KINESIS

ONCOLOGY NURSING SOCIETY

PRESIDENT ADDRESS

Welcome to this issue of Kinesis!

Allow me to introduce myself. I am Debbie (Rust) Heim, and I will be serving as your President for 2013 and 2014. I am relatively new to the chapter but not new to the area. I have been a nurse for over 37 years, all but nine of those years spent here in the tri-state. I have worked as a staff nurse, an instructor and then manager in a school of nursing, and most recently as a nurse practitioner. In fact, I know many of you from my "past lives". I have only been in oncology since 2001. To be honest, I more or less fell into oncology, but immediately fell in love with the specialty. I joined ONS almost immediately upon taking my first oncology position, and have been involved on both the chapter and national level.

The Board met in February and set goals for the next two years. We will be updating the Strategic Plan to comply with the new format set forth by national ONS. We will be updating documents such as bylaws and delineation of roles. We plan to investigate sending notices of meetings electronically and registering for meetings electronically as well. We also will move to an electronic format of voting for Board members.

As always, it is exciting to be an oncology nurse, meeting the needs of patients and keeping up with changing cancer treatments. The Board and I hope to continue to meet your educational needs through our monthly programs.

I want to encourage everyone to attend the Vendor Fair on March 21, 2013. We have 37 vendors who will be displaying information about their services/products. The cost has been reduced to $20. Raffle prizes will include a Kindle Fire and a national ONS membership.

I am looking forward to serving you the next two years and beyond!

VOLUME 23, ISSUE 1

In this issue:

Letter from the Editor

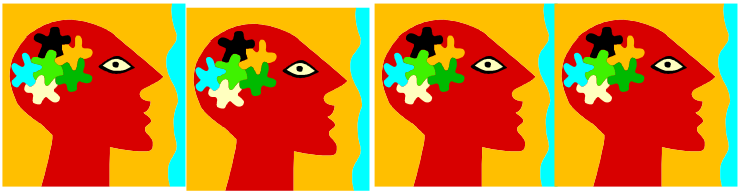
From the Editor

I am sure I am not alone in saying "I am sooooo busy"! 2013 marks the 40th anniversary of my graduation from nursing school- who would have thought. Sometimes it feels like yesterday and other times I feel old when I review the past nursing care to the present. (patients not being told they have cancer, 4 day hospitalizations for cisplatinum with ativan for sedation). I continue to get excited about learning and making a difference yet I think I was too naïve in thinking that my education was over when passing the boards! Oncology Nursing is changing very fast and often we need to take a deep breath to absorb it all.

The goals of this newsletter are to stimulate learning, an opportunity to share and question and above all bring the Oncology Nurses in the tri-state area together! We need to keep the sharing coming, provide kudos to each other and provide excellent care. Stay positive and keep the passions flowing.

Ruth Gholz

The PSYCH Corner



The PSYCH Corner

Alleviate Your Burnout & Compassion Fatigue!

By: Barb Henry, MSN, APRN-BC

Burnout and compassion fatigue are conditions that occur in many professionals, particularly nurses working in high trauma specialties such as oncology.

Burnout is emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment (Maslach, Schaufeli & Leiter, 2001). Compassion fatigue is behaviors and emotions resulting from helping or wanting to help a traumatized or suffering person (Figley, 2006). Antecedents come before burnout or compassion fatigue and may include the following: • Exposure to traumatic care of cancer patients • Vulnerable individual personality traits or lack of coping skills • Lateral violence from others • Excessive worries • Compulsive sensitivity • Disabled resiliency • Emotional contagion • Empathetic distress and strain • Physical and mental fatigue • Work and emotional overload • Existential suffering • Final availability (end of life care) • Exposure to indirect trauma • Secondary victimization • Soul pain • Vicarious trauma • Functioning as wounded healer (Boyle, 2011). Difficulty balancing work and life outside work is also an antecedent to burnout and compassion fatigue.

There are many possible consequences of burnout and compassion fatigue: • hypervigilance, • substance abuse, • flashbacks, • re-experiencing the trauma, • depression, • anxiety, • insomnia, • mood swings, • anger, • apathy, • cynicism, • desensitization, • discouragement, • bad dreams, • preoccupation with patient experiences, • feelings of being overwhelmed, • hopelessness, • irritability, • lessened enthusiasm, • sarcasm, • intellectual boredom, • concentration impairment, • disorderliness, • weakened attention to detail, • increased somatic complaints, •lack of energy, • loss of endurance, • loss of strength, • proneness to accidents, • weariness, • fatigue, • exhaustion, • callousness, • feelings of alienation, • isolation, • inability to share in or alleviate suffering, • lateral violence (lashing out against colleagues) • indifference, • loss of interest in activities once enjoyed, • unresponsiveness, • withdrawal from family or friends, • lack of spiritual awareness, • poor judgment, • absenteeism, • avoidance of intense patient situations, • desire to quit, • diminished performance ability (i.e., medication errors, • decreased documentation accuracy/record-keeping), • stereotypical/impersonal communications and tardiness (Aycock & Boyle, 2009; Coetzee & Klopper, 2010; Griffin, 2004; & Showalter, 2010).

With experience, self-care, and support from peers and healthcare organizations, competent oncology

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nurses learn to establish appropriate boundaries that are more semi-permeable than other clinical specialties. Because of the semi-permeable boundaries unique to oncology nursing and high risk of developing burnout and compassion fatigue, oncology nurses need annual therapeutic programs in addition to more frequent support outlets. One such annual program is the ***CTC-ONS Annual Awards & Products Fair on 3/21/13 at the Blue Ash Embassy Suite Hotel***. The new lower price of $20 allows any nurse interested in oncology (non-members welcome) to enjoy a nice meal, inspirational talk, and chats with vendors that may lead to you ***win a Kindle Fire, National ONS membership, and other prizes!***

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(Above are excerpts from my papers I wrote for a DNP nursing research and theory class at Northern Kentucky University.)

Membership News:

Please welcome new members:

Burns Brenda S , Bryant Mary E , Carter Nancy, Combs Susan L , Gibson Kelley , Greenfield Carli N
Heuker Patricia A ,Iams Christie R , Kegley Deanna R , Krummen Kelly, Kumar Harriet , Mendenhall Molly Parker Laura M, Perkins Amy M ,Rask Lee Ann, Reynolds Kathi E ,Siuda Jenny L ,Sorter Patti M , Stengel David A, Sulick Rosemary, Turner Brandi J, Woolery Adrienne, Worcester Brenda L

Chapter member News

Monica Feiler MSN, CNP, AOCNP has accepted a Nurse Practioner position in Chicago and will be leaving her position at UC in April. We wish her well and thank her for all of her work as chair of the membership committee
Rhonda Bowman is the new COO of OHC

2012 Exemplary Contributions in Service Award: Adrianne Lane, EdD

"Where does the time go?" It's not a question that anyone who knows UC College of Nursing Professor Adrianne J. Lane, EdD, would have difficulty answering. "One might truly wonder whether she has managed to clone herself," a colleague says of Lane receiving the 2012 Faculty Award for Exemplary Contributions in Service to the University of Cincinnati. But there is only one Lane, and the honor is hers and hers alone.

WHAT IS EVERYONE ELSE DOING? Your name could be here, please provide information for sharing!!!

Debbie Heidrich and four other nurses completed a four day palliative care nursing course in the Sultanate of Oman. This group was part of ONS International Strategic Plan

On Saturday 3/2/13 many members of our chapter participated in the Leukemia Lymphoma Program "New Paths to Treatment and Hope for Blood Cancers. Due to the leadership of Sue Partusch the following nurses presented: Lynn Brophy, Natasha Clinton, Lisa Gebhart, Ruth Gholz, Sarah Godfrey and Nancy Murrin Susan Colding has been nominated by the chapter for the Ohio Outreach Award Educational opportunity from the greater Cincinnati Oncology Nursing Consortium: Updates in Oncology Nursing 5/24/13 at Christ Hospital. For details contact Gigi Robison

NEWS FROM NATIONAL ONS

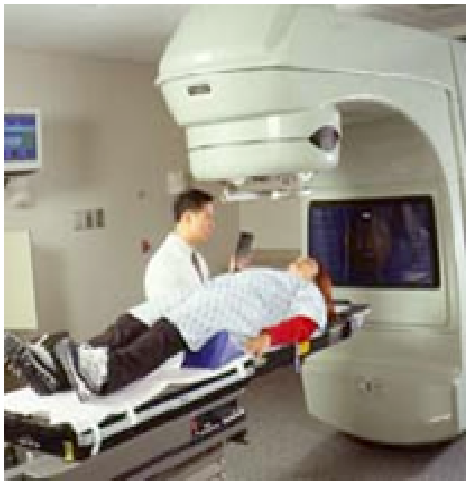
Oncology Nursing Month is May this gives a chance to recognize the outstanding contributions of oncology nurses with gifts featuring the "**Oncology Nurses: Providing Care for Life**" theme. Items may be purchased. Gifts and posters may be purchased at ONS.ORG

ONS 38th Annual Congress: 4/25-4/28. Please share with others if you are attending. Nurses in Ohio meet at opening ceremonies in the right front and Ohio State often has an Ohio reception.

Please be sure to explore the ONS website for all of your oncology concerns and issues.

Radiation Therapy:
What do we need to know?

Sarah Godfrey, RN, BSN, OCN



What is Radiation?

High energy x-rays **or** charged particles

Protons, electrons, beta particles, and gamma rays

What are the types of radiation patients can receive?

External Beam : 80 % of patients receive EBT (external beam therapy). This is where an external source of radiation is pointed at a particular part of the body. Ex.: Head, neck, chest, breast, abdomen/pelvis. **The picture above is an EBT machine.

High Dose Radiation: A temporary insertion of a high dose radioactive material. (Ex: breast, cervix, uterus)

Permanent Radiation Therapy: Radioactive seeds are inserted interstitially and are not removed. (Ex: prostate or brain seeds)

Radiopharmaceutical Therapy: administration can be given by injection or oral route. (Ex: I-131 for thyroid cancer)

Since most patients receive external beam radiation, let's look at some of the most common side effects. Side effects for radiation are site specific, i.e, side effects can occur wherever the patient is being treated.

3 main side effects that can occur with EBT are skin reactions, nutritional issues and fatigue.

Skin reactions: Radiation dermatitis usually starts to occur 2-3 weeks into treatment and can last until 1-2 weeks after completion.

-Evidence and consensus are limited to support the use of products for the prevention of acute radiation skin reactions (Bolderston et al., 2006; Roper, Kaisig, Auer, Mergen, & Molls, 2004).

-Keeping the skin the moist/hydrated with lotion/creams is ok as long as approved by the physician and should not contain metals, perfumes or alcohols.

-General supportive measures include: using a mild soap, wear loose fitting clothing, avoid sun exposure or other irritants, and avoid shaving treatment area.

-If late skin effects occur, such as moist desquamation, the pt will be put on a break from treatment. Leave area uncovered as much as possible, if necessary, cover with a loose dressing of non-stick material. Take pain medicine PRN for comfort.

Nutritional issues: These can occur 2-3 weeks into treatment and last for weeks to months after completion.

-Patients may have nausea, vomiting, anorexia, diarrhea, odynophagia, and dysphagia.

-With radiation to the head, neck, and esophagus, nurses need to assess the patient's nutritional status PRIOR to the start of treatment. These patients may need a dietician and then a GI consult for feeding tube placement. The patient needs to be weighed at least weekly and monitored for signs of nutritional deficiency.

-If the treatment is causing nausea, it's important to have to patient take anti-nausea meds 30 min prior to treatment, eat small frequent meals, and drink plenty of fluids.

-Diarrhea with radiation can be severe. It's crucial to know how many loose/watery stools a day the patient is having and to treat accordingly with anti-diarrheals, a low fiber diet, and IV hydration, if necessary.

Fatigue:

-Fatigue from radiation therapy can range from a mild to an extreme feeling of being tired. Many people describe fatigue as feeling weak, weary, worn out, heavy, or slow.

-Fatigue can happen for many reasons. These include: Anemia, anxiety, depression, infection, lack of activity, medication.

-Ways to manage fatigue can include: getting 8 hrs of sleep at night, plan rest periods during the day, exercise, plan a work schedule that is right for you, let others help you at home, and maintaining your diet.

*This is brief look at radiation oncology. The care we give to these patients must include:

- A thorough patient assessment
- Education
- Psychosocial support/counseling
- Symptom management
- Coordination of care and support needs

Chemotherapy Administration Sequencing

with permission from Chemotherapy SIG: January 2013 Newsletter

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Multi-agent chemotherapy regimens were created with the goal of attacking cancer cells from many different angles at one time, thus improving efficacy. However, in the process of interacting with cancer cells, the individual agents also can interact with each other. These drug interactions can have one of three effects: one drug enhances the effect of another (synergy); one drug inhibits the effect of another (antagonism); or the interaction does not end in any clinically relevant outcome.

Considering this, those of us who are at the bedside are left wondering, "What is the safest and most effective sequence of administration for the agents in a chemotherapy regimen?" The answer is, unfortunately, not a simple one. A cornucopia of literature on this subject exists, but very few studies provide clear guidance for practitioners. A bulk of the studies looking at one drug's effect on another are carried out in the laboratory. Many times, these results cannot be extrapolated clearly to a patient, as the human body itself can have various effects on each of the drugs that enter it. Scientists often hypothesize one drug's effect on another based on each drug's mechanism of action, but this does not always manifest as a clinically significant effect in the actual patient with cancer. Even when data exist on an interaction between two agents, this information cannot be extrapolated to other agents in the same class. Lastly, in some studies, a sequence results in a beneficial effect, and in other studies, the same sequence does not. These conflicting data leave the clinician with little practical information.

Let's explore one particular combination as an example—cisplatin and gemcitabine. Cisplatin is an agent in the class of cytotoxic drugs known as platinums. It exerts its effects by cross-linking with DNA inside the cell and causing disruptions in normal DNA function. Gemcitabine is part of a class of agents known as the cytidine analogs, and it exerts its effects by tricking the cell into incorporating gemcitabine into the DNA structure, disrupting normal DNA function. These two agents often are given together in the same chemotherapy regimen for a variety of cancer types. Interestingly, giving cisplatin prior to gemcitabine or giving gemcitabine prior to cisplatin result in synergistic effects (increased killing of cancer cells). The exact way these two drugs interact within the cell is not clear, but some evidence exists for the following mechanisms (Kroep et al., 1999; van Moorsel et al., 1999).

- When cisplatin precedes gemcitabine administration, clearance of gemcitabine is delayed, allowing it to exert its effects on the cancer cells for a longer period of time.

When gemcitabine precedes cisplatin, cisplatin's ability to stick to the DNA it is trying to attack increases, increasing its ability to kill the cancer cells.

With only this information, one could argue that the sequence with which these two agents are administered is irrelevant. However, when applied to the clinical setting, patients who received cisplatin prior to gemcitabine experienced higher rates of serious leukopenia and neutropenia. On the other hand, when gemcitabine was received prior to cisplatin, no additional side effects were seen. Thus, the optimal sequence of administration seems to be gemcita-

…. Continue from page 7….

In general, the complex nature of each of these interactions makes it difficult to know which agent should be first and which should be last. Clinicians need more practical information on this topic. To date, the most useful piece of literature on this subject was published in 2011 in the *Journal of Hematology Oncology Pharmacy*. In this review article, Mancini and Modlin (2011) searched the current available literature relating to sequencing methods for same-day multi-agent chemotherapy regimens in human subjects. They then evaluated 57 articles on this subject and analyzed data on 62 potential chemotherapy combination sequences. Their efforts resulted in the identification of 21 different chemotherapy doublets that had clinically relevant data to support the use of a particular sequence of administration. For more specific information, please refer to the article. It is informative and has been very useful to me thus far in my practice.

In what other practical ways can we apply these principles without having to stop and study the literature each time we are about to administer a chemotherapy regimen? One general principle is to follow the same sequence of drug administration that was used in the study from which a particular chemotherapy regimen was developed, keeping in mind, of course, that not all studies specify the sequence they used. If your institution utilizes standardized chemotherapy order sets, then the sequence of administration may be built into the order set and, therefore, clearly defined for the dispensing pharmacist and bedside nurse each time a chemotherapy regimen is ordered. Otherwise, a set of internally published standards for sequencing different chemotherapy agents also may be helpful in guiding the clinical staff. In cases in which two medications have no known interaction, we still can identify a sequencing approach, taking into account the stability of each agent (giving agents with shorter stability first), compatibility (two agents may be given concurrently), and infusion times (drugs with shorter infusion times may be given in the chair or bed unit, followed by infusion of drugs with longer or continuous infusion via ambulatory pump).

In lieu of national standards and given the paucity of practical data, each practice site should use an interdisciplinary approach to determine the best sequence for the chemotherapy regimens commonly used at its center. Also, we should strive to share our clinical experiences and approaches to the sequencing of chemotherapy administration across the national spectrum.

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2013 Cancer Education Plan (last updated 12-12-12)

Dates	Class or Course	Location	Registration Deadline
Mondays, January 28 & February 4, 2013 7:30 AM-4PM	ONS Chemotherapy & Biotherapy course	KH Dining Room # 1	Thursday, January 10
Wednesday, February 20, 2013 8AM-4:30PM	FHH Chemo Class (open only to FHH RNs)	FHH - TBA	Wednesday, February 13
Monday, March 25, 2013 8AM-4PM	Cancer Primer	KH Nelson 2	Monday, March 18
Monday, April 22, 2013 8AM -3PM	Oncology Emergencies	KH Nelson 1-2	Monday, April 15
Fridays, May 17 & 24, 2013 7:30AM-4PM	ONS Chemotherapy & Biotherapy course	KH Nelson 4	Wednesday, May 1
Wednesday, September 4, 2013 12N-2PM/2PM-4PM	Hazardous Drugs: Hidden Danger /Radiation Therapy 101	KH Nelson 4	Wednesday, August 28
Tentative September 8AM-4:30PM	FHH Chemo Class (open only to FHH RNs)	FHH - TBA	TBA
Mondays, September 30 & October 7, 2013 7:30AM-4PM	ONS Chemotherapy & Biotherapy course	KH Nelson 4	Thursday, September 12
Tentative November 8AM -4PM	Cancer Primer	FHH - TBA	TBA

Brochures with contact hour and registration information will be available at a later date.

For more information and updates, contact:

Rae Norrod, MS, RN, AOCN®, CNS

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2013 Schedule

January 12, 2013
St. Elizabeth Cancer Center
1 Medical Village Drive
Edgewood, KY 41017

February 9, 2013
TriHealth - Group Health
379 Dixmyth Avenue 8th Floor – Dermatology
Cincinnati, OH 45220

March 9, 2013
The Christ Hospital Ambulatory Center
Dr. Mary Blades Office
5885 Harrison Avenue
Suite 3500
Cincinnati, OH 45248

April 13, 2013
Mercy Health – Clermont Hospital
Outpatient Infusion Center
3000 Hospital Drive
Batavia, OH 45103

May 11, 2013
UC Health
Dermatology Clinic at Hoxworth Center
3130 Highland Avenue
Cincinnati, OH 45219

June 8, 2013
St. Elizabeth Healthcare - Grant County
238 Barnes Road
Williamstown, KY 41097

July 13, 2013
UC Health
Dermatology Clinic at Hoxworth Center
3130 Highland Avenue
Cincinnati, OH 45219

August 10, 2013
TriHealth
Bethesda Arrow Springs
100 Arrow Springs Drive
Lebanon, Ohio 45036

September 14, 2013
Mercy Health – Fairfield Hospital
3000 Mack Road
Fairfield, OH 45014

October 12, 2013
St. Elizabeth Healthcare – Covington
1500 James Simpson Jr. Way
Covington, KY 41011

November 9, 2013
The Christ Hospital
Cincinnati Sports Club
3950 Red Bank Road
Cincinnati, OH 45227

December 14, 2013
Mercy Health – West Hospital
Address will be announced once the facility opens

ALL CLINICS SCHEDULED **10:00 AM TO NOON** ON 2ND SATURDAY OF EACH MONTH.

For appointments at a Christ Hospital clinic, call 513-585-1000.
For appointments at a Mercy Health clinic, call 513-956-3729 (95-MERCY)
For appointments at a St. Elizabeth clinic, call 859-301-7276 (SCRN).
For appointments at a TriHealth clinic, call 513-862-4242.
For appointments at a University clinic, call 513-475-7631.
For clinic up-dates, as well as additional information on melanoma and MKM programs, check the Melanoma Know More website: www.melanomaknowmore.com

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