Volume 3, Issue 1

February 2009

HAEMATOLOGY SOCIETY OF AUSTRALIA AND NEW ZEALAND NURSES GROUP

HSANZ NG News

From the president

Dear members and colleagues,

I write this at a time of tragedy particularly in Victoria and also in Queensland. My heartfelt thoughts go out to those of you affected in any way. I mention this in my 'word,' not only because of my sense of community but also because of the impact, particularly by the bush fires, on nurses working in our specialty.

As you are aware there are calls for blood donation to support those critically injured. Platelets and red cells in particular are destroyed in severe burns. Studies have found that a severely burned patient presents the greatest dysregulation of homeostasis of any injury. It was back in 1865 that a chap called Schultze noticed fragmentation of red cells (haemolysis) and in 1944 that Alexander Brown and colleagues noticed that patients with more than 15% burns to their body surface suffered moderate to severe anaemia. The impact of homeostatic dysregulation has been found to demonstrate; a relationship between the extent of deep burn and the amount of red cell destruction (Muir 1966); shorter life span of red blood cells (Baxter 1979) and that 10% of the total red cell mass may be injured during the burn process (Erasmus 1979). These changes have been attributed to the presence of a detrimental plasma factor as the serum of burn patients has been found to contain substances that inhibit erythropoiesis. In severe burns this is accompanied by haemaglobinaemia and haemaglobinuria (Shinton 1998) . Disseminated Intravascular Coagulation (DIC), as many of you are aware is frequently a feature of severely infected and septic patients, as we see with people with severe burns.

Well on that note, as we can't all head for Victoria or Queensland with bales of hay and other such useful items, I suggest that we give support by way of the Red Cross by donating blood, giving money and offering words of support through our organisation.

The link for the Red Cross is www.redcross.org.au/default.asp

With best wishes,

Moira Stephens

February 2009

Baxter C.R.: Problems and complications of burn shock resuscitation. Surg. Clin. North Am., 58: 1313-22, 1979.

Enremus K.: Hematologic changes in burns. In: "Burns: a team approach", 132-48, Artz, Moncrief J., Pruitt B. (Eds). W.B. Saunders, Philadelphia, 1979.

Muir I.F.: Red cell destruction in burns, with particular reference to the shock period. Br. J. Plast. Surg., 14: 273, 1966.

Shinton N (Ed) CRC Desk Reference for Hematology. CRC Press, 1998.

Please note: The Australian Red Cross Blood service has been overwhelmed with the support it has received and currently has sufficient blood products available. However, it is anticipated over the coming weeks and months that the injured will require ongoing transfusion support. The ARCBS appreciates your support in encouraging people to contact 13 14 95 or to register online, at donateblood.com.au to make appointments to donate over the coming days and weeks. (www.transfusion.com.au)

Inside this edition

Coming in the next issue:

- *Ask the Expert—email in with your questions and your answer will appear in the next issue.*
- *How Do I — 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 angkrb@gmail.com

From the Travel Grant Winners!

Got the Protocol – How to Achieve Compliance? E-learning Lessons as a Tool to Improve Compliance to Clinical Protocols.

Julija Sipavicius (presented paper at HAA) and Chris Sargeant

At the time of the project, both authors were employed at St George Hospital, Sydney

Background:

Intrathecal chemotherapy can result in serious adverse events. No intrathecal policy existed at St George Hospital, Sydney, up until 2003 when a patient inadvertently received intrathecal vincristine. Recommendations following this event prompted the development and instigation of stringent institutional guidelines regarding all matters related to prescribing intrathecal chemotherapy with an accompanying educational session for all new medical officers and nurses employed within Cancer Services. However compliance was haphazard and remained poor, with clinical incident reports relating to deviations from the policy occurring regularly.
Thus alternatives to the paper policy were sought;

• To reduce errors in intrathecal chemotherapy prescribing
• To improve compliance in adherence to the policies regarding intrathecal chemotherapy
• To develop a methodology that was workable in the clinical setting

Method:

An e-learning lesson was developed by a physician and several Registered Nurses in an attempt to overcome this situation and improve compliance through Cancer Solutions™. Cancer Solutions™ http://moodle.educan.com.au is an integrated electronic learning management system that was developed for all clinical staff employed in the Comprehensive Cancer Service at St. George Hospital.

Results:

Since its implementation all medical staff who prescribe intrathecal chemotherapy are mandated by the institution to undertake the lesson and attain a 100% grade prior to prescribing intrathecal treatments. Since this inception no prescribing errors have been reported to date, and compliance to the policy has been almost complete. These results demonstrate that the lesson has been successfully integrated into the clinical setting.

Conclusion:

The success of this e-lesson has encouraged staff at St George Hospital to adapt its application to other hospital policies in order to improve compliance in other important clinical practices. Currently this methodology is being developed and trialled at St George Hospital using the Neutropenic Sepsis policy and preliminary results to date are encouraging.

I would like to thank the HAA organising committee for not only providing me with the opportunity for presenting the work at the HAA meeting in Perth 2008, but also awarding a travel grant for one of three best abstracts.

Julija Sipavicius
(julija.sipavicius@cancerinstitute.org.au)

The Assessment of a Senior Haematology Nurse Performing Un-sedated Bone Marrow Biopsies in a Large Tertiary Cancer Centre

Simon Kuzyl *Institute of Haematology, Royal Prince Alfred Hospital (RPAH), Sydney, Australia*

Aim: To implement a Nurse initiated bone marrow aspirate and trephine (BMAT) policy and procedure at RPAH.

Background: Physicians have traditionally performed BMAT. However, increasing demands on healthcare resources has reduced the time available to perform minor medical procedures. Specialist trained nurses are performing BMAT at institutions throughout the world.

Method: A nursing policy and procedure was researched, developed and approved by the key stakeholders. Training of the Haematology CNS was undertaken by the Haematology Registrar and consisted of successful completion of 10 supervised and 10 independent BMAT.

Key Performance Indices:

• Number of successful versus unsuccessful BMAT;

• Quality of slide preparation and specimens;

• Patient satisfaction and pain surveys.

Results

• Between Sep 2007 to Feb 2008, 41 BMAT were performed (10 newly diagnosed and 31 for re-staging).

• Successful BMAT in 40 out of 41. In the single unsuccessful BMAT material was not obtained after two attempts and the Haematology Registrar completed the procedure.

• 21 patients completed patient satisfaction surveys. Of the 20 surveys not completed, 12 patients were of non- English speaking background (NESB), 5 had previously completed the survey and 3 were confused.

- Pain/discomfort was reported as none or minimal through to mild or moderate in 19 of the 21 surveys. 2 patients described the pain/ discomfort as the worst possible.

**Note: BMAT performed by Medical Officers have previously not been measured, therefore, comparisons with a nurse led service is unavailable.*

Conclusion

• All the Bone Marrow Biopsies attended to by the CNS at RPAH resulted in satisfactory outcomes for the patient, demonstrated by the successful diagnosis and re-staging of haematological malignancies. Evidence is validated from the satisfaction of the Department of Haematology and patients on whom these procedures were performed.

• This ward- based service will continue with ongoing reviews of the KPI's and offers an alternative provider of BMAT.

I would also like to thank the HSANZ Nurses Group for nominating me as a travel grant recipient.

Simon Kuzyl

(simon.kuzyl@email.cs.nsw.gov.au)

From the Travel Grant Winners!

AMD3100 for Patients Failing Haemopoietic Stem Cell (HSC) Mobilisation – The Illawarra Experience

Authors and Affiliations: Fran Owen, Julie Ryan, Peter Presgrave, Kim Cartwright, Pauline Warburton, Haematology Department, Wollongong Hospital, NSW, Australia.

Aim: Failure to mobilise sufficient HSC limits the ability to deliver optimal treatment in several haematological malignancies. AMD3100 (Genzyme) is a novel HSC mobilising agent that inhibits SDF-1/CXCR4 interaction. In combination with G-CSF, it has been shown to mobilise CD34+ HSC in patients with NHL, Hodgkin's Lymphoma (HL) and Multiple Myeloma (MM) who have previously failed mobilisation. Six patients in Wollongong have received AMD3100 through the AnorMED (Genzyme Corp.) CUP.

Method: 6 patients (ages 24-57) had failed 7 previous attempts to collect sufficient HSC. Diagnoses were MM – 2, relapsed NHL – 2, relapsed HD - 2. Prior mobilisation regimens were high dose Cyclo + G-CSF and ICE + G-CSF. 4 had been heavily pretreated and 1 had received a prior HSC transplant. G-CSF 10mcg/kg/BD sc. was given for 4 days, with AMD3100 240mcg/kg/D sc. given 10-11 hours prior to first anticipated apheresis. AMD3100/G-CSF was continued until the final apheresis.

Result: Patients had a median of 3 apheresis procedures (range 2-4). A median cell dose of 2.3 x 10^6 CD34+ (range 1.5-5.1) was obtained. The median PB CD34 count was 10.7 prior to AMD3100 and 18.35 after. 1 patient required 2 mobilisations with AMD3100 and 1 patient failed to mobilise. Prior mobilisation attempts had produced a median PB CD34 count of 5.7. There was 1 report of diarrhoea and abdominal cramping and 1 report of stinging at the injection site. 3/5 patients have proceeded to transplantation. Median time to engraftment was 12 days.

Conclusion: The use of AMD3100 at Wollongong Hospital has enabled 5/6 patients to mobilise sufficient CD34+ cells to proceed to autologous transplant. Three have been transplanted successfully to date.

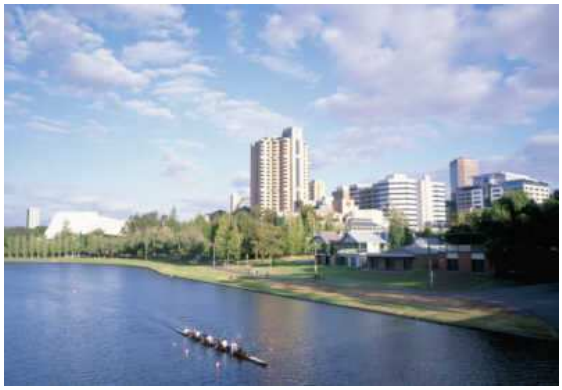
Addit: Since the abstract was written four more patients have been mobilised with AMD3100 (Plerixafor) and had stem cell collections. All except one have successfully had autologous transplants.

Fran Owen

(Fran.Owen@sesiahs.health.nsw.gov.au)

From HAA 2009 Organizing Committee

Come to Adelaide for HAA October 18-21!



For those truly dedicated souls interested in advancing their knowledge and improving their practice we have an engaging and stimulating **three day** program. That's right, this year we are expanding so there will be even more sessions for nurses to present their research, audits, practice improvements and share their valuable know how. We have more sessions too for invited speakers to update us on the science behind our practice. A couple of examples will be presentations on fungi as well as the effects of steroids on blood glucose regulation. These experts in their fields will tell us the why, how and when in fungal infection and blood glucose level management.

We have invited Sherri Ozawa to be the lead nursing speaker. She has helped create one of the largest multidisciplinary bloodless medicine and surgery programmes in the world. Sherri will share her knowledge of alternatives to transfusion as well as share ideas on how to lead onto successful programmes that will be useful for all nurses.

For those that have networking, making friends and the conference dinner as some of the highlights of their conference attendance – we aim not to disappoint and promise dancing, good food and good wine. As you may know, Adelaide is literally surrounded by wine, head north to the Barossa Valley, south to the McLaren Vale or east to the Adelaide Hills - all terrific wine country with wonderful cellar doors. We have eager individuals tackling the very difficult job of choosing some great wines for the conference dinner.

You may even be tempted to come a few days earlier or stay on for the weekend. The SA tourism web site www.southaustralia.com has some great day tours and suggestions of places to see.

Start thinking about writing and presenting the work you have been doing, booking your leave and writing the funding applications to let you come to HAA 2009. Visit the conference website to check out the invited speakers and conference updates: www.fcconventions.com.au/HAA2009/

So please take the break to meet your colleagues and relax in Adelaide while feasting on the fabulous programme of the Conference this coming October!

Beverleigh Quested

Fantastic New Myeloma Initiatives

National Myeloma Telephone Support Group Pilot Project

Do you look after those with Myeloma? Do your patients struggle to gain access to face to face support groups for geographical or physical reasons? Could they benefit from joining a telephone support group?

The National Myeloma Telephone Support Group (TSG) Pilot Project is a free and confidential support service to Myeloma Patients from the ACT, NSW, NT, SA, Tasmania and Victoria. Two trained facilitators provide participants with emotional support, up to date information, and the unique opportunity to connect with other Myeloma patients in a similar situation to discuss and share their related experiences. The National Myeloma TSG will be run on the 2nd and 4th Thursdays of the month for one hour per fortnight.

The Pilot is a joint project of the Cancer Councils of ACT, NSW, NT, SA, Tasmania and Victoria in collaboration with the Myeloma Foundation of Australia. The Project is funded in part by Cancer Australia and will run until 2010.

For further information and referral to the Pilot Project contact:

Julie Hill

National Myeloma TSG Pilot Project Officer
Cancer Council NSW
Ph: 02 9334 1828

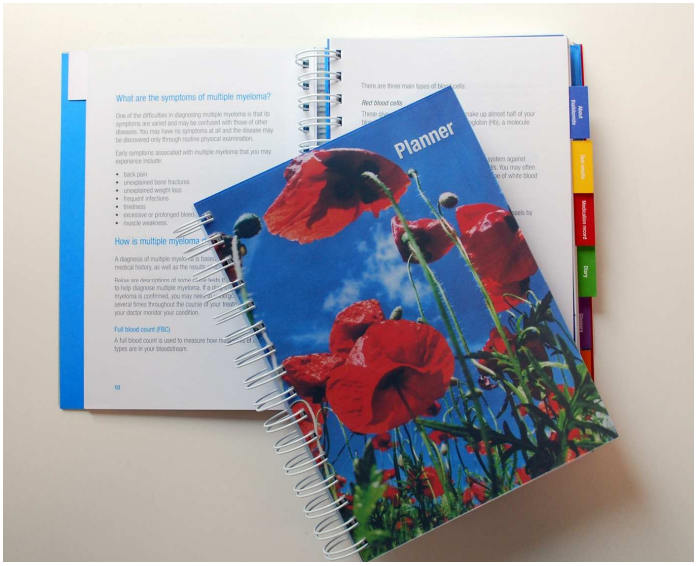
For general information and services regarding Multiple Myeloma contact:

Myeloma Foundation of Australia
Ph: 1800 693 566

The Myeloma Patient Planner - Fantastic Patient Resource

Life with myeloma is complicated enough without having to try and keep track of the vast amount of information generated, appointments to keep, blood results, treatment regimes and more. Many patients keep a diary or note book, some have a folder jammed packed with scraps of paper, scripts and appointment cards, some just trust their health care providers to keep track of things for them.

Well now there is a FREE resource to help patients contain and manage their life with myeloma. Celgene have developed and produced the 'Myeloma Patient Planner', a useful resource to document and store a wide range of information regarding myeloma and its management.
This A5 size, ring bound planner provides space to collect a range of information.



Tabs include:

- Useful contact details
- Medication lists
- Test Results
- Diary
- Notes pages
- Clear plastic sleeves for scripts and business cards

If you look after those with myeloma and would like to find out more about the 'Myeloma Patient Planner' or to obtain a supply for your patients, please contact your local Celgene representative or contact Tracy King from the Myeloma Foundation of Australia.

Tracy.king@email.cs.nsw.gov.au Ph 02 9515 7310 or 0447 334 435

CI-SCaT update

Thanks for the invitation to contribute to this newsletter. If you are not familiar with CI-SCaT you can visit the site at www.treatment.cancerinstitute.org.au where you will find evidence based, peered reviewed Cancer treatment protocols, educational and patient information resources available at no cost , 24/7.

Last year was very busy for the CI-SCaT team, and this year is shaping up to be even busier. In 2008 the site received over 6.1million hits (averaging over 512,000 monthly) and CI-SCaT staff answered over 6,000 feedback queries! The focus of our activity this year is the rebuilding of the CI-SCaT website which will include some fantastic new features that have been requested over the last year. The estimated time for launching our new site is the beginning of June and yes our name will be changing.

Reference Committee Activity 2009

Haemopoietic Stem Cell Transplantation (HSCT)

It is anticipated that the first national HSCT reference committee meeting will be held in mid-2009. The BMT calculator and new content is currently under development. Two nursing related HSCT protocols have been placed on the website following the September HSCT nurse's reference committee meeting.

Haematology

We aim to have a Haematology reference committee meeting in early 2009. Please feedback any protocols you would like developed.

Nursing

Thankyou, to all those who have applied to attend the 2009 Nurses Reference Committee meeting, 29 April to 1 May, at the Menzies Hotel in Sydney. We are extremely grateful to Cancer Australia for providing financial support for this meeting which will allow for a significant number of non-NSW nurses to attend. Protocols up for discussion at the meeting include: septic shock, hypersensitivity reactions, neurotoxicity, management, DIC, infertility and sexuality, to name a few.

Patient Information

New patient information sheets have been developed and will be reviewed at the next consumers meeting, scheduled for 26 February 2009. We want to ensure that patient information developed is relevant, readable, and understandable.

Anyone wishing to be involved in protocol development or wanting further information, please contact Karen Eaton;

Phone: (02) 8374 5714 or Email: karen.eaton@cancerinstitute.org.au

2009 Dates for the diary

International Conferences

17-20 Mar: World Apheresis Assoc, Buenos Aires, ARGENTINA

29 Mar-1 Apr: European Blood and Marrow Transplant , Goteborg, SWEDEN

22-25 Apr: American Society of Pediatric Hematology/Oncology, San Diego, USA

30 Apr-3 May: Oncology Nursing Society, San Antonio, USA

20-23 May: American Association for Apheresis, San Diego, USA

29 May-2 Jun: American Society for Clinical Oncology, Orlando, USA

3-6 June: International Society for Cellular Therapy, San Diego, USA

4-7 June: European Haematology Association, Berlin, GERMANY

11-16 Jul: International Society for Thrombosis & Hemostasis, Boston, USA

20-24 Sep: European Cancer Organisation, Berlin, GERMANY

14-18 Nov: ISBT (Asia), Nagoya, JAPAN

5-8 Dec: American Society for Hematology, New Orleans, USA

National Conferences/Meetings

6-8 May: Australian Leukaemia & Lymphoma Group (ALLG) , Sydney

18-20 June: CNSA Winter Congress, Newcastle

8-11 Oct: ANZ Haemophilia Conference, Brisbane

18-21 Oct: HAA, Adelaide

11-13 Nov: ALLG, Melbourne

Regional Meetings

NSW Educational Supper Meetings (for more information contact Tracy King - Tracy.king@email.cs.nsw.gov.au)

26 Feb
16 April
18 June
20 Aug
19 Nov

If you'd like your local events added, please email Angela on angkrb@gmail.com

Research News – a short trip around some recent key journals

Changes in quality-of-life and psychosocial adjustment among multiple myeloma patients treated with high-dose melphalan and autologous stem cell transplantation

Sherman AC, Simonton S, Latif U, Plante TG, Anaissie EJ. Biol Blood Marrow Transplant. 2009 Jan;15(1):12-20
High-dose melphalan and autologous hematopoietic stem cell transplantation (HSCT) is a standard treatment for myeloma, but very little is known about the psychosocial or quality-of-life difficulties that these patients encounter during treatment. Data regarding older patients is particularly scarce. Using a prospective design, this investigation evaluated 94 patients at stem cell collection and again after high-dose therapy and transplantation. Outcomes included quality-of-life (FACT-BMT) and psychosocial adjustment (ie, Brief Symptom Inventory, Impact of Events Scale, and Satisfaction with Life Scale). Findings were compared with age- and sex-adjusted population norms and with transplantation patient norms. At stem cell collection, physical deficits were common, with most patients scoring 1 standard deviation below population norms for physical well-being (70.2%) and functional well-being (57.5%), and many reporting at least moderate fatigue (94.7%) and pain (39.4%). Clinically meaningful levels of anxiety (39.4%), depression (40.4%), and cancer-related distress (37.0%) were evident in a notable proportion of patients. After transplantation, there was a worsening of transplant-related concerns ($P < .05$), depression ($P < .05$), and life-satisfaction ($P < .001$); however, pain improved ($P < .01$), and social functioning was well preserved. Overall, the declines in functioning after transplantation were less pronounced than anticipated. Older patients were not more compromised than younger ones; in multivariate analyses, they reported better overall quality of life ($P < .01$) and less depression ($P < .05$) before transplantation. Our findings emphasize the importance of early screening and intervention.

The incidence of and risk factors for venous thromboembolism (VTE) and bleeding among 1514 patients undergoing hematopoietic stem cell transplantation: implications for VTE prevention

Myers KC, **Davies SM**. Biol Blood Marrow Transplant. 2009 Mar;15(3):279-92.

Bone marrow failure (BMF) syndromes include a broad group of diseases of varying etiologies, in which hematopoeisis is abnormal or completely arrested in one or more cell lines. BMF can be an acquired aplastic anemia (AA) or can be congenital, as part of such syndromes as Fanconi anemia (FA), Diamond Blackfan anemia, and Schwachman Diamond syndrome (SDS). In this review, we first address the evolution and current status of bone marrow transplantation (BMT) in the pediatric population in the most common form of BMF, acquired AA. We then discuss pediatric BMT in some of the more common inherited BMF syndromes, with emphasis on FA, in which experience is greatest. It is important to consider the possibility of a congenital etiology in every child (and adult) with marrow failure, because identification of an associated syndrome provides insight into the likely natural history of the disease, as well as prognosis, treatment options for the patient and family, and long-term sequelae both of the disease itself and its treatment.

EPO in combination with G-CSF improves mobilization effectiveness after chemotherapy with ifosfamide, epirubicin and etoposide and reduces costs during mobilization and transplantation of autologous hematopoietic progenitor cells.

Hart C, Grassinger J, Andreesen R, Hennemann B. Bone Marrow Transplant. 2009 Feb;43(3):197-206. Epub 2008 Sep 22

A successful stem cell harvest is a prerequisite for peripheral blood SCT. We investigated the number of CD34(+) cells mobilized, the number of leukaphereses needed and the expenses of treatment for 28 patients with multiple myeloma randomly assigned to receive either G-CSF alone or G-CSF+EPO for stem cell mobilization after chemotherapy with ifosfamide, epirubicin and etoposide. All patients treated with G-CSF+EPO reached the threshold of 6 x 10(6) CD34 (+) cells per kg body weight (kgbw), with a mean of 1.3 leukaphereses. On average 15.4 x 10(6) CD34(+) cells/kgbw were collected. In the G-CSF-alone group, the mean number of leukaphereses was 1.8, and 12.6 x 10(6) CD34(+) cells/kgbw were collected, and two patients failed the threshold. Overall costs per patient for mobilization and leukaphereses were 8339 euro (G-CSF+EPO) and 8842 euro (G-CSF). After transplantation, fewer blood transfusions (0.6 versus 1.3, $P=0.05$), fewer days on antibiotics (2.3 versus 6.1, $P=0.02$) and a shorter hospital stay (15.2 versus 17.8, $P=0.06$) were noted in the G-CSF+EPO group resulting in a 19.2% reduction of costs for each transplant ($P=0.018$). In summary, EPO improves the mobilization efficiency of G-CSF and so reduces costs of mobilization and SCT.

Restoring Patency to Central Venous Access Devices

C Cummings-Winfield, C and Mushani-Kanji, T. Clinical Journal of Oncology Nursing. Dec 2008. Vol. 12, Iss. 6; pg. 925

In September 2006, the Oncology Nursing Advisory Board met to discuss the current management of central venous access device (CVAD) occlusions for patients receiving cancer treatment in centers across Canada. The board found inconsistency in practice across the country and advocated for the development of evidence-based, standardized guidelines for the use of thrombolytic agents to clear thrombotic occlusions. PubMed was searched for articles related to catheter occlusion, catheter patency, and catheter complications published from 1997-2007. The board compared institutional and published protocols for thrombolytic treatment of occluded CVADs, in light of a systematic, evidence-based review of the literature on CVAD-related complications. Restoration of CVAD

patency, when appropriate, represents a safe, effective, and cost effective alternative to device replacement and improves patient quality of life. The treatment algorithm presented in this article reflects the board's consensus recommendations for managing thrombotic CVAD occlusions in adult patients with cancer

Bendamustine: A Novel Cytotoxic Agent for Hematologic Malignancies

Susan Blumel, Amy Goodrich, Cheryl Martin, Nam H Dang. **Clinical Journal of Oncology Nursing**. Oct 2008. Vol. 12, Iss. 5; pg. 799.

A significant need exists for effective and well-tolerated treatments for patients with hematologic malignancies. Bendamustine hydrochloride is a novel cytotoxic agent that possesses alkylator and purine-like structural groups, which may confer a unique mechanism of action. Bendamustine recently was approved by the U. S. Food and Drug Administration for the treatment of chronic lymphocytic leukemia (CLL) and currently is being used in clinical trials for a number of hematologic and solid tumors. Bendamustine has demonstrated promising clinical activity in patients with hematologic malignancies and has manageable toxicities when administered as monotherapy or in combination with other agents. In clinical trials, nausea, fatigue, vomiting, fever, diarrhea, constipation, and headache were the most commonly reported nonhematologic side effects. Reversible myelosuppression also was reported. Nurses need to understand the efficacy and safety profiles of bendamustine to educate patients and their families about its use and expected side effects. Knowledge of specific measures for preventing and managing associated side effects and dose modifications is integral to the provision of optimal care.

Acquired Hemophilia A: Clinical Features, Surgery and Treatment of 34 Cases, and Experience of Using Recombinant Factor VIIa.

Lak M, Sharifian RA, Karimi K, Mansouri-torghabeh H. Clin Appl Thromb Hemost. 2009 Feb 11. [Epub ahead of print]

Acquired hemophilia A is a rare, but life-threatening disorder caused by autoantibody against factor VIII. As it is useful to gather more data on epidemiology, clinical pictures and therapy of it, we evaluated relevant medical findings in 34 acquired hemophiliacs from Dec 1999 to Dec 2007. Eight patients (23.5%) had low titers (<10 Bethesda Unit BU) and 26 patients (76.5%) had high titers of inhibitors (>10 BU). The mean of inhibitors was 548.38 +/- 359.27 SD BU. The most common hemorrhagic symptoms were hematoma 21 (33.33%), ecchymosis 16 (25.39%), hemarthrosis 8 (12.69%), hematuria 6 (9.52%), menorrhagia 4 (6.34%), compartment syndrome 3 episodes (4.76%). The eliminator therapies were recruited according to titers of inhibitor and types of bleeding and it's results were 27 efficient treatments (79.4%), 5 partial efficient treatment (14.7%) and two treatments inefficient (5.9%). Elimination therapy using steroid alone or with combination can terminate complete remission in most cases.

WISECARE+: Results of a European study of a nursing intervention for the management of chemotherapy-related symptoms.

Kearney N, Miller M, Maguire R, Dolan S, MacDonald R, McLeod J, Maher L, Sinclair L, Norrie J, Wengström Y. Eur J Oncol Nurs. 2008 Dec;12(5):443-8.

While the use of chemotherapy has significantly improved survival rates, the symptoms associated with chemotherapy remain a major burden for patients. Preventing or appropriately managing side effects significantly improves patients' functional status and quality of life, ultimately leading to greater patient acceptance of chemotherapy. However, symptom assessment and management are fraught with difficulties such as poor patient recall, retrospective assessment conducted by clinicians and lack of appropriate, clinically relevant and patient friendly symptom assessment and management tools. Furthermore the differences between clinician and patient perceptions of stresses and distress during chemotherapy are well recognised. This study aimed to evaluate the impact of a nursing intervention incorporating structured symptom assessment and management, facilitated by information technology, on chemotherapy-related symptoms, nausea, vomiting, fatigue and mucositis. This pan-European study, involved 8 clinical sites from Belgium, Denmark, England, Ireland and Scotland. Adults (n=249) receiving first line chemotherapy for breast, lung, ovarian or colorectal cancer, osteosarcoma, acute myeloid leukaemia (AML), acute lymphoblastic leukaemia (ALL) or lymphoma were recruited to the study. Patients completed daily symptom assessment questionnaires for 14 days following consecutive cycles of chemotherapy. Symptom outcomes were compared before and after the introduction of the intervention with positive impact on patients' experiences of nausea, vomiting and oral problems. Fatigue was not significantly improved.

The nurse's role in administration of intravenous immunoglobulin therapy.

Kirmse J. Home Healthc Nurse. 2009 Feb;27(2):104-11

Intravenous immunoglobulin is a valuable therapeutic agent for many patients with primary immune deficiency disorders and for some with secondary immunodeficiency, and its use has expanded to other areas such as neurologic, hematologic, and infectious disorders. Nurses administer the majority of immunoglobulin. This article discusses indications for various immunoglobulin products available, potential adverse reactions, routes of administration, and the important role of the nurse in the administration of immunoglobulin.

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News from the regional groups

New Zealand (North Island)

Things have been quiet in the lower North Island over the Christmas New Year period. We have done a questionnaire mail-out to Haematology nurses in the lower North Island asking them what they would like out of the HSANZ NG branch in this part of the country. We have had some very positive feedback, but would like to hear from more nurses about how they would like to see the structure and function of their group. We are also keen to find out what topics nurses would like discussed. Please get in touch with me at Catherine.Wood@ccdhb.org.nz if you missed the mailout and are keen to join up.

The NZ branch of HSANZ is having their annual meeting in Wellington on the 12th and 13th March 2009. There are guest speakers from the Mayo Clinic, USA and there is some time allocated especially for nurse presentations. The meeting details are at www.sixhats.co.nz/hsanz09 . I look forward to seeing you all in Wellington for what looks like an excellent conference programme. ***Catherine Wood***

New Zealand (South Island)

At the end of November 2008 the sub committee held the first education evening for HSANZ Canterbury branch. We were really appreciative of support from the Leukaemia and Blood Foundation of NZ who provided food and wine for the occasion. The topic was Aphaeresis and was presented from a Nurse from the New Zealand Blood Transfusion Service who currently manages the stem cell harvests for the service. We invited other services within the Hospital and this was well attended.

In April the committee are again hosting an education evening addressing issues relating to fertility in women who have had intensive treatment related to their cancer. This will be presented by two specialist Nurses. Alison Trengrove is the South Island Bone Marrow Transplant coordinator and Glynis Cummings is the Gynae/Oncology Nurse Specialist. We are hoping for a great attendance.

The committee have had two successful fundraisers and the money has been used for education purposes. The committee is currently planning their next fundraiser.

The committee members are Jane Worsfold (chair) Wendy Jar (treasurer) Alison Trengrove, Natasha Chilsom , NZBS, Anne Marie Evans (secretary) and Christine Kerr LBF

Sharron Ellis

South Australia/Northern Territory

The South Australian and Northern Territory group have just held their second educational meeting, a morning of presentations about stem cell and bone marrow transplantation. We were lucky enough to have four excellent speakers present at The Lion conference venue in North Adelaide.

Bev Quested from the Australian Red Cross Blood Service spoke about the history of transfusion and bone marrow/ stem cell transplantation from the early experiments with transfusion, leading up to our current understandings of transplantation. We also heard about some of the major innovations along the way and what we can expect in the future.

Terry Ventrice from ward D6, the inpatient haematology and bone marrow transplant ward at the Royal Adelaide Hospital gave an excellent overview of transplantation: from what it is, where the cells come from and who gets them. We also heard about the process of collection, transplanting the cells and the types of complications that can arise early on as well as some of the late complications.

Alison Virieux is one of the Bone Marrow Transplant Coordinators at the Royal Adelaide Hospital and gave an overview of the many and varied roles they play in preparing adult patients for transplantation and working with these patients, often from shortly after diagnosis, through transplantation and beyond. Additionally we were able to hear how they work with the Australian and International Bone Marrow Donor Registries to search for matches, work donors up for transplantation through to collecting cells from other locations, both local and overseas.

Sheree Westthorp is the Hudson Maher Foundation Bone Marrow Transplant Coordinator for the Women's and Children's Hospital who gave us an overview of her role in the paediatric setting. Sheree outlined some of the many challenges faced in this population as a result of their age or family situation as well as the challenges of distance, the large catchment area for the hospital results in many families having to relocate from country SA, VIC and NSW as well the NT for treatment. Additionally, some of those families must travel interstate for treatments that are not able to be offered locally.

Bev Quested returned to close the morning discussing the findings of her PhD research regarding the patient experience of allogeneic transplantation. Ten allogeneic haematopoietic stem cell transplant recipients were interviewed before, during and at several timepoints in the 12 months after transplantation. It was a very insightful and interesting presentation hearing how patients themselves viewed the experience and the common themes that they expressed.

We had a great turnout on the day with fifty participants enjoying the presentations and getting to network over a light lunch. There was a great mix of interested nurses from a variety of workplaces; both public and private metropolitan hospitals, non government organisations, the ARCBS, as well as a couple of nurses from Tumby Bay in Country SA. The feedback on the day was overwhelmingly positive and we look forward to compiling the evaluations so we can start planning our next educational event, a breakfast meeting in April/May.

Our thanks go out to our sponsors who made it possible to enjoy a great location away from the hustle and bustle of hospitals: Amgen Australia Pty. Ltd., Gilead Sciences Pty. Ltd., Novartis Oncology and Roche Products Pty. Ltd. A special thanks to Gilead for sponsoring travel costs for our country nurses to be able to attend, giving them a learning opportunity that is harder to come by away from the major treating centres.

Allan Hayward

Tea Room Guru

Dear TRG,

A mate of mine was telling me that the Department of Health has changed when you die. I mean they have said that when you're dead is different. How can they do that? It's simple isn't it? Your either dead or you're alive …. Aren't you?

It certainly appears that way for most people. However – your mate was referring to new guidelines which propose that transplant doctors would be able to retrieve organs from people whose heart and circulation have ceased irreversibly but who have not been certified brain dead, http://www.health.nsw.gov.au/policies/gl/2007/pdf/GL2007_012.pdf .

The NSW The Human Tissue Act 1983, in referring to opportunities for cadaveric organ donation, states that

Death is confirmed by:

(a) irreversible cessation of all function of the person's brain, or

(b) irreversible cessation of circulation of blood in the person's body

The term "Brain death" was introduced in 1965 following a report of renal transplantation from a heart-beating but brain dead donor and was defined formally by an Ad Hoc Committee of Harvard Medical School in 1968.

It was then widely adopted by professions and acknowledged by church and State. This successfully delineated boundaries of organ procurement and enabling heart-beating donation of organs, which made for a much better outcome for the recipient as the organ would be in a much better shape (well perfused). However, brain death has been called a *"convenient fiction"* because it is philosophically incoherent, biologically simplistic, legally uncertain (Kerridge 2008). Australian legislation sets out limits for the medical determination of death. These are that there must be irreversible cessation of ***all*** brain function or irreversible cessation of blood circulation but there is often persistent brain function in most patients who are brain dead, the law doesn't make a distinction between *meaningful* brain function but rather just states *all* brain function, so this makes the law inconsistent with biology. In fact RD Trulog summed this up quite nicely when he said **'Brain death – too flawed to endure, too ingrained to abandon.'** Truog RD *J Law Med Ethics* 2007;35(2):273-81.

For cadaveric and brain dead donation the *'dead donor rule'* must apply which means that the person:

Must have irreversible cessation of circulatory function or all brain function.

But

Irreversibility may be defined liberally or conservatively (there is relative arbitrariness!):

10 minute (Maastricht protocol)

2 minutes (Pittsburgh protocol)

2-5 minutes (American College of Critical Care Medicine)

So- when is dead?

We know that dying is a process, and so the choice of a point to say that someone is dead is necessarily arbitrary and this choice of a point in time may depend on circumstances and maybe a reflection of ;

- evidence of auto-resuscitation

- priority given to organ integrity

- the definition of death (does the person actually need to be dead or just 'as good as dead'?)

Is the person who has spent the last hour in a freezing lake with no cardiac output yet are able to be fully resuscitated – less dead than the person with little, but some, cardiac output and no measurable blood pressure in florid leukaemic relapse and septic shock?

Ah such questions – is it all just death by decision – stopping the resuscitation, the antibiotics, the chemotherapy , deciding not treat to start with?

I am sure this hasn't helped, but simply highlighted the point that death is a slippery thing to define……..

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, HZANZ – NG News.

HSANZ – NG National Committee Members

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