international ICNN cancer nursing news

quarterly newsletter of the international society of nurses in cancer care

VOLUME 23 NO 4 2011

Tobacco control in China

The tobacco control project partners meet together in Beijing to plan for the launch of the initiative in November 2011

ISNCC collaboration

With over 350 million smokers, tobacco control is an important issue for oncology nurses in China. Nurses could have a significant impact on decreasing tobacco-related morbidity and mortality in China if they are educated and equipped to support smokers' efforts to quit.

The ISNCC in collaboration with Professor Linda Sarna, University of California, Los Angeles (UCLA) School of Nursing and Dr Stella Bialous, Tobacco Policy International, received two-years of funding from the Pfizer Foundation to test an innovative distance learning educational project. The project aims to increase Chinese nurses' delivery of smoking cessation interventions to hospitalised smokers as reported through web-based surveys at baseline, three and six months.

The study methods are based upon a recent project conducted by Professor Sarna and Dr Bialous in the United States in 30 hospitals in three states. The investigators hope to enrol 1,000 nurses from Beijing in the project, which launched in November, 2011.

The Chinese Oncology Nursing Association played an important role in facilitating the project. This project was initiated after Professor Sarna and Dr Bialous hosted a successful preconference workshop on nursing research and tobacco control in Shenzhen, prior to the UICC meetings in China in 2010 — see ICNN volume 23 number 1.

Chinese partners

The team travelled to Beijing in July 2011, to meet with their Chinese partners, Dr Xiao Nong Zou, Cancer Institute and Hospital, Chinese Academy of Medical Sciences (CIHCAMS), and Dean Guifang Guo, Peking University School of Nursing and, Dr Sophia Chan, University of Hong Kong. This face-to-face meeting was critical to the success of the project.

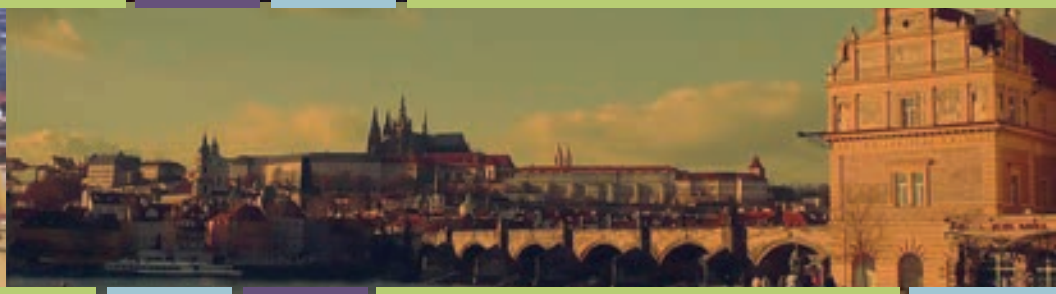
At the meeting, they confirmed procedures, web-based survey instruments, and PowerPoint presentations that will be included in a Chinese language webinar. Nurse leaders from the four hospitals in Beijing involved in the project (CHICAMS, Beijing Chaoyang Hospital, Peking University Cancer Hospital, and Peking University Third Hospital) also participated in the workshop and provided helpful suggestions.

The UCLA team also included Dr Marjorie Wells, project director and Lisa Chang, research assistant with Sarah McCarthy from ISNCC providing technical support. During the visit the team was able to tour the CHICAMS and Peking University Cancer Hospital.

17th ICCN in Prague 2012 – see page two for details

International Society of Nurses in Cancer Care

17TH INTERNATIONAL CONFERENCE ON CANCER NURSING



Prague, Czech Republic

September 9-13th, 2012

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PRAGUE 2012

Developing and engaging cancer nurse leaders: our fourth strategic initiative

ISNCC is continuing to evolve our four new strategic directives to be achieved in the next three years:

1 Building coalitions and partnerships,
2 Influencing health policy and cancer control,
3 Advancing and applying knowledge,
4 Developing and engaging cancer nurse leaders.

This article addresses the fourth strategic initiative — Developing and engaging cancer nurse leaders. Leadership is the process or ability to clearly see the issues of today, envision a preferred future, and then take action to fill the gap between today's situation and the preferred future. Achieving a preferred future requires a team who are as engaged as the leader.

The ISNCC is committed to working with our members to identify and build the next generation of nurse leaders in cancer control.

Our goal is to provide opportunities for nurses to develop leadership practices and to support nurses in engaging in national and international cancer control efforts.

The overarching goal of this strategic initiative is to build capacity in cancer nursing to effect change in local, regional, and international communities.

The first strategy

The first strategy of this initiative is to identify and recognise nurses' leadership practices that influence cancer control systems, policy, processes or outcomes.

This will be achieved through the development of a twinning programme to connect international nursing leaders in specific knowledge areas (for example tobacco control). The Member Development and Communications Committee and the Knowledge Development and Dissemination Committee will be working on this important activity.

The second strategy

The second strategy is to identify ways to support leadership development for cancer nurses that can be offered collaboratively with member organisations.

This will be achieved through the identification of appropriate special interest topics from ISNCC members. We will then encourage these networks to connect, potentially via an online networking programme. The Member Development and Communications Committee will be working on this crucial aim.

The third strategy

The third strategy of this initiative is to identify gaps in leadership preparation and develop projects to address these gaps.

This will be achieved through determination of what the educational gaps are for ISNCC members with regard to leadership training. We will then develop new ISNCC educational programmes to address these gaps, including, but not limited to, train the trainer, text and online webinar programmes.

In addition, the ISNCC will review external materials and determine whether it is appropriate for the ISNCC to facilitate distribution of leadership information internationally as a "clearing house".

This could be via adaptation, translation or other means. The Knowledge Development and Dissemination Committee will work on this initiative. The Corporate and Philanthropic Committee will work to develop project funding for specific opportunities to hold leadership development workshops (2nd and 3rd strategies).

The fourth strategy

The fourth strategy of this initiative is to promote succession planning throughout the ISNCC board and committees.

This will be achieved through development of a succession plan for identifying future nursing leaders in the ISNCC membership. The ISNCC Nominations and Awards Committee will be working on this project.

Through our initiative to develop and engage cancer nurse leaders, we expect to increase the base of nurse leaders and member groups who work through ISNCC to achieve a preferred future where nurses have an active and effective role in cancer control in their networks and communities of influence.

Greta Cummings, ISNCC President

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News from the European Multidisciplinary Cancer Congress

Oncology nursing was included in a fully integrated, multidisciplinary regional cancer conference when the European Multidisciplinary Cancer Congress (EMCC) took place in Stockholm, Sweden at the end of September. Here are some of the highlights

Nurse survey on managing breakthrough cancer pain

A European oncology nurse survey has called for greater clinical consensus on the diagnosis and treatment of breakthrough cancer pain — and there is the promise of new guidelines in the near future.

Presenting the results, Professor Tone Rustøen, Division of Emergencies and Critical Care, Oslo University Hospital, Norway reported that this was the first European survey to investigate the perception of oncology nurses with regard to breakthrough cancer pain and its management.

She said that this initiative reflected the views of 1,164 cancer nurses from 12 European countries; Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Norway, Slovenia, Sweden, the Netherlands and the UK.

A key finding from the survey was that 57% of those questioned said they had not received any training in the management of breakthrough cancer pain — representing a significant unmet need and a major challenge for nurses working in a cancer setting.

The proportion of nurses receiving such training varied considerably from country to country, for example 72% in Finland but only 6% in Greece.

Most nurses (78%) reported that breakthrough cancer pain has a significant impact on the lives of the patients they are caring for, although as many as 81% had been unable to help control that pain. Indeed, 38% said they were not aware that medication specifically designed to treat such pain is readily available.

Other key findings from the EONS survey:

- 64% had seen up to nine patients with breakthrough cancer pain within the last month,
- 36% did not feel confident in advising patients on how to control such pain,
- 77% felt there was a need for more information on breakthrough cancer pain — both for nurses and patients — as well as nurse-specific guidelines.

EONS executive director Clair Watts said in the absence of consensus and guidance, there was an urgent need to develop nurse-specific guidelines to deal with this dilemma.

Synchronous radiotherapy

A new way of delivering chemoradiation to women with early-stage breast cancer has resulted in a 35% reduction in the risk of local recurrence, according to new data from a landmark clinical trial.

The data showed that synchronous radiotherapy — delivered between or during chemotherapy cycles — has minimal adverse effects and no detrimental effect on quality of life.

In the randomised phase III SECRAB study, data on 2,296 women from 48 UK centres who had undergone breast-conserving surgery or mastectomy was analysed.

After a follow-up of 8.8 years, only 41 patients randomised to synchronous chemoradiation experienced local recurrence compared to 63 patients in the sequential arm (5 year local recurrence rate 2.8% v 5.1%). Sequential radiotherapy is delivered either after or before chemotherapy.

Dr Indrajit Fernando, consultant clinical oncologist, University Hospitals Birmingham NHS Foundation Trust, UK commented on the results of the study: "One breast cancer death can be avoided for every four local recurrences prevented. Therefore, even small improvements in local control will have a significant long-term benefit."

Value of pre-operative visits

The value of pre-operative oncology nurse visits to patients about to undergo surgery for breast cancer is being assessed in a prospective study involving 140 women.

The aim of such visits is to reduce anxiety levels, and revealed an 88% level of patient satisfaction when first assessed in 2008.

In the current study at the Paul Strauss Cancer Centre, Strasbourg, France, patients will be randomised to one of two groups — those who have received a pre-operative visit (POV) and those who have not. Theatre nurses subsequently use a dedicated assessment tool to evaluate blood pressure, pulse rate and anxiety status.

A total of 109 patients have thus far been recruited to the study which, if successful, may be extended to other university hospitals where women with breast cancer are treated.

Nurse role in robotic-assisted surgery

Nurses are at the forefront of developments designed to improve the use of robotic techniques in oncology surgery at the European Institute of Oncology (EIO), Milan, Italy.

An investigation into nursing "best practice" in robotic-assisted surgery at the EIO has revealed a number of challenges — not the least of which is a determination of the specific skills and training required for nurses to make a meaningful contribution to new technology that to many in the profession is still something of a mystery.

The investigation also recommended that oncology nurses should be more closely involved in the creation of treatment protocols and guidelines, as well as playing a key role in data collection, analysing trends and outcomes, and identifying safety issues.

- *Report provided by medical writer Stephen Pinn*

Q&A

In each issue of International Cancer Nursing News we ask an ISNCC leader about their work, about cancer nursing and about their life. In this issue Lena Sharp, Chief Nursing Officer at the Karolinska University Hospital Department of Oncology, Stockholm, Sweden answers our questions

What is the most satisfying part of your job?
The most satisfying part is the opportunity to lead, and together with the nursing teams, develop and improve cancer care in many areas. So many nurses have such a lot of drive and ambition to change their practice in order that their work will be even more beneficial for their patients and their families.

What are its challenges?
The challenges are a shortage of specialist trained cancer nurses, financial issues and the hierarchies that still exist within health care organisations.

Why did you decide to specialise in nursing patients with cancer?
My first position as a nurse student was on an oncology ward. I was not very happy because I was the last student to choose and I wanted, as all the other students, a position on a paediatric ward. But after the first week, I was hooked!

I was so impressed with the care that was offered to cancer patients and their families and how interesting and rewarding it was to care for people with cancer. During the remainder of my nursing studies, no other specialty came even close. After I got my nursing degree I was offered a job at the Department of Oncology, and I have never regretted my choice. I am still working at the same department, even if I have changed position a few times.

What characteristics do you think make a good cancer nurse?
Empathy, engagement, knowledge, curiosity, being a team player.

What advice would you give to a nurse who was thinking of becoming an oncology nurse?
Go for it! It is the best job in the world and you will not regret your choice. The work is very flexible and you learn new things all the time.

What are your proudest achievements in your career?
To be nominated as the best female leader in Swedish health care by my nursing team.

What job would you have liked to have done if you had not become a nurse?
Very difficult question, since I love nursing so much, but maybe I would have become a chef or a gardener.

Why did you decide to become involved in the work of ISNCC?
I have always been interested in international work and working together with nurses from other counties. We can learn a lot from each other.

What one thing would make a difference to cancer care around the world?
A high proportion of specialist trained cancer nurses at cancer centres to significantly improve patient safety and quality of care.

What would you like to achieve in the future in your career?
Improved patient safety in cancer care — we still have a lot to learn from other areas of care. That all the nurses at our department are specialist trained and that all cancer nurses are better recognised for their extremely important work.

What are your interests outside of work?
My family, cooking, reading, travelling.

Submit an abstract for the 17th ICCN

The International Society for Nurses in Cancer Care (ISNCC) invites you to submit an abstract for presentation at the 17th International Conference on Cancer Nursing (ICCN). The conference *Enhancing Patient Safety through Quality Cancer Nursing Practice* will be held in Prague, Czech Republic, September 9–13, 2012.

The ICCN Scientific Planning Committee invites abstracts to be submitted related to the conference theme and will consider all abstracts highly significant to nurses in cancer care worldwide. The committee has outlined the following abstract topics and encourages you to share your expertise by submitting an abstract related to:

- Prevention, genetics and screening,
- Cancer across the life span,
- Education: nurse and patient,
- Models of care delivery,
- Quality and patient safety,
- Supportive and palliative care,
- Survivorship,
- Cultural and spiritual care,
- Innovation in practice and roles,
- Treatment development,
- Ethics, informed consent and clinical trials,
- Workforce and healthy workplace issues.

To ensure diversity and to meet the needs of the audience, abstracts will be selected based on the following categories:

Administration/leadership development
Issues, projects, trends in management and leadership;

Clinical/evidence-based practice
Issues, application of products, programmes, trends in care of patients with cancer, nursing-sensitive patient outcomes, and/or use of research findings and/or best evidence with nursing clinical practice or research implications;

Education
Educational programs and issues; may be based in service or academia and patient or nurse focused;

Research
In progress or completed nursing research studies. Only completed research is eligible for podium presentation.

When you submit your abstract you need to choose the intended presentation method or rank them in order of preference from the following formats:

Oral — a 15-minute PowerPoint presentation by the author(s) plus five minutes for questions (20 minutes total).

Poster — a visual display. Designated poster session times will be included in the programme. Presenting authors will be required to stand by their poster during an assigned presentation time. There

will be two poster awards each day – one for clinical practice and education, and one for research;
Moderated poster — authors will have the opportunity to present their poster in a dedicated space based on topic of interest, and have dialogue with other peers.

The abstract submission process is simple and submissions may be edited at any time up to the deadline. As part of the abstract submission process, a short biography typed into the submission site will be required. Abstract text must be no longer than 300 words, not including spaces and the abstract title. Only abstracts listed as "complete" in the submission system will be considered for review. Abstracts are accepted on-line via the ISNCC website at **http://tinyurl.com/ICCNabstracts**

This site is now open. The key date is the submission deadline of midnight Pacific Standard Time (North America) on January 15, 2012. Successful applicants will be notified by the end of April 2012.

Each author is limited to two abstract submissions within two different categories.

Each abstract will be published in the 17th ICCN program and abstract book exactly as it is submitted online, so accuracy of submission is essential. By submitting your abstract you are granting ISNCC permission to list your name and abstract in our programme materials.

Authors whose papers have been accepted will be required to pay the standard conference registration fee.

Mentorship for abstract, poster and PowerPoint presentation development may be available through your ISNCC regional representatives. Please contact ISNCC for a list of available representatives.

Any questions regarding the submission process or the conference can be directed to ISNCC Head Office by telephone at: +1.604.630.5516, or by email at: info@isncc.org.

The Scientific Planning Committee is looking forward to meeting you at this exciting conference, where cancer nurses around the globe can share their nursing stories and work. We hope to see you in Prague!

Cath Glennon Member of the ICCN Scientific Planning Committee and Conference Management Committee

EDUCATION COLUMN

教育・研究活動委員会からのお知らせ

ISNCC is committed to spreading education about cancer nursing care around the world. To improve access to our materials, the education column will be in a different language in some issues of the newsletter. This issue of the education column is in Japanese.

1.　平成23年度　アドバンストセミナー
メインテーマ：がん患者の意思決定支援の鍵となるコミュニケーションサポート
ー治療選択に戸惑う相談場面におけるコーチングサポートー

「がん患者の意思決定支援の鍵となるコミュニケーションサポート」をメインテーマとするセミナーの2年目となる今年度は、「治療選択に戸惑う相談場面におけるコーチングサポート」をテーマに行います。治療の選択肢が増え、意思決定の過程で、戸惑い悩む患者への支援は、重要性を増しています。今回は、治療選択に関する意思決定の相談場面に焦点をあてて、コーチングの観点から行うコミュニケーションのスキルアップをめざします。

＊セミナー参加者には、日本がん看護学会より修了証が授与され、自己研鑽として4ポイントを取得することができます。
＊第26回学術集会会長ならびに事務局のご協力を得て、学術集会会場での開催となります。

日　時：2012年2月10日（金）13：00～17：00（学術集会前日）
場　所：くにびきメッセ（学術集会会場）501大会議室
受講資格：申込時に日本がん看護学会会員であること（定員80名程度）
受講料：5,000円　申込み方法：10月初旬からの受付になります。
詳細が決まり次第、日本がん看護学会ホームページでお知らせします。
http://jscn.umin.jp/seminar/

2.　平成23年度　教育セミナー
第26回日本がん看護学会学術集会の会期中に教育セミナーを企画しています。
本年度の教育セミナーは、事前申込み制となります。先着順に受け付けをし、予定人数に達した時点で受付を終了します。
教育セミナーの事前申込みは、11月8日（火）より開始する予定です。
詳細が決まり次第、日本がん看護学会ホームページ でお知らせします。
http://jscn.umin.jp/seminar/

3.　平成23年度　専門看護師および認定看護師の継続的なキャリアアップ支援事業
1）　専門看護師支援事業
テーマ：がん診療連携拠点病院でがん看護研修を企画・開催している看護師を対象としたOCNSによる相談事業
内容：事前に相談依頼のあった施設に対する専門看護師によるコンサルテーション
日時：2012年2月12日（日）9：20-11：00
場所：松江勤労者総合福祉センター（愛称「松江テルサ」）JR松江駅前
＊本企画は個別の施設に対する相談のため、事前申込みいただいている施設の関係者の方を対象として開催されますので、関係者以外のオブザーバーでの参加はお断りしております。申込みにつきましては、2011年10月頃各、施設宛てにご案内させていただきます。なお、今年度をもって相談事業は終了とさせていただきます。

2）認定看護師支援事業
テーマ: 認定看護師ができるがん患者・家族に向けた災害支援
内容: 東北地方太平洋沖地震が発生し、今も現地で支援をされている認定看護師の方も多いと推察いたします。これまで行ってきた災害支援を振り返り、今後起こりうる災害に備えて「災害時におけるがん患者・家族への支援がどうあれば良いのか」を意見交換していきたいと考えています。
なお、今年度からは演題を公募とし、認定看護師の皆さまが自分たちの活動の実際を発表して参加者の方々と交流する場にしたいと考えています。
日　時: 2011年2月11日(土) 15:30-17:00
場　所:くにびきメッセ国際会議室

4. がん看護コアカリキュラムに関する交流集会の開催
テーマ：がん看護コアカリキュラムの活用報告（仮）
日時：2012年2月12日（日）13：30～15：30
場所：松江テルサ大会議場
前期の教育・研究活動委員会で「がん看護コアカリキュラム日本版2010年度」が作成されました。第26回日本がん看護学会学術集会において、「がん看護コアカリキュラム日本版2010年度」の活用例を報告し、がん看護の質向上のためにどのように活用できるか、意見交換したいと考えています。

Kazuko Onishi, Board Director of ISNCC Professor Emerita and Appointed Professor, Graduate School of Medicine Mie University, Japan

UNITED NATIONS FOCUS

Sustained investment yields results in HIV infection rates

The launch of the 2011 *UNAIDS World AIDS Day* report reveals a reduced annual number of new infections at 2.7 million, suggesting a levelling of the epidemic. However there is now the largest ever number of people living with HIV around the world at 34 million.

The report shows that there are 6.6 million people, almost half of eligible patients, in low and middle-income countries receiving anti-retroviral treatment. Eleven low and middle-income countries, including Botswana and Brazil, have already reached a level of 80% access to treatment. As a result, an estimated 700,000 AIDS-related deaths were averted in 2010 alone.

Launching the report, Bertil Lindblad, director at the New York Office of the Joint United Nations Programme on HIV/AIDS (UNAIDS), said that properly targeted and sustained investments had achieved results. He said he hoped that the framework outlined by UNAIDS would be used by countries in times of financial crisis or austerity.

This framework includes essential activities, such as focused interventions for key high-risk populations, particularly sex workers and their clients, men who had sex with men, and injecting drug users. It also includes prevention of new HIV infections in children, behaviour change programmes, condom promotion and distribution, treatment, care and support for people living with HIV, as well as voluntary medical male circumcision in high HIV prevalence countries.

A new level of political commitment has been evident in 2011. Member states adopted concrete targets to halve infections and increase global funding to an annual $24 billion by 2015.

On a less positive note, Eastern Europe and Central Asia has seen an alarming 250% increase in HIV infections since 2001, with 90% of cases from the Russian Federation and Ukraine. Drug use was cited as the main driving force for the increase.

Mr. Lindblad said HIV was a political issue requiring political commitment at the highest level, and this had been a message from UNAIDS since 2001. In several Eastern European countries there was a political "block" that was resistant for a variety of reasons to, among others, a comprehensive treatment, prevention and support package for injecting drug users.

A root cause of increased HIV infections in that region was the rise in the number of injecting drug users, following the fall of the Soviet Union.

He added that traditional and cultural factors, such as perceptions about homosexuality, were among the more difficult aspects of the HIV response. However, he maintained, human sexual behaviour and social phenomena, such as drug use, or commercial sex were important factors that needed to be examined.

Go to **www.unaids.org** for the full report.

RESEARCH COLUMN

Distressful symptoms suffered by patients with advanced cancer

Introduction

Patients with advanced cancer often suffer from various symptoms that have adverse effects on their quality of life. These are due either to the disease itself or to its treatment (Brechtl et al, 2006). Research indicates that effective symptom management plays a primary role in improving patients' quality of life (Shi, 2000). Several studies have examined distressful symptoms commonly experienced by Chinese cancer patients (Yan et al, 2005; Zhou, 2009; Chen, 2009; Wang et al, 2011) However, only that of Wang et al (2011) deals with the prevalence and severity of symptoms experienced by patients with advanced cancer.

The findings showed that the three most common symptoms experienced by 201 advanced cancer patients at home were:

- fatigue (89%),
- difficulty in remembering (78%),
- dry mouth (74%).

The three most severe were:

- fatigue [mean (SD)=4.19 (2.81)],
- difficulty in remembering [mean (SD)=2.91 (2.37)],
- disturbed sleep [mean (SD)=2.89 (2.72)].

However, patients who were in hospital with advanced cancer at the time were not included in the study. Since about 20% of patients at an advanced stage of the disease are normally in local cancer hospitals, examining the prevalence and severity of common symptoms is essential to estimate the services required for symptom management.

The aim of the study was to examine the most common and distressful symptoms suffered by Chinese patients with advanced cancer. The three research questions were:

1 What are the five most common symptoms experienced by Chinese patients with advanced cancer?
2 What are the five most distressful symptoms perceived by these patients?
3 Are the five most common symptoms experienced by these patients also the most distressful?

Methods

Study design

A cross-sectional design was used.

Sample and setting

Eligible subjects were recruited from the following units of the Tianjin Cancer Hospital of China: radiation treatment, chemotherapy, combined Chinese and Western medicine, biological therapy, interventional therapy, blood disease treatment and pain management. The inclusion criteria covered patients diagnosed with stage IV cancer, able to communicate in Mandarin, conscious and without any diagnosis of mental disorder. A total of 200 eligible subjects were approached in 2009, 170 of whom consented to participate in the study and complete the questionnaire, a response rate of 85%.

Measurements

An author-developed questionnaire was used. It consisted of two parts: demographic data and a symptom distress scale. Demographic characteristics include gender, age, marital status, educational level, occupation, type of cancer and family income. The symptom distress scale consists of 30 symptoms (Table 1). An 11-point rating scale (0 = no symptom distress, 10 = the worst that you can imagine) was used to evaluate the severity of an individual symptom. A panel of nursing experts and statisticians assessed the clarity, appropriateness and relevance of the items.

Data collection procedure

After the eligible subjects had consented to join the study, the investigator distributed the survey to all participants, who were asked to fill it in and return it to the investigator. In the case of those who were illiterate, the investigator read the questions one by one and then asked the participant to respond verbally to each.

Data analysis

SPSS 13.0 statistical software was used for data analysis, and descriptive statistics to analyse all variables.

Results

The mean age of the participants was 59.5 years (SD = 11.9, range = 24–82 years). More than half were male (57%) and most had completed a secondary education (89%). The great majority was married (95%) and had a relatively high monthly household income (84%), while 44% were retired. The thoracic cavity (39%) was the most common primary cancer site among the participants, followed by the abdominal (23%) and pelvic cavities (14%).

Among 30 symptoms listed in the survey, the three most common symptoms experienced by the participants were fatigue (72%), pain (68%) and anorexia (67%) (Table 1). The mean total number of symptoms among the participants was 9.5 (SD = 4.423), with a range of 1 to 22.

The three most distressful symptoms were pain [mean (SD) = 3.42 (3.06)], fatigue [mean (SD) = 3.35 (2.93)] and anorexia [mean (SD) = 2.93 (2.99)].

Limitations

The study has several limitations. First, the cross-sectional design only provided information at one point in time, and the pattern, consistency and intensity of symptoms over time were not evaluated. Second, patients usually experience more than one symptom, so any future study will need to examine symptom clusters among this population. Third, an author-developed questionnaire was used, and additional work will therefore be needed to assess the effectiveness of the instrument.

Table 1: Descriptive statistics for author-developed symptom scales

Rank	Symptoms	Number of participants N (%)	Rank	Symptoms	Intensity mean (SD)
1	fatigue	123 (72.4)	1	pain	3.42 (3.06)
2	pain	115 (67.6)	2	fatigue	3.35 (2.93)
3	anorexia	114 (67.1)	3	anorexia	2.93 (2.99)
4	sleepiness	92 (54.1)	4	hair loss	2.80 (3.75)
5	hair loss	81 (47.6)	5	sleepiness	2.06 (2.62)
6	abdominal distension	76 (44.7)	6	abdominal distension	2.01 (2.74)
7	dry mouth	76 (44.7)	7	cough	1.92 (2.81)
8	insomnia	72 (42.4)	8	constipation	1.78 (2.74)
9	cough	71 (41.8)	9	dry mouth	1.69 (2.53)
10	constipation	68 (40.0)	10	insomnia	1.67 (2.64)
11	weight loss	64 (37.6)	11	nausea	1.55 (2.68)
12	memory loss	62 (36.5)	12	weight loss	1.46 (2.30)
13	nausea	61 (35.9)	13	dyspnea	1.35 (2.53)
14	mood swings	57 (33.5)	14	mood swings	1.33 (2.50)
15	dyspnea	49 (28.8)	15	fever	1.19 (2.41)
16	hot flushes	47 (27.6)	16	memory loss	1.15 (1.93)
17	headache	44 (25.9)	17	oedema	0.98 (2.26)
18	vertigo	43 (25.3)	18	vomiting	0.95 (2.31)
19	fever	42 (24.7)	19	hot flushing	0.89 (1.82)
20	oedema	37 (21.8)	20	frequent urination	0.88 (2.11)
21	vomiting	34 (20.0)	21	hot flushes	0.87 (2.01)
22	frequent urination	33 (19.4)	22	vertigo	0.82 (1.79)
23	numbness of limbs	31 (18.2)	23	gastro-intestinal spasms	0.65 (1.89)
24	depression	28 (16.5)	24	numbness of limbs	0.58 (1.47)
25	gastro-intestinal spasms	26 (15.3)	25	depression	0.58 (1.63)
26	diarrhea	23 (13.5)	26	diarrhoea	0.49 (1.41)
27	oral mucositis	17 (10.0)	27	oral mucositis	0.46 (1.68)
28	difficulty in swallowing	16 (9.4)	28	difficulty in swallowing	0.37 (1.37)
29	retention of urine	9 (5.3)	29	retention of urine	0.21 (1.01)
30	incontinence	5 (2.9)	30	incontinence	0.16 (1.12)
(n = 170)					

Implications

The three most common symptoms are the same as the three most distressful, though they occur in a different order. The findings provide direction in designing and developing future symptom management programmes to meet patients' needs. For example, pain control is often considered to be the most important element in the symptom management of existing practice. However, not much attention is paid to patients' fatigue and anorexia, the top two most common and distressful symptoms. Management strategies to relieve these two symptoms should be incorporated into future practice.

It is important for nurses to understand the most common and distressful symptoms experienced by this specific population. Thus, symptom assessment including both subjective and objective parameters should be incorporated into nursing assessment charts.

Nurses should also encourage patients to tell them what symptoms they experience so that appropriate relief strategies can be planned and instituted. Teaching materials can be developed to instruct patients in ways to relieve or minimise their distressful symptoms, while family involvement may help them to work out more effective symptom management strategies.

The experience of symptoms is complex in patients with advanced cancer as they usually perceive more than one. Indeed, the findings of the present study show that the mean number of symptoms suffered by the participants is 9.5, reflecting the importance of assessing a cluster of symptoms rather than a single symptom in future studies. Additionally, an examination of how symptoms influence the patient's physio-psycho-social well-being is also recommended for future research.

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