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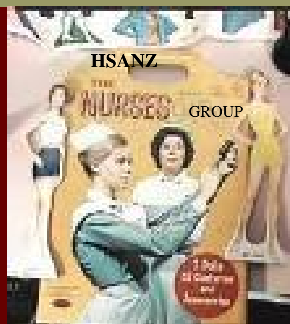

HAEMATOLOGY SOCIETY OF AUSTRALIA AND NEW ZEALAND
NURSES' GROUP

HSANZ NG News

From the president

Dear colleagues,

Welcome to another year (although it's nearly Easter!). We continue to grow as a specialist nursing society and now have State committees in SA in addition to NSW with active representatives across the country and Tasman (see inside). The October meeting in Perth is coming together and looks exciting. Don't forget there are travel scholarships to be won, kindly offered by the HSANZ, so get your thinking caps on and share the work you are doing. The next issue will have guidelines and tips on writing abstracts. I met with the Council in Sydney last month and it was a very collegiate and successful meeting with the council being immensely supportive of our development. So all from me for now, enjoy the journal, have a great chocolate egg fest.

Moira

Our Gaucher Quiz winners

Courtesy of Genzyme, congratulations to our 10 lucky quiz winners!

- **Carmel Henderson** - Flinders Medical Centre, Adelaide, SA
- **Daryl Pollock** - Palmerston North Hospital, NZ
- **Anne Wilks -** Mersey Community Hospital, Latrobe, TAS
- **Jodi Hyman** - St Vincents Public Hospital, Darlinghurst, NSW
- **Deidre Mathis** - The Canberra Hospital, Woden ACT
- **Lisa Shailer -** Gosford Hospital, NSW
- **Kate Hackett -** Westmead Hospital, Westmead, NSW
- **Fiona Pearce** - Leukaemia Foundation
- **Cathie Milton** Newcastle Mater Hospital, Waratah, NSW
- **Grainne Dunne** Sydney Childrens Hospital, Randwick, NSW

Each of the above has won a copy of *"Haematology at a Glance, revised 2nd Ed."* by Mehta & Hoffbrand!

Thanks again to Genzyme for their generosity!

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Coming in the next issue:

- *Practice Corner—What are you doing on your Unit?*
- *Ask the Expert—email in with your questions and your answer will appear in the next issue.*
- *How Do I—write an abstract? Make a presentation? Understand statistics? Let us know what you want to know.*
- *Tea Room Guru—What's your beef?*

Please send your comments, questions & articles to angela.booth@cancerinstitute.org.au

From our 3rd travel grant winner

Intraventricular Treatment: Experiences at Royal Brisbane and Women's Hospital *by Carmen Worthey*

The aim of this paper is to evaluate the effectiveness of administering Rituximab, Methotrexate and Cytarabine via the intraventricular route by nursing staff.

Recent literature expresses the opinion that intravenous administration of Rituximab has limited penetration into the leptomeningeal space. Papers focusing on recent trials have concluded that the administration of intraventricular Rituximab together with Methotrexate and Cytarabine for Diffuse Large B-cell Lymphoma (DLBCL) with CNS involvement, recurrent CNS lymphoma, mantle cell lymphoma, and anaplastic lymphoma with CNS involvement is effective.

Intraventricular treatment is used in conjunction with systemic chemotherapy. An example of this is the MSK (Memorial Sloan Kettering) pre radiation phase protocol with I/O Rituximab.

Methotrexate IV 3.5g/m² Day 1

Vincristine IV 1.4mg/m² Day 1

Rituximab IV 375mg/m² Day 1

Procarbazine PO 100mg/m² Days 1-7 cycles 1,3,5 only

Methotrexate IO 12mg/dose Day 8

Rituximab IO 25mg/dose Day 8

Folinic Acid 15mg q6h (12doses minmum) Day 2 Commencing 24hrs after commencement of IV MTX **plus** 15mg q12h (8 doses total) Day 9 Commencing 24hrs after IO MTX CYCLE every 14 days for 5 cycles total.

This protocol uses the intraventricular route to give direct administration of chemotherapy to the involved CNS. However, an ommaya reservoir may be used in other protocols for reasons such as; difficulties accessing the intrathecal space, protocols that require frequent intrathecal/ intraventricular administration or in other protocols that also require the direct administration of chemotherapy to the involved CNS.

This method is being administered by nursing staff. Patients with Primary CNS Lymphoma (PCNSL) and Post Transplant Lymphoproliferative Disorder (PTLD) received this treatment option using a significant range of equipment including but not limited to:

- Personal Protective Equipment
- an Ommaya reservoir;
- a 25g butterfly needle;
- Betadine;
- a calculation of CSF sampling, discard and flush;
- an administration time of 1-2ml/minute when administering Methotrexate and Cytarabine; and
- an administration time of 10 – 15 minutes when administering 25mg of Rituximab.

Methotrexate and Cytarabine are administered 1-2ml per minute. Methotrexate and Cytarabine are compatible visually at room temperature for 4 hours, therefore when used in the same protocol may be administered consecutively. However, in the literature review, Rituximab was administered over 3 to 5 minutes, with minor to nil side effects.

Administration should be ceased and medical advice sought if:

- Unable to draw back CSF
- CSF is cloudy or bloody (retain sample for pathology)
- The patient's level of consciousness is altered
- The patient complains of headache
- The patient is febrile
- There is redness or oedema over the reservoir site

Following administration the patient should remain supine (30 degrees maximum) for at least 30-45 minutes post procedure and may be discharged if they do not experience any complications eg headache, nausea and vomiting or hypotension.

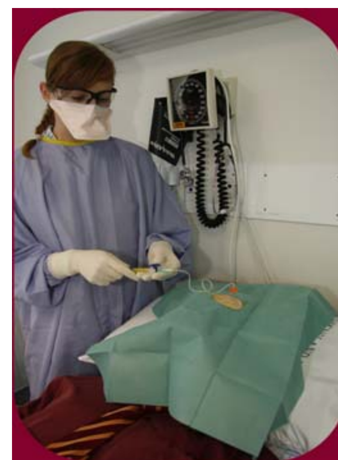
Nurses have been successfully administering Rituximab, Methotrexate and Cytarabine at RBWH without any adverse incidents or device infections. The results of the consulted papers are reflective of experiences at RBWH with the administration of Rituximab. The Giovanni and Rubenstein study reported no major dose limiting side effects. The Wang and Villela (2007) studies reported only minor side effects (grade I-II) but all were resolved within 10 to 20 minutes.

In the last 3 years RBWH have treated 13 patients with intraventricular chemotherapy experiencing no dose limiting side effects. Minor side effects such as nausea were expressed and in 2 cases patients described throat tightness with intraventricular administration of Rituximab. All side effects resolved within 10-20 minutes post completion of procedure without any interventions.

Although the side effects experienced with the administration of Rituximab did not limit the dose, it did lengthen the administration time to 10-15minutes. The lengthening of the administration time for the Rituximab nil side effects being recorded.

At the RBWH historically nurses have been accessing intraventricular catheters (Ommaya or Rickman's). Nurse's previously accessed Ommaya Reservoirs for pain management procedures and are now successfully administering Rituximab, Methotrexate and Cytarabine at RBWH without any severe adverse incidents or device infections.

Why should nurses continue administering intraventricular therapies? We are chemotherapy competent, we administer chemotherapy daily, we are accessing similar devices regularly eg Intra-peritoneal, Port-o-caths and we are more experienced with accessing difficult devices.



In the last 3 years RBWH has treated 5 patients with PCNSL. Four out of five are still alive today and all 5 patients were treated with intraventricular chemotherapy.

Nursing staff at the RBWH are covering new ground by administering Rituximab, Methotrexate and Cytarabine by the intraventricular route. The absence of device infections indicates training procedures for nurses using this method are effective. Intraventricular Rituximab together with Methotrexate and Cytarabine appear to be fairly well tolerated by the patient and effective in the treatment of Lymphoma's with CNS involvement resulting in a significant extension in survival.

This project was undertaken in collaboration with Maree Bransdon (NUM Oncology Day Unit RBWH), Ron Middleton (CNC BMT RBWH), Dr Glen Kennedy (BMT Haematologist), Alanna Geary (Nursing Director Cancer Care Services RBWH))

Are you thinking of attending HAA 2008?

Are you thinking of attending the Haematology conference in Perth in October this year and wondering how you can get funding to attend?

Below is a list of possible sources of funding.:

HSANZ nurses group offers **3** travel grants for best abstract. More information will be available before the call for abstracts goes out—so thinking caps on!

Cancer Council of your state—each state is different in what if offers, but a number offer travel scholarships— see www.cancer.org.au for more information

RCNA website has a number of travel scholarship opportunites listed on www.NurseInfo.com.au

Leukaemia and Blood Foundation (NZ) offer a number of scholarships see www.leukaemia.org.nz

Nurses Registration Boards in most states offer travel scholarships— see your state board for more information.

If you know of other sources local to you please let us know so we can publicize them.

Forthcoming Educational Opportunities

- **Queensland**

HSANZ state branch ASM - 29 March at Ridges Brisbane

0830 - 1700hrs — see

www.hsanz.org.au for more details.

Looks a fascinating program

- **South Australia**

Introduction to Haematology for Registered and Enrolled Nurses

2-day program 17 and 31 March at Royal Adelaide. Call 08 82225107 for more information

- **NSW**

Palliative Nursing—two day course at University of Sydney 17 & 18 April

Enquires to n.dunda@usyd.edu.au

- **National**

ARCBS Transfusion Update

5 - 7 April, Melbourne

See www.transfusion.com.au for further information

To have your local activities included, please email

angela.booth@cancerinstitute.org.au

Are you looking for a scholarship to undertake further study?

The **Mona Ham Scholarship** (up to $5,000) is offered to the following categories of students:

Registered Nurses studying Oncology, Medical Radiation Physics and Medical Radiation Therapy.

Contact Stephanie Chesher 02 9362 3429 schesher@cancerpatients.com.au

Closes 14 March 2008, but annual

The **Winston Churchill Memorial Trust** offers annual fellowships to study overseas where that study cannot be done in Australia. See www.churchilltrust.com.au for more information or phone 02 6247 8333

Website review— www.NurseInfo.com.au

This is an exciting new website that provides a directory of just about everything you could ever want to know about nursing!
It is funded by the Commonwealth government and developed by the Royal College of Nursing Australia.

www.NurseInfo.com.au provides information on professional development, postgraduate courses, different areas of speciality, scholarships, registration, working and pay conditions, rural and remote nursing, and many other areas of interest.

The website also caters for those students and individuals interested in nursing or midwifery as a career, those looking to re-enter the professions and overseas qualified nurses and midwives wanting to work in Australia.

Report from Tandem BMT Meetings, San Diego

This meeting was held from 12 - 17 February and consisted of four conferences in one – a CIBMTR data management meeting, a BMT nurses meeting, a BMT pharmacy meeting and the medical and scientific meeting.

The meeting began with the data management meeting. It was a very important meeting this year to attend as new forms have been brought into use for data collection for all the transplant data we submit to the CIBMTR and new on line submission of forms will begin in the next couple of months. Training and instruction on both the new form requirements and the on line submission was given which will be very useful. There is a lot more new data required to be collected.

I also attended a number of sessions in the BMT nurses meeting. These covered such topics as graft versus host disease (GVHD), psychological impacts of transplant, learning to recognise early signs of BMT complications. The calibre of the nursing programme was excellent and I look forward to being able to apply some of what I learnt into my practise and to update patient information.

I attended one session in the BMT pharmacy meeting. This session was about re-immunising allogeneic recipients post transplant with their childhood vaccines. This is a somewhat controversial area in post transplant care with a transplant centres all around the world doing different things. The talk was very informative with lots of references given. I also have some information about what the CDC and the EBMT recommend – I will use this to stimulate some discussion with the haematology team to see whether a change in our current protocol is required.

Related to the vaccination debate was a presentation in the Medical and Scientific conference with regard to cervical dysplasia in women post allogeneic stem cell transplantation and whether we should be offering these women the new HPV vaccine. Thirty-eight post transplant women were analysed. 92% of these had cervical cytology performed. Of these, 40% had abnormal cervical cytology with 34% having HPV

intraepithelial lesions. Factors associated with cervical dysplasia were chronic and extensive GVHD. They recommended that regular annual cervical cytology should be performed as part of routine post transplant care. We do have routine gynaecology assessment as part of our pre and post transplant care however cervical screening is not done any more frequently than what the cervical screening programme in New Zealand recommend.

Other presentations of interest in the medical and scientific conference were:

A presentation looking at disparities in post transplant survival between rural and urban areas. This presentation also looked at survival in urban areas away from the transplant centre. There appeared to be no significant differences between survival which is reassuring seeing as a large percentage of our transplant population are from out of Wellington.

An update on the use of antifungal therapy in the transplant population.

A presentation about neurocognitive defects in the five years post transplant. It was found that up to a third of post transplant patients still have some neurocognitive defects. They postulated that the use of calcineuron inhibitors for more that 12 months was a contributory factor.

The two poster evenings also had some interesting posters. The highlights include:

Uncovering sexuality in stem cell transplantation. This poster talked about the lack of prominence that issues around sexuality had in their hospital's transplant programme. They introduced various models around assessment of and intervention for sexuality issues and discussed the fact that sexuality education was now a greater part of education programmes for nurses caring for transplant patients.

There were various posters about different ways of teaching and education transplant nurses. These looked at case studies, study days, modular teaching, videos and workbooks and had a few ideas for future nurse education.

A poster comparing the rates of hypothyroidism in patients who had received myeloablative and reduced intensity transplants. A retrospective analysis of 181 patients found similar rates of hypothyroidism therefore all patients irrespective of their type of transplant should have thyroid function assessed post transplantation.

All in all the conference was very worthwhile indeed. There was a good mixture of things to think about with respect to the care we provide in Wellington and reassurance that we do a good job here in Wellington.

Catherine Wood,
BMT Coordinator, Wellington NSW

A Message from the BMT Network NSW

This year looks like being a busy year with lots of changes happening. Many of you have supported the BMT Nurses Discussion Forum since it began. Unfortunately, due to technical issues it has had to change and has now moved over to HSNET. You can join the BMT and Haematology nurses group, by login into HSNET at www.hsnet.nsw.gov.au regardless of whether you work in NSW or not.

We will also be offering scholarships to do the Graduate Certificate in Nursing (Apheresis Nursing) and details of this have been sent to all the apheresis units, so speak to your NUM. or contact me for further details. (NSW only)

Our study days this year are:

June 13 "Innovations in BMT Nursing"

August 28 Senior BMT Nurses Forum (yet to be titled)

November 28 Junior Nurses Forum (all you wanted to know about Lymphoma, but were afraid to ask!)

And also in November the 3 day paediatric BMT Nursing course

Details of how to register for these days will be sent out nearer the time and all are welcome.

On all of the days there will be a chance for nurses to present, so we will be sending out a call for papers with the information packs nearer the time. In the meantime if you need any further information please contact me on

dcollins2@stvincents.com.au or

0410 550363

David Collins

News from the regional committees

2008 is already off to a flying start. We have two newly formed state or local committees with the south island of NZ and South Australia leading the way.

South Australia

Twelve enthusiastic nurses working within SA haematology and haematology/oncology units attended the inaugural meeting of the South Australian HSANZ NG in mid February. A lot was discussed, including the background of the nurses group and what SA nurses would like to see happen with such a group. Discussion also included how sessions might look in terms of information /networking/ clinical questions/sharing unit innovations etc. and some of the unique challenges for SA in maintaining a specialty group.

An invitation was extended for people to nominate, be nominated or be volunteered for a local committee…and pretty soon all seats were filled!

Allan Hayward - chairperson,

Amanda Catherwood - secretary

Kirstin Bubner - education officer.

A call for periodic assistance was met with an overwhelming response, almost all remaining attendees volunteered to assist in the planning and running of education sessions. Our next step is to prepare a questionnaire and distribute it widely around the state to help us determine the educational needs and desires of SA nurses working in Haematology and see if we can't share resources with the NT. Then we can plan our sessions and topics for the remainder of the year!

All in all, a very productive meeting with a lot of enthusiasm from the group! I for one am looking forward to an exciting year and a chance to get to know other nurses working within haematology around the state (and the NT). Thank you to Angela Porter from Amgen for providing some nourishing foods. And lastly, a big thank you to both Debbie Hayes and Terry Ventrice for all their hard work in getting the SA group to this point!

Allan Hayward

The South Island of NZ have also established their regional committee. Key members are:

Gill Parkin—chairperson

Anne Marie Evans - secretary

Jane Worsfold and Ali Ebbett - co-treasurers

Jo Wilson and Sue Sheppard - fund-raisers

The initial aims of this group are to establish study days for the small centres on the South Island and to look at practice issues.

Their first meeting will be held in June at Grey Hospital at Greymouth on the west coast of the south island. It will be addressing practice issues for patients with haematological disorders. The Grey Hospital will bring nurses in from remote Westport and the Haast. They will also be holding an education evening for patients relating to haematological disorders. All members of this committee are very motivated and keen to kick off their program.

Sharron Ellis

Tea Room Guru

Dear TRG,

We have been discussing the meaning of life. A friend of mine asked me what is reality, does it exist, is it different for me and her, if not is one of us lying or partially sighted ? I wondered if she had been taking something because reality is reality , facts are black and white, something is or it isn't eh? Can you help?

Ontology is about asking the question "What is the form and nature of reality ?", Epistemology is asking the question "What can be known about reality?" and methodology asks the question " What is the way of finding out about reality?" So ontology is about what a reality a piece of knowledge is. Epistemology is about what the relationship between the known fact and the person knowing it is. Another way of putting this is to say that a person with leukaemia has a large number of specific white cells circulating. This is the knowledge, the ontology. The doctor's epistemology might see this is as pathological feature of a specific disease and this means that the person has a specific type of leukaemia and the prognosis is "x" and the treatment required is Hyper CVAD, for example. The patient's relationship with the knowledge (the high white cell count), their epistemology, might be that a high white cell count makes you unwell and disrupts your life in that you can't do your usual activities , go to work etc. So, one ontology –there is a high white count and two epistemologies, depending on the perspective – the relationship of the knower – the patient or the doctor – and the known – the high white cell count.

What can be known about reality is determined by the epistemological approach. The epistemology frames the approach about a subject in illuminating the relationship between the knower and the known (Guba 1990). For instance, the general nature of one way of conducting qualitative research, using a grounded theory approach is based on the systematic generating of theory from data (Glaser, 1978) and the more specific approach of a constructivist grounded theory offers an interpretive portrayal, or construction of, reality (Charmaz, 2006). So depending on how you conduct any research – your framework, gives you a different view of someone's reality!

In an attempt to answer an ontological question that might be asked, such as "what is the experience of living with leaukaemia", an epistemological position of pragmatism may been taken. This position might be taken with reference to an American philosopher/ sociologist Herbert Mead's (Mead, 1934) ideas about the development of self and the view that whilst acknowledging that the social world is real and reality exists, it is only known to people in the form in which they perceive and interpret it.

Mead's (1934) view of reality is that it is something that is socially shared and that maybe subject to reconstruction as perceptions of the reality change as in the experience of illness over time.

Although Mead (1934) articulated the paradigm of Symbolic Interactionism as a view of human society, a chap called Herbert Blumer (1969), through his methodological tenets of 'exploration' and 'inspection', actually coined the term "symbolic interactionism," and set out three basic tenets:

1. "Human beings act toward things on the basis of the meanings that the things have for them"
2. "The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows."

"These meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he/she encounters."

A symbolic interactionist approach leads a person to view self and the meaning as processes and this perspective fosters study of the multiple dimensions and realities of the person's lived experience (Charmaz, 1990).

So, in answer to your question – it all depends on how you see the world!

If you have any of life's questions, personal problems or niggling concerns about a major decision and you can't trust your star sign – write to me: Tea Room Guru, c/o The Editor, HSANZ – NG News.

2008 Dates for the diary if you'd like your local events added please send them in.

Mar 30—Apr 2—EBMT, Florence, Italy

Apr 17—NSW HSANZ—NG meeting, Sydney - Haemophilia Day!

Jun 12-14, CNSA Winter Congress, Gold Coast

Jun 12-15 EHA, Copenhagen, Denmark

Jun 19- NSW HSANZ—NG meeting, Sydney

Aug 21 NSW HSANZ—NG meeting, Sydney

Sep 25-27 RCNA Annual Conference, Perth

Oct 19 –22 HAA , Perth

Nov 20—NSW HSANZ—NG meeting, Sydney

Dec 6-9 ASH, San Francisco, USA

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