HAEMATOLOGY SOCIETY OF AUSTRALIA AND NEW ZEALAND NURSES GROUP

HSANZ NG News

From the president

Dear members and colleagues,

As you read this the annual meeting is upon us, in fact you may be reading this on the plane , at the conference or at work, while others are at the conference!

This year saw an unprecedented 32 abstracts, all of which are of a very high standard and I, for one, am looking forward to some exciting presentations. Three travel awards are to be granted for best abstracts and these will be/have been announced in the first session of the nurses meeting.

The Annual General Meeting of the Nurses Group will take place on Monday 19th October in the Lunchtime Break – so please come along, hear what is happening and contribute your say to your organisation.

Elections: Nominations were called for and elections held for the positions of President and Treasurer. Both Alan Hayward and I sought re election for these positions and at the time of going to press we await the results which will be announced at the AGM.

This year we have continued to hold quarterly national teleconference meetings with representatives from all states, territories and New Zealand. The plans for the next twelve months are to continue to develop local groups, increase nurse membership of HSANZ and to continue to build develop the nurse's section on the HSANZ website.

For the first time the Nurse's council will meet together in Adelaide to workshop a number of items. Getting together for four hours will really allow us to achieve concrete and practical outcomes and I for one am looking forward to this.

So, to those of you going to or at the conference, have a fabulous meeting and enjoy the weather provided, along with a great programme by Bev Quested and the local organizing committee, and, to those unable to attend this year—have a great October and plan for Auckland next year!

If you have not yet got around to joining the HSANZ NG – pick up a membership form from the HSANZ stand or from the website – it really is great value for $55 a year, but more importantly, I believe that your membership of this, the only professional organisation for haematology nurses, says something about you as an expert and specialist and, by having a strong membership, says a lot about haematology nursing as a discrete specialty - so stand up and join up!!

We also now have our own page on the internet to share web pages or other resources of mutual interest—go to http://groups.diigo.com/group/haematology-nursing

Moira Stephens

Inside this edition

What do you want to know?

- *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

angela.booth@gsahs.health.nsw.gov.au.au

HAA 2010—Auckland, New Zealand

Next year's HAA is in beautiful Auckland and our invited speaker is Shelley Dolan, Chief Nurse at the Royal Marsden Hospital, London, UK

See you there!!

CNE Points and more

As you may know, the HSANZ NG is an Authorised Provider of Endorsed Courses (APEC) organisation. So don't forget to complete your documentation and collect your certificate at the end of the nurses' programme. One CNE point equals 1 hour of learning, in case you're not sure. If you would like more information re CNE see www.rcna.org.au/ or www.3lp.rcna.org.au/.

Some useful websites

http://www.clinicaloptions.com/Oncology.aspx This is an extremely useful site where you can find interactive activities, the latest conference updates, treatment updates, PowerPoint presentations for download and much more.

http://www.oncologystat.com/index.html Another great resource for keeping up to date with the latest in regard to drugs, treatments, journal summaries and more.

http://www.cancerlearning.gov.au/about/index.php This is the online initiative of Cancer Australia containing evidence-based learning and other resources and information. It contains resources developed by the Professional Development Packages and Ed-CaN projects and is well worth a visit.

All of the above websites can be subscribed to for email updates.

Myeloma telephone support group update

You may be aware that a joint pilot project of Cancer Australia, The Cancer Council and The Myeloma Foundation has been running telephone support groups since April in ACT, NSW, NT, SA, TAS and VIC. Groups are held every 2nd and 4th Thursdays of the month and are free and confidential.

They are seeking referrals for this important national supportive care pilot. If you would like to refer a patient to this pilot or for more information please contact:

- The local Cancer Council Helpline on 131120 in each participating state or territory
- Julie Hill, National Pilot Project Officer—Cancer Council NSW on 02 9334 1828

Update

Blood and Marrow Transplant Network NSW

September saw the launch of our new website. The website has taken some of the features of the old website and improved them, with more to come over the coming months.

We have asked everyone to re-register for the website so that we get the most up to date information on our membership. Our membership that is not confined to NSW, but is global.

At the present the information on the website is still basic, but we wanted to get it up and running and use our membership to test it and listen to what they have to say about what else should go onto it.

There are two areas—public and members only The public area will have information for patients and carers on it as well as a list of links to other resources. The members area will allow access to further information including live and recorded web casts, and the three discussion forums: Nurses, Scientists, and Doctors.

These forums are already operational and being used. If you haven't used these before, they are a great facility allowing clinicians to communicate with colleagues from all over the world.

The events page will show what study days are coming up within the BMT Network as well as those of other groups.

If you are not already a member you can join by going to www.bmtnsw.com.au and and clicking on the "become a member" link on the right-hand side of the page.

If you have an event that you would like us to advertise for you please send us the details so we can add them to the calendar, or if you have any comment we would be pleased to here them.

You may also have noticed that we've changed our name, we are now the "Blood and Marrow Transplant Network NSW". This is to keep in line with changes within transplant.

For more information, please contact

David Collins

CNC BMT Network NSW

david@bmtnsw.com.au

2009/2010 dates for your diary

International Conferences

14-18 Nov: International Society of Blood Transfusion (Asia), Nagoya, JAPAN

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

2010

24-28 Feb: BMT Tandem Meetings, Orlando, Florida, USA

7-10 Mar: International Society of Nurses in Cancer Care, Atlana, Georgia, USA

21-24 Mar: European Group for Blood and Marrow Transplantation, Vienna, AUSTRIA

19-21 Apr: British Society of Haematology, Edinburgh, SCOTLAND

22-25 May: International Society on Thrombosis and Haemostasis, Cairo, EGYPT

10-13 Jun: European Haematology Association, Barcelona, SPAIN

26 Jun-1 Jul: International Congress of the International Society of Blood Transfusion, Berlin, GERMANY

10-14 Jul: World Federation of Haemophilia, Bueons Aires, ARGENTINA

10-13 Oct: International Society of Haematology, Jerusalem, ISRAEL

National/Trans-Tasman Conferences/Meetings

18-21 Oct: HAA, Adelaide

11-13 Nov: ALLG, Melbourne

2010:

17-20 Oct: HAA, Auckland

Regional Meetings/Conferences

NSW

19 Nov - Stem Cell Sources

If you'd like your local events added, please email Angela on angela.booth@gshas.health.nsw.gov.au

News from the regional groups

New Zealand (North Island)

The North Island section of the HSANZ Nurses Group finally had their first education evening in August. We had sixteen attendees who listened to an excellent presentation by Professor John Carter giving an overview of acute leukaemia. The evening was sponsored by Roche with a little help from the Leukaemia and Blood Foundation who very kindly provided a spot prize of a Haematology Nursing text book. The presentation, dinner and venue were all evaluated very positively with the plea for more such evenings to happen. CNE points/hours were awarded from the RCNA.

There will be another meeting held in Wellington in November (date to be confirmed). The topic this time will be on Haemophilia. The plan is for six meetings to be held next year - three in Wellington and three in Palmerston North so that some of our more rural colleagues will be able to attend. The hope is also that someone from the upper North Island will step up and volunteer to do a similar style of programme for nurses in the Auckland/ Waikato region.

Catherine Wood

New Zealand (South Island)

The Christchurch branch of HSANZ NG have raised $700 from selling entertainment books a huge effort thanks to Ali Trengrove one of the branch committee members. Another $500 was raised from a Hypnotist night. This was a fun evening and well supported. These funds are used to support nurses to attend conferences and any study days they wish to attend.

Due to heavy workloads over the winter months and low staffing levels relating to sick leave we have had to postpone the education evenings but we hope to get these up and running again shortly. There are now five Nurses travelling from Christchurch to attend the HSANZ conference in Adelaide so see you all there!

Jane Worsfold

South Australia/Northern Territory

The SA/NT group are very much looking forward to the upcoming HAA meeting which is almost upon us.

We have not had the opportunity for a meeting since the last newsletter but have kept people updated through our e-mail lists with educational opportunities and other items of interest to haematology nurses. If you would like to be included in this mailing list feel free to get in touch! allan.hayward@health.sa.gov.au We are currently planning another education session to occur before the end of the year.

Meanwhile, we hope to see as many of you as possible at the HAA meeting here in Adelaide!

Allan Hayward

WA

The inaugural HSANZ Nurses Group Meeting in WA was held on the 31st August 2009. Nurses from both the public and private sector attended the meeting at the Cancer Council, Crawford Lodge. The response for a WA haematology interest group is encouraging. We are currently forming a committee to promote haematology nursing throughout the State. We hope to have 3 to 4 sponsored clinical seminars per year. Due to the extensive geographical area of WA we will have videoconferencing facilities at our seminars to attract rural nurses interested in haematology nursing.

Cassi Sprague

NSW

NSW continues to host 5 educational dinner meetings a year. Next meeting is November 19th - subject: Stem Cell Sources. The April meeting in Gosford was a resounding success and next year the group is planning a meeting in Gosford again and a meeting Wollongong with the remainder being held in Sydney. The topics continue to cover a broad range of genres including ethics and patient perspectives as good old science and medicine.

Sponsorship will continue to be sought and provided by Pharmaceutical Industry which the group gratefully acknowledge.

Moira Stephens

Hodgkins Lymphoma Research Project

Are you an HSANZ Nurses Group Member and interested in participating in a research project?

Long-Term Follow Up of Hodgkin Lymphoma Survivors:

An Australian and New Zealand Patterns of Care Study. : ALLG HD9

Investigators: Eng-Siew Koh, Andrew Wirth, John Seymour, Michael Barton.

This project aims to assess the variability in current patterns of care of long-term survivors of Hodgkin lymphoma across Australia and New Zealand. A further study objective is to explore current and potential surveillance strategies for treatment-related late effects.

This research is being conducted by cancer clinicians from the Collaboration for Cancer Outcomes Research and Evaluation (CCORE), University of New South Wales, the *Peter MacCallum Cancer Centre*, and is endorsed by the *Australasian Leukaemia and Lymphoma Group* (ALLG).

The study is in the format of an on-line survey sent to health professionals who manage Hodgkin survivors The survey takes approximately 10-15 minutes to complete and is also available in hard copy.

The study is currently open to members of the following professional groups:

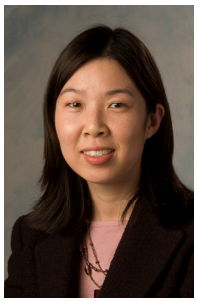
- Haematology Society of Australia & New Zealand (HSANZ) – Medical and Nursing Groups,
- The Faculty of Radiation Oncology (RANZCR),
- Lymphoma Network New Zealand,
- New Zealand Association of Cancer Specialists (NZACS),
- Medical Oncology Group of Australia (MOGA),

If you would like to participate go to:

http://www.surveymonkey.com/s.aspx?sm=khhXz8c84amkZNo1S2SNeg_3d_3d

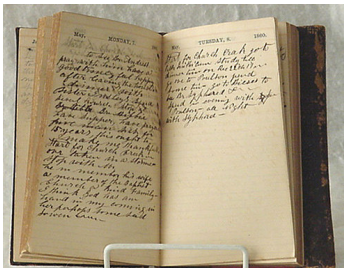
For further information, please contact Dr Eng-Siew Koh, Radiation Oncologist, on telephone 02 9828 6541 or email eng-siew.koh@sswahs.nsw.gov.au.

ALLG
AUSTRALASIAN LEUKAEMIA & LYMPHOMA GROUP



CCORE
Collaboration for Cancer Outcomes Research and Evaluation

Research News – a short trip around some recent journals



Treatment of chronic myeloid leukemia following imatinib resistance: a nursing guide to second-line treatment options.

Bauer S, **Romvari E**. Clin J Oncol Nurs. 2009 Oct;13(5):523-34.

The introduction of the BCR-ABL inhibitor imatinib revolutionized the treatment of patients with chronic myeloid leukemia (CML). However, resistance to imatinib has become a clinically significant issue, limiting its long-term efficacy. Numerous mechanisms have been associated with imatinib resistance, including mutations to the BCR-ABL gene, increased production of BCR-ABL, and activation of BCR-ABL-independent pathways (e.g., SRC-family kinases [SFKs]). Resistance to imatinib has driven the development of second-line therapies, such as dasatinib, a dual BCR-ABL/SFK inhibitor more potent than imatinib at targeting BCR-ABL. Dasatinib is approved for the treatment of patients with imatinib-resistant and -intolerant CML and Philadelphia chromosome-positive acute lymphoblastic leukemia. Nilotinib, an analog of imatinib, more potent than its parent compound, is another approved agent for patients with imatinib-resistant or -intolerant CML in the chronic or accelerated phase. Nurses must be aware of what constitutes a requirement for treatment change and the mechanisms of resistance that inform the choice of second-line agents. Oncology nurses also must ensure that patients have been educated appropriately to understand imatinib resistance and second-line treatment options. This article explores the mechanisms and identification of resistance and treatment options for when resistance occurs, as well as nursing implications.

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Defining the scope of haematology nursing practice in Europe.

Aerts E, Fliedner M, Redmond K, Walton A. Med Lett Drugs Ther. 2009 Feb 9; 51 (1305):10-1

PURPOSE: The changing role of haematology nurses has never been mapped systematically which makes it difficult to plan practice development initiatives in a strategic manner. METHOD: A survey was conducted to gain insight into the role of European haematology nurses and identify their learning needs. RESULTS: Two hundred and seventy one questionnaires were completed by nurses from 25 countries, most of who were unit-based clinical nurses (116, 43%), had 10years or more of experience in haematology (56%) and no specialist qualification (65%). The most common professional activities undertaken involved the detection and management of side effect. Respondents believe that they are well trained, possess good communication skills and play a key role within the multidisciplinary team. However, a small but significant number of nurses indicated that they had a limited role to play in patient education (42%) and only 38% (102) agreed that they played an important role in facilitating patient choice. Lack of time, limited course availability and staff shortages are perceived as key barriers to developing practice. CONCLUSIONS: Nurses are most interested in receiving further education about graft versus host disease and late effects of treatment. The knowledge component of the questionnaire revealed numerous deficits. Demographic factors such as role and experience had a significant influence on responses.

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Research priorities for haemato - oncology nursing: results of a literature review and a Delphi study.

Grundy M, **Ghazi F**. Eur J Oncol Nurs. 2009 Sep;13(4):235-49. Epub 2009 Apr 14. PURPOSE: The study aimed to review the nursing haemato-oncology literature followed by a Delphi study to determine research priorities of UK nurses working in haemato-oncology. METHODS AND SAMPLE: The review analysed relevant literature from 1996-2008. In the Delphi study, all members of the Royal College of Nursing (UK), Haematology and Bone Marrow Transplant Forum (n=1444) were invited to participate. Data were collected in three sequential rounds of postal questionnaires. Research topics identified in round 1 were used to compile subsequent questionnaires. KEY RESULTS: A final list of 33 research priorities was identified. Clear research themes emerged from the data including chemotherapy, psychosocial issues and information giving, psychological support needs of nurses, ethical considerations and palliative care, nurse-led services and guidelines. CONCLUSIONS: Results show both similarities and differences to priorities identified in previous haemopoietic stem cell transplant and cancer nursing studies. Further exploration of priority areas is required but priorities identified in this study provide a good starting point for further exploration and development of research programmes.

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Patient-related barriers to fatigue communication in cancer patients receiving active treatment.

Shun SC, Lai YH, Hsiao FH. Oncologist. 2009 Sep;14(9):936-43. Epub 2009 Sep 8.

OBJECTIVE: To explore barriers to reporting fatigue in cancer patients receiving active treatment and the significant factors associated with those barriers from fatigue characteristics (i.e., intensity, duration, and interference with daily life), to demographic characteristics and disease/treatment variables. METHODS: Patients with various types of cancer (n = 288) were recruited from an outpatient chemotherapy center, and from seven oncology and hematology units in a teaching hospital in northern Taiwan. Data were collected using the Fatigue Management Barriers Questionnaire to explore barriers to fatigue communication. RESULTS: Fear of distracting the doctor was rated as the highest barrier of reporting fatigue. The degree of fatigue interference with daily life by patients was associated with the willingness to report fatigue. Patients with gastrointestinal cancer experienced more barriers to reporting fatigue than those with hematological cancer. Patients without religion

perceived the highest level of barriers to fatigue communication. Outpatients had higher levels of concern than inpatients. CONCLUSIONS: Discussion with patients about their high level of perceived fatigue barriers before implementing patient education is recommended. Assessing fatigue interference with daily life and identifying factors associated with barriers to reporting fatigue (i.e., type of cancer, religion, and the setting for receiving treatment) are suggested in order to provide better fatigue management in clinical settings.

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The impact of dry versus moist heat on peripheral IV catheter insertion in a hematology-oncology outpatient population.

Fink RM, Hjort E, Wenger B, Cook PF, Cunningham M, Orf A, Pare W, Zwink J. Oncol Nurs Forum. 2009 Jul;36(4):E198-204.

PURPOSE/OBJECTIVES: To determine whether dry versus moist heat application to the upper extremity improves IV insertion rates. DESIGN: Two-group, randomized, controlled clinical design. SETTING: An academic cancer infusion center in the western United States.Sample: 136 hematologic outpatients with cancer or other malignancies. METHODS: Participants were randomly assigned to dry or moist heat with warmed towels wrapped around each patient's arm for seven minutes prior to IV insertion. Skin and room temperatures were monitored pre- and postwarming. Two experienced chemotherapy infusion nurses performed the venipunctures according to protocol. Outcomes were examined using variance analysis, with 34 patients for each combination of nurse and heat type. MAIN RESEARCH VARIABLES: Number of IV insertion attempts, time to achieve IV insertion postheating, patient anxiety levels pre- and postheating, and patient comfort. Findings: Dry heat was 2.7 times more likely than moist heat to result in successful IV insertion on the first attempt, had significantly lower insertion times, and was more comfortable. Heat type had no effect on patient anxiety. CONCLUSIONS: Dry heat application decreases the likelihood of multiple IV insertion attempts and procedure time and is comfortable, safe, and economical to use in an outpatient oncology setting.

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Phase III prospective randomized double-blind placebo-controlled trial of plerixafor plus granulocyte colony-stimulating factor compared with placebo plus granulocyte colony-stimulating factor for autologous stem-cell mobilization and transplantation for patients with non-Hodgkin's lymphoma.

DiPersio JF, Micallef IN, Stiff PJ, Bolwell BJ, Maziarz RT, Jacobsen E, Nademanee A, McCarty J, Bridger G, Calandra G; 3101 Investigators. J Clin Oncol. 2009 Oct 1;27 (28):4767-73.

PURPOSE: This study evaluates the safety and efficacy of plerixafor (AMD3100), a CXCR4 antagonist, in mobilizing hematopoietic stem cells for autologous stem-cell transplantation in non-Hodgkin's lymphoma (NHL) patients. PATIENTS AND METHODS: This is a phase III, multicenter, randomized (1:1), double-blind, placebo-controlled study. Patients with non-Hodgkin's lymphoma requiring an autologous hematopoietic stem-cell transplantation in first or second complete or partial remission were eligible. Patients received granulocyte colony-stimulating factor (G-CSF; 10 microg/kg) subcutaneously daily for up to 8 days. Beginning on evening of day 4 and continuing daily for up to 4 days, patients received either plerixafor (240 microg/kg) or placebo subcutaneously. Starting on day 5, patients began daily apheresis for up to 4 days or until > or = 5 x 10(6) CD34+ cells/kg were collected. The primary end point was the percentage of patients who collected > or = 5 x 10(6) CD34+ cells/kg in 4 or fewer apheresis days. RESULTS: This report presents all data for all patients (n = 298) through 12 months follow-up. Eighty-nine (59%) of 150 patients in the plerixafor group and 29 (20%) of 148 patients in the placebo group met the primary end point (P < .001). One hundred thirty-five patients (90%) in plerixafor group and 82 patients (55%) in placebo group underwent transplantation after initial mobilization. Median time to engraftment was similar in both groups. The most common plerixafor-associated adverse events were GI disorders and injection site reactions. CONCLUSION: Plerixafor and G-CSF were well tolerated and resulted in a significantly higher proportion of patients with non-Hodgkin's lymphoma achieving the optimal CD34+ cell target for transplantation in fewer apheresis days, compared with G-CSF alone.

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Five-step model of professional excellence.

Marble SG. Clin J Oncol Nurs. 2009 Jun;13(3):310-5.

The bone marrow transplantation program at Banner Good Samaritan Medical Center in Phoenix, AZ, has successfully developed and implemented a process model using the theory of Novice to Expert for the education of its nurses. The five-step model of excellence provides a fluid and individualized framework for the professional development of the healthcare providers working in the oncology program and a method to measure progress. In addition, the requirements for education and a method to measure progress are clear for nurses who would be considered experts in the unit. As a result of the implemented process model, 65 of 96 RNs (68%) met the criteria for expert compared to 18% prior to the implementation, 58 of 79 RNs (73%) are oncology certified (OCN) compared to 24% prior to implementation, and 42 of 96 RNs (44%) are mentors compared to 19% prior to implementation. The five-step model has helped foster a culture of staff and leadership development with engaging, motivating, and high-performing work groups that promote career progression within the workforce.

Tea Room Guru

Dear TRG ,

A patient of ours had a serious bout of acute respiratory distress recently, a couple of hours after a blood transfusion and ended up in ICU very quickly. One person said that the patient had pneumonia before and nobody had noticed, someone else said the blood was given too fast and the CNC said that it was TRALI or Trolley – and then she ran off, said she was busy or had a life to save or something ? What is TRALI??

TRALI is Transfusion Related Acute Lung Injury and is caused by donor antibodies that react with the recipient's white cells or vice versa. The lungs fill with a high-protein fluid and the patient displays acute respiratory insufficiency with their x-ray showing bilateral symmetric pulmonary oedema, often described as a "white out".

The patient is suddenly acutely unwell with dyspnoea, cyanosis, tachycardia, and hypoxemia. They become very frightened and distressed, as does the nurse and any family members in the vicinity. It is quite rare but is being increasingly recognized/reported. It occurs in about 1 in 5,000 transfusions, most frequently with FFP/cryosupernate, then PRC, then Platelets. It has been seen, albeit rarely, following Whole Blood, Cryoprecipitate and IVIgG infusions also.

Symptoms occur within 2 hours and PO_2 levels usually return to pre-transfusion levels within 48 -96 hours and CXR returns to normal within 96 hours. It is, however, it is a serious condition that requires prompt recognition as TRALI is associated with a high morbidity with the majority of patients requiring ventilatory support. Although the lung injury is generally transient TRALI is associated with a significant mortality rate, often approximated at 5 to 10%. Due to the good news of significant gains in safety made within the blood component production industry, particularly with respect to transmission of infectious diseases, TRALI is now among the three leading causes of transfusion related fatalities along with ABO incompatibility and bacterial contamination.

Treatment of TRALI is supportive. Mild forms of TRALI may respond to oxygen therapy but if severe patients often require mechanical ventilation and ICU support. Steroids used to be the treatment of choice, often with little effect and now, as with acute respiratory distress syndrome (ARDS) it is thought that there is no role for corticosteroids or for diuretics. The majority of patients recover within 72 to 96 hours and subsequently recover to their baseline pulmonary function without apparent after effects, apart from anxiety and fear to be expected following such a sudden, severe and unanticipated event. However, some people are slower to recover and may remain hypoxic with persistent pulmonary infiltrates up to seven days and for approximately 5 to 10% of people, it is fatal in spite of aggressive supportive care.

The Canadian Blood Service (CBS) has adopted the definition put forth by the Canadian Consensus Conference Panel on TRALI as outlined below This definition is applied consistently to all cases of TRALI reported to CBS and is used to determine whether reported cases will be investigated.

Table 1: Canadian Consensus Conference Panel TRALI definitions

Term	**Definition**
TRALI	Acute lung injury (defined below) occurring within 6 hours of completion of transfusion of blood component. No pre-existing acute lung injury. No other temporally associated risk factors for acute lung injury (see below).
Possible TRALI	Acute lung injury (defined below) occurring within 6 hours of completion of transfusion of blood components. No pre-existing acute lung injury. One of more temporally associate risk factors for acute lung injury.

Table 2: Definition of Acute Lung Injury (ALI)

Term	**Definition**
Acute Lung Injury	New onset Hypoxemia SpO2 <90% or Pa02/Fi02 < 300 mm Hg on room air, or other clinical evidence of hypoxemia Bilateral infiltrates on frontal chest X-ray

Table 3: Risk Factors for Acute Lung Injury	
Direct Lung Injury	**Indirect Lung Injury**
Aspiration Pneumonia Toxic inhalation Lung contusion Near drowning	Severe sepsis Shock Multiple trauma Burn injury Acute pancreatitis Cardiopulmonary bypass Drug overdose

(http://www.bloodservices.ca/ - accessed 9/10/2009).

Every nurse who administers blood components should have a look at the Australian Red Cross Blood Service (ARCBS) information website here: www.transfusion.com.au/home.aspx and, the really useful manual here: www.manual.transfusion.com.au/Home.aspx Both the Serious Hazards of Transfusion haemo-vigilance organisation in the UK www.shotuk.org/home.htm and the Canadian Blood Services http://209.217.107.132/Web/tmws.nsf/page/TRALI+Main_Page?OpenDocument have many interesting resources available. This is a comprehensive list of pertinent TRALI related articles where the reader may find further information collated by, and with thanks to, the Canadian group:

Recent Reviews

- Chapman CE, Stainsby D, Jones H, Love E, Massey E, Win N, Navarrete C, Lucas G, Soni N, Morgan C, Choo L, Cohen H, Williamson LM. Ten years of hemovigilance reports of transfusion-related acute lung injury in the United Kingdom and the impact of preferential use of male donor plasma. Transfusion. 2008 Oct 28. [Epub ahead of print]
- Silliman CC, McLaughlin NJ. Transfusion-related acute lung injury. Blood Reviews 2006; 20(3):139-59.
- Silliman CC, Ambruso DR, Boshkov LK. Transfusion-related acute lung injury. Blood 2005; 105(6):2266-73.
- Bux J. Transfusion-related acute lung injury (TRALI): a serious adverse event of blood transfusion. Vox Sanguinis 2005; 89(1):1-10.
- Shander A, Popovsky MA. Understanding the consequences of transfusion-related acute lung injury. Chest.2005; 128(5 Suppl 2):598S-604S.

Definition/Consensus articles

- Toy P, Popovsky MA, Abraham E, Ambruso DR, Holness LG, Kopko PM, McFarland JG, Nathens AB, Silliman CC, Stroncek D; National Heart, Lung and Blood Institute Working Group on TRALI. Crit Care Med. 2005;33(4):721-6.
- Kleinman S, Caulfield T, Chan P, Davenport R, McFarland J, McPhedran S, Meade M, Morrison D, Pinsent T, Robillard P, Slinger P. Toward an understanding of transfusion-related acute lung injury: statement of a consensus panel. Transfusion. 2004;44(12): 1774-89.
- Skeate RC, Eastlund T. Distinguishing between transfusion related acute lung injury and transfusion associated circulatory overload. Current Opinion in Hematology. Nov 2007; 14(6):682-687.
- Gajic O, Gropper MA, Hubmayr RD. Pulmonary edema after transfusion: How to differentiate transfusion-associated circulatory overload from transfusion-related acute lung injury. Crit Care Med. 2006;34(5) Suppl:S109-S113.

Pathophysiology of TRALI

- Silliman CC, Curtis BR, Kopko PM, et al. Donor antibodies to HNA-3a implicated in TRALI reactions prime neutrophils and cause PMN-mediated damage to human pulmonary microvascular endothelial cells in a two-event in vitro model. Blood. 2007;109(4): 1752-1755.
- Curtis BR, McFarland JG. Mechanisms of transfusion-related acute lung injury (TRALI): anti-leukocyte antibodies. Critical Care Medicine. 2006; 34(5 Suppl):S118-23.
- Silliman CC. The two-event model of transfusion-related acute lung injury. Critical Care Medicine. 2006; 34(5 Suppl):S124-31.
- Toy P, Hollis-Perry KM, Jun J, Nakagawa M. Recipients of blood from a donor with multiple HLA antibodies: a lookback study of transfusion-related acute lung injury. Transfusion. 2004 Dec; 44(12): 1683-8.
- Kopko PM. Leukocyte antibodies and biologically active mediators in the pathogenesis of transfusion-related acute lung injury. Curr Hematol Rep. 2004 Nov;3(6): 456-61.
- Silliman CC, Bjornsen AJ, Wyman TH, Kelher M, Allard J, Bieber S, Voelkel NF. Plasma and lipids from stored platelets cause acute lung injury in an animal model. Transfusion. 2003 May; 43(5): 633-40.
- Silliman CC, Boshkov LK, Mehdizadehkashi Z, Elzi DJ, Dickey WO, Podlosky L, Clarke G, Ambruso DR. Transfusion-related acute lung injury: epidemiology and a prospective analysis of etiologic factors. Blood. 2003; 101(2): 454-62

Prevention/Donor Management

- Engelfriet CP, REesink HW, Wendel S et al. Measures to prevent TRALI. Vox Sang 2007; 92 (3): 258-77.
- AABB association bulletin #05-09
- AABB association bulletin #06-07

For Nurses

- Knippen MA. Transfusion-related acute lung injury. Am J Nursing. 2006;106(6):61-4

I hope this helps. Sincerely yours, TRG

The Royal Melbourne Hospital

Bone Marrow and Haematopoietic Stem Cell Transplants

8.30 am - 5.00 pm
Charles LaTrobe Theatre
The Royal Melbourne Hospital
Grattan St
Parkville, VIC, 3052

17 & 18 November 2009

About the Course
The Bone Marrow Transplant short course was developed to meet the learning needs of nurses caring for patients undergoing bone marrow or peripheral stem cell transplantation.

Topics include

- Overview of Haemopoiesis and Immunosuppression
- The history of Bone Marrow Transplants
- Tissue Typing
- Clinical Indications and selection of BMT
- Infectious Disease Issues in BMT
- Role of the BMT Coordinator and the BMT donor search coordinator
- Complications of BMT including: Sexuality Issues, Symptom Management, Mucositis Management, Total Body Irradiation Management, Psychosocial/Ethical Issues, Nutrition Management, Fatigue and its Impact, Graft versus Host Disease (GVHD)
- From Cure to Palliation
- Going Home after a BMT/Role of the Ambulatory Day Care Centre
- Research in Bone Marrow Transplant field

To Register
Please complete the registration section below.
Registrations close:
Friday, 06 November, 2009

Course fees

External Applicants:	$260.00
Melbourne Health Employees:	$100.00

Lunch and refreshments provided.

For more information about the clinical content of this course, contact:
Jo-Anne Martin
Clinical Nurse Educator
Ph: 03 9342 7000 pager: 7343
Email: joanne.martin@mh.org.au

For registration and payment queries, contact:
Short Course Administration
Ph: 03 9342 4981
Fax: 03 9342 4970
Email: shortcourse@mh.org.au

Conditions: Please make cheques/money orders payable to: 'Nursing Education Services, RMH'. The fee is not refundable and must be paid prior to course commencement. The Royal Melbourne Hospital reserve the right to cancel any course should attendee numbers be insufficient. A full refund will be given, should a course be cancelled. SEND REGISTRATION TO: Nursing Education Services. The Royal Melbourne Hospital, c/o Post Office, Parkville, VIC, 3050. telephone: 0393424981 fax: 03 93424970 or email: shortcourse@mh.org.au. *Please note: All correspondence regarding confirmations and course details will ONLY be communicated by email. Please ensure the email address provided is one that is checked regularly.

Registration Form - Please PRINT clearly.

Name: _____

Tel (BH): _____

Email address*: _____

Current employer: _____

Ward/Unit: _____

Melbourne Health employee: YES / NO (please circle)

Payment Method

☐Cheque ☐Money Order ☐Mastercard ☐Visa ☐Other

CASH IS NOT ACCEPTED

Amount: (please circle) $100.00 $260.00

Credit card number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Cardholder name: _____

Cardholder signature: _____

Expiry date: _ _ / _ _ _ _ (mm/yyyy)

Nurse Unit Manager/Manager Approval (required for Melbourne Health employees only)

Course participation approved by: Name: _____ Signature: _____ Date: ___ / ___ / 2009

BONE MARROW TRANSPLANT 2009

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