



PUGET SOUND QUARTERLY

Oncology Nursing Society

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Palliative and Hospice Care in England: An American's Perspective

By Elizabeth J. White, RN, MN, AOCN

Work exchanges can get the creative juices flowing as you watch others deliver care in different ways. The Puget Sound Health Care System (Puget Sound Veterans Administration) and Kent County Council Social Services in Southeast England are at the mid point of a three-year exchange program. In June I traveled with two VA social workers along with a social worker from The Ark, a Seattle program for adults with cognitive disabilities, to the district of Kent - East Kent to be precise, to spend two weeks learning about how the Brits deliver care. This article will provide a basic overview of British social and health care then explore how palliative and hospice fit into their system.

The Kent District covers the geographic area east of London to the white cliffs of Dover. East Kent has a population of approximately 500,000. The geography consists of rolling hills, many farms, coastal communities with fishing and tourism, as well as the gated city of Canterbury and many small villages like Broadstairs where I lived with a family for my two-week adventure. East-Kent does have some manufacturing and is the international headquarters for Pfizer Pharmaceutical Company. Kent is also the largest of England's districts. And, as the Kent County Council's Social Services Directorate has consistently met its goals it is rewarded by the national government with more money to establish innovative project - such as



this exchange.

Two large bureaucracies provide social services and health services in Great Britain, the Social Services Directorates (SSD), and the National Health Services (NHS). The Kent Social Services Directorates delivers social services to the elderly and the physically and mentally disabled. It provides centralized services similar to those provided by DSHS together with senior service provided by local government and private charities here in the States. Services

include multidisciplinary domiciliary care packages (people who can provide personal care, light housekeeping, meal preparation, and medication reminders up to twice daily in a client's home), adaptive equipment, meal services, guardian ship services, and day care. Social Services in Great Britain place a high value on keeping people at home and provide more services under one umbrella than we have in our country. They also have programs supporting the

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PRESIDENT'S MESSAGE

Goals Set for My Term as President of PSONS

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Goal: The final purpose or aim; the end to which a design tends, or which a person aims to reach or attain.

With the presidency comes the responsibility of establishing annual goals based on the needs of PSONS members often blended with personal strengths and preferences. Some goals are established for you due to the nature of one's role and responsibility and some are led by personal interest, community need, request, political responsibility, a need for spur of the moment decisions, etc. Some goals are easily recognized and some can be developed as you grow and learn the expectations of the job. During the July 23rd, 2007 board meeting I shared

my chapter goals and requested support in accomplishing these by the end of my term as your PSONS president. I would now like to share them with all of you who have entrusted me to continue making this chapter one that you are proud to be affiliated with.

True story: At the end of the March symposium Barb Otto (past president) informed me that she had brought me "the boxes" that belonged to the president. Imagine my surprise as she pulled five boxes full of materials out of her SUV and told me they were now mine for safe keeping. My first concern was what if my house burned down and all the records and history of PSONS went up in flames never to be seen again? On one hand my presidency would be remembered for years (vanity steps in) but on the other hand is this really how I wanted my presidency to be remembered? Along the way I also found out



Mary Jo Sarver

that each treasurer (since the computer age) had developed their own system of tracking and paying bills. Dependant upon their personal computer preference and software compatibility the new treasurer may or may not be able to jump in. Barb started an electronic record during her presidency and two of my goals stem from this.

My first goal is that all the boxes

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EDITORS' NOTES

A Look at Palliative Care Guidelines and Philosophies

*Cathy Goetsch, MSN, ARNP, AOCNP
Janice Gibson, RN, MSN, OCN*

This issue could be regarded as an issue of change. We will be transitioning to new editors after this issue. Our new editor will be Deborah Leslie RN, BSN, OCN. She comes to us from the Seattle Cancer Care Alliance. Her current position is the emergency response education coordinator. Welcome Deborah.

The focus of this edition is hospice or palliative care which is for patients, families and their provider team a time to change directions and goals in care. Hospice has come along way since the term was first used to describe the specialized care for dying patients in 1967 by Dame Cicely Saunders. There are now

websites dedicated to Hospice and the National Comprehensive Cancer Network (NCCN.org) has advanced cancer and palliative care guidelines for patients. Hospice care is a philosophy of care which recognizes death as the final stage of life, and provides humane and compassionate care for people in the final stages of an incurable disease. Palliative care is a natural off-shoot. Care vs. cure is the focus and appropriate delivery requires an interdisciplinary team which can include nurses, physicians, social workers, counselors, home health aides, clergy, and volunteers. This issue includes multiple perspectives on the philosophy. Liz White shares her experience in a hospice in England. In Community Crossings, Gina Richie gives us a list of local hospice and transition care resources,

and Dr Malpass provides an overview of hospice from a physician perspective. Changing gears from active treatment to "comfort" is not always an easy transition for patients and families to make or a comfortable conversation for us to have with our patients. Carol Hile brings us a nurse's perspective on palliative care.

Our Member Profile highlights Judith Hill, a nurse practitioner who is a palliative care consultant.

What we can take away from this issue is this: It is important for us to freely begin this dialogue with our patients, just as we discuss other impact of disease and treatment on life. Nurses as always have an important role as educators, "translators" and guides.



Palliative and Hospice Care in England: A Safety Net for All Citizens

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Carers (family or friends) who are caring for the patient by providing respite, counseling and support groups.

The National Health Service (NHS), on the other hand, funds hospital, home-care, respite care, terminal care, rehabilitation, and nursing home care. NHS provides general practitioners, other primary care services, and specialist medical services. Privacy is limited in British hospital wards. They have large open bays with six to eight patients in each bay. There may be only one or two side rooms (private rooms) on a unit. The UK provides a health and social services safety net for all its citizens, but more care is being privatized as individuals with financial resources opt out of the system for quicker or more luxurious services. The buildings were older with additions of varying ages. I was startled to find that the Pilgrim's Hospice, a three facility programs in East Kent was not a part of the NHS, but a private charitable organizations with only a small portion of their annual budget coming from NHS.

The Brits originally came to Seattle to study our TeleHealth program, which they implemented as a means to help keep people in their homes. TeleHealth remotely monitors clients' responses to preset disease related questions, their vital signs, blood sugars, ECGs, heart and breath sound, and pulmonary function over phone lines to a centrally located server. It can also provide video conferencing. A nurse monitors the computer readouts daily and follows up with the client and their GP when values fall outside the preset guideline. The nurse provides instruction and encouragement through the system. In the US, community health agencies as well as closed health care providers such as the VA are providing this service in an attempt to keep chronic illnesses under control and patients out of hospitals.

On many days, I took trains to far reaching locations in East Kent. I visited with Care Managers (case managers, SSD), a role filled by both social workers

and nurses, at the three main hospitals in East Kent. Nigel Stokes, Community Liaison Nurse, (NHS) was my guide at the Queen Elizabeth Queen Mother Hospital. He used a national screening tool to identify potential recipients of NHS Continuing Healthcare (visiting nurse services) and participated in the Joint Care Planning meeting, which is completed 24 hours before discharge. If the discharge is delayed after the Joint Care Plan is completed, either the hospital or social services is responsible for a fine. I visited patients in their homes

ment. The issues discussed in their team meeting, including pain and symptom management, patient and family coping, and support needs, are identical to the issues discussed in the VA's Palliative Care & Hospice Service team meetings.

I spent three days at Queen Elizabeth Queen Mother Hospital in the city of Margate. Twenty-five yards from the main entrance of the hospital stands Pilgrims Hospice of Thanet, a two-story building with lovely gardens. It is one of the three hospice facilities of Pilgrims Hospice, which started 25 years ago as the dream of Ann Robertson, a private citizen, to serve the dying in East Kent. Pilgrims Hospice started as a place where the dying could go for end of life care, but evolved into a comprehensive program cutting across care settings. Entering Pilgrims Hospice of Thanet is like entering a large living room with groupings of sofa and armchairs. Volunteers greet you and offer you a cup of tea. The chapel is to the right of the lobby and is a quiet place for reflection. The chaplain's office is just behind the volunteer desk, and like many chaplains, Rev. Stuart Piper is multi-talented man who can take a patient down to the beauty salon to cut



using TeleHealth equipment and observed programs for independent elderly including an exercise program and community lunch program similar to lunch at Senior Centers here. The British also have lovely step-down facilities in the form of one bedroom apartments for clients coming out of the hospital or nursing home that need just a little bit more supervision to assess their ability to fend for themselves at home. All of these services are available to individuals with cancer. The general hospitals in Kent each have a Palliative Care Team coordinated by a McMillan Nurse (a foundation funded position). These teams are comprised of a rehab therapist, physician, social worker, and chaplain, round on cancer patients and others with life threatening diseases. They make recommendations to the GP and assess the need for hospice involve-

ment. The issues discussed in their team meeting, including pain and symptom management, patient and family coping, and support needs, are identical to the issues discussed in the VA's Palliative Care & Hospice Service team meetings.

hair as well as minister to the soul. The staff dining area is just down the hall. A trolley of alcoholic beverages available to patients is located there, a good idea since life for many Brits revolves around the pub. A large nursing station in the center of several corridors is the next site that you see. Thanet has eighteen beds and is about the same size as its sister facilities in Canterbury and Ashford. Two rooms are private while the remaining four bays each contain four beds. The patient bays open out on a large common balcony that looks across a garden. Volunteers maintain all the gardens. The first level holds the cramped offices of the home care team, which provides visits to 500 home care patients. This program is similar in size to Providence Hospice of Seattle.

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Barriers to Hospice Referrals in Oncology

Thomas Malpass, MD

Hospice is a philosophy of care that was developed to provide comprehensive services to allow dying patients to experience the best quality of life through the end stages of their illness. As the hospice movement has grown, the need to incorporate palliative care earlier in the trajectory of a chronic life limiting disease has been recognized.

Although physicians are notoriously wrong in predicting lifespan, most chronic illnesses have a clinical course that lends itself to some predictions. The hospice eligibility guidelines can be extremely helpful especially for nonmalignant diseases such as congestive heart failure and chronic obstructive

pulmonary disease. Cancer remains the disease with the most predictable clinical course in terms of estimating lifespan. In spite of this, many medical oncologists remain reluctant to make timely hospice referrals

In the US, only about 50% of patients dying of cancer are referred for hospice care and when referral occurs, it is woefully late in many cases. Many experts believe that a hospice stay of at least three months is most desirable to achieve optimal benefits and that less than three weeks is much too short. In spite of these statistics, the average cancer patient is on hospice less than three weeks prior to death; one-third of hospice patients are referred one week or less prior to death. Unfortunately one in ten are referred in the last 24 hours of

life. These short hospice stays do not allow hospice personnel adequate time to fully assess and meet the physical and emotional needs of dying patients and their families. After the patient's death, families often express regret that hospice had not been offered sooner. (1)

The reasons for oncology's failure to make timely referrals are numerous. If treatment goals are not clearly defined and frequently reinforced, patient's and physician's expectations may be vastly different. Physicians often over-estimate patient lifespan. Time constraints in a busy practice often make it more efficient to continue with another line of chemotherapy rather than embark on a time consuming discussion (often involving several family members) regarding changing the pathway of care. Primarily the reason for continuing chemotherapy (when the patient would be better served by transitioning to comfort care) is simply the momentum of a series of aggressive treatments with patient expectations reinforcing physician inertia.

Earlier introduction of palliative care
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Palliative and Hospice Care in England: Lights Turned Off After Lunch

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The day care program has a large multi-purpose room with an art therapist and diversional therapist who have various activities available for clients. The mid-week day care program runs for 3-4 hours a day, giving the client's carer a break while the client enjoys activities, socialization, and lunch. Volunteers can provide rides to and from day care for clients who need them.

The multi-purpose room is also used for bereavement groups. Additional services provided as part of bereavement care are also available within the building. There is also an exam room for the small outpatient clinic. Next to the beauty salon is the complementary therapist room set up with a massage table and aromatherapy materials. Offices for social workers, physiotherapists physicians and the administrator are also housed in this building. In 2006, Pilgrims Hospice programs saw 1600 admissions to its inpatient facilities. The average length of stay was 13 days. This is similar to our national average hos-

pice length of stay of 18 day.

It took £10 million (\$20 million) to run these three facilities, with the NHS contributing about 10%. Fund raising occurs year-round for this private charity. I didn't get a chance to talk to many hospice patients, because after lunch at the hospice, as well as the hospitals, a brass school bell is rung, the lights are turned off, and all visitors leave for the patient's rest period. The staff doesn't take naps but works quietly, charting and meeting with each other. I must have looked surprised when I saw the lights go off because one of the ward sisters (staff nurses) said "You need rest in order to recuperate".

My British exchange improved my understanding of just how different the US and British health care and social services are. While the British may have taken back technology from their visit to Seattle, I have an interest in trying to implement a lost low-tech change. Naptime is a lost opportunity for a slice of calm in the middle of the intensive rush

of the day in my inpatient facility. It may be a bigger cultural challenge than I realize to have the change implemented.

British centralization provides standardized social and health services to its people along with a care pathway at the end of life. Comparatively, hospice in the US is generally located in the home and is provided by many different agencies in a sort of patchwork quilt arrangement. We could use more social services to help keep patients in their homes. We could use more day care programs and inpatient facilities to provide hospice and palliative care. We need to change the rules in order to provide respite for families when patient have more than just a few days to live. In both countries dedicated groups of people, both professionals and nonprofessionals, value holistic care for people facing the end of their lives. They work diligently to support patients and families both during the dying process and through the survivor's bereavement despite the existing obstacles.



OCN Review: Test Your Knowledge

Mirtha T. Cuevas-Boff RN, BSN

Studying for Certification can be made easy by looking at one practice question at a time. By using a certification review tool one can learn even if they answer incorrectly. By reading the rationales you learn where you went astray, key words to look for and in many cases more about topic in general. Below are two questions from the certification review book.

1) **Mr. S. has been admitted for pain control because of bone metastases from advanced prostate cancer. He is still seeking aggressive treatment. Which of the following types of care is indicated?**

- A. Acute care.
- B. Palliative care.
- C. Rehabilitative care.
- D. Hospice care.

2) **Nurses can make a difference in supporting coping terminally ill clients with cancer and their families by:**

- A. Avoiding any discussion about death or dying
- B. Helping clients and families get a second opinion
- C. Encouraging clients to drink fluids every two hours
- D. Offering information about how symptoms can be controlled.

Reference:

Study guide for the core curriculum for oncology nursing, 4th edition, Ed: Suzanne M. Mahon. 2005 pg. 47-48.

Answers to these questions can be found on page 13.

ISNCC Small Budget Research Grant Program

The International Society of Nurses in Cancer Care (ISNCC) Small Budget Research Grant Program has been established to address clinical nursing research. The grant is for a maximum of \$5,000 depending on the nature and budget of the project.

Eligibility for grants:

- Registered nurse in good standing within own country
- The principal investigator is a member in good standing of a member organization of ISNCC

The deadline for submitting your application for the 2008 Small Budget Research Grant is October 15th, 2007. For more information about the ISNCC Small Budget Research Grant Program access their website: www.isncc.org

President's Message: Progress on Formalizing a Relationship with PSINS

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bestowed upon me are categorized by year and topic, and then scanned into an electronic history. Luckily I am married to a wonderfully patient and computer savvy man who has volunteered to help me.

The second goal is for the chapter to have a consistent Treasurer Report and develop Guidelines for bill submission. To accomplish this board has agreed to purchase a notebook or laptop computer and purchase software so that each treasurer uses the same program and tracks the information in a consistent manner. Many thanks to our current treasurer and other board members from the education cooperative, symposium committee, finance subcommittee, and a vendor liaison for working with me to make this a reality. To have all the information in one location and not on member's personal computers will also make the information much easier to locate and obtain as well as more secure.

The third goal is to continue with the monthly electronic e-mail and to continue to revise the template based on membership feedback. With the boards help I am developing guidelines for content and will eventually seek approval for a policy which can be passed onto members.

The fourth goal is to review the

PSONS chapter Strategic plan and make sure it is in line with ONS 2007-2009 strategic plan. This will include updating and incorporating changes, for example the reimbursement policy for educational events.

My fifth and final goal is to formalize our relationship with the Puget Sound Intravenous Nursing Society. Topics and alliance that has been approved by the board in my term as president-elect were:

1. Sharing educational offerings with each others' memberships via mail, email, website postings
2. Placing links on respective web sites to each other as professional partners
3. Reduced registration at each others' symposiums
4. Collaboration on joint educational events
5. Advertising in each others' newsletters

It is now time to work with Janine Pritchett the new PSINS president on details and have board members from each society connect and share timelines and information.

For the year I also set two personal goals for myself that I would like to share. The first was to serve on an ONS committee in 2007. In June of this year I sent in an application to the Oncology

Nursing Certification Corporation (ONCC) because they sent an e-mail "seeking AOCN®, AOCNP, and AOCNS certified nurses who work as an oncology nurse practitioner (NP), oncology clinical nurse specialist (CNS), or combined NP/CNS role to write test items for the advanced oncology nursing certification examinations". For me this was a huge step outside the "comfort zone" but my application was accepted and I ended up having a great experience, learning a lot, net working and making contact with other nurses from all over the United States. The best part was they didn't expect me to know everything and the mentoring was phenomenal!

My second personal goal, to sit for the National Infusion Certification Examination (CRNI), is not yet completed so we will see how it goes in September.

In closing I would like to thank Linda Curon who has stepped up and taken on the board position of communication committee chair. I would also like to thank Deborah Leslie, RN, BSN, OCN from the Seattle Cancer Care Alliance and Mirta Cuevas-Boff RN, BSN from Northwest Hospital for answering our call for editor and writers for the Puget Sound Quarterly Newsletter. Hope you're all having a great summer.

What's Nursing Got To Do With It?

A Nurse's Overview of Palliative Care

Carol Hile, RN, BSN, OCN

Many oncology nurses recall a time in their careers when critically ill cancer patients had no choices as they faced the end of their lives. Patients accepted that the only place for care was in a hospital, that physicians made all the decisions about their care, that pain and suffering were often an expected part of the journey.

The Hospice movement, first introduced in the 1970's, changed this situation. This health care revolution believed that each person can instead participate in one's final months of life according to personal wishes, goals and beliefs. It recognized that the advances in medicines could be used in alleviating pain and other symptoms, not just

for curative intent. The efforts of hospice continue today, realizing the vision that all people deserve a dignified and peaceful death on their own terms. Sadly, the majority of hospice admissions still today occur in the last 24-72 hours of life.

Millions of cancer patient have realized the hospice experience is what they most benefit from in the last stage of life. This recognition led many to wonder if the principles that improve the quality of end of life (EOL) care could make an impact earlier in the disease process, before "life expectancy determination" was made. With the escalation of treatment options and technological advances, this determination is often delayed or avoided all together. As more patients choose to continue active

therapy despite the lack of possibility for cure, the need for symptom management, family support and education must still be met. As our population ages, the provision of quality care to patients and families during this transition to EOL becomes crucial.

In response to this growing need, palliative care (PC) programs emerged in the 1990's. The WHO definition of Palliative Care "is the active, total care of patients whose disease is no longer responding to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of PC is achievement of the best quality of life for patients and families. Many aspects of PC are also applicable earlier in the course of the illness in conjunction with aggressive medical treatment."

In PC the emphasis becomes on the patient instead of the disease. In this shift of focus nurses play a highly important role. As we know, nurses spend more time with patients and families, hearing more of their concerns and needs. As part of this relationship with our patients we often have a more acute

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Barriers to Hospice Care: Earlier Access Allows Continued Treatment

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as an integral part (rather than the antithesis) of comprehensive cancer care can facilitate the ultimate transition to hospice. The concept of earlier introduction of palliative care also integrates well with the new philosophy of "open access" adopted by some hospice organizations. Open access allows patients to continue with certain treatments including chemotherapy, radiation and transfusions provided that the primary purpose of such treatments is to provide comfort. If the symptomatic burden of such treatments outweighs the benefits, then admission to hospice should be delayed until the focus of care changes more toward symptom management. Providence Hospice of Seattle adopted an open access policy in 2004. Since that time the average length of stay has increased from 47 to 64 days and the census has more than doubled from 211 to 460.(2)

What should be the nurse's role when he/she senses a need for a transition toward comfort care? It is certainly not unreasonable to suggest directly to the treating oncologist the need for a change in direction. A family conference to discuss treatment goals, code status and symptom management are best conducted with both the nurse and physician present. It is often useful for completeness and practice efficiency for the nurse to spend additional time to discuss the plan and implement appropriate referrals. A dictated note specifically outlining the palliative plan can be extremely useful at subsequent clinic visits and especially at the time of crisis and emergency room visit. A hospice referral when the patient and family are inadequately prepared for a need to change pathways may be counterproductive and lead to family and patient anger. A clinic waiting room that is well stocked with appropriate educational

materials regarding palliative care and hospice may be a useful prompt for families and patients to begin thinking about these questions and to address these issues with their physician. Access to a social worker in the outpatient setting can be extremely useful. Access to an ARNP and/or MD staffed palliative care consultative service would be the ideal. Many clinics and hospitals are moving in this direction.

Dr. Malpass is a practicing hematologist/oncologist at Virginia Mason Medical Center where he is also director of the palliative care consult service, and is a medical director at Providence Hospice of Seattle.

References

- (1) Palliative Care. Clinical Practice Guidelines in Oncology. JNCCN 2006; 4: 776-818.
- (2) Providence Hospice of Seattle 2006 data. Seattle Times July 30, 2007

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understanding of their suffering, awareness of unvoiced or unmet needs and are in position to provide comfort. The nurse's role as advocate and teacher can not be underestimated. Nurses are generally better at communicating, giving reassurance and explaining. A primary goal of PC is that all persons dying from advanced illness will have access to nurses who provide knowledge and compassionate care to lessen the burden of suffering and improve the quality of living and dying. Fundamental to PC nursing is acknowledging patients and family have the right to make informed decisions about all aspects of care and respecting the level of participation desired by the patient and family. Nurses have the unique and primary responsibility for advocating for the rights of patients to maintain their quality of life for as long as possible and to expect a dignified and peaceful death. The specialty of EOL nursing contains the six following dimensions¹:

- Emotionally based care
- Symptom management
- Facilitating communication with patient and family
- Facilitating care decisions
- Offering dignity to dying process
- Guidance and support

Given the importance of this role, as nurse's work with patients facing life threatening and/or life-limiting illnesses we commonly face confusion and uncertainty about our place in PC. Many view the physician as the "owner" of the patient's care and the "keeper" of all information about patient's goals and wishes.

The barriers to effective communication about emotional and EOL issues are well recognized by physicians and nurses alike. Practitioner concerns include causing distress, damaging hope and having inadequate time for such discussions. Patients and families often face similar concerns when talking to their providers.

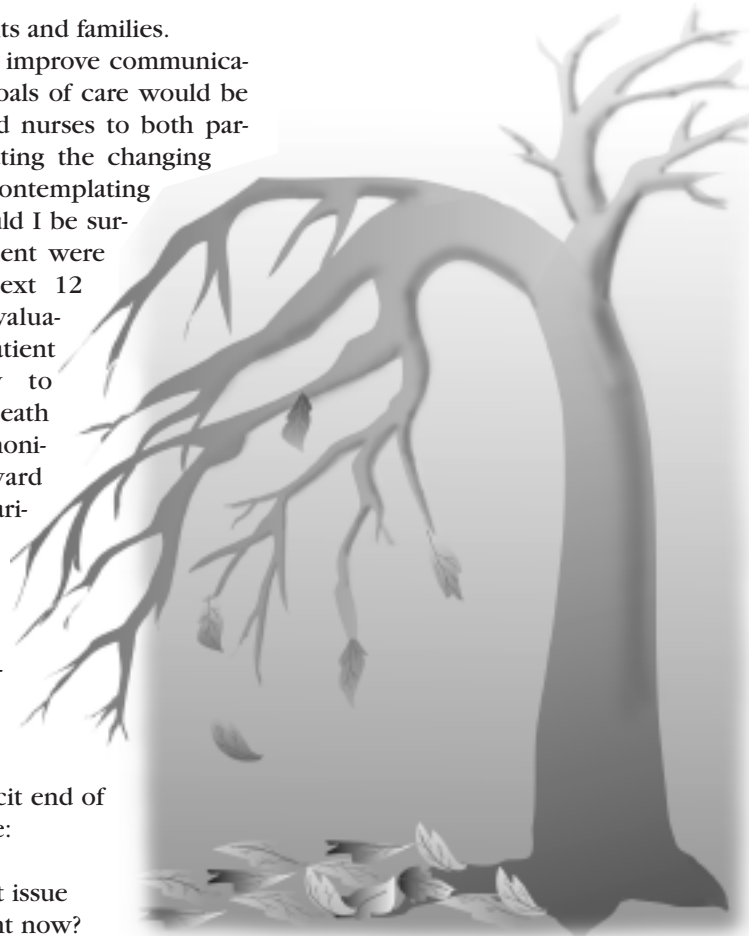
Barriers seen by nurses include: lack of collaboration and difficulty communicating with practitioner about plan of care and whether patient's goals and wishes have been addressed, lack of empowerment in information sharing, time availability, and lack of education on how to appropriately discuss EOL

issues with patients and families.

One attempt to improve communication and clarify goals of care would be for physicians and nurses to both participate in evaluating the changing goals of care. Contemplating the question: would I be surprised if this patient were to die in the next 12 months? This evaluation gives the patient the opportunity to plan for a good death instead of just monitoring a downward set of physical variables until death.

Improving education about discussing EOL issues is important in reducing this barrier. Some suggested questions to ask to elicit end of life goals might be:

- What's the most important issue in your life right now?
- What helps you keep going?
- How do you see your future?
- What is your greatest worry or concern?
- If things get worse for you, where would you like to be cared for?
- What is your understanding of your illness? Is there anything else you would like to know?
- What are your past experiences with serious illness and loss?
- Who are your social supports?
- What are your goals of care?
- Is there anything else that you would like us to know? (making more space for patient and family concerns, values, goals)
- What do you want to accomplish or do?
- What are your needs at this time?
- What do you wish you could still do?
- What is important for you to maintain control over?
- How do you feel about your treatments?
- Is there anyone you would like to see, talk or visit with?
- What are you hopeful about?²



Practicing these questions will assist providers, including nurses, in gaining more comfort with discussing EOL issues and assisting the patients and families in acknowledging our desire to hear their stories.

Palliative Care programs are on the rise in many hospitals and clinics around the world. Oncology nurses should recognize their role within these programs as well as in their daily practice. Besides providing comfort and symptom management, we need to strengthen our role in assisting patients and families in identifying and clarifying goals of care. In advocating for them we must devise protocols and communication tools with our physicians so that our patients receive the best care possible to ensure a quality life while confronting their dying.

References

- 1 ELNEC Training Program, 2000
- 2 Modified from the Hospice of Florida Suncoast, February 2001 and Caring Conversations: From Cure to Palliative Care, Stu and Lu Farber Tyler Associates, Virginia Mason, December, 2002

Healing Touch: A Gentle Treatment for Palliative Care

Mary M. Sallet RN, OCN, CHTP

Healing Touch (HT) is a complementary (or integrative) energy therapy that can be used in conjunction with traditional care. HT is a relaxing, nurturing energy therapy. The practitioners use their hands with light or near-body touch to balance the physical, emotional, mental and spiritual well-being of the patient. It works with the patient's energy field to support their natural ability to heal. It is safe for all ages and works in harmony with standard medical care.

HT was developed in 1989 by Janet Mentgen RN, BSN, HNC. The program originally started as a medically-based energy training program for nurses. In 1996 the program became its own certifying authority with the American Holistic Nursing Association's endorsement. Over the last 17 years HT has opened their classes to health care professionals and other individuals desiring an in-depth understanding of healing work using energy based concepts. Because the effective results over recent years, HT is now part of patient care systems in several hospitals in the United States. HT skills are becoming increasingly validated in health care systems around the country. Hospitals that have supported the practice of HT as part of their integrative care system have found it facilitates the return of compassion to the forefront of patient care. Healing Touch is widely respected and increasingly accepted, not only in the United States, but in many countries around the globe. It is considered one of the leading energy medicine programs in the world.

Healing Touch practitioners have a philosophy of caring. We use our hands with compassion and heart centered

care to restore harmony and balance within the patients energy system. We set the stage for the person to do self healing. Healing comes in many forms. It can take place on a physical, emotional or spiritual level. Healing Touch focuses on relief of symptoms, not curing the disease, which people often get confused.

Healing is an ongoing process

How Can Healing Touch Help in the Palliative Care Setting?

- ▶ Reduce stress
- ▶ Calm anxiety
- ▶ Relieve depression
- ▶ Decrease pain
- ▶ Alleviate side effects of treatments received
- ▶ Deepen the spiritual connection
- ▶ Create a sense of well-being
- ▶ Ease acute and chronic conditions
- ▶ Improve quality of life
- ▶ Support the dying process (relaxation, peace, acceptance)
- ▶ Assist with the grief and bereavement process of the caregiver

throughout life from birth until death. To be able to help someone cope with their chronic illness and the everyday changes can be challenging.

After many years on oncology nursing I had lost my passion for the work. Fortunately I had registered for the Scripps Memorial Oncology Symposium in San Diego. I was hoping for that "shot in the arm" I needed to get inspired again. One of the last sessions was titled "Intro to Healing Touch." It sparked my interest so I attended; not knowing it would be a life changing experience. I

knew at the end of the program that I was to do this thing called Healing Touch. I came back to Seattle and attended my first class in the fall of 1998. I became a certified practitioner in 2001. My passion was restored in a new way. I had acquired new skills to offer the patients. I had something different than a pill, syringe, or a needle. I now feel my heart and my hands are the best tools in my nursing kit.

I was able to develop a Healing Touch practice on an oncology floor. I was able to see first hand how HT works. By clearing their energy field and balancing their energy centers patients had fewer side effects from chemotherapy and tolerated their treatments better. The patients I treated were all able to receive some emotional healing concerning their disease and the life situation they were encountering. Spirituality was very important to all of them. They found a centeredness and peace that was able to carry them through whatever they had to face in the future. I also included caregivers in my treatments. Healing touch is very gentle and many times they would break down in tears and relief, allowing themselves to feel and be nurtured.

Everyone in life gets wounded from time to time. Life does not allow us to slide under the radar and escape it challenges. What patients and caregivers do with their stress is optional. Sometimes they need extra help to sift through the problems. They need to learn new ways to cope with life's terms. When nurses do the work of the healing that their own woundedness requires, they have the capacity to become "wounded healers" for others.

HT practitioners do not only learn techniques, but develop themselves as a vessel for healing for others. Having untaken the task to be healed from old wounds the wounded healers are unafraid of the healing journey and are most courageous companions on the healing journey for our palliative care patients. Frances Vaughan, a transpersonal psychologist states "Healing happens more easily through us when we allow it to happen to us."

The current health care system focuses almost exclusively on the curing

Continued on page 9

COMMUNITY CROSSINGS

Local Hospice and Palliative Care Resources

Gina Ritchie, MSW, LICSW
Oncology Social Worker

Hospice care helps patients and their loved ones face the physical, emotional and spiritual challenges at end-of-life.

Hospice Agencies

King County:

Providence Hospice of Seattle (all of King County, limited South Snohomish County)
206.320.000 / 206.320.7333 fax

Evergreen Hospice (most of King County, some South Snohomish County, focus on Eastside) Maintains an inpatient hospice unit in Kirkland.
425.899.3300 / 425.899.1033 fax

Swedish Home Hospice (all of King County)
206.386.6602 / 206.386.6956 fax

Highline Home Hospice (South King County)
206.439.9095 / 206.433.1031 fax

Group Health Home and Community Services (King, Pierce and Kitsap County, covers patients in Group Health network)
206.326.4444 / 206.326.4525 fax

Services provided by hospice include nursing, social work services, pastoral care, volunteers, home health aides, durable medical equipment and bereavement support. Most hospice services are done in the home, though it can be done in a nursing

home or free standing inpatient hospice facility. Insurance generally covers the cost of hospice care but not day to day care (i.e., the cost of an at home caregiver, or the room and board charges of a nursing home or hospice facility).

Snohomish County:

Providence Hospice and Home Care of Snohomish County
425.261.4800 / 425.261.4725 fax

Pierce County:

Good Samaritan Home Health and Hospice (Pierce County and Southern King County)
253.697.7600 / 253.845.5970 fax

Providence SoundHomeCare and Hospice (Pierce, Mason, Lewis and Thurston Counties)
800.869.7062 / 360.493.4659 fax
*Franciscan Hospice (South Puget Sound) Maintains an inpatient hospice facility in Tacoma.
253.534.7000 / 253.534.7098 fax

Other Local Resources

Providence Hospice of Seattle Transitions Program: Transitions is a non-medical program that provides informa-

tion, resources, and support services to adults and their families coping with a life-limiting illness. Transitions can help patients clarify goals and explore the scope of care and assistance patients may need. Services are offered free of charge.
206.320.7396 / 320.7366 fax

Safe Crossings: Safe Crossings is a program for children who are facing or have experienced the loss of a loved one. It offers a variety of education and support opportunities, including phone consultations, grief support groups, activities and workshops, a special weekend summer camp. Services are available to any child in King County free of charge.
206.749.7723

Stepping Stones: Offered by Providence Hospice of Seattle, this is a medical program dedicated to pediatric patients with a life-limiting illness in King County, including Vashon Island. 206.749.7652

Healing Touch

Continued from page 8

process, thus making it more a sickness-curing system. While necessary and excellent in its own right, this system is incomplete. We have the ability to give people longer lives, but as they move from the treatment into the palliative phase complementary/integrative care can play a large role in their quality of life.

References:

1. Healing Touch International website, <http://www.healingtouchinternational.org>
 2. Dossey B, Keegan, L, & Guzzetta C. Holistic Nursing: A Handbook for Practice, 4th ed. Sudsbury, MA: Jones and Bartlett (2005).
-

Apply Today for ONS Awards, Grants, and Scholarships

You can also nominate your deserving colleagues and be eligible for a one-year membership to ONS. Apply today and don't miss out on this unique opportunity! The nomination process is simple and convenient.

The Oncology Nursing Society each year bestows awards that celebrate and honor best practices and excellence in the oncology nursing field. By nominating yourself or a colleague, you will help raise the profile of your specialty and contribute to telling the story of oncology nursing.

For more details on these awards and many others, and to access the simplified application, simply visit www.nursingawards.org.



Recent Drug Approvals by the Food and Drug Administration

Doxil Plus Portezomib for Multiple Myeloma

On May 17, 2007, the U.S. Food and Drug Administration granted approval to doxorubicin HCl liposome injection (DOXIL® , Alza Corporation) for use in combination with bortezomib in patients with multiple myeloma who have not previously received bortezomib and have received at least one prior therapy.

Efficacy and safety were demonstrated in a randomized, multi-center, international study comparing the combination of DOXIL® plus bortezomib versus bortezomib alone in patients with multiple myeloma who have not previously received bortezomib and had received at least one prior therapy. DOXIL® , 30 mg/m² , was administered as a one-hour intravenous infusion on day 4 following bortezomib, 1.3 mg/m², administered on days 1, 4, 8 and 11 in both treatment arms every twenty-one days. Data were evaluated from 646 randomized patients. The primary endpoint of time-to-progression (TTP-defined as time from randomization to progression or to death due to progression) was evaluated in a pre-specified interim analysis. Median TTP was 9.3 months in the combination arm compared to 6.5 months with bortezomib alone (HR=0.55; 95% CI [0.43, 0.71]; p < 0.0001). Survival data are immature at this time.

Safety data were evaluated from 636 treated patients (318 in each treatment arm). Grade 3/4 reactions reported in greater than or equal to 10% of patients and in a greater proportion of patients treated with the combination of DOXIL® and bortezomib included neutropenia and thrombocytopenia. Additional all-grade reactions reported in greater frequency with the combination arm included anemia, fatigue,



pyrexia, nausea, vomiting, diarrhea, mucositis/stomatitis and hand foot syndrome. The incidence of heart failure events was similar in the two treatment arms (3% in both groups). Left ventricular ejection fraction decreases were seen in 13% of patients in the combination arm and in 8 % of in the bortezomib only arm.

The initial rate of infusion of DOXIL® should be 1 mg/min to help minimize the risk of infusion reactions.

Full prescribing information including clinical trial information, safety, dosing, drug-drug interactions and contraindications is available at www.fda.gov/cder/foi/label/2007/050718s029lbl.pdf.

Temsirolimus for Renal Cell Carcinoma

On May 30, 2007, the U. S. Food and Drug Administration granted approval for temsirolimus (TORISEL™ , Wyeth, Inc.) for the treatment of advanced renal cell carcinoma (RCC).

Efficacy and safety were demonstrated at a second interim analysis of a phase 3, multi-center, international, randomized, open-label study in previously

untreated patients with advanced RCC who had 3 or more of 6 poor prognostic factors. These factors included time of diagnosis to randomization of less than one year, Karnofsky performance status of 60 or 70, hemoglobin less than the lower limit of normal, corrected calcium of greater than 10 mg/dL, lactate dehydrogenase >1.5 times the upper limit of normal, and/or more than one metastatic organ site.

Six hundred and twenty six patients were randomized to one of three arms: Interferon alfa (IFN) alone (n=207), temsirolimus 25 mg alone (n=209), or the combination

of temsirolimus 15 mg and IFN (n=210).

Patients were stratified for prior nephrectomy and geographic region.

Seventy percent were less than 65 years old and

69% were male. Temsirolimus was infused intravenously over 30-60 minutes once a week either until disease progression or unacceptable toxicity. Premedication with an antihistamine (e.g., diphenhydramine) was recommended.

Single-agent temsirolimus was associated with a statistically significant improvement in overall survival (OS) when compared to IFN (hazard ratio 0.73 [95% CI: 0.58, 0.92]; p=0.0078. The median OS was 10.9 months on the temsirolimus arm and 7.3 months on the IFN arm. Progression-free survival (PFS) was a secondary endpoint and the median PFS was 5.5 months on the temsirolimus arm and 3.1 months on the IFN arm [hazard ratio 0.66 (95% CI: 0.53, 0.81)]. The combination of temsirolimus 15 mg and IFN did not result in a significant increase in OS when compared with IFN alone and was associated with an increase in multiple adverse reactions.

The most common adverse reactions (incidence ~30%) were rash, asthenia, mucositis, nausea, edema, and anorexia. The most common laboratory abnormalities (incidence ≥30%) were anemia, hyperglycemia, hyperlipemia, hypertriglyceridemia, elevated alkaline phosphatase, elevated serum creatinine, lymphopenia, hypophosphatemia, thrombocytopenia, elevated AST, and leukopenia.

PSONS PROFILE

Judith Hill, ARNP

Cathy Goetsch, MSN, ARNP, AOCNP

I am happy to introduce a new PSONS member, Judy Hill. Judy is an adult nurse practitioner with a special interest in palliative care. She is a University of Michigan alumnus, as is her husband, a UW Research Scientist. They have lived in the Pacific Northwest since 1997, have 2 grown children and love to travel together. Biking, hiking, and kayaking are some of their favorite activities.

Judy has had a long career in nursing, working in a variety of settings as a staff nurse and later as a nursing administrator following her MPH degree which she completed in 1980. After earning an MS in Nursing in 1990, she spent 8 years as a family practice nurse practitioner before moving on to geriatric primary care with nursing home clients. Her work with elderly clients and their families led to an interest and involvement in palliative care.

Currently, Judy's professional role is as an in-patient palliative care consultant at Virginia Mason Medical Center. In this advanced practice nursing position, she is developing and implementing the role for a nurse practitioner consultant. One notable contribution is the development of an internal web-site of extensive palliative care patient/family/staff resources. A main focus continues to be

helping care providers to identify appropriate palliative care referrals. She does this through direct physician education, use of printed materials, and on-going role modeling and teaching, much of which takes place during her daily rounds.

The complexity of her job is challenging. She often finds herself explaining the difference between palliative care and hospice care to patients, families and health care providers. As she helps identify goals of care, comfort rather than cure is the focus. She differentiates hospice and palliative care in the following way: palliative care is aimed at helping patients with advanced &/or life-threatening conditions establish goals of care and control symptoms. Treatment can be actively targeted toward disease control if that is what best allays symptoms. Hospice care has the common goal of symptom management, but with end-of-life care as an integral part of the process. Referral to both of these services, in Judy's experience, should be made much sooner in the illness continuum for patients and families to fully benefit from these services.



Judith Hill

Although she absolutely loves her job and her team, the limitations of working without an assigned palliative care interdisciplinary team is challenging. In addition, although she works full-time, there is currently no evening, nights, or weekend coverage for the service. She is looking forward to further expansion of the service including adding another nurse practitioner and physician to her team to provide better coverage and, in the long term, expand coverage to areas of need outside the acute care setting.



FDA News: Anti-Cancer Drug Gets 'Fast-Track' Designation

Marqibo®

Biopharmaceutical company Hana Biosciences announced fast-track designation has been granted by U.S. health regulators to its anti-cancer drug, Marqibo. This drug is a liposomalized form of vincristine, encapsulated in a rigid, lipid bilayer of sphingomyelin.

Since vincristine is a cell cycle specific agent whose anti-tumor activity is dependent on the duration of drug exposure. The sphingosome encapsulat-

ed technology employed by Marqibo results in a liposome which is more rigid than conventional liposomes, allowing the active vincristine leaks out of the liposome slowly. Drug levels are maintained for prolonged periods of time compared to standard vincristine delivery. This improved pharmacokinetic, which mimics a continuous vincristine infusion, may result in greater activity in rapidly dividing cancers.

The anticipated activity associated with vincristine has traditionally been limited

by its short half-life, and its inability to be dose escalated beyond 2mg due to neurotoxicity. In Phase I and II studies, Marqibo has shown to have a significantly longer half-life and patients have been able to tolerate doses that are 100 percent greater than conventional vincristine. It is hoped that this technology will improve responses in lymphoproliferative diseases, such as ALL, Hodgkin's and non-Hodgkin's lymphoma.



Expert Perspective from ASCO: MRI for the Diagnosis of DCIS

A study in the August 11 issue of *The Lancet* concludes that screening for breast cancer with magnetic resonance imaging (MRI) could improve the ability to detect ductal carcinoma in situ (DCIS), especially high-grade DCIS. DCIS is a form of preinvasive breast cancer. High-grade DCIS grows quickly and is more likely to develop into invasive breast cancer.

Background

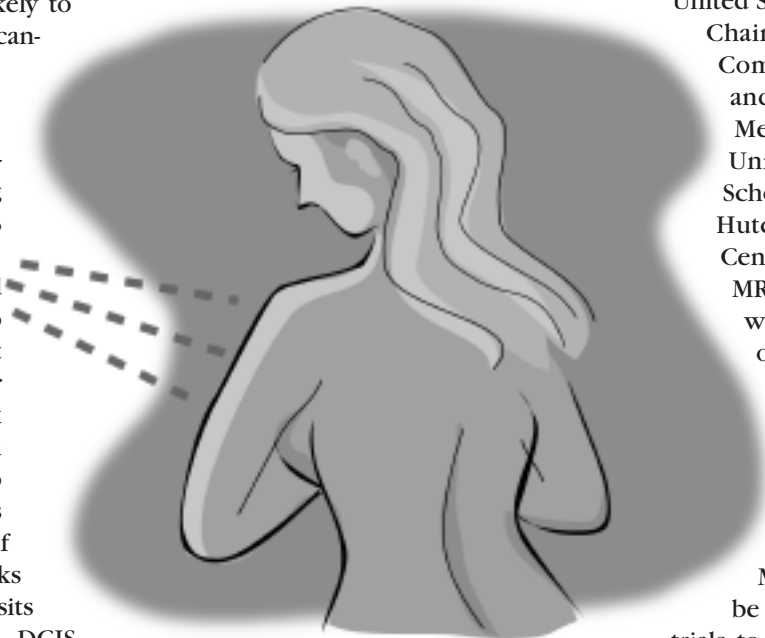
Mammography is the standard method for diagnosing DCIS, which accounts for 20% of diagnosed breast cancers. Left untreated, DCIS could progress over several years to a high-grade invasive breast cancer. MRI may be used for screening very high-risk women (such as those with known BRCA mutations) or to evaluate the both breasts before surgery at the time of diagnosis. Mammography works by highlighting calcium deposits (calcifications) around the DCIS lesions. MRI works by detecting areas of increased vascularization (growth of blood vessels), which is more commonly found around high-grade DCIS lesions.

The Study

In this study, researchers at the University of Bonn (Germany) offered mammography and high-resolution breast MRI to more than 7,000 women. From this group, 167 women had a confirmed diagnosis of DCIS. Researchers found that 93 (56%) of these lesions were visible on mammography and 153 (92%) lesions were found with MRI. Of the 89 lesions that were high-grade DCIS, 87 (98%) were found using MRI compared with 46 (52%) by mammography.

Additional Perspective

"This is an exciting study that was first presented at the ASCO Annual Meeting this year, and it is encouraging to see these results published. However, this is not a recommendation for routine screening with MRI," said Nancy



Davidson, MD, ASCO President and Director of the Breast Cancer Program at the Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins University in Baltimore, Maryland.

When an MRI shows suspicious findings, the next step is a biopsy, and this can be difficult to do if the lesion is only visible with MRI. "Not many centers are able to perform an MRI-guided biopsy," added Dr. Davidson.

Gabriel Hortobagyi, MD, FACP, ASCO's Immediate Past President and Chair of the Department of Breast Medical Oncology at the University of Texas M. D. Anderson Cancer Center in Houston, agreed that the results were encouraging, and discussed the concerns with MRI.

"First, this was a single study, and addi-

tional studies will need to be done to support these results. Second, this study was done at an academic medical center, with experts who have the equipment, extensive experience, and knowledge to accurately perform and interpret the MRI. Right now, there are no standards in the United States to ensure consistency between testing centers. Finally, the risk/benefit ratio for MRI screening needs to be established and communicated with patients. A false positive test leads to additional, invasive biopsies and other tests."

Bottom Line

"MRI is not the standard of care for diagnosing every breast cancer in the United States," said Julie Gralow, MD, Chair, ASCO Cancer Communications Committee and Associate Professor of Medicine/Oncology at the University of Washington School of Medicine and Fred Hutchinson Cancer Research Center in Seattle. "The use of MRI screening is supported for women with a very high risk of breast cancer. The next step is to adopt standards for performing and interpreting breast MRI, including the ability to biopsy lesions seen only on MRI. Once the quality of breast MRI is established, we will be ready to implement clinical trials to determine whether screening MRI can improve survival without increasing the financial and psychological costs when compared with mammography, which is a standardized screening tool proven to reduce deaths from breast cancer."

Reference

MRI for diagnosis of pure ductal carcinoma in situ: a prospective observational study. *The Lancet*, 2007; 370:485-492.

For Your Patients: Resources on this topic include the PLWC Guide to Breast Cancer, PLWC Feature: Mammography: What to Expect, and the PLWC Feature: Magnetic Resonance Imaging-What to Expect.

UPCOMING EVENTS

Fundamentals of Oncology Nursing

Aimed at nurses new to oncology.
Presented by the Puget Sound Oncology Nursing Education Cooperative
Date: September 17, 18, 24 and 25, 2007
Time: 7 a.m. to 4:30 p.m. each day
Where: Valley Medical Center, Renton
32.5 nursing CME available.
Contact: JaRon Snow, Alliance Strategies
(206/283-9292)
Email: alliancestrategies@verizon.net

Third Annual Chicago Supportive Oncology Conference

Date: September 27 - 29, 2007
Where: Hyatt Regency Chicago, 151 East Wacker Drive, Chicago, IL 60601
A CME conference for clinicians who strive to provide high-quality supportive care to their patients with cancer. *Presented by The Journal of Supportive Oncology and Reed Medical Education.* **Information:**
www.ChicagoSupportiveOncology.com

Nurse Competence in Aging: Caring for Older Adults

Proudly presented by the American Nurses Association and the Idaho Nurses Association.
Date: October 4, 2007
Where: Coeur d'Alene, Idaho
Registration: www.nursingworld.org

Breast Care for the Primary Care Provider

Date: Friday, October 5, 2007
Where: Virginia Mason Medical Center, Seattle.
A comprehensive update on the evaluation screening and management of benign and malignant breast disease including screening the high breast cancer risk patient.
Further information: (206) 223-6165 or **E-mail:** cheryl.hauskins@vmmc.org

2007 Clinical Trials Workshop

Presented by ONS, the American Society for Clinical Oncology, and the Coalition of National Cancer Cooperative Groups
Date: October 26 - 28, 2007
Where: Hyatt Regency Denver · Denver, CO
16.25 continuing nursing education credits provided at the completion of the program.
For information: Visit ASCO or ONS websites.

The ONS Chemotherapy and Biotherapy Course

Virginia Mason Medical Center and the Oncology Nursing Society sponsor this comprehensive review of current knowledge and techniques. Certification for 2 years as a Chemotherapy and Biotherapy Provider is awarded at the successful completion of the course and post-test. (16.2 CEUs for nurses).
Date: November 6-7, 2007, 8 a.m. - 5 p.m.
Where: Virginia Mason Benaroya Institute, 1201 Ninth Avenue, Seattle.
Registrar: Barara Van Cislo 206-341-0122
E-mail: Barbara.vancislo@vmmc.org

8th Annual ONS Institutes of Learning November 9-11

AND

ONS Advanced Practice Nursing Conference

Date: November 8-10
Where: Hyatt Regency Chicago on the Riverwalk Hotel, 151 E. Wacker Drive Chicago, IL 60601
Information: www.ons.org

ONS Radiation Therapy Trainer Course

ONS Train-the-trainer course offering during IOL/APN conferences
Date: November 8, 2007
Where: Chicago, IL

15th International Conference on Cancer Nursing

The International Society of Nurses in Cancer Care looks forward to welcoming you to Singapore for the 15th International Conference on Cancer Nursing (ICCN)
Date: August 17-21, 2008
Where: Suntec Singapore International Convention and Exhibition Centre.
Information: www.ISNCC.org
Please check the PSONS webpage www.psons.org for more listings.



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Call PSONS @ 206-283-9292 between 9 a.m. and 5 p.m.

Answers to OCN Review Test Questions

Questions found on page 5

1. Answer: B

Rationale: Palliative care is defined as care that provides symptom management, comfort and support to clients living with a life-threatening illness. Hospice care is care that is initiated when the client has less than 6 months to live.

2. Answer: D

Rationale: Nursing can make a difference in supporting coping in terminally ill clients and their families by offering information about how symptoms can be controlled, active listening, and helping open up communication about concerns and preferences with death and dying.

New Guidelines for Breast Cancer Screening in Women at High Risk of Breast Cancer

From the American Cancer Society

Breast magnetic resonance imaging (MRI), in addition to mammography, is now recommended for women who are at high risk for breast cancer, and to improve detection of early breast cancer. An expert panel assembled by the American Cancer Society (ACS) concluded that sufficient evidence exists from nonrandomized screening trials and observational studies to support the recommendation for an annual breast MRI, in addition to annual mammography, in the following groups of women:

- BRCA1 or 2 mutation carriers
- Untested (i.e., mutation status unknown) first-degree relatives (mothers, sisters, and daughters) of BRCA1 or 2 carriers
- Those with an estimated lifetime breast cancer risk of 20%-25% or greater, based largely on family history.

Based on estimates of elevated lifetime breast cancer risks, the expert panel also issued a consensus opinion that an annual MRI and mammography be offered to women who have:

- Received radiation therapy treatments to the chest between ages 10 and 30 (usually as treatment for other malignancies).
- Li-Fraumeni syndrome and their first-degree relatives.
- Cowden and Bannayan-Riley-Ruvalcaba syndromes and their first-degree relatives.

Breast screening with MRI and mammography is recommended to begin at age 30 (or 5-10 years before the earliest previous breast cancer in the family, if prior to age 30) and to continue for as long as a woman is in good health. The newly revised breast cancer screening recommendations appear in the March/April 2007 issue of *CA: A Cancer Journal for Clinicians* (Saslow et al., 2007).

In forming their recommendations, the expert panel examined the results of six major studies in the Netherlands, the United Kingdom, Canada, Germany, the United States, and Italy to determine the value of adding annual breast MRI to mammography for women who have an increased risk of breast cancer.

Despite differences in patient population and MRI technique, all groups reported that MRI was more sensitive in detecting breast cancer than mammography. Women with proven breast cancer had an abnormal MRI 71%-100% of the time. However, the women had an abnormal mammogram only 16%-40% of the time. MRI was able to find cancers that were missed by mammography.

These studies were done in women who already had breast cancer, not as an initial screening. Another caveat is that there is no data yet to show that the increased sensitivity of the MRI screening leads to increased life expectancy. Additionally, the greater ability of MRI to detect breast cancer comes with a tradeoff: MRI finds many more abnormalities that ultimately prove not to be cancer and do not require treatment. MRI is less specific than mammogram. Women without breast cancer had a normal MRI only 81%-99% of the time, compared to 93%-99% of the time through mammography. Thus, MRI produces more "false alarms" than mammography, resulting in extra and unnecessary tests and biopsies, especially in the first year of MRI screening. Even in high-risk women, breast biopsy done for MRI, abnormality results in findings of cancer only 20%-

40% of the time.

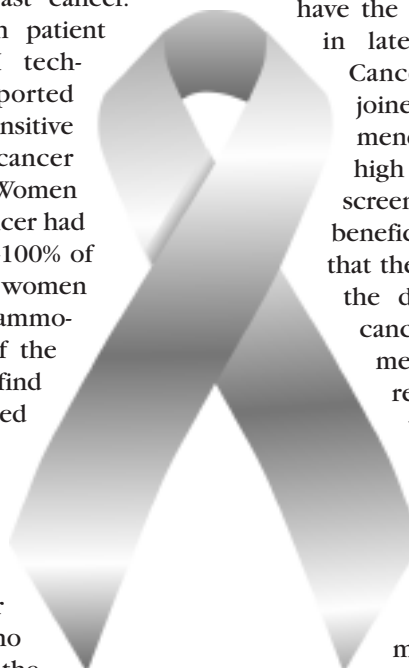
The expert panel strongly recommends that MRI screenings be offered to women who are at high risk of developing breast cancer, in addition to, not instead of, mammography. With the combination of MRI and mammography, the ability to detect cancer while minimizing false alarms is greater than with MRI alone. The panel expressed concerns about high costs and limited availability of high-quality MRI breast screening services for women who are at high risk of developing breast cancer. The American College of Radiology (ACR) is developing an accreditation process for centers that perform breast MRI and MRI-guided biopsy. The ACR intends to

have the MRI guideline available in late 2007. The National Cancer Institute has not joined in making the recommendation because the very high standard required for screening tests to be proven beneficial (i.e., firm evidence that the screening test reduces the death rate from breast cancer) has not yet been met. Meeting the standard requires larger studies that follow women over long periods of time, and such studies have not been done. Meanwhile, many experts believe that it is prudent to make reasoned recommendations based on what

currently is known from the studies. The ACS panel represents the opinion of experts with special knowledge related to breast cancer screening. The experts have evaluated evidence that is currently available and have concluded that the benefits of MRI screening outweigh the risks for high-risk women.

Reference

Saslow, D., Boetes, C., Burke, W., Harms, S., Leach, M.O., Lehman, C.D., et al. (2007). American Cancer Society guidelines for breast screening with MRI as an adjunct to mammography. *CA: A Cancer Journal for Clinicians*, 57, 75-89.



ONS PEP Resources Provide Quick Information on Evidence-Based Interventions

Margaretta S. Page, MS, RN

I was fortunate to have been involved with the development of the ONS Putting Evidence Into Practice (PEP) resources. Because of my involvement at this level, I've had a vested interest in the resources and find myself using them often in my practice. I also have shared them with my colleagues. The first four ONS PEP resources address prevention of infection, sleep-wake disturbances, fatigue, and nausea and vomiting. An additional eight are slated for release in the spring. These ONS PEP cards will address caregiver strain and burden, constipation, depression, dyspnea, mucositis, pain, peripheral neuropathy, and prevention of bleeding. Although the ONS PEP resources are designed to be general enough for all specialties in the oncology community, certain populations may benefit from some more than others.

I am a neuro-oncology clinical nurse specialist. Historically, the drugs given to our patient population have not caused significant nausea and vomiting or put patients at risk for infections. A new chemotherapy regimen (irinotecan/bevacizumab) recently has become rather popular among treating physicians as well as patients. The regimen has the potential to cause significant nausea and vomiting, increased risk for infection, diarrhea, and fatigue. I didn't feel particularly savvy about how to best handle all of these outcomes. I used the ONS PEP card to make recommendations for acute nausea and vomiting, delayed nausea vomiting, and anticipatory nausea and vomiting for a good deal of patients receiving the regimen. Having a resource that summarizes the available evidence-based interventions has been wonderful. Our practice also has debated about the use of prophylac-

tic antibiotics in this subgroup. The ONS PEP resources and recent accompanying articles in the Clinical Journal of Oncology Nursing (CJON) have been excellent summaries and references to facilitate discussion about clinical questions such as these.

Another area that I now feel more equipped to address with patients is sleep-wake disturbances. I must confess, that prior to my involvement with the Sleep-Wake Disturbance ONS PEP team, I was quick to agree with the prescription of pharmaceutical sleep aids for complaints of insomnia. Our patients have cancer, so of course they had trouble sleeping! Recently a 21-year-old patient's father asked me about a drug for sleep. Instead of rushing to a pharmaceutical solution, I stopped and assessed the problem and referred to the ONS PEP card. What were the patient's sleep habits? I used the BEARS (bedtime, excessive daytime sleepiness, awakening, regularity, and snoring) tool. It turned out that the patient was sleeping for long periods of the day and then having difficulty at night. I discussed with the father the basics of sleep hygiene, sleep restriction, and sleep consolidation, all from the ONS PEP card and recent CJON article. These were basic interventions that were easy to introduce and actually had a positive effect. My colleague recently shared the card with a patient who was having trouble sleeping. The patient, who is a PhD-prepared professor at the University of California, Berkeley, liked seeing how the interventions had been categorized by strength of evidence; because of this, he placed value on the interventions recommended. We have yet to evaluate how they worked for him.

Are you using the ONS PEP cards or the ONS Outcomes Resource Area

(www.ons.org/outcomes) for information regarding evidence-based interventions in your practice? Please share a story with your SIG members and others about the use of the ONS PEP Resources cards, resource area, or CJON articles with a particular problem or patient. Perhaps together we can learn to maximize these recently created and useful resources. Please contact the ONS Research Team (research@ons.org) if you have an exemplar to share.

Note: The next ONS PEP resources to be developed will address anorexia, anxiety and psychological distress, diarrhea, and lymphedema.

ONS PEP Cards Are Available in a Volume 1 and Volume 2 Package

A new six card volume of ONS PEP cards is now available. Topics include caregiver strain and burden, constipation, depression, dyspnea, mucositis, and peripheral neuropathy. Order now through <http://esource.ons.org> and receive FREE with your purchase the first four ONS PEP cards covering fatigue, nausea and vomiting, prevention of infection, and sleep-wake disturbances. To sustain the ONS PEP project, a small fee is charged to cover the cost of printing future ONS PEP cards.

- Member Price: \$5.40
- Non-Member Price: \$7.50

News From CE Central

Pharmacology CD-Available Now!

Pharmacology Update: Volume One is the first of a new series of in-depth, self-paced CD-ROMs designed to present detailed information on pharmacotherapy in cancer care. Order your copy at <http://esource.ons.org/ProductDetails.aspx?sku=INCD0174>.

Cancer Biology Web Course

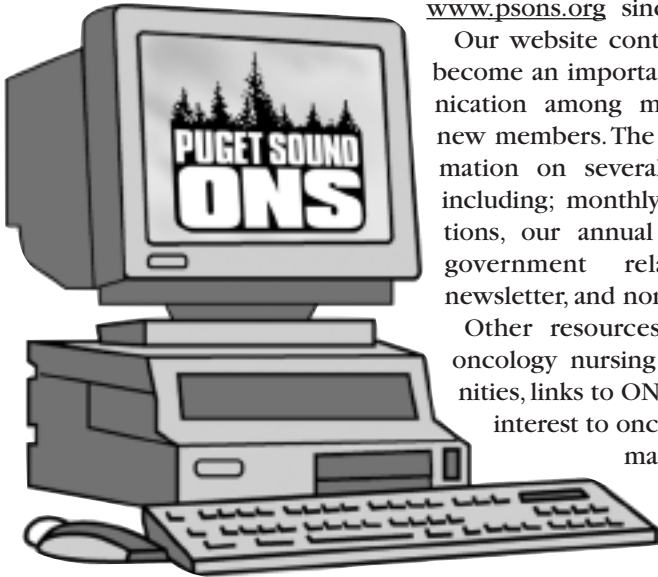
You don't want to miss the Cancer Biology Online Education Series that is designed to meet the educational needs of oncology nurses and other health-care professionals interested in gaining a fundamental understanding of cancer biology. You will receive cutting-edge information that enables you to provide the quality care your patients deserve. Registration is now open at <http://onsopcontent.ons.org/Education/DistanceEducation/CancerBiology/indx.shtml>



Discover the PSONS Web Site

DID YOU KNOW?

The Puget Sound Oncology Nursing Society has had a website at www.psons.org since 1999.



Our website continues to grow and has become an important medium for communication among members and potential new members. The website includes information on several committee activities including; monthly educational presentations, our annual symposium, research, government relations, membership, newsletter, and nominating committees.

Other resources on the site include oncology nursing employment opportunities, links to ONS and other websites of interest to oncology nurses. The site is managed and updated by PSONS members.

PSONS Email and Paper Mail Communication

We regularly communicate with our membership about chapter events, political action items and oncology educational offerings in our community. We send this information via paper mail monthly. In 2006 the President initiated an electronic newsletter to highlight timely information and events for the chapter. Other time sensitive information is also sent via email. If you would like to contribute contact our secretarial service, Alliance Strategies for format information: alliancestrategies@verizon.net

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