

Kinesis



Letter from the President

Kathy White

I can't believe our last meeting for the summer is this May. Summer is right around the corner.

I want to take this time to thank everyone who helped in any capacity to make our CTCONS chapter so successful this past year. I also

especially want to thank all of the members who offered advice, coaching, and mentoring to me over these past several months.

The board will continue to meet over the summer and the program committee will also be meeting over the summer to start planning for next year's programs.

Anyone can get involved and

attend these meetings. It's a great way to contribute to the success of the chapter.

Thanks again to everyone who supported our local chapter.

I hope everyone has a fun and safe summer.

See you in September.

****Next meeting is
September 18, 2012!!!!**



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EDITOR'S CORNER RUTH C. GHOLZ RN MS AOCN



I want to thank Jennifer Hester for co-chairing this newsletter with me. Deadlines are always difficult for me and I do not work in a silo thus her partnering with me is a great

gift. The goal of the newsletter is to disseminate information, share knowledge and hopefully excite you as a member of CTSONS. With

this in mind I would like YOU to send us any news you may have about members, accomplishments, job changes, babies, marriages and other scoops that would be fun to share. Unfortunately when I was speaking to a colleague about the newsletter the comment basically stated it is not even being read- OUCH! The newsletter can only get better if we know what you want, need and dream about.

In looking at nursing careers I often think about retiring and want to make sure the things I am passionate about continue. Volunteering is a fabulous opportunity to get involved and to network. As my church pastor mentioned yesterday- we need does not just Sunday afternoon chair quarterbacks. Enjoy this newsletter, thank the authors and remember you can make a difference by contributing to the Kinesis!

Submitted by:
Kathy White, RN, OCN
 2011-2012 CTC-ONS Chapter President

Anorexia



DEFINITION:

Anorexia is defined as an involuntary loss of appetite. (CJON, 2/2009)

OCCURANCE:

Approximately 50% of newly diagnosed patients with cancer experience the symptom, which often is accompanied by weight loss typically associated with advanced disease. (CJON, 2/2009)

SYMPTOM ASSESSMENT:

Clinical assessment is essential in identifying and managing cancer-related nutritional problems. All patients should be screened at diagnosis and re-evaluated at regular intervals to monitor nutritional status. Early prevention is the key to prevent or treat malnutrition early. Screening should include the following: (ONF, 2002)

- Weight changes
- Dietary intake
- Functional status
- Symptoms affecting nutrition
- Physical examination findings
- Projected nutritional problems from treatment or disease progression

APPLICATIONS TO PATIENT CARE:

Oncology nurses should perform ongoing assessments of patient's dietary patterns and caregiver roles. (CJON 7/8 2002)

STEPS:

- Perform ongoing assessments of patient's attitude and feelings regarding appetite and eating patterns throughout diagnosis, treatment and end of life process.
- Assess patient's social and cultural beliefs towards food.
- Involve caregivers in the process, and allow patient and caregivers to establish a system of eating. Often the patient feels the caregiver is pushing food on them and being nagged to eat while the caregiver is constantly trying to find new ways to make them eat. A system should be worked out between the patient and the caregiver.
- Provide proper education to patient and caregivers in face to face conversation and provide written information as well for reference.

TREATMENT OPTIONS:

- Liquid supplements such as Ensure®, ProSure® or Boost®. Try to have the patient drink two cans a day. These supplements provide essential protein and other dietary supplements.
- Medication to stimulate appetite such as Megace®, Marinol®, or corticosteroids. (CJON, 2/2009)
- Take anti-emetics if prescribed by physician to control nausea.
- Nutritional counseling with a registered dietician.
- Physical activity to increase muscle mass, muscle strength, and level of physical functioning. (ONF,2002)

EATING HINTS:

- Avoid strong food odors or foods that are not appetizing.
- Try colds foods such as vitamin enhanced smoothies and yogurt.
- Eat several, small frequent meals a day.
- Add spices to food to enhance flavor.
- Add protein supplements to foods.
- Eat when you feel the hungriest, regardless of the time of day.
- Choose foods that are desirable.
- Eats nutritious high-protein foods, such as fish, lean meat, eggs and nuts.
- Minimize factors that decrease food intake or increase energy expenditure.



SUMMARY:

As oncology nurses, we can play a vital role in the success of managing a cancer patient's issues with anorexia. Ongoing assessment, planning, and implementation are key factors to success. Positive reinforcement is necessary when dealing with anorexia issues. Encouragement from the oncology nurse can help these patients succeed. Patience and understanding can make a big difference in the process when dealing with such a difficult issue for these patients.

REFERENCES:

- Adams, Lynn A. (2009). Putting Evidence Into Practice®; Evidence-Based Interventions to Prevent and Manage Anorexia. Clinical Journal of Oncology Nursing 13, 95-102.
- Brown, J.K. (2002). A systematic review of the evidence on symptom management of cancer-related anorexia and cachexia. Oncology Nursing Forum, 29, 517-532.
- Cope, D.G. (2002). Management of anorexia, cachexia, and weight loss in patient with advanced cancer. Clinical Journal of Oncology Nursing, 6, 241-242.
- Guenter, P., Ferguson, M., Thrush, K., & Voss, A.C. (2002). Understanding tumor-induced weight loss. Medsurg Nursing, 11, 215-227.
- Whitman, M.M. (2000). The starving patient: Supportive care for people with cancer. Clinical Journal of Oncology Nursing, 14, 121-125.

Clinical Pearls from ONS Discussion Boards & Newsletters...

DOUBLE FLUSHING AFTER RECEIVING CHEMOTHERAPY

When we revised the latest version of the ONS Safe Handling of Hazardous drugs (2011), we essentially said that double-flushing is warranted only if there is organic debris left over in the toilet (e.g., with low-volume toilets). There is NO evidence to support this age-old practice, which makes it not evidence-based.

Seth Eisenberg RN OCN

Professional Practice Coordinator, Infusion Services
Seattle Cancer Care Alliance

PAIN MANAGEMENT PEARLS

Breakthrough Pain

Marsha Farrell, BSN, RN-BC, CHPN
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Question: What is breakthrough pain?

Answer: *Breakthrough pain* (BTP) is episodic pain that "breaks through" otherwise well-controlled persistent pain (also known as chronic pain). This patient would be taking either a long-acting opioid to treat persistent pain or would be on a scheduled, around-the-clock, short-acting opioid. It is usually best if the long-acting and short-acting opioids are the same drug (e.g., MS Contin® for persistent pain and morphine sulfate instant-release [MSIR] for BTP).

Question: Are there different types of BTP?

Answer: Yes. BTP can be classified as either end-of-dose pain, spontaneous pain, or incident pain.

- *End-of-dose pain* is when pain recurs prior to the next scheduled dose of the around-the-clock pain medication.
- *Spontaneous pain* is just that: spontaneous. It can occur out of the blue with no warning. This type of BTP can be severe in intensity and distressing to the patient because it is unpredictable.

Incident pain is pain that occurs secondary to an incident or cause. Examples include movement, wound care, personal care, or coughing. Some incident pains are under the patient's control, but others, such as coughing, are not.

Question: What is a rescue dose?

Answer: A *rescue pain dose*, also called a *breakthrough dose* (BTD), is the analgesic dose taken to relieve BTP. Remember, this dose is in addition to either a long-acting opioid or scheduled around-the-clock opioids.

Question: What is an appropriate rescue dose for a patient on *long-acting opioids* like MS Contin?

Answer: Most pain management literature suggests that the rescue dose, or BTD, be 10%-15% of the 24-hour long-acting opioid dose in order to be effective. (Some sources suggest 10%-20%, which is easier to calculate.) BTD is ordered every one hour or every two hours PRN pain. Avoid using a range order (i.e., q 1-2 hrs) for the dosing frequency.

Question: What is an appropriate rescue dose for a patient taking a *short-acting opioid around-the-clock every four hours*?

Answer: The BTD should be 25%-50% of the scheduled q 4 hours around-the-clock dose, and it would be given in between the scheduled doses. (For example, if the patient is taking MSIR 15 mg q 4 hours around-the-clock, the BTD would be 3.75-7.5 mg morphine or, practically speaking, 5 mg of morphine q 2 hours PRN.)

Question: Are all short-acting opioids good choices for BTP relief?

Answer: Keep in mind that the pharmacokinetic properties of short-acting opioids vary. One important question to ask is how *lipophilic* or *hydrophilic* the opioid is. Lipophilic (fat-soluble) opioids have a faster onset of analgesia than the more hydrophilic (water-soluble) opioids. For example, morphine (oral) is a hydrophilic opioid, and the onset of analgesia is 30-40 minutes. Fentanyl (transmucosal) is a lipophilic opioid, and the onset of analgesia is 5-10 minutes. The characteristics of the BTP (i.e., the onset of the pain and the duration of the BTP) must be taken into consideration when selecting the most appropriate opioid for a rescue pain dose. Cost also may be an important factor in this selection.

Reference

McPherson, M.L. (2010). *Demystifying opioid conversion calculations: A guide for effective dosing*. Bethesda, MD: American Society of Health-System Pharmacists.

Article originally published in the Pain SIG newsletter. Volume 21, Issue 1, March 2012

A SCHOLARLY GATHERING

Journal Club



*Please call/email Gigi or Barb to
RSVP by 8/19!!!*

Date: Wed. August 22, 2012

Time: 6:30 to 8:30 p.m.

**At the Christ Hospital
Cancer Center
Conference Room**

TOPIC: COMPLEMENTARY THERAPY
PART II

ARTICLES ARE POSTED UNDER "DISCUSSIONS" AT:

www.cincinnati.vc.ons.org

or email Barb Henry Bjzh@aol.com to obtain copies.

*This meeting will follow up on the 3/28/12 meeting, which focused on
complementary therapy demonstrations rather than article & topic discussion.*

DIRECTIONS: Contact Gigi: 720-9198

Barb's Cell Phone: 237-6840

******You do not have to read the articles; all interested
nurses & new participants are encouraged to attend!**

**A light dinner & water will be served, feel free to bring a
dessert (or not) and RSVP by 8/19/12☺**

Psych Corner

by: Barb Henry, MSN, APRN-BC

For those of you regular PSYCH Corner readers, you know that I entered the “blog-osphere” for ONS about a year ago. I recently retired from blogging after returning to DNP classes. Blogging takes more time than you might think. Our own **Ruth Gholz** has now joined the Traveling Companions blog team, congrats to Ruth!

These ONS website & blogs are new and under-utilized at present. Please check them out and share with patients, caregivers & colleagues.

The Cancer Journey summarizes reviews of symptom management research and peer reviewed by ONS experts: <http://thecancerjourney.org>

Traveling Companions is a blog written by oncology nurses and caregiver experts to provide support and advice for patients with cancer and their family caregivers: <http://blog.thecancerjourney.org>

In case you missed my blogs: <http://blog.thecancerjourney.org/author/bhenry/>
Below are pearls of wisdom from some of Ruth’s blogs; enjoy & stay tuned!

“I was just reviewing tips for caregiving on the Leukemia Lymphoma Society website <http://www.lls.org/> and began to reflect on the suggestion to “do only things your loved one can’t do.” Relating this concept to parenting may be an easier way to grasp this,” <http://blog.thecancerjourney.org/2012/04/do-only-what-your-loved-one-can%e2%80%99t/>

“In my oncology career, I have had the pleasure of helping others with important end-of-life decisions and am now making them myself, which has provided me with new opportunities for growth. Stress can be reduced for everyone if we all take care of our end-of-life plans while we are alive and well. We are all born and we all die, but what we do in between will be our story,” <http://blog.thecancerjourney.org/2012/04/birthdays-are-only-a-part-of-our-story/>

“On March 24, 2012, the city of Cincinnati sponsored a program titled “Cincinnati Combats Cancer—United to Fight All Cancers.” As an oncology nurse, I was in awe of the entire session. Ten female physicians described their roles in oncology and answered some very challenging questions. The fashion show had cancer survivors as models and all of the clothes and accessories modeled were donated to an American Cancer Society resale shop to support their mission. Music blared, skirts swirled, and smiles radiated. The grand finale was a young woman who had been diagnosed with breast cancer when she was pregnant with her daughter. Hope and enthusiasm encircled her as she modeled with minimal hair, and pushed her daughter in a pram. Everyone stood and gave the entire group of models an ovation for their courage and strength,” <http://blog.thecancerjourney.org/2012/04/cincinnati-combats-cancer/>

“In my experience of more than thirty years as an oncology nurse, I have not ceased to be impressed by the never-ending commitment of oncology nurses to be present in all aspects of the cancer journey. I was 22 years old when my mother died of advanced ovarian cancer in 1973. I made a vow that if possible, I would never let a person with cancer suffer as she did. I am so thankful for the field of oncology through which I have loved and cared for so many. My goal is always to share my passion for this field and encourage others to reach for the brass ring and pass it forward,” <http://blog.thecancerjourney.org/2012/02/oncology-nurses-walk-the-walk/>



Looking to Get Involved??

...consider joining the Program Committee...

The Program Committee for CTCONS plans and implements monthly programs for the chapter.

We meet as a committee once in late May/early June, and then again late in the summer to confirm programs for the upcoming year. From the Needs Assessment that is conducted every 2 years, we attempt to provide topics that are of interest to the chapter membership. Our goal is to provide fascinating speakers on desired topics, with CEs awarded, at top rate restaurants, and at little cost to the members. Of course, not all of those objectives can be met with every program!

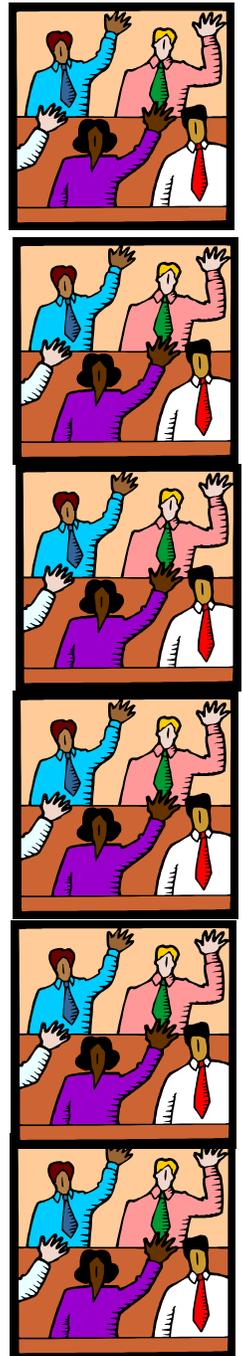
As a committee we plan the topics for the upcoming year; as a member of the program committee, you volunteer to plan one program (hopefully, a topic near & dear to your heart). . .from finding a speaker and sponsor, to planning the location and/or food. We depend on you to get the necessary biographic info and a rough content outline from the speaker, and submit this information to Gigi Robison, who is our CE liaison.

The creative juices really flow when we are together, and we usually come out of that first meeting with a rough plan in place.

During the second meeting, we touch base, just to be sure that at least the Fall programs have a firm direction and the others are in motion. This is a GREAT way to get involved in the chapter, and more than ever, we depend on our diverse membership to recommend topics, speakers (nurses/physicians etc..) from their own institution/office, or experience. The best is that your involvement in meetings is limited to 2 meetings/year, and the remaining work is done on your own time and at your own pace. . .PLEASE JOIN US!

It's a lot of fun, and we need your input. . .absolutely no skill level required!!!

Please call me at 862-2845 or email me at susan_partusch@trihealth.com.



The Clinical Trials Nurse:

FUNCTIONAL COMPETENCIES FROM AN ESSENTIAL ROLE

Clinical trials are the pathway by which new therapeutic discoveries from the laboratory bench to accepted standardized regimens. Any advances made in the treatment of cancer are due to the successful and systematic movement of novel treatments through the FDA approval pipeline. The clinicaltrials.gov website serviced by the National Institute of Health (NIH) defines a clinical trial as “a research study to answer specific questions about vaccines or new therapies or new ways of using known treatments... Carefully conducted clinical trials are the fastest and safest way to find treatments that work in people.” The success of any clinical trial is dependent on a combination of timeliness, effective communication, attention to detail, protection of participant rights, and precision. Clinical trials nurses (CTN) are essential components of this process.

In 2010, the ONS published *Oncology Clinical Trials Nurse Competencies* in an effort to define the role (and quantify the contributions) of the CTN. The ONS defines nine functional areas of competent CTN practice: protocol compliance, clinical trials related communication, informed consent process, management of clinical trials patients, documentation, patient recruitment, ethical issues, and financial implications.

Currently I work as a CTN for Phase 1 clinical trials. Phase 1 trials are the first step in determining the dose, method of delivery and potential side effects of a new therapy. Many of the trials are examining these parameters in novel agents being administered to people for the first time. Most patients come to the Phase 1 clinic through referrals within the UC system, however we receive numerous referrals from oncologists throughout the community in order to recruit our patients. During the recruitment process patients are screened for eligibility in all ongoing trials and seen by the physicians or nurse practitioner in our clinic.

Eligibility for trials is determined by the clinical trial protocol, which essentially serves as the roadmap for patient care, monitoring, and reporting throughout an individual’s participation in a trial. Although it is improbable that any CTN has entire protocols memorized, it is important to be familiar enough with them to be able to find answers to eligibility questions efficiently so they may be communicated to the team as well as prospective participants.

The informed consent process truly begins when patients first come to the clinic to be screened, and is ongoing. Although it is the responsibility of the principle investigator to present information contained in the informed consent to patients, the CTN must constantly evaluate participants to ensure comprehension. This can be a particular challenge in Phase 1 trials, where clinical benefit is not a main goal of the study. The CTN often must reinforce this along with the potential risks of participation. This process must be documented accurately, as well as any tests, examinations, drug administration, and adverse events as outlined in the study protocol.

The CTNs communication and compliance monitoring extends to the study team as well. The importance of quality communication cannot be overstated as the CTN must interact with the inpatient and outpatient areas, radiology, phlebotomy, clinic staff, physicians, nurse practitioners, community providers, and others. Quality care of the patient must always be the first priority; however the CTN needs to remain constantly involved to assure compliance with the protocol and timely reporting of adverse events to the study sponsor whenever possible. This level of follow up is also essential to track protocol related expenses and ensure accurate billing of all patient care.

Coordinating Phase 1 trials is exciting work as they are pivotal in the translation of new drugs from the bench to the bedside. It is through the implementation of these nine functional areas that the unique care provided by CTNs is defined.

Crystal Spellman, RN, BSN, OCN®, is a research coordinator for Phase I clinical trials in hematology/oncology for the University of Cincinnati’s Experimental Therapeutics Program, and is currently pursuing her DNP in the Adult/Gerontology CNS tract at the University of Kentucky. She is a regular contributing blogger for the ONS RE:Connect Blog. You can read more articles by Crystal at <http://www.onsconnect.org/author/cspellman>



References:

Oncology Nursing Society. (2010). *Oncology clinical trials nurse competencies*. Pittsburgh, PA: Author. Retrieved from <http://www.ons.org/media/ons/docs/publications/ctncompetencies.pdf>

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