President Sultan Kav speaks out
Interview by: Jim Boumelha

Screening: PSA test is not the answer
by: Mark R. Haythorn and Richard J. Ablin

Surviving Cancer, Living Life:
a nurse-led telephone service
by: Jannike Nordlund and Jan Hanson
The Big C in Prostate Cancer: Controversy

This issue of the EONS Newsletter focuses on prostate cancer – a cancer marked by being the most commonly diagnosed in many countries, but also one of the most controversial. This debate continues, despite recent large-scale clinical trials that have failed to provide clear evidence of whether men should be offered routine screening, and if they are, what should this entail, how often should it happen and for what degree of benefit?

Haythorn and Ablin make the point in this newsletter that PSA, a method commonly used to screen men for prostate cancer, is too imprecise for this purpose. It may best be saved for situations where high levels are detected indicating aggressive disease, or for detecting disease recurrence or progression.

Fifteen years ago when I started out on my doctorate research on prostate cancer, I was told that PSA study, described in this issue by Jane Cockle-Hearne, was of little value. Men were more aware about prostate cancer – particularly those who have been diagnosed and have faced the realities of treatment. In my own country, the United Kingdom, prostate cancer is now a problem that is growing exponentially and is likely to continue to evoke controversy over when, whether and how it should be treated.

Recently, two large-scale screening studies have been published, intending to offer some direction – the Prostate, Lung, Colorectal and Ovarian (PLCO) trial from the United States and the European Randomized Study of Screening for Prostate Cancer (ERSPC) trial. However, they failed to offer definitive evidence. The controversy surrounding prostate cancer may mask the need for greater awareness about the impact of this disease and its treatment. If men are told they should be screened regularly by one group of professionals, only to be told by others, “No, it’s best to wait for symptoms”, whom should they believe? This is certainly not helpful to men who are being encouraged to be more aware of their risk.

Across Europe, there is also huge variation in support for greater awareness about the impact of this disease and its treatment. If men are told they should be screened regularly by one group of professionals, only to be told by others, “No, it’s best to wait for symptoms”, whom should they believe? This is certainly not helpful to men who are being encouraged to be more aware of their risk.

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A Message from the Board

We are pleased to welcome two new Board members, Mary Wells and Dimitrios Papageorgiou, who have joined us since the annual General Meeting in Berlin last September. But now members also means that we had to bid farewell to departing Board members Yvonine Wengström from Sweden and Rolf Bäumer from Germany. Although they will be missed, we expect to continue collaborating with them.

During the autumn, the EONS Board took a key role in the EONS nursing programme at the ECCO15-ESMO congress in Berlin. It was easy to get lost in such a vast venue but in the end, it was a massive success, with 784 nurses in attendance. We would like to thank everyone who participated as a speaker, session chair or delegate, as well as the KIK and all members of the scientific committee who delivered a truly exceptional programme. As we left Berlin, the planning for ECCO16-ESMO16, taking place in Sweden in 2011, is already in full swing with the appointment of a Scientific Nursing Committee. The Swedish Oncology Nursing Society has agreed to join us in this work.

At the Berlin congress, we launched two specialist training curricula: the “lung cancer curriculum” and the “breast cancer curriculum”. If you want a copy, please ask the EONS secretariat.

For other updates on our projects, please visit our redesigned website http://www.cancernurse.eu/. By the way, what do you think of the new look newsletter? We decided to continue publishing it four times a year, but only in hard copy to coincide with EONS conferences. We always welcome your views and suggestions.

Finally, the Board wants to remind you of the 2010 EONS Spring Convention that will be held on 15-16 April 2010 in The Hague, The Netherlands, on the theme ‘Advancing Cancer Nursing’. We hope to see you there.

Unika Öfkund, EONS Board Secretary

EONS General Meeting: From Strength to Strength

EONS held its General Meeting during the ECCO-ESMO congress in Berlin. It started with changes to the Board – welcoming new members Mary Wells, Senior Lecturer at Dundee University in Scotland and Dimitrios Papageorgiou, Head Nurse of the Oncology Department at Eυνελίκη Αθήνας, Greece, and bidding farewell to Yvonine Wengström who completed her term as Past-President and Rolf Bäumer, former Treasurer. The meeting thanked them for their excellent contribution.

The EONS Excellence in Education Award was awarded to Corien Eeltink who teamed up with Daniel Kelly over the presidency of EONS from Sara Faithfull. The meeting also dealt with proposals for changes to the EONS constitution and bylaws to allow a limited degree of flexibility to the elected Board during the process of appointing future President-elects. The amendment, adopted by the EONS legal team, was carried by a large majority – 47 votes for the change, 6 against, and 1 abstention. Further clarifications to the constitution and bylaws are likely to be submitted to the Board for approval at the next General Meeting in Spring 2010.

Daniel Kelly moved the financial report, stressing the need for prudent management. The two sides also agreed to organise a joint clinical leadership workshop at the next EONS spring convention in 2010 in the Netherlands.

Nurses – A Leading and Dynamic Force in Urology

For a team from EONS, visiting the congress of the US Oncology Nursing Society (ONS) from April 30th to May 3rd in San Antonio, met with its leaders to form a formal agreement setting up closer links. EONS President Sultan Kay and Past-President Sara Faithfull joined their American counterparts, ONS President Brenda Neviljon (top left) and CEO Paula Trahan Reiger (bottom left), to sign the memorandum. Among joint initiatives will be the translation of EONS “Putting Evidence into Practice” (PEP) for European nurses, an outstanding compilation of evidence based reviews to assist in making local policies, improving standards, education and training and identifying nursing outcomes in 12 key areas of nursing activity and symptom management. The two sides also agreed to organise a joint clinical leadership workshop at the next EONS spring convention in 2010 in the Netherlands.

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Multidisciplinary Congress Strengthens Oncopolicy

More than 15,000 participants, including 800 nurses, packed the International Congress Centrum in Berlin to take part in the first congress since the European Cancer Organisation and the European Society for Medical Oncology joined forces. The Scientific Programme, incorporating a record number of 26 different tracks devised by over 100 leading experts, gave a distinct track to EONS oncology nurses incorporating 103 nursing abstracts – 75 posters and 28 oral presentations.

The variety of topics presented was outstanding, bursting with new ideas for future directions aimed at improving cancer across Europe and with a wide range of data from early clinical trials to multicentre Phase III trials. At the EONS session, Distinguished Merit Award recipient Jan Foubert presented his honorary lecture “From baby to granny: why do we consider older persons living with cancer different?” and pointed out the inadequacies in care and treatment, limited research and lack of awareness of the needs of this patient group. A randomised controlled trial of a symptom-oriented home care nursing programme for patients receiving oral chemotherapy, presented by Alex Molasiosis, concluded that home care programme was able to assist patients managing toxicities and support. This session ended with a presentation on reimbursement opportunities and on the shortcomings of supportive care and nursing role in the German health system.

‘SPIRIT’ OF THE NURSING TRACK

Three sessions in the nursing track attracted a keen audience despite the early start. Emma Room, UK, established the ‘spirit’ of the nursing track by emphasising patient-controlled care. Emma Room, UK, and Christine M haskowitz, USA, presented a joint session on ‘linking symptom science to practice’ using case studies to demonstrate the complexity of symptom clusters. Finally, in a session on ‘Using evidence-based cancer nursing practice’, Michael Traynor, UK and Meirin Krishnamury, Australia, talked about factors for successful evidence implementation, mainly from the managers’ perspective, emphasising the importance of organisational change.

CANCER NURSING ROLES

A teaching lecture on “The value of quality indicators for cancer services”, by Ulrich Wagner, provided an interesting meta-perspective on the evolution of quality indicators in general and how they apply in nursing practice. The scientific symposium was equally well-structured allowing a lively discussion on the gap between the UK, Canada and the rest of the world, following a presentation on “Tvergemo within cancer nursing roles,” where Miranda L aunait, Diane Doran, Catriona Kennedy and Paul T revatt each offered interesting perspectives on cancer nursing roles – in particular the potential for community nursing and the challenges of workforce planning. Oral chemotherapy was one of the scores of topical issues discussed at the congress.

Burty Quinn, UK, described a successful collaborative project between acute hospital and community settings regarding care of patients with oral chemotherapy, following a national safety alert in 2008, which highlighted the risks involved with oral chemotherapy.

EXPERIENCE OF CARE

Among the preferred papers, “Experience of care” turned out to be an exceptionally well-balanced mix of talks from childhood, disadvantaged groups and elderly patients, ending with a discussion about euthanasia. The session was opened by Susie Pearce, who discussed a study “The experiences of young people from first symptoms to the diagnosis of cancer”, highlighting the difficulties in prompt diagnosis, referral and treatment of cancer in young people.

Nuka Hove presented an educational network-focused nursing”. One of the most important innovations of this congress was the involvement, for the first time, of patient groups and clinicians, not only to tell their stories, but as speakers in seminars and debates, as well as organisers and chairpersons. This gave a new perspective and showed that EONS is taking a great step towards viewing patients as partners in cancer care.
Dear Colleagues,

On behalf of European Oncology Nursing Society (EONS) in partnership with V&VN - the Dutch Oncology Nursing Society, we cordially invite you to the 7th biennial EONS Spring Convention that will be held in The Hague, The Netherlands, 15-16 April 2010. The general theme for the 2010 Spring Convention is ‘Advancing Cancer Nursing’. The conference format is specifically designed to meet the needs of nurses working in the field of cancer care, education and research. This is the ideal connective platform to exchange and debate the very latest in patient treatment and care as well as novel approaches to managing cancer care in a rapidly changing health care environment.

Incorporating all the essential elements common to past Spring Convention programmes – striking an essential balance of instructional methods, plenary lectures and selected proffered papers, we also hope to heighten quality, attendance and exposure through the addition of yet more educational and interactive sessions as well as varied clinical update symposia.

A first class panel of speakers presenting on the very latest trends and developments within the field, will tackle a broad range of timely topics including EU policy across the borders, the value of cancer clinical nurse specialists, survivorship and late effects, neurological complications, symptom science, rehabilitation, ethical issues in cancer care, psychosocial issues, leadership, updates surrounding breast, lung, prostate, and GI cancers, as well as cutting edge developments in targeted therapy, radiotherapy and genetics.

The intensive two-day programme incorporating discussion forums, workshops and an exclusive opportunity to visit the only dedicated cancer centre in The Netherlands combining treatment and research will guarantee an essential educational and interactive approach throughout the convention.

Simultaneous translation will also be especially arranged for National nursing organisations and societies that can guarantee an attendance of at least 75 nurses from their respective memberships. We are looking forward to welcoming you all to the Netherlands in April 2010 for what promises to be our most exciting and innovative convention yet!

Sultan Kav
Organising Committee Chair

To view the Advance Programme, register early before 29 January 2010 and bookmark the Abstract Submission pages visit: www.ecco-org.eu (select ‘Congresses and conferences’ > EONS 7).

Should you require any additional information please do not hesitate in contacting the EONS 7 Secretariat directly: Tel: +32 2 775 02 01, Email: EONS7@ecco-org.eu.
President Sultan Kav speaks out

Internationalism can offer a litmus test to gauge how effectively a professional society represents all its members. Cultural and language barriers can be hard to bridge, but EONS President-elect, Dr Sultan Kav, is determined to do it. Taking over at the Berlin Annual General Meeting, she came armed with years of experience and is poised to give the organisation a new impetus.

Jim Boumelha asks her about her plans and ambitions.

Being in the driving seat at EONS is a lengthy affair. You will have been a Board member for two years, President-elect for another two years, then you take on the Presidency for a further two years, after which you become Past President. Eight years in total. But Sultan remains unfazed. Having started her nursing career after graduating nursing high school, she was appointed to work in oncology in a patients’ unit at one of the biggest university hospitals in Turkey. At that time she was also studying in nursing college for a BSN degree.

“I had very limited knowledge and skills about oncology and learned in a hands-on practice, supplemented with further education. I worked nights or in evening shifts while studying during the day”, she reminisced.

It was hard, it was demanding and in the end it was frustrating, says Kav. But she stuck with it, showing grit, determination and compassion. Remembering with a tinge of nostalgia her first days, she recalled that, “It was a huge unit with 36-bed capacity and we had a very mixed patient population. We had bone marrow transplant patients, radiation oncology patients, all kinds of haematology/oncology patients, as well as patients with other diseases such as renal and liver failure. I was 19 years old and it was very hard for me to handle these kinds of patients. I really felt I needed someone to help me to get the necessary knowledge and skills. But I stayed in that area, and I aimed to be an oncology nurse educator to pass on my knowledge to the new graduates and those who started to work in this area.”

Dedicating her life to cancer patients

Few of the young nurses working alongside her stayed. Sultan remains unfazed. Having started her nursing career after graduating nursing high school, she was appointed to work in oncology in a patients’ unit at one of the biggest university hospitals in Turkey. At that time she was also studying in nursing college for a BSN degree.

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Few of the young nurses working alongside her stayed in oncology. “People stayed only a couple of months then moved to other places. It was considered like a school to learn from, then they went to another place,” she recalls. There were times when she was tempted to do the same. “Almost every day I was faced with losing a patient, and at that time I felt we were not helping the patients and their families. We were just helping them to pass away quicker than they were supposed to. But that feeling and that experience with patients made me stay, because they really needed well-educated people and people who knew what they were doing,” she said.

Having decided to dedicate her life to nursing cancer patients, Kav joined the National Oncology Nursing Association in 1995, which gave new impetus to her career. She was elected to the post of General Secretary, and this is when she stumbled upon EONS. “I was in email correspondence with Rudi Brise, from the EONS secretariat, not knowing for a long time whether it was a lie or a she,” she laughs. But she was very serious in attending EONS educational programmes, which she found helped her considerably in her career. Her first course, which she attended in 1996, explored learning to live with cancer. “This was my first international experience,” she recalls with warmth. “I felt that I was in the right place with the right people”.

Building a stronger voice in Brussels

A few years later she was firmly implanted at the heart of various societies – joining the Board of the International Society for Nurses in Cancer Care in 2000, then the Multinational Association of Supportive Care in Cancer, and then the Board of EONS “My career developed through my involvement in the professional organisations, both through the national organisations and most importantly EONS.” Such a long and serious apprenticeship may have just been the ticket to prepare her for leadership role, but she does not take her new post for granted. “Personally it’s really a big honour and also a big responsibility and I feel privileged to be awarded this task.”

Having herself been a keen practitioner for nearly two decades, Sultan has a strong sense of what nurses wish to get out of EONS. “I think they want support for what they are doing at all levels, training, networking, attending conferences, and support for their research and dissemination of their projects. There are many EONS activities such as the Spring convention, educational conferences and curricula that can get involved in.”

Above all, she can’t wait to get stuck in on the main priorities that EONS has already mapped out. Building a stronger voice in Brussels remains the cornerstone to any attempt to influence EU policy. This can be achieved much quicker if EONS can strengthen its profile and improve its partnership with other European professional cancer organisations. “We should advertise what we are doing. We should be lobbying and partnering with other organisations and doing more projects together.”

Implementing and disseminating EONS curricula such as the older persons with cancer, breast cancer and lung cancer curricula and keeping them updated, will be crucial in promoting convergence between the organisations of cancer nurses across Europe. Bearing in mind that EONS covers countries with so many different levels and concepts of cancer nursing, she sees cultural differences and language barriers as limitations but not real obstacles. Equally important are economic barriers – the current economic crisis, for instance, is making it harder for nurses to obtain funding to travel and attend courses. But she also sees a strength in diversity, which brings many different perspectives to a shared experience. “We share common issues and problems for cancer. Nurses and patients are natural allies.”

Sultan is confident that the current EONS leadership is well equipped to bridge any gaps that may arise. She is keen, however, to push through a programme of modernisation that will make the organisation more effective. And she is determined to keep her eye on the ball – staying focused on members’ best interests, helping nurses to improve the patient experience and serve the common good, and mentoring new people so they can work with and for EONS.

If there was one thing she could change during her time in the Presidency? “I would like to make nurses believe in themselves, believe in what they are doing now and what they can do in the future.”
The Plight of the Cowgirl
A reflection on healthcare inequality

I have always taken health care for granted, especially working within a government single payer, the UK National Health Service. We talk about health inequalities in terms of access for minority or vulnerable groups for example, however, I had never appreciated what it means not to have health care. Visiting the congress of American Oncology Nurses was an eye opener on how different systems are funded and their impact on cancer care provision. Cancer care in the USA is characterised on the one hand by generous spending on biochemical and clinical research, with “cutting edge” treatments for some patients, and on the other, large inequalities, rising costs and inadequate quality. From 1999 to 2008, average health insurance premiums and individual contributions for family coverage have increased by approximately 120%. Healthcare spending, both public and private, is increasing, the American system costs more per head than anywhere in the world and is increasing faster than inflation. This may be due to over treatment, high cost of therapies and a litigation culture. In Europe we are also facing rising costs in health care, including the cost of providing expensive cancer drugs. This has forced some countries to review the cost-effectiveness of new medications. However, we provide health care in a variety of ways through social systems as well as through insurance. Discussion of health care reform is in many political debates at EU level, but do we have such inequalities? Most probably not. However, perhaps we assume too much about the benefits of our own systems and need to reflect on those who face inequalities. Oncology nurses in the US face difficult times ahead and it made me realise that nurses in Europe will also be facing reform in the future. As economic pressures, increased ageing and workforce shortages grow, this will increasingly influence health service provision and we should be prepared for changes ahead.

Luca Incrocci
Sexual Healer Willing to Listen

An active member of the International Society for Sexual Medicine (ISSM), Luca Incrocci has worked closely with psychologists, sexual therapists and nurses to develop interventions for men suffering sexual problems following radiotherapy. In this interview he talked to EONS past-president Sara Faithfull about his involvement in sexual health medicine and the experience and research he brought to the field of oncology.

SF: Do you think that sexual dysfunction in men with prostate cancer is not well represented in clinical practice?
LI: Urologists often do not have enough time to properly address the problem, and in most cases they focus on erectile dysfunction only and not on other sexual dysfunctions, for example problems with ejaculation, libido, intimacy and partner sexual relationships.
SF: How did you first develop an interest in the sexual aspects of oncology?
LI: I am not a urologist but an oncologist specialised in urological cancer. My training taught me to spend more time in communicating as well as talking to my patients about their issues. I am therefore used to spending more time in communicating about sexual dysfunction related to cancer diagnosis and treatment. I started in 1992 doing research on sexual dysfunction after prostate cancer surgery, then became interested in the influence of different oncological treatments, including radiotherapy and also chemotherapy on sexual functioning. In those years this was seen as extremely daring.
SF: Do you think most clinicians have an understanding of sexual counselling?
LI: Not yet. Fortunately today’s training for doctors is changing and students are taught to communicate more with patients. In earlier days, urologists considered operating theatres as more important.
SF: Most prominent urologists and researchers working in this area are based in the Netherlands. Is this a reflection of a more open society or culture?
LI: It is true that Dutch people are open-minded, but even in the US there are some active researchers within the oncology world, for example radiotherapists and nurses.
SF: What do you think has been the biggest breakthrough in this area in the support for men?
LI: The introduction of oral medications to treat erectile dysfunction has certainly made a difference. Before Sildenafil (Viagra) was introduced in 1998, male cancer patients did not talk about their sexual problems because they knew that there was no treatment. Following the publication of studies on the efficacy of Viagra after surgery and radiotherapy for prostate cancer, and even after colorectal cancer and haematological malignancies, men were now willing to consult a physician for their sexual problems.
SF: What are the barriers in clinical practice to good communication and support for men with sexual issues following prostate cancer?
LI: The main problem is the training of the onco- logists, as they are not used to talking to patients about sexual problems. Furthermore, the limited time available in clinical practice is a real problem. Sexual difficulties cannot be addressed in the 10 minutes before the next patient enters the room. In such limited time, sexual problems are usually treated by prescribing a pill, and this is not the best way to go. Many patients need to be counselled on sexuality, and not only have a functional penis restored.
SF: What is the commonest sexual problem you had to deal with?
LI: Questions about erectile dysfunction and a decrease in libido and solutions for these.
SF: How do you see the oncology nurses’ role within the urology team?
LI: Nurses are very important in such a team. In the Netherlands, there has been a switch from specialist to advanced practice nurses in the follow-up of cancer patients and also for the preparation of treatments. Nurses have more time to spend with the patient (and their partner) and patients often find it easier to talk about their sexual problems with a nurse than with a busy physician who is going to see the next patient in a few minutes. But for nurses, the question arises: do they have enough knowledge on how to deal with sexuality?
Nursing Patients with Localised Prostate Cancer

In today’s multidisciplinary teams, everybody collaborates to ensure the best care of patients. The quality of care depends more and more on the cohesiveness of this partnership, where cancer nurses have become an irreplaceable and dynamic element.

Nursing a cancer patient in France is a big challenge. Until recently, there was no recognised specialisation for nurses working in cancer care, and health authorities were slow in accepting this professional group. However, since the publication of the Cancer Plan in 2003, the role of the nurse started gaining value. Chapter 40 of the Plan was unequivocal in recognising the proper role of nursing.

The initial diagnosis of cancer, thus formally establishing the professional group. However, since the publication of the Cancer Plan in 2003, the role of the nurse started gaining value. Chapter 40 of the Plan was unequivocal in recognising the proper role of nursing.

Other initiatives strengthened this role. In education, the School of European Training in Oncology (Ecole de Formation Européenne en Cancérologie, EFEC) and the departments of continuous medical education in hospitals and cancer centres have started offering appropriate courses in cancer care for nurses.

More recently, the annual congress of the French Association of Nurses in Cancer Care (AFIC), held in March 2009, set out a forum to discuss new initiatives.

Françoise Charney-Sonnek

Françoise Charney-Sonnek is head nurse of the Cancer Centre Paul Strauss and is an EONS Board member.

VITAL ROLE

Since this breakthrough, cancer nurses have become an integral component of the cancer care team, earning the respect of physicians, other health care professionals, and, most importantly, patients and their families. In the field of the treatment of localised prostate cancer, for example, you will find oncology nurses engaged in a collaborative practice with all members of the care team to provide optimal management of patients with cancer.

Cancer nurses play a vital role in coordinating the multiple and complex technologies now commonly employed in cancer diagnosis and treatment. They are involved in therapy and symptom management, in educating both the patient and the family, and in counselling through diagnosis, therapy and follow up.

If you take the surgical urological department at the Centre Paul Strauss, in Strasbourg, cancer nurses practice in a variety of settings, including surveillance, hormonal therapy, open, laparoscopic or robotic radical prostatectomy and high intensity focussed ultrasound (HIFU).

Other treatment options performed in the centre include brachytherapy as well as 3D conformal radiotherapy and IMRT (Intensity Modulated Radiation Therapy).

A patient suspected of prostate cancer will first undergo various investigations (prostate biopsy, PSA test, bone scan, MRI). The case is then discussed in the uro- oncology multidisciplinary fortnightly meeting between surgeons, oncologists, radiation oncologists, radiologists and pathologists. After a treatment plan is agreed, the patient is counselled by the urologist who presents the different treatment strategies including a riskbenefit assessment – surgery, hormonal therapy, radiotherapy, brachytherapy as well as the option of surveillance. The patient can then choose the treatment.

RADICAL PROSTATECTOMY

If surgery has been chosen, the surgeon will discuss with the patient common risks including infection, bleeding, erectile dysfunction and urinary incontinence. It is at this stage that pre-admission nurses play a crucial role in explaining to the patient what he has to do prior to admission for surgery. They assess the patient’s understanding of the procedure and, if necessary, arrange further follow up with the surgeon. Most importantly, they outline what to expect on the day of the surgery, arrival time to the hospital and the preparation for surgery. They also liaise with the anaesthetist who will prescribe pre-operative screening tests. This pre-operative care includes documenting baseline information such as temperature, blood pressure, and heart rate. The patients are usually admitted the day before surgery.

Post-operatively, the nurse is also there to provide physical and psychological comfort. As the patient progresses from the recovery room to the unit, he is continuously assessed and treated if necessary. The urinary catheter can be painful and should be actively managed. The nurse is responsible for monitoring urine output for bleeding, clots, shingles, or smell. Symptoms such as fever and increasing abdominal or flank pain should be reported to the surgeon.

OTHER THERAPIES

HIFU

High intensity focused ultrasound is a therapy that destroys tissue with rapid heat elevation that essentially “cooks” the tissue. In this therapy the post-operative role of cancer nurses is fundamental in assessing the patient’s understanding of the treatment and ensuring compliance. The main patient’s concerns are incontinence and sexual dysfunction after the treatment. Incontinence after removal of the catheter is due to the intra-operative alteration of the sphincter. It is then very important to be able to listen to the patient to assess his needs in order to give tailored advice; for example pelvic floor training. Pelvic floor electrical stimulation or pharmacologic intervention are other ways of managing these side effects.

Brachytherapy

Brachytherapy is an ultrasound-guided transperineal implantation of radioactive seeds into the prostate. It is a minimally invasive procedure but does require general anaesthesia. Patients are selected according to specific criteria such as the size of the tumour, the volume of the prostate, the IPSS (International Prostate Score Symptom) and the result of the micrometry. Weeks before the intervention, the patient is counselled by the radiation oncologist and the radiotherapist assistant and receives an information sheet with information and explanation of the procedure.

Pre-operatively the patient is advised on the physical implant procedure, as well as its associated symptom management and radiation safety precautions. But in the cancer nurse who leads the post-operative care, in particular anaesthesia recovery, monitoring of urinary status, catheter care, medication administrations, and comfort measures such as ice packs. Advice on how to filter the urine is crucial and, the day after the intervention, the urinary catheter is removed. Throughout it is very important to listen to the patient and to answer any outstanding questions before he is discharged. And it is the cancer nurse who is better equipped than any other member of the health care team for this role.

Cancer nurses practice in a variety of settings, working with several oncologic disciplines which prepare them to assist patients to cope with their diagnosis and symptoms, and make long-term adjustments. Nurses will continue to develop as a dynamic element within the health care delivery system as their understanding and expertise advance.
Screening: PSA test is not the answer

Mark R. Haythorn and Richard J. Ablin

Discovered in 1976, prostate-specific antigen (PSA) has become the gold standard screening test for prostate cancer. And yet PSA is not cancer-specific. Rather, it is present in the normal, benign, and malignant prostate. “The normal level of PSA is often cited by the medical community as between 0-4.0 ng/ml, but studies have shown that there is no level of PSA that is diagnostic for cancer. An elevation of PSA ng/ml, but studies have shown that there is no level of cancer to distinguish between cancer that is aggressive and life-threatening and those that will never become symptomatic. New screening methods are needed to avoid unnecessary treatment.

More men die with prostate cancer than from it. However, the PSA test that we currently rely on cannot distinguish between cancers that are aggressive and life-threatening and those that will never become symptomatic. New screening methods are needed to avoid unnecessary treatment.

The concept of ‘screening’ pertains to the use of a screening tool for prostate cancer. And yet PSA is not cancer-specific. Rather, it is present in the normal, benign, and malignant prostate. “The normal level of PSA is often cited by the medical community as between 0-4.0 ng/ml, but studies have shown that there is no level of PSA that is diagnostic for cancer. An elevation of PSA ng/ml, but studies have shown that there is no level of cancer to distinguish between cancer that is aggressive and life-threatening and those that will never become symptomatic. New screening methods are needed to avoid unnecessary treatment.

Overdiagnosis

The rate of overdiagnosis (defined as the percentage of men diagnosed via screening who will never develop clinically-significant prostate cancer in their lifetime), based on the ERSPC trial estimates is approximately 50% – the same chance as flipping a coin. Other studies put the rate of overdiagnosis via screening at 36%. A recent study estimates that over 1 million excess men (in the United States) have been diagnosed with prostate cancer due to screening, and that for each man who experienced the presumed benefit, more than 20 had to be diagnosed with prostate cancer.

PSA testing is not without merit – extremely high levels of PSA indicate that something is wrong and warrants further exploration, and the rate of change of PSA over time, or PSA kinetics, provides valuable early warning for disease recurrence or progression. However, the use of PSA testing for screening all men – not just those with symptoms or a family history of prostate cancer – has not resulted in increased cancer survival. This lack of survival benefit has cost enormous amounts of emotional distress, overtreatment resulting in impotence, incontinence, or other adverse effects, and a significant financial burden of billions of euros on the health care system.

INSUFFICIENT EVIDENCE

The inability of the PSA test to do what it is purported to do, its lack of cancer-specificity along with the recently reported mortality data from the PLCO and ERSPC trials, interim as they are, leave little doubt that there is insufficient evidence to support population screening for prostate cancer with the PSA test.

Why do we continue to study the use of PSA as a screening tool for prostate cancer? How many more studies need to be run? How many more papers need to be written? How many more expensive biopsies need to be taken? How many more men need to suffer through overtreatment for prostate cancer before the medical community finally undertakes what one of us (RJA) has explained for more than 30 years - that the PSA test as currently used for screening could not do any harm, and indeed could not do any good? A serendipitous observation?

A serendipitous observation?

“Serial PSA screening has at best a modest effect on prostate cancer mortality during the first decade of follow up. This benefit comes at the cost of substantial overtreatment and overdiagnosis.”

An important next step is for a neutral body, such as the US Preventive Services Task Force, to update its analysis of prostate cancer screening, given these new data. Healthcare policy makers also need to ask boldly whether the PSA screening juggernaut – with all the time, energy and resources consumed by screening and its sequelae – is appropriate in an era of unstoppable growth in healthcare spending.
Surviving Cancer, Living Life: A Nurse-led Telephone Service

Building the confidence and skills to cope with the anxiety of living life after a cancer diagnosis remains among the most difficult challenges for survivors. A telephone-based support programme could be the answer to help ease the transition from patient to survivor.

In the UK, approximately 2 million people are currently living with or beyond cancer and the number is rising by circa 3% per year. The Cancer Reform Strategy highlighted that survivors of cancer have a range of physical, psychological, spiritual, financial and informational needs which are not always met. A study by Ream et al. reported that men living with prostate cancer in England have specific and significant unmet supportive care needs, with the greatest need being related to psychological distress, sexual issues and management of enduring lower urinary tract symptoms.

HOLISTIC SUPPORT
Following the publication of the Cancer Reform Strategy, the National Cancer Survivorship Initiative (NCSI) was launched in the UK. This programme is considering a range of approaches to support cancer survivors and to ensure that care and support are tailored to meet individual patient needs.

In 2006, Birmingham North and Birmingham East Primary Care Trusts, in partnership with Pfizer Health Solutions and NHS Direct, commissioned a telephone-based model (OwnHealth) for supporting individuals with long-term conditions such as diabetes, cardiovascular disease and chronic obstructive pulmonary disease (COPD). Specially trained nurses, known as Care Managers, were used to deliver holistic support and motivation, enabling individuals to become competent self-carers (Figure 1). This resulted in improving health-related behaviours that affect their condition and also had a positive impact on clinical indicators and service utilisation. Results obtained in the first year showed that the service was delivering significant changes, and in 2008 it was extended for a further three years.

During this time, cancer was increasingly being described as a long-term condition and, in 2007, Pfizer Health Solutions approached Guy’s and St Thomas’ NHS Foundation Trust to explore the possibility of applying the OwnHealth concept to people suffering from cancer. It was subsequently decided that the initial pilot would focus on people living with and beyond cancer, and that it would initially be offered to breast and prostate cancer patients. As a result, the ‘Surviving Cancer, Living Life’ pilot service, developed from the OwnHealth model, was launched in May 2008 for survivors of breast and prostate cancer. The pilot is funded by Guy’s and St Thomas’ Charity and Pfizer Health Solutions.

SURVIVING CANCER, LIVING LIFE
The Surviving Cancer, Living Life service is a telephone-based support programme delivered by Care Managers who are employed by Guy’s and St Thomas’, and based at Guy’s Hospital. It is a holistic service and uses the concepts of motivational support and health coaching to help people to:

- Better understand the factors that affect their health.
- Build the confidence and skills to cope with, and overcome, the anxiety of living life after cancer.
- Acquire the skills, knowledge and habits to remain fit and healthy.
- Follow their treatment correctly.
- Understand how to engage with, and use, local NHS, social and voluntary services more effectively.

Patients are invited to join the service shortly after they reach the end of their ‘active treatment’ (surgery, chemotherapy, radiotherapy). Each person eligible is allocated a dedicated Care Manager who calls at pre-arranged times to provide advice, support and encouragement on specific aspects of their treatment programme and any other health-related issues. Once enrolled by the Care Manager, a detailed initial assessment is undertaken, which provides the necessary information to help the patient achieve the best quality of life for themselves and their families and carers. Assessment is undertaken using the ‘Basic Eight’ priorities for self-care (Figure 2).

Following assessment, the Care Manager and the patient identify priorities and together agree and develop an individual care plan, focusing on the areas of greatest need. The decision as to where to start and the subsequent interventions are decided with the patient, and future telephone calls are planned according to the needs of the patient, initially at fortnightly intervals, before moving to monthly. Patients will be graduated from the service after approximately 9 months.

POSITIVE EVALUATION
Evaluation of the service is being undertaken by Pfizer Health Solutions and Florence Nightingale School of Nursing and Midwifery at King’s College London to determine the impact of the service on patients’ quality of life, psychosocial and informational unmet needs, return to work and utilisation of health care services. The evaluation also aims to assess the feasibility of a telephone-based support service and its acceptability in terms of patient satisfaction and also satisfaction of carers, providers and commissioners.

Initial qualitative research was carried out using telephone interviews of up to an hour with a sample of prostate patients enrolled in the service. The results were extremely positive and patients felt that the service answered a need for support at a time when they felt particularly vulnerable. They were impressed by the holistic approach of the Care Manager to care, and felt confident of the advice and guidance they received, both in relation to cancer and to any co-morbidities. The programme helped them to understand their illness and its treatment, to improve their morale and face life with new confidence, often to adopt necessary changes in lifestyle and in some cases to develop better relationships with their families and an increase in personal confidence when dealing with other professionals.

FROM PATIENT TO SURVIVOR
This small-scale qualitative evaluation suggests that the Surviving Cancer, Living Life programme is beneficial to prostate patients. The service is able to respond to a range of previously unmet needs, providing continuity of care and easing the transition from patient to survivor.

Results from a quantitative evaluation will include further whether those promising findings are replicated in the evaluation group as a whole, by comparing them with a group of prostate cancer survivors who were not exposed to the Surviving Cancer, Living Life programme.

The focus in the immediate future is how best to integrate Surviving Cancer, Living Life with mainstream cancer services in order to ensure effective working relationships and to maximise the potential to enhance patient care in the period following treatment.

Details of the references cited in this article can be accessed at www.cancer nurses.eu/com munication/issue_newsletters.html

Jasmine Nordlund and Jan Hanson
Promoting Bone Health in Men with Prostate Cancer

Bone health poses a challenge for men with prostate cancer who are being treated with hormonal therapy. Nurses have a significant role in increasing men’s awareness of bone health issues and educating them on diet and lifestyle interventions, prevention of falls and medication management.

Kay Leonard

Prostate cancer is a major public health problem as it is the commonest cancer in men in Europe and the USA. Many men with prostate cancer receive androgen deprivation therapy (ADT) at some point during the treatment, as adjuvant therapy combined with radiotherapy or surgery in locally advanced disease; or to treat biochemical progression following radical treatment; or to treat metastatic disease. Androgen deprivation can be achieved by surgical castration or administration of a gonadotropin-releasing hormone (GnRH) or luteinising hormone-releasing hormone (LH RH) agonist with or without an anti-androgen. Hormone therapy and other therapies such as chemotherapy, radiotherapy and surgical castration can directly or indirectly damage bone, resulting in the loss of bone density, i.e. osteopenia and osteoporosis, and significantly increase the risk of fractures.

Cancer-treatment-induced bone loss (CTIBL) is a well-recognised long-term toxicity that occurs in many patients with cancer. Despite this, many of our patients are not aware of the risks of osteoporosis caused by their treatment and they are not receiving any tertiary care for it. Pathological fractures in men on ADT have been correlated with decreased overall survival.

Nurses who administer hormone therapies have a significant role to play in the early identification of those at risk of developing ADT-associated bone loss, educating patients about bone health and promoting preventative measures to reduce bone loss. It is therefore crucial that nurses’ awareness of bone health issues for men with prostate cancer increases so they can identify risk factors and be involved in setting up strategies for the prevention and management of CTIBL.

CAUSES OF BONE LOSS

The primary cause of cancer-treatment-induced bone loss is hypergonadism induced by chemotherapy, hormone therapy, surgical castration or radiotherapy; bone metastases, inactivity and inadequate intake of calcium and vitamin D. LH RH analogues +/- anti-androgen therapy reduce the level of circulating testosterone and oestrogen and induce hypergonadism causing significant decreases in bone mineral density. Therefore, men who are receiving ADT for prostate cancer are at risk of developing CTIBL.

Pathophysiology

Bone is living tissue and is therefore constantly changing. Normally, bone undergoes a continual process of loss and formation called remodelling, to maintain its structure and mineral integrity. Due to the natural aging process and reduction of hormone production, bone loss outnumbers bone formation, resulting in an overall loss of bone and increasing the risk of fractures. Testosterone plays a fundamental role in maintaining bone mass by directly or indirectly suppressing bone resorption. During ADT, circulating levels of testosterone and oestrogen are significantly decreased, inducing hypergonadism and decreased in the levels of these hormones, resulting in accelerated bone loss. Unless bone formation rates increase, continual loss of bone will occur, leading to osteopenia and eventually osteoporosis. Although bone loss occurs more rapidly and tends to be more severe in patients with CTIBL, the clinical consequences of developing it are similar to osteopenia. CTIBL increases bone fragility, and fractures may occur even when the bone is subjected to mild trauma. Some of the other clinical consequences are acute pain, chronic pain, decreased functional capacity, height loss, increased mortality rate and kyphosis.

BONE HEALTH

Although men usually have a higher bone mass than women, both lose bone mass over time and can develop osteopenia and osteoporosis. Approximately, 10 million Americans have osteoporosis and, of those, 2 million are men. In addition, approximately 34 million people are estimated to have osteopenia placing them at risk for developing osteoporosis.

Risk Factors

Men on long-term ADT have a five-fold increase in the development of osteoporosis-related fractures compared to their healthy male counterparts. Men who are receiving LH RH analogues with or without an anti-androgen for treatment of non-metastatic prostate cancer experience spine or femoral neck bone density loss of 2-10% within nine months to a year of initiating ADT. Furthermore, bone mineral density tends to progressively decrease and the risk of fractures increases the longer the duration of ADT. However, it must be stressed that not all men will...
The World Health Organisation issued guidelines for diagnosing osteopenia and osteoporosis. They have identified four categories: normal bone mineral density, osteopenia, osteoporosis and severe osteoporosis.

WHO categories of osteopenia and osteoporosis

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>T-Score</th>
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<tbody>
<tr>
<td>Normal bone mineral density</td>
<td>&gt;+1.0</td>
</tr>
<tr>
<td>Osteopenia</td>
<td>-1.0 to -2.5</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>&lt; -2.5</td>
</tr>
<tr>
<td>Severe osteoporosis</td>
<td>&lt; -2.5 with fractures</td>
</tr>
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Information from Maxwell

Exercise
Exercise promotes increased bone and muscle strength and thus reduces the risk of falls and fractures. Weight-bearing exercise, such as walking or climbing stairs, and resistance exercise such as weight lifting for 30 minutes once or twice a week can decrease the risk of CTIBL and increase BMD. However, other studies have shown no increase in BIMD but have demonstrated improvements in quality of life measures such as fatigue, and in muscle strength, balance, mobility and reduced body fat. Exercise programmes need to be individualised and developed under medical supervision.

Pharmacological interventions
Currently, the US FDA has approved no drugs specifically for the prevention or treatment of CTIBL. However, numerous drugs are approved for preventing or treating men and women with osteoporosis, and it is likely that they are also effective in CTIBL. Bisphosphonates are standard treatment for osteoporosis and have been shown to reduce cancer-related bone complications and have a potential role in the prevention of CTIBL in prostate cancer. They have also been used to treat bone loss caused by ADT. Bisphosphonates work by binding to bone undergoing remodelling and slow down both the rate of growth and dissolution thereby reducing the rate of bone turnover. Bisphosphonates can be given orally or intravenously and their benefits include halting bone loss caused by ADT and other cancer therapies, reducing the occurrence of fractures, decreasing bone pain from metastases, reducing or preventing skeletal-related events (SREs). SREs may include pathological fractures that may require radiation/surgery to the bone, spinal cord compression or hypercalcemia.

Details of the references cited in this article can be accessed at www.cancernurse.eu/communications/eons_newsletter.html
There are currently more than two million men living with prostate cancer in Europe. A man has a 1 in 12 lifetime risk of being diagnosed with the disease in response to clinical symptoms, signs or PSA testing. Despite guidelines issued in 2003 by the European Association of Urology on the medical management of prostate cancer (www.uroweb.org/professional- resources/guidelines/online), there is still no consensus statement for the health care management of men’s supportive care needs across Europe. In addition, there is a dearth of understanding about the roles and training needs of nurses and young oncologists and, furthermore, what patients feel their health care professionals should know about their supportive care needs.

This project has been set up to remedy this lack of information and to provide educational solutions. The first research phase is to survey the working practices, skills, knowledge and training needs of nurses and young oncologists, and to compare and collate these with patient reports of what support they feel they need and how this is being met by their health care teams. In the final development stage, a comprehensive and tailored education package for nurses and young oncologists working in prostate cancer will be produced for dissemination across European countries.

A project team of representatives from the partner organisations, including Daniel Kelly (Project Lead), Françoise Charnay-Sonnek, Sara Faithfull, Kay Leonard, Bente Thoft Jensen and Louis Denis has been assembled and will steer the project through all its phases. Initial work started in October 2008 and is planned to be complete by the end of 2010. Middlesex University and the University of Surrey in the UK are undertaking the research stage jointly, and Virtual Surveys Limited, an independent market research company, has been managing the questionnaire and data entry. The resulting education package, based on the research data, will be created by the project team and other collaborator representatives.

ON-LINE SURVEYS

For the initial stage, cancer nurses, young oncologists and patients across seven European countries are questioned separately via on-line surveys individually designed for each group. The nurses’ survey was posted on-line in June 2009 and the response rate was excellent. Surveys of this nature can present a significant challenge in terms of achieving response rates large enough for meaningful analysis, and the success achieved was due largely to the efforts and encouragement of many collaborators across the cancer nursing societies and networks in each country. Waves of e-mails were circulated to members via national societies and contacts in each country, announcing the launch of the survey and inviting nurses to visit the EONS website to complete and submit the survey on-line. During the course of the survey, two further reminders and announcements were sent. This strategy paid off and the response rate achieved was excellent. The researchers anticipated around 50 completed questionnaires in each country, but in the end some 472 responses in total were received: 60 from Denmark; 51 from France; 57 from Ireland; 56 from The Netherlands; 55 from Spain; 52 from Turkey; 112 from the UK and 27 from a variety of other countries. Producing the research instruments presented a challenge, but again this was accomplished successfully. The questionnaire was developed in close consultation with the project team, and several volunteer nurses and urologists across Europe took part in piloting and helping to refine the final version. All the advertisements about the survey and the questionnaires were translated and presented in each country’s native language and the responses were then translated back so that the analysis could take place in English. These data are now being analysed and top-line results are providing useful guidance for developing two further on-line surveys. The first, involving junior oncologists and urologists across the same seven countries, is running in January and February 2010. The data from this stage, together with the nurse data, will be used to develop the third and final stage, which will involve a patient survey. This is set to take place later in 2010, again across the same countries.

The findings from the nurses’ survey will be available in an edited form on the EONS website and in the EONS Newsletter later in the year. Papers based on data from all the stages will also be published in peer-reviewed journals and the findings presented at conferences. Most importantly, the aim is to produce an educational programme, aimed at the needs of oncology nurses and young oncologists working with prostate cancer patients, which can be incorporated into training across all European countries.
Hampered by Hormones?

The Prostate Cancer Charity calls for better information and support

Men with prostate cancer continue missing out on vital information and support to help them live with the impact of the disease and of its treatment. Research by The Prostate Cancer Charity makes for uncomfortable reading.

Men with prostate cancer have consistently reported worse experiences of care within the National Health Service (NHS) than patients with other common cancers.

Now research undertaken by The Prostate Cancer Charity on the experiences of men receiving hormone therapy, a common treatment for prostate cancer, suggests that this legacy continues – with many men missing out on vital information and support to help them live with the impact of prostate cancer and of this treatment on their lives. Feedback from the men who took part in this research makes for uncomfortable reading:

- Seven out of ten men who took part in Charity’s survey experienced fatigue;
- One in four men who experienced fatigue side effects found the impact it had on their lives difficult to cope with;
- One in four respondents said that hormone therapy affected their ability to work;
- Eight out of 10 said that they experienced erectile dysfunction as a result of their treatment – with a quarter of these men reporting that they found it difficult to cope with the impact this had on their lives.

- One in every two men reported serious issues related to their mental wellbeing, for example, feelings of depression, loss of confidence and cognitive problems.

Despite these experiences, over half of the men who responded to the survey said that they received “too little” information before they began hormone therapy, and “too little” support whilst they were on the treatment. Many did not receive verbal or written information on the potential side effects of hormone therapy before they began treatment – nor were they asked by the health care professionals involved in their care about their experiences of side effects, or their support needs.

The Prostate Cancer Charity believes that the failure to provide information and to talk to men about the effects of this treatment means that too many are left unaware that there are practical medical interventions and support services available that could help them better manage and cope with the impact of the treatment.

The research also found evidence of serious shortcomings in the information and support provided to the partners of men who receive hormone therapy. When surveyed, significant numbers reported that they found the side effects experienced by the partner undergoing hormone therapy difficult to cope with, but nearly two-thirds said that they had not received appropriate support from health professionals to help them cope with the impact of these side effects on their lives.

These findings highlight serious inadequacies in how well the information and support needs of men living with the effects of hormone therapy – and their partners – are understood and provided for. They also suggest that existing guidance from the National Institute for Health and Clinical Excellence (NICE) in England and Wales and NHS Quality Improvement Scotland (NHS QIS), on the standards of care that should be in place for men with prostate cancer, have not been implemented.

GAPS IN CARE

Through this campaign, the Charity is calling for the urgent full implementation of current guidelines on the care of men with prostate cancer, to address the unacceptable gaps in care. The Prostate Cancer Charity has also set out a number of recommendations within this report to improve the information, support and care provided by the NHS to men receiving hormone therapy, and their partners. The Charity is calling on Government Health Departments across the UK, the National Cancer Survivorship Initiative in England and the Scottish Cancer Taskforce to take action in accordance with the Charity’s recommendations.

For more information please contact The Policy and Campaigns team via email at: policy@prostate-cancer.org.uk, or by calling the Charity’s helpline on: +44 (0)800 074 8383. Website: www.prostate-cancer.org.uk

Recommendations for improved care

The Prostate Cancer Charity has made nine recommendations for improved care and support arising from its research:

- All men considering hormone therapy for prostate cancer should be informed about the potential side effects of the treatment by a health care professional.
- All men receiving hormone therapy should be given verbal and written information about how they can manage the side effects of the treatment and where to go to receive support.
- All men receiving hormone therapy should be regularly assessed by a health care professional for the side effects of the treatment and associated support needs.
- Appropriate medical interventions and support services that can help men manage the side effects of hormone therapy should be available to men across the UK.
- Further research should be conducted into the impact of hormone therapy on the lives of men (and their partners) who receive the treatment and interventions to help them cope with, or manage these side effects.
- The National Cancer Survivorship Initiative in England and the living with Cancer Group of the Scottish Cancer Taskforce should consider the advice they have given to improve the support and information provided to men receiving hormone therapy.
- NHS Quality Improvement Scotland should develop Standards for Cancer Services for prostate cancer to ensure men receiving hormone therapy receive high quality care.
- The partners of men receiving hormone therapy should be informed about the side effects of the treatment and signposted to support services by health care professionals involved in their partner’s care.
- National guidance related to the effective treatment and care of men with prostate cancer must be fully implemented.

John Neate

The Prostate Cancer Charity’s campaign “Hampered by Hormones!” aims to highlight the needs of men on hormone therapy and their partners and to ensure that they receive the high standard of care and support they deserve and are entitled to. This includes access to appropriate information, the assessment of side effects and associated support needs and the provision of appropriate interventions and support to men (and their partners) to help them cope with and manage these side effects.

MISSING OUT ON VITAL INFORMATION

In the United Kingdom, 35,000 men are diagnosed every year and one man dies from the disease every hour. Yet, despite the incidences and impact of this condition, men with prostate cancer have consistently reported worse experiences of care within the National Health Service (NHS) than patients with other common cancers.

The research also found evidence of serious shortcomings in the information and support provided to the partners of men who receive hormone therapy. When surveyed, significant numbers reported that they found the side effects experienced by the partner undergoing hormone therapy difficult to cope with, but nearly two-thirds said that they had not received appropriate support from health professionals to help them cope with the impact of these side effects on their lives.
Gathering user information to improve prostate care services

It is often believed that health differences between the sexes are mostly the result of biology and therefore inevitable. But men and women react differently to their health needs and services must be designed in a way to enhance good health for all.

Socio-economic groupings and ethnicity have long been accepted as important factors in determining a person’s state of health. But gender, on the other hand, continues to be viewed as peripheral. It is often believed to be an issue for women but not a person’s state of health. But outcomes and one that we are a long way from understanding fully. Men and women react differently to their health needs, yet services are often still designed in a way that seems blind to this.

The European Men’s Health Forum (EMHF) is an independent, non-governmental, non-profit making organisation established to raise male health awareness across Europe. It aims to promote collaboration between interested individuals and organisations on the development and application of health policies, research, education and prevention programmes. EMHF provides a unique platform for non-discriminatory co-operation and information exchange within Europe and with other countries worldwide.

With a view to contributing to more gender-aware health service delivery, EMHF has amongst its key objectives to:

- improve the delivery of health services to men, including primary care and health promotion information;
- increase the awareness among health professionals of men’s health issues and improve their ability to work effectively with male patients and men generally.

Obviously, improvements in health cannot be achieved through the development of services alone, so EMHF also works to:

- increase men’s awareness of their own health and their treatment options; and
- foster improvements in men’s health-related behaviour, not least in terms of increasing their willingness to access health care and reducing the risks they take with their health.

EMHF is currently running a project designed to meet both sets of objectives – encouraging men to seek advice and information on two areas of health that are often seen as difficult to discuss: prostate health and sexual dysfunction. In this way the current concerns of men in these health areas can be assessed, and this information will be used to influence the decision-making processes of service providers and policy makers. It will also be used to develop a publication for men on sexual dysfunction.

This is a web-based initiative using two sites where men, or their partners, can seek confidential advice from specialist health professionals. Using the web to research what their next steps should be in any given situation is normal for many men. When men feel comfortable they will discuss their health openly.

At www.yourprostate.eu, men can ask questions about erectile dysfunction and premature ejaculation. In this way the current concerns of men in these health areas can be assessed, and this information will be used to influence the decision-making processes of service providers and policy makers. It will also be used to develop a publication for men on sexual dysfunction.

This website, www.malehealthquestions.eu, offers men the opportunity to ask questions about erectile dysfunction and premature ejaculation in total confidence. Specialists with experience of dealing with these issues are available to answer questions in twelve European languages.

This project is not designed to duplicate or replace any of the great work being done in men’s health by organisations across Europe, but as a complementary piece of research. Where appropriate visitors to the website will be referred to specialist services should that be a suitable option for their particular circumstances.

With this initiative, EMHF is working on the principles that improvements in service delivery must be driven by the experience of those who use them, and that men should be offered support to help them take responsibility for their health.

If you would like more information on these projects, or on any other aspect of EMHF please visit www.emhf.org or email office@emhf.org.

Erick Savoye
Supporting Practitioners in Setting Quality Standards

Putting the improvement of standards in urological nursing as top of its agenda, the European Association of Urology Nurses believes that excellent health care goes beyond geographical boundaries and a European urology nursing alliance is essential to promote excellence.

Bente Thoft Jensen

The European Association of Urology Nurses (EAUN) has grown as an organisation since its inception in 2000 and aims to bring urology nursing in Europe to a higher professional level. With members in more than 20 countries, and the numbers steadily growing in recent years, EAUN aims to create a dynamic and open forum for the exchange of ideas and knowledge, which will hopefully continue to strengthen and improve urological nursing care locally and throughout Europe. EAUN also aims to bridge the diversity in approach brought about by the differences in our daily working environments, backgrounds and health care systems.

EXCELLENCE IN UROLOGY NURSING

EAUN has scientific and not-for-profit objectives and is characterised as a general urology nurses association. In seeking to foster a European urology nursing alliance to provide and promote excellence in urological nursing, it has set out as its main ambition the sharing of knowledge and the setting of standards for quality urological nursing practice, research and education. Nursing is obviously the backbone in any health care system around Europe and EAUN strives to act as the representative body of the European urological nurses, with the purpose of facilitating the continued development of urological nursing in all its aspects.

GUIDELINES ON BEST CLINICAL PRACTICE

With administrative, financial and advisory support from the European Association of Urology (EAU), EAUN aspires to develop European standards for education and accreditation of urology nurses. Publications like the Good Practice in Health Care series, a comprehensive compilation of theoretical knowledge and practical guidelines on incontinent urostomy, have been essential in fulfilling this goal. Based on a consensus process, the guidelines are supplemented by clear illustrations, case report summaries, extensive references and annotated procedures to help nurses to identify potential problem areas and efficiently carry out possible options for effective patient care. The guideline has just been approved by the American Clearing House. The full text can be accessed at www.uroweb.org/professional-resources/guidelines/

MULTIDISCIPLINARY RESEARCH AND DEVELOPMENT

One of the goals in EAUN’s long-term strategy is to liaise and collaborate with other organisations in the field of urology and uro-oncology. This includes co-operating with EONS in projects of mutual interest. Today, perhaps more than ever before, European health care associations are being forced to join forces due to economic factors as well as the desire to promote multidisciplinary research and development. A major initiative has been the decision by EAUN to extend its boundaries and accept the invitation by EONS to take part in the PSA-project described elsewhere in this Newsletter (p.24). Both organisations see this first step as the beginning of a fruitful partnership and many other future projects addressing the care of patients with cancers and associated urological conditions.

EONS members are invited to the 11th Annual Meeting of EAUN taking place in Barcelona from 17th till 19th April 2010 and held in conjunction with the Annual EAU Congress.

Further information can be found at: www.eau.uroweb.org
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mCRC: metastatic colorectal carcinoma

**Vectibix** is indicated as monotherapy for the treatment of patients with EGFR-expressing, metastatic colorectal carcinoma (mCRC) with nonmutated (wild-type) KRAS after failure of fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy regimens.

**INDICATION:** Vectibix® is indicated as monotherapy for the treatment of patients with EGFR-expressing, metastatic colorectal carcinoma (mCRC) with nonmutated (wild-type) KRAS after failure of fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy regimens.

**PHARMACEUTICAL FORM:** Vectibix® 20 mg/ml concentrate for solution for infusion. Each vial contains 100 mg of panitumumab in 5 ml or 400 mg of panitumumab in a 20 ml vial. Excipients: sodium chloride, sodium acetate trihydrate, acetic acid (glacial [for pH adjustment]), water for injection.

**CONTRAINDICATIONS:**

- Hypersensitivity to the active substance or to any of the excipients; interstitial pneumonitis or pulmonary fibrosis.
- Lords, including gastrointestinal, and cough were reported as very common (≥1/10) in the overall mCRC monotherapy population.

**INTERACTIONS:**

- There have been reports of acute renal failure in patients who develop diarrhoea or become intolerable at 50% of the original dose, the use of Vectibix should be permanently discontinued. Pneumonitis should be permanently discontinued if a severe reaction occurs at any time post-infusion. Patients should be instructed to report symptoms of a pneumonitis to their physician. Acute renal failure has been reported to occur alone or in combination with anaphylactic reactions.

**UNDESIRABLE EFFECTS:**

- The safety profile of panitumumab in patients whose tumour expresses KRAS wild-type was generally consistent with overall mCRC monotherapy set described above. The only differences were that nausea, vomiting, dyspnoea, and cough were reported as very common (≥1/10) in the KRAS wild-type population whereas these adverse drug reactions were reported as common (1/10 to <1/10).

**MARKETING AUTHORISATION HOLDER:** Amgen Europe B.V., Amgen Europe, B.V., Minervum 7061, NL-4817 ZK Breda, The Netherlands. Further information is available from Amgen (Europe) GmbH, Dunweirsstraat 11, PO Box 1557, Zug, Switzerland, CH-6301. Additional information may be obtained from your local Amgen office.

**LEGAL CLASSIFICATION:** Medicinal product subject to restricted medical prescription.

**STABILITY AND STORAGE:** Store vials in the original carton under refrigeration at 2°C to 8°C until time of use. Protect from light. DO NOT FREEZE. Do not shake vigorously or agitate the vial. Vectibix® should be administered as a single infusion (continuous or bolus) over 90 minutes; the infusion must be completed within 30 minutes.

**DOSAGE AND ADMINISTRATION:**

- The recommended dose of Vectibix® is 6 mg/kg of bodyweight given once every two weeks. The recommended infusion time is approximately 90 minutes. Doses higher than 1000 mg should be infused over approximately 90 minutes.

- Contraindicated: Hypersensitivity to the active substance or to any of the excipients, intestinal pneumonitis or pulmonary fibrosis.

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Advancing nursing management approaches with new targeted therapies for ErbB2-positive metastatic breast cancer

Prior to the ECCO 15 – ESMO 34 Conference, an educational workshop for cancer nurses was held on Sunday 20th September 2009 in Berlin, Germany. The meeting was accredited by EONS with sponsorship provided by GSK. The purpose of the workshop was to discuss current knowledge behind clinical therapies in ErbB2-positive breast cancer, common side effects associated with these interventions and step-by-step proactive nursing management. Fifty four nurses from 12 countries across Europe attended the event and took part in interactive sessions with the various speakers.

Epidemiology and pathology of breast cancer

Annie Young, Nurse Director, 3-Counties Cancer Network (Gloucestershire, Herefordshire and South Worcestershire, UK). Past-president UK Oncology Nursing Society.

Despite many recent advances in diagnostic investigation technology and improvements in treatment and supportive care, breast cancer remains the leading cause of cancer-related mortality in European women. Evidence-based public health measures exist in many European countries to reduce mortality from breast cancer. National screening programmes that detect early invasive cancers have greatly improved early detection and hence survival rates. In Europe; Belgium, France and Sweden recorded the highest incidence (probably due to the presence of screening programmes), while the lowest incidence is to be found in countries, such as Cyprus, Belarus and the Ukraine.

Recent research has suggested patterns of gene expression may better predict prognosis and response to different types of cancer treatment. This research implies that there are four basic subtypes of breast cancer. The gene expression patterns of these cancers are comparable to the normal cells that line the lumen of breast ducts and glands. Luminal A and B cancer subtypes are both oestrogen receptor positive and are the most common. Luminal A cancers are associated with the best prognosis. Luminal B cells have a higher expression of proliferative genes such as ErbB2. They therefore grow more rapidly and are associated with a poorer prognosis.

Amplification and over-expression of ErbB2 has been found to be associated with a median survival of 3 years. ErbB2-(or HER2)-positive, oestrogen receptor negative breast cancers are less common but are also linked to a poor prognosis. Basal type cancers are principally triple negative phenotype – that is to say they lack oestrogen and progesterone receptors and have low expression of ErbB2. The gene expression of these cells is akin to cells in the deeper basal layers of the breast ducts and glands. Basal type cancers tend to be high grade tumours that grow quickly and have a poor prognosis.

Growth factors and receptors

Growth factors (or ligands) may be characterised as protein “signals” circulating in the blood or near to the cells that secrete them and are typically present in low concentrations. They initiate various cellular activities by first binding with their associated receptor on the cell’s surface. There are about 58 tyrosine kinases which act as growth factor receptors. When bound to the growth factor, the receptor triggers various processes within the cell such as cell division, development of blood vessels, blood vessel formation and embryonic development. The process of message transfer to initiate these intracellular activities is known as signal transduction – a complex and tightly regulated network of signal pathways, with many starting points and alternative routes for message transfer.

The ErbB family of receptors are major regulators of cellular processes such as cell division, growth, differentiation, migration and survival. The family comprises four related transmembrane receptor tyrosine kinases (RTK’s) that bind to members of the epidermal growth factor...
(EGF) family to trigger these processes. Malignant tumours, including breast cancer, may be a consequence of unregulated or dysregulated control of the ErbB signaling pathway by other genes.

Approximately 20-30% of invasive breast carcinomas have ErbB2 over-expression or gene amplification. This over-expression is associated with aggressive disease, poorer response to conventional cytotoxic chemotherapy and hormonal therapy resulting in a reduced survival time.

**Strategies to inhibit ErbB2**

A number of strategies have been developed to target the ErbB2 signalling pathway. However so far only monoclonal antibodies (mAbs) and small-molecule tyrosine kinase inhibitors (TKIs) have been developed to the greatest extent in a clinical setting. Trastuzumab (Herceptin®) is the only mAb currently licensed for use in ErbB2-positive breast cancer. Other mAbs under investigation for this indication include pertuzumab (Omnitarg®), bevacizumab (Avastin®) and T-DM1. Trastuzumab binds to the extracellular domain of the ErbB2 receptor, thereby preventing activation of the receptor. mAbs have limits to their activity in that they are specific to only one receptor (e.g. ErbB2) and they can only act outside the cell. Therefore, if a receptor does not have an extracellular domain, a monoclonal antibody might not be effective.

TKIs are small enough to enter the cell and block the activation of downstream signaling pathways. The TKI lapatinib (Tyverb®) is the only TKI currently licensed for use in ErbB2-positive breast cancer. Lapatinib binds with the intracellular tyrosine kinase domain of the ErbB2 receptor to block its activation and prevent signal transduction inside the cell. The same tyrosine kinase domain may be present on more than one type of receptor (e.g. ErbB1 and ErbB2). Therefore TKIs have the potential to be active against multiple receptors. That TKIs can enter the cell and be active is significant in instances where no extracellular domain is present.

**Targeted therapies for ErbB2-positive breast cancer**

*Thomas Bogenrieder, GSK Clinical Director Oncology, Oncology Center of Excellence, Europe, Asia-Pacific, Japan & Emerging Markets*

Trastuzumab (Herceptin®) was the first humanised monoclonal antibody to be developed to treat breast cancer. Compelling clinical trial evidence in metastatic and adjuvant settings has resulted in trastuzumab becoming a crucial component of therapy for ErbB2-positive breast cancer as both monotherapy and in combination with other cytotoxic agents.

Lapatinib (Tyverb®), an oral tyrosine kinase inhibitor (TKI), acts inside the cell to block growth and survival of breast cancer cells and may therefore also be active in cells which do not have an extracellular ErbB2 domain. Pre-clinical investigation of lapatinib has shown that it is a potent inhibitor of both the EGFR and ErbB2 receptors. Dual receptor inhibition is a hopeful therapeutic strategy as it may potentially block multiple signalling pathways. Lapatinib, in combination with capecitabine, is indicated for the treatment of patients with advanced or metastatic breast cancer whose tumours overexpress ErbB2. Patients should have progressive disease following previous therapy, which must include anthracyclines, taxanes and therapy with trastuzumab in the metastatic setting.

**Safety Considerations and Side Effect Management with Lapatinib (Tyverb®) and capecitabine.**

*Annie Young, Nurse Director, 3-Counties Cancer Network (Gloucestershire, Herefordshire and South Worcestershire, UK). Past-president UK Oncology Nursing Society. Paz Fernandez, Institut Català Oncologia ICO, Barcelona, Spain*

Empowerment is a primary objective of patient education, which is the cornerstone of the safe administration of oral anti-cancer drugs. Topics that the patient needs to be educated upon include potential and anticipated side effects; how to monitor them as and when they occur, what to do and who to call in the case of their happening. Nurses therefore need to be able to confidently and competently explain how the prescribed drug works, discuss the benefits of the treatment; how the drug should be taken; the drug schedule; do’s & don’ts associated with the regimen including what to do if tablets are missed, or inadvertently overdosed.

**Questions you may be asked about lapatinib and capecitabine:**

*What should I do if forget to take my tablets?*

*If it is still the same day, take your lapatinib tablets as soon as you remember. Do NOT double the dose the next day. If capecitabine dose is missed (e.g. morning dose), take next dose as usual (do not double up). Remember to inform the cancer unit.*
The patient’s usual bowel routine should be assessed in order to understand what their normal state is and record the baseline measure. Subsequent grading can be monitored against readily available and utilised Common Toxicity Criteria, such as the North American NCI Common Terminology Criteria for Adverse Events v3.0 (CTCAE).

<table>
<thead>
<tr>
<th>Grade</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&lt; 4 stools per day more than baseline</td>
</tr>
<tr>
<td>2</td>
<td>4-6 stools per day more than baseline. Not interfering with daily routine.</td>
</tr>
<tr>
<td>3</td>
<td>&gt; 7 stools per day. IV fluids. Needs health professional support. Requires hospitalization for complications.</td>
</tr>
<tr>
<td>4</td>
<td>Life threatening consequences e.g. haemodynamic collapse. Potential for electrolyte imbalance or similar. Requires immediate attention.</td>
</tr>
<tr>
<td>5</td>
<td>Death – extremely rare</td>
</tr>
</tbody>
</table>

Management guidelines based on those developed by the American Society of Clinical Oncology (ASCO) may be followed on diarrhoea occurrence with lapatinib treatment.

Management of diarrhoea associated with lapatinib + capecitabine

Early identification is critical for optimal management of this embarrassing and distressing side effect, so it is important that nurses both find ways to encourage patients to talk freely about this symptom in order to help them as quickly as possible and undertake a rigorous assessment. The diarrhoea triggered by targeted therapies is due to damage of the epithelium in the colon due to the presence of the EGFR receptor in this region. As this damage is repaired, the body recovers and for this reason the symptom experience is of short duration.

Evaluation

It is important to evaluate patients for disorders that may dispose them to diarrhoea, such as surgical shortening of the bowel, concurrent non-malignant bowel disorders, or prior bowel irradiation. The assessment and record of medications that may induce diarrhoea, such as antibiotics, should also be completed.
Figure 2. Complicated Diarrhoea

In a pooled analysis of eleven clinical trials of patients receiving lapatinib and/or capecitabine (n = 1,811), diarrhoea occurred in around 55% of patients and was mainly mild and that it tended to last around 5 days\(^{10}\). Most (92%) diarrhoea events were grade 1 or 2. The majority (85%) of patients required no interruption of therapy or dose adjustment; 2% discontinued treatment because of diarrhoea. Patients who required intervention responded to standard anti-diarrhoeal management (e.g. loperamide). In more severe cases, management included hydration and use of antibiotics. Women are more likely to suffer from diarrhoea than men because of the physiology of their gut; older women will suffer a worse experience than younger women.

Management of skin rash associated with lapatinib + capecitabine

A rash is an obvious side effect and many patients will be sensitive about their appearance, particularly if they experienced hair loss during their initial chemotherapy. Rash is a common side effect of drugs that target the ErbB1 receptor.\(^ {11} \)

Among lapatinib-treated patients across several trials (n=1,417)\(^ {12} \), skin events were reported by 50% treated with lapatinib monotherapy; 70% with lapatinib + capecitabine; 76% with lapatinib + paclitaxel. The majority of events were of low-grade severity (Grade 1 or 2); there were no Grade 4 events. Events tend to present early in the course of treatment and are usually self-limiting (median duration 29 days).

The correct term for the rash is ‘papulopustular rash’ or ‘pustular eruptions’. The rash may resemble seborrhoeic dermatitis, folliculitis or acneiform drug eruption and it is commonly, (though technically incorrectly), called an acne-form rash because it is similar in initial appearance to acne vulgaris. However, it is not the same since the rash is not associated with the same clinical or histological characteristics, such as the presence of comedones (“blackheads”). Nevertheless, for women experiencing metastatic breast cancer, the visibility of this rash and obvious further change to their body image may be quite upsetting and worrying. The papules are small, rounded, elevated lesions in the skin. They tend to be smaller than half a centimetre diameter. A pustule is a collection of purulent exudates in the top layer of the skin and the epidermis, or beneath it in the dermis. Pustules frequently form in sweat glands or hair follicles. The papulopustular rash commonly affects areas such as the face, the upper back and the V-shaped open neckline area of the chest.

The CTCAE grading gives a common standard to describe the severity of the rash.

<table>
<thead>
<tr>
<th>CTCAE grading</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Grade 1</td>
<td>Macular or papular eruption or erythema without associated symptoms</td>
</tr>
<tr>
<td>Grade 2</td>
<td>Macular or papular eruption or erythema + itching / other associated symptoms. Local desquamation. Covering &lt;50% BSA</td>
</tr>
<tr>
<td>Grade 3</td>
<td>Severe. Confluent lesions, or vesicular eruption; desquamation covering &gt;50% BSA</td>
</tr>
<tr>
<td>Grade 4</td>
<td>Generalised rash, deep ulcerations, exfoliative or bullous dermatitis</td>
</tr>
<tr>
<td>Grade 5</td>
<td>Death</td>
</tr>
</tbody>
</table>

Nurses should perform a skin examination (scalp, radiated areas, hair, nails and oral/genital mucosa) and identification of skin type at baseline and perform follow-up dermatological assessments every 4 weeks throughout treatment or until an adverse reaction appears; after a dermatological event perform skin examinations at every visit until one month after resolution. This will necessarily mean that nurses need to be conversant with the anatomy and physiology of the skin and be able to articulate their findings in language appropriate to this aspect of practice. Patients should be encouraged to avoid exposure to sunlight and apply...
broad spectrum sunscreens (containing titanium dioxide or zinc oxide) with an SPF ≥ 15. A full body skin examination should be performed on any patient who displays signs or symptoms of dermatological disease.

Fig 3, management of maculopapular reaction
There are no clear evidence-based treatment options for management of lapatinib-associated rash, however see Figs 3 and 4 for management guidelines derived from one study\(^1\). The management of mild rash is relatively simple and may include the application of topical corticosteroids, although there is not consensus for this decision. No discontinuation of treatment is required for mild rash but, if the rash is severe and covering more than 50% of the body surface area or symptomatic, the treatment may be suspended and a short course of oral corticosteroids prescribed and the effect reviewed after 2 weeks. Patients with extensive or persistent skin involvement should be referred to a dermatologist.

Fig 4 Management of papulopustular reaction
Taken as a whole, side effects with this combination of treatments are less severe than with standard chemotherapy. As always, the nursing contribution to side effect management can make a big difference to the patient experience and quality of life that they will gain from these new therapeutic modalities. In particular, effective communication with patients and efficient education of how to monitor for side effects will be especially important in helping them to get the best from their treatment. Most cancer patients wish to be involved in decision making and are entitled to be treated with dignity and respect - a proactive approach to symptom management will help patients and their carers achieve this.

Nursing considerations for oral agents for cancer.
Sultan Kav, Faculty member at Baskent University, Faculty of Health Sciences, Department of Nursing, Ankara, Turkey.

We all want to see our patients’ experience of their cancer and its treatment improve; the attraction of an oral medication is obvious. Administering IV chemotherapy is costly in staff time, clinic space and equipment. It is habitually inconvenient and worrying for patients, often associated with long journeys to hospitals, lengthy waiting times etc. Assuming efficacy and toxicity are equal, it has been shown that patients prefer oral therapies to IV as this reduces disruption to daily schedules, and enables a better quality of life\(^1\). Nevertheless there are many things that we need to consider for the whole process to be safe and to ensure the best possible outcome for the patient.

Oral medication is associated with a degree of non-compliance. Reasons given for poor adherence to oral anti-cancer agents include a lack of information about the treatment; the perception of the drug’s influence over their disease experience and a dislike of certain unbearable aspects of treatment e.g. unpleasant side-effects\(^1\). A patient’s beliefs may be influential in their decision about whether or not to continue with treatment. Providing support beyond the initial consultation, based on open and honest dialogue combined with a firm, friendly and therapeutic relationship is an important factor in managing such essential outpatient-based services. Other straightforward suggestions for improving adherence include follow up via telephone links; consultations at key points in timeline of patients treatment; involving the support of a third party, such as a carer; informing the patient about reliable and appropriate patient support groups or other voluntary and non-statutory organisations that can help. Even advocating the use of simple measures such as diaries, timers, or post-it notes which serve to remind the patient to take their medication to time could be a useful nursing intervention.

In order to make this a positive and valuable treatment option for the long term, nurses will play a vital role in supporting patients for optimising successful outcomes.

A teaching tool for patients receiving oral agents for cancer has been developed by MASC’s professional education study group and can be found at www.mascc.org/mc/page.do?sitePageld=89760\(^1\).

This article was supported by an unrestricted educational grant from GSK Oncology.
Summary
Breast cancer remains the leading cause of cancer-related mortality in European women. ErbB2-positive breast cancer accounts for 20–30% of invasive breast carcinomas and is a particularly aggressive form of the disease with a poor prognosis. Knowledge of how intracellular processes are controlled in ErbB2-positive breast cancer has led to the development of targeted therapies which block key signal transduction pathways. Trastuzumab (Herceptin®) is a humanised monoclonal antibody that acts on the extra cellular domain of the ErbB2 receptor and is a crucial component of therapy for ErbB2-positive breast cancer. Lapatinib (Tyverb®) is the first oral tyrosine kinase inhibitor licensed for use in ErbB2-positive breast cancer and has been shown to target both the EGFR and ErbB2 receptor kinase domains inside the cell. The main side effects of the lapatinib + capecitabine combination are diarrhoea and rash. Taken as a whole, side effects with this combination are less severe than with standard chemotherapy. Nurses need to be able to explain to patients how their prescribed treatment works, discuss the benefits of the treatment, how to monitor for any side effects and what to do if they occur. Management and education of patients receiving oral anti-cancer therapy needs to be especially thorough to ensure that patients get the best from their treatment. The importance of the nursing contribution for this cannot be underestimated.

References

Prescribing Information
Abbreviated Prescribing Information (Please refer to full SmPC before prescribing):
Tyverb® (Lapatinib) 250mg film-coated tablets. Each tablet contains 250mg lapatinib as ditosylate monohydrate.
Indications: In combination with capecitabine for treatment of patients with advanced or metastatic breast cancer whose tumours overexpress ErbB2 (HER2). Patients should have progressive disease following prior therapy which must include anthracyclines and taxanes and therapy with trastuzumab in the metastatic setting. Dosage and administration: Only to be initiated by physician experienced in use of anti-cancer agents. Lapatinib: 1250mg (5 tablets) once daily continuously. Taken at least one hour before, or at least one hour after food. Standardise administration in relation to food intake. Capecitabine: 2000 mg/m² /day taken in 2 doses 12 hours apart on days 1-14 in a 21-day cycle. Taken with food or within 30 mins after food. Renal impairment: No lapatinib dose adjustment in mild to moderate renal impairment. Caution advised in severe renal impairment as no experience of lapatinib in this population. Hepatic impairment: Discontinue lapatinib if changes in liver function are severe and do not retreat patients. Insufficient data available to provide a dose adjustment recommendation. Use with caution in moderate to severe hepatic impairment due to increased exposure to product. Elderly: Limited data in patients ≥65 years. Paediatrics: Not recommended. Dose delay and dose reduction: Cardiac events: Discontinue lapatinib in patients with symptoms associated with decreased LVEF that are NCI CTCAE grade ≥3 or if LVEF drops below institution's normal limits. May be restarted at 1000mg/day after a 2 weeks and if LVEF recovers to normal and patient is asymptomatic. Intestinal lung disease/neumonitis: Discontinue lapatinib in patients who experience pulmonary symptoms that are NCI CTCAE grade ≥3. Other toxicities: Consider discontinuation or interruption of lapatinib dosing if patient develops toxicity that is NCI CTCAE grade ≥2. Can be restarted at 1250mg/day when toxicity improves to ≤ grade 1. If recurs, restart lapatinib at 1000mg/day. Consult capecitabine SmPC for guidance on dose delay and dose reduction recommendations for capecitabine. Contra-indications: Hypersensitivity to active substance or excipients. Refer to capecitabine SmPC for relevant contraindications and safety information. Special Warnings and Precautions: Decreases in LVEF observed in ≤ 0.1% of patients on lapatinib monotherapy. Most cases grade 1 or 2 and did not result in discontinuation of lapatinib. Rashes: Occurred in ~28% of patients on lapatinib + capecitabine. Generally low grade and did not result in discontinuation of lapatinib. General information: Capecitabine: May have an effect on warfarin; titrate as appropriate. Diazepam: Avoid abrupt withdrawal. Lapatinib: Decreases in LVEF reported. Capecitabine: May have an effect on warfarin; titrate as appropriate. Zolpidem: Avoid abrupt withdrawal. Diarrhoea: Occurred in ~28% of patients on lapatinib + capecitabine. Generally low grade and did not result in discontinuation of lapatinib. Overdose: No specific antidote. Haemodialysis not expected to be effective method of elimination as lapatinib is not significantly renally excreted and is highly bound to plasma proteins. Marketing authorisation (MA) no. EU/1/04/0001 and EU/1/07/440/001. MA holder: Glaxo Group Limited, Berkley Avenue, Greenford, Middlesex UB6 0NN. Legal category POM. TMY001/010/01 January 2010.

Further contact information is available from http://www.gsk.com/contactus.htm or email Oncologywebmaster@gsk.com
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