



# EONS

## **eons** newsletter

The Quarterly Newsletter of the European Oncology Nursing Society

Summer 2007

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from...

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

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# Letter from the Editor

A diagnosis of prostate cancer can be a life-altering experience for patients and their families. With the aging of the population, prostate cancer has received increasing attention over the last 15 years as it is the most frequent type of cancer in men above 70. The older a man is, the more likely he will be diagnosed with prostate cancer. Although only 1 in 10,000 men under age 40 will be diagnosed, the rate shoots up to 1 in 39 for ages 40 to 59, and 1 in 14 for ages 60 to 69 with about 65% of all prostate cancers diagnosed in men over the age of 65. Prostate cancer has not been reported very often in previous issues of the EONS Newsletter and therefore I am therefore pleased that this issue will highlight the most important aspects on this important cancer.

Although genetics might play a role in deciding why one man might be at higher risk than another, social and environmental factors, particularly diet and lifestyle, likely have an effect on the development of prostate cancer. The exact relationship between obesity and prostate cancer remains unclear although there is no doubt that obesity can have a negative effect on outcome. Research in the past few years has shown that diet modification might decrease the chances of developing prostate cancer, reduce the likelihood of have a prostate cancer recurrence, or help slow the progression of the disease. The introduction of Prostate Specific Antigen (PSA) and the painless transrectal biopsy changed the course of diagnosing prostate cancer: a simple blood test used for diagnosis raised the incidence of prostate cancer to the most common tumor diagnosed in men.

Prostate cancer management was the underdog of medical oncology treatment for most of the last century. Curative treatment consisted of surgery and radiation treatment (radium implantation) but not practiced as the majority of patients were diagnosed with advanced disease and survival was relatively short. No surprise then that endocrine treatment by surgical or medical castration developed in the second half of the century. This treatment plan, which received two Nobel prizes, provided spectacular pain and symptom relief for patients. It is of interest to note that diethylstilboestrol (DES) is considered as the first chemotherapeutic drug with an unequaled 80% response in symptom reduction. Most patients were castrated in the course of treatment with adjuvant chemotherapy for patients who were resistant to hormone manipulation. As this is a slow growing tumor, most patients die with rather than from their cancer.

Today, a man diagnosed with localized or locally advanced prostate cancer has three major treatment options: active surveillance, surgery, and radiation. Active surveillance involves carefully monitoring for signs of disease progression during which the patient undergoes a PSA blood test and rectal examination every six months with a yearly biopsy of the prostate. A radical prostatectomy is the surgical removal of the entire prostate gland. The procedure can produce significant side effects that might affect patient quality of life. External beam radiation, with precise targeting, is used in conjunction with brachytherapy and combined with hormone therapy. Clinical research will bring progress of wisdom to provide patients with a treatment tailored to meet individual needs.

In this issue Professor Louis Denis provides an extensive overview on prostate cancer screening. The Prostate Cancer Clinical Nurse Specialist role has been described as 'the provision of an all-encompassing service for patients and their families going through investigation, diagnosis, treatment and monitoring of prostate disease' and more information about this role is provided in an article by Janette Nichol. Side effects of the disease and treatment can have detrimental effects on all aspects of men's lives including sexual function and the personal sense of masculinity, body-image and self-esteem. More information about prostate cancer and sexual well-being can be found in the article written by Daniel Kelly.

Two Dutch nurses, Jan Alex Van Spil and Erik Van Muilekom are the authors of a book called a "Guide to Prostate Carcinoma" which is published by Elsevier Gezondheidszorg. An interview with the authors of this helpful and timely publication can be found in this issue.

As always, this issue of the Newsletter contains lots of information on EONS activities and projects and an interview with the president-elect who will assume the presidency of EONS starting in October 2007.

Of special note, I would like to draw you attention to the article on "Causes, Diagnosis, and Treatment of Extravasation" in this issue. Guidelines on the management of chemotherapy extravasation will be available in the near future on the EONS Guideline Toolkit which can be found at the EONS website. I wish you a nice summer and look forward to meeting you at ECCO 14 in Barcelona!

Hasta la vista!

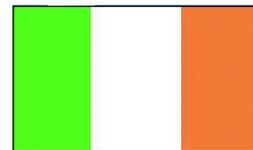
Jan Foubert

Editor in Chief



# Our colleagues from.....

## Ireland



Marie Lavin, President IANO

### Background/History

The Irish Association for Nurses in Oncology was founded in 1982. It is a non-profit making organisation that promotes continuing nurse education and provides a forum for exchange of knowledge for members of the nursing profession, who care for people with cancer.

As an association we are conscious that patients with cancer are being cared for in most wards in every general hospital, in institutions for the elderly and the community. The education and support of nurses working in these particular environments is crucial.

Our members are nurses working in both a specialist and non-specialist capacity. They work in hospitals, hospices, community, education, research and administration. Currently, we have 250 members.

### The mission statement of the IANO is:

To provide a programme of education and a forum for exchange of information for members of the nursing profession who care for people with cancer

### Aims/Goals

#### Aims of Association:

- To participate fully in the development of cancer nursing in Ireland
- To participate fully in the development of cancer nursing in Europe through our active membership of the European Oncology Nursing Society (E.O.N.S.).
- To participate appropriately with international nursing organisations

#### Objectives of the Association:

- To promote ongoing education in cancer care
- To increase awareness amongst nurses of cancer prevention and early detection
- To educate nurses in all aspects of cancer diagnosis, treatment, rehabilitation and palliation
- To provide a network for nurses working in cancer care
- To be a forum of support for nurses working in cancer care

### Organizational Structure

Our governance structure is an eleven member National Executive Committee (NEC), composed of the President, representatives of each regional branch, two standing representatives of the European Oncology Nursing Society and nationally elected members. In relation to the election of the president, if there is more than one person nominated, the members of the entire organisation are asked to vote for the nominee they wish to be president, and the nominee with the most votes is elected. To elect other members, each member has to be nominated and seconded by an NEC member, in order to be elected. Our organisation has approximately two hundred and fifty members. We have five regional branches in Dublin, Cork, Limerick, Galway and the Northwest.

### Projects/Initiatives/Activities

The IANO hold an annual national conference in the autumn. The NEC meets in the spring prior to the conference to plan the content and decide on the speakers, thus aiming to ensure that optimal learning will be provided to members, in terms of content and quality.

In the past three years, in association with EONS, the IANO have facilitated two TITAN (Training Initiative for Thrombocytopenia, Anaemia and Neutropenia) courses and one Target (Targeted Therapies) Course for members, which were very successful.



### Membership Benefits

The IANO publishes a newsletter each quarter, which is distributed to members. We also have a section in a multidisciplinary journal called Cancerwise, which we use to advertise the associations activities.

In 2003 the Tiger Trust, a National Cancer Charity donated money to the IANO. To date this money has been used to part fund the Training the Trainers Course for the Learning to Live with Cancer Programme and for bursaries for Master's Degree and Degree Programmes. In 2005, three bursaries of €3,000 each were awarded to oncology nurses undertaking Master's Degree programmes.

### Affiliation/Collaboration with other Societies

In June 2006, a 'Strategy for Cancer Control in Ireland' was launched which will be the blueprint for cancer services in Ireland, over the next decade. The IANO had representation on this committee which was led by the Minister for Health and Children.

We work in collaboration with the Irish Society of Medical Oncology (ISMO). For the past two years we have held a joint ISMO/IANO symposium which was very successful. In relation to the nursing contribution to this symposium, we held a competition whereby nurses were asked to submit an abstract of research they had carried out or a clinical innovation they had implemented. The abstracts were short listed and the nurses chosen were asked to present (in either the clinical or research category) at the symposium. One winner was chosen from each category by a judging panel and were awarded a 5000 Euro bursary to attend the Memorial Sloan Kettering Cancer Centre, New York, for a weeks clinical placement.

We also work in collaboration with the Oncology Nurses Association (ONS) and EONS.

### Interface/Relationship with EONS

The IANO has strong links with the European Oncology Nursing Society (EONS) since the early 1990s and has worked with them to develop education programmes for oncology nurses.

In 2004, Ireland under the auspices of the IANO was the first pilot site for an EONS TITAN course and due to the success of this initiative, a second TITAN course was held in May 2006.

The IANO facilitated the Target Course which was very well evaluated by the members who participated in the course.

### Future Directions

We are presently working towards encouraging nurses who work with patients with cancer in non specialist centres and the community to become members so they will develop their knowledge of cancer nursing but more importantly, their patients will also benefit by the evidence based care they will receive. As an organisation, we will continue to contribute to the development of cancer services in Ireland. As we celebrate 25 years in existence, we wish to strengthen our involvement in cancer nursing education and remain active at a European and International level.

# Prostate cancer and sexual wellbeing

Daniel Kelly PhD, MSC, BSc, RN, Onc Cert, PGCE.  
Reader in Cancer & Palliative Care, School of Health & Social  
Science, Middlesex University, London

## Introduction

The prostate grows slowly until puberty, and then rapidly until around the age of 30 when its size and function remains constant for about 15 years. Abnormalities tend to occur after this age. Approximately 20,000 men are diagnosed with cancer of the prostate in the UK each year. In England and Wales alone, 8500 will die from this cancer and it is now the most commonly diagnosed cancer in men. (1) Registration rates have increased over the past decade – with increased detection most likely being due to the PSA (Prostate Specific Antigen) blood test being more readily available. About 1 in 4 men will already have advanced disease (i.e. spread beyond the prostate and its closest structures) at initial diagnosis. Despite this widespread screening is not currently supported. (2)

Prostate cancer can be controlled using surgery or radiotherapy or less invasive methods such as HIFU (High Intensity Focussed Ultrasound). Hormone therapy is often reserved for more advanced or relapsed disease. Men with low-grade disease may also be monitored closely for signs of progression. However, the majority will receive some combination of the treatment options available (3). There may be considerable uncertainty about which treatment to accept and often the nature and likelihood of side effects will impact on the man's final decision.

All the available treatment induce side-effects (to varying degrees) including incontinence; impotence; proctitis and other bowel disturbances; lowered libido; growth of breast tissue; hot flushes; weight gain; fatigue and altered mood state. These can obviously have detrimental effects on all aspects of men's lives including their usual sexual function, as well as the personal sense of masculinity, body-image and self-esteem (4).

Management of treatment related side-effects present particular challenges for health care practitioners. The impact on sexual wellbeing and intimate relationships, for example, should be an integral element of general health assessment following treatment for prostate cancer. Without giving these issues adequate attention, however, it is easy for them to be ignored when the focus is on controlling the cancer. Nurses can play an important role by raising awareness, encouraging patients to talk about relationship concerns and encouraging further discussion and research about this aspect of prostate cancer care – whether they are involved in delivering care in the clinic or home setting.

## The Psychosexual Impact of Prostate Cancer

With such a close association with men's sexual organs, the impact of prostate cancer is dependent on the nature and severity of the disease and treatment-related side-effects. The literature suggests, however, that professionals do not find sexual issues easy to deal with (5). There is also considerable evidence that men and their partners do want sexual problems to be addressed during prostate cancer treatment (6).

Some men may consider having penile erections with sufficient strength to achieve and maintain penetration to be a measure of health and recovery. Others, however, may feel pleased with developing new ways of being intimate with their partners through other means. It should be remembered that sexual function cannot

always be predicted- some men report having erections shortly after prostate surgery, for instance, even when a urinary catheter is still in situ, while others may take months to recover this ability. Others may feel less sexual as a result of the embarrassment and smell associated with urinary incontinence. Wearing incontinence pads may be advocated without considering the impact on wider aspects of men's lives- including their self-esteem and sexuality (7).

Discussion of psychosexual concerns may reveal previously private aspects of couple's intimate relationships. For some this may provoke intense feelings of embarrassment. In a current project being undertaken with prostate cancer couples, it has become evident to us that the attitude and skills of health professionals can either encourage or deter the full disclosure of sexual concerns. There are also boundaries that couples may place on such disclosure that professionals should be aware of and respect. Importantly, this may be true in specialist prostate cancer settings as well as general practice or domiciliary care. Nurses, therefore, need to be aware of their own attitudes towards sexuality and whether they feel confident to enter into discussions with people who may be feeling vulnerable, yet concerned, that sexual issues are not important to busy practitioners. Training opportunities do exist for those who feel less confident in this area.

## Promoting sexual health and wellbeing

The key to assisting men with altered sexual function following prostate cancer treatment is the availability of an appropriate form of assessment (8). The PLISSIT model, for example, emphasises giving the client permission to discuss sexual issues; providing limited information where possible; offering specific suggestions if appropriate and referring to intensive therapy services where necessary. The above authors suggest an 8 week model of psychosexual assessment where each of the above steps are introduced into general health assessments as recovery takes place. Similar approaches may also be helpful in radiotherapy or other treatment settings. For men who are living at home, such as those on hormone therapy, some similar, but adapted, form of psychosexual assessment should also be available for use by primary care professionals.

It is important to emphasise once again that such assessment needs to take into account the values that men, and their partners, place on the sexual dimension of their relationship. Whilst some will emphasise the importance of erectile function, others may stress the importance of maintaining emotional closeness and the value of companionship. For the former group, it is important that cancer nurses are aware of the specialist psychosexual services available and how they can be accessed. For the latter group it may be equally important to check how they are coping and whether their views have changed over time.

## Conclusion

Prostate cancer is now a chronic disease that men can be expected to live with for many years. Professionals are, therefore, increasingly likely to meet men in different health settings who have been living with prostate cancer, and its treatment, over a prolonged period of time. This article has suggested that awareness of the importance of sexual wellbeing, as well as being able to apply a simple method of psychosexual assessment, are both essential to promote psychosexual wellbeing in the increasing numbers of men who will face a diagnosis of prostate cancer in the future.

For references see page 13

## Letter from the president

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The month of April has been filled with activities for EONS. For example, it was fantastic to meet and discuss breast care nursing issues with nurses at the Interconference Breast Cancer Meeting in Sarajevo. Despite language barriers, a very skilled translator provided us with the possibility to effectively communicate to conduct workshops and discussions. It is a humbling experience to meet nurses that lack the infrastructure we are used to and despite this, provide support to patients throughout their illness and treatment. I would like to extend my sincere thank you to the EONS members that participated as faculty for this meeting and also to the European School of Oncology for inviting EONS to collaborate in this conference.

A group of EONS members are working hard on developing new guidelines for the web-based toolkit. The topic for the new guideline is "Extravasation guidelines" which was prioritised as a useful guideline for our members.

I recently attended a breast cancer patient summit held in Prague. The meeting focused on discussions between health care

professionals and patient organisations and a central topic was how we can collaborate better in the future.

At the last Advisory Council it was decided that EONS should start developing a breast cancer nursing module as addendum to the core curriculum and this month a work group met in Paris to start the development process. The goal is to start writing the first part of this module which will focus on treatment of symptoms and side effects. I look forward to working with this expert group in moving the project forward.

With this short summary of EONS activities I would like to wish you a very restful summer holiday and hope to meet many of you at the ECCO conference in Barcelona in September.

Sincerely,  
Yvonne Wengström



## A Prostate Cancer Clinical Nurse Specialist

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*Janette Nichol, Prostate Cancer Clinical Nurse Specialist, Guys and St Thomas NHS Foundation Trust, London, UK*

In September 2000 the NHS Cancer Plan (DOH, 2000) was published heralding a new way forward for cancer services in the UK. Its aims were to save more lives, ensure people with cancer get the right professional support and care as well as the best treatments, tackle the inequalities in health and to build for the future through investment in the cancer workforce, so that the NHS never fell behind in cancer care again.

This plan required a huge increase in the cancer workforce and in particular key roles to support and inform patients through this process. One of these was the Prostate Cancer Nurse Specialist.

The Prostate Cancer Clinical Nurse Specialist role has been described as 'the provision of an all-encompassing service for patients and their families going through investigation, diagnosis, treatment and monitoring of prostate disease'. (Higgins, Professional Nurse May 2000).

The origins of this role lie within the necessity to address the needs of men with or at risk of prostate disease, who are disadvantaged by virtue of age, isolation, economic status, education, disability or ethnicity and to ensure that systems are developed which are accessible, inclusive and sensitive of these factors.

In the UK this role traditionally involves, some or all of the following. Diagnostics, counselling, patient follow up and symptom control, representing patients at multi-disciplinary meetings ensuring that their needs are assertively presented and that appropriate care packages are developed, counselling patients pre and post treatment, providing education and training, data collection, audit, research and liaison with government and charitable organizations.

The complex mix of skills required to fulfill this role require a versatility rarely seen in other health related professionals, from diagnostician to counsellor and friend. Formalized training for this role has been lacking until fairly recently. The introduction of specialist cancer courses through higher education at both degree and masters level, has reinvented UK specialist cancer nurse training. Recognition from our medical colleagues has also opened up a world of opportunities to train alongside them with regards to diagnostics (e.g. prostate biopsy, ultrasound and flexible cystoscopy certified courses) and follow up in addition to recognition in our own right as bringing new, complimentary skills and experiences to the medical team.

As a new Prostate Cancer Nurse Specialist in 2000, training consisted of consultant led assessment. My training started through a role I obtained at The Prostate Cancer Charity leading a nurse team working on a helpline receiving phone calls from men with prostate cancer, their partners and friends. Telephone consultations can be difficult when the individual is known to you; however this was a baptism of fire. Picking up the telephone without being able to anticipate the questions you may be asked or how to handle the caller at the other end is a challenge in itself. Communication courses now exist for Specialist Nurses and organizations such as The Telephone Helpline Association run more in-depth courses aimed at the medium of telephone consultation.

These experiences have helped our team focus on the strength of different mediums of consultation, most recently, e-mail and web based sessions.

My current position was new to the Hospital Trust, at its conception. The vagaries around the role allowed its development to take place

very naturally. It gave me time to help set up new treatment services for prostate cancer and immerse myself in the governance surrounding these procedures, as High Intensity Focused Ultrasound (HIFU) and Brachytherapy treatments were relatively new to the UK and Europe. My responsibilities now include the provision of a diagnostic service for prostate cancer in the form of a prostate biopsy clinic, specialist advice on symptom control post treatment, psychological support for both patients and their carers and a nurse-led erectile dysfunction service.

I act as an advocate, 'key worker' for patients and their families educating them on all treatment options enabling them to make an informed choice. I help them to communicate their wishes to the medical team, together negotiating an agreed pathway of care. I ensure that patient's physical, psychological, spiritual and cultural needs are assessed in relation to their disease and proposed treatment plan making appropriate referrals to supportive agencies as indicated.

My role within the department includes liaison with our patient focus group that help give input into service development within the unit. A succession of patient days over the last 3 years have ensured that changes made within the department are led by the patients

themselves rather than the needs and wants of the clinicians and nurses.

This consultation process has already allowed us to set up a new and innovative role in the shape of a Prostate Cancer Support and Information Nurse Specialist post. This post is a shared post between the hospital and a leading Prostate Cancer Charity. The nurse is able to give unbiased information and support to patients and their families with regards to treatment options for prostate cancer. Over a 6 month period it has become an invaluable part of our service and the patients we treat. Due to the success of this role, other collaborative roles with charities are now being discussed at management level.

The field of prostate cancer is continually breaking new ground and I believe this will provide great opportunities for nurses over the next 10 years. Professional clinical development and a solid education now established within the UK will insure the continuance of a robust training programme for Prostate Cancer Specialist Nurses of the future.

#### References

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DOH (2000) The NHS Cancer Plan. [www.dh.gov.uk](http://www.dh.gov.uk).

## Prostate Cancer

### A Guide for Nurses

Jan Foubert

**1. Both of you are the authors of a book called Guide to prostate carcinoma, published by Elsevier Gezondheidszorg: Please introduce yourselves?**



Erik van Muilekom & Jan Alex van Spil

My name is Erik van Muilekom (1965). I hold a Masters in Advanced Nursing Practice and work in the Netherlands Cancer Institute-Antoni van Leeuwenhoek Hospital in Amsterdam. For many years I worked as a Clinical Nurse Specialist in the field of urological, gastro-intestinal and gynaecological surgical oncology. At the present time I work as a project manager in private care with international patients.

My name is Jan Alex van Spil (1961); I too hold a Masters in Advanced Nursing Practice and work as a Nurse Practitioner at the Department of Radiation Oncology of the University Medical Centre Groningen. As a Clinical Nurse Specialist I have gained enormous experience in the field of medical oncology.

### **1a. Why did you publish this book? Is it common in the Netherlands for nurses to publish clinical texts?**

In 1981 the first Dutch Cancer Nursing study book was published in the Netherlands. Since then this book has been revised and updated several times. The last complete revision was in 2005. It provides education on the basic information on cancer nursing.

Our book is the first specific book covering the field of prostate cancer. It is primarily written for (oncology) nurses and other healthcare professionals. Following attendances at International conferences (especially in the US), there were many written resources on the subject of prostate cancer available for nurses. This was not the same in Europe. This was one of our first triggers to write a book about prostate cancer in the Dutch language.

### **2. How did you proceed?**

Previously, one of us had reviewed an English cancer nursing book for the publisher "Elsevier Gezondheidszorg" in the Netherlands. After this contact, we discussed our thoughts about the potential book with them. Elsevier Gezondheidszorg did some market research and after a positive result, they agreed with our plan to publish a book on this subject. For some chapters we asked specialists in a certain fields to contribute to specific sections and we also invited our colleagues to review the text. Based on evidence based literature and our own experiences, we both wrote the main chapters of the book. This resulted in a book which covers all dimensions of prostate cancer care including epidemiology, anatomy, treatment options, psychosocial problems and support for sexual dysfunction and palliative care.

### **3. Do you know if the book has been well accepted by the nursing community?**

The book launched in September 2006 and by February 2007 there were about 1200 books sold. We both are pleased with the popularity of the book. Not only nurses buy this book, general practitioners and patients have found it a useful source of information. We had a lot of positive response from our colleagues. The responses have supported our belief that there was an identified knowledge deficit about prostate cancer among nurses.

### **4. Was there a need for a book like this and did you discover things that you did not know?**

In the foreword of the book we wrote: "For many years there has been little attention to prostate cancer, but with the growing incidence in the western world and the consequences for health care there is now more

attention for this healthcare problem. The ignorance of the subject by a lot of healthcare professionals and the little attention in the literature was the main reason for writing this book".

### **5. As men, do you think that nurses have enough knowledge and awareness on the topic prostate cancer?**

The question raised whether the little attention for prostate cancer by nurses is due to the fact is that so many nurses are female? After finishing the book we still don't know for sure. What we do know is that in the books written by female American nurses there is no attention given to the male anatomy and little attention about male sexuality. These two subjects are very important if you want to understand the way treatments work and the causes of side effects. We hope that our book will contribute to a better knowledge and awareness about prostate cancer, and will lead to a better care for patients and their families confronted with a diagnosis of prostate cancer.

### **6. Can nurses play a role and if yes how?**

We think that nurses play an important role in the care for men and their families confronted with prostate cancer. A lot of treatments affect important issues in a man's life. For example the disease can affect their sexual life, body image, continence and relationships. In all these issues nurses can play an important role in talking with men about their concerns and provide them with information about disease and treatment. Some literature suggest that nurses can play a vital role in the decision making process. Besides that, it is important to talk and inform men and partners about interventions to minimize side effects of the treatment.

### **7. Do you have a message for the European oncology nursing community?**

We are not aware of all the initiatives in Europe concerning publishing books in the various languages but we would like to encourage colleagues to write books about cancer and cancer nursing. Our initiative is an example of how an idea becomes reality. Talking to publishers about ideas and try to persuade them of the value of writing books for nurses and other health care professionals. In Europe there should be more initiatives for international meetings for oncology nurses working in cancer care. Sharing experiences and networking is a valuable vehicle to improve care for our patients.

For questions: e.v.muilekom@nki.nl, j.a.van.spil@rt.umcg.nl

## **Communicating Cancer Pain**

The European Pain in Cancer (EPIC) survey investigated the prevalence and impact of pain in cancer patients across Europe. Pilot results have identified a lack of communication about cancer pain between patients and the healthcare professionals (HCPs) managing their pain. As a result, the Cancer Tales workbook has been developed as a communication tool to support HCPs in developing more effective communication with their patients to improve both the identification and management of cancer pain.

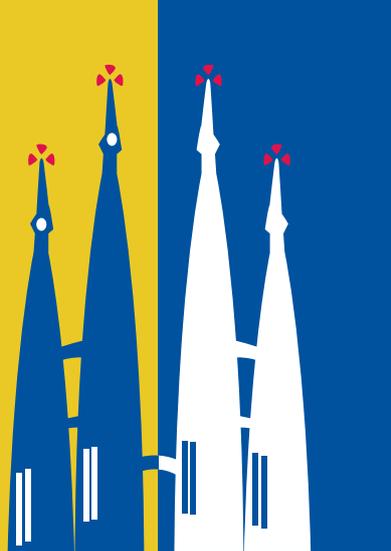
Cancer Tales is an emotive play developed from a collection of cancer patients' personal stories. The Cancer Tales workbook uses themes from the play to highlight key areas for improvement in communication around cancer, its diagnosis and treatment.

The workbook provides guidance and practical exercises to help primary care and specialist nurses, general practitioners and secondary care physicians improve their communication with patients.

The original text of Cancer Tales was reproduced with added educational chapters and a foreword by the play's author, Nell Dunn. The workbook was reviewed by a European editorial board of palliative care, pain management, oncology, nursing and communications specialists.

Copies of the workbook will be distributed to patient associations and organisations across Europe for distribution to healthcare professionals and students in June 2007. It will provide them with a resource to further develop understanding of the emotional and psychological impact of cancer for patients, and to improve communication with patients, carers and families.

The EPIC survey and Cancer Tales workbook are sponsored by Mundipharma International Limited, Cambridge, UK, under the auspices of the European Oncology Nursing Society (EONS) and the European Association of Palliative Care (EAPC).



# ECCO 14

## the European Cancer Conference



# Barcelona

23 - 27 September 2007

**ECCO 14 – a truly outstanding MULTIDISCIPLINARY oncology conference -  
unique in its kind**

A comprehensive educational and scientific programme with  
a strong integration of science and clinical medicine

A focus on the increasing role of nurses in care, research and education

A platform for health care providers and patients to meet  
in a two-day Patient Forum



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EUROPEAN  
CANCER  
SOCIETIES

Organised by the Federation of European Cancer Societies

**info: [www.fecs.be](http://www.fecs.be)**

## European Cancer Patient Coalition

The European Cancer Patient Coalition (ECPC) organised a landmark meeting in November 2006 to support Europe's continuing fight against cancer. The Slovenian Cancer Summit took place over three days in Ljubljana with the direct encouragement of the President of the Slovenian Republic and under the patronage of the Slovenian Ministry of Health and the European Commissioner for Science and Research. With Alojz Peterle, founding member and co-chair of MEPs Against Cancer (MAC), its moving spirit, and the ECPC's resolve to bring a truly patient-centred focus to cancer care, the Summit drew together more than 160 delegates including government health officials, researchers in oncology, public health experts, as well as the patient community.

If you are interested in learning more about the Summit, please consult the following website which contains information on the event: [www.unitedagainstcancer.eu](http://www.unitedagainstcancer.eu).

## Extravasation Guidelines Task Force

EONS is working on updating clinical guidelines for the treatment of chemotherapy-associated complications and one complication which should be considered is the extravasation of anthracycline agents. Although nurses have been implementing treatment of drug extravasations for many years, no common guidelines for treatment exist within Europe. Therefore, EONS has decided to establish a task force to develop a new guideline and for this frequently occurring problem with support from our new sustained partner TopoTarget.

The purpose of establishing guidelines for anthracycline extravasations within EONS is to aid oncology nurses in their understanding of recommendations for best practice when extravasations occur. Once developed, the extravasation guidelines will be included in the Guidelines Implementation Toolkit being developed by EONS. The Toolkit is a work-in-progress. Completed and approved guidelines will be available on the EONS website.

## Educational Programme on the Management of Breast Cancer

EONS is interested in setting up an expert panel of oncology nursing specialists in order to develop and deliver an independent educational programme for nurses which focuses on the management of breast cancer. The programme will be sponsored by an independent educational grant from sanofi aventis.

The main objective of this programme is to provide oncology nurses with state-of-the-art education on the latest advances in the treatment of breast cancer and how these advances impact the treatment management of patients. The content of the programme will be based on the educational needs of nurses, as revealed by a recent EONS breast cancer nursing survey of 302 nurses in 19 countries.

The results of the survey showed, among other items, that there is a requirement for further information and education on breast cancer nursing. Almost all of the oncology nurses surveyed (94%) stated that they would like to know more about issues related to the care of patients with breast cancer including the management of toxicities

related to cancer treatment. Over half of the respondents (55%) rated knowledge of chemotherapy as their top educational priority. This ties in with the result that the side effects of chemotherapy, including providing patient education on side effects and the management and monitoring of side effects, were in the top 4 parameters of daily nurse involvement in breast cancer care (from a total of 21 parameters). Respondents also expressed interest in improving their knowledge of managing the psychosocial aspects of cancer.

It is envisaged that the content and scope of this educational programme will be developed by an international expert panel with EONS overseeing the activities in order to ensure scientific credibility and independence.



## Time to Take Aim – the TARGET is moving!

Regular readers of the EONS Newsletter will already be aware of the TARGET course; the exciting initiative for training European oncology nurses about targeted therapies, an innovative approach to treating cancer. TARGET focuses specifically on anti-EGFR (epidermal growth factor receptor) therapies, and was developed by EONS with the support of Merck KGaA. The training programme has been fully accredited by EONS and earns attendees 8 hours of EONS credits as they undertake 2 hours of pre-course preparation followed by 6 contact hours during the course itself. TARGET materials had been translated into 8 main European languages (French, German, Spanish, Dutch, Swedish, Estonian, Italian, Greece as well as English). Training courses have taken place in Estonia, Germany, Ireland, Israel, The Netherlands, Switzerland, United Kingdom with courses planned in Belgium, Germany, Greece, Portugal, Slovenia, Spain, Sweden, Switzerland and the UK.

## Name Change

As of January 1st, the national cancer nursing organisation in the Netherlands (Nederlandse Vereniging van Oncologie Verpleegkundigen [VvOV]), a full member of EONS, is now known as the Verpleegkundigen en Verzorgenden Nederland, Oncologie (V&VN). The name change is a result of the fusion of the two organisations, the VvOV and the V&VN.

## Accreditation Update

The European Blood and Marrow Transplantation Nurses group (EBMT) received EONS accreditation for its 23rd meeting which was held in Lyon, France from 25-28 March. Accreditation was also granted to the pre-meeting study day for nurses which took place in conjunction with the meeting.

The University of Glamorgan School of Care Sciences, Faculty of Health, Sport, and Science located in Scotland, UK has received EONS accreditation for the following course: Cancer Care/BsC (Hons) via Distance Learning. For more information please contact: [www.glam.ac.uk](http://www.glam.ac.uk)

# Sara Faithfull

## Our next EONS President

### Who are you and what is your job?

I am Professor of Cancer Nursing at the European Institute of Health and Medical Sciences, University of Surrey. As part of my role I strategically lead the cancer and palliative care curriculum for nurses and allied health professionals as well as teaching specialist areas such as practice development, nurse led outcomes, health evaluation and clinical research methods. Most of my day-to-day work is educational, developing curriculum, running workshops or supervising students a smaller part of my week is clinical research. Like most nursing academics my job is very educational and university focused although I would like to have a different balance to this in the future. I primarily in my heart am a nurse and like to continue to work with those with cancer and be amongst nurses in clinical practice. Currently I work two half days a week in a specialist cancer centre with men who have been treated for prostate cancer providing strategies for managing urinary problems post radiotherapy. I also work with different clinical teams and facilitate the introduction of new services or innovative roles and evaluate these innovations so that change can be sustained. It is good to still be closely connected with cancer practice and to still feel I have skills that are useful. An analogy I think of being an academic is a bit like being a foot baller who hangs up his boots to become the coach. Although you get pleasure out of others successes and skills there is still a part of you who wants to be kicking that foot ball around!

### What do you love about your current job?

I am very happy at Surrey because of the ethos of the work environment which is to provide practice based education and research. This philosophy means that our courses are dynamic changing in collaboration with local health networks with new courses running each year. Furthermore practice is central to provision and this draws together research and how ideas are utilised in practice through work based learning, e technology and cross-disciplinary approaches. The team I work with are exceptional individuals specialists in their own field and as such contribute immensely to the spirit and ethos of the cancer and palliative care team.

### What do you do to relax?

My garden is the place I relax. I sit and watch the birds, smell the flowers and savour the peace and quiet. I don't sit long as there is always some area to dig or flowers to tie up and I always feel restless to be active. I also enjoy music and find it a good way to relax. My son plays trumpet and I flute so we are very noisy neighbours. We have lots of fun playing Jazz and Latin music, which often ends in laughter, as I am not such a good player as my son.

### What is your greatest indulgence?

This is a difficult question as I think I have many indulgences! I suppose apart from chocolate, it has to be time. The time to sit and read a book or just be with my family. It would be possible to work always and it is hard to get that life balance right.

### What is your favourite piece of technology?

This has to be the introduction of satellite navigation. My friends know that I am not good at finding my way to places and the area that work covers i.e. Surrey, West Sussex and Hampshire is quite big so this piece of kit has been revolutionary for finding destinations.

### Where do you go for inspiration?

Rather than where do I go may be it is where do I find inspiration? This has to be in practice. Listening to clinicians and talking with patients can be very insightful; people often know what would be



useful or how to make things better. Being an outsider to the clinical team makes it easier to see possible solutions or to explore ways to implement innovation. Inspiration often comes out of simple things and when you are busy involved in practice the solution may not be clear. A questioning approach and often a fresh look at how things can work often provides inspiration.

### What do you most admire?

I admire people with positive enthusiasm and a lust for learning and knowledge. I also admire nurses who are studying. Students have many challenges funding such studies, working in uncertain job situations, but also managing family life and children. Most students at university have only one focus not multiple and I admire the tenacity of nurses who are studying for postgraduate degrees and qualifications.

### What is the best piece of advice you have ever been given?

The best piece of advice I received was not to me individually but as part of a lecture I heard. Lesley Degner from the USA was talking about how she developed research capacity in cancer care. She talked very honestly about the difficulties of attracting research funding in clinical practice and encouraging change. In the UK only 1 in 20-research applications are successful so it's tough to keep applying and taking rejection. Her advice was to focus on the team not the individual project, as the team are the most important asset in any research enterprise. Who you work with and how you interact is essential for developing any team not just research. No one person can hold the knowledge or different skills and recognising and celebrating a community of practice makes for a healthy environment and research success. Apply for broader grants and make sure your area of research is integrated in this so that knowledge grows as part of wider themes. This advice has been helpful in developing a wide variety of skills within the European Institutes cancer research team with health evaluation, economics, older age expertise and multi method approaches. She also advised not to give up promoting difficult areas as they will eventually have their own time and this is something that has stayed with me.

### What do you find difficult?

I am bad at saying No!

### What haven't you done that you would like to?

I would like to combine my academic role with clinical working in a hospital or community to provide advice and support post treatment. These higher academic roles don't exist in the UK unlike our medical

colleagues. If you stay as an academic there is a clear divide in roles and it would be a dream to have a legitimate clinical role. A more ethereal dream is to be able to ride a horse. I learnt to ride in France on holiday but was not able enough to gallop along the beach and watched in envy as my friends were let loose. I may need to win a lottery ticket before I could do this.

#### **What has been your finest moment?**

My greatest achievement and finest moment was passing my nursing degree. I studied hard part time whilst working as a full time ward sister and never thought I could do it. I had trained the old fashioned way as an apprentice and had gone on to study many years after qualifying. This meant having only 1 day off a week for 3 years and one year study full time without any income! I didn't believe I could do it but felt it was the most amazing achievement when I saw my name on that list of passes.

#### **Do you look forward to your presidency?**

I do look forward to it but also find it a rather scary responsibility with so many excellent presidents to live up to. Many of the board members are leaving to go on to new things and I hope the new members of the EONS board will have vigour and enthusiasm for the challenges ahead and be supportive to each other. I know that it can be a lot of fun and an opportunity to make life long friends. Much of what is required is unknown and I know that I will have to spend more time away from my family. EONS have already given me pleasure in meeting new people so I look forward to widening my horizons.

#### **What will be the challenges during the presidency?**

I see the challenge of the presidency as to be able to provide the EONS board direction and leadership so that as a team we can deliver outcomes not only for national societies but also individual EONS members. This is a great period of change not only in cancer care but also in technology. Cancer care is being provided in very varied environments and being able to physically reach cancer nurses is becoming harder not easier, because care is located in so many diverse settings. I see this as a period of consolidation rather than expansion, using technology and developing practice projects to provide a greater variety of resources to members. We have some good models that work well in developing training projects and in developing curriculum but we also need to encourage new networks and technology to share these innovations. Furthermore as a board we react to the needs of the membership who help us decide long-term goals so the challenges will always be a little unknown.

#### **Do you have a message for the EONS membership?**

Being part of any community involves listening, respect, commitment and action and I would like to be a president who fosters this community of practice. Being able to provide directly a range of services for EONS members and develop the ability for nurses to network would be for me a key achievement in strengthening European cancer nursing.

# ANNOUNCEMENT



## ***European Journal of Oncology Nursing* – Impact Factor from 2008**

The *European Journal of Oncology Nursing* is delighted to announce that it has been accepted for inclusion in the Science Citation Index Expanded, the Social Sciences Citation Index and Current Contents/Social and Behavioural Sciences. Inclusion in these databases will lead to substantial international exposure for authors publishing their work in *EJON*.



- *EJON* will be awarded an Impact Factor. Our first Impact Factor will calculate the number of citations in 2008 to articles published in 2006 and 2007. The 2008 Impact Factors will be published by Thomson Scientific in 2009.
- Please remember to use the full name of the journal – *European Journal of Oncology Nursing* or *Eur J Oncol Nursing* – to cite articles published in *EJON*. You must also include the year of publication, the volume number and the pages of the article that you wish to cite.



**Anthracycline extravasation  
could strike at any time**

**Savene™ – Brief prescribing information**

(based on the UK Summary of Product Characteristics SPC)

Please refer to the SPC for full prescribing information.

Each Savene™ box contains 10 vials of Savene™ (dexrazoxane) Powder (10 x 500 mg each) and 3 bags of Savene™ Diluent (3 x 500 ml each) for infusion. **Indications:** Treatment of anthracycline extravasation. **Dosage and administration:** Administration of Savene™ should begin as soon as possible and within 6 hours after the accident. Savene™ should be given as an intravenous infusion once daily for 3 consecutive days according to body surface area: day one, 1000 mg/m<sup>2</sup>; day two, 1000 mg/m<sup>2</sup>; day three, 500 mg/m<sup>2</sup>. For patients with a body surface area of more than 2 m<sup>2</sup> the single dose should not exceed 2000 mg. Cooling procedures such as ice packs should have been removed from the affected area at least 15 min before administration. Before infusion, Savene™ Powder must be reconstituted with sterile water before further dilution in Savene™ Diluent. Savene™ is not recommended in children and patients with renal and hepatic impairment. Safety and efficacy have not been evaluated in the elderly. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients, women of child-bearing potential not using contraceptive measures, lactation or concomitant vaccination with yellow fever vaccine. **Precautions:** Local examination should be performed on a regular basis after treatment until resolution and haematological monitoring should be undertaken regularly. Savene™ should be administered only under the supervision of a physician experienced in the use of cancer chemotherapeutic agents. Routine liver function tests are recommended before each administration of Savene™ in patients with known liver function disorders. Patients with renal dysfunction should be monitored for signs of haematological toxicity. Men are advised not to father a child during and up to 3 months after treatment. Women of childbearing potential must use contraceptive measures during treatment. This product is generally not recommended in combination with live attenuated vaccines or with phenytoin. Dimethyl sulfoxide (DMSO) should not be used in patients who are administered Savene™. As the Savene™ diluent contains potassium (98 mg/500 ml) the plasma potassium level of the patient must be closely monitored in patients at risk of hyperkalaemia. It also contains sodium (1.61 g/500 ml) which may be harmful to patients on a low sodium diet.

**Interactions:** Interactions common to all cytotoxics, which may also react with oral anticoagulants. Concomitant use of immunosuppressives such as cyclosporine and tacrolimus receive extra consideration due to excessive immunosuppression. **Pregnancy and lactation:** Savene™ should not be administered to pregnant women unless clearly necessary. Women of childbearing potential should use contraceptive measures during treatment. Mothers should discontinue nursing during Savene™ therapy.

**Side-effects:** Very common: nausea, injection site pain, post-operative infection. Common: vomiting, diarrhoea, stomatitis, dry mouth, pyrexia, injection site phlebitis, injection site erythema, fatigue, injection site induration, injection site swelling, peripheral oedema, somnolence, infection, neutropenic infection, wound complication, weight decrease, decreased appetite, myalgia, dizziness, sensory loss, syncope, tremor, vaginal haemorrhage, dyspnoea, pneumonia, alopecia, pruritus, phlebitis, thrombophlebitis superficial, limb venous thrombosis. All adverse reactions have been rapidly reversible. More rarely increased concentrations of liver enzymes (ALT/AST) have been reported. Refer to the SPC for additional information. **MA:**

EU/1/06/3350/001. Date of Preparation: January 2007. TopoTarget A/S Fruebjergvej 3, DK



## Be prepared

Anthracycline chemotherapy has long been a cornerstone of cancer therapy. However, it carries a relatively rare but potentially devastating risk: extravasation.

Anthracycline extravasation can result in severe injuries including ulceration, necrosis, slow-healing lesions, serious joint damage and may not only require surgical intervention, but also long-term suspension of cancer chemotherapy<sup>1</sup>.

**Now there is an Antidote\* - Savene™ from TopoTarget.**

Savene™ has shown a clinical success rate of > 98% in biopsy proven anthracycline extravasation. It not only avoids the need for surgery but also allows to continue chemotherapy without interruption<sup>2</sup>.

Savene™ is available as an 'on-site-ready-to-use' emergency kit – allowing you to always prevent an accident from becoming an emergency.

[www.savene.com](http://www.savene.com)



### The Antidote to anthracycline extravasation

\* Effective against doxorubicin, epirubicin, daunorubicin, idarubicin

1. Mouridsen H.T. et al. Treatment of anthracycline extravasation with Savene (dexrazoxane): results from two prospective clinical multicentre studies. Ann Oncol. 2007; Volume 18 Issue 3:546 - 550. 2. Mouridsen HT, et al. Treatment of anthracycline extravasation with Savene (dexrazoxane). Results from two prospective clinical multicenter studies. ESMO late-breaking Abstract Session: 2 Oct 2006.

# EONS Awards:

## Excellence in Cancer Nursing Management, Education and Clinical Practice

The European Oncology Nursing Society is pleased to announce that the following grants will be awarded at the 6th EONS Spring Convention which will take place in Geneva, Switzerland, from 27-29 March 2008: the EONS Excellence in Education Grant, the EONS Excellence in Clinical Practice Grant and the EONS Nursing Management Grant.

EONS awards these grants each year to outstanding nurses engaged in cancer education, management or clinical practice. The aim of these awards is to acknowledge excellence in these three distinct areas of cancer nursing, promote excellence and the dissemination of good practice, and provide the European cancer nursing community with appropriate models of excellence as a stimulus to further development.

The question as to how one defines 'excellence' is one that has exercised the minds of nurses, managers and educators for many years and it would appear that European cancer nurses are reticent at nominating themselves or others for one or more of these awards. Information about nominating yourself or another person for an award will be available shortly, but it seems appropriate to start thinking about the process early. Some forewarning of the criteria to be used should help you in thinking about the merits of any nomination you may wish to make once the nomination period has been announced.

The definition of excellence which will be used by members of the nomination committee in deciding this year's winners is, 'performance which is of outstanding merit and distinguishes the nurse as exceptional amongst his or her peers'. It is envisaged that nominees will demonstrate creativity, leadership, team spirit and vision in addition to expertise in the area of cancer education, management or clinical practice. One important factor to consider is that excellence can be demonstrated at local, national or European level – or any combination of the three. Nominations which demonstrate excellence within your own unit, hospital, organisation or educational institution are of equal consideration to those demonstrating excellence at national or European level so long as they meet the above definition of excellence. The area of work of the nominated individual must be devoted primarily (if not uniquely) to the clinical care of cancer patients or their families, the education of those engaged in caring for patients, or the management of services,

staff or organisations providing cancer care. A detail of the nomination process is available at the EONS website [www.cancerworld.org/eons](http://www.cancerworld.org/eons) and has been sent out to the national societies and the EONS membership.

In the meantime, start looking for examples of excellence in your own or others' practice and don't be embarrassed to let others know about it!

### Call for Applications for the Novice Researcher Award 2008 sponsored by the European Journal of Oncology Nursing

As part of the Society's ongoing strategy to promote the conduct, dissemination and utilisation of oncology nursing research, EONS is pleased to announce the Novice Researcher Lecture at the 6th EONS Spring Convention which will take place in Geneva, Switzerland, 27-29th March 2008.

EONS invites members to apply for this prestigious award. The successful candidate will be invited to attend the Spring Convention and to deliver the Award Lecture. Conference fees, hotel and travel expenses will be covered.

Applications are welcome from novice nurse researchers who are actively involved in nursing research and who are willing to present the successful project during the Spring Convention.

Applicants should submit a summary in English of their work in no more than 1500 words along with an abstract (a summary of the work on one A4 page), which will be published in the proceedings book of the Spring Convention and a short curriculum vitae with a passport sized photo.

Applicants must be members of EONS. Submitted applications will be reviewed by a panel of expert nurse researchers. Selection criteria will involve scientific merit, relevancy to cancer care, feasibility, and expertise. Results will be communicated in January 2008. Applications should be submitted to the EONS office no later than September 30th 2007.

We look forward to receiving applications from nursing colleagues from all over Europe.

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# Prostate Cancer Screening

L. Denis

Director, Oncology Centre Antwerp (OCA), Antwerp, Belgium  
Europa Uomo

One ounce of prevention is worth a pound of treatment remains a popular idea in many cultures. It is certainly true that this statement applies to a number of public health threats such as speed control and seat belts to prevent car accidents, smoking cessation programs, and information on lessening the risk of sexually transmitted diseases such as HIV disease. However, prevention of cancer remains controversial and prevention of prostate cancer even more so.

Prostate cancer was somewhat neglected in the previous century for three reasons: it was usually incurable after diagnosis, it was a disease of the elderly, and hormonal treatment brought relief in the great majority of cases. This situation changed drastically with the introduction of Prostate Specific Antigen (PSA), a simple blood test that indicates the risk for having prostate cancer. Simultaneously we saw the development of the biopsy gun, allowing multiple painless biopsies of the prostate gland, and transrectal ultrasound (TRUS) offering accurate positioning of the biopsy needle in the different regions of the prostate. A star technique was born resulting in thousands of publications extolling the virtues of this diagnostic procedure.

## Cancer Screening

The enthusiasm for the hypothesis overcame caution and most people forgot that the U.S. Food and Drug administration took one year to approve the use of PSA in diagnosing progressive disease but needed five years to approve PSA as a diagnostic marker for prostate cancer. No heed was taken to the complex reality that screening results in over detection, increases false positive and false negative results, and can lead to over treatment. A classic case is the neuroblastoma screening in 1996 in Japan with a five-fold increase in incidence, surgery and identical mortality (1). We all know the difficult course in judging the advantages of breast cancer screening in women over 50 and the debate in screening from the age of 40. TRANSBIG, the international translational research network linked to the Breast International Group (BIG), makes it clear that it aims to develop individualized breast cancer treatment and reduce over treatment in breast cancer estimated to range from 10 to 20% of cases (2). Recent results of a failed lung cancer screening test received media interest. In this case, a CT scan detected lung cancer 144 times in 3.246 people. More than 300% of the expected cases and a 1000% increase in surgery resulted from this trial ending up with the same mortality rate achieved without screening (3).

**Table 1: Principles of screening for cancer**

- The disease should be an important health problem
- The disease should have a detectable preclinical phase
- The natural history of the lesions identified by screening should be known
- There should be an effective treatment for such lesions
- The screening test should be acceptable and safe

(Adapted from AB Miller, 1996)

The public health experts and epidemiologists who recognize the danger of simplistic thinking and described the principles of screening which were condensed to five points by Anthony Miller in 1996 (Table 1).

The use of correct definitions is important: screening is the systematic examination of asymptomatic men to detect and hope to cure localised disease in a given population. Screening is not intended to fit the need of the individual patient. Here it is more appropriate to use case finding, cancer testing or early diagnosis.

To be blunt you don't need to be Einstein to use a test that finds more cancer and if you treat all cancers you will save lives. The question is how many lives are saved and at what price of human suffering and health costs? Currently, one needs to operate on 17 to 22 men to save one life leaving half of those treated impotent and a fourth of those patients incontinent (4) which leaves the benefit of such procedures in doubt. Europa Uomo, the European coalition against prostate cancer, believes that quality of life is of utmost importance and that the indication for curative treatment which is aggressive should be limited to younger patients with potentially fatal disease – in reality, only a of the total number of men diagnosed with prostate cancer.

## The Miller Principles applied to Prostate Cancer

### An important health problem

Prostate cancer is the leading cancer in males (20.3%) in Europe. This figure may be influenced by the frequency of use of the PSA test which had a similar effect as mammograms did in breast cancer. Still the number of deaths has risen 16% since 1995 due to the rapid increase in the number of men reaching older age. The figures for incidence (new cases/year) of 237,800, mortality rates of 85,200, and the prevalence of cancer of 2 million men in the EU makes prostate cancer management a priority in public health (5).



### A detectable preclinical phase

Prostate Cancer is characterized by a long (10 to 20 years) subclinical stage. Considered as one of the strong arguments for screening, the long subclinical stage is also an argument to avoid diagnosing prostate cancer without symptoms in men with a life expectancy limited to 10 years. Indeed after the first diagnosis it

takes another 10 to 15 years to die of the disease. With a mean life expectancy of + 77 years in the EU it would seem reasonable from a screening point of view to not screen men over age 70.

The establishment of PSA > 4 ng/ml as the cut-off risk factor (now considered outdated) prompted a tsunami of biopsies resulting in increased incidence. The detection of smaller tumors including indolent cancers, led to a significant shift in the stage of cancer detected and a lower mean age of patients at the time of diagnosis (6).

In simple words, PSA-directed biopsies anticipate the clinical diagnosis by 10 years and the majority of patients in the PSA era present with earlier stages and few with metastatic disease. However, 50% of patients do not need immediate treatment, 30% will probably never need treatment and 25% of those that we treat have locally advanced disease (7).

#### *The natural history of identified cancers*

The facts look easy to understand. Prostate cancer starts at age 30 and half of all men have some type of precancerous lesion (prostate intraepithelial neoplasia - PIN) or microscopic cancer that can only be identified by a meticulous histologic examination on autopsy or surgical specimen by the age of 50. The percentage of these mini-cancers increases with age. At age 80, a man has an 80% chance of having a microscopic cancer. These histologic cancers are called latent since they don't seem to act like cancer.

However some of these cancers controlled by our body defenses do grow very slowly and given enough time can be detected usually at a size of 0,5 cc in up to 30% of men by age 60 in the western world. The detectable number of cancer by biopsy is variable in different parts of the world: there is much less cancer in Asiatic countries and much more in African-Americans which raises the question of genetic determination and/or lifestyle as a possible contributing factor of cancer.

Only one third (10%) of men in the western world develop prostate cancer with symptoms. After a long disease course, metastasis is detected after 7 to 10 years and 2% to 4% of patients die of their cancer after 10 to 15 years.

These figures show that most small cancers remain latent and that screening must lead to over detection and possibly over treatment. There is no guarantee that these mini cancers will never become aggressive over the remaining years of a lifetime. Generally speaking, a relaxed policy is indicated over the age of 65 but extra caution advised in the age range of 50 to 65. It is understandable that this point of uncertainty can be used pro or against screening practice and lies at the base of a continuing controversy between public health experts and clinicians.

**Table 2: Prostate specific problems among Dutch prostate cancer survivors and an age matched norm population in percentages**

	Treated	Norm
Incontinence urine	23 - 48%	4%
Incontinence bowel	5 - 14%	2%
Erectile dysfunction	40 - 74%	18%

(Adapted from TF Mols, 2007)

#### *There should be an effective treatment*

There is no doubt that surgery, radiation (external or internal) and other forms of treatment by cold (cryosurgery) or by heat (high-focused ultrasound) can destroy the prostate and all cancer limited to the gland.

The preferred treatment policy of the last century was seek and destroy. Based on our increased knowledge and experience we now aim treatment to focus and control. Approximately 50% of screen-detected cancers do not need treatment meaning patients could be saved from the side-effects of obliterating the prostate. Treatment side effects are decreasing through improvements in technique both in surgery and radiation therapy but they remain substantial if one observes the reported side effects in a study of 964 patients alive 5 to 10 years after primary treatment based on UCLA-EPIC and SAC questionnaires (Table 2) (8).

#### *The screening test should be acceptable and safe*

There is no dispute that the serum PSA test, used to indicate the risk of having prostate cancer, is acceptable to the patient and safe to perform. It was readily accepted by the medical profession and is now a widespread test used routinely in aging men. However, the PSA is not specific for prostate cancer but for prostate diseases which then produces increasing numbers of false positive and false negative test results causing anxiety for the patients or a false sense of security. The development of a number of derivatives to increase the positive predictive value (PPV) shows that PSA testing is very not reliable (in the clinical accepted ranges from 4 to 10 ng/ml). Free screening with PSA is unreliable as laboratory blood analysis must be performed within 2 to 3 hours of drawing blood samples. More reliable are repeated tests over time to evaluate the kinetics of PSA.

#### **Proving the Advantage of Population Screening for Prostate Cancer**

It is obvious that reflections on the answers to the five requirements to advocate screening for prostate cancer leave room for uncertainty and speculation. To settle the dispute, an evaluation of randomised controlled trials (RCT) may provide evidence of the benefit of screening in lowering cancer mortality in the population with acceptable morbidity (9). The complexity of running and interpreting RCTs on prostate cancer screening, which requires a 10 to 15 year follow up, is one of the reason that only 3 RCTs to evaluate screening benefits were started in the last century.

The Quebec trial, started in 1988 and included 7,155 screened patients, received short-lived fame claiming a reduction in mortality of 69% after publication in 1999 (10). However, it was quickly established that the analysis did not follow the required intent to screen methodology and formal reanalysis showed an excess of deaths in the study group suggesting a selection bias (11). The PLCO study accrued 74,000 men for digital rectal examination and PSA testing annually starting in 1993 and the results will be available in the next years. The ERSPC trial accrued close to 270,000 men and was officially launched in 1993 (12). Its main endpoint on mortality measures the value of the employed screening test DRE, PSA and TRUS, and further evaluation of quality of life (QoL) and cost-benefit were assessed.

Recently new screening trials compare curative treatment [PROTECT study (13)] or a genetic predisposition [IMPACT trial (14)] or on an evaluation of over detection while eliminating over treatment by selecting indolent prostate cancers for active surveillance (PRIAS study). The latter study constitutes an integral part of the PROCABIO study as the PRIAS patient cohort is the ideal model to complement the prognosis based on histology by the search for biomarkers that indicate the early genetic changes of aggressive cancers ([www.prias-project.org](http://www.prias-project.org)). We expect that the results of this study will provide guidance for tailored, individual prostate cancer management in EU countries.

#### *Preliminary Results of the ERSPC Trial*

End results on mortality by prostate cancer screening are not yet available as these depend on the number of events (deaths) of the

trial participants. However, results confirm that prostate cancer has a long treatment history and the mortality is low. Analysis of secondary endpoints has provided valuable information on the screening tools DRE, PSA and TRUS.

#### Digital Rectal Examination (DRE)

Symptoms are not reliable as screening tools. Difficulty voiding, for example, could be caused by benign prostatic hyperplasia (BPH). Further, urinary symptoms caused by prostate cancer indicate incurable disease.

Some time ago, a national screening program in Germany based on DRE failed completely. Where DRE is a standard examination in any physical examination its use in screening programs in this PSA era is of little or no benefit to the detection of early prostate cancer (15). The performance of a DRE in a screening program can be a barrier to patient participation (16). However we insist that physicians looking for early diagnosis of prostate cancer on an individual basis should perform this simple examination.

#### Transrectal Ultrasound (TRUS)

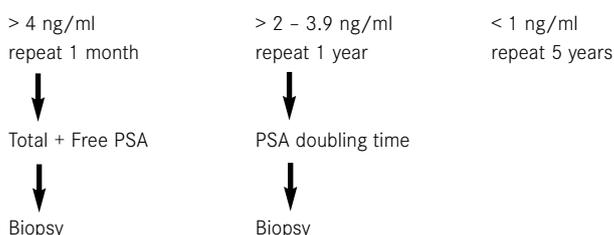
When transrectal ultrasound was introduced in Europa in 1975 we had great hopes to establish a painless, inexpensive, and reliable imaging diagnosis of prostate cancer. The examination has become a standard in the urological evaluation of the lower urinary tract in measuring prostate volume and directing the biopsy needle in specific areas of the prostate, but failed to be reliable in the diagnosis of early cancer (17). Numerous improvements in hard- and software have been introduced without a breakthrough. One of the latest is histoscanning which is performed by extracting and quantifying the statistical features of the reflected ultrasound waves. Other imaging techniques including magnetic resonance imaging (MRI) have not proven effective.

The reliability of TRUS is highly dependent on technique and interpretation: the physician must be skilled at performing TRUS and the radiologist must be skilled at reading the scans. An additional biopsy should be obtained if an area is considered suspicious for cancer.

#### PSA and Derivates

In terms of its volume in clinical use and its qualities in evaluating progression of prostate cancer, PSA and its derivatives remains one of the best and the most popular marker in oncology. Its limitations in diagnosis are due to its specificity for prostate diseases in general rather than prostate cancer in particular and the prevalence of benign prostatic hyperplasia (BPH) in men over 50. Moreover there exists a variability of up to 40% of the reported values in a clinical setting due to biological and methodological variability. It is understandable that sexual activity and bicycle riding increase the PSA and not all clinicians recognize the different results obtained by the different available assays (18). A practical guide to a more reliable use of PSA to determine prostate cancer risk after the age of 50 is presented in Table 3.

**Table 3: Algorithm for risk of prostate cancer diagnosis at age 55-70 based on PSA tests**



(From OCA, 2007)

The final blow to one cut-off value of total PSA (tPSA) resulted from the Prostate Cancer Prevention Trial (PCPT) (19). In this trial, a biopsy was performed in all consenting participants after seven years of follow-up. Up to 40% of cancers were in the low PSA ranges. This finding had been previously recognized and was the reason that the ERSPC lowered its biopsy indication from 4 to 3 ng/ml PSA.

#### Conclusion

Sound clinical evidence is lacking to support a population screening based on the endpoints of mortality and morbidity of prostate cancer. Furthermore there is controversy over the reliability and validity of DRE, TRUS and PSA and its derivatives as screening tools for prostate cancer.

The reality is even worse as we start questioning the basis for cancer diagnosis on histological tissue. The Gleason score was adopted as a fine-tuned grading system but demonstrated shortcomings in clinical practice. There is a trend to return to the classic recording of the amount of high grade cancer present in the biopsy specimen (20). The number and position of the biopsies influence the percentage of diagnosis which as false negative results adds to the overall uncertainty in the diagnosis of prostate cancer.

Waiting for the results of extensive and long-term randomized trials is no consolation to the 80,000 European men dying of prostate cancer each year. We have to do better.

Paradoxically, a way out of this dilemma is the over detection in screening for prostate cancer which reported finding indolent cancers in 50% of screened men which may cause anxiety for the patient and doctor but will not harm the patient in his lifetime (21). These patients are candidates for active surveillance in contrast to the classic radical surgery or radiotherapy. Active surveillance should not be confused with watchful waiting. Primary treatment for localized prostate cancer leaves the options open for cure if against all predictions there is a progression of the indolent cancer. Patients partaking in active surveillance are suitable for undertaking research of new biomarkers that indicate aggression and progression on localized prostate cancer. The PROCABIO (PROstate CAncer BIOMarkers) project intends to do this with the conclusion of the PRIAS (Prostate cancer Research International Active Surveillance) trial to evaluate the active surveillance protocol. This will also include the evaluation of some PSA derivatives such as density, velocity and doubling time.

The right of each man to optimal medical treatment is beyond question and any request by an individual person to be checked for early prostate cancer diagnosis deserves personal attention. Patients should be provided with complete information on all aspects of early prostate cancer diagnosis. There is a trend to lower the ages of patients undergoing PSA evaluation hoping to catch aggressive tumors earlier while avoiding the false positive results of BPH which usually causes problems after the age of 50. The low prevalence of aggressive disease is the cause of a difficult clinical exercise to be used with caution and restraint. The discovery of a new effective biomarker would of course change the total concept.

Last but not least is the potential harm of PSA testing leading to additional testing and treatment, unnecessary side effects and psychological and social distress. As there is more chance to over treat in the senior generation and to under treat in the middle-aged males, special consideration by the physician should be directed to the patient, his (biological) age and his needs.

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## ANNOUNCEMENT

The European Society of Mastology, The European Society of Surgical Oncology, The European School of Oncology and the European Oncology Nursing Society are pleased to announce:

### **“The Training of Specialised Health Professionals dealing with Breast Cancer”**

One month of training in a European Breast Unit  
between January and April 2008

*Prior to the training period the selected candidates will be offered a comprehensive teaching package*

The aim of the programme is to allow young clinicians and nurses dedicated to breast cancer to improve their theoretical knowledge and practical skills in the patient management, in order to create a core team made up of health professionals from various disciplines who have undergone specialist training in breast cancer beyond that given in general training.

#### **Training Fellowship by competitive application**

**Final deadline for application: 31 July 2007**

- ✓ Potential candidates have a maximum age of 40 years for MDs and 45 years for nurses
- ✓ Priority will be given to applicants already working in the field of breast cancer (radiologists, pathologists, surgeons, radiotherapists and medical oncologists, breast care nurses)
- ✓ Candidates from Eastern Europe will be given the priority
- ✓ A good knowledge of the English language is required

Interested candidates should send a copy of their curriculum vitae in English, together with an accompanying letter of recommendation from the Head of the Department that they are working in and a covering letter explaining their motivation. Successful candidates will be notified September 15<sup>th</sup>

For more information or to submit an application,  
please contact the European Society of Mastology  
Via del Pratellino, 7 - 50131 Florence Italy  
Tel: +39 055 576260 fax: +39 055 55374209 e-mail: [information@eusoma.org](mailto:information@eusoma.org)



**This programme has been made possible by an educational grant from the Federation of European Cancer Societies Special Projects Fund**



*6th • EONS Spring Convention*

**GENEVA**  
**SWITZERLAND**  
27-29 MARCH 2008



**New ways of working: innovation in cancer nursing practise**  
**Nouvelles méthodes de travail: innovation des pratiques de l'infirmierie en oncologie**  
**Neue wege in der praxis: innovationen in der onkologiepflege**

Conference Chair: Sara Faithfull

In partnership with  
the Swiss Oncology  
Nursing Society

Powered by

# The 1st EONS Masterclass an Overwhelming Success

Following in the footsteps of the European School of Oncology-sponsored multidisciplinary Masterclasses, EONS launched the first Masterclass in Oncology Nursing in February/March of this year. From a large number of applications, 40 participants representing 14 countries received approval by the EONS review committee to attend the event.

This multidisciplinary, practice-oriented educational event was taught by an international faculty. Continuing education credit points were awarded and registration and accommodation fees were waived for participants. A variety of topics were covered assuming that the participants had an advanced level of knowledge in these areas. Some of the topics presented by the medical and nursing expert faculty included the pathology, diagnosis, and treatment of various cancers and assessment and treatment of symptom clusters. In addition to didactic sessions which were sometimes taught by a joint nursing/medical team, a workshop on palliative care was offered. As the target group for the Masterclass was nurses involved in nursing research, sessions on evidence based nursing and its contribution to cancer care, preparing a research proposal, and scientific publishing were also offered.

The resonance from participants was overwhelmingly positive. The majority rated the content of the course as very relevant to their work and the overall quality of the educational programme was rated as very good or excellent.

In addition to the evaluation survey, EONS requested the participants to complete a short questionnaire on their experience at the 1st EONS Masterclass. Following are some highlights from the results of this questionnaire:

Financial support to attend the Masterclass was almost evenly provided by either the participant or the employer. The overwhelming majority of participants took annual leave with very few reporting that they were provided educational leave to attend.

In terms of suggestions for improving the Masterclass, a majority of respondents requested that more nursing-relevant topics be presented. Although the medical topics were of interest, considering the short length of the course the respondents felt that time would be better spent concentrating on nursing issues in cancer care. Some suggestions for future topics were the provision of psychological support services for nurses, case presentations focusing on symptom management, and more in-depth information on designing nursing research studies.



When asked what message or experience from the course made a lasting impression, the respondents overwhelmingly answered that it was reassuring to learn from colleagues that problems and challenges in cancer nursing are the same throughout Europe. The sharing of these common problems through discussion seemed to promote a feeling of unity among the participants and helped to break down cultural barriers. A majority of nurses responded that although there was little idle time, they utilised coffee breaks and dinner to network – an activity reported by many to be of extreme usefulness in brainstorming on solving problems commonly encountered in everyday practice. As the focus of the Masterclass was on nursing research, many respondents reported that they now came to realise the importance of implementing evidenced based research results into their practice.

Of course the respondents also provided a critical review of the course. As previously mentioned, one common critique was the amount of medical information presented. Respondents recommended more joint sessions and fewer French-speaking physicians! Further, the participants signalled that they would have liked more workshop sessions. As the programme schedule was rather tight, longer coffee breaks and shorter dinners were recommended as a means of providing time for more casual conversation or more time for individual reflection.

Some direct quotes from participants in answer to the question, “What message would you like to communicate to the EONS membership about your experience?” were:

- It was great to actually meet those nurses who have contributed so much to cancer nursing in Europe.
- Networking with other nurses is a fantastic experience.
- Attendance at the Masterclass has provided me with a cornerstone for my work as a clinical nurse specialist.
- If a nurse is looking for inspiration from the experiences of nurse experts, then attend the Masterclass!
- Nursing research isn't frightening.
- A unified European approach to cancer nursing is possible.
- This was an exhausting and exhilarating experience.
- Networking is a method of empowering cancer nurses in Europe.

The results from the EONS 1st Masterclass in Oncology Nursing show that the programme goals were achieved and the participants left the course with new knowledge, new insights, and perhaps even renewed energy. The course organisers were highly praised for the excellent programme and flawless flow of events. Based on the positive results of the 1st Masterclass, a second Masterclass is already in the planning and shouldn't be missed.

# Hungarian Nursing Conference and Exhibition on Oncology

12-14th April, 2007 Tihany, Hungary



A conference for cancer nurses working in Hungary took place from 12-14 April in Tihany. This was the second time the conference, organised by the Hungarian National Institute of Oncology and by the Hungarian Cancer Society, has taken place.

The goals of the conference were:

- to strengthen the specialty of cancer nursing by providing participants with an opportunity to share knowledge through presentations;
- to provide continuing education credit points to attendees;
- to exchange information on best practice;
- to reorganize the Oncological Nursing Section of Hungarian Cancer Society;
- to build and maintain International relations;
- to provide attendees with a memorable and pleasant weekend.

A record 275 cancer nurses representing several institutes from all parts of the country participated. There were 72 oral presentations, 37 poster presentations and 8 satellite symposia. Some of the topics presented included: medical treatment of tumors, cancer surgery, radiation therapy, rehabilitation, pain management, aspects of early diagnosis, the role of nurses in the present health care system, post graduate education, and legal issues in nursing care.

Participants were in agreement on the importance of professional development. Continuous education is an indispensable element to providing quality nursing care and for further developing the profession of nursing. These thoughts are also strongly supported by the Oncology Nursing Section of the Hungarian Cancer Society. Prof. Dr. Edit Oláh, President of the Hungarian Cancer Society, noted that the recognition of professional unity is evidenced by the fact that 30 nurses applied for membership in the organisation during the course of the congress.

EONS was present at the congress. Mr Jan Foubert, Executive Director of EONS, provided participants with an insightful presentation on the function and organisational structure of EONS as well as on the activities and educational opportunities which EONS provides for its members.

Members of the planning committee for this congress are certain that future events will take place. The nursing section of the Hungarian Cancer Society is dedicated to providing cancer nurses with activities that not only provide quality education but the opportunity to meet colleagues in a relaxed and supportive atmosphere.



## ECCO 14, Symposia and Presentations of Interest to Nurses

24 – 27 September, Barcelona

### **EONS/Spanish Oncology Nursing Society Joint Symposium**

Developing advanced nursing practice, Specialist nursing in Europe: issues and concerns; Challenges in cancer nursing

### **EONS/ISNCC/ONS Joint Symposium**

Hereditary cancer risk assessment: what is missing?; Psychosocial issues in screening for hereditary cancers: implications for practice; Comprehensive cancer risk assessment and management: the essence of oncology nursing

### **EONS/ECPC Joint Symposium**

Meeting cancer patients' informational needs: rising to the challenge; Do we know what patients need?; Access to information - the reality for European patients today

### **EONS/EBMT Joint Symposium**

Nursing implications of innovative treatment; Oral oncology agents; The changing face of GvHD; Innovations in prevention and treatment of oral mucositis: where to go from here?

### **Excellence in Patient Education Award Lecture TITAN: Best (local) Dissemination Project Award EONS General Meeting (Tuesday, 25 September) EONS/SIOP Joint Symposium**

Meeting the ongoing care and support needs of adult survivors of childhood cancer:

How might we do it?; What consequences of childhood cancer do young adults consider important?; Post traumatic stress symptoms in adult cancer survivors of childhood cancer: implications for care

### **EONS/ESO Joint Symposium**

The role of the breast care nurse; A systematic review of the effectiveness of specialized nursing in breast cancer

### **EONS/IPOS Joint Symposium**

Patient needs and psychosocial interventions in oncology; Good communications skills as psychosocial care; Clinical practice guidelines for the psychosocial care of adults with cancer

# Disseminating the Results of TITAN

EONS' highly successful and popular nurse education programme, TITAN, continues to improve as content is updated to reflect current practice.

One of the reasons why TITAN is so highly valued is that in addition to providing up-to-date information, participants are given the opportunity to actively apply what they have learned to improve patient care by completing a dissemination project. A dissemination project can focus on educating colleagues, educating patients and their families, or designing practical tools (for example, a simple checklist) to implement the most up-to-date clinical practice guidelines. Nurses who take on this exciting challenge are rewarded by a huge sense of achievement. Project leaders clearly see the positive changes they have made to their workplace and to the lives of the patients they care for and they often feel empowered to do more. For example, 2004 Dutch dissemination project prize-winner, Sylvia Verhage, together with colleagues Vincent Keijsers, Niek Golsteijn, Caroline Kuijpers and Jo Graat, developed a flip-over, visual communication aid to educate patients about the side effects of chemotherapy. In response to positive feedback from their project survey, the tool was further developed with Amgen support to include other topics, such as nausea and vomiting, and is now in clinical use in hospitals all over the Netherlands.



EONS and Amgen continue to receive positive feedback about dissemination projects and would like to hear more about projects that are being successfully implemented in clinical practice. Leaders of successful projects are encouraged to submit their work for presentation at a National or International conference. Submitted project owners are encouraged to discuss their projects with their local Amgen representative.



*Irish national TITAN dissemination project prize winners for 2006, Hilary Noonan and Fiona Brady, designed a pocket guide checklist for nurses and doctors titled "Care of paediatric patients with febrile neutropenia/sepsis" and engaged colleagues in a shared care education session. They were presented with their award in March by the Irish Association for Nurses in Oncology (IANO). Pictured from left to right: Winner Hilary Noonan, Paediatric Unit, Midwestern Regional Hospital, Limerick; Winner Fiona Brady, Paediatric Unit, Porticuncla Hospital, Ballinasloe, Galway; Joan Kelly, Nursing Services Manager, Irish Cancer Society; Dr. Annette Kent, Medical Manager, Amgen Ireland Ltd.; Marie Lavin, President IANO, Lecturer, School of Nursing, Midwifery and Health Systems, UCD.*

In January, EONS opened nominations for the 2006 TITAN Dissemination Project Award. Course organisers were invited to select the best dissemination project they received from participants at TITAN courses run between October 2005 and October 2006. Six projects of exceptional quality have been submitted by Finland, Germany, Greece, Ireland, Portugal and the Netherlands. These will be judged by an international panel of nurse experts and the winning project will be announced in May. The winner will present his or her project at the ECCO 14 conference, which will take place in Barcelona, in September 2007. Dissemination projects provide a great example of how the knowledge gained from the TITAN course can be put to practical use to benefit patient care.



*As the result of the TITAN course all Estonian oncology clinics have informative materials for patients about the side effects of chemotherapy that were made by oncology nurses.*

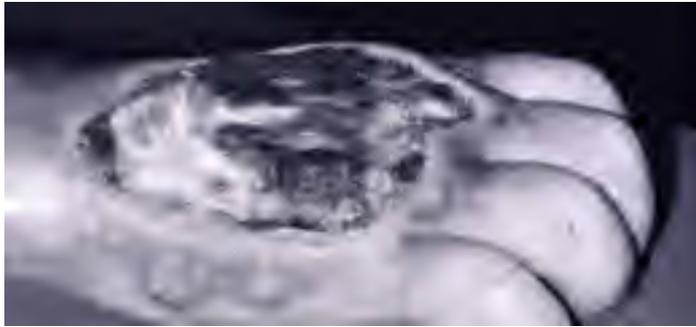
The Dutch, Irish and Estonian experiences illustrate how TITAN empowers nurses to bring positive changes in their workplace and to the lives of the patients they care for.

# Causes, Diagnosis, and Treatment of Extravasation

*Maïke de Wit, MD, PhD, Member of the Faculty, Consultant Oncology, Department of Internal Medicine Oncology/Hematology/Bone Marrow Transplantation and Section Pneumology, University Clinic Hamburg, Eppendorf, Hamburg. Germany*

## Introduction

Extravasation is the unintentional leakage of intravenous drugs into the surrounding perivascular tissue or subcutaneous spaces. Accidental extravasation is relatively rare and has been estimated to occur in 0.5% to 6% of all patients receiving chemotherapy. The extravasation of anthracycline is recognized as a complication that is often underreported and under treated and is associated with a poor outcome (1). However, due to increased awareness among health care professionals of the debilitating consequences of extravasation, more careful administration of anthracyclines, and the widespread use of central vein catheters (CVCs), the incidence of extravasations is probably closer to the lower end of this range.



*Tissue necrosis following extravasation of anthracyclines. The photo is by courtesy of S. Langer*

Cancer patients are at risk for extravasation for several reasons. Firstly, patients often require multiple IV infusions. Malnourishment, frequent administration of drugs via the intravenous route as well as other treatment-related side effects (i.e. chemotherapy, radiation therapy) may cause thin and fragile veins and reduce the number of safe intravenous sites.

## Irritants and Vesicants

Extravasated agents generally cause two types of local cutaneous reactions: irritant and vesicant reactions. An irritant reaction usually occurs as a temporary phlebitis along the affected vein. Extravasation of vesicant drugs such as anthracyclines, however, may cause severe reactions including progressive tissue damage that may continue to progress over days and weeks. Frequently observed symptoms are pain, redness, swelling, tissue necrosis, joint destruction, and permanent dysfunctional and cosmetic changes of the involved area.

The mechanism behind the devastating soft tissue injury is not fully understood. Proposed explanations relate to site specific free radical damage or DNA damage via topoisomerase II interference. The progression relates to local diffusion of drug DNA complexes into adjacent tissue and the induced tissue necrosis may deteriorate if it is not treated.

## Prevention of Extravasation

Most extravasations can be prevented through the systematic implementation of careful administration techniques. Chemotherapy should be given only by trained personnel and the patient should be observed throughout the infusion. Patients should be informed to notify the nurse immediately if burning, pain or other unusual sensations are experienced at the infusion site. Venous punctures

Chemotherapeutic agents listed according to local toxicity	
Vesicant	Doxorubicin, epirubicin, daunorubicin, idarubicin, dactinomycin (anthracyclines) Vinkristin, vinblastin, vindesin, vinorelbine, vinflurin (vinca alkaloids) Mitomycin-C, mechlorethamin, carmustin (alkylating agents)
Irritants	Mitoxantrone, aclarubicin (DNA-intercalating antibiotics) Etoposid, teniposid (epipodo-phyllotoxin) Fluorouracil, floxuridin (Antimetabolites) Cisplatin, carboplatin, dacarbazine, oxaliplatin (Alkylating or DNA-binding) Paclitaxel, docetaxel, bleomycin (others)
Non - Vesicants	Metotrexat, cytarabin, pentostatin, gemcitabin, capecitabin (Antimetabolites) Cyklofosfamid, ifosfamid, melphalan (Alkylating agents) Irinotecan, topotecan, trastuzimab (other)

should be performed with the use of flexible catheters only. Butterfly needles should be avoided when administering known vesicant agents. Prior to infusion, aspiration of blood is mandatory as well as flushing with saline for 5 minutes. This procedure should be repeated at the end of the infusion. A parallel infusion of saline and a venous port should be used in patients with poor venous access. Small and fragile veins adjacent to tendons, nerves and arteries, or limbs affected by lymphoedema should be avoided as well as sites where neurological problems could impair the patient's ability to sense an extravasation.

The use of CVCs has helped to reduce the incidence of extravasation, although CVCs are associated with additional problems. Port systems may malfunction, may become dislodged, or venous vessels may be perforated with potentially disastrous consequences including mediastinitis. Thus, central venous catheter extravasation should be considered in the differential diagnosis in patients who present with fever, severe pleuritic pain, upper extremity and neck swelling, and a widened mediastinum while receiving chemotherapy through central lines. The incidence of extravasations from a CVC varies between 0.01% and 6.5% (2, 3, 4).

## Clinical Signs and Symptoms of Extravasation

Early signs and symptoms of an extravasation include:

- Pain, swelling, erythema, and/or blistering. These signs may, however, initially be absent if the drug slowly leaks into the local tissue after completion of an apparently well-controlled drug administration.
- Symptoms of chest wall infiltration in patients with a CVC may have a delayed onset and may present with atypical signs and symptoms, e.g. as shoulder pain.

Late effects of an extravasation include:



- Marked induration, often brownish, lasting for days to months with skin atrophy.
- Invasive ulceration which may occur after 1-4 weeks and progressively enlarges in size extending to deep tissue structures where anthracycline can persist for months. This occurs in about one third of patients experiencing an anthracycline extravasation which is not appropriately recognised and treated.
- Long-term pain, contractures, dystrophy, and potential loss of function of the affected limb.

#### Immediate Treatment Measures

Prompt intervention is mandatory if an anthracycline extravasation is suspected. First the infusion should be discontinued, the residual drug should be aspirated without applying pressure to the injection site, a saline flush should not be used, the venous access device should be removed, and the extremity should be elevated and local cooling should be applied. If treatment with Savene™ (dexrazoxane) is the standard of practice, then the affected area should not be cooled during Savene™ infusion. The site of extravasation should be marked and the extravasated volume should be estimated. Appropriate documentation of the event is essential.

#### Treatment Approaches

So far, there have been no uniformly accepted guidelines regarding treatment for extravasation of anthracyclines. However, many hospitals have developed their own guidelines for the management of this adverse event. Single or combined application of cooling and the topical use of corticosteroids or DMSO are the most commonly used treatment approaches for extravasation of a vesicant. When managed using conventional techniques, the outcome of anthracycline extravasation is typically poor, with many patients experiencing serious sequelae as a result of the extravasation or subsequent surgery. Surgery has proven to be effective if performed at the optimal time, but since anthracyclines can persist in the lesion for weeks to months, the surgical procedure must be extensive and can lead to large defects which require skin grafting.

#### Systemic Treatment of an Extravasation

Last year, Savene™, an antidote for anthracycline extravasation damage, was approved by the European Medicines Agency (EMA). Two clinical trials provided evidence for the efficacy of Savene™. In these

trials, Savene™ provided protection from the damage caused by the anthracycline extravasation thereby sparing the patient from surgical interventions. Savene™ should be used as soon as possible but no later than 6 hours following the extravasation. It should not be combined with DMSO which could diminish its effectiveness and cooling should be discontinued 15 minutes prior to administration.

The most common side effects experienced by patients who received Savene™ were nausea and haematological toxicity (5). The recommended dosing regimen is 1000mg/m<sup>2</sup> on Day 1 and Day 2 and 500 mg/m<sup>2</sup> on Day 3. Savene™ is administered per IV infusion over 1 to 2 hours in a larger contralateral vein and repeated after 24 h and 48 h.

#### Summary

The consequences of anthracycline extravasation represent a significant risk in the treatment of cancer. Even though anthracycline extravasation is rare, it may have potentially serious immediate and longer-term effects. Systemically administered Savene™ may protect patients against the potentially devastating effects of extravasation.

This article is the first in a series which focuses on anthracycline extravasations. Future articles will focus on specific patient cases of anthracycline extravasations and the presentation of guidelines for anthracycline extravasation developed by EONS members.

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Images of extravasation before and after administration of Savene™. The left image shows swelling and redness at the site of infusion, while the right image shows the same area following administration of Savene™ (TopoTarget, data on file from clinical trials).



# Neulasta® protects your patients from febrile neutropenia

## Use Neulasta® to:

- Minimise the consequences of febrile neutropenia and maximise chemotherapy delivery.<sup>1,2</sup>
- Provide self-regulating protection when patients need it most.<sup>3</sup>

 **Neulasta®**  
(pegfilgrastim)

Optimal protection

### Neulasta® (pegfilgrastim) Abbreviated Prescribing Information

Please refer to the Summary of Product Characteristics before prescribing Neulasta® (pegfilgrastim). Neulasta® 6 mg solution for injection is presented in a pre-filled syringe. Human granulocyte colony stimulating factor (G-CSF) is a glycoprotein, which regulates the production and release of neutrophils from the bone marrow. Neulasta® is a covalent conjugate of filgrastim, recombinant human G-CSF (r-methHuG-CSF) with a single 20 kd polyethylene glycol (PEG) molecule. **INDICATION:** Reduction in the duration of neutropenia and the incidence of febrile neutropenia in patients treated with cytotoxic chemotherapy for malignancy (with the exception of chronic myeloid leukaemia and myelodysplastic syndromes). **DOSAGE AND ADMINISTRATION:** Solution for injection presented in a pre-filled syringe containing 6 mg of pegfilgrastim, for single dose use only. One 6 mg dose (a single pre-filled syringe) of Neulasta® is recommended for each chemotherapy cycle, administered subcutaneously approximately 24 hours following chemotherapy. There are insufficient data to recommend the use of Neulasta® in children and adolescents under 18 years of age. **CONTRAINDICATIONS:** Hypersensitivity to pegfilgrastim, filgrastim, *E. coli* derived proteins, or to any excipients. **SPECIAL WARNINGS AND PRECAUTIONS:** The safety and efficacy of Neulasta® have not been investigated in patients receiving high-dose chemotherapy. Limited clinical data suggest a comparable effect on time to recovery of severe neutropenia for pegfilgrastim and filgrastim in patients with de novo acute myeloid leukaemia (AML). The long-term effects of Neulasta® have not been established in de novo AML; therefore, it should be used with caution in this patient population. The safety and efficacy of Neulasta® administration in de novo AML patients aged < 55 years with cytogenetics t(15;17) have not been established. Neulasta® should not be used in patients with secondary AML. The safety and efficacy of Neulasta® for the mobilisation of blood progenitor cells in patients or healthy donors have not been adequately evaluated. Rare pulmonary adverse effects, in particular interstitial pneumonia, have been reported after G-CSF administration. Patients with a recent history of pulmonary infiltrates or pneumonia may be at higher risk. Onset of pulmonary signs such as cough, fever, and dyspnoea in association with radiological signs of pulmonary infiltrates, deterioration in pulmonary function with increased neutrophil count may be preliminary signs of Adult Respiratory Distress Syndrome (ARDS). In such circumstances Neulasta® should be discontinued at the discretion of the physician and the appropriate treatment given. There have been common but generally asymptomatic cases of increased spleen size and very rare cases of splenic rupture in healthy donors and patients following

administration of granulocyte-colony stimulating factors. Some cases of splenic rupture were fatal. Therefore, spleen size should be carefully monitored (e.g., clinical examination, ultrasound) and this diagnosis should be considered in patients reporting left upper abdominal pain or shoulder tip pain. Regular monitoring of platelet count and haematocrit is recommended during Neulasta® therapy. Neulasta® should not be used to increase the dose of chemotherapy beyond established dosage regimens. Physicians should exercise caution and monitor appropriately when administering Neulasta® in patients with sickle cell disease and be attentive to the possible association of Neulasta® with splenic enlargement and vaso-occlusive crisis. Transient elevation of leucocyte counts  $\geq 100 \times 10^9/L$  have been observed in <1% of patients receiving Neulasta® with no attributable adverse events. Elevations were typically seen 24–48 hours after administration. **INTERACTIONS:** Concomitant use of Neulasta® with chemotherapy has not been evaluated in patients. In animal models, concomitant Neulasta® and 5-fluorouracil (5-FU) or other antimetabolites have been shown to potentiate myelosuppression. **PREGNANCY AND LACTATION:** No adequate experience in human pregnancy and lactation. Neulasta® should not be used during pregnancy unless clearly necessary. Do not administer to women who are breast-feeding. **UNDESIRABLE EFFECTS:** The most frequently reported study drug-related undesirable effect was bone pain, which was generally mild to moderate, transient and controlled with standard analgesics. Reversible, mild to moderate elevations in uric acid, alkaline phosphatase and lactate dehydrogenase, with no associated clinical effects, occurred in patients receiving Neulasta® following chemotherapy. Allergic reactions, including anaphylaxis, have been reported both with Neulasta® and its parent compound, filgrastim. **PHARMACEUTICAL PARTICULARS:** Store at 2°C–8°C (in a refrigerator). Do not freeze. Keep container in outer carton to protect from light. Neulasta® may be exposed to room temperature (not above 30°C) for a maximum single period of up to 72 hours. Neulasta® is incompatible with sodium chloride solutions. **LEGAL CLASSIFICATION:** Medicinal product subject to medical prescription. **MARKETING AUTHORISATION HOLDER:** Amgen Europe B.V., Minervum 7061, 4817 ZK Breda, The Netherlands. Further information is available from Amgen (Europe) GmbH, Dammstrasse 23, PO Box 1557, Zug, Switzerland, CH-6301. Additional information may be obtained from your local Amgen office. **MARKETING AUTHORISATION NUMBER:** Pre-filled syringe: EU/1/02/227/001-002. **Date of preparation:** November 2005.

**References:** 1. Ozer H, et al. *J Clin Oncol*. 2006;24(18S part I of II):485s. Abstract 8569. 2. Vogel CL, et al. *J Clin Oncol*. 2005;23:1178-1184. 3. Green MD, et al. *Ann Oncol*. 2003;14:29-35.

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