



EONS

eons newsletter

Summer 2008

Theme:

Cancer

Prevention

- **Lifestyle choices**
- **Genetic counseling**
- **Inequalities in Health Care**
- **Cancer screening**



Editor in Chief:

Jan Foubert, RN, MSc

Communications team:

Carol Krcmar, RN, MN
Emile Maassen, RN, CRN
Cath Miller, MA, RGN Dip Hsm

The aim of the EONS newsletter is to provide a written resource for European nurses working in a cancer setting. The content of the articles are intended to contribute to the growing body of knowledge concerning cancer care.

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

EONS Secretariat:

Rudi Briké
Avenue E Mounier 83/4B-1200 Brussels, Belgium
Tel: + 32 (2) 779 9923 Fax: 32 (2) 779 9937
E-mail: eons.secretariat@skynet.be
Website: www.cancereurope.org/EONS.html

EONS acknowledges Amgen, AstraZeneca, Merck, Mundipharma, Novartis, Roche, Sanofi Aventis and Topotarget for their continued support of the Society as Sustaining Members.

Print run: 4200 copies
Electronic version accessible to 24000 EONS members

Printed by:

Drukkerij Trioprint Nijmegen Bv
The Netherlands

Disclaimer

The views expressed herein are those of the authors and do not necessarily reflect the views of the European Oncology Nursing Society. The agency/company represented in advertisements is solely responsible for the accuracy of information presented in that advertisement.

The European Oncology Nursing Association (EONS) does not accept responsibility for the accuracy of any translated materials contained within this edition of the EONS Newsletter. Comments about the Italian version of the EONS Newsletter should be addressed to the Associazione Italiana Infermieri di Oncologia (AIIO) by emailing info.aiio@libero.it



Letter from the Editor

Dear Colleagues,

The World Health Organization (WHO) declared cancer prevention and control as one of the most important scientific and public health challenges of our time. Some rather impressive reasons for this declaration are:

- Cancer is a leading cause of death worldwide. From a total of 58 million deaths worldwide in 2005, cancer accounts for 7.6 million (or 13%) of all deaths.
- More than 70% of all cancer deaths in 2005 occurred in low and middle income countries.
- Deaths from cancer in the world are projected to continue rising, with an estimated 9 million people dying from cancer in 2015 and 11.4 million dying in 2030.

The training of health care professionals in cancer prevention and health promotion is an important first step in reducing the rising incidence and prevalence of cancer worldwide. In his article, Csaba Avramucz describes a programme which aims to help students in their future professional practice to demonstrate health-promoting behaviour and contribute to effective disease prevention. The programme also focuses on increasing understanding of the development of malignant tumours.

Did you know that at least one-third of all cancer cases are preventable and that prevention offers the most cost-effective long-term strategy for the control of cancer?

Tobacco, for example, is the single largest preventable cause of cancer in the world today. It causes 80-90% of all lung cancer deaths, and about 30% of all cancer deaths in developing countries, including deaths from cancer of the oral cavity, larynx, oesophagus and stomach.

Dietary modification is another important approach to cancer control. There is a link between many types of cancer such as oesophagus, colorectum, breast, endometrium and kidney cancers and obesity. Diets high in fruits and vegetables may have a protective effect against many cancers. Conversely, excess consumption of red and preserved meat may be associated with an increased risk of colorectal cancer.

Regular physical activity and the maintenance of a healthy body weight along with a healthy diet can considerably reduce cancer risk.

In the article "Lifestyle choices and breast cancer prevention" Alex Molassiotis puts together information about what is and what is not linked with increased risk of breast cancer, based on a review of current scientific evidence.

A summary of the 5th International Conference on Cancer Prevention held in St. Gallen in March 2008, provided by Agnes Glaus, gives you an update on ongoing research in prevention. Screening refers to the use of simple tests across a healthy population in order to identify individuals who have disease, but do not yet have symptoms.

Examples of screening in cancer include breast cancer screening using mammography and cervical cancer screening using cytology screening methods, including Pap smears. Screening programmes should be undertaken only when their effectiveness has been demonstrated, when resources (personnel, equipment, etc.) are sufficient to cover nearly all of the target group, when facilities exist for confirming diagnoses and for treatment and follow-up of those with abnormal results, and when prevalence of the disease is high enough to justify the effort and costs of screening.

Both prevention and screening are essential components of oncology nursing practice. Although some nurses may believe that cancer prevention and the care of cancer patients are separate issues, they are in fact intrinsically related. The oncology nurse must be capable of conveying information about risk in a clear manner. Clarity of message is important in all aspects of screening and detection and has become even more critical in relation to genetic screening, as explained in the article "Genetic Counselling about Cancer Genetics in the UK and the Role of Consultant Genetic Counsellor by Chris Jacobs.

The EONS communication team wishes you happy reading and an enjoyable summer holiday filled with lots of rest, "safe" sun and "safe" fun.

Jan Foubert
Editor in Chief

Our colleagues from...

A.I.I.O.



Associazione Italiana Infermieri di Oncologia

Fabio Mazzufero, Secretary, AIIO

History

The Italian Oncology Nursing Association (Associazione Italiana Infermieri di Oncologia, AIIO) was born in Genova in 1986. The headquarters of AIIO is at the National Cancer Research Institute of Genova but the organisation is widespread throughout Italy. The AIIO is operated as a non-profit organisation.

The nurse-members are those working within or undertaking activity in oncology institutes, divisions of oncology and oncology services in Italian hospitals and universities. Freelance nurses who work in oncology or are interested in the care of the oncology patient can become members provided that they are in possession of the professional requirements.

The Board of Directors can grant honorary association to those who have shown special merits in the field of oncology, for example publishing, have contributed to the struggle against the cancer, or to those who on the basis of professional characteristics have been instrumental in further developing the AIIO or to those who are involved in the care and assistance of the person with cancer.

Goals

The goals of the AIIO are as follows:

- To unite in free association nurses who work in the area of prevention, care and rehabilitation of the cancer patient;
- To promote and coordinate educational programs geared to improving oncology nursing;
- To encourage sensitivity and professional participation in the organisation;
- To develop new methods and specific tools regarding nursing care of the oncology patient through nursing research;
- To improve communication by building and maintaining a network of nurses practising in cancer care;
- To promote collaboration with other organizations who influence the development of nursing interventions in cancer care.



Organisational Structure

The organisation is governed by the General Assembly and the Board of Directors. The General Assembly is composed of 350 nurses. The Board of Directors is composed of President, Vice President, Secretary, Treasurer, Auditor of the Accounts and seven advisors who

are given specific assignments according to their competencies. The areas covered by the advisors include: research, overseeing of the publications of the AIIO, our website, IPASVI (Professional Order of Nurses), public relations with other associations, representative to EONS, clinical pathways, and the group of nurses who work to translate the EONS Newsletter.

Other important committees of the AIIO are the "Study Groups". Each group has a coordinator and a variable number of members that develop programs of research and education focused on cancer therapies, symptoms, issues regarding mobility, radiotherapy, venous access, emergencies and support systems to name but a few.

Activities of the AIIO

The AIIO offers educational programmes and congresses on a regular basis. An annual congress is held at which current topics in cancer nursing are presented. We collaborate with the Italian Medical Oncology Association to organise a national congress. Further, we collaborate closely with affiliated professional organisations to offer multidisciplinary congresses on cancer-related topics.

The AIIO offers its own educational programmes and collaborates with several other professional organisations to provide state-of-the-art education of a high quality. For example, in collaboration with various Italian universities, we offer specialist nurse training. During the years 2005 to 2006, we were involved in the TITAN project through which 307 nurses from 10 different oncology settings received training. We plan to start offering TARGET educational programmes this year.

Several research projects have been undertaken by the organisation. For example, we have initiated a training programme for patients severely affected with osteoporosis and plan to evaluate the feasibility of self-administration of protective agents. Another research project involves the management of nausea and vomiting using acupuncture in patients who have not responded to standard antiemetic treatment. In terms of professional development, we have launched a project to evaluate nursing knowledge of cancer pain. And, in the clinical setting, we are collaborating with the faculty of medicine of the University of Florence to assess the management of port venous access devices.

Affiliation /Collaboration with other Societies

The AIIO collaborates with a number of medical oncology associations, special interest groups, and groups representing supportive care services in oncology at both the national and European levels.

AIIO is strongly affiliated with EONS. In 2006 the "translation group" of the AIIO was established. This group of energetic volunteers is responsible for the Italian translation of the EONS Newsletter. We plan to create an interface between our website (www.aiio.it) and the EONS website as well as with websites of other European nursing societies that are EONS members.

Future Directions

In the future, the AIIO plans to start working groups with an inter-professional theme. We are also planning to increase our publishing activities by developing a plan to write and publish scientific articles on emerging clinical trends in cancer nursing. Last but not least, we want to increase our involvement in Italian and European networks of oncology and cancer prevention organisations.



See you at the 15th Congress of
the European CanCer Organisation
Berlin, 20-24 September 2009

ECCO
15

www.ecco-org.eu

EONS is pleased to welcome the Portuguese Oncology Nursing Association as a full member of the Society. We also look forward to future collaboration with the Leeds Teaching NHS Hospital trust (UK) and the Scuola Universitaria professionale della Svizzera Italiana (Switzerland). Both institutions have recently joined EONS as Associate members. On behalf of the EONS Board, we warmly welcome these associations to EONS and thank them for their support in continuing the implementation of the goals of EONS.

EONS has been notified of changes in the governing boards of some of our member societies. Mrs. Eleni Kyritsi is the newly elected President of the Hellenic Nurses Association and Mrs. Thorunn Saevarsdottir has recently taken office as the President of the Icelandic Oncology Nursing Society. Mrs. Hrefna Magnúsdóttir will be the Icelandic representative to the EONS Advisory Council. The Danish Cancer Society has appointed Mrs. Louise Pengelly as their representative to the EONS Advisory Council. We say goodbye to Mrs. Elizabeth Haralambidou and Mrs. Jonina Jonsdóttir, former Presidents of the Hellenic Nurses Association and the Icelandic Oncology Nursing Society, respectively. We also would like to thank Mrs. Charlotte Belli (Danish Cancer Society) and Mrs. Arnardóttir (Icelandic Oncology Nursing Society), both of whom were Advisory Council representatives of their respective societies, for their contribution and support of EONS.

The section Oncology Nursing of the Hungarian Cancer Society will be organizing their first conference from 12-14th June 2008 in Eger, Hungary. EONS extends congratulations to the Society on this achievement and we wish them a very successful conference.

Update on 2008 EONS Research Awards

Four projects were submitted for this year's EONS Research Grants: one in the Mentoring category and three as Major Grants. We would like to thank all those who submitted proposals. Unfortunately, it was felt that the proposals submitted were not yet ready for funding.

Each proposal was evaluated and ranked in terms of its scientific merit, clarity of the problem, significance of the research question, international relevance, adequacy of the methods and feasibility of carrying out the study. Furthermore, the training, experience and research competence of the investigator(s) and team, the suitability of the facilities and availability of resources, the appropriateness of the budget, and the contribution to clinical cancer nursing in Europe were all appraised.

In light of this outcome a new deadline has been set for application to EONS Research Grants. This is October 1st, 2008. For more information and application form please visit EONS website. Applicants are encouraged to apply and to take into account the criteria listed above.

Accreditation Update

The following is a listing of educational programmes which have received EONS accreditation thus far in 2008:

- Escola Superior de Enfermagem de Lisboa: Post Graduation Course in Oncology Nursing, educational programme of study, September 2007-June 2008.
- The 8th National Conference in Cancer Care, Swedish Cancer Nursing Society, 8-9 May 2008. For more information: www.cancervard.se.
- ESO/EONS, European School of Oncology: 2nd Masterclass in Oncology Nursing, educational event, Sofia, Bulgaria, March 2008. More information: www.cancerworld.org
- TITAN Training Initiative Update Material 2008.
- Nursing Management approaches with a New Targeted Therapy for ErB2 Positive Breast Cancer, Symposium, 6th EONS Spring Convention, 2008.
- Optimising Patient Management in Breast Cancer, Symposium, 6th EONS Spring Convention, 2008.
- Strategies to help MDS Patients on their Journey to Hope, Symposium, 6th EONS Spring Convention, 2008.

Masterclass in Oncology Nursing

Sofia, Bulgaria

Following on the success of the first EONS Masterclass for Oncology Nurses, the 2nd Masterclass was held in Sofia, Bulgaria in early March. As was the case for the first Masterclass, potential participants had to complete an application procedure and were then selected by a review panel to attend the meeting. Nurses eligible to attend were those with a Master's degree (or equivalent), demonstrated involvement in direct cancer patient care, cancer nursing research, cancer nursing education, or in the management of cancer patients; fluency in English; directiveness in a career pathway; and, an individual member in EONS.

The Masterclass is a full-immersion, clinically-oriented, multidisciplinary, one-week educational event. In previous years, nurses with advanced education practising in advanced roles were eligible to attend the yearly Masterclass (sponsored by the European School of Oncology) which was medically-oriented. The start of the nursing-oriented Masterclass signalled not only the need to organise advanced cancer nursing training, but also helped to provide recognition for the role of the cancer nurse

specialist. In the present form of the Masterclass, multidisciplinary sessions are taught and attended by both nurses and physicians with breakout sessions targeted for either nurses or physicians.

The participants at the 2nd EONS Masterclass in Oncology Nursing came from 14 European countries - one participant came from as far away as Canada. Of the participants who completed the evaluation questionnaire, 23 identified themselves as specialist oncology nurses. The majority of nurses were over the age of 35 and, of no surprise, the number of female nurses in attendance was far greater than the number of males.

It is somewhat surprising that the majority of participants financed their participation at the event using personal resources (12 responders). Other sources of financial support included hospital employer (8 responses), the industry (2 responses) and 'other' (5 responses). A comparable number of participants found out about the event either via the internet (7 respondents) or 'word-of-mouth' (8 respondents) or through the EONS announcement sent via post (12 respondents).

Participants were asked to rate the Masterclass in terms of the course content, organisation of the event, and to provide their opinion on whether or not the course generally met their expectations. Using a Likert scale (1=poor to 5= excellent), evaluation results revealed that the course content was very useful and relevant to daily practice, there was sufficient time for discussion between participants and lecturers, and skills in nursing research were improved through attendance at the Masterclass (Table 1).

Table 1:
General Evaluation of the Masterclass in Oncology Nursing

Question
Rating*

• Overall rating of quality of educational programme	3.5
• Were skills in nursing research improved through attendance	3.3
• Was the information presented useful to practice	3.6
• Was information presented balanced and supported by evidence	3.6
• Did the programme allow adequate time for discussion and questions	3.7
• Were the facilities appropriate for the conference	3.2
• What is your rating of the management and organisation of the conference	3.6

*1=poor to 5=excellent

The 4th - day conference covered a variety of topics of interest to the oncology nurse advanced practitioner. The focus of the first day was breast cancer. Not only did participants update their knowledge on prognostic factors and new treatment modalities in breast cancer, they also heard about how nurses and patients can collaborate to improve the situation for patients living with breast cancer.

Another clinical topic presented during the Masterclass was the treatment of various types of colorectal and gastrointestinal cancers. Included in the sessions was information on what patients want to know about their condition and how physicians can be helped by patients to improve delivered treatment.

Multidisciplinary lectures also covered the diagnosis and treatment of haematological diseases, ovarian cancer, lung cancer, and prostate cancer.

Two topics of timely relevance received a lot of attention during the Masterclass. Survivorship was discussed from the prospective of breast and prostate cancer. The topic cancer in the elderly was introduced with a general description of the issues surrounding the growing number of older cancer patients followed by a discussion on tailoring cancer treatment to fit the physical and psychosocial needs of older patients.

The theme of the nursing research lectures at the 2nd Masterclass was the development of a research question and, subsequently, the development of a research proposal. This information was presented in a plenary session as well as in inter-active workshops. A team of well-known European nurse researchers who have been successful in obtaining grant money shared their knowledge and insider tips with the more 'novice' researchers in attendance on how to write and submit a research proposal.

The teaching format for the Masterclass is plenary lectures and tutor co-ordinated working groups. In plenary lectures, state-of-the-art cancer treatments are presented providing the participant with useful take-home messages. In the working groups, case presentations and discussions enable the participant to put theory into practice and to enhance knowledge through interaction with other participants. A multidisciplinary faculty shared their experience and expertise on a variety of topics. With pen in hand, participants were eager to provide EONS with suggestions for the content of future Masterclasses in Oncology Nursing and to express their opinions on what they found useful about this Masterclass. In the future, participants would like more information on patient care management problems that typically fall within the realm of nursing practice. These include care of skin reactions, treatment side effects and drug extravasation to name a few. Participants would also like more information on psychosocial issues to be presented and more in-depth coverage of symptom management presented in a multidisciplinary session.

From the written comments received, the nurse participants seemed to benefit from the multidisciplinary character of the Masterclass. Some participants commented that the information on clinical oncology presented in some lectures was too in-depth and that information on treatment options was not relevant to nursing practice.

The organisers of the EONS Masterclass in Oncology Nursing will closely review the comments received and use them to plan the development of the 3rd course. Further information can be found in due time on the EONS website.



Short report from EONS Board



Ulrika Östlund, EONS Board Member

The new board took up their posts at ECCO in Barcelona and have now been working for over half a year in developing the EONS strategy and projects for 2008/9. We have had three board meetings and want to give you a short report from our work.

The board started by undertaking a 'risk assessment' which is required for the charity commission to explore potential risk areas and ensure that the board work in accordance with the charity commission laws, for example financial checks and measures and that we work well together as a board. This is checked every year and is the responsibility of the executive board members and president. In this assessment those risks which may endanger the charity or threaten the achievement of its objectives were considered. Furthermore, the systems which have been implemented to mitigate those risks were reflected on and new systems which need to be implemented were introduced. One of the new developments from this was a web based share point which allows board members and those involved in EONS projects to share documents and have discussions on line.

The board has discussed the different grants that members can apply for. For information on grants, don't forget to check the EONS Website. Under 'research' you can also see EONS research priorities for 2007-2011. News on grants is that the board has agreed to establish an annual "clinical bursary" or travel scholarship in order to give support for applicants to visit and learn from another clinical setting. The work to formulate this grant is in progress and more information will be available from the Website in the summer.

The board is, together with EONS collaborators, continuously working with updating EONS ongoing projects. For example there is an updated version of TITAN (EONS training programme to better manage hematologic toxicities) been available with regard to courses running in 2008. Also the work with updating the TARGET (Training Initiative on Targeted Therapies) program has been started including a range of targeted therapies. The BREATHE (Breathing and Respiratory Education And Training for Health professionals with E technology) project the learning needs analysis has been completed and the curriculum is in the progress of being reviewed ready for the development of the training materials. The board has furthermore agreed on developing a 'Specialist Breast Cancer Nursing Curriculum' which will be available by the end of this year. Finally, on projects, the board has begun a project on prostate cancer. The work on raising funding and developing collaborative partnerships is underway.

The work for the nursing programme for the ECCO 15 and 34th ESMO conference in Berlin is underway with discussions about topics of interest for nurses in oncology. For the 6th EONS Spring Convention in 2010, the board has decided to arrange this conference in 'Den Haag' in the Netherlands. The board has also agreed on analysing the interest on a 'leadership training event in a European context' and this work is ongoing.

The board continuously reflects and discusses EONS strategic direction, and priorities for EONS taking into account the feedback from advisory council meeting in November 2008.

The New Face of FECS

Sofia, Bulgaria

Officially announced at the 14th Congress of ECCO last September, FECS (Federation of European Cancer Societies) was disbanded and replaced by a dynamic new entity: ECCO – the European CanCer Organisation.

Representing much more than a re-brand, this rigorous reorganisation represented a welcome turning of the tide for the European cancer community. While it has long since been accepted that the only way to operate within today's biomedical arena is from the multidisciplinary and collaborative perspective the challenge of translating discovery into a reality at the 'bedside' still remains a challenge.

By interconnecting all stakeholders in the oncology field, actively contributing to the 'must have' conversation with policy makers, advancing education through the organisation of leading conferences and timely initiatives, ECCO has been successfully engineered to drive towards closing the 'bench to bedside' loop full circle.



The ECCO Community

No matter how well oiled the new ECCO engine may be, it cannot hope to advance progress without the vital support, willing and collaboration of its member societies; each of which represent the interests of their respective professions/groups spanning the entire spectrum from basic, applied and translational research to practice, treatment, care, prevention and advocacy.

ECCO's member organisations facilitate the pieces of the puzzle that will help solve the many yet unanswered questions and issues in cancer.



*ECCO president
Alexander M.M. Eggermont
and Chief Executive Officer
Michel Ballieu*

As a Founding Member of ECCO, the European Oncology Nursing Society (EONS) – comprised of 200 individual cancer nurses, 33 national member societies/inter European specialist groups as well as 19 institutions involved in cancer care; the European oncology nursing community – is a crucial component of ECCO's platform, reach, and educational scope.

Centering the Patient Interest

ECCO follows the philosophy that every cancer patient deserves the best. To deliver on this thinking the patient is centered firmly at the core of all ECCO activities and educational programmes.

Emphasising this commitment to the patient interest, ECCO has recently launched its online Patient Information section. This resource aims to offer a broad selection of innovative, reliable and up-to-date information on cancer related issues expressly collated to meet the needs of patient advocates and organisations. To discover more visit: www.ecco-org.eu (select 'Patient Information').

Congresses and Conferences

The recently announced collaboration between ECCO – the European CanCER Organisation, and ESMO, the European Society for Medical Oncology, was happily received by the European oncology community as a turning point in uniting forces, efforts and professionals across Europe; furthering multidisciplinary towards improved research and care.

One critical outcome of the ECCO-ESMO collaboration has been the paring of two leading educational opportunities in European Oncology: ECCO and ESMO Congresses. Setting the stage, pace and standard for Congresses to come, the very first - the joint ECCO 15 and 34th ESMO Multidisciplinary Congress - will take place in Berlin, Germany, 20-24 September 2009. For all forthcoming announcements surrounding the Congress visit: www.ecco-org.eu (select 'Congresses and Conferences').

In addition to the joint ECCO and ESMO Multidisciplinary Congresses, the European CanCER Organisation organises multidisciplinary meetings of excellence on behalf of some of its member organisations. To heighten quality, interest, attendance and exposure, ECCO is committed to supporting these educational opportunities through the provision of additional organisational, communication and marketing expertise.

New Committees – Fresh Horizons

To better respond to the needs of the European cancer community and cater to all stakeholders in oncology, ECCO is setting up dedicated focus groups in the form of officially appointed Committees.

The recently established Patient Advisory Committee (PAC), under the Chairmanship of Louis Denis (Antwerp, Belgium), will provide European patient organisations and bodies involved in patient care with greater opportunity to take significant steps forward and afford ECCO further insight into current issues and challenges faced by cancer patients.

Chaired by Dirk Schrijvers (Antwerp, Belgium), the Education Committee organises and drives educational initiatives tailored to meet the scientific, educational and professional needs of oncology specialists. One such initiative is ECCO's eLEARNING programme to provide home learning and on-line continuing education courses to all oncology professionals. Find out more: www.ecco-org.eu (select 'Education' > 'E-learning').

Contact
ECCO – the European CanCER Organisation
Phone +32 2 775 02 01
Fax +32 2 775 02 00
Email: info@ecco-org.eu
www.ecco-org.eu

6th EONS Spring Convention

New ways of working: Innovation in cancer nursing practice

Change is happening rapidly in cancer care. But with so many changes bombarding the daily practice of the cancer nurse, it is often difficult to step back, take a new look at an old situation, then move forward by implementing new trends that really make a difference in patient care. The fresh, crisp early spring weather which greeted participants to the 6th EONS Spring Convention held in Geneva in late March provided just the right atmosphere for talking about innovation in cancer nursing practice.

The topics presented at the EONS Convention ranged from new ways of working in the changing setting of oncology to developing practice based evidence for cancer nursing. Moving beyond issues related to practice, topics related to supporting carers and patients and understanding how researchers can develop nursing sensitive outcomes rounded off the fully-packed educational and interactive programme.

One trend in health care that almost everyone is experiencing is the increased involvement of patients and their families in decision-making as well as in the provision of care. What is innovative is that patients are also becoming more involved in policy making. G. Hubbard conducted a literature review on the involvement of cancer patients in health care research policy. While patients are becoming better at negotiating bureaucratic hurdles, this researcher found that they require training and mentoring to be successful in influencing policy makers.

Cancer nurses are well-aware of the importance of providing information to patients and their families. However, as nurses in Rome found out, communicating with elderly cancer patients presents new challenges and nurses must adapt their methods of communication to meet the needs of this fast-growing subpopulation of cancer patients. Nurses in Zurich developed a patient education program for patients with head and neck cancer. They found that patient competence and confidence in self-management was improved through structured teaching activities. It is widely recognized that specialist nurses can improve the quality of care. In Bern, Switzerland, specialized breast cancer nurses implemented a project to provide patients with consultation and support during the treatment process. The results of their study, which evaluated needs as expressed by a control group of patients who received standard care and an intervention group who were continuously consulted and supported by specialist nurses, showed quite interestingly that the intervention group had an increase in unmet needs over the control group. The results suggest that the provision of more specialized care may increase patient awareness of their needs and may encourage patients to more openly voice their needs. The innovative use of technology was discussed by several

presenters as a means of changing and perhaps even updating the way nurses practice their profession.

The Canadian researcher, D. Doran, found that nurses could improve the quality of the care they provided by using benchmarking methods to compare individual patient outcomes to outcomes provided in databases. Using mobile phone and computer technology supported by a multidisciplinary team including engineers and IT specialists, A. Young from the UK found that patients could easily use the technology to alert nurses to changes in their condition. Further, the researcher found that the technology provided patients and their carers with an increased sense of security. Programmed into the system was a grading of symptoms; certain symptoms could trigger an alert and the nurse would respond within 30 minutes if the symptoms were severe or within 12 hours if the symptoms were less acute. Patients reportedly appreciated the opportunity to manage their condition at home knowing that help was just a phone call away. Some old and familiar problems in cancer nursing were presented but with suggestions for new solutions. For example, a Canadian oncology unit overcame problems related to staffing shortages and work overload through participatory action strategies aimed at improving interdisciplinary practice. E. Serrano and S. Lamont reported that members of the health care team experienced greater satisfaction with their practice and patients and family members experienced safe, competent and ethical care as a result of their interventions. Unrelieved pain is still a problem in cancer symptom management that affects 30% to 40% of patients. By providing patients with instruction on how to take pain medication, how to monitor their pain, and how to communicate their feelings of pain to health care providers, R. de Wit and colleagues found that patients reported decreases in pain intensity. Despite their positive results, the researchers are still uncertain which interventions are most successful in decreasing pain in cancer patients.

As in previous years, the 6th EONS Spring Convention was an occasion to learn through interaction and networking. A record 600 participants from 34 different countries attended the convention demonstrating that nurses have recognized the trend to use scientific meetings to find out more about "what works when" and introduce innovation in their practice. Although the theme for the 7th Spring Convention has not yet been finalized, the date and location are set. So plan to join your EONS colleagues and friends in April 2010 in Den Haag, The Netherlands for the next Spring Convention. Watch the EONS website for advanced information on the convention.

Country Representation at the EONS 6th Spring Convention

Country	Number of Participants				
Albania	1	Greece	16	Romania	8
Austria	7	Croatia	11	Sweden	14
Australia	2	Hungary	3	Slovenia	1
Belgium	13	Ireland	28	Syria	3
Bulgaria	2	Iceland	4	Thailand	1
Canada	8	Italy	10	Turkey	3
Switzerland	193	Lithuania	3	U.A.E.	2
Germany	23	Latvia	4	U.K.	51
Denmark	25	The Netherlands	23	U.S.A.	7
Spain	27	Norway	1	Venezuela	1
Finland	18	Portugal	20		
France	66	New Zealand	1	TOTAL	600

IBCM

Interconference
Breast Cancer
Meeting

2

23-25 April 2009

SARAJEVO, BOSNIA AND HERZEGOVINA



Chair

T. Čufer, (SI)

Co-Chairs

H. Basič, (BA) (ESO)

G. Mastruk, (UA) (EUROPA DONNA)

J. Foubert, (BE) (EONS)

Host Chair

S. Beslija, (BA) (Sarajevo)

Scope

Further to the successes of the first Interconference Breast Cancer Meeting 2007, IBCM returns to bring the very latest in breast cancer research, treatment, care to the Balkan area, Central and Eastern Europe.

Within a truly multidisciplinary setting, participants can expect 3 days' rigorous review of cutting edge discovery from the basic, translational, and clinical levels, the latest trends and developments in nursing and cancer care as well as updates on topical issues from the patient advocacy perspective.

For all forthcoming announcements please bookmark:

www.ecco-org.eu

(select 'Congresses and Conferences' > 'IBCM-2').

Secretariat

For further information and general enquiries please contact the IBCM Secretariat directly:

ECCO – the European CanCer Organisation

Avenue E. Mounier 83

B-1200 Brussels

Belgium

Tel: +32 2 7750201

Fax: +32 2 7750245

Email: IBCM2009@ecco-org.eu

Venue

Parlamentarna Skupstina Bosne i Hercegovine

(National Assembly Sarajevo)

Trg BiH,1

71000 Sarajevo

Bosnia & Herzegovina

5th International Conference on Cancer Prevention

Conference Summary, St. Gallen 2008

Agnes Glaus, PhD, RN

Around 180 international experts from 30 countries met in St. Gallen, Switzerland for a three day conference to discuss ongoing research in cancer prevention. The meeting was organized and co-sponsored by St. Gallen Oncology Conferences (SONK), the European School of Oncology (Milano/Italy), the International Society of Cancer Chemoprevention (New York/USA), the European Society of Medical Oncology (Lugano), the Cancer Research UK (CRUK/London, UK), the Union Internationale Contre le Cancer (UICC, Geneva), the European Association of Cancer Research (EACR), the American Cancer Society (ACS/Atlanta, GA, USA) and the Swiss Cancer League (KLS/Bern, Switzerland).

The first session traditionally focuses on health politics, because international health care systems still somehow neglect cancer prevention. As Hans Jörg Senn pointed out in his welcome lecture, health systems still work in a 'treatment-oriented' way. In Switzerland – and in many other countries – more than 98% of the national health budget of >50 billions Swiss Francs are spent for 'cure and care'. In contrast, less than 2% is dedicated for disease prevention. This may become even worse as less money will be available in the future.

Peter Greenwald (NCI, Bethesda, USA) also raised the question whether the potential of cancer prevention is used. He emphasized the importance of public health policies and education, especially concerning smoking prevention and cessation as well as the fight against obesity. He strongly recommended expansion of chemoprevention research, to develop risk assessment models using new technologies and bringing prevention into mainstream.

Early markers – potential for prevention

Keynote lecturer Scott M. Lippman (MD Anderson Research Center, Houston, Texas) outlined the new potential of a "cancer prevention-therapy convergence" which represents a therapeutic strategy shift towards pre-malignancy. From his point of view the real target of prevention should be the status of micro-neoplasia that can be eradicated and detected by markers or molecular risk assessment. He focused on oral pre-malignancies and the incidence of head and neck squamous cell carcinoma (HNSCC). A genetic test has been developed that applies a sensitive PCR technique and uses microsatellite markers to determine loss of heterozygosity (LOH) in chromosome regions containing critical tumour suppressor genes. He reported that leukoplakia lesions with LOH carried a higher risk of HNSCC. Such technologies will enable physicians in future to provide targeted therapy in secondary prevention. Other biomarkers for early cancer stages were discussed as David Sidransky (Johns Hopkins University, Baltimore, USA) gave insights into his investigation of hypermethylation as an early marker for HNSCC, lung, prostate or bladder cancer. Ugur Sahin (Johannes Gutenberg University, Mainz, Germany) reported about cancer specific gene products that give rise to cancer associated auto-antibodies as potential diagnostic markers. These auto-antibodies may be detectable several years before cancer diagnosis and serve as predictive diagnostic marker for in the future.

Nutrition and lifestyle: more in focus than ever

Nutrition, diet and food compounds remain highly relevant issues in cancer prevention. Michael Pollak (General Jewish Hospital, Montreal, Canada) gave insights into the effect of energy metabolism on cancer risk. Risk is influenced by BMI, caloric intake, birth weight and exercise. These factors influence serum levels of insulin and IGF-I, that mediate at least partially the effects of energy balance on risk. Research is focussed on Anti-IGF-I-receptor drugs and phase I/II trials. Anthony Howell (University of Manchester, UK) presented a paper dealing with metabolic aspects of cancer prevention. It has been shown that continuous energy restriction (CER) or exercise reduce risk, especially in postmenopausal breast cancer. Howell could demonstrate intermittent energy restriction (IER, 650kcal on 2 days per week) may be superior or at least as effective as continuous energy restriction (CER, 1500kcal/day). Interestingly the insulin serum level was more reduced with IER. Wanda Baer-Dubowska (University of Medical Sciences, Poznan, Poland) investigated the effect of chemopreventive isothiocyanates which are present in cabbage juice and modulate the expression and activity of phase 1 and 2 enzymes like CYP1A P450 in a rat model. New data were presented for chalcones, present in cloudy apple juice or in Kava tea. Clarissa Gerhäuser (German Cancer Research Center, Heidelberg, Germany) demonstrated that polyphenols may reach the colon after oral intake in an active status and still might be capable to prevent adenoma formation. Studies with recovered ileostomy effluents from patients treated with apple juice showed a transient increase in radical scavenging activity with a maximum at 4h after apple juice consumption. This suggests that polyphenols may reach the colon and exert a local antioxidant effect. Kava is a traditional beverage in the South Pacific Island region. Epidemiological information implies that kava might be chemopreventive against lung tumorigenesis.

Chemoprevention: Aspirins and NSAIDs

Chemoprevention with Aspirin and NSAIDs was discussed by a panel of international experts in cancer prevention. The attempt was made to find an international consensus recommendation for the use of aspirin. The evidence that NSAIDs interfere with carcinogenesis in the large bowel is accepted. This is not the case for reduction of breast cancer but may be for other cancers, e.g. lung cancer. The experts were cautious when considering toxicity and costs. Colonoscopy was considered more cost effective than daily aspirin. No general recommendation for the regular intake of aspirin was made. More research is needed to identify risk groups, to define the dose of aspirin needed and length of treatment. A consensus paper, summarising this expert panel discussion will be published soon.

The next Cancer Prevention Conference for epidemiologists, basic research scientists and clinicians from all disciplines, will take place in St. Gallen in March 2010.

St. Gallen Oncology Conferences

c/o Tumor Center ZeTuP (Detection, Treatment + Prevention)
Rorschacherstrasse 150, CH-9006 St.Gallen
www.oncoconferences.ch and www.zetup.ch



European Oncology Nursing Society (EONS)

INTRODUCTION

The European Oncology Nursing Society (EONS) has provided support to cancer nurses across Europe since 1984. The mission of EONS is to add value to the work of its individual members and national societies in delivering care to patients with cancer. It aims to assist in the promotion of healthy communities through influencing, research and education.

The changing landscape of cancer management in relation to cancer treatments, new technologies, psychosocial care and health care provision has meant a significant shift in the way nurses apply their clinical skills and knowledge in the workplace. However, the professional development and status of cancer nurses across Europe is not uniform and EONS strategic agenda (CARE) aims to address this inequality by working with oncology nurses through their national societies.

STRATEGIC PRIORITIES

Communication

Communicating with and to oncology nurses across Europe remains a challenge. Developing diverse communication pathways is complex and EONS is committed to doing this by continuing to produce and distribute (through the national societies) a newsletter four times a year. The EONS website (part of Cancerworld) is an established forum for cancer nurses and EONS will be developing multi-language sections within the site as well as options for interactive forums to promote professional discussion, information and networking. The European Journal of Oncology Nursing continues to be one of the leading cancer journals and celebrated 10 years of publication in 2006.

Political Agenda

EONS is one of the professional cancer societies that form part of the umbrella organisation renamed ECCO in 2007 (European CanCer Organisation) previously known as FECS – Federation of European Cancer Societies. The organisation provides a collective political voice in Europe. EONS is also a member of the European Specialist Nurses Organisation (ESNO) which consists of associations from both European Nursing Specialist and Nursing Interest Groups. The organisation acts as a platform to represent nursing in the wider political forum.

CARE encompasses four bodies of work:

- C Communication
- A Activities for the Political agenda
- R Research
- E Education

Research

Promoting evidence based clinical practice through research has always been a core function of EONS. Various grants are distributed through EONS to promote and facilitate research initiatives. One of the priorities is to develop a European cancer nursing research network which will enable wider collaboration, participation and sharing of research evidence as well as build a body of research and development expertise.

Education

The themes as priorities in education are to develop cancer nurse educators to develop and accredit teaching programmes which have education quality standards as part of the review process. Inequality in accessing post-registration cancer nursing education exists across Europe. Alongside this work is the commitment to develop specialist education and leadership programmes which can be viewed in www.cancerworld.org/eons

Notwithstanding the busy agenda the patient experience lies at the heart of the CARE Strategy. By utilising and working in collaboration with patients, EONS will continue to provide a unique contribution to the agenda of cancer care in Europe, whilst promoting the unique contribution of cancer nursing in this process.

For more information on EONS, please contact the secretariat at

eons.secretariat@skynet.be

European Cancer Policy Review

Cath Miller, EONS Communications Team

Of all the elements contained within the EONS strategic agenda CARE (communication, political agenda, research and education), the item that frustrates most is policy issues. The reason is that most nurses feel that they are poorly informed about governmental policies which affect cancer care and they further feel that they are not used as expert consultant in matters related to setting cancer care policies. In an effort to inform EONS members about policy issues affecting cancer, this article summarises a cancer policy update, originally produced by Roche, which outlines key communications at the European level.

EUROPEAN PARLIAMENT

The EU Parliament Conference of Presidents has placed an amended Motion for a Resolution on combating cancer in the enlarged European Union. The discussion and vote on the resolution is expected to take place at the April session of the Parliament. The Resolution is likely to gain the backing of a large majority of Parliament members.

MEP'S AGAINST CANCER (MAC)

MAC is an all-party informal group consisting of Members of the European Parliament (MEP's) committed to promoting action on cancer as an EU priority and using European health policy to that end. The latest MEP to join MAC is Magor Imre Csibi (Romania).

HEALTH FIRST EUROPE (HFE)

This is an awareness-raising forum consisting of patient groups, healthcare workers, academic experts and the medical technology industry. George Andrejevs MEP (Latvia), co-author of the Draft Resolution on combating cancer in the enlarged EU, has pledged his support to the HFE. (www.healthfirsteurope.org)

INTERNATIONAL AGENCY FOR RESEARCH ON CANCER (IARC)

IARC and the European Commission established the EUNICE (EU Network for Information on Cancer) project which monitors the status of the cancer burden in populations and evaluates central measures at national and EU level. The interim report on EUNICE's progress, conclusions, and achievements was presented to the EU Commission in April. EUNICE also can assist in refining indicators in cancer screening, treatment and outcome evaluation. From these recommendations, a common database is to be established that can assist in the development of European control programmes which will also provide assistance in monitoring patient outcomes. (www.iarc.fr)

EUROPEAN CANCER ORGANISATION (ECCO)

The official journal of ECCO (previously known as FECS), the European Journal of Cancer (EJC), recently published an interview with Professor Jan Willem Coebergh. In the article, Dr. Coebergh stated that greater effort should be made on cancer control at the EU level. His message was reinforced by highlighting that countries working as individual units are not able to respond quickly to the challenges of increasing of cancer patients numbers which by developing as well as implementing new cancer programmes including prevention and treatment. He believes a European perspective on investment should be considered as the way forward. The next special issue of EJC will publish 'Cancer control in Europe: State of the art in 2008'.

CANCER NEWS ITEMS

European Colorectal Cancer Awareness Month was launched on the 4th and 5th of March this year. The objective of the launch,

hosted by Roche, was to raise awareness of colorectal cancer and access to care with special emphasis on the importance of early diagnosis and screening. The need for a pan-European cancer plan and prevention strategy was highlighted.

Dr Marios Matsakis MEP (Cyprus) tabled a written question to the European Commission whether it agrees that preventative colonoscopic examinations should be available free of charge to all EU Member States. In his statement Dr Matsakis pointed out that prevention programmes would save many lives as well as being a cost-effective health care measure.

Mr Proinsias de Rossa MEP (Ireland) has also tabled a written question to the European Commission on the subject of breast cancer. He asks how the EC has responded thus far to the European Parliament's Resolution on Breast Cancer in the Enlarged EU which was adopted in 2006. Mr de Rossa also highlighted the need for future financing of breast cancer screening projects. Further, Mr de Rossa tabled a second written question on the subject of breast cancer screening for women over the age of 69.



Mrs Kathy Sinnott MEP (Ireland) has tabled a written question specifically asking about EU funding for the prevention of cancer in males. Two issues were highlighted as specific to the male population. Firstly, men are known to be less likely than women to consult a doctor when a health problem occurs which can lead to a higher cancer incidence among men with poorer outcomes. Secondly, men have a poor awareness of symptoms associated with the most common male cancers. There is currently no targeted EU funding for screening programmes to reduce the cancer incidence in men.

The process used by the Commission to answer written questions is usually not cancer-specific and therefore responses may be general. Ongoing cancer initiatives promoted by the Commission may have application in cancer and therefore help to shape the direction of future work.

THE EUROPEAN MEN'S HEALTH FORUM (EMHF)

The EMHF Steering Group recently met for the second time in Brussels to discuss early diagnosis of lung cancer in the workplace. The Steering Group is developing an initiative to bring together stakeholders to develop a roadmap to earlier diagnosis and improved prognosis through the workplace. Their work will hopefully contribute to current and forthcoming EU and WHO policies.

EONS national societies and individual members are asked to consider whether the initiatives discussed in this article have a relationship to cancer-related priorities established in their own countries. If so, please contribute to the European debate by providing a written article (of any length) to a future EONS Newsletter. In this way, EONS will strive to keep communication in relation to political awareness open.

Life Choices and Breast Cancer Prevention

Prof. Alex Molassiotis, Professor of Cancer & Supportive Care, University of Manchester, UK & Frances Bloomberg International Distinguished Visiting Professor, University of Toronto, Canada

The question of whether lifestyle choices are linked with increased risk and/or the development of breast cancer has been put forward some years ago; since then conflicting information (often misinformation) exists as to which factors are linked with higher risk of breast cancer. This complicates and interferes with lifestyle choices that women may want to make for themselves, and increases their anxiety about putting themselves at higher risk. The information below attempts to put together accurate information about what is and what is not linked with increased risk of breast cancer, based on a review of current and up to date scientific information.

There are certain factors for increased risk of breast cancer for which people do not have control over, such as gender, age and genetic makeup. However, an increasing body of evidence suggests that certain other factors do exist, and these may be controlled by individuals. Often these factors are associated with lifestyle choices. This is demonstrated by epidemiological research and migrant studies showing changes in incidence of breast cancer following migration, ascribed to contemporary ways of living – sedentary lifestyle with little exercise or changes in diet. Obesity might also contribute to the increased risk of breast cancer, although the situation is more complex. Some of these reasons are discussed below:

Reproductive and Hormonal Factors



Prolonged use of **hormone replacement therapy (HRT)** is the leading lifestyle risk factor for breast cancer, contributing to 4.7% of the breast cancer cases. Long-term (several years) use of HRT (both oestrogen and combined with progesterone) is associated in some studies with increased risk not only of breast cancer, but also ovarian or uterine cancers as well as other health risks (health disease, strokes, blood clots, etc). For combined oestrogen/progesterone HRT the risk applies only to current and recent users, and the risk seems to return to that of the general population within 5 years of stopping HRT. For oestrogen only HRT, the risk does not seem to be high unless used for >10 years. Other confirmed reproductive factors of increased breast cancer risk include **early menarche** (<12 years old), **late age** at first birth (>30 years old), **low parity** and **late menopause**. The risk, however, from these factors is only slightly greater than the general population. Multiple pregnancies and becoming pregnant at an early age somewhat reduces the risk of breast cancer. There is only a slight increase in risk (or no risk at all in some epidemiological studies) from the use of oral contraceptives. If there is any risk, however, this decreases when oral contraceptives are stopped, and there is no risk 10 years post-use. Decisions to use oral contraceptives need to balance the slight risks and the many benefits (including decreasing ovarian and endometrial cancers, relieving menstrual disorders, improving bone mineral density, etc).

Some studies suggest that breast feeding may have protective effects and lead to lower levels of breast cancer, but the decreased risk is low and may need long-term breast feeding (i.e. for 1.5 to 2 years), a difficult area to study with any certainty particularly in our western societies, where long-term breast feeding is not common.

Smoking

Another risk factor is smoking because cigarettes contain many chemicals which can initiate and promote the development of cancer, and some studies have found that breast fluids of women who smoke contain chemicals from the cigarettes. The evidence on the effect of adult active and passive smoking is not clear. What seems to be more clear is that age at which a woman begins smoking may be the important factor, as heavy smokers below the age of 20 have 30-80% more likelihood to develop breast cancer.



Alcohol Use

In the past decades it has also become more socially acceptable for women to drink. However, all studies point out that women below 35 years old who regularly drink are twice as likely to develop cancer as those who avoid alcohol, and some studies point out that with each unit of alcohol in adult age the possibility of developing cancer increases from 6-10%. Adequate folic acid (vitamin B) may decrease the risk in women who drink more than 1 drink/day, although this finding needs further investigation.



Obesity

This is a complex area. Obesity seems to be associated with decreased premenopausal breast cancer risk (25% decrease), while the same is associated with increased postmenopausal breast cancer risk (about 200% increase). This may be related to subtle differences in the fat cells and also the production of oestrogens. Also, obesity is often concurrent with lack of exercise and/or diets high in fat consumption, and the cause and effect of these factors relative to each other is difficult to pinpoint.



Nutrition

This is another unclear area with a number of conflicting studies. High-fat foods are not clearly linked with risk for breast cancer, and this is the result of several large studies. These studies may have been complicated by other sample differences, such as activity levels, intake of other nutrients and genetic factors. Hence, high-fat diets may not be linked with increased breast cancer



risk, although calorie intake clearly counts (extra fat increases the production of oestrogens outside the ovaries), and further such diets are linked with other cancer risk and heart disease. Whole grains and fibre may have protective effects in the body and should be added to every day diet, while red meat consumption may have a role in increasing risk and should be decreased/limited.



Physical Activity

An increasing body of evidence clearly shows a link between low levels of activity and increased risk of breast cancer. The question, of course, is how much exercise is good, and we have little information to support any recommendations. The

Women's Health Initiative large 15-year study has shown, however, that as little as 1.25 to 2.5 hours/week of brisk walking has reduced the risk by 18% and 10 hours of walking/week has decreased the risk a little more. The American Cancer Society recommends 45-60 minutes of intentional physical activity 5 or more days/week. The decreased risk through exercise may act possibly through changing menstrual activity (i.e. age at menarche), body characteristics (i.e. decreased body fat) and hormone levels (i.e. decreased oestrogen levels).

Controversial or Unproven Factors

While there is much lay discussion around the use of **antiperspirants**, through their possible absorption from the skin and interference with lymph circulation, there is little (if any) valid scientific support for any link with risk of breast cancer. **Bras** have also been thought to obstruct lymph circulation leading to breast cancer, but there is no scientific or clinical basis for this. Possibly women who do not wear bras are also more likely to be thinner, which may contribute to this perceived difference in risk.

Breast implants are also not associated with any increased risk of breast cancer, although they may make more difficult to see breast tissue in a mammogram (although additional x-rays with implant displacement views could lead to a more correct evaluation of the breast tissue). **Night work** (i.e. nurses working in night shifts) has been suggested by several studies that it may increase breast cancer risk, possibly through disruptions in melatonin and/or other hormones still to be identified. This is a relatively recent finding and more work is underway to examine this possibility more accurately.

Hence, some lifestyle choices do make a difference in the risk of breast cancer and some of them are easily controllable. If we hypothetically apply the potential risk percentage of developing breast cancer to the current number of breast cancer patients in Europe, we can see that, had this risk was completely decreased, we should have expected at least 30,000 less cases of breast cancer in Europe every year (see Table 1). This lower number translates into more lives saved, less lives affected by cancer or living with cancer, less service utilisation and higher health gains. Lifestyle changes have the potential of preventing the development of breast cancer, although health promotion messages need to be culturally appropriate and sensitive, and accommodate the realities of living in different lifestyle nowadays from a generation or two before. Clear messages need to be communicated to women, and balance risks and benefits of such choices, allowing women to make informed decisions about their lives.

Table 1.

Prevention of breast cancer cases in the EU countries annually

Risk factor	% contribution	Cases prevented
Use of HRT	4.7%	12,690
Obesity	4%	10,800
Activity	3.2%	8,640
Alcohol, smoking	Some ?	?
Breastfeeding	Some small ?	?

Further reading:

Chlebowski RT, Pettinger M, Stefanick ML, Howard BV, Mossavar Rahmani Y, McTiernan A. "Insulin, Physical Activity, and Caloric Intake in Postmenopausal Women: Breast Cancer Implications." *J Clin Onc* 2004;4507-4513.

Collaborative Group on Hormonal Factors in Breast Cancer. "Breast cancer and hormonal contraceptives: collaborative reanalysis of individual data on 53 297 women with breast cancer and 100 239 women without breast cancer from 54 epidemiological studies." *Lancet*. 1996;347(9017):1713-27.

Cui Y, Page DL, Chlebowski RT, Hsia J, Hubbell FA, Johnson KC, Rohan TE. "Cigarette Smoking and Risk of Benign Proliferative Epithelial Disorders of the Breast in the Women's Health Initiative." *Cancer Causes Control* 2007;18(4):431-438.

Cui Y, Page DL, Chlebowski RT, Beresford SA, Hendrix SL, Lane DS, Rohan TE. "Alcohol and Folate Consumption and Risk of Benign Proliferative Epithelial Disorders of the Breast." *Int J Cancer* 2007;121(6):1346-1351.

Forman MR. "Changes in dietary fat and fiber and serum hormone concentrations: nutritional strategies for breast cancer prevention over the life course". *J Nutr*. 2007;137(1 Suppl):170S-174S

Heiss G, Wallace R, Anderson GL, Aragaki A, Beresford SAA, Brzyski R, Chlebowski RT, Gass M, LaCroix A, Manson JE, Prentice RL, Rossouw J, Stefanick ML, for the WHI Investigators. "Health Risks and Benefits 3 Years After Stopping Randomized Treatment With Estrogen and Progestin." *JAMA* 2008; 299(9):1036-1045.

Kolstad HA. Nightshift work and risk of breast cancer and other cancers—a critical review of the epidemiologic evidence. *Scand J Work Environ Health*. 2008;34(1):5-22.

Morimoto LM, White E, Chen Z, Chlebowski RT, Hays J, Kuller L, Lopez AM, Manson J, Margolis KL, Muti PC, Stefanick ML, McTiernan A. "Obesity, Body Size, and Risk of Postmenopausal Breast Cancer: The Women's Health Initiative." *Cancer Causes and Control* 2002;13:741-751.

Genetic Counselling

About Cancer Genetics in the UK and the Role of the Consultant Genetic Counsellor

Chris Jacobs, Consultant Genetic Counsellor and Joint Lead for Cancer Genetics, South Thames Regional Genetics Service, Guys and St Thomas Hospital NHS Foundation Trust, London, England

Introduction

Over the last 15 years, recognition of the role of family history on cancer risk and the identification of genes conferring a high risk of certain cancers has resulted in a huge increase in the number of patients referred for genetic counselling regarding their risk of cancer. In consequence, genetic counselling in cancer has become an increasingly large part of the work of genetic counsellors (GCs) across the UK with a growing number of GCs developing specialist expertise in cancer genetics. This article will discuss the role of the GC in cancer genetics within the UK, and the role of Consultant Genetic Counsellor in Cancer Genetics at the South Thames Regional Genetics service based at Guy's and St Thomas Hospital NHS Foundation Trust in London.

Background

Genetic counselling is 'a communication process which deals with the human problems associated with the occurrence, or the risk of an occurrence, of a genetic disorder in the family' (1). The central components of the role are to educate and inform clients about their genetic condition in a non-directive manner; provide support and help with coping and to facilitate informed decision-making.

Prior to the mid 1990s, the study of genetic predisposition to cancer was largely confined to the rarer cancer family syndromes. However, it had long been recognised that many common types of cancer show a tendency to run in families. Identification of the BRCA1 gene (2) in 1995 and the BRCA2 gene (3) in 1996 were important developments in understanding the significance of breast cancer family history and the risks associated with a genetic predisposition. Many more cancer predisposing genes have subsequently been isolated, leading to a greater understanding of the aetiology, risk and management of cancer. As a result of these advances, there has been a huge increase in awareness of the significance of family history amongst the general population and, in consequence, referral to genetics services now constitutes at least half of clinical genetics activity in the UK.

The role of the Genetic Counsellor in cancer genetics in the UK

There are 23 Regional Genetics Centres in the UK with many of these running satellite clinics. The role of the GC varies across the UK. In most centres GCs have their own clinical workload and are key members of the multidisciplinary team. In some centres there are specific cancer and general teams and in others GCs see both cancer and general patients.

There are two routes of entry into the profession in the UK: via an academic science background with a Masters degree in genetic counselling or as a Registered Nurse with a Masters degree. All GCs in the UK are now encouraged to undergo professional registration, which it is hoped will become statutory. The registration process includes training, experience and evidence of competence and continuing professional development in all areas of genetics.

The role of the GC in cancer genetics is to verify the family history, explore the patient's concerns, explain the significance of the family history, provide personalised risk and screening advice, help the patient and family adjust to the cancer risk, provide support



and counselling and, where appropriate, explore the option of genetic testing. In order to offer genetic testing for cancer susceptibility in the UK, there needs to be at least a 20% chance of a mutation being present, and in most cases, a relative with cancer who is willing to be tested. If a mutation can be identified in a relative with cancer,

a predictive genetic test can then be offered to other relatives. Genetic testing in the UK is only offered following genetic counselling and with informed consent. Inheritance and the risks associated with specific gene mutations, the possible outcomes and implications of genetic testing, confidentiality and the potential impact of a positive and negative result, and the psychosocial and support needs of the individual are all discussed prior to the test. The number of appointments offered pre and post testing will vary depending on the situation and needs of the individual.

Until the late 1990s, cancer genetics in the UK was funded entirely by research. The expansion of cancer genetics services within the National Health Service and the increasing number of GCs entering the profession from an oncology background lead to specialisation of some GCs and the development of specialist senior genetic counselling roles within the cancer genetics field.

The role of Consultant Genetic Counsellor in Cancer Genetics

The South Thames Regional Genetics Centre, serves a population of approximately four million people. Referrals are received from general practitioners, specialist clinicians and specialist nurses. The role of Consultant Genetic Counsellor in Cancer Genetics was developed at the South Thames Regional Genetics Centre in 2006 as a result of the increase in cancer referrals and the need for development of the cancer genetics service. The role includes providing expert practice, leadership, education, service development, liaison with other cancer specialists and research. This role poses many opportunities and challenges, some of which are described below.

One of the challenges of genetic counselling is to provide a service to those who need it without raising unnecessary anxiety and expectations. Within the South East of England, we have worked with specialist nurses to establish a network of cancer family history clinics in secondary care, ensuring that referral to genetics is appropriate and timely. Specialist nurses in breast, colorectal and gynaecology cancer are trained by GCs to take a three-generation family history and assess and explain cancer risk and risk management with direct referral to genetics for those at increased risk in accordance with local and national guidelines (4).

An annual eight-day course is run by GCs from the South London

Regional Genetics Centres, together with Kings College, London and the University of Kingston, to train specialist nurses in all aspects of cancer genetics and family history assessment. In addition, a competency-based assessment programme has been established for nurses who are setting up family history clinics with support and supervision from the GCs. An audit of our service in 2006 showed that referrals from the family history clinics to the South Thames Regional Genetics Centre were far more accurate and appropriate than referrals from primary care.

Recently we have completed a three-year pilot project setting up cancer risk assessment clinics in the local community (5). The area around Guy's Hospital is one of the most socially deprived and ethnically diverse in the UK. Providing local clinics in the community to which patients could refer themselves increased the proportion of non White British patients accessing the cancer genetics service from 3% to 46%. Sixty three percent of the patients seen by the service were at moderately increased risk of cancer or greater and were referred on to screening or genetic counselling. We now have funding to build on this service in order to develop a comprehensive cancer risk assessment service across primary, secondary and tertiary care in the local area.

We have run a pilot project for two years setting up a multidisciplinary one stop clinic for patients who carry mutations in the high risk breast cancer predisposing genes (BRCA1 and BRCA2). Patients are offered an annual review with specialists in genetics (GC or geneticist), breast surgery, gynaecology, oncology and psychology in order to provide consistent information and counselling in liaison with their local clinicians. In addition, patients are offered the opportunity to take part in research studies and to access a support group, patient information days and an annual newsletter. The two year data is currently being evaluated, however interim data at 11 months showed that patients were highly satisfied with the service and the number of women opting for prophylactic surgery and entering research studies increased as a result of the clinic. This service also now has ongoing funding.

Conclusion

Developments in scientific understanding are involving cancer genetics even further in mainstream oncology practice. There is a growing demand for genetic testing amongst women who are newly diagnosed with breast cancer and have a strong family history of the disease in order to inform surgical management. In addition, the use of biomarkers in determining cancer treatment is becoming an increasingly realistic possibility. These developments highlight the importance of an understanding of cancer genetics amongst all health professionals in the field of oncology. Genetic counsellors in the UK are likely to play an increasing role in integrating cancer genetics into oncology, in developing patient pathways and targeting appropriate referral, raising awareness of the service amongst the public and educating other health professionals.

Cancer genetics is a rapidly expanding field and the future is exciting. The changing shape of genetics referrals has led to a shift in the clinical workload of genetic counsellors and development of new roles within the profession. However, an understanding of the importance of family history on cancer risk is essential for all nurses working in the field of oncology and as further scientific advances are made cancer genetics will become even more integral to cancer management.

References

1. American Society of Human Genetics Ad Hoc Committee on Genetic Counselling: Genetic Counselling. *American Journal of Human Genetics* 27, 240-242, 1975
2. King M-C and Szabo C: Inherited breast and ovarian cancer. *Human Molecular Genetics* 4, 1811-1817, 1995
3. Stratton M: Recent advances in understanding of genetic susceptibility to breast cancer. *Human Molecular Genetics* 5, 1515-1519, 1996
4. McIntosh A et al: Clinical guidelines and evidence review for the classification and care of women at risk of familial breast cancer. London: National Collaborating Centre for Primary Care/ University of Sheffield. NICE guideline CG014. www.nice.org.uk, 2004; updated 2006
5. Jacobs et al: Providing a community-based cancer risk assessment service for a socially and ethnically diverse population. *Familial Cancer* 6 (2) 189 - 195 Epub 2007 May 23

Joint SIOP Europe and EONS ECCO Special Project Collaboration Between Nurses and Doctors in Paediatric Oncology

The research project funded by ECCO and led by Dr Faith Gibson from the UK, started as a two year project in 2006 and continues to progress well. It involves pairs of doctors and nurses from across Eastern and Western Europe working collaboratively to improve patient care in their centres using Appreciative Inquiry. This is a technique which seeks to develop the positive aspects of existing practices and develop them further.



So far there have been two residential weekends in November 2006 and June 2007. The third and final seminar will take place in Prague in June 2008. The project began with 15 pairs from 13 countries. Unfortunately four groups have had to leave the project due to work commitments and lack of time to progress their proposals. The countries involved are in Switzerland, Greece, Belgium, Poland, Estonia, Lithuania, Serbia, France, Germany, UK and Netherlands. The 11 pairs remaining in the project are now working on their own piece of developmental work in their own centre. Such projects include the following:

- o Collaboration between doctors and nurses in providing information to the patients and their families during the course of treatment.
- o Improving phone communication between parents, medical and nursing staff in a paediatric oncology unit.
- o Implementation of a paediatric pain protocol in the paediatric haematology / oncology ward.

We look forward to proving a fuller report on this project at the end of the year.

Dr Faith Gibson
On behalf of the project team

European Men's Health Forum

Tackling inequalities in men's health across Europe

Nicola Beech, Research Officer, University of Surrey

Introduction

The European Men's Health Forum (EMHF) aims to improve men's health across all countries in Europe by promoting collaboration between interested organisations and individuals on the development and application of health-related policies, research, education and prevention programmes. A current focus for EMHF relates to the earlier detection of lung cancer in men, through the workplace. The second steering group meeting was held on 11th March in Brussels and EONS were invited to send a representative. The steering group includes representatives from throughout Europe including doctors (Norway, Sweden and UK); nurses (EONS); occupational health advisors (WHO, Royal Mail (UK)); trade unions (UK); pharmaceutical companies; European Network for Workplace Health Promotion; EU officials; and the Department of Health (UK).

Background

Lung cancer is the most prevalent cancer in over half of the 38 countries in Europe (1), with an estimated 243,000 cases in the year 2000 (2). Incidence rates show different trends between European countries in gender; age; and socioeconomic status (3), with lung cancer the second most commonly diagnosed cancer in men (n=292, 200, 17.2%) (4). Survival for lung cancer patients remains poor, with estimates of 1-year relative survival ~30% for both sexes, and age adjusted 5-year survival ~10% in men and women (5). European countries with the highest incidence of lung cancer also demonstrate the highest levels of mortality from lung cancer. For men, these countries in ranked order are Hungary, Poland, Croatia and Belgium (1). In 2006, lung cancer was the highest cause of mortality from cancer deaths in Europe, with 252, 300 deaths in men (4).

Changes in incidence, survival and mortality rates are a reflection of a range of social and epidemiological factors including health promotion programmes; individual lifestyles, occupation exposures; health screening; the existence and accessibility of health care facilities; and human, financial and material resources for health and economic development (3). Variations in survival and mortality rates across Europe are most likely a result of varying access to specialised care (6), therefore suggesting that service improvements can be made (7). Patients often present late when lung cancer is already locally advanced or has metastasised (8), partly as a result of a lack of knowledge and awareness amongst the general public regarding lung cancer risk, symptoms and services (9,10).

Workplaces represent an important venue for providing health education and promotion as they provide access to large numbers of men. In addition, the workplace offers an opportunity to collaborate with labour unions who can enhance access to the population, and offer an organizational structure through which programmes may be administered (11).

Key Themes from the Meeting

During discussion between members of the steering group, the following key themes were identified:

- Widespread inequality throughout Europe with regard to overall expenditure on health care and on cancer care resulting in poorer outcomes for the diagnosis and treatment of lung cancer.
- Men wait longer before seeking advice regarding symptoms.

- Many health professionals and the public are not necessarily aware of the benefits of earlier detection.
- There is a lack of simple, easy to use diagnostic tools for lung cancer detection.
- The media are less likely to focus on issues relating to lung cancer, possibly because of the associated stigma and also because of the poor prognosis.
- The development of smoking prevention measures such as combating smoking in the workplace. Some European countries have introduced `smoking bans` in public places, but this is not commonplace.
- Health promotion campaigns targeting lung cancer have shown that all stakeholders must be involved from the beginning, and should be seen as a continuous, rolling programme.
- With regards to workplace interventions, it is critical to ensure employers are committed to the programme.
- Health professionals have to be included at all stages, particularly with regards to early detection in the workplace.
- Workplace health and safety will require complex risk assessment systems with regards to lung cancer.

There was general agreement that the workplace is an effective setting for the communication of health messages and for affecting positive changes in health behaviours, particularly with regard to migrants. The session resulted in a series of recommendations as regards measures needed in the workplace for earlier diagnosis of lung cancer in men (see box 1).

Box 1: Draft Recommendations

- 1) Secure early buy-in from employers through demonstration of "business case" for workplace health programmes
- 2) Engage trade unions in workplace health promotion and recognise the invaluable contribution that trade unions have made and can make
- 3) Promote further research into simple and practical diagnostic tools to allow for earlier diagnosis of lung cancer
- 4) Lobby for European smoke free workplace and general availability of tobacco dependence treatment
- 5) Encourage companies to uphold health and safety regulations, particularly with regard to migrant workers
- 6) Promote better education and training for health professionals through dissemination of best practice
- 7) Highlight and combat the significant inequality of health outcomes with regard to lung cancer survival rates for men across Europe
- 8) Prioritise good health literacy through use of clear and jargon free communication methods to get the message across to the general public
- 9) Recognise and disseminate examples of good practice in workplace health promotion
- 10) Engage all relevant stakeholders to ensure the widest possible coalition of interests represented
- 11) Ensure prompt recognition of WHO Global Plan of Action on Workers' Health
- 12) Collect evidence of best practice in workplace health promotion schemes and disseminate

Future Action

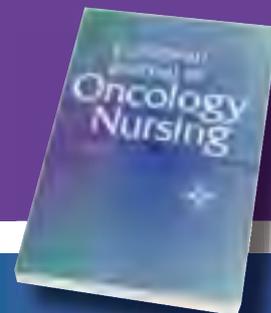
EMHF will seek expertise from partner organisations to further develop the current set of recommendations and to contribute to the production of a comprehensive background report. The report will include case studies of workplace interventions that have been successful in helping employees to recognise and address the symptoms of lung cancer. A series of background meetings will be organised with key organisations and individuals in preparation for the third steering group in early Autumn 2008.

Representatives of major European level stakeholder groups will be invited to this steering group meeting to discuss the key recommendations and generate commitments for the dissemination of agreed measures. Project partners will generate opportunities within their areas to disseminate the outcomes while EMHF will provide a workshop during the European Health Forum Gastein in October. The health forum would be a particularly suitable opportunity since, in addition to high ranking EU officials; it attracts national policy makers and other senior public health stakeholders.

References

1. Bray F: The burden of cancer in Europe. In Coleman MP, Alexe D, Albrecht T and McKee M, editors: Responding to the challenge of cancer in Europe, Slovenia, 2008, Institute of Public Health.
2. Cancer Research UK: UK lung cancer incidence statistics, London, 2007, CRUK
3. Alexe D, Albrecht T, McKee M, et al: Responding to the challenge of cancer in Europe. In Coleman MP, Alexe D, Albrecht T and McKee M, editors: Responding to the challenge of cancer in Europe, Slovenia, 2008, Institute of Public Health.
4. Ferlay J, Autier P, Boniol M, et al: Estimates of the cancer incidence and mortality in Europe in 2006, *Annals of Oncology*, 18(3), 581-592, 2007.
5. Sant M, Aareleid T, Berrino F, et al: EURO-CARE-3: survival of cancer patients diagnosed 1990-94—results and commentary. *Annals of Oncology*, 14 (suppl_5), v61-118, 2003
6. Janssen-Heijnen ML, Gatta G, Forman D, et al: Variation in survival of patients with lung cancer in Europe, 1985-1989. *European Journal of Cancer*, 34(14), 2191-2196, 1998.
7. Corner J, Hopkinson J, Fitzsimmons D, et al: Is late diagnosis of lung cancer inevitable? Interview study of patients' recollections of symptoms before diagnosis. *Thorax*, 60(4), 314-319, 2005
8. Biring SS, Peake MD: Symptoms and the early diagnosis of lung cancer. *Thorax*, 60(4), 268-269, 2005.
9. Corner J, Hopkinson J, Roffe L: Experience of health changes and reasons for delay in seeking care: a UK study of the months prior to the diagnosis of lung cancer. *Social Science and Medicine*, 62(6), 1381-91, 2006
10. Tod AM, Craven J, Allmark P: Diagnostic delay in lung cancer: a qualitative study. *Journal Advanced Nursing*, 61(3), 336-43, 2008
11. Allen JD, Stoddard AM, Mays J et al: Promoting breast and cervical cancer screening at the workplace: results from the Woman to Woman Study. *American Journal Public Health*, 91(4), 584-590, 2001.

Impact Factor is coming...



Make your article count!

A few tips on how to cite.

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.

Here is an example of how to cite an article:

Miller M., Maguire R., Kearney N. (2007). Patterns of fatigue during a course of chemotherapy: Results from a multi-centre study. *European Journal of Oncology Nursing*, 11 (2), 126-132



Women's Perspectives on Cervical Cancer Screening

Issues beyond morbidity and mortality

Karin Blomberg RN, PhD student*, with A. Forss, B-M Ternstedt, C. Tishelman, & C. Widmark (in alphabetic order)

Introduction

Cervical cancer is the second most common cancer disease in women worldwide (1). In Sweden 440 women were diagnosed with cervical cancer in 2006 (2) and 136 died from the disease in 2005 (3). The decrease of morbidity and mortality in cervical cancer in the western world has been related to effective screening programmes using the Pap smear to discover cervical cancer during early, non-invasive, asymptomatic stages. The Pap smear was developed by Papanicolaou in 1943 and has been used in screening programs and opportunistic screening (that is, Pap smears taken outside screening programmes and without sign or suspicion of a medical problem) for many years. Population-based cervical cancer screening in Sweden has existed since the 1960s and differs from those in many other countries, as it is a population-based outreach program (PCCSP), coordinated by six regional Oncologic Centers (OC).

In the last few years a shift in scientific knowledge has occurred, with evidence implicating a virus, human papilloma virus (HPV) as a necessary precursor of cervical cancer (4). HPV is the most common sexually transmitted disease in both sexes, particularly among adolescents and young adults (5). There are many types of HPV, with approximately 15 types classified as 'high risk' due to their association with cervical cancer (5). Most HPV-infections resolve spontaneously, but persistent HPV-infections can lead to pre-cancerous dysplasias (5). A HPV-vaccine has been developed and marketed, first in the US in 2006 and in Sweden in 2007. The HPV-vaccine is described as effective for 70% of the HPV-types, and since is most effective for those who have not been HPV-infected, vaccination programs will still need to be combined with continued cervical cancer screening for best prevention of cervical cancer. These rapid scientific and technological developments emphasize new challenges in relation to the existing cervical cancer screening programmes. Most of the research in this area to date has focused on factors that impact on women's attendance in cervical cancer screening and interventions to increase the compliance in the screening programmes. There is a need for more knowledge about women's experiences and reasoning about cervical cancer screening and about the link between HPV and cervical cancer, as well as about the HPV-vaccine.

My PhD research is an expansion of a larger multidisciplinary research project with Professor of Nursing Carol Tishelman as project leader and main scientific supervisor and in collaboration with Dr Catarina Widmark, who is a midwife and Dr Anette Forss, a nurse and anthropologist. Several studies have been previously published by the research group (6-12) about cervical cancer screening, based on different research questions and different stakeholder perspectives. The overall aim for my studies is to explore how women experience and reason about cervical cancer, its causes and prevention, such as cervical cancer screening and HPV-vaccines.

Women's experiences and reasoning about screening for cervical cancer

In the literature, women who do not take Pap smears are often referred to as one reason that cervical cancer has not been successfully eliminated (13-14). Despite this there is a lack of knowledge about how the women who choose not to attend screening or at all take a Pap smear reason about their decision.

Through analysis of interviews and fax messages* by women who had actively chosen not to participate in PCCSP, it became apparent that women could reason somewhat differently about their decision (15). There was a common theme in their reasoning, as tensions between the private and public spheres were salient. The participating women distinguished between what they saw as belonging to the private arena respectively the public domain. Women spoke of a division between the individual and society which they felt existed with regard to responsibility for health maintenance. There was also a difference in manner in which women described being able to 'know' one's own body as opposed to more public, professional knowledge. Women often described believing that a healthy lifestyle protects one from cancer and the Pap smear could therefore be seen as unnecessary. The women's descriptions also included previous negative experiences of health-care system and the PCCSP, for example a feeling of distrust, or previous encounters with health care staff that were described as disrespectful. Some of these women expressed a strong view that the screening program represents an undesired societal control of private issues. The PCCSP was spoken of by some women as "Big Brother"; these women also highlighted issues related to moral aspects of the PCCSP, such as self-determination versus a feeling of implicit coercion to participate. On the other hand, some women showed a willingness to share private aspects of their private life to the PCCSP, for example sending fax messages about private aspects of their personal lives to the anonymous fax number of the screening program.



As a result of the PCCSP, some women receive an abnormal or unclear Pap smear result and are therefore called for further medical follow-up, including examinations and treatments. This follow-up is often described in the existing literature and in clinical practice as an 'unproblematic' intervention for prevention of cervical cancer. In our study, which is based on unstructured, repeated interviews with thirty women who had received some type of abnormal Pap smear result after attending PCCSP, we interpreted the period of medical follow-up as involving strongly embodied experiences for these women (16). These experiences can also be seen in relation to aspects of the private and public spheres. Women's descriptions of their bodies were found to involve experiences which changed over time, of both "having" and "being" a body. Two overarching, integrated processes were found to be important. One process involved the change from a taken-for-granted body experienced as 'silent', healthy, and asymptomatic to a body which becomes 'heard' through pain, vaginal discharges, and bleeding experienced after professional mediation and treatment. These women's reasoning was also related to what was believed to be 'normal' or 'abnormal' experiences during follow-up. For example pain related to the biopsy was described as unexpected and could lead to women questioning if they were oversensitive to pain and if this could be interpreted as a sign of weakness.

The other process involved how women's conceptualization of their bodily boundaries appeared to change. These changes could be catalyzed through professional mediation, for example as a

result of visualization of the cervix, a previously unfamiliar area of the body for most women, as well as through pain, vaginal discharge and bleeding which often could result from professional treatments. In addition, women seemed to move from conceptualizing their own risk for cervical cancer as related to their individual body and private life, to begin to relate their risk for cervical cancer to the bodies and diseases of women in their extended families through the generations.

Issues related to the private and public spheres were also raised through focus group discussions (FGDs) with 30-year old women, which we held to investigate their reasoning about PCCSP. Preliminary analysis of the FGDs indicates the importance of the complex context in which these women live, in their reasoning regarding cervical cancer and screening. These women described the public spheres as having access to knowledge which the women describe themselves as not having. The women expressed uncertainty about a wide array of issues related to the PCCS and cervical cancer, e.g. if, when, and by whom the Pap test had been taken; what could screening detect; and the extent and nature of any information received. Few women described being aware of any relationship between HPV and cervical cancer. A "healthy lifestyle" was described as protective against cervical cancer, with perceived risk factors for cervical cancer varying from air pollution to vague notions about sexually transmitted infections. A salient finding was women's strong expressions of surprise when the link between sexuality and cervical cancer was brought up by the moderators in the FGDs.

Discussion and future implications for research and practice

These different studies highlight women's experiences and reasoning of different aspects of the PCCSP. The manner in which women conceptualized the roles and responsibilities of the private and public spheres appeared essential in their reasoning about screening for cervical cancer. Women's ways of conceptualizing health, illness and risk for disease in general was also seen to impact on their decision-making about participation in PCCSP (12, 15). Tensions between the public and private spheres were also related to perspectives of knowledge, for example, what knowledge about women's bodies is relevant, how it can be obtained and who 'owns' such knowledge. These issues are also important in light of the discourse in the contemporary culture regarding the responsibility of the individual for her health maintenance and disease prevention (12). This was apparent in both in the women's reasoning about their decision not to participate PCCSP but as well as women's descriptions of their bodily experiences of the medical follow-up of an abnormal Pap smear (15-16).

Women's view of the PCCSP as an integrated and comprehensive system suggests a need for increased collaboration around direct and indirect encounters with potential participants, among professionals involved in different stages of the programme. An additional consideration is the tension that exists between the needs of the individual and societal needs, in efforts to improve public health (see also CW's article reference 6, for a similar discussion in relation to the role of the midwife in screening).

As a HPV vaccine was licensed after the FGDs with 30-year old women were conducted, new data is needed how these developments are understood by young women in Sweden. We therefore continue data collection with the same population. Knowledge about young women's understandings of the PCCS and related areas are increasingly important, as HPV-vaccination programs are being discussed as an option in several countries. These 30-year old women may also be in the position of determining whether or not their children should receive future HPV-vaccines. In the existing literature the risk for stigmatization is emphasized, due to the link between HPV, a sexually transmitted

disease, and cervical cancer. This, in addition to the rapid scientific and technological developments raises new challenges for the individual woman, partners, families and the society. The results of these studies can therefore hopefully add knowledge which can be used for optimizing the cervical cancer screening program, future HPV-vaccination programs, and information to better meet the needs of women.

References

1. Ferlay F et al.: GLOBOCAN 2002: Cancer Incidence, Mortality and Prevalence Worldwide, Lyon, 2004, IARC Press.
2. National Board of Health and Welfare: Cancer Incidence in Sweden 2006. Official statistics of Sweden, report No 2007:16, Stockholm, 2007, Centre for Epidemiology.
3. National Board of Health and Welfare: Causes of Death 2005. Official statistics of Sweden, report No 2007:15, Stockholm, 2007, Centre for Epidemiology.
4. Walboomers JM et al.: Human papillomavirus is a necessary cause of invasive cervical cancer worldwide, *J Pathol* 189(1):12-9, 1999.
5. Frazer IH et al. Advances in prevention of cervical cancer and other human papillomavirus-related diseases, *Pediatr Infect Dis J* 25(2 Suppl):S65-81, quiz S82, 2006.
6. Widmark C et al.: Opportunities and Burdens for Midwives Working in Primary Health Care: An example from population-based cervical cancer screening in urban Sweden, *J Nurse Midwifery* 43(6):530-540, 1998.
7. Tishelman C et al.: Research on Risk and Risk in Research: Theoretical and practical experiences from a multi-disciplinary study on cervical cancer screening in urban Sweden, *Qual Health Res* 9(1):45-60, 1999.
8. Forss A et al.: "I got a letter..." A qualitative study of women's reasoning about attendance in a cervical cancer screening program in urban Sweden, *Psychooncology* 10:76-87, 2001.
9. Lundgren E.-L et al.: Midwives' descriptions of their familiarity with cancer: A qualitative study of midwives working with population-based cervical cancer screening in urban Sweden, *Cancer Nurs* 23(5):392-400, 2002.
10. Sarkadi A et al.: The 'Hows', 'Whos' and 'Whens' of screening: Gynaecologists' perspectives on cervical cancer screening in urban Sweden, *Soc Sci Med* 58(6):1097-1108, 2004.
11. Forss A et al.: Women's experiences of cervical cellular changes: An unintentional transition from health to liminality? *Social Health & Illn* 26(3):306-325, 2004.
12. Widmark C et al.: Cancer screening in the context of women's health: Perceptions of body and self among women of different ages in urban Sweden. *International journal of qualitative studies on health and well-being* 3(2): 89-102, 2008.
13. Sung H-Y et al.: Papanicolaou smear history and diagnosis of invasive cervical carcinoma among members of a large prepaid health plan. *Cancer* 88(10): 2283-2289, 2000.
14. Bos AB et al.: Nonattendance is still the main limitation for the effectiveness of screening for cervical cancer in Netherlands. *Int J Cancer* 119(10): 2372-2375, 2006.
15. Blomberg K et al.: How do women who choose not to participate in population-based cervical cancer screening reason about their decision? *Psychooncology* Published online in Wiley InterScience (www.interscience.wiley.com) DOI: 10.1002/pon.1270, 2007.
16. Blomberg K et al.: Women's bodily experiences of medical follow-up after an abnormal Pap smear. Submitted for publication, 2008.

At the time for data collection for this study, women who did not want to participate in PCCSP were asked to return the invitation to OC with an explanation for their choice.

**Department of Neurobiology, Care Sciences and Society, Division of Nursing, Unit for Cancer Care, Karolinska Institutet, Stockholm and School of Health and Medical Sciences, Örebro University, Örebro, Sweden, and the Swedish National Postgraduate Research School in Health Care Sciences.*

The multidisciplinary approach to teaching cancer prevention

Csaba Avramucz, Assistant Lecturer, Semmelweis University Faculty of Health Sciences Budapest, Hungary

As a lecturer at the Semmelweis University, my field of research is the multidisciplinary approach to the prevention of malignant tumours. I have been committed to dispelling the general misconception about malignant tumours, which is cancer is always a fatal disease. In my work I strive to reduce the high number of people suffering from cancer through knowledge and education.

The goal of the programme is to transfer up-to-date knowledge about cancer prevention to students at the Faculty of Health Sciences of the Semmelweis University. The students need to have a better understanding of the benefits of complimentary lifestyle therapies alongside conventional treatment for cancer. The programme supports the recent research findings of the World Health Organisation which state that among the factors influencing our health; lifestyle plays a remarkable role. (12, 19)

In the world of science, the first decade of the 21st century was named the Decade of Health Behaviour, referring to the fact that the quality of our lives relies more in the way of life we choose for ourselves. This recognition challenges the theory and practice of medicine as well as the education of doctors and applied research methodology. Medicine is shifting its paradigm, which reflects above all, a new attitude towards behaviour as bio psychological phenomenon. (6, 8)

A bio psychological approach has existed in medicine for a long time. The inseparable unit of body and soul has been observed in practice by some doctors through the ages; however, there has been little scientific evidence that supported such thinking. (18)

Nowadays the physiological and biochemical effects of behavioural processes can also be proved with scientific methods. Since the subject of medicine is the human being in a bio psychological state, it is mainly medical science that implies the possibility of integrating biological, scientific, behavioural and sociological paradigms. (14) Healing has to stand on a solid scientific basis, and sociological knowledge also has to be applied when there is a discussion between a doctor and a patient. There are always questions raised during healing, among them there are psychological, sociological, ethical, cultural and anthropological issues. This is well referenced in the definition of behavioural medicine. At a Yale-conference in 1977 the essence of behavioural medicine was formulated as the following:

It is an interdisciplinary field whose aim is to apply (in an integrated way) all we know about behavioural and biomedicine and their methodology in the course of problems related to health and illness in every field of prevention, diagnosis, healing and rehabilitation. (16)

Behavioural medicine is in connection with almost all fields and specialisations of medical science, traditionally this relation is very close with psychiatry. (9)



(12, 19)

If a person does not have a healthy lifestyle, chronic diseases may appear earlier in life. Nutrition plays a significant role in avoiding the development of such disease processes. (19)

Malignant tumours are multifactorial. Education, prevention and treatment also need to be multifactorial in its approach, as healing can only be achieved by treating all the emerging symptoms at the same time.

Considering all these factors, a new curriculum was introduced which is still regarded to be a unique programme in higher education in Hungary.

In the second semester of the academic year 2003/2004, a course was organised at the Faculty of Health Sciences of the Semmelweis University under the title: 'Multidisciplinary Approach of Tumour Prevention'.

Aim of the course:

It has been our aim to help students in their future professional practice to demonstrate health-promoting behaviour and contribute to effective prevention, as well as to increase their understanding of the development of tumours. At the completion of the course, the student is able to provide information and advice to healthy individuals as well as ill people of different ages and to be able to implement a holistic approach which considers one's body, soul and consciousness. Furthermore, students are prepared to teach others about the prevention and treatment of cancer.

The programme calls attention to health behaviour factors which could possibly have an influence on the development of malignant tumours. It includes the importance of proper nutrition, environmental hazards, the role of regular physical exercise in cancer prevention, enhancing treatment effectiveness, psychic factors, and the role of stress in the development of malignant tumours.

The programme is a multidisciplinary approach to the understanding of the development of malignant tumours, as well as to their prevention and general health promotion. It relies on the findings of psychoneuroimmunology in oncology. In the book edited by Urbán it is stated that there is interrelation between the soul and the immune system and presents factors of lifestyle and health behaviour which may influence the development of a malignant tumour. (21)

In the belief that primary, secondary and tertiary factors all play an important role in cancer prevention; this programme attaches great importance to the individual responsibility of all health care professionals working in health care institutions. Their exemplary health behaviour is one of the most effective tools in oncological health prevention and in psycho-educative activities.

Student's population:

Full-time and part-time students: Registered Nurses, Midwives, Physiotherapists, Dieticians, Public Health Inspectors, Health Visitors, Health Care Teachers, Ambulance Officers, Physicians

Number of classes: 60, Credits: 2

The course was developed by Csaba Avramucz, (expert lecturer)

Views and knowledge imparted during the course:

- o The expression of "holism" and the "holistic" view are interpreted.
- o The qualities and characteristics of a health care specialist who practice a holistic approach.
- o The components of the bio psychosocial model.
- o The complex understanding of the notion of "health" in the western and Asian way of interpretation. (7, 13)

Diagram of HEALTH,



Health: prayer, dream, sleep, laughing, play, dance, massage, vitamins, enzymes, mineral substances, physical exercises, clear water, appropriate diet, clean air, breathing exercises, positive thinking, relaxation, visualization, stress- management, creative thinking, poetry, humour, singing, music (22)

Unfortunately, we often fail to link mental health as an organic part of the healthy way of life. The following considerations are covered in the course curriculum.

Definition and characteristics of mental health,

- o The importance of mental health care in the 21st century as an indispensable part of leading a healthy way of life. (13)

The word 'incurable' is still associated with cancer in Hungary. The attitude of a great part of the society towards ill people and being ill is often based on fear and ignorance, so the student will learn about: Cancer and its mysterious meanings.

Why do we speak about cancer with difficulty? Students will cover this aspect on the course considering the meaning, stigmatizing effect, fear, lack of special knowledge of cancer as a disease.

Since students have little knowledge about the atmosphere of oncology wards and the reactions of patients with cancer, they get an insight into oncopsychology. (7)

The morbidity and mortality of malignant tumours in Hungary and worldwide is discussed.

giving students a clear understanding about:

- the cause of the problem
- options for prevention, screening, early detection and effective treatment (5)

The risk factors of tumours covered by the course:

- I. Carcinogens of the workplace
- II. Viral carcinogens
- III. Physical reasons:
 - o UV radiation,
 - o Noise and vibration,
 - o Vibration,
 - o Electromagnetic field ,
 - o Microwave radiation,
 - o Ionising radiation, isotopes.
- IV. Factors of the lifestyle:
 - o Smoking,
 - o Nutrition:
 - Energy intake,
 - Fats,
 - Proteins,
 - Alcohol,
 - Natural and artificial food contaminative materials
 - Food additives,
 - Synergism,
 - Physical inactivity,
- V. Nosocomial medicines and radiation diseases
- VI. Micro environmental tumours,
- VII. Macro environmental tumours,

VIII. Chemical factors,

IX. Genetic factors,

X. Psychosomatics and tumours

- Personality: 'C' type personality (carcinogenic personality)
- The influence of emotional and mood changes on health
- The relationship of stress and tumours
(4, 5, 7, 11, 13, 15, 19, 21, 22)

Anticarcinogenic factors considered by the course:

Nutrition:

- o Basics of comprehensive nutrition,
- o Healthy ingredients, anticarcinogenic alimentation factors,
- o Suggested nutrition factors,
- o Nutrition factors to be avoided (1, 11, 15, 22)

Orthomolecular medicine:

- o The role of antioxidants in prevention and treatment
 - Definition, physiological and pathophysiological role, characteristics and types of the free root
 - Environmental factors that cause oxidative stress. (15)

The influence of physical activity in the prevention of tumours:

- o Colon cancer,
- o Breast cancer,
- o Prostate cancer,

The effect of physical exercises on patients with tumours:

- o Breast cancer
 - General guidelines of aerobic load,
 - General guidelines of resistance training (on the trunk)
 - Precautions (bone metastases) (4)

In order to achieve mental health and harmony:

- o Strengthening one's coping ability,
- o Ability to control stress
- o A right self-image and self-picture
- o Self-estimation,
- o Self-development, ability to develop,
- o Autonomy,
- o Ability to change,
- o Accepting social allowances, participation in social movements.
(17,20)

Example for relaxation and meditation techniques considered by the course:

- o Autogenic training,
- o Breathing therapy,
- o Simonton therapy,
- o Yoga, (17, 22, 23)

Complementary and alternative medicine, definitions:

Terms applied to therapies not commonly included in mainstream medicine have repeatedly changed over time, evolving from a very negative 'quackery' through 'unorthodox,' 'unconventional,' 'questionable,' 'unproven,' and 'alternative.' Current, but still evolving, terminology favours 'complementary' and 'alternative' medicine, or the acronym of both: CAM. The shifting language is exemplified by the creation of the National Institutes of Health (NIH) Office of Alternative Medicine, which was established over a decade ago and which was renamed the National Centre for Complementary and Alternative Medicine (NCCAM) in 1999. (2)

Health professionals have long promoted what we see as a necessary distinction between complementary and alternative therapies, despite

the acronymic convenience, and the viability of a newer term, integrative oncology. Complementary therapies are used as adjuncts to mainstream cancer care. They are supportive measures that control symptoms, enhance well-being, and contribute to overall patient care.

Alternative therapies are typically used for use instead of mainstream treatment. This can present a problem in oncology, when delayed treatment can reduce the possibility of remission and cure. Interventions sold as literal alternatives to chemotherapy, surgery, and radiation therapies tend to be biologically active, potentially harmful, and extremely expensive and unproven. Over time, some complementary therapies are proven safe and effective. These become integrated into mainstream care, producing integrative oncology, a synthesis of the best of mainstream cancer treatment and rational, data-based, adjunctive complementary therapies. Such integration is evolving. The term applied to the program at the Memorial Sloan-Kettering Cancer Centre (Integrative Medicine Service) and similar titles applied to related programs in North America, the United Kingdom, and Europe, suggests that complementary therapies are being brought into mainstream medicine, including cancer care. Integration as well as the quality of therapies vary from country to country. CAM therapies may be categorized in many ways. NCCAM currently distinguishes five categories within CAM therapies: biologically based therapies, alternative medical systems, energy therapies, mind-body interventions, manipulative and body-based methods. Currently popular therapies within each of these categories are discussed below. Many of these approaches are unproven methods and they are promoted as alternatives to mainstream cancer treatment. Helpful complementary or adjunctive therapies are discussed in a following section. (2)

Traditional Medical Systems: These complete systems of theory and practice were developed by ancient cultures and remain essentially intact. Prominent examples include traditional Chinese medicine (TCM), India's ayurvedic medicine, homeopathy and naturopathy medicine. (3)

After completing this course, the students will be able to:

- o Describe the differences between complementary and alternative therapies.
- o List common complementary and alternative therapies used by cancer patients.
- o Know where to access reliable information.

Complementary ways of nutrition: The Macrobiotic Diet in Cancer,

Macrobiotics belongs to the most popular alternative or complementary comprehensive lifestyle approaches to cancer. The centrepiece of macrobiotics is a predominantly vegetarian, whole-foods diet that has gained popularity because of remarkable case reports of individuals who attributed recoveries from cancers with poor prognoses to a macrobiotic diet and the substantial evidence that the many dietary factors recommended by macrobiotics are associated with decreased cancer risk. Women consuming macrobiotic diets have modestly lower circulating oestrogen levels, suggesting a lower risk of breast cancer. This may be partly due to the high phytoestrogen content of the macrobiotic diet. As with most aspects of diet in cancer therapy, there has not been much research carried out in the field, which could evaluate the effectiveness of the macrobiotic diet in alleviating suffering or prolonging survival of cancer patients. A few studies have compared the experience of cancer patients who tried macrobiotics with expected survival rates or assembled series of cases that may justify more rigorous research. On the basis of available evidence and its similarity to dietary recommendations for chronic disease prevention, the macrobiotic diet probably carries a reduced cancer risk. However, at present, there is a limited empirical scientific basis for or against recommendations for use of macrobiotics for cancer therapy. Any such recommendations are likely to reflect biases of the recommender. Because of its popularity and the compelling evidence that dietary factors are important in cancer aetiology and survival, further research to clarify whether the macrobiotic diet or similar dietary patterns are effective in cancer prevention and treatment is guaranteed. (10)

The most effective method in the healing of a tumour is to apply conventional methods combined with healthy lifestyle therapies, since lifestyle has a high percentage among the factors affecting one's state of health.

Regional and cultural differences in cancer incidence suggest strongly that environmental factors are important determinants of carcinogenesis. The diet is the most common vehicle for carcinogen transport into the body – the other routes being inhalation and skin absorption (including radiation.) Along with other environmental differences, nutritional factors may account for as much as 30 % or more of cancer incidence. Despite the difficulties in determining the roles of individual compounds and specific conditions, research on natural products will remain a fertile field of debate, and will have potential for making a significant contribution to human health. Nutrition will also lead into unavoidable, unproductive cul-de-sacs and will remain a fertile field for unfounded claims. (23)

The Definition of Psychoneuroimmunology will be taught: The behaviour of conducted mental life and the immune system in health and illness.

PNI examines numerous questions whose clinic and epidemic aspects are significant both in healing and in prevention. E.g.: The relationship of psychosocial factors, lifestyle and immunity. (21)

Students will understand the factors which affect the treatment and outcomes of patients with cancer.

- o The histological type of the tumour,
- o The time and the sort of intervention/treatment and when it was recognized,
- o The age and general state of the patient,
- o The patient's attitude towards his own illness,
- o Other illnesses,
- o Premorbid (time before illness) and present psychosomatic features.

The primary goal of the programme is to enable students to

- o reduce the risk factors of malignant tumours through increasing the effectiveness of primary secondary and tertiary prevention;
- o contribute to the development of a general thinking which regards health as a value;
- o promote a healthy lifestyle;
- o improve the quality of life of those suffering from cancer.

At the completion of the theoretical course, the students' examination comprises of a written test and a presentation before an audience on one of the topics discussed during the course.

Conclusion

We live in historic times when considering the fight against cancer, where oncology practice that applies a multidisciplinary approach and prevention as mainstream has a significant role. The main reasons for death and common illnesses as well as the development of tumours mainly stem from the way of life people choose and the behavioural decisions they make in connection with their lifestyle. The percentage our way of life is responsible for our physical health is approximately 50 %. The deliberate and consequent change in the lifestyle also contributes to the decrease of early deaths related to cancer. Examples like in Canada, Australia or Finland (19) illustrate that the mortality rate of those suffering from cancer can be reduced significantly but there are certain requirements that need to be fulfilled: well-organised work, effective prevention and multidisciplinary co-operation of well-trained, motivated experts with a holistic approach to care and treatment.

Nowadays patients receive a huge amount of unauthentic, moreover, harmful information about the alternative ways of healing, therefore it is crucial that future experts know the safe, effective complementary therapies and when to use this to benefit patients with cancer. According to WHO, these therapies have to be gradually integrated

into medical care, ensuring the patients' right to choose freely. These topics were widely discussed at the conference „Controversies about Complementary and Alternative Medicine (CAM) in Oncology” in Brussels, which was organised by EORTC (European Organisation for Research and Treatment), based in Brussels and the Milan-based ESO (The European School of Oncology) in 2006. Therefore it is essential that students as future experts are acquainted with appropriate and authorised information and professional resources in relation with multidisciplinary tumour prevention.

Considering the complexity of the topic, there is a need for special training programmes that are in accordance with social expectancy and international trends. These programmes should be organised in institutions where patients with cancer are treated so that patients, their relatives and particularly specialists working there can enrich their knowledge. The team treating oncological patients is the most suitable to convey reliable, authentic and professional information to patients and their relatives.

To conclude it has to be highlighted that success and the enhancement of effectiveness cannot be accomplished without the personal example of professionals, especially oncology nurses, in health care and in the related disciplines. Our lifestyle, the way we lead our lives should be an example to follow for our families, patients, students and the whole society.

References:

1. Bishop B. A Time to Heal – My triumph over cancer the therapy of the future. New Canaan: Keats Pub, 1985.
2. Cassileth BR, Deng G. Complementary and alternative therapies for cancer. *Oncologist* 2004;9(1):80-89.
3. Cassileth BR. The Alternative medicine handbook: The complete reference guide to alternative and complementary therapies. New York: W. W. Norton, 1998. 16–52. p.
4. Courneya KS, Mackey JR, McKenzie DC. Exercise for breast cancer survivors: research evidence and clinical guidelines. *PhysSportsmed* 2002; 30(8): 33-42.
5. Ember I, Kiss I, Sándor J. The epidemiology and prevention of tumours. Budapest: Dialóg Campus, 2000.
6. Engel GL. The need for a new medical model: A challenge for biomedicine. *Science* 1977; 196(4286): 129-36.
7. Horti J, Riskó Á. *Oncopsychology in practice*. Budapest: Medicina, 2006.
8. Kopp M, Pikó B. The role of behavioral sciences in the Hungarian and international medical education: overview and possibilities. *Orv Hetil* 2001; 142 (49): 2715-21.
9. Kopp M, Pikó B. Teaching behavioural sciences in Hungary. The relationship between psychiatry and behavioural sciences, behavioural medicine on the field of educating doctors and professional training. *Psychiatr Hung* 2001; 16(2):183-190.
10. Kushi LH, Cunningham JE, Hebert JR, Lerman RH, Bandera EV, Teas J. The macrobiotic diet in cancer. *J Nutr* 2001; 131 (11 Suppl): 3056S-64S.
11. Lützner H. Active dietetics, Lent, intensive diet, nutrition therapy. Budapest: Civil Foundation „Against Cancer, for Humanity, for Tomorrow!” “A Rák Ellen, Az Emberért, A Holnapért” Társadalmi Alapítvány , 2002.
12. Pikó B. (ed.) Introduction to medicine. Basic Principles of Behavioral Sciences and Preventive Medicine. Szeged: University of Szeged, Faculty of Medicine, 2004.
13. Pikó B. Mental health in the modern society Budapest: Akadémiai Kiadó, 2005.
14. Pikó B. The competency of social sciences for biomedicine. *Valóság* 1999; 42(12): 22-30.
15. Schmiedel V, Leitzmann C, Lützner H, Heine H. *Ernährungsmedizin in der Naturheilkunde. Handbuch für Therapie. 2. Auflage.* München, Jena: Urban & Fischer Verlag, 2001.
16. Schwartz GE, Weiss SM. Yale Conference on Behavioral Medicine: a proposed definition and statement of goals. *J Behav Med* 1978; 1 (1): 3-12.
17. Simonton CO, Matthews-Simonton S. *Getting Well Again*. New York: Bantam Books, 1992
18. Stephenson J, Imrie J. Why do we need randomised controlled trials to assess behavioural interventions? *Br Med J* 1998; 316: 611-613.
19. Tompa A. Why Hungarians are ill? *Komplement Med* 2005; 9(3): 6-14.
20. Tudor K. Elements of mental health promotion. In: *Mental Health Promotion: Paradigms and Practice*. New York : Routledge, 1996, 63-82 p.
21. Urbán R. Interactions of behaviour, mental health and immune system. A collection of psychoneuroimmunological essays. Budapest: ELTE Eötvös Kiadó, 2003.
22. www.rakellen.hu Civil Foundation „Against Cancer, for Humanity, for Tomorrow!” “A Rák Ellen, Az Emberért, A Holnapért” Társadalmi Alapítvány. 2008. 04.
23. Yuan CS, Bieber EJ, Bauer BA. *Textbook of Complementary and Alternative Medicine*. London: Informa Healthcare, 2006.

Launch of the new extravasation guidelines

Yvonne Wengström, Professor of Cancer Care, University of Stirling

Introduction

With over one million intravenous chemotherapy infusions and injections given worldwide everyday, health care professionals endeavor to minimize adverse events and complications for patients. However, in a relatively small number of cases, accidental leakage of chemotherapy drug from the vein into the surrounding tissue can lead to severe and permanent disability. The degree of injury associated with "extravasation" can range from very mild skin reaction to severe necrosis. When you consider that adverse events with cancer therapy are quite common, the total number of extravasations which take place is significant.

As EONS Past President, I was delighted to be part of the team who has been involved in developing the new guidelines, and to chair the satellite symposium where they were officially launched. Developing and using guidelines are such an important part of providing the highest quality care to our patients and through the process of development, involving critical analysis of local protocols and policies, care pathways and quality evaluation, we can see why.

EONS is therefore calling for the adoption of new guidelines on how to deal with extravasations, with the aim of improving patient safety. The management of this potentially debilitating condition is very inconsistent across Europe and most nurses do not receive the appropriate training on how to manage the condition which is a problem since nurses are increasingly taking the lead in administering chemotherapy and they are often in the best position to notice adverse symptoms. Nurses have an important role to play in recognizing and managing extravasation in the clinical setting and these compact guidelines are an excellent resource which will support them in doing so.

During the official launch of the guidelines at the Spring Convention

it became clear that when it comes to dealing with extravasations involving anthracyclines, clinical practice varies and includes different treatment regimens with different outcomes. Dr Jan Buter, a medical oncologist from the Department of Medical Oncology, Vrije Universiteit Medical Centre, Amsterdam stated that the optimal treatment of anthracycline extravasation has previously been controversial, with experimental methods including cooling/heating, flushing and topical DMSO. Two recent multi-centre studies which investigated Savene® found it to be an effective acute treatment, which was well tolerated in the patient population and worked in extravasations from both a peripheral line and central venous access. Savene® has since become the only licensed treatment for anthracycline extravasation.

At the Spring Convention all the speakers at the symposium called for action for adoption of the new guidelines, even though changing practice is not easy. There is a tendency to take the view that 'this is the way we have always done it' and some resist change. Although there are some local guidelines, not all are evidence based. There is a need to guide nurses as well as healthcare teams to ensure patient safety. The guidelines will help them manage and prevent extravasations in a competent way and the guidelines are evidence based and peer reviewed.

It is important to recognize that the new guidelines currently provide the best source of information for professionals. It is anticipated that these guidelines will encourage adoption of recommended procedures and the successful management of extravasation which will provide the patient with the safety they deserve. The UK oncology nursing society has in fact already developed an abridged version of the guidelines concerning anthracycline extravasations into a UKONS specific guideline.

The EONS guidelines are available for download from the EONS website.

Extravasation guidelines 2007



Guidelines
Implementation Toolkit

PREVENT

Prediction, Recognition, Evaluation and
Eradication of Normal Tissue effects

January 11-12, 2009
Brussels, Belgium

Information > www.estro.be

ESTRO 

European Society for Therapeutic Radiology and Oncology



Anthracycline extravasation could strike at any time



*The only proven and approved antidote
for anthracycline extravasation*

Be prepared

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/m²; day two, 1000 mg/m²; day three, 500 mg/m². For patients with a body surface area of more than 2 m² 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 childbearing 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, postoperative 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/1/06/350/001. **Price:** 9,750 EURO. Date of Preparation: January 2008. TopoTarget A/S. Fruebjergvej 3, DK