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INSIDE

TEACHING CANCER PREVENTION AND EARLY DETECTION

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Oncology nurses know first hand about cancer and its impact on patients and their families. Most oncology nurses work with patients during or after their diagnosis of cancer. We make a tremendous impact on their cancer journey by offering emotional and physical support, and teaching patients and their families about the multiple aspects involved in the management of their cancer. We have educated ourselves about theories of carcinogenesis, and we take patient histories with these in mind (i.e. risk factors that might have influenced development of their disease—smoking and alcohol use, occupational, medical, behavioral or environmental exposures to carcinogens, familial history of cancers, etc.) We help patients deal with the guilt of long term unhealthy habits that may have contributed to their current health crisis state.

Oncology nurses also have the opportunity to rise to the challenge of impacting cancer incidence by "preaching" prevention and educating women about early detection. When we look at the contributing causes to cancers as a whole, and to the risk factors, 75-80% are lifestyle related. The contributing factors are diet, tobacco and alcohol use, occupational exposure, pollution, sexual behavior, and sunlight radiation exposure. Actually less than 1% are attributed to food additives. All cancers caused by smoking of course could be prevented. When we look at how to prevent cancer we would need to completely avoid exposure to all carcinogens. For those who live in a modern society such as ourselves this is nearly impossible. However, some risk factors for cancer can be modified with lifestyle and environmental changes. The answer for what to "preach" to make a difference is very simple and includes five steps. For some, these steps are not such drastic changes and require just a bit more diligence. For others it will be much more difficult and include changing some not so healthy habits or treating serious addictions. The lifetime risk for cancer for all sites for males is one in two and females one in three. The message in these cancer statistics is not difficult to find. It is time to be proactive, to speak up. The fact of the matter is that at any decade we can make a difference in our risk factors by addressing the following areas:

1) Healthy Diet
2) Physical Activity
3) Limiting Consumption of Alcohol
4) Avoidance of Tobacco
5) Sun Protection

Where do we take this simple message and to whom do we tell it? As oncology nurses we have a unique role

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President's Message

New Beginnings

Margot Hill

Margot Hill, BSN, RN, OCN

As I write this column for the fall issue it is now mid-summer. This is a pivotal point in the year for PSONS, to look back at our successful spring and forward in anticipation to new goals and actions for this fall and the coming year, 2002. I have always looked at fall as a time for new beginnings. All those years of school I happily went off in September anticipating a new experience. With the fall colors and cooler feel of the air that longing returns for something new in my life. During my adult years I have usually planned to take a class and/or start a project. This year PSONS offers for all members a smorgasbord of choices for participating in a meaningful challenge. Of the many choices, these are a few: taking the Workshop to Improve Presentation and Writing Skills, joining and participating on a committee where you will meet new people, attend Institute of Learning in St Louis in November, investigate and apply for an ONS award or grant, log on to the web pages (psons.org and ons.org), work on a political campaign, and/or study a health care issue you care about and contact your elected officials. The personal payoff to making the commitment of time and energy to a new experience is feeling alive and becoming more energized.

A warm welcome is extended to our new members. Membership is what PSONS is about. Each member supports the organization financially with dues and participates in a network that expands knowledge, influences the community and facilitates the political process in issues of importance to oncology nurses, their patients and people who support them. I encourage all new members to become involved in a committee this fall. Once you become active you will be hooked. The satisfaction of learning, contributing and meeting friends who share your passion for oncology nursing will enrich your life. Ask anyone who has been an active member for a few years about their experience in PSONS and what it has meant for them. Our chapter is so special that some members who have moved from the area have maintained their membership. Among them are Ann Reiner, Director-at-Large of ONS and Brenda Nevidjon, President of the ONS Foundation.

At Congress in May our Puget Sound Chapter was singled out by ONS President Paula Trahan Rieger in the welcoming speech titled "The Power of One", about collaboration, power and transformation of cancer care. She mentioned our Education Cooperative which involves a number of regional institutions and then the presentation and writing skills workshop made possible through partnering with The Bone Marrow Transplant Consortium. A good number of our members and regional oncology nurses presented at Congress. With apologies to anyone I missed, they were: Colette Chaney, Juanita Madison, Donna Berry, Barbara Fristoe, Cathy Goetsch, Gloria Winters, and Rosemary Ford.

Two new projects took place this year. The Communication Game: Workshops to Improve Presentation and Writing Skills was offered in May and again in September. These two workshops were provided by a one-time grant from the Seattle Bone Marrow Transplant Consortium. Participants will provide a base of professional members in our organization who have been trained in making presentations and writing for publications.

Another successful new undertaking has begun. Five nursing students in their junior year at Seattle Pacific University each worked on an assignment with a board member. Their goal is to learn the role of professional organizations in advancing nursing practice as well as the role of nonprofit organizations in doing advocacy work for

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From the Guest Editor

Cathy Goetsch, MSN, ARNP, AOCN

Women's health and cancer related issues is the broad umbrella that unites the varied articles in this issue. Prevention of cancer has specific implications for women's health. In her article, "teaching women about cancer prevention and early detection," Carla Jolley reminds us of the importance of oncology nurses in promoting screening in asymptomatic women. When we thing of women and cancer, breast cancer is at the top of the list. I have tried to review the complex and controversial subject of hormone replacement therapy including the newest research data as it relates to breast cancer risk and prevention. Margot Hill shares with us the first hand experience of entering a clinical trial looking for additive benefit of another agent after traditional tamoxifen adjuvant therapy. Looking at another problem facing breast cancer survivors, Liz White instructs us on the topic of lymphedema. Finally the most important women's health issue of all, CHOCOLATE. My (little) sister, Mary Moss, takes a look at the data to support the use or avoidance of this often maligned and yet universally coveted chemical. I hope you find these articles instructive and entertaining.

Cancer Detection and Prevention: Five Factors Affect Health

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in the health of our community. The definition of "community" is not limited only to our neighborhood, but includes those we gather with in our personal lives, extended family, workplace, church groups, soroptomists, quilting groups, PTA. It includes those who know us personally and know that we are oncology nurses. It is not uncommon in these communities to be consulted, seen as the "expert" or a valued resource about cancer and cancer care as an oncology nurse. For our patients and their families we often have a very captive audience as they are feeling vulnerable, at risk, and mortal with their exposure to the disease of cancer. They are searching for ways to support long-term wellness and healing. The challenge becomes how to internalize and act on the information for ourselves, how to educate and/or motivate our loved ones, and how to incorporate prevention based teaching into our roles as nurses and to get the message out to the broader spectrum of community or public.

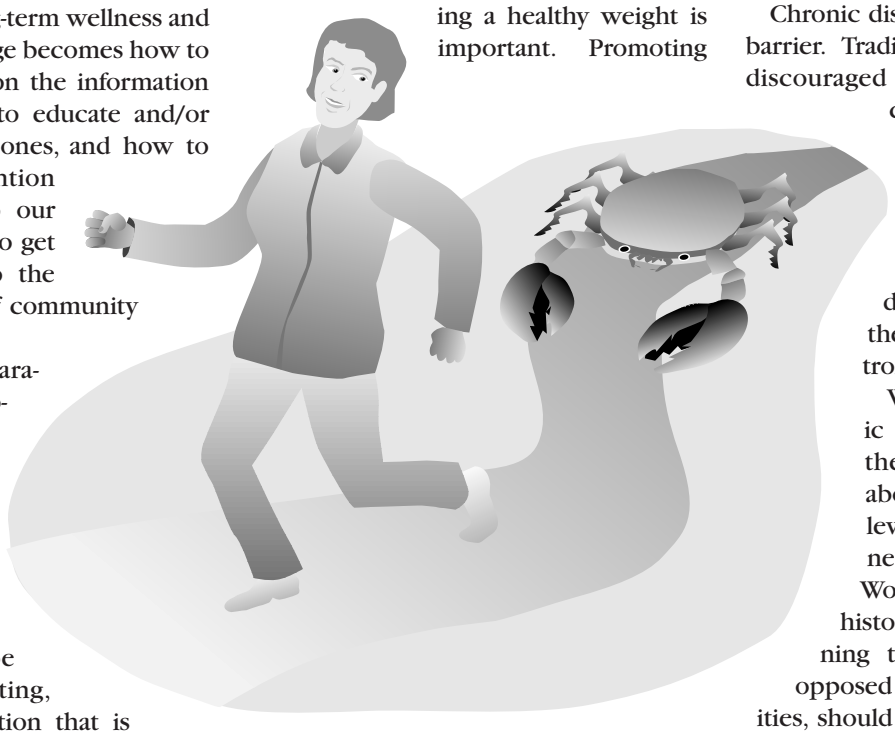
The following paragraphs present supporting information for the general message in each step. The need to expand or review information will depend on the audience to be addressed, the setting, and the time limitation that is imposed. This information can be shared informally with friends and family members or to the larger community through health fairs, community classes, or church education programs. The "take home" or "take to heart" bottom line needs to be simple and easily recalled.

Healthy Diet

The dietary recommendations from the American Cancer Society are very simple. There are no fancy menus or difficult food combinations to learn. It all comes down to three easy things to remember (though not always so easy to adapt).

- Choose most of your foods from plant sources
- Eat five or more servings of fruits and vegetables daily
- Limit high fat foods

These recommendations provide the protective mechanisms in food of antioxidants, phytochemicals and fiber. Antioxidants provide defense mechanisms against oxygen free radicals, which are major contributors to DNA damage. (Good news-chocolate is an antioxidant, bad news-its high in fat.) Dietary fat is actually a "cancer promoter". The recommendation is to limit fat to 20-30% of daily caloric intake. Obesity itself is a risk factor of several cancers and maintaining a healthy weight is important. Promoting healthy weight loss and proper nutrition are key components in addressing obesity. Ideal weight does not necessarily mean having an ideal body.



Physical Activity

Physical activity is considered part of cancer prevention, though it will support and improve your cardiovascular health too. Part of the benefit comes with weight loss or maintenance, but it improves overall immune response, decreases level of stress hormones, and improves circulation. The Surgeon General's recommendation for health includes engaging in moderate activity for 30 minutes for most days of the week. What is moderate activity? It is any activity that causes the body to work harder than the norm. This means the heart beats faster, muscles contract, and body temperature rises. Getting thirty minutes can be broken up even into 10 minutes three times a day. How much to do depends on a person's unique situation. The goal is to improve from wherever they are right now. It is important to start out at a level they can manage and work their way up gradually. Some people are reluctant to start exercising because they are afraid it will be too strenuous. Even small amounts of increased activity brings many health benefits.

Chronic diseases are not necessarily a barrier. Traditionally, exercise has been discouraged in people with certain chronic conditions. But researchers have found that exercise can actually improve some chronic conditions in most older people, as long as it's done during periods when the condition is under control.

Women living with a chronic illness should check with their health care provider about increasing their activity level to make sure their illness is stable before starting. Women over 50, with a family history of heart disease, or planning to start with vigorous as opposed to moderate physical activities, should check with their primary health care provider. Most older adults, regardless of age or condition, will do just fine in increasing their physical activity.

Choose an activity they are comfortable with. Many people choose walking because it is cheap and easy and easy to work up to the thirty minutes at a comfortable pace. But gardening, a dance class, playing catch with the kids works too. Just do it!!!!

Limiting Consumption of Alcohol

Alcohol consumption is not recommended. If consumed at all, it is recom-

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Cancer Detection and Prevention: ACS Guidelines

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mended to limit alcoholic drinks to less than two drinks a day for men and one for women. There is convincing evidence that alcoholic drinks increase the risk of cancers of the mouth, pharynx, larynx, esophagus, and liver. This risk is multiplied for drinkers who also smoke. Though the data is not as strong for cancers of the colon, rectum and breast, alcohol consumption probably increases the risk for these cancers too.

For some this will not be a difficult task. Simply heightened awareness and changing consumption patterns will be sufficient. For others, identifying and dealing with addiction will be more threatening and problematic, requiring referral to treatment and community programs.

Avoidance of Tobacco

Tobacco is the single major cause of cancer deaths in the United States. Tobacco use in all forms is deadly. About 87% of lung cancer and 30% of all cancer deaths can be attributed to smoking. In the year 2000 171,000 cancer deaths were due to tobacco use and 19,000 to alcohol use. Smoking also weakens the immune system, irritates the lining of the lungs, and interferes with breathing. It is also the major cause of lung diseases such as chronic bronchitis and emphysema. Secondhand smoke is considered a human carcinogen for which there is not a safe level of exposure.

It is very difficult for smokers to stop. Without support about one third of quitters relapse within 24 hours of quitting and by 48 hours two thirds have resumed smoking. Withdrawal symptoms are a major reason for this failure. The sheer physical discomfort of quitting can overwhelm even the most determined. There are new treatments to assist in quitting smoking, and more compelling health reasons to try again than ever before.

Sun Protection

Skin cancer is emerging as an epidemic. It is known the greater than 90% of basal cell and squamous cell carcinoma result from the ultraviolet ray exposure with the incidence increasing each decade of life. Depletion of the ozone layer is believed to be a factor because of its decreased ability to screen out UV radiation. The relationship of sun exposure and melanoma is a bit more complex with the incidence of childhood burns and chronic exposure impacting the statistics. Teaching focuses on emphasizing the guidelines for skin protection. These include:

- Minimize exposure
- Wear protective clothing
- Apply sunscreen and reapply frequently
- Beware of reflective surfaces
- Avoid tanning parlors
- Teach children sun protection early!!!!

Adapting these lifestyle changes will help support a healthier life and

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ACS Guidelines for High Risk Populations

Breast

Breast Self Exam (BSE) Monthly 20 and over

Clinical Breast Exam (CBE) 20-40 every 3 years, over 40 CBE q year scheduled near and with yearly mammogram.

High Risk Populations: Have a first degree relative with breast cancer at a young age, have several relatives with breast and/or ovarian cancer.

Cervix

Pap and pelvic exam to begin yearly at 18 or when sexually active. After 3 or more normal may be less often on the discretion of MD.

High Risk Populations: Risk factors of intercourse before age 18, many sexual partners, smoking, sexually transmitted diseases (STDs).

Prostate

PSA and DRE age 50 and over annually with life expectancy of at least 10 years.

High Risk Populations: Men with a family history of prostate cancer and all African American men should consider screening beginning at age 45.

Additional information: Should receive information on the benefits and limitations of PSA by health care provider.

Colon

Ages 50 and older should have:
FOBT annually and flex sigmoidoscopy q 5 yrs.,
or flex sigmoidoscopy q 5 yrs.
or FOBT annually
or Double Contrast barium enema at 50 and q 5-10 yrs.
or colonoscopy at 50 and q 10 yrs. DRE recommended with flex sig, DBE, and colonoscopy.

High Risk Populations: First degree relatives with colorectal cancer, personal or family history of breast, ovarian or endometrial cancer, polyp history, uclerative colitis of 10+ years duration ,relatives with familial polyposis.

Additional information: FOBT= fecal occult blood test, refers to collicting and testing 6 samples from 3 stools at home following specific guidelines.

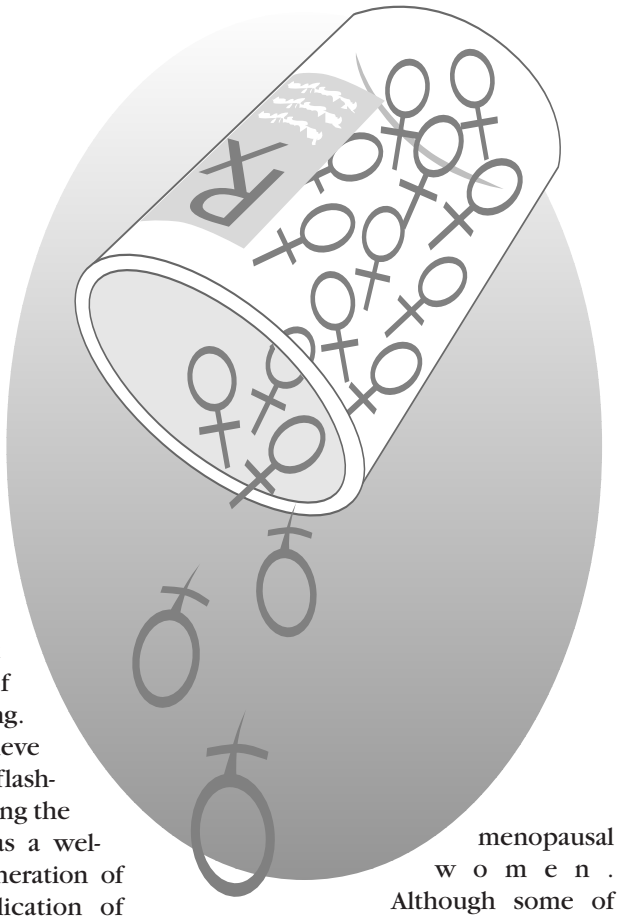
Other

Cancer Check up

Men and Women age 20+, Examinations every 3 years from ages 20-39 and annually after 40 the cancer-related check-up should include: Examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors sexual practices and environmental and occupational exposure.

Figure 1

Controversies in Hormone Replacement



Cathy Goetsch, MSN, ARNP, AOCN
Hereditary Cancer Consultant and Cancer Prevention Trial Coordinator, Virginia Mason

Hormone replacement in postmenopausal women is more controversial now than ever before. At the same time, the largest number of U.S. women ever is entering this phase of life. Breast cancer survivors and women who have increased risk of breast cancer face difficult choices related to this topic. This article offers an overview of recently published evidence about estrogens and selective estrogen receptor modifiers (SERMS), comparing actions, side effects, benefits and risk and relation to cancer risk.

During the 1980s conjugated estrogen replacement therapy (ERT) in the form of Premarin", became the most prescribed drug in the U.S. In a sociopolitical climate of rising awareness of women's issues and feminist activism, the specialty of women's health was emerging. Availability of oral ERT to relieve vasomotor symptoms (hot flashes) and mood alterations during the transition to menopause was a welcome boon for a whole generation of women. Additionally, publication of studies pronouncing other benefits of ERT led the primary care/family health and women's health communities to look on estrogen replacement as a panacea for health maintenance of postmenopausal women. Although some of these studies were poorly designed, without control groups, non-randomized, and had questionable transferability to the population as a whole, their

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Cancer Detection and Prevention: Know the Early Signs and Symptoms

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decrease the lifestyle risk factors for developing cancer. The other important part of impacting the cancer statistics is to find cancer early.

Early detection of cancer literally can save lives. As oncology nurses know all to well, finding cancer at an early stage allows for a better chance of a lifetime cure. Figure 1 provides the current screening guidelines from the American Cancer Society. These are updated yearly. Become familiar with them and refer to them often when providing patient education. Encourage health check ups and compliance with screening recommendations. Know the early signs and symptoms of the various cancers. The American Cancer Society's "Warning Signs" are easy and familiar to share and encompass many of the signs and symptoms.

- Change in bowel or bladder habits
- A sore that does not heal
- Unusual bleeding or discharge
- Thickening or lump in breast or elsewhere
- Indigestion or difficulty swallowing
- Obvious change in wart or mole
- Nagging cough or hoarseness

Teaching cancer prevention and early detection to women we know or encounter in our practice is every oncology nurse's "line" or responsibility. We are in a position to share important simple information about modifying lifestyle choices and follow screening recommendations that could impact cancer statistics in the future, possibly our own individual future. Make a difference today! Set a goal for yourself, tell a friend, teach a patient!

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Hormone Replacement: Benefits of ERT Facing Serious Questions

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impact was huge.

The most influential and widely disseminated and assimilated evidence of ERT benefit came from the Framingham epidemiological studies of heart disease. There seemed to be a striking difference in heart attack rate between women who did and did not take hormone replacement therapy after menopause. It was previously suspected that estrogen might have a role in protecting women from heart disease since the average age of onset in women was about 10 years older than in men.

Other studies indicated that post menopausal osteoporosis could be delayed and perhaps reversed by ERT. Near the same time, articles appeared that associated ERT with preservation of cognitive function and implied benefit in Alzheimer patients. Topical estrogen application was prescribed for prevention and reversal of post menopausal skin, external urethral, and vaginal mucous membrane changes.

No wonder women and healthcare providers rushed to embrace ERT. It seemed as though one could prevent or reverse the ravages of aging, providing benefit to cardiovascular, genital-urinary, psycho-cognitive, and skeletal systems with just one drug. This remained the common wisdom into the 1990s.

The first chink in estrogen's wall of presumed benefit came in the late 1990s as two large longitudinal studies showed increased breast cancer incidence in women who took hormone replacement. Interestingly the medical community remained cautiously unconvinced of the validity of the findings. Even those who acknowledged breast cancer risk elevation as a potential result of ERT continued to assert that benefits to heart and bone more than counterbalanced this risk.

During the same period in which ERT blossomed, the prognostic value of estrogen receptor status in breast cancer was well accepted. Large cooperative group clinical treatment trials showed the benefit of tamoxifen alone and in addition to other breast cancer therapy (surgery, radiation, and chemotherapy). This treatment effect was attributed to the antiestrogen action of tamoxifen. A diagnosis of breast cancer became a lifelong contraindication to estrogen use.

Looking at the effect of estrogens on other cancers, elevated risk of endometrial cancer was recognized in women receiving ERT. The addition of progestins to estrogen as hormone replacement therapy (HRT) for women with an intact uterus became the standard of practice, without research findings to suggest what the effect might be on the risk of breast cancer or heart disease.

Interesting, an elevated incidence of thromboembolic events (TEE) in women using ERT was recognized.

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However, this risk, which increased with age and length of ERT use, was seldom mentioned in scientific or lay publications. Nor was risk of TEE routinely a topic of teaching for women beginning ERT.

In the last two years, research results have challenged several of the assumed benefits of ERT and have quantified some of the risks. Prospective trials designed specifically with estrogen as the variable of interest surprised the medical community by documenting higher rather that lower risk of heart attack in the first year after initiating ERT. Other studies recorded elevated risk of breast cancer in current ERT users, which increased as time on ERT lengthened. The cumulative risk in one study was an additional 1% per year for estrogen only users and up to a 1.5% per year increased risk for those on combined HRT. Unexpectedly new evidence has also suggested an increased risk of ovarian cancer is associated with ERT use.

Tamoxifen is currently the standard of care for adjuvant therapy in estrogen receptor positive breast cancer. Over the last 30 years the body of knowledge about its effects has accumulated. Because of its use in cancer clinical treatment trials, its many known and suspected adverse events have been well documented and highly publicized in breast cancer patients.

In 1998 results from the National Surgical Adjuvant Breast & Bowel Program's (NSABP) protocol P-1: the Breast Cancer Prevention Trial (BCPT) demonstrated a forty-nine percent (49%) reduction of breast cancer risk in high risk women age 35 and older. Based on the strength of this evidence, the federal Food and Drug Administration (FDA) granted approval for prescription of tamoxifen as a breast cancer risk reduction agent. Approval was given despite the documented increased risk of thromboembolic events and endometrial cancer. Although sensationally reported in the lay press and television, the so-called tripling of endometrial cancer risk was still miniscule in comparison to the breast cancer risk of the women in the trial. There was no increase in other cancer events, including liver cancer, which was included as a risk when informed consent to participate in the study was obtained from study entrants. In fact, overall survival was higher in the tamoxifen arm of the BCPT.

Many of the risks attributable to tamoxifen are thought to be due to estrogenic effects. The agent category for tamoxifen was redesignated selective estrogen receptor modulator (SERM) rather than antiestrogen. Conversely, some of the estrogenic effect of tamoxifen resulted in benefits. The tamoxifen users in the BCPT had fewer bone fractures than those in the placebo group. Cholesterol levels/lipid profiles improved in the tamoxifen group as well, but over the short period of observation in the trial, no effect on cardiac events was seen.

Other SERMs have been developed looking for the perfect "designer estrogen". Another study with provocative results related to breast cancer prevention was also published in 1998. Results from the Multiple Outcomes of Raloxifene Evaluation (MORE) trial showed evidence of breast cancer risk reduction activity for raloxifene compared to placebo. Postmenopausal women with osteoporosis treated with raloxifene had fewer cases of breast cancer than the placebo group, and with short follow-up, had no excess of endometrial cancer. These preliminary findings were heavily publicized by the drug manufacturer and led to premature prescription of raloxifene for breast cancer risk reduction.

Although promising, the MORE trial data has limitations: Breast cancer was a secondary endpoint; breast cancer risk was not assessed prior to trial entry; very few breast cancers occurred in either the raloxifene or the control group, and lowered bone density (the eligibility criteria for the MORE trial) correlates with lower breast cancer incidence. No clinical indication exists at this time for use of raloxifene in breast cancer treatment or prevention except within the confines of clinical trials. The current National Cancer Institute funded, NSABP sponsored, STAR trial

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Hormone Replacement: No 'Designer Estrogen'

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(Study of Tamoxifen And Raloxifene) for breast cancer prevention in high risk post menopausal women will answer the question of which of these two drugs has the best risk benefit profile.

As is always the case, past research results raise new questions to be answered. There is not a one-size-fits-all answer to the question "Should I take estrogen replacement?" Clearly, the perfect "designer estrogen" is yet to be, but stay tuned as new data are reported on what seems like a weekly basis. Oncology nurses can help to educate and guide patients through the maze of sometimes conflicting study results and direct consumer advertising for prescription medicines. Providing a knowledge base for women and encouraging them to ask questions about their medication will lead to a strong partnership for individualizing optimal health maintenance.

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President's Message

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clients. We are learning how best to meet their needs and interests while being energized by their enthusiasm.

As your president, I must "practice what I preach". My new experiences for this fall will be to attend a two-day advocacy training sponsored by ONS called One Voice Against Cancer (OVAC) in October. I am also starting an exercise class at the local gym.

Enjoy this fall!

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Role Reversal: Taking Part in a Clinical Trial

Margot Hill, BSN, RN, OCN

Since April of 2000 I have been a participant in a clinical trial. During my years in a hematology oncology outpatient section, part of my work was to encourage and guide many patients through the clinical trial process. This was a favorite part of my job because it is so important and a challenge to understand and teach all facets of the protocol offered. Each person in a study is adding to the pool of knowledge that may improve outcomes for future patients and before, during and after treatment they are more closely supervised and monitored. Even so, their choice of agreeing to be placed in a study is admirable when it can involve more expense, time, energy and, most important, the element of the unknown.

This article is about my experience in breast cancer treatment. I have tried to document what it has been like for me to be an oncology patient and an oncology nurse. Some of my thoughts are illogical and trivial in contrast to my professional voice. Having worked in the "trenches" of a tertiary oncology hospital unit and clinic I feel very fortunate to have had stage one breast cancer. In fact, I have felt almost guilty about all the fuss and attention I have received from the health care community and my family and friends over a relatively small primary tumor with no metastasis. After all, most of my patients over the years have had advanced or terminal cancer.

A few weeks before Christmas in December 1995 I accidentally felt an inch sized lump in my left breast. Note this was not by methodical monthly self

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Calendar of Events

October

18 Chery Pflug, RN, An evening with a Washington State Representative

25 PSONS Board meeting - Strategic planning

November

5-6 Foundations in Chemotherapy practice, Shoreline Conference Center, Continuing Nursing Education, UW

15 Lenise Taylor and Carla Jolley:Getting nurses interested in early detection and prevention

29 PSONS Board meeting

December

1 Quarterly deadline. Focus on promoting nursing, and chapter growth

January

17 Fostering Hope, Mary Ersek RN, PhD

24 PSONS Board meeting

February

1 Quarterly deadline

21 Fatigue and its treatment, Lillian Nail RN, PhD

March

8-9 Putting it all together. PSONS Annual Symposium, Doubletree Inn, SeaTac

April

29-30 Foundations in Chemotherapy practice, Shoreline Conference Center, Continuing Nursing Education, UW

June

8 America's Oncology Nurses: Advocates in Action. ONS Regional Workshop on Health Policy Making

November

1-3 2002 ONS Institutes for Learning

Role Reversal: Reluctant Participant Completes Study

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breast exam as we educate our patients. My last mammogram had been seven months before, in May. My first inclination was to forget it and not interrupt my busy life. I knew if I did not call for an appointment that same day I would keep putting it off. My health insurance was an HMO with all possible providers at the same clinic where I worked. At times this was uncomfortable, especially at the beginning when everyone knew my diagnosis and the awkwardness of scheduling my appointment, and other times funny, when my oncologist who I worked with said I was denying my cancer because I did not see him for followup appointments. I went to work for two weeks with my drain still in which was painful and I ran downstairs just before work for my radiation treatments. I had an uneventful course of treatment: lumpectomy and node dissection, radiation treatment and five years of tamoxifen. Looking back I would have taken more time off work with the drain and the last week of radiation.

When I finished my five years of tamoxifen I celebrated freedom from a daily pill and the confidence of being a true survivor by buying myself a beautiful pair of earrings. Then I received a call from my good friend and colleague, Cathy Goetsch who is the nurse practitioner with the Community Clinical Oncology Program at Virginia Mason and also this month's Quarterly editor. She asked if I would be interested in a clinical trial. I was probably eligible for a phase III Double Blind Study of Letrozole vs placebo.

My first thought was it did not sound fun. If I was going to be involved in a protocol why couldn't it be like the Fred Hutcheson study on exercise and the prevention of cancer which, of course, I was ineligible. Voluntarily taking a pill every day for five years did not appeal to me. Now the tables were turned, all the altruistic reasons for being on a study that were offered to my patients did not seem so persuasive an argument. I was ready to put the whole cancer experience behind me. This study would involve either taking an empty pill, a placebo, with no benefit to me, or a drug, Femara (leatrozole) 2.5 mg that could have possible nuisance side effects or dangerous consequences. The window of time for a decision was short. In a few days I decided to participate on the premise I needed to put into action my belief system of advocacy for research.

Then the reality set in. The window of time to start was shore, within the next two weeks I needed a history and physical, breast exam, chest xray, mammogram and lab work, all that were not covered by my health insurance. I was told there was a special funds available but I knew I did have discretionary money other participants would not have. I paid the bill while thinking of other options I could enjoy with the money.

When the pills arrived a years supply was packaged in four, 4 ounce size bottles. Each bottle contains 100 tiny pills that take up about a tenth of the space inside the bottle. My math told be it did not compute: 4 X 100 equals 400 and there are 365 days in the year. My illogical thinking also said how could there be enough of anything in so small a piece of matter to be effective.

One important part of the study is a quality of life questionnaire. I have helped many patients fill out similar ones but at that time it seemed in the abstract. Participating and answering all those questions for myself made me realize the very personal nature of the questions and all the possible ways psychologically there are to feel bad or just plan wretched about yourself, others or the whole world. It makes me appreciate how very blessed I am to be basically a happy person who enjoys life.

I have now passed my first year on the study. At first I blamed any new symptom on the pill such as an elevation in blood pressure. I have been surprised that the few doctors I have been to in the past year do not know, or are not familiar with, letrozole or can't find it in my chart. I now bring the drug sheet with me to any appointment. I suspect I am on the placebo because soon after I was on it (or after I was off the Tamoxifen) for the first time in five years, I could wear wool and actually preferred turtleneck tops with my jeans. My wool sweaters were safely stored in mothballs but my turtlenecks had been given away.

At the end of the first year when it was time to turn in my empty bottles I was mortified. First, I could not find one bot-

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Hormone Replacement: References

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Help! My Arm Is Swelling: Lymphedema and Its Treatment

Elizabeth J White RN, MN

More than one breast cancer survivor has told me, "Dealing with my lymphedema has been more difficult that dealing with my breast cancer treatment." Lymphedema is the abnormal collection of excessive tissue, proteins, edema, chronic inflammation and fibrosis (Marcks, 1997). But lymphedema is an enigma. The literature lacks consistency in describing its incidence, measurement, prevention and treatment. There is room for additional research in all areas. The following is a review of both research findings, theories, and current treatment of lymphedema as a consequence of breast cancer treatment.

The goals of early stage breast cancer treatment are local tumor removal by surgery and radiation, and axillary lymph node dissection (ALND) for staging, thereby determining, the need for chemotherapy and hormonal therapy. Surgical techniques have varied from the radical to those that promote breast conservation. Halsted's procedure involves removal all of the breast tissue as well as pectoralis muscles and all three levels of axillary lymph nodes. A modified radical mastectomy removes all the breast tissue as well as level one and two lymph nodes. The newest surgical technique involves a partial mastectomy (lumpectomy), the removal of the tumor with a wide margin along with a Sentinel Lymph Node Biopsy (SLNB). SLNB is accomplished with the removal of only the first lymph nodes that drain the primary tumor. Zack's comprehensive review of the topic of (SLNB) detailing the procedure and subsequent nursing care is recommended additional reading (Zack, 2001).

Tangential radiation follows partial-mastectomy surgery and includes the lower lymph nodes in the radiation field. Radiation is also recommended for women who have multiple positive nodes who are treated with mastectomy. Only one study to date has examined the difference in incidence between ALND and SLNB. The study found that the SLNB had a lower incidence of lymphedema than ALND (Schrenk, Rieger, Shamiyeh, & Wayand, 2000). Even with the potential reduction in lymphedema through surgical techniques, adjunct radiation alone can damage the lymphatic system

The lymph system functions as a one-way circulatory system with porous capillaries and larger vessels that help maintain blood volume. It provides a way for larger molecules such as proteins to return to the circulatory system. The lymphatic system also helps fight infection by passing lymph fluid through the macrophage lined nodal filters before returning fluid to the circulatory system (Marcks, 1997). Normally, Starling's Law of forces maintains a steady state between hydrostatic pressure in the vessels versus colloid osmotic pressures in the interstitial spaces. When the lymphatic system is damaged transportation capacity results in an accumulation of protein, and macrophage-rich, lymphatic and edema fluid within the interstitial spaces. This fluid overload deprives the tissues of adequate oxygenation, leading to chronic inflammation and fibrosis (Boris, Weindorf, & Lasinski, 1994; Miller, 1994). The accumulation of protein rich fluid provides an excellent medium for bacterial infections, which would further exacerbate the condition.

Lymphedema can be found in the treated breast and in the upper body trunk as well as the extremity on the affected side. Oddly, it can present as swelling in just one place along the arm and not the whole arm. Patients describe a feeling of heaviness or fullness; a dull ache or pain radiating down the affected extremity. Besides pain, disfigurement and depression can result if lymphedema is left untreated. Women may find that it is difficult to find clothes that fit and lymphedema can necessitate career and hobby changes. It is a chronic lifelong condition, which can flare and, over time, worsen. If left untreated, it can lead to pain, disfigurement, and disability.

Causes

Congenital defects are responsible for primary lymphedema (Disa & Petrek, 2001). Secondary lymphedema results from the damage to lymphatic circulation or the removal of lymph nodes. Various types of trauma and other conditions can damage the lymphatic system and increase the risk of lymphedema. These include:

- Surgery
- Radiation
- Tumor
- Infection
- Obesity
- Limited range of motion to the affected extremity
- Pregnancy
- Venous insufficiency

Occurrence

Incidence studies of lymphedema vary widely with reports of lymphedema ranging from 8% to 100% among breast cancer survivors (Disa & Petrek, 2001). Reports include different surgical techniques, and study definitions of lymphedema ranging from 1cm increase in arm diameter to 6-7 cm increases. If an incidence rate of 20% were used, as many as 400,000 American breast cancer patients would be coping with this lymphedema daily (Disa & Petrek, 2001). Lymphedema onset can occur any time from days to 30 years after surgery.

Stages

An 82-year-old breast cancer survivor of three years reported that, " My rings are tight for the first time ever, but my oncologist says I shouldn't worry about it. I'm scared I might have that lymphedema."

Reversible stage 1 lymphedema is frequently not identified by health care practitioners and results in patients waiting until lymphedema has advanced to irreversible stages 2 or 3 before receiving proper treatment. The sooner the treatment is started the less treat-

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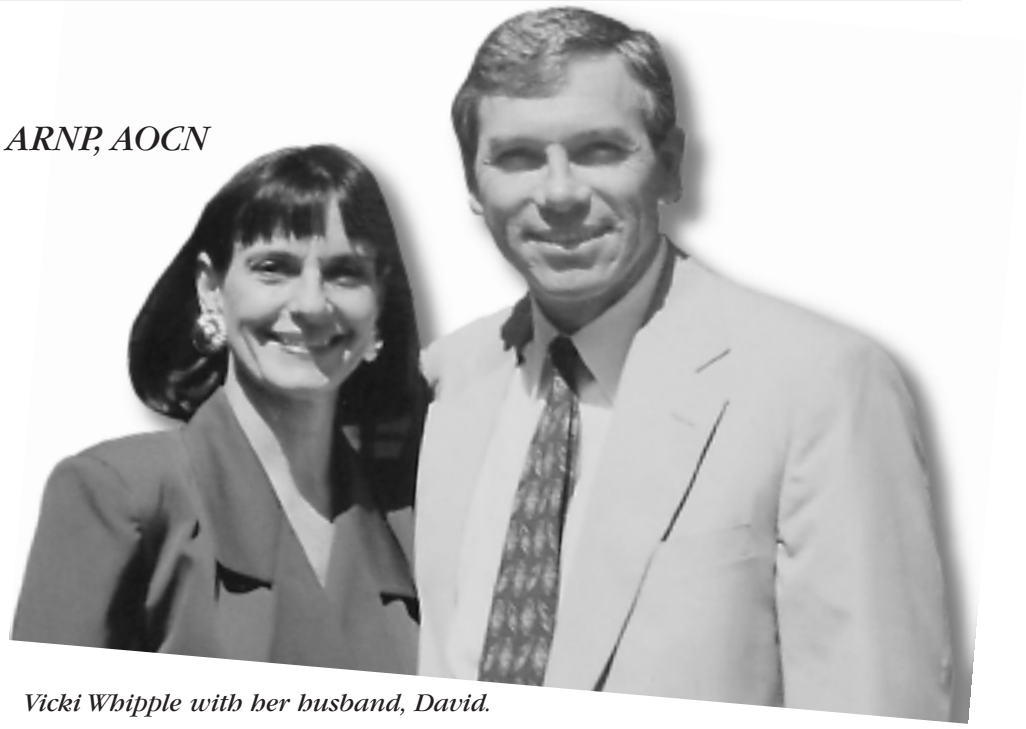
PSONS Profile

Vicki Whipple, *RN, MN, ARNP, AOCN*

Gloria Winters, RN



Vicki Whipple with her husband, David.

Little did I know when I decided to profile Vicki Whipple that it would be an opportunity to honor one of PSONS chapter leaders as she prepares to leave the region. Vicki has been in the Puget Sound area now for over 20 years, making an indelible impression on cancer services and cancer nursing. This fall she will be returning to her home in Jacksonville, Florida to begin working at the Mayo Clinic as a Nurse Practitioner in the Hematology/Oncology Division, specifically with Dr. Edith Perez in the Breast Cancer Center. But more about that later…

Vicki has an insatiable appetite for learning more and growing professionally. She identifies her job at Providence Medical Center Everett (where she was for 17 years) as the most memorable. This position started as a CNS in an ACoS community hospital cancer program and evolved as she added skills and responsibilities. By the time she left she had become Clinical Director of Cancer Services. In this capacity she had traditional administrative and operational duties, but she also retained the role responsibilities of the CNS. She simply didn't want to lose that clinical focus. Needless to say, her long history with this organization left her with many fond memories and a rich network of colleagues.

From "Prov Everett" she went to become the Director of Cancer Services at Providence Seattle "Prov Seattle" was in a redevelopment phase, and also had two programs that were missing in Everett. Vicki wanted hands on experience with a comprehensive breast center and inpatient palliative care service, so took the position in Seattle as a way to expand her knowledge and expertise in these services.

That expertise led her to NexCura, a Seattle-based clinical data and communication services company that provides proprietary web-based decision support technologies for cancer patients. In a singular effort to apply computer technology to the medical field, NexCura developed the Cancer Profiler which is the "first interactive, web-based tool to generate personalized, reliable treatment-planning information based on published medical studies." A physician colleague on the advisory board of what was then cancerfacts.com recommended Vicki, and she became the first Clinical Specialist on board.

The job at Nexcura pulled together all of her prior knowledge and experience in new and challenging ways. Vicki has been responsible for researching, designing, building, and maintaining the Cancer Profilers for three cancers: breast, ovarian and pancreatic. Because of the commitment to reflecting the most current standards of care that is grounded in evidence-based medicine, the position has forced Vicki deeply into the science and medical literature of these diseases. Before going live, each Cancer Profiler is reviewed by a Medical Editorial Board of national cancer experts and thought leaders in the respective field. Vicki stated that it has been extremely gratifying and rewarding to get to know on a first name basis and work with such a renowned group of cancer experts, who were formerly known to her only through their published research.

I asked Vicki how she got started in oncology, and the answer was one I had not heard before. When she was in her junior year of nursing school, the American Cancer Society offered a fully funded summer scholarship to work at MD Anderson Hospital and Tumor Institute, Houston, TX. The scholarship was a traineeship, complete with room and board. She had considered medsurg her primary interest prior to this, and with this exciting experience became immediately hooked on oncology. The problem was that oncology was not yet a specialty area in nursing schools. When she returned to her undergraduate program at University of Florida (Gainesville) she had to put together the electives to support this new interest. When she returned to graduate school two years later, she again had to develop her own course of study to focus on oncology.

Vicki was born and raised in the south, living in Atlantic Beach, Florida (15 miles east of Jacksonville) from the age of 4. (She talks fondly of running up and down the beach as a child.) Her transition to the NW came slowly. She joined the Army Nurse Corps to pay for graduate school, and then served the requisite two years of active duty. Her military time took her to Brook Army Medical Center (AMC) in San Antonio and Fitzsimmons AMC in Denver. While in the Nurse Corps she met her husband David, who was in the reserves. His job subsequently took them to Kansas City, where Vicki worked as a

CNS at the Veterans Administration Medical Center as their first Clinical Specialist. In 1980, David was again transferred, this time to the NW, and Vicki began her work in the Providence System. She also joined the Navy Nurse Corps Reserves from which she was honorably discharged as a Lieutenant Commander in January 2000.

So this new transition for Vicki is one of homecoming. What got me most in hearing her tell it was that she is the last of her first grade friends to migrate back. And the opportunity is one of a lifetime. Mayo Clinic Jacksonville is implementing a huge cancer service and research expansion having just completed the first Mayo research facility dedicated solely to cancer research. A new acute care hospital will also begin construction soon on the 700 acre Mayo campus. Vicki will be working with the Breast Cancer Team and Dr. Edith Perez, a leader in breast cancer research within this world class organization and a national breast cancer expert. (For those like me who thought the Mayo Clinic was only in Rochester, they have two additional sites: Jacksonville and Scottsdale).

Vicki will be leaving behind some important members of her family. Her husband David will be staying on to sell the house, before joining her. He is currently the Sr. VP for Heery International, Inc., (Atlanta, GA) a subsidiary of Balfour-Beaty, London (one of the largest engineering and construction firms in the world), and will be able to transfer to Florida with them. Her oldest daughter Melissa is married and settled in Bothell. She is a first grade teacher, and mother to Vicki's two grandchildren ages 3 1/2 and 11 months. Her middle daughter Ashley is awaiting notification of transfer to the University of Florida (Gainesville) to complete her undergraduate business degree, while her youngest child, Matthew, will continue his undergraduate work (also in business) at USC in LA.

Through the years Vicki has maintained active involvement in many professional organziations and cancer associations. She is currently a member of the Society of Gynecologic Oncology and ASCO. Within ONS, she is a member not only of PSONS, but the Nurse Practitioner, Clinical Nurse Specialist, Patient Education, and Pharmaceutical/ Industry Nursing Special Interest Groups. She has been serving recently as the chair of the Education Committee for the local Susan G. Komen Foundation. Her commitment to this organization led her daughter Ashley to become involved as a intern helping to plan, coordinate, and produce the Seattle Race for the Cure.

PSONS will surely miss Vicki. It's hard to imagine the organization without her consistent and powerful presence. Vicki believes strongly that those who have knowledge and expertise to share have a professional responsibility to mentor and encourage the next generation. And while her career may in some ways be viewed from a management and clinical specialist perspective, it is in teaching that PSONS has come to share so much in Vicki's gifts.

In the early 1980's Vicki served on the ACS nurse's education subcommittee with Judy Peterson, Ann McElroy, and Anna Quincy. Together they created what she now calls the beta version of the Oncology Nursing Education Cooperative (ONEC) – a traveling 2 day chemo course that they took throughout WA state. From this course they developed a teaching module for other organizations to use. Vicki continued to be active in teaching through the PSONS/UW chemotherapy courses, the OCN review courses, Purdue and Novartis nurses speakers bureau, and now in the ONEC. Vicki spearheaded the development of the ONEC within PSONS, oversaw its infancy, and presented it to ONS Congress. While she describes it as an incredible and rich experience for her, its impact on PSONS has been equally great. Vicki's vision and dedication to this project has brought together our talents in a way that has rejuvenated PSONS and refocused our commitment to quality nursing care in our region.

Vicki acknowledged that the down side to leaving is leaving her colleagues, but the desire to stay in contact is clearly mutual. We at PSONS will certainly continue to claim her as one of our own, even as she goes on to contribute to her new community and the Jacksonville chapter of ONS.

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Lymphedema: Early Treatment Means Faster Recovery

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ment is required (Disa & Petrek, 2001).

Prevention and Treatment

Historically, treatment for lymphedema in the United States has lagged behind Europe and Australia, where Vodder proposed manual lymphatic drainage (MLD) in the 1930s. In the 1980s, Foldi's research supported short term arm bandaging to eliminate microvascular arteriovenous shunting in which hyperdynamic blood flow occurs (Foldi, 1998). Casley-Smith contributed a specific set of exercises for patients with lymphedema in the early 1990s (Casley-Smith, 1991). Together this treatment is called Complete Decongestive Physiotherapy.

In just the last year Complete Decongestive Physiotherapy has become available at many Puget Sound area hospitals and clinics. Special training is required to provide the appropriate care. Patients and their advocates should ask specifically whether or not Complete Decongestive Physiotherapy is practiced in the setting. Patients should be willing and able, with the help of friends and family, to perform the exercises, massage and bandage wrapping, and regularly wear compression sleeves. To keep lymphedema in check may require lifestyle changes and a significant amount of time when daily bandaging is required.

The Three Stages of Lymphedema

Stage 1 Reversible

- Lymphedema disappears with bed rest and/or elevation overnight
- Swelling is soft and pitting
- No fibrosis
- High plasma protein content

Stage 2 Irreversible

- Protein enriched edema which is refractory to elevation, night rest
- Connective tissue and scar formation (i.e. fibrosis)
- Non pitting edema
- Edema becomes hard

Stage 3 Elephantiasis

- Enriched edema in connective and scar tissue
- Hardening of dermal tissue; papillomas of the skin
- Significant increase in fibrosis
- Fat deposits, notice deep sulci at joints
- Thickening of dermal tissue
- Protein located in the ground substance and is interwoven with the collagen fibers. The protein is more gel than a solvent.

Components of Complete Decongestive Physiotherapy

Meticulous skin care is required by these patients. Clean, lubricated, intact skin provides the body's first barrier to infection. Preventing sunburn, insect bites, burns and cuts become routine activities. When first aid measures fail, antibiotic treatment can arrest or prevent a lymphedema flare.

Manual lymphatic drainage (MLD) massage uses specific gentle massage strokes to each of the dermal lymphotomes. Skin massage stimulates the superficial and deep lymphatic systems. Massage also stimulates the parasympathetic nervous system helping to close the one way valves in the walls of the lymphatic trunks reducing retrograde lymph flow. The lymph moves from "congested to "decongested" areas. A firm sustained manual pressure is applied to consolidating watershed areas adjacent to lymphatomes. Massage is carried out in a predetermined sequence with emphasis on edematous regions (Boris, Weindorf, and Lasinski 1994; Perdroma, 2000).

Compression bandaging provides increased tissue pressure, and edema reduction. Stockinet, cotton batting, chips of latex in gauze (over fibrotic areas) and finally a layer of low stretch bandages comprise the bulky dressing that must be around the clock until maximum circumferential reduction is achieved. Finally a custom ordered sleeve is used to keep swelling in check. Compression pumps are sometimes used to reduce swelling but MLD, bandaging and exercise must accompany pump use to move the protein past the top of the pump sleeve.

Compression sleeves and gauntlets (hand pieces) provide maintenance arm support following the lymphedema reduction provided by bandaging. Proper garment fit is essential. Improper fit can cause constriction or allow lymphedema formation. Garments are available over the counter and custom made. They should be washed nightly and need to be replaced every three to six months. Often they are not reimbursed by insurance.

The exercises proposed by Casley-Smith help stimulate the lymphatic system thus assisting with lymph drainage and reducing arm swelling. They also help to mobilize the shoulder area. They need to be done is a certain order and take about 30 minutes to perform. A support sleeve or compression bandages should be use if lymphedema has been diagnosed to maintain adequate support while lymph volumes increase (Casley-Smith, 1991).

Postoperative Instruction

Unchanged in 40 years, arm and hand precautions are on based two principles. The first is: limit increased lymph production, which is directly proportional to blood flow (avoid infection, heat, and vigorous arm exercises). Secondly, prevent additional obstruction to the system (avoid wearing tight garments, caring heavy handbags). These recommendations are based on "common sense" rather than clinical research.

Patient instructions for lymphedema prevention include:

✔ Avoid injuring the skin in any way. Use meticulous skin and nail care/cuticle care. If injury does occur use standard first aid measures.

✔ Avoid injections, vaccinations, blood draws, IV administration, and blood pressures in the affected arm.

✔ Avoid constricting sleeves or jewelry and use wider or padded bra straps.

✔ Avoid heat as in saunas and hot tubs.

✔ Avoid strenuous exertion, wear a properly fitting compression sleeve when doing aerobic exercises.

Airline travel without a protective

Continued on ncxt page

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sleeve has also been noted as a trigger of lymphedema (Casley-Smith, 1991).

In summary, lymphedema is a frequently occurring side effect of breast cancer treatment, which can appear immediately following treatment or many years later. It can cause pain, disfigurement, decreased range of motion as well as lead to job and lifestyle changes. Lymphedema has no cure but can be controlled with meticulous skin care, exercise, manual lymphatic drainage and a support garment. In the words of Marisa Perdroma, a physical therapist who has taught patients and professions alike how to treat lymphedema, "You can learn to live with lymphedema but cancer could kill you."

■

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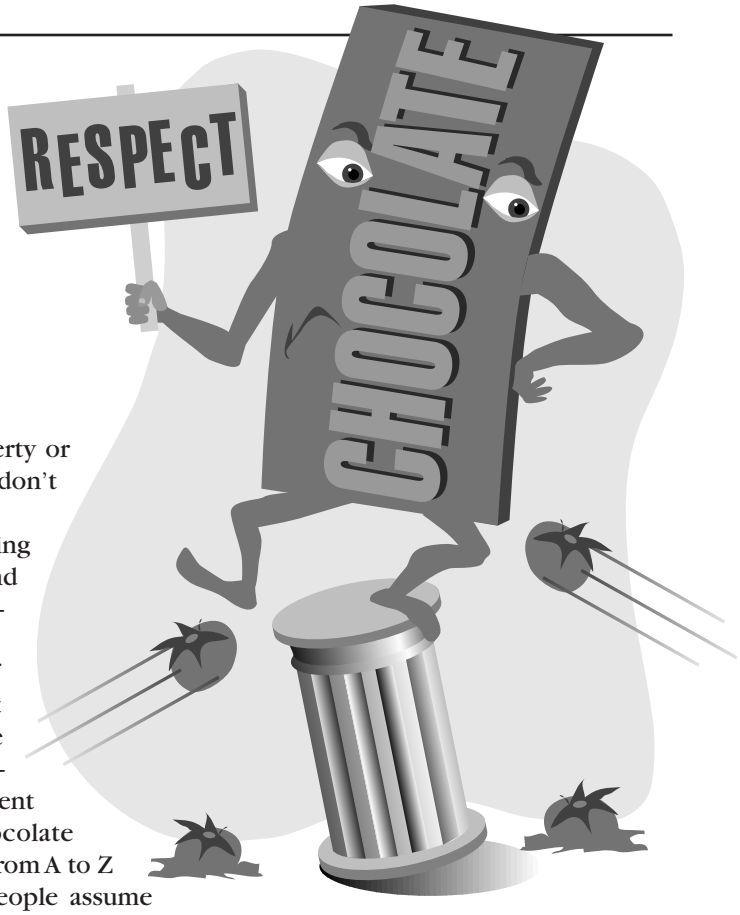
Reluctant Participant: Lost Track of Remaining Pills

Continued from page 10
tle. I looked all thru the bathroom cabinets and could not find it. How was I going to turn in only three bottles when I knew better. Then there were all these pills left. I tried to count those remaining little pills and match them to the calendar. I really don't know if I forgot to take the pills all those days or there were extra pills provided. As a nurse it was embarrassing not to have a perfect score.

I am pleased to be able to participate in a clinical study. At the same time I consider it an easy one and am grateful. One of the benefits has been to tell others of my experience and promote participation in clinical trials. It is amazing to me the many friends and acquaintances that have been diagnosed and treated with cancer, yet I know the numbers will grow. There have been and will continue to be many opportunities in my life to support other women and men in this journey of cancer.

■

Chocolate: More Divine Than Devilish



Mary Robinett Moss

Americans love controversy. Our media shovels out the daily dirt while we anxiously anticipate raking through the most malicious muck. Constant tittle-tattle has dulled our senses. We have slowly been seduced into a world of gossip and negativism. When is enough, enough? When can we admit that sensationalism has robbed us of all that was once praiseworthy? I for one have reached my breaking point. I can not sit still while the perfect American confection is being rocked off its pedestal. I am talking about Theobroma Cacao – "food of the gods." Give me liberty or give me death – and don't tread on my chocolate!

In the American melting pot of old wives tales and urban legends, chocolate has been held responsible for a host of human ailments. Most of these claims are myths and exaggerations. According to recent article headlines, chocolate has caused everything from A to Z – addictions to zits. People assume that if a food tastes heavenly, it must be very wicked. But chocolate is not too good to be true. If eaten sensibly and in moderation, chocolate is definitely more divine than devilish.

Chocolate comes from the cacao bean which grows on trees in temperate rainforest regions. In 200 BC, Toltec, Itza and Maya Indians used the prized bean as currency. Aztec emperor Montezuma introduced Cortez to chocolate in the form of a cold spicy drink, sweetened with honey. It soon became popular in Spain and throughout the rest of Europe. In the mid-1800s, a British company created solid eating chocolate, launching an international love affair that has never ended.

Chocolate is a concentrated food source that tastes wonderful. It contains approximately 20 percent protein, 40 percent carbohydrate and 40 percent fat. During World War II, it was issued to soldiers as "fighting food" and "nourishment in the smallest possible bulk" (Austin, 1997). However, many people believe that chocolate is a "bad food" and that it should be avoided. If you love chocolate, there is no need to deprive yourself of it. Just cut back on other rich foods in your diet. For those who are watching their weight, cocoa powder is a fine substitute for baking chocolate. It's low in fat and still has

that terrific chocolate taste. Weight loss programs that restrict all sweets usually are not successful. People feel deprived and usually end up cheating. If you crave chocolate, it's better to stay in control, indulge a little now and then and not let the food you love become a source of guilt.

It is important to note that the fat in chocolate is not all "bad." Cocoa butter contains a combination of saturated, polyunsaturated and monounsaturated fats. The two saturated fats are palmitic acid and stearic acid; the first raises cholesterol and the second lowers it. So overall, chocolate has a neutral effect on blood cholesterol (For the love of chocolate, 1999). Besides, a well-balanced diet requires a certain amount of fat. Some of it might as well come from chocolate. After digestion, the fatty acids in chocolate may serve as a reservoir for stored energy. They may be also used to protect body surfaces and regulate body functions. In addition, they may become phospholipids – a structural material that is part of the make-up of every human cell.

We can easily blame chocolate for some of the overstuffed baggage we carry around, but can we honestly say that it causes eating disorders? Some believe that irresistible taste brings on binge eating and food addiction. Because its melting point is 97 degrees, just below body temperature, it dissolves in the mouth immediately and zaps the taste buds in a way no other food can. Psychologists at the University of Pennsylvania learned from a survey that 50% of their female students crave chocolate before and during the first two to three days of their menstrual period (Sommerfeld, 1996). There is no doubt that women have a particular weakness for chocolate. Dr. Daniel Piomelli of the Neuroscience Institute in San Diego California has also found that chocolate contains anandamide, a chemical that acts on the pleasure center in the brain triggering "feel good" endorphins (The Health Report, 1996).

So why aren't people who eat chocolate high all the time? Dr. Piomelli also stated, "Nobody experiences chocolate highs" (The Health Report, 1996). According to Christian Felder of the National Institute of Mental Health, a 130-pound person needs to eat about 25 pounds of chocolate in one sitting to get a noticeable buzz (Got that crazy chocolate craving, 1997). That's more than most are willing to eat, although I wouldn't mind trying. Even though it's true that many women want chocolate, its mystic powers are merely mythical. We must remember that the desire or craving for sweet tasting food is a natural biological drive. At birth, we prefer the taste of mother's milk, which is sweet and fatty. As adults, our tastes broaden and sweet foods like chocolate become favorites. An article in the May/June 1996 issue of Psychology Today states, "No tightly controlled studies have yet been done that prove that chocolate does anything but taste good" (Au chocolate, 1996).

Chocolate has been charged with plenty of crimes, some old and some new. One of the most ancient accusations is that chocolate brings on acne. The American Medical Association has refuted that allegation by stating, "Diet plays no role in acne treatment in most patients… even large amounts of chocolate have not clinically exacerbated acne" (Dixon, 1997). Another old contention is that chocolate contains a lot of caffeine and can make a person jumpy. The truth is, a typical 1.4-ounce milk chocolate bar contains six mg of caffeine – about the same amount as a cup of decaffeinated coffee. Brewed coffee can contain between 100 and 655 mg of caffeine (The sweet truth about chocolate, 1999). It would require eating about 17 chocolate bars to match the caffeine in a weak cup of coffee.

What about hyperactivity – isn't sugary chocolate at fault? Despite widespread beliefs to the contrary, sugar does not cause hyperactivity in children. Recent studies conducted at Vanderbilt University and the University of Iowa College of Medicine found no evidence that sugar has an adverse effect on children's behavior (The sweet truth about chocolate, 1999). But there's no doubt that chocolate causes cavities, right? Actually, chocolate is not going to cause tooth decay any more

Continued on page 18

THINKING OF YOU

Where were you on that fateful day? Our hearts go out to the many people who have suffered loss in the recent terrorist attack. The circle of PSONS reaches out well beyond the NW with family members, colleagues, patients, and patient families. It reaches out to our pasts, and friends of years ago now affected by this tragedy. It reaches beyond our bond with other nurses, in other specialties. We remember those in the reserves, who wait for calls. We give thanks for the many people who have responded with tangible support and with their prayers.

■

Pam Ketzner received a $1000.00 scholarship from the St. Joseph School of Nursing Alumni. Pam is hard at work on her BSN – and still doing all the other things she does as nurse, professional, and mom. This is clearly a well-deserved honor.

■

We belatedly offer our congratulations and support to **Linda Cooper**, who with her husband **Keith** welcomed their son **Keith Owen Cooper** into the world, May 24th. It was said that he was born with the hands of a basketball player. Now almost 6 months old, we hope all the marvelous transitions of parenthood are being accomplished with ease and rejoicing.

■

Did you see the June 2001 issue of the ONForum? **Stacey Young-McCaughan** is again making the news. This time she has been named to the NCI Gyn Cancers Progress Review Group. She is only the second nurse and the first ONS member to be named to PRG. This group assists in setting priorities for organ site-specific research. Way to go Stacey!

■

After many years of working part time, **Liz White** is returning to the VA full time to work in palliative care and home health. Liz, are you sure your daughter Amy is old enough yet?

■

Pat Jordan and **Mary Jo Tornberg** will be attending the ONS course on palliative care in southern California.

■

And did you know that **Anna Schwartz**, a former member now an associate professor at OHSU, received an ONS Foundation biotherapy grant for her study entitled "A biobehavioral randomized trial for patients on interferon." She was also commended as the ONS new investigator for work done while she was at the University of Washington. Congratulations, Anna!

Chocolate: Unfairly Blamed for Ailments

Continued from page 17

than any food containing starches or sugars. In fact, chocolate washes out of the mouth faster than other candies that stick to the teeth and cause enamel-eroding acid levels to rise. Chocolate also contains tannins that may exert a protective effect against dental plaque.

Have you heard that chocolate gives people headaches? Not so, say researchers from the University of Pittsburgh Medical Center. They have found a lack of evidence for the association of migraine headaches with chocolate. They theorize that chocolate has been blamed for headaches when the cause was probably other foods, stress or premenstrual syndrome (Chocolate may be unfairly blamed for causing headaches, 1998). Some people think they are allergic to chocolate as well. For instance, one challenger states, "My mother starts coughing and wheezing as soon as she eats it" (Petersen, 1999). According to investigation, she is one of the very few. The American Dietetic Association reports that a true chocolate allergy is uncommon and difficult to prove (For the love of chocolate, 1999). A recent study showed that only one out of 500 people who thought they were allergic to chocolate actually tested positive. Dr. S. Allan Bock of the National Jewish Center for Immunology and Respiratory Medicine says, "The idea that chocolate is a common allergen has been around for a long time, but recent evidence suggest allergy to chocolate to be quite rare" (The sweet truth about chocolate, 1999).

There is no denying the power of chocolate. People love it! Over 1,000,000 tons of cacao beans are harvested each year to fulfill chocolate hunger worldwide. Americans consume an average of a half-ounce per person per day. That's 4-_ grams of fat and 8-_ grams of carbohydrates – 77 calories total – not a national epidemic. After all the folklore and hoopla, the only legitimate concern to have about chocolate is the high fat and sugar content. So don't call for the vice squad, because it's not a drug. If obesity or diabetes is your health concern, be careful with chocolate. Otherwise, go easy, but don't deny yourself an occasional sampling of the "food of the gods."

■

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Resolve now to become more active in PSONS and Volunteer to Serve Your Profession and Your Colleagues as an Officer!

In accordance with our new standing rules, nominations are being sought to serve PSONS not only as executive officers, but also as chairs of the standing committees. This year the following positions are sought:

- **President-Elect**
- **Secretary**

And the chairs of the

- **Membership Committee**
- **Communications Committee**
- **Symposium Committee**

Individuals interested must be in good standing with PSONS and submit a biographical sketch, consent to serve, and goals for the office if elected. The standing rules of PSONS, including descriptions of the positions open, are available on the web at http://www.psons.org. A nomination form is also available at that site. This form must be returned by January 1 to ***Patricia Buchsel at 18503 SE 64th Way, Issaquah, WA 98207***.

Those interested or seeking further information should contact:

Pat Buchsel at pbuchsel@nwlink.com or 425-643-3529

You may also contact any current officer or committee chairperson.

Needed:
Treasures for the PSONS Archives

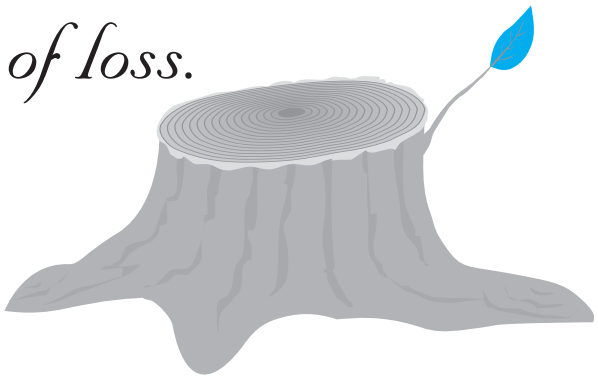
If you have any pictures, notebooks, extra brochures, Quarterlys, or anything that may be of historical value please let Margot Hill know at 206-364-5355 or marghill@home.com. This fall a group will sort and compile materials for a new scrapbook.

TREASURER'S REPORT

for Second Quarter 2001, ending June 30, 2001

Checking (3/30/2001 bank statement	$28,191.81		
Investment Account (3/26/2001 bank statement)	47,087.34		
Total Balance	75,279.15	$75,279.15	
Uncleared checks Q1		2,480.39	
A. BEGINNING BALANCE (Ending Balance Last Report)		**$72,798.76**	
REVENUES			
Dues (amount per person $25-30)		$ 462.50	
Program Participation Fees		1,150.00	
Interest (Checking/Savings/Certificate)		5.57	
Donations (List name, address and amount for each)		500.00	
Exhibit Fees		4,450.00	
Miscellaneous Other (Specify)			
Newsletter Subscriptions		680.00	
Total Quarter Income		7,248.07	
Gain		2,133.81	
IDS			
B. TOTAL REVENUES		**$9,381.88**	
			$82,180.64
EXPENSES:			
Printing (Typing, xeroxing, etc.)		$ 2,039.79	
Postage		467.96	
Supplies		393.26	
Meetings (Place, refreshments,etc.)		20,213.96	
Accounting Fees/Bank Service Charges		3.60	
Miscellaneous Others (Specify)			
A.V. Services	3,466.24		
Chapter Renewal Fee	283.00		
Newsletter Production	700.00		
Phone	5.63		
Photocopying	12.73		
Secretarial Services	2,286,32		
Transcription Services	312.50		
Taxes	217.79		
Web page	29.85		
Total Miscellaneous		7,314.06	
C. TOTAL EXPENSES		**$30,432.63**	
D. ENDING BALANCE THIS PERIOD		**$51,748.01**	

May we honor in our living
the enduring experiences of loss.
September 11, 2001



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