression fractures. HRT is also beneficial in relieving vasomotor symptoms such as hot flashes and night sweats. Vaginal dryness, vaginitis, dyspareunia, decreased sexual desire, as well as urinary tract changes including increased urinary tract infections and incontinence may all be experienced in menopause and treated with HRT.

Hormone Replacement for women with Breast Cancer?

An area that has more recently come into consideration is the use of HRT in women who are breast cancer survivors. Historically, hormonal therapy has not been

considered for these women due to risk of activating occult disease. However, many women who undergo chemotherapy for breast cancer experience an early menopause. These women are at increased risk for coronary heart disease and osteoporosis as well as vasomotor symptoms, vaginal and urinary tract changes which interfere with the qualify of life. Post-menopausal women with breast cancer are also at significant risk for heart disease and osteoporosis.

Few studies have been done to evaluate hormone replacement in women with breast cancer. One report includes 77 women with a history of breast cancer who decided to start or continue with HRT. The median time between diagnosis and start of HRT was two years, although 48% started within two years. The majority of women had Stage I disease (43). Seventeen women had Stage II and five had Stage III. Eighteen percent of patients had positive lymph nodes and 28 patients had positive estrogen receptors. Seven women had recurrence of their breast cancer with after an average of 45 months on HRT. Of the original 77 women, 72 have no evidence of disease. Two women are alive with disease and three have died, although one woman who died had no evidence of disease.

With conflicting and contradictory information from studies of hormonal effects on breast cancer development, there are no clear answers on HRT for women with breast cancer. There is currently one clinical trial at M.D. Anderson Cancer Center to evaluate hormone replacement therapy in women with breast cancer, and hopefully, more studies and reports will be available in the near future. At the present time, HRT may be considered in individual cases when the benefit may outweigh the risks, with full disclosure of risks and benefits as well as exploration of alternative therapies for menopausal symptoms.

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Outdoor adventures for people who live with cancer

FREE is an outdoor adventure program for people who live with cancer, Through wilderness experiences, "FREE" promotes healing on a physical, emotional and spiritual level. With goals of independence and self reliance, this program encourages participants to break free from cancer and get on with their lives. Through the sharing of this experience, participants learn they are not alone in their recovery.

This program is a collaborative effort between Flathead Valley Community College and North Valley Hospital.

Program Structure

Once a person has made the decision to participate, there are three components to the program:

1) A history and physical exam must be completed by the person's physician.
2) Each participant is expected to develop their own exercise program which would include aerobic conditioning, muscle strengthening as well as flexibility. An exercise physiologist is available to offer an individualized exercise prescription for each participant. An eight to 12 week training period is recommended.
3) The actual week long wilderness adventure which includes activities such as hiking, canoeing, backpacking, rock climbing. A solo experience is also encouraged to allow participants time for reflection and introspection.

Experiencing the wilderness with its physical as well as psychological challenges develops confidence, willingness to accept risks and courage to overcome difficulties. Self confidence, courage and determination are all important guides for health. By understanding our strengths as well as our weaknesses, we discover the hidden resources within ourselves. Long term recovery is enhanced by renewed physical strength, an improved emotional outlook, and increased spiritual awareness.

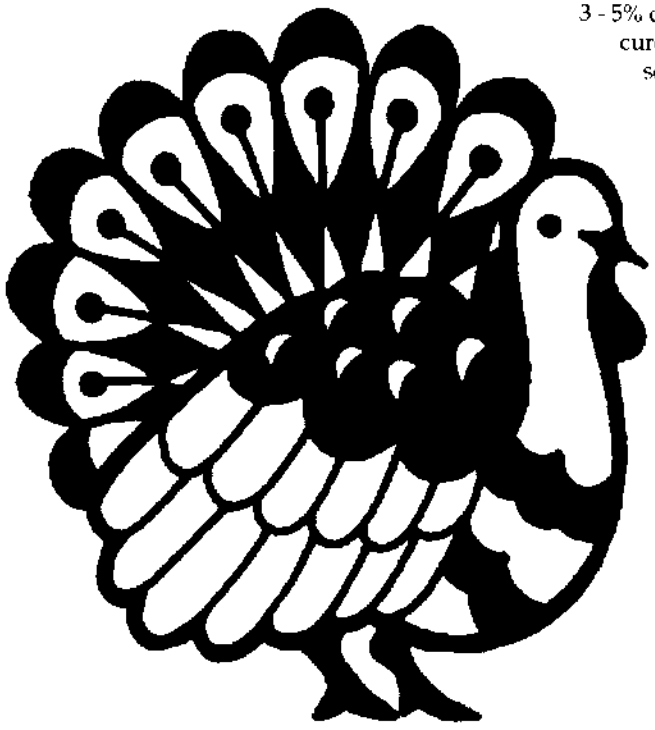
If you would like more information regarding this program or if you would like to participate, contact:

Wellness Center
North Valley Hospital
6575 Hwy 93 South
Whitefish, MT 59937
(406) 863-3502

Nutrition

Continued from page 7

promote colon cancer risk by increasing production of bile acids and sterols which possibly produce carcinogenic compounds and mutagens. The current recommendation by the American Cancer Society, American Heart Association and the National Cholesterol Education Program (NCEP) is for all persons older than two years of age to reduce total fat intake to 30% or less of total daily calories. Present consumption averages 37% of total calories. Reducing dietary fat can be achieved by reducing use of fats and oils high in fat, such as some meats and whole-fat dairy products, with their lower fat counterparts, and choosing processed foods with less added fat. "Fat banking" — reducing fat from certain foods in order to eat more fat in others — does not change the overall percentage of fat in the diet and will not enable a person to reap the benefits of an overall lower fat diet. A current trend in research is studying the effects of canola oil, fish oils and flaxseed — rich sources of omega-3 fatty acids — which may decrease or alter inflammatory mediators such as prostaglandins, cytokines and leukotrienes, and help stimulate immune function.



- **Limit Consumption of Alcohol.** Heavy alcohol consumption greatly increases risk for head and neck cancers, including oral cavity, larynx, esophagus and possibly breast (alcohol may promote higher estrogen levels). Current guidelines suggest limiting consumption to two drinks (24 grams of alcohol or 2 ounces hard liquor) per day for men and one drink for women. The mechanism of alcohol-induced carcinogenicity is not clear. Factors include direct carcinogenic metabolites, associated malnutrition with excessive intake and host immunosuppression.

- **Limit Consumption of Salt Cured, Smoked, Nitrite Preserved Foods.** Data from international research shows a correlation between stomach and esophageal cancer and smoked/pickled foods. Conventionally smoked, grilled, charcoaled and blackened foods absorb tars which arise from incomplete combustion in the heating process. Tars contain numerous carcinogens similar chemically to those found in tobacco smoke. Nitrates and nitrites used in food processing and preserving are believed to enhance carcinogenic nitrosamine formation in foods and the gastrointestinal tract. There is evidence that modern methods of food processing and preserving appear to avoid many cancer-causing byproducts. Currently approximately 95% of nitrites come from metabolism of naturally-occurring ingested nitrates in vegetables and are impossible to avoid; only about 3 - 5% of dietary nitrites come from cured meats, making this risk somewhat insignificant.

Antioxidants and Phytochemicals

The antioxidant micronutrients vitamins C, E, Beta-carotene and Selenium neutralize free radicals. Free radicals are produced in the body as products of normal metabolism and from exposure to radiation and environmental pollutants. They cause damage, inflammation and mutation of cellular components such as DNA and are implicated in a variety of diseases. Antioxidants may prevent the induction and promotion stage of carcinogenesis.

The carotenoids (provitamin A) include dark green, yellow and orange fruits and vegetables. Inadequate amounts of vitamin A and its derivatives may cause abnormalities in epithelial growth and differentiation. Vitamin A supplements in high doses are not recommended due to toxicity from excessive storage in fat tissue. There are no known serious side effects from diet supplementation with water-soluble beta-carotene.

Vitamin C sources include citrus fruits, peppers, berries and broccoli. This vitamin may exert anti-carcinogenic effects by reacting with nitrites before nitrites can react with dietary amines to form toxic nitrosamines. Some studies have found evidence that vitamin C may be especially protective against stomach, esophagus and colon cancer. Though water soluble, high daily doses of one gram or more can cause harm, inducing osmotic diarrhea, hyperoxaluria, promoting hemolysis, and destroying vitamin B_{12}.

Vitamin E (alpha-tocopherol) is found in green, leafy vegetables, grains, vegetable oils, nuts and seeds. Its possible mechanisms to reduce cancer risk include free radical scavenging, limiting lipid peroxidation, competing for available nitrites and blocking conversion to nitrosamines. Regular daily doses greater than 800 IU may displace absorption of other water soluble vitamins and impair leukocyte function.

Selenium is a trace element found in fruits and vegetables. It has a major role in the activity of glutathione peroxidase, an enzyme which protects against oxidative tissue damage. The unsupervised use of this supplement is not recommended due to potential selenium poisoning.

Results from recent clinical trials on antioxidants do not support widespread supplementation as a means to reduce cancer risk. Biological action ultimately depends on the concentration of the protective compound in the target tissue at the crucial point in the pathophysiologic process that determines disease. The epidemiologic link between antioxidant micronutrients and disease has been based on data using food intake or blood levels that are the result of food choices, not supplements. No biologically active agent administered in high doses can be considered risk free for all people, even if the substance is a normal component of the food supply. Thus, the focus is on a healthy diet that includes more fruits and vegetables as a strategy for disease prevention.

Fruits and vegetables also contain non-

nutritive chemicals known as phytochemicals which show great promise in cancer prevention. These beneficial chemicals — indoles, flavonoids, phenols, isothiocyanates, lycopenes, sulforaphanes, carotenoids, allyl sulfides, to name a few — can increase the activity of protective detoxifying enzymes such glutathione S-transferase, block hormonal and enzyme receptor sites, regulate production of prostaglandins, perform antioxidant roles, inhibit nitrosamine formation and help cells remain differentiated. Phytoestrogens, found in berries, soy and produced by fiber- digesting colonic bacteria, may be able to reduce the risk of hormone-related cancers by competing with endogenous estrogen for binding on available estrogen receptor sites.

Summary

Current recommendations for an optimum diet to reduce cancer risk emphasizes a decrease in fat intake to 30% or less of total calories, an increase of grains to 6 - 11 servings and 5 - 9 servings of high fiber fruit and vegetables every day. Based on current food trends, it would seem that Americans are either unaware of the significance of healthy eating, unconvinced of the need to change, or unwilling to take a proactive role in disease prevention.

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Cancer-Related Checkup Guidelines

Judy Peterson, RN MN

While our patients ask the question "why me?" and worry about recurrence, their family and friends often worry also: " Will I get cancer?" "Can this happen to me too?"

We as oncology nurses need to acknowledge this fear in our patient's, their family members and caregivers, and in ourselves too. Becoming familiar with the American Cancer Society (ACS) guidelines for screening is one way to face the fear and act against it. Review the guidelines with your patients family members. When you're asking them, "How are you?", also ask them how they are taking care of themselves. Use this opportunity to discuss cancer fears, hereditary links, prevention activities, and cancer screening. The family member and caregiver can easily put off care of themselves, ("no time", "can't worry about me now") when feeling overwhelmed with their loved one's illness. Our encouragement and advice can give them permission to help them take that step to care for themselves. A negative screening exam result can help family member & patient sleep better! We can all do with a few less things to worry about!

These ACS guidelines are for asymptomatic individuals. Individuals who are symptomatic, have had a previous cancer, or are at high risk should discuss what screening tests and frequency are appropriate for them with their health care provider. By the way, have you had *your* mammogram?

Summary of American Cancer Society Recommendations For the Early Detection of Cancer in Asymptomatic People

Test or Procedure	Population		
	Sex	Age	Frequency
Sigmoidoscopy, preferably flexible	M & F	50 and over	Every 3-5 years
Fecal Occult Blood Test	M & F	50 and over	Every year
Digital Rectal Examination	M & F	40 and over	Every year
Prostate Exam*	M	50 and over	Every year
Pap Test	F	All women who are, or who have been, sexually active, or have reached age 18, should have an annual Pap test and pelvic examination. After a woman has had three or more consecutive satisfactory normal annual examinations, the Pap test may be performed less frequently at the discretion of her physician.	
Pelvic Examination	F	18-40 Over 40	Every 1-3 years with Pap test Every year
Endometrial Tissue Sample	F	At menopause, if at high risk**	At menopause and thereafter at the discretion of the physician
Breast Self-Examination	F	20 and over	Every month
Breast Clinical Examination	F	20-40 Over 40	Every 3 years Every year
Mammography***	F	40-49 50 and over	Every 1-2 years Every year
Health Counseling and Cancer Checkup****	M & F M & F	Over 20 Over 40	Every 3 years Every year

*Annual digital rectal examination and prostate-specific antigen should be performed on men 50 years and older. If either is abnormal, further evaluation should be considered.
**History of infertility, obesity, failure to ovulate, abnormal uterine bleeding, or unopposed estrogen or tamoxifen therapy.
***Screening mammography should begin by age 40.
****To include examination for cancers of the thyroid, testicles, prostate, ovaries, lymph nodes, oral region, and skin.

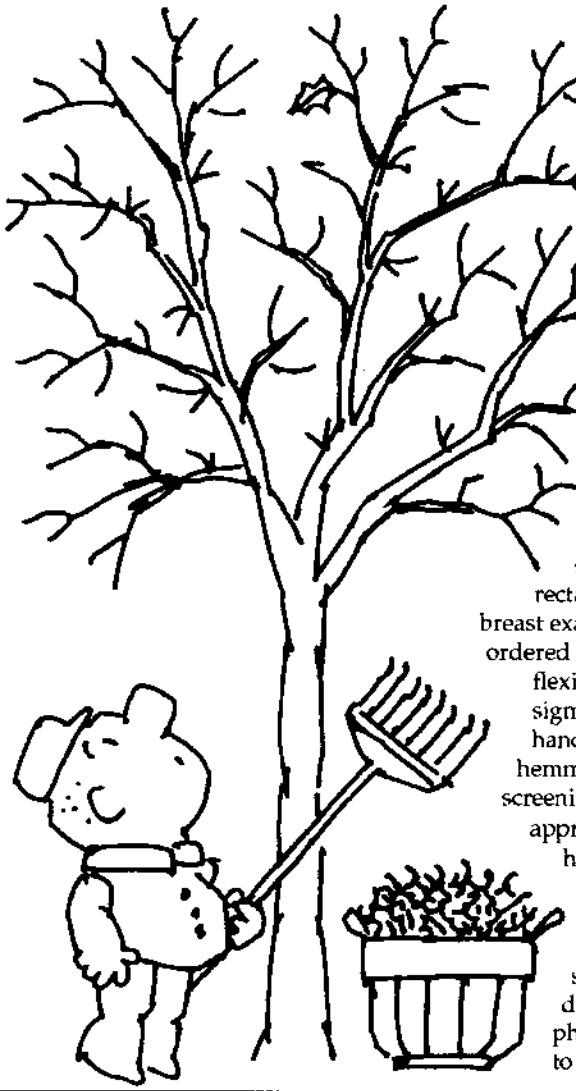
Revised November 1992.

Oncology Nursing and Cancer Prevention and Detection from the Primary Care Perspective

Irene J. Karlsen Thompson RN, MSN, ARNP, OCN
Village Family Medicine, Issaquah, WA.

For the first time in my 21 year career as an RN, I am not employed in an oncology setting. I recently left employment with Fred Hutchinson Cancer Research Center, and have taken a part-time ARNP position with a very pleasant, family practice clinic in Issaquah. The reasons for the change at this time in my life, were two fold: 1) As a relatively new ARNP, I wanted the opportunity to solidify my general medicine skills and knowledge base. 2) Personally, as an Issaquah resident, the opportunity to serve patients in my own community (and commute 5 minutes to work), and as a new mom to work part-time, were both very appealing to me. So...anyway...here I am...an oncology nurse in a primary care setting.

It is very interesting being on "the other side." What is amazing to me, is that in just my two short months of primary care, how often I use my oncology knowledge and experience. I believe I could accurately say that I do this on a daily basis. So far, I have diagnosed an older woman with two separate skin cancers, a salivary gland tumor in a young woman (benign, thank goodness), sent several people for biopsies of unresolving lympha-denopathy, performed many pap smears, pelvic, rectal, testicular and breast exams. I have ordered mammograms and flexible sigmoidoscopies, and handed out hemmoccult kits, all as screening tests for age appropriate patients. I have counseled teenagers about tobacco, particularity the smokeless type, during their physical exams prior to participation in sports. I have felt saddened to meet women, who have never been taught breast self exams (BSE). I have dispelled "cancer myths" and taught patients about lifestyle choices to help prevent cancer. And, I have utilized hospice and bereavement resources with a grieving family. In addition, I am currently in the process of purchasing breast models for use with BSE teaching, and am "decorating" my exam rooms, with American Cancer Society (ACS) and National Cancer Institute (NCI) posters and materials.



Being a primary care provider, one needs to be "a bit of a jack of all trades." And yet, one of the most frightening situations for me to think of, is missing a cancer diagnosis. Being oncology nurses, we've all heard the horror stories of misdiagnoses. While there are so many conditions that one needs to be alert to, cancer is often in the list of differentials. One of the critical components of care for me, is close and diligent follow up. Anything that doesn't resolve in the usual course, is worked up. I keep personal notes on my calendar and follow up with patients, if they haven't returned to clinic. While I realize that my perspective is quite prejudiced towards cancer as a diagnosis, I think a heightened awareness of this disease, can only serve both me as a provider, and my patients, very well.

There have been moments in my two months of primary care, that my heart has felt a tug because I am not working in an oncology setting. And yet, I am coming to realize that as an oncology nurse, there are so many opportunities for me to make a difference in people's lives right here, right now, where I am currently "planted." For example, my healthy lifestyle teaching may make a difference and help to prevent a cancer occurrence. Or, my close follow up may diagnosis a cancer in an early, more curable stage. As an oncology nurse, another practice possibility I have been thinking about, could be to provide primary care to oncology patients. With the changes in health care today, often oncologists can no longer be primary care providers for their patients. What a valuable service for oncology patients to have their primary care provided by oncology skilled practitioners.

In closing, I have loved my years as an oncology nurse. I am glad to have this unique opportunity to utilize my oncology knowledge and skills as a Family Nurse Practitioner. It allows me the chance to focus on cancer prevention and detection, and to hopefully make a difference to the people in my home community.

Chapter News

Mount Hood Chapter
Lyn Glenn, President

This fall has been a full season for the MtHCONS and we look forward to having a brief siesta during the holidays. We were fortunate to have several interesting programs over the past few months. In September we had our we had our traditional, "Wine and the Grapevine" meeting where we had a speaker on music therapy along with some time to catch up after the summer. Jayne Van Brunt spoke to us in October about preparing patients for stem cell transplantation, and in November our topic will be survivorship.

At our annual January banquet, I will turn the presidency over to our president-elect Susan Elsom. t has been a great year and I have enjoyed serving as President of the Mt. Hood Chapter. I appreciate all the support over the past year (especially the "skiing incident"), and would like to acknowledge the hard work and commitment of the board, committees and chapter members. Thank you!!

Inland Northwest News
Kappy Finstuen

The INONS has been very supportive of education for their members. n 1994 the chapter paid the tuition for Sue Herbst to attend the International Oncology Society meeting in Vancouver, BC. This year the board voted to assist with tuition for Kappy Finstiuen to attend the International Oncology Nursing Society meeting in Brighton, England. The chapter's support has enabled us to attend a wonderful conference with oncology nurses from around the world.

Kappy reports that the nurses from the USA were in the minority, and while English was the official language of the conference during breaks and lunch it was difficult to find conversations in English! There were 1400 nurses attending from 76 countries. There was more emphasis on palliative care and symptom management throughout the conference and less on high tech therapies. The next international meeting will be in 1998 in Jerusalem.

In other news, long-time oncology nurse Mary Duff, formerly at Group Health in Seattle, will be leaving her post as Director of Oncology Services at Holy Family Hospital in Spokane. She is taking a new professional direction and will be a full-time nurse practitioner with a family practice group in Coeur d' Alene, ID. We congratulate her and wish her well, but we will miss her participation in our chapter.

Columbia Basin Chapter
Jan Jacobson, President

Our chapter is excited and challenged as it helps sponsor the first "Core Curriculum for Oncology Nurses" three day Seminar. This seminar was presented November 12-14, 1996 and also was tied in with the chapter's bi-monthly meeting on November 12. Due to overwhelming response from all parts of the Tri-Cities, some individuals signing up had to be turned away as the room capacity used at the City University, Richland, was only 40!

The Pain Network, headed by Jannette Weber, in conjunction with the home health agencies in the area presented three "lunch-time seminars" to physicians and their professional and clerical staffs. The purpose was to inform them of how to give messages to the physicians when a home health agency or Hospice RN contacts an office. Hand-outs containing the most frequently used pain medications along with dosages, routes of administration, and other pertinent information to aid physicians' staffs as they communicate with RNs in behalf of home care patients. These seminars were a great success.

Elections for 1997 were recently held for the chapter with the following results:

President:	Jan Jacobson
Vice President:	Becca Hawkins
Secretary:	Nancy Hutt
Treasurer:	Nancy Bray

Congratulations to all of these individuals and thank you to those who served so faithfully in 1996.

REMEMBER:

SELECTING OUR FUTURE LEADERS
ELECTION 97
IT'S YOUR RESPONSIBILITY
ONS

Ballots will be sent out by January 2, 1997.

Call ONS (412-921-7373) if you do not receive a ballot by January 13, 1997.

Complete your ballot and return to ONS by February 6, 1997.

PSONS Call to Elections

If you would like to serve or nominate some one else to serve, as president-elect or treasurer, for the coming two-year term, please call **Renee Yanke** by December 15, 1996: (360)579-2480 home or (360)678-5151 ext. 2650 work.

Clinical Practice

What makes a Clinic a "home"?

Cathy Thomas, RN, OCN
Northwest Cancer Center
Seattle, Washington

From the entry to our cancer center clinic, laughter is often heard. Laughter? n a cancer center? We pride ourselves on the warm, family atmosphere we provide. Hugs of love, joy and sadness are easily shared with patients and family as we welcome the return of patients and family members.

Our wonderful staff at the front desk not only welcomes each patient by name, they work hard at making the schedules work for the patients (and the nurses!). They know how long each person has waited or if the news is bad. They share a warm hand and a hug too. Patients are greeted by name, and welcomed into a comfortable "living room." While they wait, there is a puzzle table which allows patients to take their minds off the wait, to meet other patients and share their experiences. A coffee station is available with juices, tea or coffee, crackers, and seasonal goodies to share. Light reading materials are available, as well as a library of tapes, videos and books on cancer and non-cancer topics. Educational or entertainment videos can be viewed on individual video machines while patients are receiving their infusion therapy. Relaxation tapes or books varying from the classics to recipes are also available.

Our laboratory has pictures of staff member's families (children and/or pets) that helps to break the ice with many patients. This provides a nice distraction from the blood draw. We also have a small stuffed animal that wears the costume of the season (a Mariners cap and bat, a pilgrim outfit, skis and goggles, etc.). This provides an opportunity to establish rapport through a laugh at something silly.

The patients often share their experiences with other patients in our large treatment center, though private rooms are also available for those wishing privacy. Nurses and patients are often heard laughing together. As we extend our graciousness to all and it seems to just continue to grow and grow! How special it feels as these individuals return the caring to themselves, and to us. Our gifts of love and compassion, and frankly our reason for being oncology nurses, develop during these special times.

Our office sends out newsletters to patients and families at various times, and this often includes a picture of us with our signatures. It's another way to reach out to the patients and families from our Northwest Cancer Center family. We can laugh together, and we can cry together. It is so rewarding! If you are in the area, please stop by so we can meet you and share our clinic.

19TH ANNUAL PSONS SYMPOSIUM

March 21 & March 22, 1997

Sea-Tac Red Lion Inn
Keynote Speaker:
Patt Schwab, Ph.D.
"When Hell Freezes Over, Ice Skate!!"

11th Annual
McCorkle Lectureship -
Ann McElroy, RN,MSN,OCN
"Cherry Ames, Transition Nurse"

Conference brochures to be mailed shortly. Call Deanna Kruckenberg, (206)845-8443, or Julie Peerboom, (206)589-3114, with any questions.

Education Committee

Judy Oliver, Sue Ford, Marge Ramsdell, Monica Smiley, Mary Underbrink, Kathleen Clapp

Pinpointing inherited genetic mutations predisposing a person to cancer has been an issue oncology nurses have wanted to know about. At our next educational meeting, on January 14 at Highline Hospital, **Cathy Goetsch RN BSN OCN** will talk about what to say when your patient or their family asks about genetic testing for cancer. She will cover genetic markers, particularly *BRCA1* and *BRCA2*. Cathy works in the Cancer Prevention Program at the Virginia Mason Research Center. OncorMed will sponsor dinner and provide educational materials. Cathy is currently the PSONS secretary, so please come meet and talk to one of our PSONS officers.

It is a pleasure to announce **Marge Ramsdell** as the next education chair. Marge is the Head Nurse of the Hematology/Oncology Clinic at Madigan. **Mary Underbrink** will be the committee chair until January and then Marge will take over.

We have three more nurses who are willing to share their expertise with you by being on the PSONS Speakers' List.:
Patricia Corcoran Buchsel RN MSN
Marrow and Blood Transplant Consultant
Senior Research Associate at the University of Washington
Long Term Complications in Oncology Patients after Chemotherapy and /or Transplant
Cancer Related Fatigue

Joelle R. B. Machia, RN BSN BA
Clinical Coordinator for the Breast Cancer Prevention Trial
Fred Hutchinson Cancer Research Center
Clinical Trials for Prevention of Breast Cancer
Tamoxifen
Self Breast Exam
Patient Advocacy

Ann W. Breen RN MN OCN CS
Transition Coordinator
Fred Hutchinson Cancer Research Center
Patient Education Programs
Preparing Patients and Caregivers for Outpatient Care
Coordination Between Inpatient and Outpatient Care

Please call Mary Underbrink if you would like more information about the PSONS Speakers' List at 823-5828.

The Chapter spent $650 to buy the *Instructor's Resource Manual for the ONS Core Curriculum for Oncology Nursing*. Included in this is 1) a manual of lecture outlines, 2) handouts, 3)transparencies, and 4) full-color slides. PSONS will be using this resource annually for teaching the *Review for OCN Certification* held in August and *Foundations in Chemotherapy* held in November. If you would like to borrow this resource when the Education Committee is not using it, please call Mary Underbrink at 823-5828.

If you are interested in studying for the Advanced Oncology Nursing Certification, using a computer CD-ROM, call Glaxo Wellcome Education Resource Center at 800-824-2896.

Just a little recap about our educational meetings: On September 18, **Donna Berry PhD, RN, OCN** spoke on Prostate Cancer at Fred Hutchinson on First Hill next to Swedish. She presented an excellent state of the art overview of what is happening in taking care of prostate cancer patients. We had an excellent turnout even though Donna's lecture competed with President Clinton coming to town that day.

On October 24, **Lee Paton RN MSN** presented at Seattle University. Her talk was on spirituality and suffering and how they intertwine.

New developments in breast cancer treatments were discussed on November 6 at Virginia Mason. **Kathy Lilleby RN,** a clinical research nurse at Fred Hutchinson Cancer Research Center, presented her work with the breast and ovarian cancer vaccines. **Lori Fagnan RN,** clinical research nurse from the Tumor Institute at Swedish, presented on using monoclonal antibodies for treating metastatic breast cancer.

Many people have made inquiries about a chemotherapy course. In conjunction with the University of Washington, *Foundations in Chemotherapy Practice* was conducted on Nov. 13 and 14. The course was designed to provide the knowledge base for nurses to safely and effectively administer chemotherapy and manage side effects. Each participant received the *1996 ONS Cancer Chemotherapy Guidelines and Recommendations*.

We hope to see you around!

PSONS NEWSLETTER
Published four times a year by the Puget Sound Chapter of the Oncology Nursing Society with the support of the American Cancer Society.
Editor: Connie Horton,
W: (206) 223-6193
Fax: (206) 223-6914

Submit materials for publication to Connie Horton, PSONS Editor,Lake City Professional Center, 2611 N.E. 125th St., Suite 305, Seattle, Washington, 98125-4357. (206) 386-2013

Call PSONS @ (206) 361-4736
between 9 a.m. and 5 p.m.

Membership Application 1997

Puget Sound Chapter Oncology Nursing Society
2611 NE. 125th Street, Suite 305, Seattle, WA 98125

Last Name _____ **First** _____ **Middle** _____

Please asterisk mailing address.

Home Address:
Street _____
City _____
State _____ Zip code _____
Phone ( ) _____
E-Mail _____

Business Address:
Institution _____
Street _____
City _____
State _____ Zip _____
Phone ( ) _____ Fax _____

New ____ Renew _____ ONS #_____ Special Interest Group _____

ONS by-laws require that chapter members must also be member of the ONS. Call (206) 361-4736 for an application.

Employment: Full Time __ Part Time __ Not Employed __ Patient Population: Adult __ Pediatric __
Career Area: Patient Care __ Administration __ Research ___ Education __
Highest Degree: Diploma __ Associate __ Bachelor ___ Master __ Doctorate __
Specialty: Chemo __ Immuno __ XRT __ Home Care __ Surg__ BMT __ Hospice __ Other _____

Dues:
1997 $25_____ Late fee for renewals after 3/31/97 $5_____ Total enclosed $_____

Dues are indicated above and must accompany this application. Chapter membership runs from January 1 to December 31. No partial payments are accepted during the year . A late fee of $5.00 will be assessed for any renewal of membership after March 31.

American Cancer Society
Washington Division, Inc.
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Seattle, WA 98109

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