APRIL 2016 VOLUME 10: ISSUE 1

HSANZ NG
Haematology Society of Australia and New Zealand

INSIDE:

Newsletter design and publishing:
InspireHCP Pty Ltd.

HAA 2016: Reduced Registration Fee for Nurses

Hayley Beer (King)

The planning for HAA 2016 is picking up pace and the Victorian Committee are now refining our first draft of the program. In addition to Sandy Kurtin from Arizona we will be tapping into some fantastic local health professionals to inspire your own practice.


SANDY KURTIN

I am very pleased to report that this year we will have a reduced registration fee for nurses and scientists. The new fee schedule is as follows:

	MEMBER	NON-MEMBER
Full registration	$805	$920
Nurse/Scientist registration	$625	$740

Even more reason to become a member if you're not already. There are also options to attend part of the conference with two day or single day packages available also discounted for nurses and scientists.

For those of you busily working on abstracts, the opening date for submission is April 5 2016. We will accept abstracts until July 5 2016. I can't wait to read what you have all been up to in your units. When open, abstracts can be submitted via the website. We will also make the program available on the website when finalised.

http://www.haa2016.com

Don't forget to get in early to request conference leave from your manager. Due to availability at the Melbourne Convention and Exhibition Centre, HAA will be held a bit later this year 13–16 November.

A WORD FROM THE PRESIDENT

I passed my local newsagents today who had calendars in the window with 25% off, yes we are a quarter of away into the year. It 's hard to think that autumn is on its way and all that the change of seasons bring. I am pleased to announce that we have some new members on the executive of the HSANZ NG, and I would like to welcome Sally Taylor into the role of National Secretary and Samantha Soggee in the role of Vice President. Both of these members have been active in their local groups and have decided to step up and take on an active part in the overall organisation of the group. I am sure you will welcome their enthusiasm. Have you ever thought about becoming involved in your local group? Our local chairs always welcome nurses who want to get involved.

Now back to the time of year, with the unusually good weather we have been enjoying it has been easy to forget that the flu season is just around the corner. It is time for us all to get our flu shots so as to protect our patients, our families and, most importantly, ourselves. In haematology and cancer, we work with some of the most immunocompromised patients in the healthcare system and by ensuring we are vaccinated, and educating the families and friends of our patient group to be vaccinated, we provide a valuable health service. Remember herd immunity is necessary to protect us all.

HAA is going to be later this year in November. Now is the time to start planning your presentations. One of the most exciting things about HAA is hearing what other units and nurses are doing. Are you undertaking care that is new or different? Have you got a story to tell? If the answer is yes, then you should be busy preparing your abstracts now, remember you can present a poster or an oral presentation, we all learn from each other.

I hope that you all enjoy this edition of the newsletter, please remember that this newsletter is also your chance to publish, ask questions, and make comments. Send your contributions to Rosie our editor. Rosie is also looking a sub-editor to assist in the newsletter, if you think you might be interested contact Rosie and have a chat.

(rosemary.hoyt@southerndhb.govt.nz or nurses@hsanz.org.au)

David Collins
PRESIDENT HSANZ NG
david.collins@health.nsw.gov.au

REPORT FROM NP TRIP TO USA

EXPERIENCES IN THE UNITED STATES (US)

NURSE PRACTITIONER (NP) MODELS OF CARE, AND THE AMERICAN SOCIETY OF HAEMATOLOGY (ASH) MEETING

Julija Sipavicius
BMT NP

The NP role is in its infancy in Australia, particularly in the speciality of BMT with less than ten NPs endorsed throughout Australia in the speciality of BMT. So I looked to the United States (US) for my own professional learning and benchmarks, where NP roles are well established (>50 years) and embedded into everyday clinical practice. My plan was to visit several Haematology centres in the US whilst attending the ASH meeting. I had the following objectives in mind:

- Observe NP models of care
- Observe physician and NP interplay – is it efficient?
- Insight into the processes to monitor and follow-up large numbers of patients
- Establish contacts / networks re collaboration
  - Clinical practices & guidelines
  - Future research opportunities

Logistically this was an easy process. I had the time, contacts and decided to self-fund the trip so avoided the tireless process of seeking travel grants. Initially I emailed some known professional contacts based in the US. At the same time the HSANZ Special Practice Network for Myeloma (M-SPN) was establishing closer links with the International Myeloma Foundation Nurse Leadership Board (IMF NLB) with a goal of facilitating mentorship and collaborations internationally with nurse colleagues working in the myeloma space. Thus I jumped at this opportunity and emailed several Myeloma NPs. Within weeks I had received invitations to visit several large US centres, and once confirmed set an itinerary based around the ASH meeting in December 2015 – as I felt this was a conference not to be missed.

My final itinerary included visits to MD Anderson Cancer Centre (MDACC), The Mayo Clinic – Rochester, and The Cleveland Clinic, Ohio. In summary these 3 centres are not only large in physical size and patient numbers seen, but provide huge and impressive haematology / BMT clinical services. As an example MDACC performs 800-1000 BMT yearly, and The Mayo Clinic conducts all transplant types (allogeneic and autologous) in ambulatory care settings.

As many of us know, the US healthcare system is very different to the Australian healthcare system; with the US healthcare expenditure being the highest in the world. However, this increased expenditure, did not seem to translate to better overall care at the bedside than what we provide in Australia. It was evident though at all 3 centres, that they had access to robust communication systems for both patients and healthcare professionals. Most evident were electronic systems, access to information, more efficient ways to communicate, and supportive services such as:

- **Technologically advanced** EMR systems
- **Formalised educational programmes** for patients regarding treatments, adverse effects and how to recognise and manage them.
- **Teaching programmes for patients** and carers to undertake parts of their care such as managing their CVADs and administering IV drugs at home
- Offer of numerous **complimentary services** such as yoga, Pilates, nutrition and eating well, physical activities; with a large focus on living well and healthy – rather than living with cancer or being a cancer survivor.

However, the most outstanding differences in my view were:

- Nurses regularly publish their work
- Patients take more responsibility for their health and healthcare
- Most care is provided in ambulatory care settings
- NPs make up the vast majority of clinicians across haematology and BMT services namely, NPs:
  - Clinically lead and manage ambulatory care units
  - Provide various nurse led clinics (e.g. disease based or post BMT follow-up)
  - Perform patient clinic reviews shared with one or multiple physicians
  - Clinically lead and manage in-patient units

I observed multiple different models of NP care principally in clinic and ambulatory care settings; their capacity and capabilities to perform this work is very well embedded into everyday practice – NPs are the norm! However despite this ingrained NP culture, the core work of NPs in the US is similar to NP models in Australia. And although we are few, we function and possess the capabilities to contribute to our healthcare system with just as much competence and value to patient care as NPs do in the US.

Thank you to my US hosts: Teresa Miceli (Mayo Clinic, Rochester), Beth Faiman (Cleveland Clinic, Ohio) and Tiffany Richards (MD Anderson, Houston).


TIFFANY RICHARDS, MD ANDERSON


TERESA MICELI: MAYO CLINIC


BETH FAIMAN: CLEVELAND CLINIC OHIO

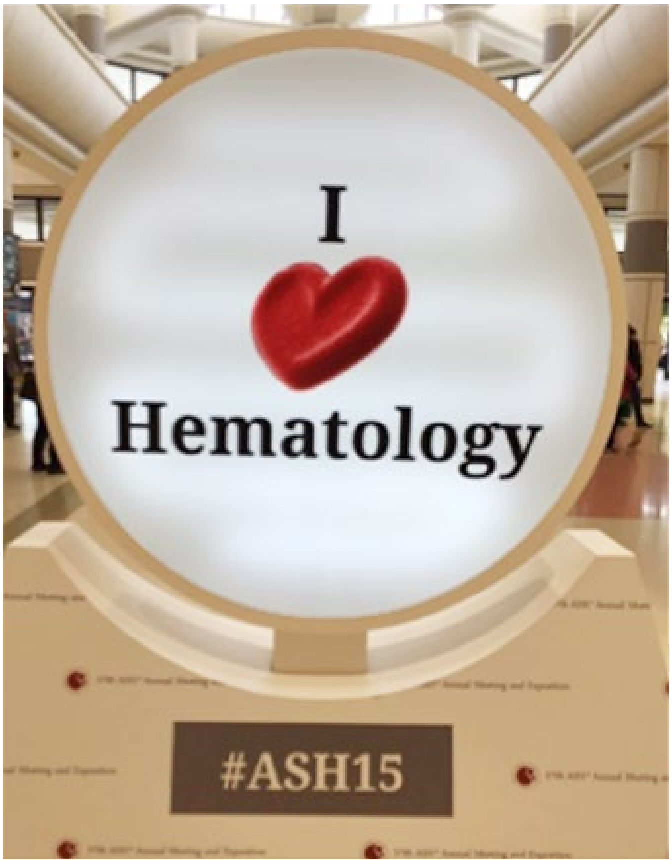
American Society of Haematology (ASH) Meeting 2015

Having never attended ASH, my first impression was it is HAA on steroids! Over 22,000 delegates attended the meeting, and all topics in non-malignant and malignant, paediatric and adult haematology are incorporated – in vast numbers. Choosing what to attend was difficult and attending everything that interested me was impossible.

In summary there were numerous abstracts discussing safety and efficacy of new drugs, including many targeted and immune modulating therapies; and multiple ongoing trials in all areas of haematology.

Some key abstract themes that stood out included:

- **Rising cost of healthcare** – how will we sustain the costs as more and more novel cancer therapies are developed, and more people survive longer?
- **Reducing transfusion burden** (in both non-malignant and malignant diseases such as sickle cell anaemia and myelodysplasia)
- **Deep venous thrombosis:** identification, its challenges and new treatments
- **New donor sources, are they better?** namely haploidentical compared with cord
- **More drugs for myeloma** (FDA approved 3 new agents in the weeks leading up to ASH)
- Nothing robust and embedded into standard care that is new for **acute leukaemia**, though there are multiple ongoing trials testing novel agents and new drug combinations
- **Promising drug developments** in lymphoma



Here is a snapshot of some of the many abstracts I heard that were interesting:

1.

A phase III study asking the question is there a role for ASCT in Myeloma in the age of novel therapies?

Attal, M.; Lauwers-Cances, V.; Hulin, C. et al.

Autologous Transplantation for multiple myeloma in the era of new drugs: a phase III study of the Intergroupe Francophone Du Myelome (IFM/DFCI 2009 Trial). Abstract #391.

Short answer – yes, it remains an important treatment modality.

2.

Hydroxyurea as an alternative to transfusion for primary stroke prevention in children with Sickle Cell Anaemia.

Abstract #3. Ware, R.; Davis, B.; Schultz, W. et al.

TCD with transfusions changing to hydroxyurea (TWiTCH).

Multiple RBC transfusions are administered to patients with sickle cell anaemia to reduce the incidence of stroke in this patient cohort (stroke incidence up to 10%). However transfusion is associated with significant morbidities. The TWiTCH trial looked at using Hydroxyurea as an alternative to transfusions for stroke prevention. The trial concluded that hydroxyurea is non-inferior, and possible superior to chronic transfusions for primary stroke prevention, and is a safe alternative to transfusion.

3.

Lusputercept treatment leads to long-term increases in hemoglobin and reductions in transfusion burden in patients with low or intermediate-1 risk myelodysplastic syndromes (MDS). PACE-MDS extension study.

Abstract #92. Giagounidis, A.; Platzbecker, U.; Germing, U. et al

Luspatercept inhibits a signalling pathway that occurs in MDS that leads to ineffective erythropoiesis. Consequently Luspatercept corrects the ineffective erythropoiesis. Although a small study (N=32) the early findings conclude treatment with Lusputercept was associated with increased haemoglobin counts and transfusion independence. Given these encouraging results, further studies are being undertaken.

4.

Results of the randomized Graall-R 2005 Study. Addition of Rituximab Improves the Outcome of Adult Patients with CD20-positive, Ph-Negative, B-cell Precursor Acute Lymphoblastic Leukemia (BCP-ALL). Plenary Scientific Session.

Maury, S.; Chevret, S.; Thomas, X. et al.

Previously some single arm studies suggested that adding Rituximab to chemotherapy could improve the outcome of these patients, no randomised study had previously been reported. The Graall-R study was conducted as a multicentre randomised trial to evaluate the potential benefit of adding rituximab to current pediatric inspired protocol – in adults. The trial concluded that adding rituximab improves EFS, and prolongs OS (when ignoring patient's outcome after transplantation in pts in 1st CR).

5.

Treatment of Acute Myeloid Leukaemia: Moving Beyond 3 + 7

In a large plenary session three speakers discussed various aspects of this topic.

Eytan Stein

Molecularly Targeted Therapies for Acute Myeloid Leukemia.

Roland Walter

Antigen-Specific Immunotherapies for Acute Myeloid Leukemia

Marcos J de Lima

Newer Approaches to Transplantation in Acute Myeloid Leukemia.

The main theme that arose is that little has changed since the introduction of 7+3 in the 1970s, and most improvements have been in supportive care; so what is happening now? In summary numerous novel agents are being tested that include agents that inhibit mechanisms that lead to AML, targeted immune therapies and vaccine therapies. In the BMT space a large US trial is ongoing comparing haploidentical versus cord donor sources for transplant, and much effort is being placed on preventing relapse post-transplant.

In conclusion

I found these experiences in the US were both personally and professionally rewarding. I would highly recommend it for anyone. I acknowledge the time and funds can be a huge commitment but I see it as a professional investment. There are also opportunities to seek funding through various organisations including:

- CNSA professional development grant and various travel grants
- Australian College of NP – scholarships
- Churchill scholarship

Having the opportunity to learn from and collaborate with any of our nursing colleagues – whether in Australia or overseas is both rewarding and professionally important. It helps inspire us to provide excellent patient care, but also continually develop our knowledge and practice for the benefit of our patients, their families and the wider health service.

ACI NSW Agency for Clinical Innovation

Blood and Marrow Transplant Network NSW

Introduction to Blood and Marrow Transplant Nursing

Thursday 26th and Friday 27th May 2016

AIM:

This two-day course is for nurses working in BMT units or those who work with pre & post-transplant patients wishing to extend their knowledge in this highly specialised field. The course focuses on the care of patients receiving both autologous and allogeneic bone marrow transplants.

Topics include: an overview of the haemopoietic system, malignancies that lead to transplant, Graft versus Host Disease, tissue typing processes and work-up for transplant, infections and other complications following transplant.

AUDIENCE:

This event is aimed at haematology and BMT nurses working in NSW health services. Nurses will have some background of haematology nursing and knowledge but have had little BMT specific education, training or experience.

VENUE:

Agency of Clinical Innovation, Level 7, Sage Building, 67 Albert Avenue, Chatswood, NSW, 2067.

COST:

Free to NSW Health employees

REGISTRATION:

Please register online by accessing the following link:

http://www.aci.health.nsw.gov.au/about-aci/calendar/introduction-to-bmt-nursing/registration

Further Information

For further information contact:

JODY GOUGH - Blood and Marrow Transplant Network, Clinical Nurse Consultant.

Email: jody.gough@health.nsw.gov.au

Phone: (02) 9464 4606

ACI – NSW Agency for Clinical Innovation Level 4, Sage Building 67 Albert Avenue, Chatswood NSW 2067
PO Box 699, Chatswood NSW 2057 **T** +61 2 9464 4666 **E** aci-info@health.nsw.gov.au **www.aci.health.nsw.gov.au**

ASH REPORT

Midori Nakagaki

Midori Nakagaki is a senior Pharmacist, within the Cancer Care Services at the Royal Brisbane and Women's Hospital.

I attended the American Society of Hematology (ASH) Annual Scientific Meeting on the 5-8th December 2015 and presented a poster about an antiemetic study I ran at the Royal Brisbane and Women's Hospital (the PRAISE trial). This study was performed in collaboration with medical and nursing staff caring for patients on the Bone Marrow Transplant Unit. The ASH meeting was a huge haematology conference with over 20,000 haematologist attending, and I was totally overwhelmed by the quality and quantity of the studies presented. At the conference there was a small number of poster presentations on palliative care and a considerable number presented on supportive care. Although the majority of attendees were haematologists, I believe the conference is appropriate for nursing and allied health professionals to present research projects. I am proud of the teamwork and collaborative approach we have at the Royal Brisbane and Women's Hospital, and am particularly thankful of my nursing colleagues who supported this project.

A Randomized Trial of Olanzapine and Palonosetron vs Infused Ondansetron for the Treatment of Chemotherapy-Induced Nausea and Vomiting in Patients Undergoing Hematopoietic Stem Cell Transplantation

Midori Nakagaki, Michael Barras, Cameron Curley, Jason Butler, Glen A Kennedy
Royal Brisbane and Women's Hospital, Brisbane, Queensland, Australia

Background

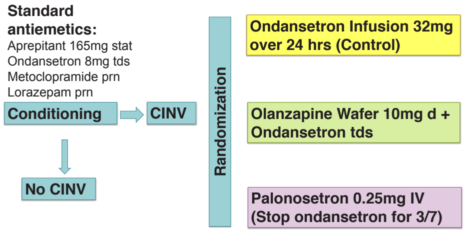
Despite routine antiemetic administration during conditioning for hematopoietic stem cell transplantation (HSCT), breakthrough chemotherapy-induced nausea and vomiting (CINV) is still problematic. Recent studies have demonstrated the effectiveness of olanzapine and palonosetron in solid tumor patients. However, there remains little comparative data on efficacy of these agents for the treatment of breakthrough CINV, especially within HSCT.

Objectives

To compare the effectiveness of olanzapine and palonosetron to an ondansetron infusion (standard of care) for the treatment of breakthrough CINV in patients undergoing HSCT

Methods

A randomized open-label prospective study was performed in HSCT patients suffering from breakthrough CINV



Standard antiemetics:
Aprepitant 165mg stat
Ondansetron 8mg tds
Metoclopramide prn
Lorazepam prn

Conditioning → **CINV**

No CINV

Randomization

Ondansetron Infusion 32mg over 24 hrs (Control)

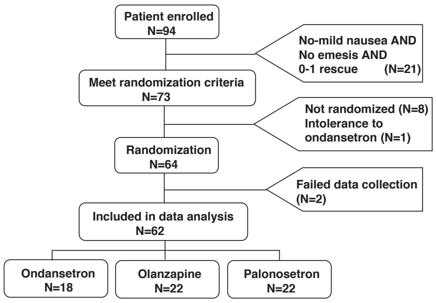
Olanzapine Wafer 10mg d + Ondansetron tds

Palonosetron 0.25mg IV (Stop ondansetron for 3/7)

- Data was collected daily on emesis, rescue antiemetic use and nausea score (VAS:0-100mm)
- The primary endpoint was a composite outcome of no emesis, no rescue & nausea score reduction ≥50% (24 & 48 hours)
- The secondary endpoint was nausea score reduction ≥50% (24 & 48 hours)

Results

Randomization diagram



Patient enrolled
N=94

No-mild nausea AND
No emesis AND
0-1 rescue (N=21)

Meet randomization criteria
N=73

Not randomized (N=8)
Intolerance to ondansetron (N=1)

Randomization
N=64

Failed data collection
(N=2)

Included in data analysis
N=62

Ondansetron N=18
Olanzapine N=22
Palonosetron N=22

Patient demographics and treatment regimen

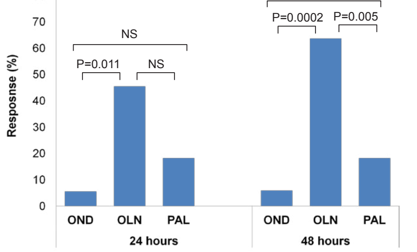
		Ondansetron	Olanzapine	Palonosetron
Age	Median	53	58	51
	Range	25-65	20-68	21-65
Gender	Male	14 (78%)	14 (64%)	11 (50%)
	Female	4	8	11
HSCT type	Allogeneic	7	8	13
	Autologous	11	14	9
Conditioning	BEAM	2	5	2
	FluMel	4	6	6
	HDM	6	5	5
	CyTBI	1	1	5
	FluCY	2	1	1
	Other	3	4	3
Alcohol intake	Chronic	1	4	3
Past CINV	Nil	5	6	3
	Mild-moderate	5	13	7
	Severe	6	2	4

Safety

- No major adverse drug reactions were reported. Mild sedation (olanzapine) and constipation (ondansetron) were reported by some patients.
- Median duration from stem cell infusion to neutrophil engraftment was not significantly different: 13 days (ondansetron, olanzapine, no treatment), 14 days (palonosetron).

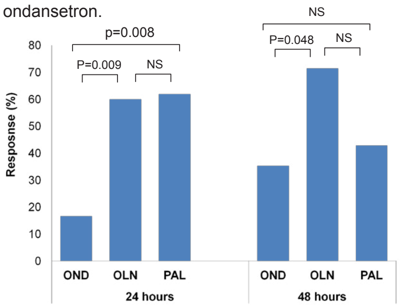
Composite primary endpoint: **No emesis, no rescue, nausea reduction≥50%.**

Olanzapine was significantly superior to ondnasetron and palonosetron (48 hours).



Secondary endpoint: **Nausea reduction ≥50%**

Olanzapine and palonosetron (24 hours) were superior to ondansetron.



Conclusions

- When compared to ondansetron infusion, daily olanzapine is a superior treatment of breakthrough CINV in patients undergoing HSCT.
- A single dose of palonosetron does not significantly reduce emesis but is effective for the treatment of nausea up to 24 hours.

There are no relevant conflicts of interest to disclose

CIBMTR CONFERENCE MEETING REPORT

TANDEM BMT MEETING, HAWAII, FEBRUARY 2016

Catherine Wood
Clinical Nurse Specialist BMT
Wellington Hospital

I was very fortunate to attend the Tandem Bone Marrow Transplant (BMT) meetings in Hawaii in February. The Tandem meetings are a number of combined BMT meetings that run concurrently. As a registrant for the conference, the attendee is able to dip in and out of any of the meetings. The concurrent meetings include:

- A BMT data management meeting
- A medical and scientific meeting
- A bone marrow transplant nurses meeting
- A bone marrow transplant pharmacists meeting
- A mid-level practitioner meeting (for nurse practitioners, nurse specialists and physician assistants).

Data Manager Meeting

The Center for International Blood and Marrow Transplant Research (CIBMTR) collects data from hundreds of transplant centres around the world and has now accumulated the data from over three hundred thousand autologous and allogeneic stem cell transplants that have been performed since the 1970's. Wellington Hospital submits anonymous data on its allogeneic stem cell transplant patients. Part of my role is to submit this data and this conference provided vital training for me, in particular around the new features of the online reporting system. There are quite a few changes to the report forms coming up over the next few months and the education around these was very useful.

Combined Clinical Education Meeting

This meeting was a combined effort between the BMT Nurses, BMT pharmacists and the Mid-level practitioners. This was a practical session which had one presentation from each special interest group. The three sessions presented were:

- **Establishing a BMT Survivorship clinic** – this was an interesting session which talked about how to establish such a clinic. It gave some useful tips which could be translated to our environment. We are a small unit so we need to think of how we can include survivorship into our routine BMT clinics.
- **Management of sexuality issues post-transplant** – this has been an interest of mine and it was good to have an update about this often overlooked issue. It gave some useful information that I will be able to include in the patient education folder we give to each patient.
- **Management of long term complications of immune suppression** – the aim with BMT is to wean patients off immune suppression over a 3–6 months period post transplant but for those patients who experience chronic GVHD, they may be on these drugs for life. This was a practical guide to problems that we should be looking out for and about the education we should be giving patients who are on long term immunosuppression.

Mid-Level Practitioner Meeting

There was a focus on Chronic Graft versus Host Disease (GVHD) in this meeting. There were some very good sessions about chronic GVHD. Chronic GVHD is a common complication post allogeneic stem cell transplant and one that may have huge impact on a patient's quality of life. The session educated about the new grading systems for GVHD, current treatment strategies and future investigational therapies.

BMT Nurses Meeting

There were two standout sessions in the BMT nurses conference:

- An excellent session about the **treatment and care of patients with chronic skin GVHD.** This has become more of a problem with the increasing use of peripheral blood stem cells as a stem cell source and we now have several patients severely impacted with sclerodermatous skin changes. Chronic skin

GVHD causes skin to become hard and shiny with no flexibility and can cause contractures meaning that patients are not able to have full range of movement of their limbs. This hard rigid skin also does not heal well. There were some good practical tips to come out of this excellent presentation.

- **The neutropenic diet** – this was an excellent session where the presenter talked about her research into the neutropenic diet. She also talked about the small randomised controlled study she did. The neutropenic diet has been used in various forms over the years and its use is based on some fairly flimsy evidence. In essence, the diet bans patients from eating uncooked fruits and vegetables, cold meats, yoghurts etc. The presenter randomised a group of BMT patients to receive either a low listeria diet or a neutropenic diet during their transplant. There was no difference in rates of infections or the types of infections between the two groups. Patients on the low listeria diet had far more food choices to choose from and were happier with their diet than those on the neutropenic diet. There was another session in the medical and scientific meeting about this very same issue. We have come back to Wellington and talked with our dietitian and are making moves to abolish the neutropenic diet. We are sure that patients and their families will find this much easier to cope with.

Pharmacy Meeting

One of the highlights from the pharmacy meeting was a talk about genital GVHD. This is a complication affecting both men and women. The session was presented by a gynaecologist who has done a lot of work in this area. It was a practical "How I treat" session which will be of benefit to some of our patients who are dealing with this difficult problem.

Medical and Scientific Meeting

The medical and scientific conference also had some very good presentations. One of the highlights of this meeting was three sessions about familial stem cell donors. It talked about research that had been done with familial bone marrow and peripheral blood stem cell donors and the physical and emotional complications that had arisen from being a donor. These sessions provided a good reminder that we need to follow our familial donors up more closely than we do.

Meet the Professor Session

I attended a "Meet the Professor" session about haploidentical stem cell transplant. This is a new kind of transplant where the donor and recipient are only half matched. These types of transplants are used when the patient doesn't have a fully matched donor available within their family or on the world bone marrow donor registries. We have done 12 of these transplants so far and this session gave useful information about the unique issues that these transplants have. It was also reassuring to hear that we are on the right track with our haploidentical programme.

This has been an excellent meeting to attend. It was stimulating and thought provoking. There has been a lot of information provided that I can bring back to my colleagues and also to my patients and their support network.

MDS AND CGA TOOLS

Lucy Cussans is a member of the MDS/MPN SPN.
If you wish to be involved in exciting activities within this group, please see Sam Soggee's invitation on page 17

Note: This was presented as an oral presentation at HAA 2015

A Pilot Study Exploring the Impact of Nursing Case Management and Comprehensive Geriatric Assessment on Patients with MDS

Lucy Cussans, Eva Brehaut, Alexia Pronol, Ian D Lewis, Peter Bardy, L Bik To, Timothy To and Devendra K Hiwase

Myelodysplastic Syndrome (MDS) is one of the most common haematological malignancies of the elderly population. With the introduction of improved treatment options, there has been significant increase in overall survival (OS) in these patients. This patient group frequently present with significant co-morbidities and require management of complex health care needs.

Ad hoc management of these extensive needs within usual clinic appointments is not conducive to a coordinated systematic approach to patient care. A dedicated health professional such as nursing case manager, may provide ongoing support, needs assessments and health monitoring to maintain quality of life and potentially improve patient outcomes.

The aim of the study was to assess the feasibility and impact of case management as well as the usefulness of frailty screening and geriatric assessment on the elderly MDS patients at the Royal Adelaide Hospital.

All MDS patients who were eligible for the study and able to comply with the study requirements were managed by the MDS nurse case manager. The case manager provided care co-ordination, health resource utilisation, support, and education. Those patients over 65 years and who had not previously been treated with hypomethylating agent, also underwent geriatric screening using two tools (G8 and VES 13) as well as geriatric assessment. These patients were also reviewed by a Geriatrician. All types of activities and types of interventions performed by the MDS case manager were time tracked for each patient.

The types of activities and interventions included; blood monitoring, attending consults in outpatient and inpatient settings, making/ receiving of phone calls with a minimum monthly contact to co-ordinate care, liaise with treating haematologist, GP, community and hospital based resources in order to better manage and plan care in their local setting where possible.

From January 2014 to May 2015, fifty-nine patients were enrolled in the study and thirty–eight of these patients were eligible for a geriatric assessment. Twenty-three patients had previously or were currently receiving Azacitidine; twenty-one patients were requiring monitoring only and the remaining fifteen patients' required supportive care. During this time; the MDS case manager provided a larger number of activities/ interventions to those patients who received azacitidine treatment or supportive care as well as to those patients who resided in the country areas. Those patients who also had an abnormal G8 screening (n= 18), potentially indicating frailty, also required more activities and interventions from the MDS case manager.

Case management provides significant ongoing support and health care monitoring to all patients, especially to patients receiving treatment or supportive care who have increased health care needs. This requires cohesive professional relationships and careful care co-ordination between the MDS case manager, treating haematologist, GP and the various health resources available within the hospital as well as the community

Whilst frailty screening tools such as the G8, which has a nutrition focus, and VES-13, which has a functionality focus, are relatively quick to use in a busy clinical setting to potentially identify frailty; the geriatric assessment is able to provide a comprehensive overview of a patient's health status and potential health care needs. When completed, the assessor can address such areas or domains as functional status, nutrition, memory, falls risk, mobility, and psychological status and co-morbidities. This allows for the identification of potential 'at risk' areas or domains and allows the MDS case manager and geriatrician to make appropriate health care referrals which ultimately aims to improve patient outcomes and quality of life. However the geriatric assessment requires dedicated people and time as it is very complex and time intensive to complete.

Geriatric assessment, early intervention and case management allows for the comprehensive assessment of patient needs and provision of health care resources which can also potentially improve treatment completion and reduce hospital admissions. At the time of writing this article, the study has been able to recruit at total of eighty one patients and the next progression is to include all Acute Myeloid Leukaemia (AML) > 65 years to also provide case management, and geriatric assessment.

References

http://siog.org/files/public/cga_practice_guideline_wildiers_jul2011.pdf

RIP, MTH

AL AMYLOIDOSIS – SUPPORTIVE CARE IS THE KEY!

Dr Simon Gibbs
Director of the Victorian and Tasmanian Amyloidosis Service


DR SIMON GIBBS

Amyloidosis is a disorder whereby amyloid deposits, consisting of misfolded proteins, accumulate in tissues. Without appropriate treatment, these deposits lead to organ impairment and failure, and ultimately death. This condition affects 1 in 1500 people, with several new cases diagnosed each week in Australia.

Amyloidosis is complex, multisystem disease. Presenting symptoms may be non-specific – which can lead to a delay in diagnosis – such as dyspnea, lethargy, oedema, bruising, weight loss, nausea, diarrhea, neuropathy ("pins and needles", numbness, burning pain) or postural hypotension and dizziness. Diagnosis is made with a biopsy of the affected organ that stains positive with Congo red.

There are 5 main amyloid types of amyloidosis, classified according to the protein that is misfolded to make the amyloid fibril:

- AL
- AA
- Wildtype transthyretin (TTR)
    - also call senile systemic
    - can mimic AL amyloidosis
- Hereditary
- LECT2

The most common is the AL type, consisting of misfolded monoclonal light chains as seen in MGUS or myeloma. This type can affect the heart, kidneys, nerves, GI tract, liver and soft tissues. Patients most commonly present with symptoms of lethargy, dyspnoea and oedema from cardiac or renal impairment. Treatment is with myeloma-style chemotherapy, such as bortezomib (Velcade), cyclophosphamide and dexamethasone (CVD). However, toxicity of these agents can aggravate pre-existing disease-related symptoms such as fluid retention and neuropathy, making chemotherapy administration particularly challenging.

Supportive care is vital to allow adequate therapy to continue and to improve patient survival and quality of life.

Strategies can include:

Fluid overload

- Strict 1.5-2L/day fluid restriction
- Strict low salt diet
- Daily weighs first thing in the morning, to help titrate diuretics
- Frusemide and spironolactone, sometimes in large doses
- Salt-poor albumin infusions if albumin <20g/L
- Consider referral to a cardiac or renal failure nurse

Nausea, weight loss and nutrition

- Domperidone 10-20mg TDS pre-meals (esp if autonomic neuropathy)
- Dietary supplements and referral to a dietitian
- Treat fluid overload (hepatic congestion)
- Nasogastric (NG) feeds/TPN in resistant cases

Diarrhoea

- Loperamide 2 tablets(4g) with each loose bowel action, up to 16 tablets/day
- Codeine phosphate 30-60mg QID PRN
- Octreotide SC +/- TPN in resistant cases

Hypotension

- Due to amyloid-related autonomic neuropathy, bortezomib , dehydration and/or cardiac medications
- Review cardiac medications and bortezomib dosing
- Exclude dehydration
- Consider midodrine 2.5–10mg TDS +/- compression stockings to elevate BP

Peripheral neuropathy

- Review neuropathic chemotherapy doses eg. Bortezomib, thalidomide
- Optimize control of diabetes
- Pregabalin (Lyrica) 25-300mg BD
- Amitriptyline (Endep) 10-25mg nocte
- Opiates
- Acupuncture
- Menthol cream
- Massage
- TENS machine

Psychological Support

While the prognosis of AL amyloidosis has vastly improved over the last decade, diagnosis can be delayed for months, compromising treatment and survival, and increasing anxiety and stress for patients and families. The Leukemia Foundation also has excellent patient information and services for all forms of amyloidosis. Patients may also benefit from a referral to a psychologist for coping strategies and support.

THE AUSTRALIAN AMYLOIDOSIS NETWORK

There are now 3 services in Australia dedicated to the diagnosis, treatment, education and care of patients suffering from any form of amyloidosis. Patients, physicians and nurses are encouraged to visit or contact these services for advice and support.

The Victorian and Tasmanian Amyloidosis Service, Melbourne

- Weekly Monday morning clinic at Box Hill Hospital
- Fortnightly multi-disciplinary team meeting with cardiologists, neurologists, nephrologists, radiologists and histopathologists

Contact/referrals:

Email:	Simon.gibbs@monash.edu
Telephone:	Haematology registrar, Box Hill Hospital 1300 342 255 Dr Simon Gibbs: 0421163696

Westmead Amyloidosis Service, Sydney

- Monthly Friday morning clinic at Westmead Hospital
- Clinic attended by haematologists, immunologists and rheumatologists, with support from cardiologists, neurologists and nephrologists
- Provide genetic analysis for hereditary amyloidosis

Contact/referrals:

Email:	Fiona.Kwok@health.nsw.gov.au linda.mekhael@health.nsw.gov.au graeme.stewart@sydney.edu.au
Telephone:	Linda Mekhael (02)9845 8738

Princess Alexandra Amyloidosis Service, Brisbane

- Second monthly clinic at Princess Alexandra Hospital
- Provide mass spectrometry for difficult-to-type amyloid biopsies

Contact/referrals:

Email:	Peter.Mollee@health.qld.gov.au

CLINICAL TRIALS now open and recruiting at these services include:

- **C16011 study:** A Phase 3, Randomized, Controlled, Open-label, Multicenter, Safety and Efficacy Study of Dexamethasone Plus MLN9708 (**ixazomib**) or Physician's Choice of Treatment Administered to Patients With Relapsed or Refractory Systemic AL Amyloidosis
- **NEOD001-CL002 (VITAL) study:** A Phase 3, Randomized, Multicenter, Double-Blind, Placebo-Controlled, 2-Arm, Efficacy and Safety Study of NEOD001 (a pan-fibrillar monoclonal antibody) Plus CVD chemotherapy vs. Placebo Plus CVD in Systemic AL Amyloidosis

The Australian Amyloidosis Network also has access to diflunisal, doxycycline with TUDCA, and EGCG for treatment of both wildtype and hereditary transthyretin (TTR) amyloidosis. A clinical trial of antisense oligonucleotide therapy for this amyloid type is expected to open in late 2016, and a trial of the anti-SAP monoclonal antibody with CPHPC, targeting all forms of amyloidosis, should open in 2017.

For New Zealand patients, Dr Hugh Goodman at Waikato Hospital is an Amyloidosis expert and happy to provide advice for local patients.

THE APHERESIS PAGE

David Collins

Welcome to your apheresis page.

I don't know about you, but the usually quiet month of January started with a bang, with a record number of procedures for the month. I am not sure if it wasn't the due to the warm weather and a number renal transplant patients not drinking enough and then starting to reject their transplants, but we seemed to have a large number coming through the unit. Of course, apheresis saved the day! That is the thing about apheresis nurses, we wear many hats and advise patients about aspects of their disease, however, the common factor is the patients blood. It is the fact that we know about the blood that ensures the patient comes to no harm.

In New South Wales we have been discussing the education of apheresis nurses, all now which undertaken at a local level, due to the demise of the Post Graduate Certificate in Apheresis Nursing at Adelaide University. We would like to know how many of you would like to do such a course if it were available. Please let me know by dropping me an email at nurses@hsanz.org.au.

A colleague of mine recently asked a question about a major mismatch in an ABO-incompatible allogeneic transplant and the use of plasma exchange pre-transplant. A major ABO mismatch refers to the presence of natural antibodies in the recipients blood to the donors A/B blood group antigens. The Isoagglutinins can cause acute haemolysis when transplanted into the patient. Haemolysis is relatively uncommon with apheresis collected cells and the volume of red cells in a product is nearly always under 20 mL. Plasma exchange is performed when the recipient has high titres of these antigens, usually above 64. Plasma exchange is performed to reduce these levels, and depending on how high they are to start with may be done over a number of days pre-transplant. The volume treated is usually 1–2 total plasma volumes, and then the titres are checked again. Of course, this is what we do, what do you in your unit?

SATURN

Expression of Interest: Formation of a Special Practice Network for Apheresis

Dear HSANZ Nurses' Group members,

Apheresis is an integral part of any Haematology or Bone Marrow Transplant (BMT) Service. Apheresis nurses collect the cellular components which enable treatments such as BMT, offering potential curative options to patients with haematological neoplasms. Apheresis nurses also provide therapeutic treatments to alleviate symptoms of malignant and non-malignant conditions. By definition it is a specialised service performed by a specialist group of nurses who often work with limited support networks within their institutions. The experience can be isolating and stressful and yet there are many of us around Australia and New Zealand providing similar services in similar situations. A special practice network (SPN) would provide opportunities for networking, support, continuing education and the potential for nurse-led research and academic publications to further enhance knowledge within the specialty.

I am keen to hear from anyone who is interested in working with me to form an Apheresis SPN across Australia and New Zealand for this diverse and interesting specialty. In the first instance I am keen to hear from anyone who would be willing to form a steering committee to undertake the establishment of the group's aims and objectives and to gauge interest for this SPN.

Further information on the 'Guidelines on SPN' can be found on the HSANZ nurse's group homepage.

I look forward to hearing from you.

Claire Dowsing
Email: claire.dowsing@petermac.org

MY TRANSFUSION

Transfusion website for patients launched

www.mytransfusion.com.au

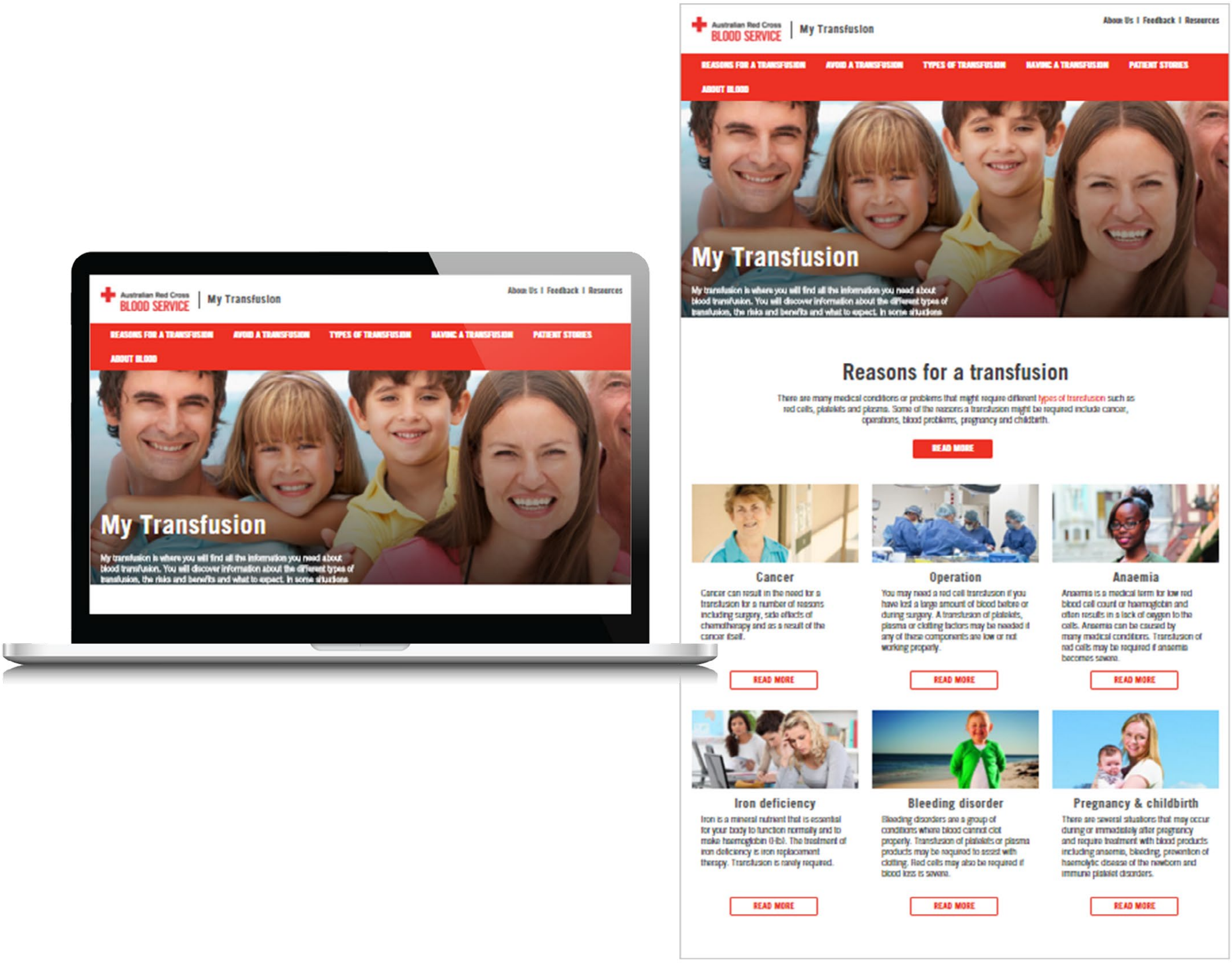
The Blood Service has just launched its updated My transfusion website, with information about blood transfusion for patients and their families.

The website has been reviewed extensively by clinicians and consumers, and incorporates new features to provide clearer information about blood transfusion.

It explains the possible reasons for transfusion, the different types of transfusion, the risks and benefits, why different blood components are used, and what patients can expect.

The website also includes questions for patients to ask their doctor, and ways patients can reduce their chance of needing a transfusion.

The upgraded site is an informative resource for patients and those who would like to learn about blood transfusion.



My Transfusion

My transfusion is where you will find all the information you need about blood transfusion. You will discover information about the different types of transfusion, the risks and benefits and what to expect. In some situations

Reasons for a transfusion

There are many medical conditions or problems that might require different types of transfusion such as red cells, platelets and plasma. Some of the reasons a transfusion might be required include cancer, operations, blood problems, pregnancy and childbirth.

Cancer

Cancer can result in the need for a transfusion for a number of reasons including surgery, side effects of chemotherapy and as a result of the cancer itself.

Operation

You may need a red cell transfusion if you have lost a large amount of blood before or during surgery. A transfusion of platelets, plasma or clotting factors may be needed if any of these components are low or not working properly.

Anaemia

Anaemia is a medical term for low red blood cell count or haemoglobin and often results in a lack of oxygen to the cells. Anaemia can be caused by many medical conditions. Transfusion of red cells may be required if anaemia becomes severe.

Iron deficiency

Iron is a mineral nutrient that is essential for your body to function normally and to make haemoglobin (Hb). The treatment of iron deficiency is iron replacement therapy. Transfusion is rarely required.

Bleeding disorder

Bleeding disorders are a group of conditions where blood cannot clot properly. Transfusion of platelets or plasma products may be required to assist with clotting. Red cells may also be required if blood loss is severe.

Pregnancy & childbirth

There are several situations that may occur during or immediately after pregnancy and require treatment with blood products including anaemia, bleeding, prevention of haemolytic disease of the newborn and immune platelet disorders.

BloodSafe
eLearning Australia

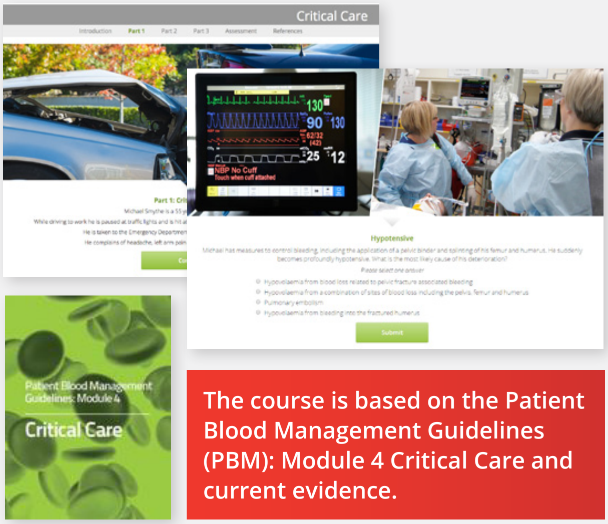
New course and videos available at
www.bloodsafelearning.org.au

Critical Care Course

A blood management Critical Care course was released in December 2015.

This course is very different to the other BloodSafe eLearning Australia courses as it:

- is based on a clinical scenario
- requires the learner to choose appropriate management
- takes the learner on alternative clinical pathways.



The course is based on the Patient Blood Management Guidelines (PBM): Module 4 Critical Care and current evidence.

Videos

The following videos are available and can be downloaded and used by anyone:

- Patient blood management - an overview
- The preoperative patient - communication and consent
- Minimising blood loss in cardiothoracic surgery
- Gastrointestinal bleeding - patient assessment and transfusion
- IV iron administration in primary care

These can be found under the Resource Centre menu of the website under Videos/Tools.

MDS/MPD SPECIAL PRACTICE NETWORK

Dear HSANZ nurse group members,

Are you a nurse who wants to improve the outcomes of people living with chronic myeloid malignancies? Then this is the group for you! Myelodysplastic Syndrome (MDS) and Myeloproliferative Neoplasms (MPN) are groups of rare chronic blood cancers. There are around 1400 people newly diagnosed with MDS and 950 people newly diagnosed with an MPN in Australia each year. MPN is an overarching term for 7 different disease subtypes – the most commonly known are chronic myeloid leukaemia (CML) and myelofibrosis (MF).

Nurses play a key role in improving outcomes for these patients and your involvement is pivotal in expanding our nursing networks and engaging our profession in advocating for these rare patient groups. Through this special practice network we will be able to deliver education, conferences, practice guidelines, informational material and much more. The goals of this group is to impact patient outcomes at a national level by utilising already established networks nationally and internationally, ensuring evidence based practices and gold standard in care and education are available for patients and nurses across Australia and NZ.

Collaboration with other professional bodies and community organisations will also be a part of the group's activities. This includes collaboration with organisations such as the Leukaemia Foundation, MDS and AA Foundation, MDS Foundation, MPD Voice, TAMS and the MPN Education Foundation. By collaborating with patient groups and our national and international colleagues we will be able to increase and channel our efforts in this rare disease space and really make an impact.

The group already has a diverse membership of nurses ranging in experience from nurses who are at the beginning of their exciting haematology career to nurse practitioners, clinical nurse consultants and nurse researchers. This broad range of experience means this group will have an impact on many areas within the healthcare environment and during the patient's complex care pathways.

Nurses who are interested in working together to improve the outcomes for people affected by MDS and MPN across Australia and New Zealand are encouraged to join our membership group by emailing sam.soggee@austin.org.au.

Samantha Soggee

The group will meet at HAA and we hope to see you in Melbourne!

THE HSANZ NG MYELOMA SPECIAL PRACTICE NETWORK

'M-SPN'

Our M-SPN continues to be active at a national level but also in the regions. Our brief is to generally fly the flag for myeloma (MM) wherever we can, working to deliver education and engage with myeloma related work. We are also working hard to establish and grow relationships with other MM related nursing groups including those in the USA and UK. The following report summarises some of our activities.

M-SPN Member Activities

USA & ASH: As a direct consequence of improved links one of our members Julija Sipavicius recently visited Haem/BMT/MM centres in the USA linking in with members of the IMF Nurse Leadership Board. Julija went to explore models of NP care in other regions whilst also attending ASH meeting. Julija's full report can be read on page 3.

Hong Kong: I was fortunate to be invited as guest speaker to the Hong Kong Society of Myeloma Scientific meeting 30th Jan 2016 in Hong Kong. The meeting was hosted in collaboration with Celgene. Prof James Chim Chairman of the Hong Kong Society of Myeloma, hosted the meeting with Prof Xavier Leleu from France as the International Key note medical speaker presenting on 'Advances in Treatment for Relapsed Refractory Myeloma'. We also heard from myeloma physicians in the ASEAN region including those from Thailand, Malaysia and India who presented local demographics on myeloma and treatment approaches in their regions. (See below reference for useful papers reporting MM in the ASEAN region). It was refreshing to hear the interest by speakers and attendees on discussing real world approaches. The challenges of managing MM in the wider ASEAN region are not dissimilar to our own in Australia with access to drugs in an affordable way and improving outcomes relating to survival and Health Related Quality of Life (HRQoL) the main areas that stood out for me. Whilst we are lucky enough in Australia to have the PBS to support our patients, this is not the case in many other ASEAN countries where 80-90% of patients have to self fund majority of costs of all treatment.

PROF LELEU FINDS HUMOUR IN HAVING THE WRONG NAME TAG!

My presentations focused on improving patient outcomes through optimised nursing care; the role of the nurse in managing disease and treatment related effects and helping patients to live well with myeloma through structured educational programs. I was delighted to meet a wonderful group of nurses from around the ASIAN region and we engaged in useful discussion and shared our experiences of nursing those with MM. I've remained in contact with some of the nurses I met and look forward to seeing them again perhaps in Australia at one of our meetings, where we can learn again from each other through sharing experiences.

Associated papers

Tan, D. et al (2013). Management of Multiple Myeloma in Asia: Resource stratified guidelines. Lancet Oncology 14:e571-81

Kim K., et al (2014). Clinical Profile of Multiple Myeloma in Asia: An Asian Myeloma Network Study. American Journal of Haematology. 89(7):751-756

International Myeloma Workshop – Nursing

I continue to be involved with my colleagues from USA and UK in developing the nursing program for the International Myeloma Workshop 2017 In New Delhi India. Look out for more information on the meeting website.

www.imw2017.org

M-SPN National Group Activities

Closer to home the M-SPN has established its goals for the year and have applied for some unrestricted educational grants to help deliver those goals. We continue to work in the area's of a) Delivering best practice with administration of bortezomib b) Developing tools to aid MM nurse role development and c) Information and education programs and resources. The group will workshop these projects during the year and hope to bring you updates at our annual seminar and during HAA this year in Melbourne.

HOLD THE DATE

1ST ANNUAL M-SPN EDUCATIONAL SEMINAR

Making Sense of a Complex Cancer: Clinical Updates and Treatment Approaches

6th August 2016 Melbourne VIC

Open to all nurses with an interest in MM
No cost to HSANZ NG members

Speakers include

Prof Andrew Spencer • Daniela Klarika
Dr Trish Walker • Dr Simon Gibbs
and more.

Register your interest: **D.Klarica@alfred.org.au**

M-SPN Local Group Activities

The **Victorian** HSANZ NG hosted a dinner meeting with Prof A Spencer, Daniela Klarica and John Coutsouvelis showcasing the work of the MM service at the Alfred. All of us will get the benefit of hearing more at our annual M-SPN seminar in August.

D.Klarica@alfred.org.au

WA HSANZ NG are working on a MM focused meeting in August that will be open to nurses and allied health.

Kerin.Young@health.wa.gov.au

NSW HSANZ NG are lucky to have secured Sandra Kurtin as our speaker for the November dinner meeting. Sandra will be the key note nursing speaker at HAA this year and will be visiting Sydney on her way home.

Tracy.king@sswahs.nsw.gov.au

Useful Myeloma Related Resources For Nurses

Tracy King
Chair HSANZ NG MM-Special Practice Network

IMF Nurse Leadership Board Webcast

Oncology Nursing Society (ONS) Satellite Symposium 2015: Nursing Implications of Evolving Treatment Paradigms

www.nurses.myeloma.org

Myeloma Academy – requires login (no charge)

Access to a comprehensive range of myeloma related resources of use to the oncology / haematology nurse including:

- Myeloma Nurse Learning Program
- Challenging Cases
- Tutorials
- Nursing Best Practice Guides
- Myeloma Tracker
- Myeloma e-bulletin

www.academy.myeloma.org.uk

Do you want to share experiences, find a myeloma mentor and share resources with like-minded nurses? Then the M-SPN is for you.

We welcome associate nurse members of HSANZ NG who have an interest in myeloma and would like to contribute to improving nursing care of those with myeloma. Application forms can be found at the hsanz.org.au website or by emailing us at nurses@hsanz.org.au or email me directly – tracy.king@sswahs.nsw.gov.au to find out more about our group.

SPECIAL PRACTICE NETWORK: EXPRESSION OF INTEREST

Formation of Special Practice Network (SPN) in Long Term Follow Up (LTFU) & Survivorship Post Blood & Marrow Transplant (BMT)

Dear HSANZ nurse group members.

Expanding indications for BMT and improvements in supportive care have led to an increasing number of people undergoing and surviving the procedure worldwide. In Australia over 5986 allogeneic BMT have been performed since 2001, with a majority of survivors now living beyond the first 2 years. As a result, this patient population is prone to a unique set of complications and late effects that are associated with significant morbidity and mortality. The need for continuing education and engagement amongst nurses working in the area of LTFU & Survivorship is essential to prevent, manage and treat the long-term issues of the BMT survivor to provide them with optimal quality of life.

I am keen to hear from HSANZ nurse members who would be interested in working together to establish a LTFU & Survivorship Post BMT SPN. If enough interest is generated from members across Australia & New Zealand, then the goal would be to work towards forming a representative steering committee who would develop the aims, objectives and activities for the group.

Anyone interested in working together to establish the LTFU & Survivorship Post BMT SPN, please feel free to contact me via the email below. For more information on SPNs, visit the nurses' page of the HSANZ website.

Megan Hogg
Long Term Follow Up
Blood & Marrow Transplant
Westmead Hospital, Sydney
Email: megan.hogg@health.nsw.gov.au

EVIQ UPDATE

eviQ Education is looking to develop a suite of resources to support an improvement in the education of patients being treated with oral antineoplastic agents and their carers. If you are an oncology health professional and you are interested in being involved in this project, please email us at eviqed@eviq.org.au.

eviQ Nursing Reference Committee

Use your skills and experience to help nursing colleagues and patients throughout Australia and beyond.

eviQ is looking for enthusiastic nurses to join a reference committee to review and develop nursing content.

If you have at least three years experience in medical oncology, radiation oncology, haematology or HPCT then you may be eligible to participate.

Participation will involve attendance at meetings and document reviews.

For further information and to register your interest, please email contactus@eviq.org.au or call 02 8374 3670.

Working together to lessen the impact of cancer

APRIL 2016
VOLUME 10: ISSUE 1
HSANZNG

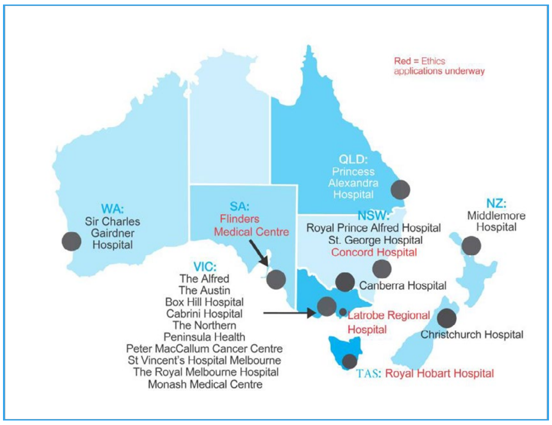
NEWS FROM THE MYELOMA AND RELATED DISEASE REGISTRY

MRDR reaches over 1000 patients

More than 1000 patients have now been registered with the Myeloma and Related Diseases Registry (MRDR), managed by the Transfusion Research Unit at Monash University. Several new sites have commenced recruitment, and patient numbers have almost doubled in the last year. Thanks to staff at all participating sites for your support. We also welcome Melissa Chee, who will be joining the MRDR as a Senior Research Officer in early April, assisting Elizabeth Moore, Research Fellow and Project Manager.

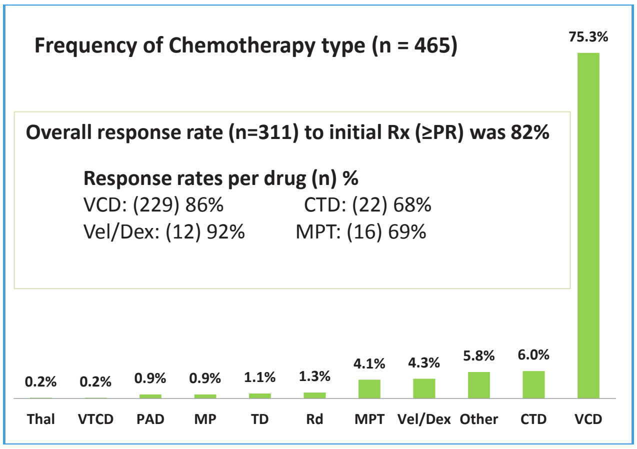
Celgene, Novartis and Takeda Corp continue to support the MRDR. We appreciate their support which enables this important research to continue.

Registry sites in Australia and New Zealand



First-line treatment

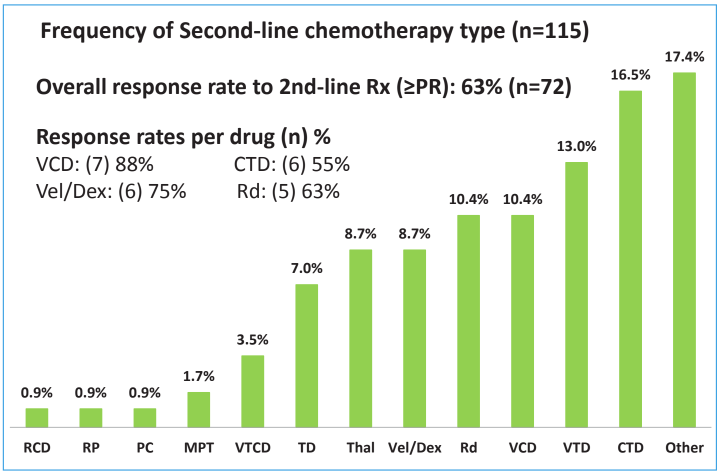
The variation and frequency of use for first-line chemotherapy combinations is shown below for 465 patients with multiple myeloma (MM) and induction therapy data available. A combination of bortezomib, cyclophosphamide and dexamethasone was most commonly used. The overall response rate (≥PR) for 311 patients with data available was 82%. Response rates for the most common drug combinations are shown below.



First line chemotherapy combination use: % of patients (n=465)

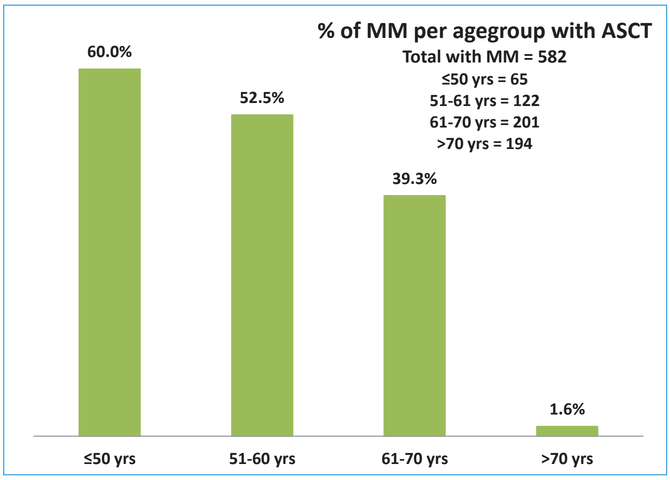
Second-line treatment

The variation and frequency of use for second-line chemotherapy combinations is shown below for 115 patients with MM and data available. The overall response rate (≥PR) for 72 patients with data available was 63%. Response rates for the most common drug combinations are shown below.



ASCT therapy per agegroup

The proportion of patients with MM per agegroup who have had ASCT is shown below.



The Myeloma 1000 Project: an update

The Alfred, St Vincent's and Box Hill Hospitals have been steadily enrolling patients to the Myeloma 1000 project in Melbourne since November 2015, and congratulations to Frankston Hospital which has recently commenced. Recruitment has consolidated and we now have specimens collected from almost 80 patients. Thanks to the registry participants and staff at participating hospital sites who have made this possible. The Peter MacCallum Cancer Centre, Flinders Medical Centre in South Australia and Princess Alexandra Hospital in Queensland are soon to commence enrolment to this project.

The Myeloma 1000 Project is supported by Amgen Australia, Bristol Myers-Squibb & Janssen-Cilag.

REGIONAL ROUND UP

VIC

Hayley Beer (King)

Our first educational evening for 2016 was a huge success with numbers reaching capacity once again. The theme was 'Myeloma Update' and included three speakers from the Alfred Hospital. Professor Andrew Spencer provided an overview of the new drugs in development for myeloma and Daniela Klarica, Nurse Practitioner Candidate and John Coutsevelis, Pharmacist gave an explanation of their innovative Velcade at Home program which stirred great interest in the room.

We have some great plans for more metropolitan events including a combined event with our CNSA colleagues featuring an international speaker. We will also be hosting regional events in Geelong, Frankston and Bendigo.

We are also working on a great program for HAA. Finding sponsorship for travel grants is proving more challenging this year but we are hopeful to be able to offer some financial support for Victorian members to attend conference in Melbourne this November. These grants are only open to financial associate members so if you've been thinking about applying for membership, now is the time. Go to the HSANZ website for information on how to apply and the application form.

www.hsanz.org.au

On behalf of the Victorian committee I'd like to congratulate Samantha Soggee on being elected the new Vice President of the national executive committee. Sam has an infectious enthusiasm about all things haematology nursing and will do a fantastic job.

Finally, I will soon be taking a break from Chair duties to go off and have my first child. Samantha Soggee has also graciously put her hand up to step in while I'm on maternity leave. Thanks Sammy!

NSW

David Collins

The NSW group has held its first meeting of the year, where nurses were given an update on lymphoma by A/Prof Judith Trotman from Concord Hospital. The talk included the latest aspects of treatment. Also during the evening, Juljia Sipalivitis described her recent study tour of the USA and attendance at ASH. Another inspiring talk for what nurses can and do achieve.

Our next meeting is being held up the coast at Gosford; this meeting is always a favourite. Other meetings this year will be held in June, August and November. Our November meeting will be a special myeloma meeting hot on the heels of HAA, with Sandy Kurtin coming to speak to the group.

If you would like to know anything about the NSW groups activities, please contact me on nurses@hsanz.org.au.

MEET OUR NEW COUNCIL MEMBERS

Sam Soggee

VICE PRESIDENT

Thank you to the membership for your support and nomination – I am excited to join the council of the HSANZ Nurses Group. Haematology nursing is a passion of mine and I specialised in this field early on in my career. I have worked across malignant and non-malignant haematology and have worked in the not for profit sector developing and delivering national disease specific support and education programs, to people affected by MDS and MPN.

My current role as a haematology clinical trials coordinator, at Austin Health's ONJCWRC, sees me working within a unit that delivers coordination of care for patients accessing investigational treatments, that one day may become standard of care. To continue my growth and learning within the field I undertook a Master of Nursing (Cancer and Palliative Care) – completing a national research project within a rare haematological disease group. I hope my experience and passion will be an enriching contribution to the group, as it continues to grow from strength to strength.

Throughout my HSANZ nurse membership I have been an engaged and active member, contributing to the local committee and working with colleagues to deliver education programs within the state. Last year the MDS/MPN Special practice network was formed across Australia and New Zealand and I hope that the membership for this group continues to grow momentum.

I look forward to working with my council colleagues, state committees and the nurse membership in building on the education programs, networking relationships, diverse plethora of programs at HAA; to continue to bring opportunities for haematology nurses across Australia and New Zealand.

Sally Taylor

SECRETARY

I would like to introduce myself. My name is Sally Taylor and I have recently been appointed the national secretary of the HSANZ nurses group. I currently work as the BMT co-ordinator at Royal Prince Alfred Hospital in Sydney. I have been a member of the HSANZ nurses group for the last six years and I have enjoyed attending local dinner meetings and networking with people at a local level. I am also on the local committee in NSW. I look forward to contributing to the growth and evolution of the group through participation on the national committee.

CONFERENCE CALENDAR 2016

DATE	CONFERENCE	DETAILS
APRIL 2016		
18–21 April	**ISH 2016:** 36th World Congress of the International Society of Hematology	Glasgow, UK. www.ish2016.com
29–30 April	**ASVASM 2016:** 1st Vascular Access Scientific Meeting of the Australian Vascular Access Society	Brisbane. http://avas.org.au.
MAY 2016		
28–1st May	**ONS** 41st Annual Congress	San Antonio, Texas. http://congress.ons.org
3–6 May	**ALLG** scientific meeting	Adelaide. www.allg.org.au/events.html
12–14 May	**Cancer Nurses Society of Australia Annual Congress 2016**	Cairns. Registration open. www.cnsacongress.com.au
JUNE 2016		
3–7 June	**ASCO 2016:** 51st Annual Meeting of the American Society of Clinical Oncology	Chicago, USA. Registrations open. am.asco.org
9–12 June	**EHA 2016:** 21st Congress of the European Hematology Association	Copenhagen, Denmark. www.ehaweb.org/congress
22–24 June	**WoCoVA 2016:** 4th World Congress on Vascular Access	Lisbon, Portugal. www.wocova.com/wocova-2016/congress-information-3/
23–25 June	**ANZCHOG 2016:** Annual Meeting of the Australian and New Zealand Children's Haematology/Oncology Group	Cairns. www.anr2016.org
23–25 June	**MASCC/ISOO 2016:** International Annual Meeting on Supportive Care in Cancer	Adelaide. Registrations open. http://mascc2016.kenes.com/
JULY 2016		
24–28 July	**WFH 2016:** World Federation of Hemophilia World Congress	Orlando, USA. www.wfh.org/congress
SEPTEMBER 2016		
4–7 September	**ICCN 2016:** International Conference of Cancer Nursing	Hong Kong. www.isncc.org
16–17 September	**ASH Meeting on Hematologic Malignancies**	Chicago, USA. http://www.hematology.org/Malignancies/
OCTOBER 2016		
11–14 October	**ALLG Scientific Meeting**	Sydney. www.allg.org.au/events.html
17–21 October	**18th International Psycho Oncology Society Congress**	Dublin, Ireland. ipos2016.net
NOVEMBER 2016		
13–16 November	**HAA 2016**	Melbourne. www.haa2016.com
15–17 November	**COSA ASM:** Clinical Oncology Society of Australia Annual Scientific Meeting	Gold Coast. www.cosa.org.au/events/annual-scientific-meeting.aspx
20–23 November	**ACIPC:** Australian College of Infection Prevention and Control	Melbourne. www.acipcconference.com.au
DECEMBER 2016		
3–6 December	**58th ASH Annual Meeting & Exposition**	San Diego, USA. www.hematology.org/Annual-Meeting/

HSANZ NG COMMITTEE CONTACT LIST DECEMBER 2015

President
NSW/ ACT representative
Special Practice Network Coordinator

David Collins

CNC Apheresis
Northern Sydney Cancer Centre
Royal North Shore Hospital
Reserve Road, St Leonards
NSW 2065
T: 02 9463 1223
E: David.Collins@health.nsw.gov.au

Vice-President

Sam Soggee

MDS/MPD SPN Coordinator; Clinical Trial Coordinator,
Haematology Cancer Clinical Trials,
Level 4, Olivia Newton-John Cancer & Wellness Centre
Heidelberg, VIC
E: sam.soggee@austin.org.au

Secretary

Sally Taylor

BMT Coordinator
Royal Prince Alfred Hospital, Sydney,
E: sally.taylor@sswahs.nsw.gov.au

SA/ NT representative

Nicole Loft

Haematology Nurse Practitioner, MNP
Royal Adelaide Hospital
Central Adelaide Local Health Network
MDP 11, Level 4, East Wing, RAH
North Terrace, Adelaide
SA 5000
T: 0447 475 132 (or internal SD 1372)
E: Nicole.Loft@health.sa.gov.au

ANZSBT representative/ HAA 2015 LOC

Bev Quested

Transfusion Nurse Educator
Transfusion Medicine Service
ARCBS Adelaide
T: 08 84221372
E: BQuested@arcbs.redcross.org.au

Treasurer

Gillian Sheldon-Collins

BMT Coordinator, Cancer Services
Royal Hobart Hospital
GPO BOX 1061, Hobart
Tasmania 7001
T: 0418136192
E: Gillian.sheldoncollins@dhhs.tas.gov.au

TAS representative

Bronwen Neely

Registered Nurse, Oncology Outpatients
The Royal Hobart Hospital
E: Bronwen.neely@dhhs.tas.gov.au

VIC representative

Hayley King

Myeloma CNC
Royal Melbourne Hospital
Myeloma Foundation VIC
T: 03 9428 7444
E: hayley.king@mh.org.au

QLD representative

Elise Button

A/Nurse Researcher - Cancer Care Services
Royal Brisbane & Women's Hospital
Brisbane, QLD
T: +61 7 3138 4235 / M: +61 4 2346 5377
E: elise.button@hdr.qut.edu.au

WA representative

Andrew Steele

Clinical Nurse Specialist Haematology
Sir Charles Gairdner Hospital
Hospital Avenue
Nedlands
WA 6009
T: 08 6383 3426
E: Andrew.Steele@health.wa.gov.au

NZ North Island representative

Catherine Wood

Clinical Nurse Specialist BMT
Wellington Hospital
New Zealand
T: +64 4 806 2091
E: catherine.wood@ccdhb.org.nz

NZ South Island representative

Jane Worsfold: ***Retiring, replacement to be advised.***

Charge Nurse Manager
BMTU, Christchurch Hospital
Private Bag 4710, Christchurch 8140
New Zealand
T: +64 3 640 640
E: Jane.Worsfold@cdhb.health.nz

Newsletter Editor

Rosie Hoyt

Clinical Nurse Specialist–Haematology
Dunedin Hospital, New Zealand
E: rosemary.hoyt@southerndhb.govt.nz