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President's Message

This is my first message to you as the new president of the CTC ONS. It is hard to believe that by the time you receive this newsletter it will be the end of May. We have already had the chance to celebrate Nurse's Day and Oncology Nursing Week. Because each of you put so much of yourselves into the care of your patients and their families I hope that it was a wonderful time. As the new president I would also like to officially welcome all of our new members.

It is my honor to be your chapter president and I want to encourage everyone to think about becoming a part of the chapter in whatever way you can. Whether it is just attending the meetings or being part of a committee, writing an article for the Kinesis or running for office, each part is very important to the chapter. In order to make the chapter your chapter you need to have a voice and I encourage you to raise your voice. Please let any of the board or committee members or myself know how we can improve the things.

Our program year will have been completed and Congress will have been a pleasant memory. I hope that you find the programs informational and the companionship of fellow oncology nurses uplifting. We have had to end the year a little differently than in times past due to our lovely Ohio weather but I hope that everyone was able to enjoy our vendors and the speaker and the products fair. The program committee is already hard at work planning the programs for the next year. I encourage everyone to make sure that they made their wishes known about future programs by filling out the needs assessment. We will start next year off with the Hot Topics from Congress to get us updated on the latest evidence from Congress.

I hope that many of you had the chance to attend Congress this year down in sunny San Antonio. It is a great time of networking and being updated on newest information available concerning drugs and treatment management for our patients. It also a great time just to relax and enjoy being part of one of the largest nursing organizations in the country. The benefits of being part of such an organization are unbelievable.

Have a great summer and I hope to see all of you in the fall.

Amy Voris
Chapter President.



Greetings From the Editor

Adrienne Lane EdD, RN-BC, CNE

Why do I do what I do for ONS? Do you ever think about why you belong to ONS? What an organization! I have been fortunate to attend many of the annual ONS Congresses. In fact, my first Congress was in 1987 in Denver when our chapter was chartered. Since then, I have missed a few Congresses, but not too many. I did miss last year and my job has changed a bit and to be truthful I was losing my zest for ONS. My life at work has become HUGE! Can you relate? I was even wondering what Congress would be like this year. I really had mixed feelings when I went to San Antonio to Congress. Then I arrived at the headquarters hotel in San Antonio....then I saw colleagues from around the country that I had not seen for 2 years...then I roomed with colleagues from here in Cincinnati...that I haven't really spent quality time with in a while. Yes, it was all coming back to me...why I do what I do for ONS.

For me a key reason is the Networking...the nurses I know in the Tri-State...the nurses I know across the country. You are and they are the absolute brightest and the best nurses ... the professionalism astounds me. This year Congress began for me with Opening Ceremonies and sitting with the Ohio Outreach bunch in the front! Have you ever attended our Ohio Outreach meetings?? If not, contact Amy Voris and tell her you would like to go. It's a great group of nurses from Ohio...providing the very best in oncology nursing across the state....I have met two of my favorite friends at Outreach Ohio. During Opening Ceremonies I took time to read the 'Recognition of Achievement' booklet and I read the names of people from our chapter who have received awards this year: Kelly Franer, Arleen Schuman, Paula McGlothlin, and Mary Ann Witschger. WOW!

Another reason I belong to ONS is to Learn as well as Earn my contact hours for re-licensure and recertification. At Congress two of my favorite sessions are the 'From Bench to Bedside' and the Mara Mogensen Flaherty Memorial Lecture. Again this year I was not disappointed...actually I learned a few tidbits about sexuality...icing on the cake! Of course, Congress is abundant with presentations and posters....several presented by CTC-ONS members....and I am sure...I do not know everyone from our chapter who presented or had a poster....but I do know a few and I have listed those in the Kudos section. If I missed you, I apologize...I have been trying to figure it out. I also want to share that the programs that we have locally in our chapter are fabulous and I belong to ONS so that I can go to Chapter meetings and Learn and Earn locally. AND lastly, I learn through Reading all of the publications....CJON, ONF, Connect, and on and on....Did you

read the April CJON's 'Heart of Oncology Nursing' by Associate Editor, Barb Henry??? (go to <http://ons.metapress.com/content/060k36v242n67r10/fulltext.pdf>)

Before I tell you that I bleed Red, White, and Blue (USA) and Blue and White (ONS), I will share that I also belong to ONS to Participate. Participation really opens the door to both Networking and Learning. As I have said I have belonged to ONS since 1987....22 years. Go figure, I cannot count all of the ways I have been involved locally and nationally...nor all of the opportunities that I have had....nor all of the money that ONS has invested in me. I know many of you have had these same opportunities....it is absolutely endless. I encourage you to talk to each other and just find out and learn about how much ONS really invests in each of us...the vast majority of the ONS budget goes directly back to the membership. What have I Learned through Participation??? I have learned that I am the nurse I am today because of ONS and the Tri-State Chapter of Oncology Nursing Society and Ohio Outreach. I have learned about providing quality patient care, about leadership, about distance education, about genetics, about research, about grant writing, about continuing education approval, about mentoring, about presenting, about developing posters, about networking, about publishing, about reviewing, about leading teams, about creating strategic planning and visioning, about health policy and advocacy, about stewardship and finances, about organizational ethics, about scholarships and awards, about philanthropic giving, and about a true understanding for me of what excellence in quality cancer care really means. It all comes together...you and me and the other members of ONS across the country and the world. Why do I do what I do for ONS? I do it for our Patients and their Families....I want to be the best that I can be...ONS provides me the pathway.





THE “PSYCH” CORNER

Barb Henry, APRN-BC, MSN
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Anxiety PEP: Pharmacologic Interventions for Anxiety in Oncology Patients

The last PSYCH Corner featured Depression PEP information. We will continue the series with current information from www.ons.org/outcomes (accessed 4/27/09.)

Anti-Anxiety Medications

Studies over the past 20 years have examined many pharmacological interventions for anxiety in cancer patients. These include alprazolam, (Xanax®); midazolam, (Versed®); propofol, (Diprivan®); fluoxetine, (Prozac®); and olanzapine, (Zyprexa®). Few studies have adequate sample sizes with patients with cancer to determine the most effective agents for decreasing anxiety. Overall, the studies combined with expert opinion show that pharmacological agents, (like those listed below), are likely to be effective in decreasing anxiety in patients with cancer. *Benzodiazepines:* Lorazepam, (Ativan®); Diazepam, (Valium®); Alprazolam, (Xanax®). *Azipirones:* Buspirone, (Buspar®). *Antihistamines:* Hydroxyzine, (Vistaril®). *Antidepressants:* Paroxetine, (Paxil®); Sertraline, (Zoloft®); Escitalopram, (Lexapro®); Venlafaxine, (Effexor®); Mirtazepine, (Remeron®). *Atypical Neuroleptics:* Olanzapine, (Zyprexa®); and Risperidone, (Risperdal®). *Other:* Propofol, (Diprivan®).

Effectiveness not yet established: Art Therapy, Complementary Alternative Medicine, (CAM), Distraction-Virtual Reality or Music, Exercise, Meditation, Progressive Muscle Relaxation, Reiki, Relaxation Breathing Exercise (RBE), Therapeutic Touch (TT). These are “yellow light” interventions meaning they have not been studied extensively

enough to recommend but they likely do no harm. Some studies have looked at the positive effects of these treatment modalities on reducing cancer patient anxiety but the sample size and/or statistical significance of these studies is limited.

In Practice

The PEP card information notes that although evidence is insufficient to recommend specific pharmacologic agents, expert opinion and guidelines recommend psychotherapy and psychosocial interventions and/or pharmacologic agents in the management of significant anxiety.

Anti-anxiety medications have potential for abuse, tolerance, and addiction. Benzodiazepines are often used on a short-term basis though patients may benefit from ongoing prn benzodiazepines for anxiety. Clonazepam, (Klonopin®), is not mentioned in the anxiety PEP card though it is often used manage detox symptoms in chemical dependency and appears to have less potential for abuse/addiction than Valium or Xanax. All benzodiazepines can be used in lower doses such as 0.25 or 0.5 mg bid or tid/prn for anxiety. All can cause memory loss and sedation, especially if taken in high doses long term. When anti-anxiety medications are not effective as a single agent, patients often benefit from an antidepressant. When this combination is not effective, a low dose anti-psychotic medication can be helpful. (It is helpful to have a psychiatric prescriber for this class of drug in particular.) *One resource that I have found helpful in my prescribing practice is: www.epocratesonline.com (accessed 4/27/09.) The website lists all drugs, has pill pictures, patient information and possible contraindications and drug interactions.*

Congress Scholarship

Ronda Bowman

Please consider applying for a National ONS Scholarship in 2010 and/or an IOL/APN conference scholarship for 2009. The application process is very easy. CTC-ONS members have an advantage due to two of the scholarships each year being funded by Oncology Hematology Care, Inc. These particular scholarships can only go to local members. This is an ongoing fund so these scholarships will be available indefinitely. I was pleased to receive this \$1000 scholarship for Congress this year. Please APPLY! If you have any questions, please just let me know.

IMPLEMENTATION OF AN ONCOLOGY-SPECIFIC, ELECTRONIC DOCUMENTATION SYSTEM IN AN OUTPATIENT ONCOLOGY AREA

By: Gigi Robison, MSN, RN, AOCN; Lois Hathorn, RN, BSN, OCN; and Connie Cook, RN, BSN

At ONS Congress, our abstract was accepted for a podium presentation on 4/30/09. Below are the highlights of this presentation:

The outpatient medical oncology department at The Christ Hospital is implementing a new oncology-specific, electronic documentation system.

Electronic documentation is the trend of the future. In May 2008, The Christ Hospital (TCH) implemented EPIC, an electronic medical record. On 4/3/09, the Cancer Center implemented Beacon, an oncology-specific application of the EPIC electronic documentation system. This module contains chemotherapy and supportive treatment plans with workflows affecting physicians, pharmacists, nurses and medical secretaries.

The **purpose of implementing EPIC and Beacon**, the oncology-specific, electronic documentation system, was to:

- (1) improve patient safety using CPOE (Computerized Physician Order Entry), which omits the potential for error due to illegible MD handwriting in med orders;
- (2) improve patient safety using bar code (for patients and meds) during medication administration, which increases the use of the "Five Rights" in med administration;
- (3) increase the use of evidenced based practice (EBP) in oncology Treatment Plans to enhance the quality, safety, and efficiency of patient care;
- (4) improve the coding and billing process (e.g., links specific diagnosis with specific treatments or labs / procedures);
- (5) provide immediate electronic access to patient information by one or multiple authorized users;
- (6) is a longitudinal collection of electronic health information; and
- (7) decrease the time required to retrieve patient data from past visit encounters.

Our **team members** to implement this new oncology electronic system included:

- Clinicians at Christ Hospital (MD, RNs, Pharmacists, Medical Secretaries)
- Epic
- Accenture (consulting company; project management)
- CareTech: IT support

The **work of the Implementation Team** included:

- (1) Meetings 2X / week to communicate, plan, brainstorm, and problem-solve;
- (2) Standardizing workflows for the Medical Oncology department
- (3) Building protocols for chemotherapy, biotherapy, and supportive care, using EBP;
- (4) Building the Beacon environment to customize the functions for our facility
- (5) Conducting Integrated Testing to test the specific functionality of the system;
- (6) Meeting Ohio Board of Pharmacy requirements;
- (7) Delivering training to each of the roles (and creating training materials);
- (8) Converting patients from paper treatment plans to electronic treatment plans;
- (9) Supporting clinicians when the Beacon system is used for patients
- (10) Supporting stabilization of the process; identifying issues and finding resolution

Throughout the hospital, med errors have decreased by 50% from June – December 2008. Epic and Beacon provides an audit trail for medication administration and patient care. We created an QA tool to follow use of Beacon functionality in patients.

In conclusion, documentation in the patient's medical record is a legal requirement. Nurses will be able to use the information in this article to guide similar projects to implement electronic documentation systems in oncology outpatient settings.

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Kudos

ONS RECOGNITION OF ACHIEVEMENT 2008-2009

Kudos to the following CTC-ONS members! We are proud of you! Congratulations!

Kelly Franer received a 2008 Master's Scholarship (\$1000) from the ONS Foundation (ONF)

Arleen Schuman received a 2009 Congress Scholarship (\$1000) from the ONF

Paula McGlothlin received a 2008 Institutes of Learning Scholarship (\$500) from the ONF

Mary Ann Witschger received a Roberta Scofield Memorial Certification Award from ONCC



Kudos to Suzanne Brungs!

A team led by Suzanne Brungs was awarded one of the 2008 Veterans Health Administration (VHA) Office of Nursing Services Innovations Awards. The theme for the awards was *Professional Practice Environment for Nursing Excellence*. Their project focused on their work to decrease both Central Line Infections and Ventilator Associated Pneumonia Infections in all Intensive Care Units throughout the VA healthcare system. The VA Innovation Award is a national nursing award created and launched in 2003, which annually recognizes nursing leadership in quality improvement. Their initiative will be formally recognized in many venues in the VA, including during the annual VA Nursing Leadership Conference, where the team led by Suzanne will receive a monetary award of \$10,000 and a plaque for their achievement.

“Fireside Chats with the Oncology Team: An Overview of Common Cancers” presented at Congress in San Antonio

Kim Blanton, BSN, RN, OCN Sue Partusch MSN, RN, OCN

Non-oncology healthcare providers at Good Samaritan Hospital expressed a need for basic cancer education. It was determined that all members of the multidisciplinary team could benefit from increasing their understanding of cancer in order to assist them in caring for their patients who had cancer. Multiple disciplines were identified as interfacing with cancer patients in the hospital and influencing their outcomes. The Fireside Chats were an attempt to educate rehabilitation therapists, non-oncology nurses, social workers, and pharmacists about cancer. A series of eleven programs was presented over a three month period, with each program highlighting a different type of cancer. Each one hour program included a presentation by a physician discussing the disease and treatment. This was followed by an oncology nurse discussing the nursing management of the patient undergoing treatment. The research staff member described open clinical trials for a patient with that type of cancer. The name, Fireside Chats, reflects the informal atmosphere of the forum. All programs were scheduled in the late afternoon to accommodate shift changes and the dinner hour. A free dinner and continuing education

credits for therapists, nurses, and social workers also encouraged participation. Attendance at the programs continued to increase as the series progressed. The audience was actively engaged with an enthusiastic question/answer period at the end of each program. Evaluation scores consistently exceeded 4.6 on a 5.0 scale. Narrative comments on the evaluations were extremely positive and commented on the volume and quality of cancer information shared. Total participation for the series approached 500 persons. Program attendance and evaluations alone supported the need for, and interest in oncology education. Oncology physicians gained visibility and validated their reputations for current understanding of disease states and treatment options. Oncology nurses developed professional presentations based on current literature and evidence based practice. The nurses were recognized as knowledgeable and valuable resources, and earned clinical points for their presentations. There was also an increased understanding of clinical trials and the nurses' role in encouraging participation. Due to the popularity of this project, three additional programs were implemented, and a new series for the next year planned.

Things I Didn't Know About C. Diff

Arleen Schuman MSN, RN, AOCN

Clostridium difficile (c. diff) infection is common in the oncology population. We detect and treat it often so I thought it was a topic for which I had fair knowledge. However, I recently found that there were many things about c. diff that I didn't know. I learned them the hard way as my father became critically ill with c. diff infection.

My Dad has many of the risk factors associated with c. diff. He is elderly (>65). He had been in a hospital and nursing home recently. He had been on various antibiotics, had nasogastric intubation, an abdominal procedure, had been on steroids—so immune-compromised, and has multiple other underlying chronic diseases including COPD, atrial fibrillation, arthritis, and diabetes mellitus. In retrospect, there are few that he did not have.

Dad had experienced mild to moderate diarrhea and had mild gastrointestinal discomfort. Cutting back on iron or taking a single dose of loperamide improved the diarrhea. In my experience, nothing helped c. diff except appropriate antibiotics so though I considered c. diff, my suspicion was not high.

In this setting, he was admitted for hip revision, which of course necessitated a few doses of antibiotics. Surgery went better than expected. However, interestingly, he was nauseated after anesthesia, not seen before with my Dad.

Time progressed and within a few days he became mildly confused and had trouble following commands which we thought was from neurontin. His blood pressure was okay though low for him and urine output borderline. He developed mild diarrhea which quickly became diffuse watery diarrhea. Luckily, it never became bloody, as can happen with c. diff. Shortly thereafter it was clear things were going desperately wrong. Before long he was in intensive care and eventually receiving dialysis and on a respirator. We were like many other families, trying to prepare ourselves for his death while being afraid to keep hope alive.

During this time we learned about c. diff and other things that we never personally wanted to experience.

C. diff is a gram positive, anaerobic spore forming bacilli. It was first linked to disease in 1978 as a causative organism of pseudomembranous colitis which can lead to toxic megacolon, bowel perforation, sepsis, and death. (Sunenshine & McDonald, 2006)

There were over two million cases of c. diff in the United

States hospitals between 1993 and 2005. On average, patients with c. diff were hospitalized almost three times longer than uninfected patients. The in-hospital death rate for patients with c. diff was 9.5 percent compared with 2.1 percent overall. (Agency for Healthcare Research and Quality, 2008)

One can also be colonized with c. diff without having active infection. Colonization in long term care facilities may be as high as 4-20% as compared to 3% of healthy adults (Sunenshine & McDonald, 2006)

Symptoms of c. diff include watery diarrhea, fever, loss of appetite, nausea, and abdominal pain/tenderness. Mild cases of c. diff may resolve simply by stopping the antibiotic causing the diarrhea. In more serious cases, antibiotics are utilized. Metronidazole is the drug of choice for mild to moderate c. diff infection. However, in recent years a more virulent strain of c. diff has been found which may not respond to metronidazole. Vancomycin is often used in these more severe cases. Both are given orally, via nasogastric tube, or even rectally. Intravenous (IV) metronidazole may be used if unable to take orally. However, IV vancomycin does not achieve high enough colonic concentrations to be effective and, therefore, is not given IV for c. diff. In my father's case, combinations of all routes of treatment were utilized. Rifaximine was also used as part of his drug therapy.

Patients with c. diff infection should be cared for in contact isolation. Alcohol based hand washes are not effective against c. diff. Soap and water are the appropriate hand washing measures in this particular situation. C. diff spores can live on surfaces (e.g. bedrails, IV poles, light switches, phones) for many months but can be killed by bleach (hypochlorite) containing products.

C. diff produces two endotoxins, toxin A and B. Though spores can live for many months on surfaces, the toxins in stool degrade rapidly and may not be detected after two hours if the stool is left at room temperature. Therefore, when checking for c. diff, stool specimens need to be fresh or kept refrigerated.

Use of anti-peristaltic agents like diphenoxylate hydrochloride/atropine sulfate and loperamide are avoided as they may pre-dispose to toxic megacolon. Narcotics should also be avoided if possible as they slow gastrointestinal peristalsis. Use of proton pump inhibitors and histamine receptor antagonists may also be avoided as it is controversial as to whether they contribute to incidence of c. diff. Probiotics such as lactobacil-

(Cont'd on page 7)

lus may be used though helpfulness not clearly documented.

Binding agents such as cholestyramine and colestipol may be used but should not be given in close proximity to vancomycin as it may bind with the vancomycin making it ineffective. The vancomycin should be given one hour before or 3-4 hours after these drugs. (PS: You can't imagine how often these two drugs were given together while inpatient.)

Other precautions for medications include that there should be no alcohol intake within 3 days of metronidazole as it can cause disulfiram-like (antabuse) effect with abdominal distress, vomiting, flushing or headache. Metronidazole also has significant interaction with warfarin.

In terms of c. diff, my Dad's story has a happy ending. He spent 8 long weeks in several hospitals but was eventually discharged to home. He continues to recover from c. diff and other health issues. We continue to learn after discharge. We learned that his 6 weeks of vancomycin pills would have cost about \$2000 whereas the liquid, though hard to find, cost \$300.

This has been a life changing experience for me and my family. Not only did we learn a lot about c. diff but we learned a lot of other things as well. We experienced first-hand how each word and action of health care workers can drastically change how you feel- good or bad. We learned that there are many wonderful doctors and nurses out there. Unfortunately, we also learned that not all health care workers pay attention or think critically nor do they all follow isolation and other policies. It is very eye opening to be on the other side of the care team.

We were poignantly reminded that every moment with a loved one is precious. We were reminded that family dynamics can make one crazy. We experienced exhaustion and caregiver strain. And we learned the power of prayer.

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Volunteerism

Amy Voris MS, RN, AOCN

According to Webster a volunteer is "a person who voluntarily undertakes or expresses a willingness to undertake a service". Oncology nurses volunteer themselves all the time to their patients and their families. They go that extra mile beyond just "doing their job" and provide the comfort, security and compassion that help their patients make it through that long journey called cancer treatment. Yet there are other areas in which your volunteering could greatly help your patients.

The Pan Ohio Ride is a bicycle ride from Cleveland to Cincinnati from July 30 to August 2 that is sponsored by the American Cancer Society to help raise funds to support the two Hope Lodges in Ohio. We are very fortunate to have a Hope Lodge here in Cincinnati. The Lodge in Cincinnati houses cancer patients and their caretakers for FREE during their cancer treatments in Cincinnati. It also provides meals and transportation to and from treatments. It is a privilege to have such a facility but it takes money to support. The Pan Ohio ride provides thousands of dollars towards that support. This year we will work in cooperation with the Western Ohio Chapter of ONS (Dayton area) to man one of the stops on August 2 to provide water and whatever else we choose to the riders. It is a great opportunity to meet other ONS members and work together to support a worthwhile cause.

The Light the Night Walk is in September and is now in two locations in Cincinnati (Sawyer Point) and Mason (Voice of America Park). It raises money for a cancer that attacks young and old alike. Whether you are just a walker on the CTC-ONS team or want to chair this endeavor, it is a great way to show our support of something that devastates many of our patients and their families.

And lastly there are many opportunities to volunteer in the CTC-ONS chapter. Whether it is being part of a committee such as the Community Outreach or Membership or Newsletter or being a co-chair of one of these committees (such as the Newsletter) you will be helping to support your local chapter of ONS. You will find out how much fun we have by being part of the chapter and you might even find that you like it. Your volunteering is greatly needed in any one of these areas, please consider volunteering today. If you wish to volunteer in any of these areas, please contact me at avoris@cedarville.edu

I shall pass through this world but once. Any good therefore that I can do or any kindness that I can show to any human being, let me do it now. Let me not defer or neglect it, for I shall not pass this way again.

Mahatma Gandhi

Highlights from the Scripps Cancer Center Oncology Nursing APN Conference

San Diego, California 3/13/09-3/15/09

By: Barb Henry, APRN-BC, MSN

One of our CTC-ONS members asked me to share some information from this conference. Aran Levine, RN, MSN, AOCN®, Course Director, issued the invitation for me to present on my usual topic, “Diagnosis and Treatment of Psychological Disorders in Oncology Patients.” Aran and I worked together on the ONS Mentorship Weekend Project Team in 2008. See what can happen when you get involved with National ONS and networking?!



Aran & Barb at Paradise Point Resort

This was an outstanding APN conference with wonderful speakers and topics. “APN Leadership and Improving Outcomes,” was a keynote address delivered by Mary Magee Gullate, PhD, RN, APRN-BC, AOCN®. Mary is Associate CNO for the Emory Crawford Long Hospital of Emory Healthcare in Midtown Atlanta. Her presentation was inspirational with many great tips on leadership.

Mary Gutierrez, PharmD, BCPP, presented on “Drug Interactions and Pharmacogenomics,” which provided attend-

ees with information that was extremely relevant to current prescribing practice. Mary is a Professor of Clinical Pharmacy and Psychiatry at Loma Linda University School of Pharmacy-Department of Pharmacotherapy and Outcomes Sciences. I will be contacting Mary in the future to obtain permission to include some of her material in a future PSYCH CORNER column.

Anne Katz, RN, PhD presented on “What You Need to Know about Cancer and Sexuality.” Anne is an Adjunct Professor at the University of Manitoba, (Canada), and a CNS at the Prostate Centre for Cancer Care. She is also the author of “Breaking the Silence on Cancer and Sexuality, A Handbook for Healthcare Professionals,” “Women, Cancer, and Sex,” and the soon to be released, “Men, Cancer, and Sex,” all available on: <http://esource.ons.org/> I don’t want to sound like a commercial but Anne was an amazing presenter obviously passionate about her work, (no pun intended-her humor:)

There were so many great presenters and topics: “The Hormone Change, Mitigating the Negative Side Effects,” “Plasma Cell Disorders,” “New Epigenetic Strategies in Malignancy and Transplantation,” “APRN Regulation: Implications for Your Practice,” “All the News about Prostate Cancer,” “The Paradigm Shift in Treatment of Breast Cancer.” I urge you to check out: www.scripps.org/conferenceservices for future conferences. I was honored to be able to be part of this conference and of course will be back to San Diego next year for Congress 2010!

Hepatitis B Testing in Patients Undergoing Cytotoxic or Immunosuppressive Therapy

By Arleen Schuman

The Centers for Disease Control (CDC) has expanded recommendations for testing for Hepatitis B Virus (HBV) to include patients undergoing cytotoxic or immunosuppressive therapy. Such therapies put the patient at risk for HBV reactivation and associated morbidity and mortality. Prophylactic antiviral therapy can prevent reactivation and possible fulminant hepatitis in HBsAg positive patients. Some studies have shown that as many as one third of people infected with HBV are unaware of their disease status. Testing should include serologic markers of HBV infection (ie. HBsAg, anti-HBc, and anti-HBs).

My collaborating physician, Dr. Michael Neuss, is on an ASCO committee and reports that representatives from ASCO are meeting with representatives of the CDC to clarify whether all three lab tests should be obtained in all patients including those who are not high risk as screening tests may not be covered by Medicare. The package insert for Rituxan (rituximab) specifically states that only patients at high risk for hepatitis should be tested though the death rate for reactivation of hepatitis in patients who undergo this complication while receiving rituximab is, at least in one series, 20%.

Fact or Fiction: An implanted venous access device when not in use must be flushed monthly to maintain patency?

Ruth Canty Gholz RN MS AOCN, Cincinnati VAMC, Cincinnati, OH
Nancy L. Whitehill RN MSN AOCNS CRNI, Mercy Health Partners, Fairfield, OH
Kelly A. Franer RN MS OCN, Mercy Health Partners, Anderson, OH

Focus Area: Clinical/Evidence Based Practice

Significance and Background: The use of implanted ports in the ambulatory oncology setting has become a standard of care. Policies and procedures are written using evidence in the management of these devices. In 2006 Cancer Care Ontario completed and published “Managing central venous access devices in cancer patients: a clinical practice guideline”, an evidence based series report. This guideline recommends that for an implanted venous device (e.g., Port a cath) is flushed with 5ml 100u/ml heparin q4 weeks when the port is not in use. On review there was no scientific data to support this recommendation other than the manufacturer.

Purpose: Describe practices in three ambulatory hospital based practices in Cincinnati, OH that have challenged this recommendation and flush implanted venous ports every two to three months.

Methods: Random reviews of 30 charts per clinic setting were completed. Criteria for inclusion were oncology patients with solid tumors and implanted venous ports that had completed their course of chemotherapy and needed port maintenance.

Analysis: Ninety patients received flushing of venous port every two to three months with less than five patients with a port flush longer than a six month interval.

Findings: Various types of implantable ports were utilized, each clinic had different policies and procedures, with one clinic using a saline flush and two clinics using the standard heparin flush. The outcomes of this review will be described including type of venous port, frequency of flush, blood return, trouble shooting and any complications as well as patient satisfaction.

Implications for Nursing: Maintenance of venous ports requires oncology nurse’s coordination of visits and trouble shooting of problems. If the patient visits were reduced to every three months the cost of health care would decrease, infections would decrease and precious nursing time would be maximized. This is one small review and warrants further investigation. We challenge the manufacturers of these products to publish the rationale used for venous port maintenance recommendations.

ONS Supported Legislation Tracking Chart

Janet Riga Goeldner, RN, MSN, AOCN



The Oncology Nursing Society is currently following several federal bills in both the House and the Senate. To discover what the organization is tracking all that you need to do is go to the ONS web site and follow the links to the ONS Supported Legislation Tracking Chart. This chart is updated on a regular basis and identifies key pieces of legislation of interest to oncology nurses and the society. The chart provides the title and number of the bill, a very brief summary of the legislation, key sponsors, and the current status – where it is in the legislative process.

Examples of legislation being tracked include the Access to Cancer Clinical Trials Act of 2009, which was sponsored by Senator Sherrod Brown (D-Ohio). There are three legislative bills that relate to specific types of cancers.

One is on colorectal screening and early detection, the second relates to biomarker research for ovarian cancer, and the third is on breast cancer patient protection which allows for minimal hospital stays post breast surgery. In addition, ONS is tracking legislation related to smoking prevention and tobacco control, the National Pain Care Act, and Pre-existing Health Condition Exclusion Act. ONS continues to track legislation related to nursing education, reimbursement to advance practice nurses, and staffing issues.

Use of the chart gives you basic information. For additional details about a bill, visit the Thomas Library of Congress web site at Thomas.loc.gov. On this web site you can view the entire piece of proposed legislation.

A Case Study of Symptoms Experienced following the Administration of Erlotinib

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Focus Area: Research Study

Significance & Background: Eighty percent of those receiving Erlotinib for treatment of cancer will develop a facial rash that is distressing both physically and psychosocially. This rash has been described but not quantified nor have the accompanying symptoms been quantified.

Purpose: To develop measurement strategies to quantify the degree of skin involvement through digital image analysis and to quantify accompanying non-dermatologic symptoms.

Conceptual Framework: The conceptual framework underpinning this research is based on the physics of light and on the L*a*b* color space in particular. Armstrong's model of Symptom Experience provided an explanation for antecedents to the perception of symptoms, followed by consequences

Methods & Analysis: Digital images were corrected for brightness and white balance before transformation into luminance and chrominance representation by converting them to the L*a*b* color space (L* - lightness-darkness; a* - redness-green-

ness; b* yellowness-blueness). The a* component image was saved as a grayscale image. We used ImageJ to obtain a histogram of erythema and the intensity of the erythema. The following self reported questionnaires were used to quantify accompanying symptoms, their intensity, distress and impact: Skin Questionnaire, Symptom Assessment Scale, Distress Thermometer, and FACT-G. Data were collected prior to the initiation of Erlotinib and weekly until the rash stabilized.

Findings & Implications: Rash erythema was quantified weekly for 8 weeks. Accompanying symptoms had an interdependent pattern. Nursing interventions, including the use of moisturizers, Diphenhydramine and Minocycline, lessened the distress experienced. When both patient and caregiver anticipate the symptom experience, it can be managed so that the therapeutic effect of Erlotinib can occur.

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I would like to take this opportunity to thank CTC-ONS members for the honor of leading such a great group of nurses these past two years. We've experienced a lot of change, mourned the loss of some dear CTC-ONS members, taken part in some fun celebrations and interesting meetings, and carried on many of the traditions of our chapter and national organization.

Amy Voris presented me with a beautiful Leadership Award from the chapter that is now proudly displayed in my office. I presented Amy with the gavel to carry on the work of President for the next two years.

I am enjoying my year as "Past President," providing ongoing support to Amy and new chapter leaders. There have already been good leadership decisions made to im-

prove our chapter. For example, the President's term will be cut back from 2 years to 1 year in order to encourage more leaders to step up and not feel overwhelmed by the time commitment. In my opinion, the rewards of being a chapter President far outweigh the work involved. (And there is one year as President-Elect before you have to step up!)

I joined the chapter 10 years ago in 1999 and I look forward to more years as a member of this excellent chapter. I was inspired and mentored by many strong leaders in the chapter and in National ONS. I hope that I may have inspired one (or more) of you to become the next President of CTC-ONS!

Thanks again,
Barb Henry, CTC-ONS Past President

KINESIS

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National News

The ONS 10th Annual Institutes of Learning will be in Tampa, Florida, November 13 - 15, 1009

NEWSLETTER

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Deadline for Contributions to the next issue of Kinesis

PLEASE remember to have any articles you would like to have included or regular information to Amy or Adrienne, co-editors of **Kinesis, by Sept. 15, 2009**