



Cancer crisis in Africa

Urgent action is needed to develop comprehensive cancer control strategies throughout Africa, according to a meeting of leaders in world health and cancer control.

The meeting, which was attended in London, UK, in May this year by over 130 leaders in world health and cancer control, resulted in the London Declaration on Cancer Control in Africa.

The declaration, which calls for cancer strategies that tackle prevention, early detection, diagnosis, treatment and palliative care, was delivered to the WHO shortly after the summit.

The London Declaration builds on previous declarations from the International Atomic Energy Agency (Cape Town Declaration on Cancer Control in Africa, December 2006) and the International Union Against Cancer (World Cancer Declaration, July 2006). However, it differs from previous declarations in that it is focused solely on cancer control in Africa.

Cancer accounts for 12.5% deaths worldwide, a greater percentage than is caused by HIV/AIDS, TB and malaria combined. By 2020 there are expected to be 15 million new cases of cancer every year, one million of them in African countries, the least able of the developing nations to cope. Only two African countries currently have a cancer plan, the issue often being neglected in favour of more publicised diseases.

Life-saving radiotherapy is available in only 21 of Africa's 53 countries, or to less than 20% of the population, and consequently cancer is a sentence to a painful and distressing death. An estimated 80% of people with cancer in Africa present to health services with late stage cancer when palliation is the only treatment option. A major obstacle in the provision of adequate health care in Africa is the lack of trained health care professionals. New local healthcare staff need to be trained to increase capacity.

Speaking at the launch, Abator Thomas, health minister in Sierra

Leone said; "We have been so involved in tackling communicable diseases that we are only now starting to think about palliative treatments for people with cancer."

The London Declaration is a call to action directed at all organisations: governments, international agencies, research bodies, global funders, the pharmaceutical industry, individual benefactors and NGOs.



The theme of this year's International Nurses Day held on the 12th May was positive practice environments. This theme is based on the conviction, supported by evidence, that quality health care workplaces provide quality patient care. The international Council of Nurses has launched a global call to address and improve the serious deficiencies currently existing in the health work environment in all regions.

Hiroko Minami, President of ICN said: "The goal of ICN's call for positive practice environments is to improve the quality of health services through health care work environments that support performance excellence."

Singapore 2008: Call for abstracts

The biennial conference of the ISNCC will be held in August 2008 in Singapore. You are invited to submit your abstract for consideration for poster or oral presentation. Please see overleaf for more information on submission. The deadline is December 3rd 2007. We look forward to receiving your abstract. Our last conference in Toronto in 2006 received a record number of submissions. Let's see if we can beat that record.

Please note new secretariat details – see page 3

World No Tobacco Day

This year World No Tobacco Day was held on May 31st. The theme for 2007 is Smoke Free Inside with the aim of promoting 100% smoke free environments. The hospital where I work, the Peter MacCallum Cancer Centre in Melbourne, Australia, chose this day to launch a totally smoke free organisation, after two years of having smoking only in a designated smoking area. The planning for this event has taken months with an organisational change process involving staff, unions and importantly some of the smokers on our staff who this change will most affect. This change process has been led by our Chief Executive Officer, Mr Craig Bennett and our smoking cessation nurse, Ingrid Plueckhahn.

One might ask how any cancer centre or cancer-related organisation could not be a totally smoke free environment when we know the critical relationship between smoking and cancer causation. As it says on the Tobacco Free Initiative at WHO "Tobacco is the second major cause of death in the world. It is currently responsible for the death of one in ten adults worldwide (about 5 million deaths each year). If current smoking patterns continue, it will cause some 10 million deaths each year by 2020. Half the people that smoke today — that is about 650 million people — will eventually be killed by tobacco". We also know from research evidence that many people undergoing cancer treatment will have a greater chance of that treatment being successful if they stop smoking.

Despite this reality there are still many countries of the world that carry out little action to address this important health problem. In some countries governments even extol the health benefits of smoking while in many more smoking taxation has become more a lucrative income stream

than a serious public health disincentive to smoke. At a local level many health care organisations fail to take a proactive stance against smoking in their work environments or to support patients to quit. It is also clear that individual health professionals, especially those working in cancer care, often fail to actively participate in the global fight against tobacco.

ISNCC seeks to work in collaboration with WHO in its fight against tobacco by encouraging the 70,000 plus nurses linked to us through our member organisations to become active in the fight against tobacco. We are establishing a Tobacco Taskforce that will lead this work and we would love to hear from nurses currently working on tobacco control initiatives who might like to join this taskforce. Register your interest on www.isncc.org.

I ask that every nurse involved in cancer care undertakes at least one action that contributes to this global effort to reduce the harmful effects of smoking such as:

- Ensuring information about smoking cessation is available to patients in their workplace
- Speaking to one patient about their desire to quit and referring them to appropriate support services
- Lobbying the hospital to provide free or reduced cost nicotine replacement products to staff and patients wishing to quit
- Organising a speaker on tobacco control at a local educational event
- If you are a smoker, making a time to discuss your own quitting needs with a smoking cessation counsellor.

I wish you all well in your efforts to promote a health society and lessen the burden of cancer in our society.

Sanchia Aranda
President, ISNCC

My child matters

The *My Child Matters* programme is funding 12 new projects on paediatric oncology in six countries: Bolivia, Indonesia, Kenya, Mali, Peru, and Romania.

The project which is supported by the International Union Against Cancer (UICC) and the pharmaceutical company sanofi-aventis set up 10 projects in 2005.

This new initiative includes a project in Bolivia to provide free leukaemia diagnosis for children. In Indonesia one of the programmes will tackle early detection and prompt treatment of retinoblastoma

There is a marked gap in survival rate between industrialised countries and the developing countries where 80% of children with cancer live.

Each year, more than 160,000 children are diagnosed with cancer and approximately 90,000 die. In industrialised countries, nearly 80% of children being treated for cancer will survive. This survival rate drops to 20% or even 10% in developing countries where access to information, early detection, effective care and treatment is often not available.

WHO cancer action plan

The World Health Organisation has launched a global action plan for cancer. The plan brings together a wide range of strategies to prevent what is preventable, cure what is curable, relieve pain and improve quality of life, and manage for success.

The multi-sectoral plan has seven strategic components. These include: promote WHO strategies impacting on cancer, promote national cancer control programmes (NCCP) in countries, support NCCP development and implementation in high-burden low- and middle-income countries, monitor implementation and impact of national and global interventions, develop a WHO global partnership and develop a cancer control research agenda to support the action plan.

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End-of-life care in the critically ill

This study explores the views of nurses and patients on the experience of end-of-life care in a critical care environment

Recent treatment advances have opened up opportunities to cancer patients that might not previously have been available. This increase in curative or life-prolonging treatments is accompanied by a moral imperative to support patients through any illness these treatments may cause. Increasing overall survival rates across cancer groups and improving survival rates of cancer patients in critical care units present a persuasive argument for cancer patients to access critical care units (Kress et al, 1999; Sculier et al, 2000).

Unfortunately, it has to be noted that cancer patients' prognoses with critical illness and after admission to critical care remain much worse than in general populations (Maschmeyer et al, 2003; Soares et al, 2005).

The study

The research study presented here outlines dilemmas experienced in providing end-of-life care for cancer patients in the high technology environment of a critical care unit. Existing research focuses on the experiences of nurses, doctors and families. Patients are rarely sampled in end-of-life care research, particularly in qualitative research.

The views of patients in critical care and end-of-life research are notoriously difficult to sample, given delirium (Ely et al, 2001); ventilation and sedation (Jones & Lyon, 2003); and the fact that dying has not necessarily been diagnosed. Therefore, some proxy assessment of patients' experiences has to be found, thus providing the rationale for the inclusion of survivor patients' experiences. This article outlines the findings from two groups outlined below: nurses and patients.

The aim of this research was to gain a picture of experiences for those whom end-of-life care affected. Witnessing, providing, deciding and experiencing care when critically ill provide the four key dimensions to exploring these processes. It was carried out in the only cancer critical care unit in the UK that currently provides level three care (full multi-organ failure support).

Written consent was obtained for all participants. Ethical approval was granted via the Royal Marsden Local Research Ethics Committee. Box 1 shows the four distinct groups comprising the whole sample.

This article presents some of the data on two groups from the whole study (groups one and three). For the two groups presented here, seven patients (with six family members) and seven nurses participated. With one exception, all patients who were approached agreed to participate. All nurses approached agreed to participate.

A phenomenological interview method was used to gain insights, meaning and experiential accounts of end-of-life care in cancer critical care.

The findings

In all of these participants' cases their critical care stay was characterised by unexpected events that were life-threatening. One of the themes common to all patients interviewed was a dawning realisation of the nature of their critical illness. This realisation came to patients at different times: whilst in critical care, recovering post-endotracheal extubation for instance, or some time afterwards, when reflecting after discharge home. These patients' accounts exemplify how that realisation was only reached when informed by others.

"When I woke up in critical care only from them telling me [did I realise] and sort of became aware of the fact that something drastic had gone wrong. You know I didn't, I didn't know what had happened and it has gradually sort of pieced together since. It was about ten days I think ..." (patient 2)

"...two of the nurses, they said 'we looked after you in ICU and you were so ill it was unbelievable, but we looked after you and you have come through'. And I tried to ask them questions and couldn't." (patient 4)

Survivorship versus confrontation of death

It was difficult for some of the patients to think about what they would have wanted for their end-of-life since they had survived. Therefore it was a hypothetical situation for them to reflect on, rather than a reality. For families however, the survivorship was tempered with the real memory of confronting death. Doctors had outlined the extent of the critical illness and seriousness of the situation to all families in the study here; the possibility of not recovering was presented in all cases. For patients who were not party to those consultations it was difficult to comprehend how sick they actually were at the time of critical care.

"I mean initially I guess I was a little bit shocked just to sort of hear about what was happening but again I didn't have to deal with it at the time and because at that point I was getting better and you know the hope was that I was going to continue to get better." (patient 3)

"For me [it was] terrifying ... Obviously you think the worst when you get that call. [The doctor] was trying to explain things that they were doing ... either both [son] and I were in a very low state and it just washed over our heads, or he just spoke over our heads." (patient 6 spouse)

Being exposed to near-death situations prompted existential reflection either during the research itself or made patients consider their religious and spiritual self, and needs. One patient found pastoral support helpful to deal with issues after the realisation of what had happened.

"I quite strongly believe in God and I believe that there is a power beyond us that controls our destiny somewhat." (patient 1)

Box 1: sample groups

- 1 Patients** who had been extremely critically ill, and deemed unlikely to survive, but who had nonetheless survived. A purposive sample of a range across tumour groups was taken. (Family members often wished to contribute to these interviews, therefore these were often joint interviews.)
- 2 Families of patients** who had died in critical care (consecutively sampled over one year to allow for poor response).
- 3 Nurses** working in critical care who provided care at the end-of-life (a purposive sample of a mixture of cancer and critical care nurses reflecting a range of experience and grade).
- 4 Doctors**, specifically: *oncologists* (purposively sampled from areas that routinely sent to critical care) who decided which patients to admit to critical care and who made joint treatments decisions with the intensivists; *intensivists* (whole sample) who decided when to forgo life-sustaining treatments; *palliative care specialists* (whole sample) who may be involved with deciding how to palliate patients in critical care for whom decisions to move to end-of-life care had been made.

Cancer and critical illness

One patient placed his problems in critical care in the wider context of his life, for him other problems meant more now than his cancer. There was almost a separation of critical care and the cancer, despite the fact that the cancer treatment was the primary reason for his subsequent critical illness.

"I've had more trouble with my prostate than I've had with this [gestures to throat to indicate site of cancer]. Honest ... I mean I'm 74 and I ain't doing bad and you've got to die of something I suppose. That's the way I looked at it ..." (patient 5)

Having come through critical illness it was important for one patient to learn the outcome of his cancer treatment, in his case surgery, as soon as possible. The focus up to that point was on life-saving measures rather than cancer treatment.

Reflection on treatment preferences

Whilst these patients did recover, they expressed the way in which priorities in critical care would shift if they knew there was no hope of recovery. Nurses focused on comfort measures whereas for patients having family present, talking to people and putting affairs in order all took priority over comfort measures.

"... Yeah I suppose putting all my affairs in order is one thing ... and saying goodbye to the wife, obviously." (patient 4)

"I'd want know that [my wife] was looked after. I'd not made any long term plans" (patient 7)

"... you don't realise that you're that ill. Perhaps if you are dying, if you really are going to you do realise, but [if somebody had told you], that your family's there obviously. And that you were comfortable, I can't really see what else you can do. The nursing's superb, you do the best you can." (patient 6)

Being near loved ones was echoed by families too:

"... the fact that Carol was so near death, I had to be there for as much as I could." (patient 6 spouse)

Practical issues around comfort centred on seemingly minor nursing issues: sliding down the bed, ensuring no pain, being free from diarrhoea, receiving minimal tracheal suction. Patients views on this were a reflection not only of what they would want at the end of life in critical care, but also on what they had actually experienced.

Personal dissonance

The data from nurses centred much more around the experience and effect of caregiving at end-of-life. The interviews unsurprisingly raised difficult issues for nurses.

Nurses from both cancer and critical care backgrounds often talked about factors complicating both the cancer and critical illness aspect of the prognosis and decision-making. Having knowledge of both cancer and critical illness seemed to be important to some nurses for them to feel confident in contributing to decision-making:

"I guess because I'm not a cancer nurse some of the things are out of my realm, ... I don't have a lot of confidence I guess to make a decision, or to input on that ..." (nurse 1)

However, nurses do not make decisions to forgo life-sustaining treatments, only contribute to decisions:

"it's not [up to] us to take the decision. The doctor takes the decision to stop or to continue, with the family, sure, but the nurses are only here to give the care and accept" (nurse 3)

Reaching and defining futility

Knowing patients were not going to get better before actual decisions had been made also created personal sadness, particularly for experienced nurses who felt they could often accurately predict prognosis:

"I knew that I was going to go that night and I just had a feeling that I maybe might not see him again so before I left I gave him a big kiss on the cheek ... I just sort of wanted to say good bye." (nurse 6)

Facilitating families' understanding

All the nurses outlined how they saw their role as reconciling what families had heard or not heard from discussions with doctors.

"It's about ensuring the message got across and making sure the opportunity is there that if something was said that they didn't understand that it can be re-discussed. But it's often difficult, they want to hear from a consultant, not a nurse." (nurse 7)

Family versus patient: split loyalties at the end of life?

Some nurses talked about the way in which at the very end of life, care shifted towards supportive and psychological care of the family, rather than the patient. The physical aspects of care continued, and nurses communicated with the patients still, ensuring ongoing presence with the patient. One nurse talked about how a patient could be almost defined as dead, even before death had actually occurred:

"He was left for three or four days on continuing treatment, even though he was to all intents and purposes 'dead', so that his mum could come from far away." (nurse 4)

Dying was also seen as a very private process and nurses were conscious about providing

the right level of support without being too intrusive on families who may have begun grieving even before actual death.

Care practices at the end of life: a good death

At the end of life, care moves away from life-saving towards a focus on comfort. It meant more to nurses, and was more fulfilling, to be able to concentrate on small things, such as mouth care, positioning, hygiene needs, and facilitating family presence once the decisions to forgo life-sustaining treatments had been made.

"Promoting a respectful, peaceful environment, that's what I'm focusing on then." (nurse 4)

Discussion

This article has presented data on the meaning of end-of-life care in a cancer critical care unit for nurses and patients, as part of a wider study .

It was difficult for some patients to think about what they would want for a good death since cancer remained a Damoclean sword overhead. For patients who did talk about what they would want if they were in that situation again, none of them expressed a wish to die outside a critical care environment. The positivity towards nursing care may be a key factor in this, in that they felt fundamentally cared for.

Whilst to those unfamiliar with critical care, it may seem a dauntingly technological and clinical place to die, the nursing and care provided humanised the environment. Sensitive nursing care transcends the domains of the critical care unit, the ward, palliative care, hospice or home. The uniqueness of a cancer critical care unit undoubtedly shapes the response in this study but nonetheless, nurses' and patients' experiences provide evidence that good end-of-life care, and a good death can be provided in any environment.

Natalie Pattison, Nurse researcher: critical care nursing, The Royal Marsden Hospital, London, UK

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The genetics of cancer

Knowledge of the human genome has grown steadily over the years since it was first mapped in 2003. As yet we are in the early stages of our understanding of familial risks and genetic susceptibility of certain cancers. However, within the next decade it may well be possible to supply our patients and families with definitive information that is personal to their genetic make up that will help them to make informed decisions about lifestyle options.

There are number of useful internet sites to keep the busy health professional up to date with such developments, so it is worth having a look at what they to offer.

People living with cancer

<http://www.plwc.org/portal/site/PLWC>

This high quality web site has some useful information in its genetics pages that is both peer reviewed and well laid to make it user-friendly. As well as easily accessed detailed information on the genetics of a range of different cancers there is also a sensitively put together section on genetic testing and the implications of this for the individual and family. The link above is for

the home page, from there click on "Learning about cancer" on the left side of the page, then choose "Genetics" from the list that appears.

Cancer genetics

<http://www.cancerindex.org/geneweb/>

This site is primarily a staging post directing the professional to a whole range of resources directly linked to cancer genetics. Once the "site map" is accessed there is very detailed information on gene therapy, epidemiology, counselling, pharmacogenetics, and a number of links to scientific databases. It is unashamedly strongly evidence-based, yet will allow you to get a good overview of cytogenetic influences on health and wellbeing.

National Cancer Institute: Understanding Cancer Series.

<http://www.cancer.gov/cancertopics/understandingcancer>

For those of you engaged in education and looking for some good quality materials on cancer genetics that can be downloaded in either pdf or powerpoint formats, this is the

site for you. It is aimed at both health professionals and the general public, so the information is detailed enough to be useful without being patronising. There are presentations on cancer genomics, gene testing, the genome project, gene variations and even cancer and the environment. The site will allow you to view slides individually if you wish, or once downloaded to mix and match. I am a big fan of sites that share resources like these. I have tried some of these materials in my own teaching with great success so can vouch for their quality and accuracy.

Cancerbackup

<http://www.cancerbackup.org.uk/Aboutcancer/Genetics/Overview>

For those of you looking for a baseline overview for yourself or to guide your patients towards helpful information in this area then you need go no further than this site. It is packed with easily accessible, user friendly guidance that takes good account of the emotional and psychosocial facets of cancer genetics as well as the scientific element.

Mentorship in cancer nursing

This article looks at mentorship in cancer nursing and its importance to the delivery of high quality care for patients and families.

Mentors are vital to the preparation of the next generation of cancer nurses and it is essential that nurses are mentored by more senior experienced cancer nurses with current experience of cancer nursing delivery. It is vital that those who act as mentors have the appropriate skills to prepare nurses for the future world of cancer care; and essential that the nurse new to cancer care is fully supported and guided, not only through her initial experiences, but in the longer term as she develops as a cancer nurse.

Different terminology is used in the literature but a mentor is essentially a senior nurse who facilitates a nurse's learning in the practice setting. Morton-Cooper and Palmer (2000) described the mentorship role as follows;

"Mentoring concerns the building of a dynamic relationship in which the personal characteristics, philosophies and priorities of the individual person interacts to influence, in turn, the nature, direction and duration of the resulting eventual partnership"

Coaching is very close to mentorship and is described as one of the best methods for improving performance. Coaching

techniques are especially effective for encouraging and correcting performance on a daily basis. Hudson (1999) says that performance coaching can help professionals develop more competence in their role and this increases their professional confidence.

Manthey (2001) used the term "clinical coaching" describing it as "a management strategy to enhance performance". Long-term coaching of staff is a major step towards building an effective professional nurse and team. Coaching has many of the attributes of mentoring but is generally not limited to one or two staff but may be used for groups to achieve a particular target.

It is clear that much emphasis needs to be placed on the mentorship role/coaching role. This includes preparation and support of the person undertaking the role and the value given to that person in the delivery of a quality service.

The World Health Organisation (1998) describes the importance of competence as requiring "knowledge and appropriate attitudes and observable mechanical and intellectual skills which together account for the ability to deliver a specific service".

The International Council of Nurses (1997) has highlighted the need for competence which needs to demonstrate the effec-

tive application of knowledge, skills and judgment. In order to achieve competence nurses need mentors and coaches. This is not an optional extra but intrinsic to a quality service. Staff are needed who are willing to take on the role of mentor or coach. This is an appeal to all experienced clinical cancer nurses. Make it your professional objective to take on the role of mentor or coach to develop the next generation of cancer nurses; and an appeal to all the managers to build this valuable resource into your service delivery. Our patients deserve it!

Virginia A. Gumley, Director of Nursing/Nursing Education, Shaukat Khanum Memorial Cancer Hospital and Research Centre, Lahore, Pakistan

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Improving the clinical trial process

Oncology nurses working on clinical trials can contribute significantly to the improvement of the research process. This article describes a project between the ISNCC and Eli Lilly and Company which gathered information and experience from control trial nurses in Europe and North America

Focus groups with clinical trial (CT) nurses and members of the oncology team at the pharmaceutical company Eli Lilly and Company were set up. The objectives of the focus groups were to gather best practices leading to more effective development, design, implementation, and enrolment in CTs and to better understand the differences and similarities between European (EU) and North American (NA) nurses with regards to CT coordination.

One focus group meeting in Paris, France in 2005 brought together nine European oncology CT nurses from the United Kingdom, Denmark, Spain, Belgium and Sweden. The other focus group, which included 10 North American oncology CT nurses from Canada and the US, met before the ISNCC conference in Toronto in 2006. All participants were selected by the International Society of Nurses in Cancer Care (ISNCC).

What was discussed?

Margaret Fitch, Head of Oncology Nursing and Supportive Care at the Toronto-Sunnybrook Regional Cancer Centre, Canada and ISNCC immediate past-president asked a series of questions developed by Lilly in collaboration with the ISNCC. Here are highlights from these discussions.

CT nurses: The role of the CT nurse varies slightly by country and institution. The EU nurse's role is to put the protocol into operation and to ensure enrolment. NA nurses reported that their role lies somewhere between the oncology nurse and the medical team. In most locations, the CT nurse must make sure that other staff members are educated about CTs, why data collection is important, and the crucial details of ongoing CTs that their patients are participating in.

Training: EU and NA nurses recommended that trial start-up training be face to face because a lot of information can be gained and relationships developed in person that cannot be accomplished over the phone. The training needs for a new nurse are different from those of an experienced CT nurse. At most sites CT nurses learn on the job, learning from each other. EU nurses reported that new CT nurses often go on a course that covers the general information or train with an experienced CT nurse.

Protocols: Some CT nurses are involved in reviewing protocols for enrolment or implementation feasibility before it is approved by the institutional review board or independent ethics committee. EU nurses reported not being involved early enough in the process. Some CT nurses request electronic protocols to ensure version control. Other best practices included the creation of a patient safety card, a trial-specific brochure, or a protocol question and answer sheet with information about the trial, drug(s), and explanations/reasons for tests and procedures.

Informed consent documents (ICDs): Country-specific ICDs are important because privacy laws differ by country. CT nurses are often responsible for explaining the ICD to patients, which is challenging because they are often very long and written at a level too high for patients in a stressful situation to understand. CT nurses may need to create supporting documents to assist the patient's understanding of the trial, such as a Q&A sheet. Some EU nurses add a page at the end of the ICD for patients to write down questions while they read the ICD at home and then the patient brings their questions back.

Patient recruitment and participation: CT nurses want more resources for

patients, such as printed materials and trusted websites. NA nurses said that they may enrol patients on competing protocols, as long as enrolment can be met for both. Some large centres are sending out lists of trials to local oncologists so they are aware of local trials. Educational meetings with referral physicians or nurses may help promote enrolment in ongoing trials too.

Budgets and LOAs: NA nurses reported that CT budgets never fully cover the costs of conducting a protocol, because increased monitoring requirements, local standard of care, or radiologist/pathologist costs are often not factored into the budget.

Symptom management: CT nurses are an integral part of symptom management for patients on a trial. The nurses reported a need to provide adequate information for the non-research nurses. Clinic and hospital staff nurses are not always aware of the importance of CTs and data collection, so CT nurses provide educational sessions for internal staff regarding a particular trial.

Data collection: NA nurses reported that it is difficult to get reliable measurements of lesions because of inconsistent reporting practices or different radiologists doing the measurements. Some suggested developing a spreadsheet for the radiologist to complete or have a paid radiologist do all the research readings.

Pharmacogenomics: Nurses need educational materials that can be shared with the patients and Institutional Review Boards (IRBs). In addition, EU nurses reported a shortage of pathologists and that the quantity of work, time, and money needed for pathologists is often underestimated.

Feedback from participants

These focus groups showed that a partnership between pharmaceutical companies and oncology nurses can be very useful. The participants found the exchange of experience, different infrastructure and culture to be very informative. They also reported a benefit in the opportunity to network with colleagues regarding mutual concerns and obstructions in enrolling for clinical trials and suggested solutions.

Margaret Fitch, Head of Oncology Nursing and Supportive Care, Toronto-Sunnybrook Regional Cancer Centre, Canada, Stephanie Moore, Susan Fox, Ying Bian, Eli Lilly Medical Oncology, Indianapolis, Indiana, United States

What are CTs and CT Nurses?

Clinical trials, also called medical research and research studies, are studies that usually compare one treatment against another. CTs are used to determine whether new drugs or treatments are both safe and effective or they may examine tumour markers, or quality of life and other patient-related issues.

CT nurses are involved in many aspects of the CT process. The CT nurse can be involved in screening and assessing patients for eligibility for the study; registering patients; keeping detailed and accurate documentation; collecting and submitting data; monitoring study adherence; maintaining a system to ensure effective data flow; monitoring patients; assessing toxicity or side effects; and providing nursing intervention according to regulations and guidelines if adverse situations occur.

A comparison of wound treatments in patients with nasopharyngeal cancer receiving radiation therapy

Radiation therapy, the main modality of treatment for nasopharyngeal carcinoma (NPC), causes moist desquamation to the treatment field involving both sides of neck. The most effective treatment for this type of wound is still uncertain and the use of gentian violet has been controversial.

Method

A prospective open-label randomised trial was designed to evaluate the effectiveness of gentian violet versus non-adherent dressing in healing radiation-induced moist desquamation wounds in NPC patients. A sample of 146 NPC patients who had developed post-irradiation wounds was assessed. To compare the two dressing protocols, patients were assessed for wound healing using the parameters of healing time, presence of infection, and wound pain. The impact of the wound on the patient was evaluated by assessing mood changes, restriction of neck movement, social isolation, sleep problems, and body image disturbance.

At the first clinic visit, patients in both groups were taught to cleanse the wound daily with homemade salted water which was reinforced in the following visit. Non-adherent dressings were applied on the wound after cleansing for patients in the study group and gentian violet was applied topically for patients in the control group. Wound assessments were made on the recruitment day and then once every two days thereafter. Patients completed the Chinese version of the 65-item Profile of Mood States (POMS) (19), and a 4-item symptom checklist that assessed neck mobility, sleep disturbance, social isolation, disturbance in appearance.

Results

Radiation-induced wounds of the study group healed in a median of 14 days (95% confidence interval 12-14 days) which was not significantly different ($p = 0.09$) from the healing time in the control group (median 14 days, 95% confidence interval 12-16 days). However, a trend of shorter time to wound-healing was noted in the study group amongst patients whose wounds took longer to heal (Fig. 1). No incidence of clinical wound infection occurred in the subjects. No patients developed cellulitis.

The worst grade of pain mean score during treatment was 2.51 in the study group and 2.80 in the control group respectively. There was a trend toward decreased subjective feeling of pain of the desquamated wound in patients with the non-adherent

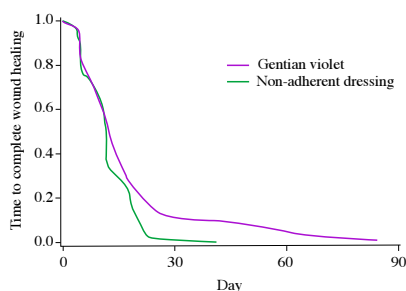


Figure 1. Healing of post-irradiation desquamation wound with use of gentian violet and nonadherent dressing

dressing, but the level was not statistically significant ($p = 0.07$).

At the beginning of the study, no differences were found between the two groups in wound pain, disturbance on neck mobility, sleep, social interaction, appearance disturbance and mood of patients. The four specific areas of neck mobility, sleep, social interaction and appearance were all significantly correlated to each other with the overall mood score at correlations from 0.40 to 0.99 (All $p < 0.0001$) during the wound dressing intervention (Time 2) and upon completion of wound healing (Time 3), reflecting high degree of relationship amongst the measures. No statistically significant differences were detected between the two groups at Time 2 and Time 3 with respect to wound pain, neck mobility, sleep, social isolation, appearance disturbance and mood disturbance.

Discussion

Gentian violet has been used traditionally and has the advantage of being easy to apply without the need for additional dressing. However, it stains clothing, dries the dermis and is carcinogenic in animal studies, so its use is no longer recommended in some centres. Non-adherent dressings do not have most of these problems, and the wound contact layer, being non-adherent, makes the dressing easy to remove. However, it produces a rather dry environment that is not conducive to fibroblast migration and epithelial proliferation. When the wound is large and moist, the fluid might not be sufficiently absorbed but remain to form a sticky layer upon drying. This would predispose to trauma especially during a course of radiation therapy when frequent removal of the dressing is required.

The results of this study are consistent with the findings of our previous study on the use of hydrocolloid in irradiated wound (Mak et al, 2000), which did not show any significant shortening of wound healing

time compared to gentian violet, in spite of the fact that hydrocolloids facilitate a rapid wound healing on the basis of the “moist wound healing” principle. The use of non-adherent dressing and hydrocolloid dressing shared a common problem in that both types of dressing require removal before each daily fraction of radiation therapy, which may cause more damage to the skin integrity because of different levels of adherency.

Although there was a trend towards lower pain scores in the non-adherent dressing group in the present study, the difference was not significant. This is also likely explained by the problem of trauma upon repeated change of dressing when a sticky dry layer had formed.

In our patients, moist desquamation is usually noted on both sides of the neck and supraclavicular fossa toward the end of the course of radiation therapy. The finding of increasing scores of disturbance in ‘mood’, ‘mobility’, ‘sleep’, ‘social interaction’ and ‘appearance’ from the time of emergence of the wound to the time of starting wound dressing, and a trend to decreasing scores at the completion of wound healing, suggests that measures to shorten the duration of moist desquamation are likely to reduce adverse effects on patients. However non-adherent dressings have not been shown to be more effective than gentian violet dressing in this regard. It is also possible that other radiation side effects such as oral mucositis, odynophagia, and xerostomia may have overriding effect over the type of dressing in determining symptom scores.

Conclusion

This present study shows that non-adherent dressing is of similar effectiveness to gentian violet in shortening the post-irradiation desquamation wound healing time and reducing the adverse impact on pain, mood states, social interaction, sleep, appearance and neck movement.

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