



EONS

eons newsletter

The Quarterly Newsletter of the European Oncology Nursing Society

Winter 2004/2005

Contents:

Core Curriculum

**Our colleagues
from...**

The NEXT study

**Evaluation of the
NOEP Project**

**Update of the TITAN
Project**



*Theme:
Skeletal issues*

Colophon

Editor in Chief

Karin Ahlberg, RN, MSc, PhD

Editorial Board:

Jan Foubert, RN, MSc
Carol Krcmar, RN, MN
Emile Maassen, RN, CRN

The goal of the EONS Newsletter is to inform nurses about EONS and its activities and to provide a forum for cancer nurses throughout Europe to network. The information published in the EONS Newsletter is intended to inspire nurses to improve the care of the cancer patient through improved knowledge.

All correspondence should be addressed to the Editor-in-Chief at:
eons@village.uunet.be

EONS secretariat

Rudi Briké
Avenue E Mournier 83/4
B-1200 Brussels, Belgium
Tel: + 32 (2) 779 9923
Fax: + 32 (2) 779 9937
E-mail: eons@village.uunet.be
Web site:
www.cancereurope.org/EONS.html

EONS acknowledges Amgen, Astra Zeneca, Novartis, Nutricia and Roche for their continued support of the Society as Sustaining Members.

Illustration page 3: watercolour painting 'Menorah' by Linda Perlmutter
www.odysseyart.com

Print run: 4500 copies
Electronic version accessible to 18000 EONS members

Printed by

Drukkerij Trioprint Nijmegen bv
The Netherlands



Recipients of the EONS-Roche Grant 2004



For several years, EONS in collaboration with Roche have provided grant money to promote and support research on various aspects of cancer nursing (see related announcement on page 11). Recipients of these grants have been awarded monies to conduct research projects and travel to the EONS Spring Convention to present and disseminate research results. The three recipients of the EONS-Roche Grant 2004 were Karin Bergkvist (Sweden), Alexander Molassiotis (UK), and Theresa Wiseman (UK). Following are short summaries of their research projects.

Karin Bergkvist: 'Subjective experiences of nausea and vomiting following chemotherapy'. The aim of this study was to explore patients' experiences of nausea and emesis during chemotherapy treatment. A qualitative approach using semi-structured interviews was used to assess patient's subjective experience of nausea and emesis, what is expressed during this experience and the significance of what is expressed. It is anticipated that results will provide a knowledge base for development of preventive support measures.

Alexander Molassiotis: 'The management of cancer-related fatigue (CRF) using two alternative therapies: pilot study of the effect of acupuncture and acupressure'. This study evaluated the effect of acupuncture and acupressure, both associated with the 'source of energy' in the body, on CRF. Fatigue was assessed before the intervention and after 2 weeks and 1 month. Results could provide indications of simple and cost-effective techniques to manage CRF.

Theresa Wiseman: 'Exploring the work of nurses who administer chemotherapy'. This study explored nurses' attitudes and beliefs concerning the chemotherapy administration process and what they say and do in practice. A questionnaire and an ethnographic study of 2 out-patient chemotherapy clinics were used to assess factors that facilitate and impinge upon chemotherapy administration. Data will provide a description of nurses' attitudes, feelings and beliefs regarding chemotherapy administration and how these impact on their practice.

Chair Dr Sara Faithfull,

EONS Core Curriculum for Cancer Nursing

The core curriculum for cancer nursing was initially developed in 1991 with funding from the EUs Europe against cancer programme. It was revised in 1998 through a consensus group conference and has remained the basis for accreditation over the past 4 years with over 22 accredited courses. The core curriculum provides information on the rationale for a post registration course in cancer nursing, curriculum philosophy, and curriculum framework. This encompasses entry criteria, comprehensive course content and expected student outcomes for the programme. Advice on assessment and course evaluation is provided. This has been the basis for accrediting partner institutions with an EONS accreditation over the last four years. The need for review occurs for several reasons, firstly the expanding developments within cancer care and the widening role of specialist nurse roles but secondly the need to respond to a rapidly changing educational structure within academic courses within Europe.

Cancer practice has also expanded with new discoveries and therapies making multimodality treatment the reality for the future. This complexity is reflected in the support needs of patients. Nurses play an important role in patient information, symptom management as well as psychological care. Across Europe cancer nurses work in many different capacities, however there are some fundamental skills and knowledge that are applicable in all settings and the revised core curriculum recognises those fundamental post basic skills. Furthermore in many countries cancer nurses are required to take leadership roles and develop the evidence base for intervention. The revised core curriculum adds new areas to the long programme reflecting the need for wider skills in cancer nursing.

Educational changes in academic credits reflect the Bologna agreement a long awaited harmonisation across Europe of educational levels. This agreement between countries has been about developing a common two-tier system of bachelors and masters degrees. The aim is to introduce a common credit transfer system allowing students to combine studies at different European centres to develop their professional qualifications. These changes in education are due to be in place by 2010.

The revised core curriculum is a future framework for educational development and EONS members are advised to adapt as necessary to meet their own professional needs for cancer nursing within their own country. The new core curriculum is a blue print and identifies clear competencies for practice, has learning outcomes identified for the different areas of practice and gives examples of assessment and evaluation strategies. A quality education framework is being written to complement the document to facilitate educators in implementation and evaluation of professional education. The new document will be launched in 2005 for ECCO 13.

Our colleagues from...

Israel



The Israeli Oncology Nursing Society was established in 1986 as an interest group for nurses working in oncology department in hospitals and caring for cancer patients in the community. In 1988, we were officially recognized as a professional organization.

Today, membership totals about 500 registered nurses; 65% of them are graduates of post-basic oncology nursing educational programs.

The Society's Vision

We believe that the oncology nurse is a valuable resource for the promotion of quality care provided to cancer patients and their families, in all stages of disease and in all care settings.

We believe in the development of the oncology nurse in order to reach professional excellence.

Aims and Goals of the Society

- To provide the best possible care to cancer patients during all stages of the disease in order to enhance quality of life.
- To encourage activities that will raise public awareness and knowledge about prevention and early detection of cancer.
- To update, disseminate, and contribute further to knowledge related to the development of cancer nursing.
- To develop members' sense of personal responsibility and become role models who work by the highest professional standards.
- To improve the professional status of the nurse in Israel.
- To become involved in health policy decisions related to cancer care through participation in influential committees and by developing practice guidelines.
- To continually strive to increase the number of members.

The Society's Structure

The Society is governed by a board of eleven members: the President, Treasurer and Chairpersons of the main committees (Constitution, Education, Scholarship and Publications) and five members at large. The term of office is 3 years and Board Members may be re-elected. The President and the Chairpersons of the committees are elected by the Board and the Board is elected by the membership. Every 3 years, half of the Board changes. Members pay an annual membership fee which provides the following benefits:

- Three issues per year of the official journal "Seud Oncology";
- Free registration to study days, seminars and the annual conference;
- The opportunity to apply for a scholarship every three years to attend an international conference or other educational activity.

Educational Initiatives

Improvement and enrichment of the nurses' knowledge and professional performance is an important commitment of the Society to its members. The Society has influence on the development and implementation of basic and post-basic cancer nursing educational programs. Appointed members of the Society advise the Ministry of Health on this topic.

The current post-basic program consists of 750 hours theoretical and clinical instruction. Four courses are held simultaneously each year.

Three study days, a national conference and several workshops are organized each year. Titles of study days and workshop topics have been: fatigue, geriatric oncology, nursing management of chemotherapy side effects, and advanced pain management. Most recently, 40 nurses completed six study days on ethical issues and dilemmas approached from different points of view – legal, moral and social. This seminar was monitored by experienced lawyers and participant participation was extremely active. The yearly conferences are based on topics contained in submitted abstracts accepted for presentation. The conference takes on a festive atmosphere when nurses have the opportunity to meet colleagues from all over the country, share ideas and network. Concurrent to the conference, a poster and commercial exhibition is held.

Interest Groups

The development of special interest groups was a mutual need that arose both from the membership and the Executive Board of the Society. Current Interest Groups are: Stoma Care Nurses, Community Oncology Nurses, Breast Care Nurses, Radiotherapy, Paediatric, Haematology-Oncology, and Bone Marrow Transplant. These groups meet several times a year to discuss specific aspects of their daily practice. Members learn from one another, share information from international conferences, develop practice guidelines and patient educational materials, and promote better practice in their particular work place.

A special project was designed for the nursing directors of oncology day care departments. The purpose of this project was to expand their ability to disseminate knowledge and skills and to positively influence the performance of other nurses.

The first step was to design a leadership workshop, funded by an unrestricted grant from a pharmaceutical company, conducted by an organizational consultant. The group met six times during the period of a year. The focus was to further develop leadership and managerial skills. The topics dealt with coping with conflict and antagonism, defining role boundaries, coping with stress and burnout, and other leadership skills. At the end of this process, the group decided to continue to work on evidence based symptom management guidelines. The third step was to publish the guidelines in the official journal of the Society. This group will continue to work on additional projects.

"Seud Oncology"

The official journal of the Society recently celebrated its 13th anniversary. The journal is published three times per year and its content reflects the educational, clinical and research activities of the membership. The journal is steadily growing both in content and the number of readers.

Articles published focus on all aspects of cancer nursing practice and patient bio-psycho-social problems. Selected presentations from the national yearly conference are also published.

Special issues on bone marrow transplantation, palliative care and symptom management guidelines have been published. For each special issue, a guest editor was chosen who then determined content and authors.

Associations with other Organizations

The Society is well-known and sought as a partner by different national and international organizations. We are represented in:

- The Israeli Nurses Council which is beginning to develop guidelines for the implementation of specialized nursing and other topics;
- The Israeli National Oncology Council, a multidisciplinary group, which deals with policy issues concerning the development of quality cancer care;
- The National Psychological-Oncological Society and the National Supportive Care Society serving as Board Members;
- As a Society we are active in EONS and in the International Society of Nurses in Cancer Care.

We hope that in the near future we will increase both the activities of the Society and the number of members for the benefit of cancer care in Israel.

Evaluation NOEP Pilot in the Netherlands

Introduction

The pilot project of the NOEP educational program was conducted at NUTRICIA in Zoetermeer on 30 July 2003. NOEP stands for Nutrition in Oncology Educational Program.

The author, an instructor and an oncology nurse, was asked by NUTRICIA to present this one-day educational pilot with Maaik de Jager -nutritionist at NUTRICIA.

The educational aspect of this program was appealing because it is based on a European-wide poll of continuing education needs among oncology nurses. The program is of current interest and fulfills needs of practicing oncology nurses. In general, nurses have minimal experience in dealing with the nutritional problems of their patients.

This article details some of the highlights regarding our experiences involving the preparation and realization of the pilot project with practicing European Oncology Nurses. We will keep you informed in subsequent articles about the continuation of the program, including results of the evaluation.

Preparation

To prepare for the pilot program, we used a ready-made educational pack which included a PowerPoint presentation, translated into Dutch. We examined all of the educational material and made our selection from it. It was not possible to use the pre-prepared pack in its entirety – the teaching materials provided could be spread over 2 days.

Teaching materials were selected based on the following criteria:

- Active program:

We decided to make the program interactive: workshop format was chosen where participants had an active role. We felt this would be the most efficient and effective method of learning, since the subject matter is applied through tasks. Taking in information merely by listening is less efficient, one's attention usually wanes after 20 minutes.

- Necessary skills for practice:

The skills and knowledge needed by oncology nurses was taken into consideration. Nutritional themes that were too specific or technical were not covered. We felt it was important that participants left having learned a few things well, rather than a lot of things superficially.

I made a topic selection, based on my background as an Oncology Nurse and as an Oncology Nursing Instructor at the Dutch Cancer Institute - Antoni van Leeuwenhoek Hospital, Amsterdam (NKI-AVL).¹

The program agenda was based on the following principles:

- Activity and content: Listing the items to be covered
- Timing: Give the approximate time spent on each item.
- Assignment of tasks: Who deals with which item and how
- Necessary tools: Selecting the slides and course material to be used

The presenters of the workshop were both experts in the field of nutrition and in oncology. The choice of presenters proved to be excellent for the following reasons:

- The presenters kept an eye on the overall structure of the day
- The presenters were familiar with the target group, could relate easily to clinical experiences and applications in practice, and could control group interaction
- The nutritionist had a strong background in nutrition and related matters, which allowed interactions to be educational and the addition of pertinent information possible
- For the participants, it was a welcome variation to listen to two different people during the day.

A group of six oncology nurses and a number of staff from NUTRICIA Netherlands attended this program.

Implementation

Participants had to do an at-home assignment to prepare for the program. They were required to answer a number of basic questions about nutrition. We provided each of the participants a reference work, *Nutricia Vademecum Deel 1*², along with a list of questions. Since the list of suggested reading contained only chapters in English, a number of current articles in Dutch were also provided.

During the first session, everybody was asked to write down questions they wanted answered and their expectations concerning the course. This enabled us to check afterwards if these expectations were met. It also helped us to keep the program in line with the participants' wishes. A few examples of the participants' expectations were: "I hope to be given practical tips that I can use at work," "Additional information on nutritional problems and what to do about them" and "New developments in the field of nutrition." All participants contributed examples of situations from the clinical setting where cancer patients in their ward suffered from nutritional problems and often too little was done, or done too late, to solve those problems.

The agreed lesson plan was followed. Halfway through, some small adjustments were made. Overall, the timing and the assignment of tasks went according to plan.

Presentations

Paper copies of selected slides were handed out for the participants to make notes on.

Activities

Most of the interactive activities, such as those focused on screening and pointing out nutritional problems, took place according to the pre-packaged program. One extra topic of discussion was added. This concerned the delineation of tasks of the dietician/oncology nurse and what criteria to use to call-in the dietician. This is a grey area in the clinical oncology setting. In some hospitals, for instance, it is standard procedure to call in the dietician for patients undergoing chemotherapy; in other institutions the doctor or the nurse makes nutritional decisions.

Screening was deemed by the participants to be an important task of the oncology nurse. When taking the patient's medical history, nurses are in a position to identify nutritional problems and make a care-plan to alleviate these. Participants felt that the section explaining the screening process could be shortened.

We decided to modify activities such as the assignment to develop an information brochure for family/carers. It took some time before the objective of the assignment was clear to everyone. The objective of the assignment was for subgroups to consider which factors influence nutritional problems in cancer treatments and what should be included in a patient brochure. We chose to map out nutritional problems, and factors influencing them using the PES-structure – known by most nurses. PES stands for: problem (P), etiology/causes (E) and signals/symptoms (S). A description of this assignment can be found in the actual program.

Another assignment consisting of tasting different liquid foods. The participants needed to have the opportunity to taste different liquid foods. This can help oncology nurses better advise their patient regarding food sort, texture, and taste.

For the activity on the theme of nutritional advice, we used a selection of nutritional problems from an earlier activity. Based on the confusion in terminology that emerged (nutritional support, nutritional supplementation, and nutritional advice), we chose for the unambiguous concept "nutritional support" for the final program.

The participants indicated in their evaluation that they received many practical tips that they could translate to their working situation. Participants indicated that they would have liked even more information on new nutritional developments. The last activity in the program was a discussion on the subject of feeding versus not feeding in a palliative-care situation. This topic resulted in a lot of interaction. Important arguments were made and advantages / disadvantages were highlighted for both options. In the actual program, more time should be reserved for this topic in order to elaborate on the arguments that lie beneath it.

Conclusion

To conclude, we asked the participants what they were going to do with the newly acquired knowledge and skills. "What can you do to make your colleagues more aware of the importance of nutrition?" This point should be given more attention at the end of the program or as a question at the conclusion of a presentation. The people attending the workshop were those who already had an interest in nutrition, who pay attention to it in their clinical practice. The program can be made more efficient if participants can actually do something constructive in their own workspace to win over their colleagues to think more about nutrition. The ultimate goal of the NOEP schooling program is to draw more attention to the nutrition in patients suffering from cancer. Obviously, the medical organization where the oncology nurse works plays an important role in highlighting nutrition.

Evaluation

The evaluation by the participants indicated that, in general, most of the expectations were met and that most of the learning questions listed in advance were answered. The schooling was judged especially practical and relevant to everyday practice. Examples of reactions on the evaluation forms are: "It was good to touch upon certain nutritional information," "I deal with nutrition problems or imminent nutrition problems on a daily basis...[and this course] ... gives a general review... and direction to your thoughts" and "A good diagnosis is very important, the basis from which you can make a care-plan. Screening can help you," and "I received hands-on information that I can use in my daily practice."

The participants rated the methods and the structure of the program positively. Remarks on the evaluation forms included "Very practical – it brushes up and stimulates!," "The discussions of cases with other nurses in small groups is especially helpful," "Subjects connected well to each other" and "The teachers taking turns was pleasant."

It was indicated that the NOEP presentations connected well with the level of experience in the target group. The knowledge, experience and training of the participants was diverse, which meant that some had a need for certain items that were left out while other items were given too much information. The subject of screening was given too much attention according to the pilot group, and more information should be provided on fish oil (EPA), which oncology nurses come across in their clinical practice.

Prerequisites for success are: 1) a thorough preparation for the program by participants and 2) a program that is flexible enough for the presenters to adapt to & use the experience of the participants.

It is important to include new developments regarding nutrition and cancer in the program.

Conclusions and recommendations

The NOEP educational program is a good basis for a one-day oncology nutritional workshop. The choice of content and the activities is dependent upon time, goals, and the target group.

Sufficient time must be allotted for:

- New developments regarding nutrition and cancer
- Discussion on feeding or not feeding in the palliative-care phase
- Translating nutritional knowledge to practice in the clinical setting

At the start of the workshop map out the 'learning' questions, expectations and experience of the participants. Based on this inventory, the presenters can cater the lectures to meet the needs of each group.

It is recommended that two presenters lead the program. Our presenters had expertise in both oncology nursing and dietetics. Good preparation and rapport between the two presenters is necessary.

The practical experience of the oncology nurse are key to the success of the program.

To build upon what participants are learning, connecting the NOEP educational program to follow-up courses in oncology nursing and/or extra training and continued education (CE) courses is important. In The Netherlands, the Oncology Nurses' Association (Vereniging van Oncologieverpleegkundigen - VvOV) sets quality standards for extra training and continued education courses for oncology nurses. 3 VvOV is currently evaluating NOEP so that it can be added to its CE program.

The NOEP educational program has been adapted/ improved basis on of the feedback from presenters and participants in the pilot program.

NOEP is currently working on a sequel to the pilot program in The Netherlands. The sequel will be rolled out in four different regions. Teaching teams, composed of a dietitian/nutritionist and an oncology nurse/instructor, have been formed for these sessions. By means of a train-the-trainer-session, all eight of these presenters have been trained to teach NOEP, guaranteeing a consistent, quality, program no matter where you attend it. All oncology nurses were mailed an invitation via the VvOV for these sessions. They will commence in autumn.

Personal note

I thoroughly enjoyed conducting this pilot program. The motivated participants and support of the NUTRICIA staff contributed to this. I feel that NOEP's success is largely contributed to the fact that it based it's program on needs identified by oncology nurses, as identified in a European poll. The objective of the program is to share best practices and educate healthcare professionals about how to best care for the nutritional well-being of their cancer patients – this program succeeds in doing this. I have had the opportunity to work with many talented professionals, and through this network, I look forward to fine-tuning the existing program and being involved in training more healthcare professionals about the importance of nutrition. Finally, it is my opinion that nutritional care is not given enough attention in the training provided to oncology nurses – this program is an excellent start to learning more about nutrition in oncology patients. I strongly recommend the NOEP workshop. You will have an inspiring, active day, and at the end of it, nutrition will be back at the top of your priority list.

Accreditation Update

The following courses have been approved for EONS accreditation: ProCom International, 'Learning to Increase Nursing Knowledge (LINK) program. This is a distance learning program that is part of the Skeletal Wellness Institute for Cancer website. It qualifies as a longer course and was accredited until December 2009. The web site was launched in late 2004. The target audience is physicians and health-care providers who manage cancer patients.

Soins Infirmiers en Cancérologie, Federation Nationale des centres de Lutte contre le cancer, Ecole de formation Européenne en Cancerologie (FNCLCC-EFEC), Paris. Module 2, Soins de support en oncologie, has received accreditation until January 2008 as a short course. The target audience is nurses with a minimum of 2 years experience in oncology who have completed Module 1, a course of the EFEC which also received EONS accreditation in 2003.

Meeting the challenge of metastatic bone pain – the nurse's role



Metastatic bone pain has a considerable impact on patients' quality of life, and can affect sleep quality, mobility and daily living activities.^{1,4} Therefore understandably, bone pain is the main reason that patients with metastatic bone disease seek help from their doctor or nurse. Nurses are often the key healthcare contact for observing the true impact that metastatic bone pain can have on the patient.

Cancer frequently spreads to the bone and affects up to 80% of patients with metastatic breast, prostate and lung cancer.¹ Bone pain is the most common symptom¹⁻³ and is one of the most difficult kinds of cancer pain to treat.⁴ Caused by bone weakening or destruction, the pain is usually felt as a deep aching or boring sensation² and although symptoms can be intermittent at first, the progression into continuous pain can be rapid.⁴ Since the pain is associated with movement, patients may become bedridden and immobile in an attempt to lessen the pain. Obviously, this reduced functional capacity and lack of exercise can have a significant effect on quality of life and wellbeing. Usually after disease progression of 12 or more months, patients can also suffer the sharp, excruciating pain caused by sudden pathological fractures. Significantly relieving metastatic bone pain and quickly restoring functional capacity are key therapeutic goals.

An unmet need

Currently, many patients are not achieving the pain relief they want or need^{1,4} as illustrated by a recent survey of 518 patients, in which a third of those with moderate-to-severe metastatic bone pain were found to have symptoms despite treatment.⁵

Furthermore, healthcare professionals themselves also recognize that pain management can be suboptimal. A survey by the Radiation Therapy Oncology Group found that 83% of radiologists believed that most patients were undertreated, and 40% of respondents thought that pain relief in their own practice was fair or poor.⁶ Telephone interviews of 900 clinicians in Europe and North America showed that two-thirds of their patients with bone metastases suffered metastatic bone pain, and a quarter continued to have severe or uncontrolled symptoms despite conventional treatment⁷⁻⁸ which includes bisphosphonates, opioid analgesics, non-steroidal anti-inflammatory drugs, and radiotherapy (often in combination).¹ It therefore appears that metastatic bone pain remains an important medical issue for cancer patients in industrialized countries.

Barriers to pain relief

It is not immediately obvious why metastatic bone pain is apparently poorly managed in many patients. The answers are likely to be found both in current medical practices and patient behaviour. While available treatment options can make a difference, healthcare professionals might simply be unable to provide complete palliation of bone pain in all patients. Inadequate assessment of the symptom also makes it difficult to tailor therapy to patients' needs. Patients can create their own barriers to pain relief, including a reluctance to report pain for fear of complaining or distracting from the treatment of the underlying disease, or poor compliance with pain medications due to worries about side effects. Some find it difficult to articulate the nature and frequency of their symptoms during consultations with a doctor or nurse, particularly if they are elderly.

Meeting the challenge

Perhaps the most important role for the nurse is helping patients to help themselves, by giving them the encouragement they need to discuss their symptoms. However, only careful and ongoing appraisal of the experience of metastatic bone pain will let patients achieve optimal pain relief, particularly in the advanced stages of their disease. One way of doing this is to provide

patients with a short list of questions about their pain, which they can think about before their next clinic or hospital visit.

- **'What to tell your doctor or nurse' – patient questions about bone pain**
- **Where is the pain?** Is it in a specific part of your body or does it move around?
- **How bad is it?** Rate your pain on a scale from 0 to 10, where 0 is no pain, and 10 is the worst possible pain imaginable
- **What does the pain feel like?** Is it sharp, dull or aching? Other words you might use to describe the pain include stabbing, throbbing, tender, intense, unbearable, severe, intolerable, nagging, annoying, constant, or 'comes and goes'.
- **Does anything make the pain better or worse?** Does it get worse at night or when you move, stand or walk?

Nurses or other members of the pain management team can also ask patients to record their symptoms on simple scales, such as those in the Brief Pain Inventory (BPI).⁹ Patients can use the BPI to report 'worst' and 'average' pain levels on a daily basis, and to estimate the effect of pain on their mood and their ability to walk, socialise and enjoy life. The completed scales (which can cover a period of several days or weeks) can be brought to the next consultation, to facilitate discussion on treatment choice. Tools like these, as well as advice for patients and tips for healthcare professionals managing metastatic bone pain, can be found at the following website: <http://www.bonepain.com>

Disseminating, collecting and evaluating metastatic bone pain scores is essential for optimizing relief. Patients should be encouraged to use these tools to assist in their cancer therapy.

References

1. Diel IJ, Solomayer EF, Bastert G. Treatment of metastatic bone disease in breast cancer: bisphosphonates. *Clin Breast Cancer* 2000;**1**:43-51.
2. Coleman RE. Metastatic bone disease: clinical features, pathophysiology and treatment strategies. *Cancer Treat Rev* 2001;**27**:165-176.
3. Janjan N. Bone metastases: approaches to management. *Semin Oncol* 2001;**28** (Suppl. 11):28-34.
4. Clohisey DR, Mathyh PW. Bone cancer pain. *Cancer* 2003;**97** (3 Suppl.):866-73.
5. Yau V, Chow E, Davis L, et al. Pain management in cancer patients with bone metastases remains a challenge. *J Pain Symptom Manage* 2004;**27**:1-3.
6. Cleeland CS, Janjan NA, Scott CB, et al. Cancer pain management by radiotherapists: a survey of radiation therapy oncology group physicians. *Int J Radiat Oncol Biol Phys* 2000;**47**:203-8.
7. Johnson G, Gralow J, Benson P. Use of bisphosphonates for the palliative care of metastatic bone pain: US market research results. *Ann Oncol* 2004;**15** (Suppl. 3):iii224 (Abstract 849P).
8. McPartland C, Grosjean L. Treatment of painful bone metastases in Europe and Canada: the role of bisphosphonates. *Ann Oncol* 2004;**15**(Suppl. 3):iii50(190P).
9. Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. *Ann Acad Med Singapore* 1994;**23**:129-38.

Investigating premature departure from the nursing profession in Europe – the European NEXT-Study

NEXT, a project financed by the EU, is investigating the reasons, circumstances and consequences surrounding premature departure from the nursing profession. Of particular interest is what consequence this action has for the person involved, their health care institution, and for health care in general.

The study is being conducted in Belgium, Finland, France, Germany, Great Britain, Italy, the Netherlands, Poland, Sweden and in Slovakia. More than 40 researchers in 14 institutions are active members of the NEXT Study. The study brings together interdisciplinary expertise from nurses, nursing scientists, physicians, psychologists, sociologists and statisticians.

The longitudinal study began in February 2002 and will be completed in June 2005. To start the study, a questionnaire was sent to 77,000 nurses in 10 countries; about 40,000 nurses have completed the questionnaire thus far. Nurses working in hospitals, nursing homes and home care institutions and with all levels of qualification are participants in the study.

Two problems form the basis for the study.

- 1 The impact of an ageing population on nursing. Almost all European countries are experiencing a shortage of nurses. Demographic changes within the coming 20 to 30 years might worsen the situation. The situation is further influenced by:
 - the proportion of younger people in the working-age population will decrease;
 - the proportion of older people in the working-age population will increase;
 - the number of people over 64 years will increase.

In many, but not all, European countries, nursing staff belong predominantly to the younger age groups. Middle-aged and older nurses often leave the profession, more than in other occupations. Older persons generally use more health care resources and this rate of use will increase as the population ages putting more pressure on the health care services. Who will provide the care needed in the coming decades?

- 2 Ensuring a sufficient pool of nurses. The input may be increased by increasing the availability of facilities training nurses. It is unlikely

that more young people will choose a career in nursing due to a variety of reasons including the unattractiveness of nursing in many countries. Another way to increase the number of nurses is to import them from other countries with excess numbers. Language problems have prevented this from becoming a viable option. Another way to increase the number of available nurses would be to raise the retirement age. There are, however, at present only a small number of nurses who are active until defined retirement age. The most effective way of assuring adequate numbers of nurses in the future is to promote the retention of nurses in the profession of nursing.

Why do nurses leave nursing?

The decision to leave nursing is likely to be the result of a process with numerous underlying causes: push and pull factors. Push factors circumscribe adversely perceived aspects which make people want to stop working in the way there are at present. Reasons could be conflicts at work or poor health. Pull factors are attractive incentives from outside such as the opportunity for further study or early retirement.

Analysis of the initial questionnaire results, carried out in 10 countries, revealed that although nurses seem to be satisfied with their work (85% of Norwegian nurses reported work satisfaction versus 42% in Slovakia), they often (on a weekly and monthly basis) think about leaving the profession. When asked 'why' they quit their jobs, common explanations were: dissatisfaction with pay, too much to do, high emotional demands, bad working hours, and poor image. Not surprisingly, there is an inverse relationship between higher salaries and intention to leave nursing.

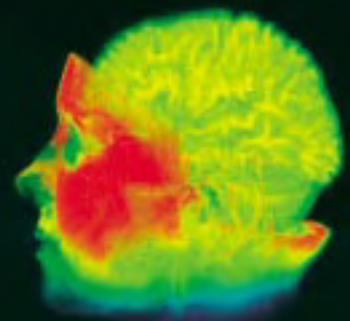
The preliminary results indicate a need to further investigate risk factors and their association with the intention to leave and reasons why nurses leave the profession prematurely. The investigators intend to bring the results of the study to the attention of health care institutions, present results at congresses, and publish the results in appropriate journals.

More information and updates on the study can be found in the Internet at www.next-study.net. Reports are available in English, German, Italian and French.

Shanne McNamara

Announcement

The **Association for Neuro-Oncology Nurses (ANON)**, part of the European Association of Neuro-Oncology (EANO) would like to announce their satellite meeting on the afternoon of Friday 6th May during the second quadrennial meeting of the World Federation of Neuro-Oncology and the sixth meeting of the European Association of Neuro-Oncology. This which will be held at the Edinburgh International Conference Centre from the 5th to 8th May 2005. Further information can be obtained from the conference website: www.eano.de/main/ or through www.feocs.be.



Skeletal Wellness Institute for Cancer



Skeletal Wellness Institute for Cancer to Promote Awareness, Identify Patients at Risk for Skeletal-Related Complications, and Provide Treatment Options to Optimize Quality of Life of Cancer Patients

Website: www.swicancer.org

Cancer and cancer treatments can adversely affect bone health, causing bone loss, bone metastases, and skeletal-related complications. This is particularly the case for patients with breast cancer, prostate cancer, multiple myeloma and other tumor types. Specifically, increasing evidence demonstrates that the administration of hormonal therapies, including aromatase inhibitors for the treatment of breast cancer, contributes to a decrease in bone mineral density with a subsequent increased risk for fracture and associated comorbidities. At present, the bone health of most cancer patients is typically not addressed until late in the course of the disease when a skeletal-related event, in the form of bone pain, bone fracture, or spinal cord compression, has already occurred.

Because skeletal complications and associated comorbidities have a significant impact on patient health and quality of life, it is critically important that healthcare professionals involved in the care of cancer patients understand that skeletal complications can be prevented, in part, by identifying patients at risk for bone loss and/or bone metastases and implementing preventive measures to reduce these risks.

The Skeletal Wellness Institute for Cancer, Maintaining Bone Health, an international web-based initiative, was developed to increase awareness of the need for skeletal wellness in cancer patients and to provide guidance on the proper stratification of patients at risk. The goal of The Institute is to adopt methods to prevent and treat bone complications in order to optimize patient quality of life and to emphasize the need for a multidisciplinary approach to the care of these patients. It will be a scientific resource for education and information related to skeletal wellness, for healthcare professionals, patients and caregivers.

CME/CE programs related to skeletal wellness in cancer patients and appropriate management of those patients, regardless of stage

of disease, will be offered to physicians and nurses through The Institute. Patient and caregiver education materials will also be available. The website is due to launch early December 2004.

Founding Members

The Skeletal Wellness Institute for Cancer, Maintaining Bone Health was founded by a group of 11 national and international leaders in oncology and skeletal-related events. The Founding Members will determine and direct all programs developed for The Institute. They will define skeletal wellness in cancer and review and endorse already established guidelines for skeletal wellness on behalf of The Institute.

Founding Members include:

Matthew R. Smith, MD, PhD, from Harvard Medical School in Boston, Massachusetts, USA;
Matti S. Aapro, MD, from the Institute, Clinique de Genolier, in Genolier, Switzerland; Karin Ahlberg, RN, PhD, from the European Oncology Nursing Society in Gothenburg, Sweden;
James R. Berenson, MD, from the Institute for Myeloma and Bone Cancer Research in West Hollywood, California, USA;
Mario Boccadoro, MD, from the University of Medicine in Torino, Italy;
Robert E. Coleman, MD, from the Cancer Research Centre, Weston Park Hospital, in Sheffield, United Kingdom;
Allan Lipton, MD, from the Milton S. Hershey Medical Center in Hershey, Pennsylvania, USA;
Carolyn Messner, DSW, BCD, from CancerCare in New York, New York, USA;
Miriam Rogers, EdD, RN, AOCN, CNS, from Cancer Services, Wake Medical, in Durham, North Carolina, USA;
Claude C. Schulman, MD, PhD, from University Clinics of Brussels, Erasme Hospital, in Brussels, Belgium;
Ellen Verschuur-van der Voort, RN, from the European Cancer Patient Coalition in Utrecht, The Netherlands.

Duties, Responsibilities and Benefits of being an EONS Board Member

Board Members are expected to:

- act from a European perspective;
- display leadership skills;
- be committed to the EONS philosophy and strategy;
- be available;
- act independently;
- demonstrate a willingness to participate in projects;
- be a critical thinker.

Duties of Board Members include:

- attendance at all board and Advisory Council meetings;
- assume responsibility for on-going development and implementation of EONS goals;
- assume leadership for projects and activities;
- represent EONS at national and European meetings;
- represent EONS at FECS meetings;
- act as a role model.

Some of the numerous benefits of serving on the Executive Board include:

- making new friendships;
- building new networks;
- experiencing personal and professional growth;
- enhancement of your curriculum vitae;
- recognition among peers and colleagues.

Candidates for the Executive Board should have experience in an area of cancer nursing. Before starting the formal application process, it is advisable that candidates seek and establish commitment from employer and colleagues. It is also essential that the candidate gain support from their national cancer nursing society and/or EONS members in her/his own country.

New EORTC Guidelines focus on Treating Anaemia

The EORTC (European Organisation for Research and Treatment of Cancer) has published guidelines to assist physicians in managing anaemia more effectively by providing advice on the appropriate use of EPO (erythropoietic proteins). Such treatment can offer relief from numerous signs and symptoms of anaemia, including debilitating fatigue, that place an added burden on the lives of cancer patients.

The evidenced-based guidelines, developed by an interdisciplinary panel of experts*, have been published in the European Journal of Cancer (1). Approximately 60% of all cancer patients are affected by anaemia and research has shown that as high as 87% develop the complication at some time throughout the course of their chemotherapy depending on the cancer type (2). EPO stimulates red blood cell production and thereby reduces anaemia-related fatigue.

Key recommendations from the new EORTC guidelines to treat anaemia effectively in cancer patients include:

- Correction of additional causes of anaemia (such as iron deficiency, bleeding, nutritional defects or haemolysis) prior to initiating EPO therapy.
- Use of EPO to manage anaemia improves quality of life and reduces the requirement for emergency blood transfusions which offer temporary symptom relief but are associated with various risks.
- Anaemia treatment with EPO should be initiated early, at a haemoglobin (HB) level of 9-11 g/dL and should be continued as long as HB levels remain \leq 12-13 g/dL and patients show symptomatic improvement.



- Dosing of EPO less frequently than three times per week is efficacious when used to treat chemotherapy-induced anaemia or to prevent cancer-related anaemia.

Commenting on the need for the guidelines, Dr Matti Aapro said, "We need to focus on managing anaemia in cancer as it has a major impact on nearly all body organ systems. Patients experience a wide range of symptoms including debilitating fatigue which negatively impacts on their quality of life. Many physicians do not realise that because we can now control pain much better, fatigue is the most important symptom that our patients with cancer want their doctors to manage."

References

1. Bokemeyer C, Aapro MS, Courdi A, Foubert J, Link H, Österborg A, Repetto L, Soubeyran P. EORTC guidelines for the use of erythropoietic proteins in anaemic patients with cancer. *Eur J Cancer*. 2004 Oct; 40(15): 2201-16.
2. Groopman JE, Itri Lm. Chemotherapy-induced anaemia in adults: incidence and treatment. *J Natl Cancer Inst*. 1990; 18:940-944.

* Contributors to the EORTC guidelines included: C. Bokemeyer, Germany, M.S. Aapro, Switzerland, A. Courdi, France, J. Foubert, Belgium, H. Link, Germany, A. Österborg, Sweden, L. Repetto, Italy and P. Soubeyran, France.

Call for proposals to advance knowledge in cancer care

EONS – ROCHE 2005 Research Grant-Announcement

The European Oncology Nursing Society (EONS) is pleased to announce the availability of 2 EONS-ROCHE Research Grants. This is possible through an unrestricted Grant from Roche. Beside the availability of those Grants we would like to mention that a part of the Grant will be used to educate nurses to conduct research and an other part of the Grant will be used to evaluate the impact of Nurse education in different markets.

Scope: Proposals should seek to address issues related to cancer care and may have an emphasis on research, practice or education.

Available funds: Two grants, each of 8000 Euro, together with an invitation to the Spring Convention in Dresden (Germany), April 2005, covering travel expenses, accommodation and conference participation (maximum of 1000 Euro).

Eligibility: The principle investigator must be actively involved in some aspects of cancer care, education or research. The Grant is being presented by the Roche Bondronat team and therefore research in the areas of metastatic bone disease (MBD) or metastatic bone pain (MPB) will be treated preferentially. Preference will be given to projects which promote nursing practice and education and that are supported by a nurse scientist. Applicants have to be a full member of the European Oncology Nursing Society.

Applications: Proposals should be submitted using the official forms. Applicants have to strictly adhere to the word limits.

Deadlines: Application submission until May 1st 2005.

Notification of outcome of review process: Applicants will be notified in writing of the outcome of the review process by 2nd week of September 2005.

Review process: Proposals will be subject to a process of blind review by a panel comprised of researchers who are members of the Advisory Council of EONS.

Communication of outcome: Successful applicants will have a chance to present their project at a special symposium at the 5th Spring Convention in Dresden.

Time scale: The project is expected to be active no later than June 1st 2005 and to be finalised by February 2006. A brief progress report would be expected after 6 months after the start of the study and a final report on its completion. It is a condition of the grant that a paper describing the project and its outcomes be submitted for consideration for publication in the *European Journal of Oncology Nursing*.

Queries about the application procedure, application forms or any aspects concerning the EONS-ROCHE Grants may be addressed to:

EONS Secretariat, Avenue E. Mounier 83/4, B-1200 Brussels
Phone: ++32 2 779 99 23, Fax: ++32 2 779 99 37
eons@village.uu.net.be

TITAN on track

Nowadays, mention the word TITAN and it is met with great excitement and interest. TITAN is EONS' major new 'Training Initiative in Thrombocytopenia, Anaemia and Neutropenia', developed with the aim of contributing to improved patient quality (and quantity) of life by focusing on the prevention, detection and management of these serious haematological toxicities. It is not the purpose here to provide another comprehensive overview for TITAN – an article appeared in the summer edition of the EONS Newsletter which achieves this. In addition, TITAN was presented at the recent EONS Advisory Council meeting, and that presentation can be accessed via the new EONS website. And, of course, some of you will have participated in the pilot testing phase of the project, giving you first hand experience of the potential benefits and value of TITAN in cancer nursing care.

It is pleasing to report that the pilot phase of TITAN really did generate a great deal of excitement and interest. From the outset of the project, it was intended that TITAN would be pilot tested in four different European countries, in conjunction with the respective national oncology nursing societies. The pilot phase is now complete, with successful courses being held in Ireland, France, The Netherlands, and the UK. Each pilot would simply not have happened without the enthusiasm and energy of those involved in organising the courses. Nor would they have been run without the high level of interest shown by those nurses wishing to attend one of the pilot courses. The previous article, in the summer edition of the EONS Newsletter, reported on the first two pilot courses, in Ireland and France, run in conjunction with the Irish Association of Nurses in Oncology (IANO) and the Association Française des Infirmier(e)s de Cancérologie (AFIC), respectively. In

The Dutch pilot course



September, a third TITAN pilot course took place in The Netherlands, organised with the support of the Dutch Oncology Nursing Society (VvOV – Vereniging van Oncologie Verpleegkundigen). This third pilot saw 32 participants attending the one-day course in Zaltbommel. As with the first two pilots, the feedback from the Dutch course was extremely positive, in terms of both the organisation of the event and the programme content itself. Some participants acknowledged the importance of the subject area and questioned whether the course should be longer.

Birmingham, in the UK, was the venue for the fourth and final TITAN pilot course, which took place in November of this year. Organised and promoted by the Royal College of Nursing (RCN) Cancer Nursing Forum, this pilot attracted 30 nurse specialists from all over the UK. Once again, the course was met with great enthusiasm – nurses eager to take the principles of TITAN back to their own settings and apply them locally. Feedback from the course was extremely positive, indicating almost without exception that TITAN is very valuable, well structured and pitched at the right level. As with the other pilots, case studies were identified as a very useful component of the programme. Likewise, the opportunity for discussion at the end of each



session, as well as with colleagues during lunch and the intervals, was an important feature of the course.

In total, 132 nurses have taken part in TITAN's pilot phase. Participant feedback suggests that this is a very robust course, meeting its objectives across the different countries and for a wide range of nurse specialists, whatever their level of experience.

Ensuring that the aims of TITAN are applied in the local setting, participants are required to complete a small dissemination project in the six months following the course itself – the project may be directed toward an aspect of patient education, or instead, may involve a learning initiative for nurse colleagues. A number of exciting and impressive dissemination projects have already been submitted by those nurses attending the first pilot course, in Ireland. By way of example, one nurse produced a credit-card sized leaflet, designed to educate patients about the risks of thrombocytopenia, anaemia and neutropenia. Another group of nurses decided to develop a poster for Accident & Emergency colleagues, outlining the admission criteria for patients with febrile neutropenia. This group also went on to develop a 'Neutropenic nursing guide' for non-specialist nurses involved in the management of febrile neutropenic patients. These examples are representative of the overall level of commitment being made by those nurses who attended the pilot in Ireland, which in turn, is reflective of the interest and importance being placed in TITAN.

Those societies taking part in the pilot have also demonstrated their continued commitment and interest in TITAN, and are starting to plan for further courses in their countries once TITAN becomes fully available next year. In addition, as more national societies become aware of TITAN, they too are beginning to explore how and when they can implement TITAN nationally. Judging by the interest already being shown, implementing TITAN at the local level will be widespread and fairly rapid – EONS has received a number of expressions of interest from national societies to-date.

With the pilot testing phase now complete, the TITAN Working Group is actively incorporating final changes into the programme, following a review of the feedback from those participating in the pilot courses. The good news to report is that only minor changes have been necessary and therefore, TITAN remains on track for Europe-wide implementation during 2005.

For those representatives of national societies wishing to implement TITAN in their own countries, be sure to register your interest with EONS. A full set of materials and guidelines will be made available to you early in 2005, which you can use to plan and run your own TITAN courses. In addition, a dedicated TITAN website, accessed via the EONS website, is being developed and this will have additional information and programme updates posted on it – all



Case study discussion at the UK pilot

national society representatives involved in organising TITAN should regularly visit the TITAN website to gain access to the latest information and programme updates. Alternatively, if you are interested in participating in a TITAN course, then look out for further announcements about TITAN course dates and venues in your own country. The TITAN website will list details of those national societies involved in organising and running TITAN courses.

The coming year is going to be a busy one for TITAN. There will be a great deal of progress to report as TITAN is implemented at the national level. All news will be published on the TITAN website and will be the subject of future updates in the EONS Newsletter. Be sure to follow the success of this important education initiative as it rolls out across Europe.

*Irish dissemination project –
patient education leaflet*



Cancer advocacy groups and Roche unite to create a new platform of expression for people with cancer

First “Images of Hope©” International Photography Award Presentation

Vienna, Austria 31 October 2004 – Images of Hope, a new international amateur photography award for people with cancer and their carers, was presented yesterday evening during the European Society of Medical Oncology (ESMO) Congress. Hülya Karamercan, a breast cancer survivor from Turkey, was honoured as the inaugural award winner for her photograph titled ‘Nothing is Impossible’ which features the captivating image of a delicate flower breaking through a crack in a barren rock. Hülya Karamercan described her feelings behind the image: “If a flower can continue to “be”, even if it has to sprout through the crack of a naked rock, I thought I could succeed in doing the same by not losing my strong urge and will power to live under any circumstances whatsoever, because I was that very flower!”

The sponsors* of Images of Hope, in partnership with Roche, have established the photography award in order to provide patients and carers with an outlet to share their feelings of hope in a medium that transcends language and nationality. ESMO is presenting this award because photography is a powerful way to communicate individual experiences and illustrate how hope can play a role in successful recovery. These images and this award send a positive message to people around the world affected by cancer.

The Images of Hope award is the first time that professional and cancer patient groups have united on a global scale to sponsor a photography award to inspire hope for patients with cancer. Anyone diagnosed with, or affected by, cancer was encouraged to submit their photographic ‘images of hope’. Judges reviewing these images have all been affected by cancer, either as a survivor, support group representative or carer. The photographs were judged on combined criteria of image, title and description of how hope is revealed.

“Roche is proud to support this initiative,” said Stefan Manth, Business Director Oncology at Roche, “Images of Hope lets us view the world through the eyes of those who have suffered, and shows us how hope can help one to overcome a serious condition.”

Other selected images are also currently on display at the European Society for Medical Oncology (ESMO) Congress to an audience of the world’s leading oncologists.



For more information, please contact:

Gretchen Fricko
International Communications Manager
Roche Pharmaceuticals
Tel: +41 (0) 61 688 8576
gretchen.fricko@roche.com
Or visit: www.cancerworld.com

Notes to editors:

*Images of Hope photography award is sponsored by:

- The European Society of Medical Oncology (ESMO)
- Cancerworld.org
- The European Oncology Nursing Society (EONS)
- The International Society of Geriatric Oncology (SIOG)
- The Multinational Association of Supportive Care in Cancer (MASCC)
- The award is endorsed by:
- Young Survival Coalition (YSC)

Images of Hope is promoted in collaboration with Roche Oncology.

Sharing views and opinions – the results of a 2004 international survey

The opportunity for nurses to share their thoughts on areas of potential concern for treating patients with cancer was provided at three international meetings in 2004 – the European Oncology Nursing Society (EONS), the Multinational Association of Supportive Care in Cancer (MASCC) and the International Society of Nurses in Cancer Care (ISNCC). Delegates were asked to complete a survey questionnaire of 15 questions to gather their views on issues such as common side-effects of chemotherapy, comorbidity, polypharmacy and bone pain in oncology treatment, in addition to factors relating to oral chemotherapy for breast and colorectal cancer treatment. A total of 268 questionnaires were completed across all the meetings, with the majority of respondents being oncology nurses from teaching or urban hospitals from around the world.

Patient concerns

Those surveyed were asked to give their opinion of patients' top three concerns with chemotherapy. The number one concern was overwhelmingly reported to be nausea. Fatigue/tiredness and vomiting were considered to be the second and third concerns and were found to be of similar relative importance. Interestingly, the relative importance rating index of nausea was almost double that of fatigue and vomiting (100 vs 57 and 53, respectively), giving an indication of the strength of concern about this treatment effect. Alopecia was also indicated as a key concern by many responders, highlighting the importance of choosing, whenever possible, a chemotherapy regimen that does not cause hair loss. Providing patients with the optimum supportive care is as important now as ever, with a particular focus needed on effective antiemetic therapy to protect patients from nausea and vomiting.

Comorbidity and polypharmacy

When asked to indicate what proportion of their patients suffer particular comorbid conditions, respondents indicated that approximately four of every ten (42%) of their patients also suffer psychological problems, and over one-third (34%) have digestive problems (Table 1).

Comorbidity	% patients
Psychological problems	42
Digestive problems	34
Respiratory disease	21
CV disease	16
Genitourinary disorder	10

Table 1. Estimated proportion of patients suffering comorbid conditions. CV, cardiovascular.

Bearing in mind the common occurrence of comorbid conditions among patients with cancer, it is perhaps unsurprising that patients were reported to receive an average of four concomitant prescription or over-the-counter medications (Table 2).

Number of concomitant medications	% patients
0-1	23
2-3	31
4-5	25
6-8	12
8+	9

Table 2. Estimated proportion of patients receiving multiple concomitant prescription/over-the-counter medications.

This figure excludes chemotherapy drugs. Considering the additional number of drugs involved in the treatment of cancer and supportive care, the potential for drug-drug interactions is clearly high and should be a key treatment consideration. It has been estimated that patients with cancer may commonly be receiving at least 6 medications (e.g. 2 chemotherapy agents, 2 antiemetics, 2 other supportive care products, for example for fatigue and pain), and that this number of concomitant drugs has been shown to be associated with a high risk of drug interactions (Table 3).¹

Number of drugs	Incidence of interactions (%)
2	5.6
3	15.8
4	34.3
5	46.7
6	72.0
7	66.0
8	100.0

Table 3. Incidence of drug-drug interactions related to number of concomitant medications.¹

Interestingly, almost half of the survey respondents indicated that they ask patients for details of concomitant medications at the start of therapy only (44%), with about one-third of respondents questioning patients at every visit (35%). Given the potential for drug-drug interactions, it may be prudent to question patients about their other medications on a regular basis, and seek to use medications with the lowest risk for drug interactions, in order to avoid possible complications, loss of efficacy or increased adverse events.

Treatment of bone metastases

The survey included questions relating to treatment of metastatic bone disease to assess the extent of bone pain, and treatment goals and concerns. For patients receiving treatment for bone metastases, overall, nurses indicate that 89% of their patients report some level of pain (Figure 1). Of these, an estimated 36% report severe pain, 38% moderate, and 26% mild pain. Despite available treatment options, pain continues to be a significant problem.

Treatment goal	Average rating
Control metastatic bone pain	9.46
Improve QoL	9.33
Restore mobility	8.77
Prevent pathological fracture	8.63
Prevent organ damage	7.95
Use oral medication to limit need for hospital visits	7.70

Table 4. Average importance rating of treatment goals for bone metastases (on a 1-10 scale). QoL, quality of life.

Survey respondents were asked to rate the importance of particular treatment goals for bone metastases on a scale of 1-10 (1 = not important, 10 = extremely important). 'Control of metastatic bone pain' and 'improve quality of life' were rated clearly as the most important goals (average scores of 9.46 and 9.33, respectively; Table 4), though all of the goals listed were rated at the upper end of the scale (above 7). Nurses clearly recognise the importance of controlling bone pain and this treatment goal appears to be directly linked with improving patients' quality of life.

Bisphosphonates have been shown to be effective in reducing bone pain and the occurrence of skeletal-related events. For example, a recent phase III clinical trial of patients with bone lesions from breast cancer demonstrated sustained relief over 2 years with ibandronate vs placebo.² However, some i.v. bisphosphonates have been associated with renal function deterioration requiring serum creatinine monitoring. Those completing the survey were asked how often in practice they perform renal function monitoring. Two-thirds reported that they conduct tests prior to bisphosphonate administration, while about one-fifth conduct tests every 3 or 6 months (Table 5).

Time of monitoring	% patients
Prior to bisphosphonate therapy	65
Every 3 months	15
Every 6 months	6
Every 12 months or less often	3
Only if patients have symptoms	4
Only at start of therapy	7

Table 5. Estimated proportion of bisphosphonate-treated patients undergoing renal function monitoring at different times.

Some bisphosphonates require regular monitoring of renal function prior to each dose to ensure patients' safety. However, trials with ibandronate show that renal adverse events are low and comparable with placebo. The need for renal function monitoring is therefore reduced with this agent and is at the physicians' discretion.

Benefits of oral chemotherapy in advanced breast and colorectal cancer

Survey participants considered some aspects of oral chemotherapy administration in patients with advanced breast or colorectal cancer. Studies looking at patient preferences and quality of life implications of oral vs i.v. chemotherapy have indicated a strong patient preference for oral treatment.^{3,4} Cited benefits of oral administration include convenience, avoiding problems with i.v. lines, and being able to administer treatment at home. Despite this, the survey results found that on average, survey respondents see three times as many patients receiving i.v. chemotherapy (mean = 173) as those receiving oral chemotherapy (mean = 62) per month. However, there was wide variation in responses.

The 2004 international survey posed questions to determine nurses' views on the benefits of oral chemotherapy and associated patient education, an essential element of outpatient management. Nurses were asked to rank four potential benefits of oral chemotherapy on a 4-point scale with 1 being least important and 4 being most important. Those who completed the survey indicated that 'greater freedom and control of their lives' is the most beneficial aspect of oral chemotherapy for their patients, with 'more time to spend with family/friends' being a close second (Figure 2). Therefore, for patients with advanced breast or colorectal disease, an oral therapy such as capecitabine is an attractive option. In addition to being highly effective,⁵ it offers greater freedom and convenience and causes less psychological stress than conventional intravenous regimens.⁶

It is important for patients to have a good understanding of their oral chemotherapy in terms of dose, what to do if they experience adverse events and general compliance issues. It is therefore important for the oncology team to spend time discussing treatment with their patients. From the survey results, it seems that there is wide variation in the length of time nurses spend with patients educating them about oral chemotherapy and its possible side-effects. However, over half (55%) of nurses reported that they spend up to 30 minutes educating patients, with just under one-third of this number spending less than 15 minutes (Table 6).

Option	Response (%)
I do not see chemotherapy patients (seen by the doctor)	16
Less than 15 minutes	17
16-30 minutes	38
31-45 minutes	16
More than 45 minutes	13

Table 6. Amount of time spent educating patients about oral chemotherapy and possible side-effects.

Knowing the workload pressures and time constraints faced by oncology nurses, the question of ideally how long they would like to spend educating patients was posed. On average, 42% of survey respondents stated they would like to spend 15-30 minutes while 46% would choose to spend 30 minutes or more discussing oral chemotherapy with their patients. The amount of time needed will of course vary from one patient to another, but it is important to ensure sufficient time is set aside to explain and check patients' understanding of their oral chemotherapy.

Summary

To conclude, the fundamental importance of supportive care and treatment to patients with cancer is clearly recognised by oncology nurses as reflected by the results of the survey. Survey respondents indicated that nausea is patients' biggest concern by far with chemotherapy, and controlling bone pain is the most important treatment goal for bone metastases. Optimizing treatment for these symptoms is essential to maintain patients' quality of life. Furthermore, the survey results also suggest that nurses recognise the potential quality of life benefits of oral chemotherapy, though currently i.v. chemotherapy seems to be three times more common than oral. Perhaps we will see a shift towards increased use of oral therapy in the future, with further emphasis on patient education and evaluation tools that lead to better relief of symptomatic adverse events and pain.

References

1. Karas S Jr. The potential for drug interactions. *Ann Emerg Med* 1981; **10**: 627-30.
2. Tripathy D *et al.* Alleviation of bone pain with oral and intravenous ibandronate in women with metastatic breast cancer. *Eur J Cancer* 2003; **1** (suppl 5): S136.
3. Liu G *et al.* Patient preferences for oral vs intravenous palliative chemotherapy. *J Clin Oncol* 1997; **15**: 110-15.
4. Borner MM *et al.* Patient preference and pharmacokinetics of oral modulated UFT versus intravenous fluorouracil and leucovorin: a randomised crossover trial in advanced colorectal cancer. *Eur J Cancer* 2002; **38**: 349-58.
5. Cassidy J *et al.* XELOX (capecitabine plus oxaliplatin): active first-line therapy for patients with metastatic colorectal cancer. *J Clin Oncol* 2004; **22**: 2084-91.
6. Payne SA. A study of quality of life in cancer patients receiving palliative chemotherapy. *Soc Sci Med* 1992; **35**: 1505-9.

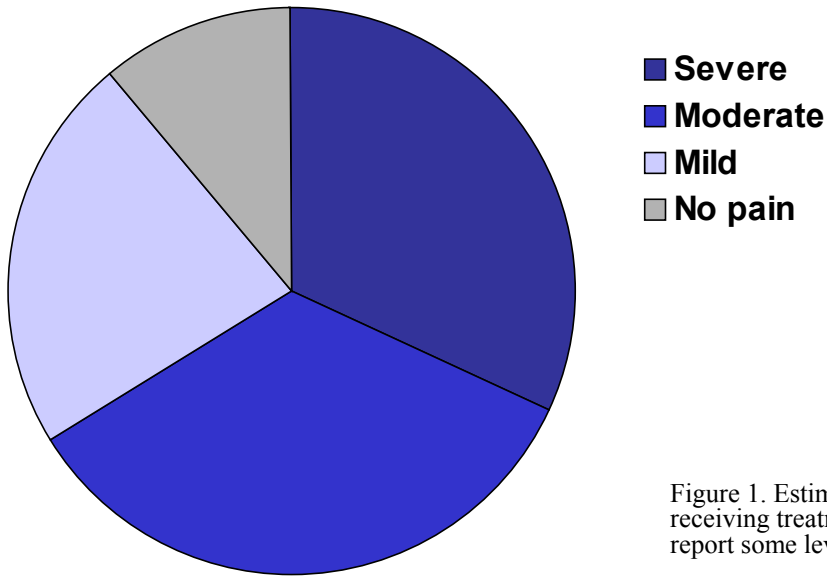


Figure 1. Estimated proportion of patients receiving treatment for bone metastases who report some level of pain.

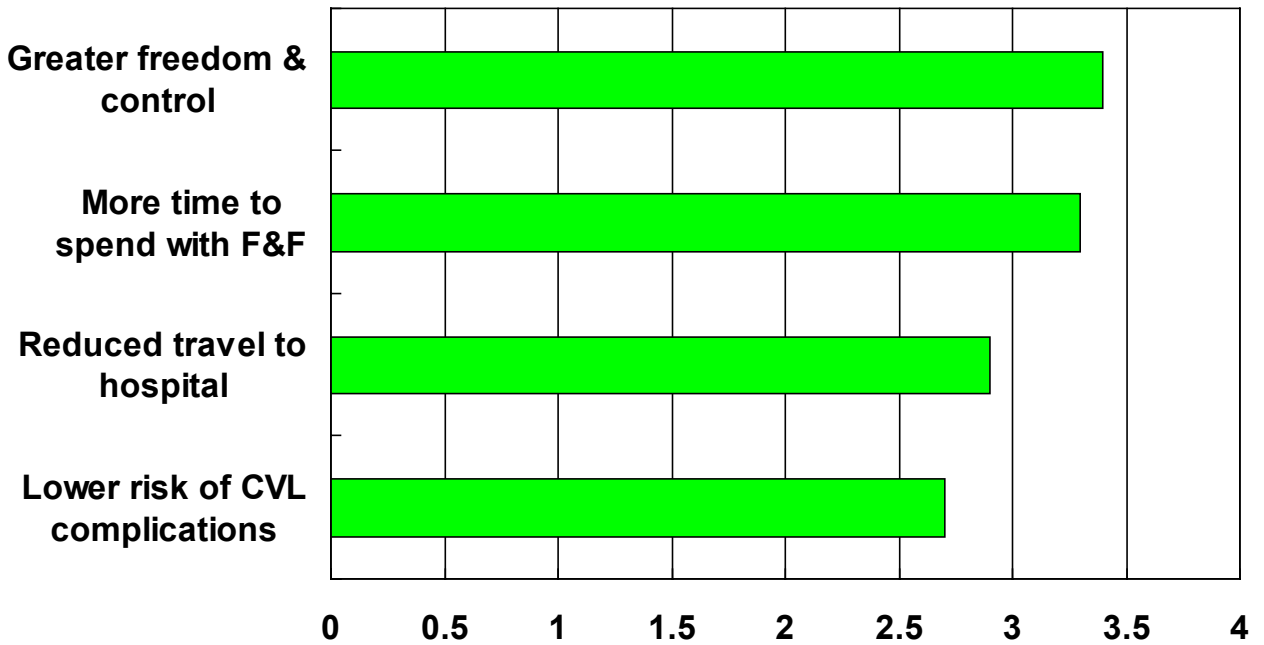


Figure 2. Survey respondents' opinions of the most beneficial aspect of oral chemotherapy for patients, ranked on a 4-point scale (4=most important). CVL, central venous line; F&F, family and friends.

Erratum

In the winter issue of the EONS newsletter there is an error in the Amgen advertisement on the back page for Aranesp (darbepoetin alfa). Today Aranesp is approved for once-every-3-week (Q3W) dosing.

You can find a dosing card with the correct information including references by clicking [here](#). You can also find the correct information in the next issue of the EONS Newsletter.

We apologise for any inconvenience that the erroneous dosing information may have caused. If you have any questions, please contact the EONS secretariat at eons.secretariat@cancernurse.eu or your Amgen representative.