HSANZ NG News Feb 2011

Volume 5, Issue 1

HAEMATOLOGY SOCIETY OF AUSTRALIA AND NEW ZEALAND NURSES GROUP

HSANZ NG News Volume 5 Issue 1

From the president

Dear members and colleagues,

I recently looked back through my filing and found my editorial piece for February 2009 – in this short piece I talked about the haematological implications of the terrible bush fires in Victoria. Unfortunately, again this summer, we have other disasters – namely devastating flooding in Queensland with other states affected by rising waters. Our thoughts are with you. One health concern with haematological implications in Queensland is that of Dengue fever. Dengue fever is a mosquito borne virus. In July and August of last year there were outbreaks of Dengue fever in Cairns and Townsville surrounds. The concerns of health officials are that the large quantities of extra water lying around may provide breeding grounds for mosquitoes, one of which, the Dengue Mosquito, carries the virus. Dengue mosquitos, however, prefer to live indoors and around the house. They don't like to travel far and bite during the day.

Dengue mosquitoes are common in Queensland but usually do not carry dengue. A female mosquito can only become infected with dengue after biting an infected human who is viraemic with dengue (ie. there are enough dengue virus particles in the person's blood to infect a mosquito).
An infected person can transmit dengue to mosquitoes at home, at work or anywhere they visit. This can happen within 3-4 days of being bitten and can continue to up to 12 days.

Dengue haemorrhagic fever (DHF) is a haemorrhagic disease which can cause the following haemostatic changes; vascular changes; thrombocytopenia and; disorders of coagulation. Patients with Dengue Shock Syndrome (DSS) and some with just DHF but not in shock have disseminated intravascular coagulation (DIC) with its thrombocytopenia, prolonged partial prothrombin time (PTT), decreased fibrinogen levels and increased fibrinogen degradation product levels (FDP). Management is thus aimed at reversing the coagulopathies, or indeed, preventing the DIC in addition to early recognition of DHF , fluid, electrolyte and plasma replacement. There is much information available on the Queensland Health and WHO resource pages below.

This issue of the News has been edited by Tracy King and Allan Hayward as Angela has taken a well earned break from editing. A task that she has been doing alone for the first four volumes of this illustrious newsletter – and, when I look back I can see how much it has grown in both quantity and quality. The next step is our own Journal and some of you may know that we have been talking to a publishing company about this. We are hoping to launch 'Haematology Nursing' in November this year – but there remains a lot of work to be done to that end. You will see a call for expressions of interest in this edition – have a think about it. Both the editorial board and the panel of reviewers is a great way to gain experience in writing for yourself, you get to see very early editions of papers! And, this is something that you can list on your CV.

Also in this edition, we have published the results of the educational needs survey that many of you completed – we have acted on some aspects and others are works in progress.

Enough from me, have a great 2011 and I look forward to seeing and hearing from you,

Moira Stephens

February 10th 2011

http://www.health.qld.gov.au/dengue/dengue_fever/disease.asp

http://www.who.int/csr/resources/publications/dengue/Denguepublication/en/

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Join the HSANZ Nurses Group

The HSANZ Nurses Group is attracting new members all the time, why don't you consider joining this professional organisation too!

Benefits of HSANZ associate nurse membership

The HSANZ Nurses' Group (NG) strives to provide educational support and a network forum for nurses specialising in haematology or working with haematology patients across Australia.

The benefits of becoming an associate member of the HSANZ nurses group:

- State based education sessions
- Access to members area of the HSANZ website
- Journal of Clinical Oncology (online)
- ASH Hematology Education program (online)
- Access to grants and awards
- Network with other nurses in Australia and New Zealand
- Nurses group quarterly newsletter
- Reduced registration cost for the annual scientific meeting

More information can be found online at:

http://www.hsanz.org.au/news/HSANZ-NG.cfm

Myeloma Learning Program

The on line 'Myeloma Nurse Learning Program' successfully receives RCNA accreditation for nurses within Australia.

The Myeloma Nurse Learning Program has been endorsed by APEC number 081219123 as authorised by Royal College of Nursing, Australia according to approved criteria. Completion of the full program attracts ***170*** RCNA Continuing Nurse Education (CNE) points as part of RCNA's Life Long Learning Program (3LP). Nurses are able to access this valuable learning resource online and work through it in their own time. Upon completion they will receive a certificate of completion, awarding them 170 RCNA CNE points to go towards their continued professional development . www.magicfornurses.co.uk

The Myeloma Foundation of Australia Inc.

Lymphoma Education Day

SAVE THE DATE !

After the success of last years Myeloma Day, SSWAHS Haematology Nurses will be holding a Lymphoma Education Day on May 16th, 2011 at Concord Hospital.

Lymphoma currently affects millions of people worldwide, for your oppurtunity to hear the latest updates on the treatment and management of Lymphoma, why not register your interest to the below contact details.

For Further Information Contact Shiraz Abdulla

Tel: 02 9767 5000 **Pager:** 60250 **E:** shiraz.abdulla@sswahs.nsw.gov.au

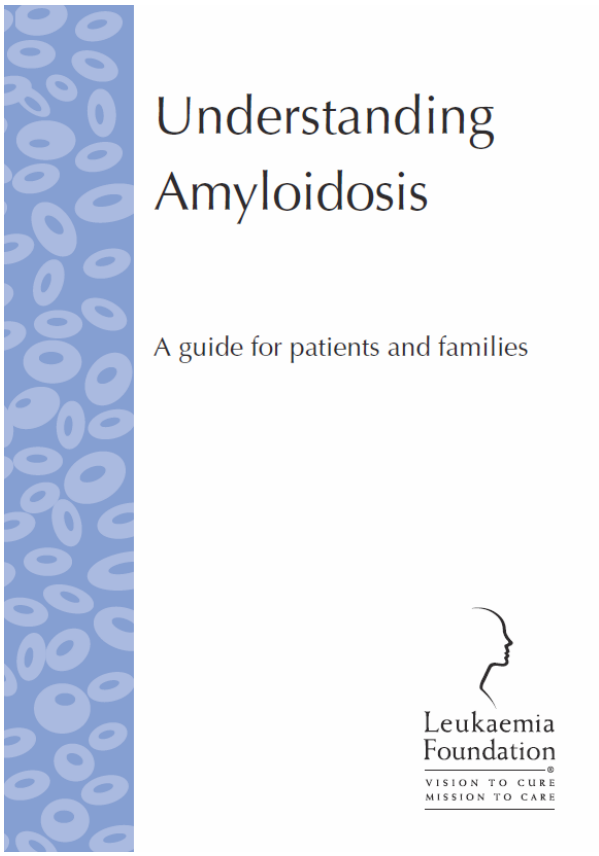
New Amyloidosis booklet

The Leukaemia Foundation have added a new booklet "Understanding Amyloidosis" to their series on leukaemia, lymphomas myeloma and other related blood disorders. Copies of the booklet can be obtained through any office of the Leukaemia Foundation and will soon be available on line through the Leukaemia Foundation web site at www.**leukaemia**.org.au

Amyloidosis is a general name given to a group of rare, very serious diseases in which an abnormal protein known as amyloid is produced. These amyloid protein fibrils progressively deposit and accumulate in organs and tissues of the body, disrupting normal function. Without treatment the outlook for the patient is often bleak.

Once an absolute diagnosis is made through a biopsy, world experience shows that Amyloidosis is best treated by a team of specialists. Depending on the organ damage these may include cardiologists, haematologists, renal physicans, gastroenterologists and neurologists. World experience also shows that early diagnosis is a major factor influencing a good prognosis. Sadly, many patients still visit a number of specialists before a correct diagnosis is made.

This booklet has been written to help patients and families gain a better understanding of their disease but it is also hoped that it may help to raise awareness amongst doctors and other health professionals about this complicated group of diseases



Patricia Neely
Consultant, Amyloidosis Services, Leukaemia Foundation of Australia
Email: PNeely@leukaemia.org.au

Lymphoma Patient Seminar

Lymphoma Seminar for Patients and Carers

Lymphoma Australia will be holding a Lymphoma Patient and Carer Symposium on Friday the 4th of March, 2011 in Sydney and it would be greatly appreciated if patients were advised about this event during hospital and clinic visits.

The patient Symposium coincides with a national blood cancer meeting for clinicians which will mean access to a great range of speakers for the attendees.

Attendees can register on our website at any time www.lymphoma.org.au

If you would like to have additional information about this and /or would like to have the posters etc sent to you directly please email me,

Sharon Millman at Lymphoma Australia.

E: sharon.m@lymphoma.org.au

T: 1800 359 081

Sharon Millman
CEO
Lymphoma Australia
Mobile 0431 483 204

HAA-ISPHAD 2011 Sydney, Aust.

2011 JOINT SCIENTIFIC MEETING **30 OCTOBER - 2 NOVEMBER 2011** Sydney Convention & Exhibition Centre, Darling Harbour, Sydney, Australia

[Invitation to Attend] [Programme] [Speakers] [Abstracts, Awards & Travel Grants] [Registration] [Accommodation] [General Tourism] [General Information] [Sponsorship & Exhibition] [Email registration of interest] [Site map]

Invitation to Attend

Abstracts due	**1 June 2011**
Notification of abstract acceptance	**Late July 2011**
Registration brochure available	**March/April 2011**
Accommodation bookings close	**to be advised**
Early Bird registration closes	**to be advised**

In 2011, the Annual Scientific Meeting and Trade Exhibition of the HAA (Haematology Society of Australia and New Zealand, the Australian & New Zealand Society of Blood Transfusion and the Australasian Society of Thrombosis and Haemostasis) will be held jointly with the XIIth Congress of the ISHAPD (International Society of Hematology, Asia-Pacific Division), the 16th Congress of the APBMT (Asian-Pacific Blood and Bone Marrow Transplantation Group) and the ISCTA (International Society for Cellular Therapy: Australia). This will be one of the largest Haematology conferences ever held in Australia. It is anticipated that approximately 1500-2000 delegates from Australia and the Asia-Pacific region, including clinicians, scientists and nurses, will attend HAA-ISHAPD 2011.

The meeting will cover a comprehensive range of topics including haematological malignancies, stem cell transplantation, transfusion medicine, haemostasis and thrombosis and other non-malignant haematological disorders.

The meeting will again include participation from many other special interest groups including the Australasian Leukaemia and Lymphoma Group and the Bone Marrow Transplant Scientists Association of Australasia.

HAA-ISHAPD 2011 will be held at the Sydney Convention & Exhibition Centre, darling harbour, Sydney, Australia from 30 October to 2 November 2011. Set-up for exhibitors will be on Saturday 29 October.

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For ANZSBT

Szu Hee Lee
For ISHAPD

John Rasko
For ISCTA

The HAA annual conference is taking place in Sydney from Sunday 30th October through to Wednesday 2nd November – so, time to start thinking about your abstract….

Here are four criteria to think about when writing your abstract

1. Originality: abstracts containing significant new findings or that present innovative practice will be given higher scores than those that describe updates or modifications to older findings

2. Quality: abstracts that contribute to the knowledge of haematology nursing practice and /or /patient care and demonstrate the use of sound scientific (qualitative or quantitative) methodology or evaluation will be given higher scores.

3. Importance: abstracts that present new information about practice or care, or that add relevance to the broader context framed by the subject heading, will receive higher scores.

4. Presentation: higher scores will be awarded to abstracts that clearly state the specific objectives to be attained, the methods used, the main results, and provide a concise interpretation of the findings or discussion.

New Haematology Nursing Journal

EXPRESSIONS OF INTEREST

Haematology Nursing

Editorial Board and Reviewer Panel

Editorial Board

Expressions of interest are sought from clinical and academic haematology nurses with writing experience at the post-graduate level and an interest in publishing, to join the Editorial Board of the new journal Haematology Nursing.

Successful applicants will serve a 2 year term of office, commencing 1 June 2011, and will be responsible for:

- peer review of manuscripts
- assisting the Editors in planning content for future editions of the journal
- assisting with the development of resources and educational activities to promote writing skills amongst HSANZ Nurses' Group members
- providing a written editorial for specific editions when requested by the Editors
- reviewing final proofs of the journal before printing

It is anticipated that the individual commitment will be no more than:

- 2 teleconferences per year
- review of 2 manuscripts per year
- writing 1 editorial per year
- proof reading 1 edition per year

Review Panel

Expressions of interest are sought from financial members of HSANZ NG who are clinical or academic nurses with some post graduate education and an interest in publishing, to join the Review Panel for the new journal Haematology Nursing. The journal will be published twice a year and it is anticipated that it will be launched in November this year.

A resource pack about manuscript review will be provided and new reviewers may be mentored (if they wish) by a more experienced reviewer or a member of the editorial board.

Successful applicants will serve a 2 year term of office, commencing 1 June 2011, and will be responsible for:

- peer review of manuscripts
- promoting writing skills amongst HSANZ Nurses' Group members

It is anticipated that the individual commitment will be no more than:

- review of 2 - 4 manuscripts per year

Expressions of interest, outlining relevant experience and including a brief curriculum vitae should be forwarded by email to:

Moira Stephens

Email: moira.stephens@sydney.edu.au

Closing date 4th March 2011.

BMT Network NSW News

February 9 will see the recommencement of the BMT Network monthly webcasts. The February presentation will be Dr Nicky Gilroy talking about "The Management of Neutropaenic Fevers and the Diagnosis and Management of Fungal Infections". The webcasts are live on the first or second Wednesday of each month at 2pm. Following this they are available for download to view and listen to in your own time; you only need to be registered with the website. Registering with the website is easy, just log on to www.bmtnsw.com.au and click on the registration button on the right hand site. The website also has a nurse's forum where you can post questions on anything and with over 300 nursing members from across the world you're sure to get an answer.

Blood and Marrow Transplant Network NSW

December saw the release of the State-wide Plan for BMT across NSW; this plan has been a number of years in the making and has involved nurses and doctors from all over the State. The plan outlines directions for BMT up to the year 2016, and is available for download from the NSW Health website.

The BMT network is still looking for one or two nurses to work on our Long-Term Follow Up project. The project is funded for 18 months and will involve working with clinicians at one of the four allogeneic centres in NSW to follow up patient who have undergone BMT. To apply for the post you should have experience in allogeneic transplants and a can do attitude, secondment in to the post is a possible option. For further details on this post or any other BMT Network issues please contact

2011 dates for your diary

National/Trans-Tasman Conferences/Meetings

3-6 May: ALLG, Melbourne, Australia
http://www.allg.org.au/

16 May – Lymphoma Nurses Day, Sydney, Australia
shiraz.abdulla@email.cs.nsw.gov.au

25-30 Oct: ANZCHOG 2011, Auckland, New Zealand
http://www.anzchog.org/

29 Oct: Haematology Nurses Pre HAA Study Day, Sydney, Australia
Further enquiries or to register interest: tracy.king@sswahs.nsw.gov.au

30 Oct-2 Nov: HAA 2011, Sydney, Australia
http://www.haa-ap2011.org/

8-11 Nov: ALLG, Brisbane, Australia http://www.allg.org.au/

International Conferences

3-6 Apr: EBMT, Paris, France
http://www.congrex.ch/ebmt2011/

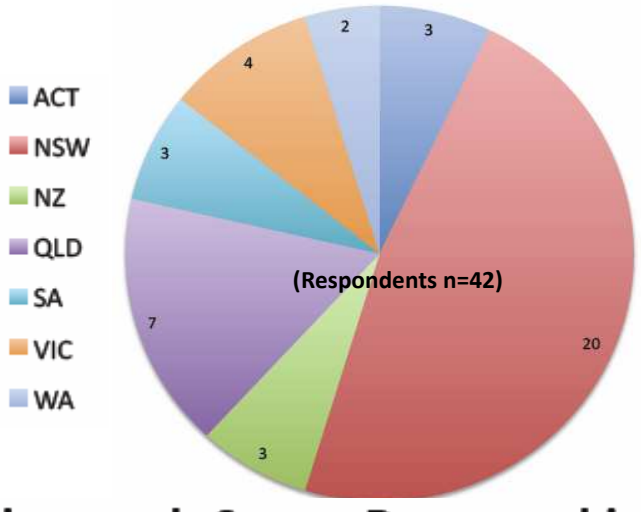
3-6 May: International Myeloma Workshop, Paris, France
www.myeloma-Paris2011.com

9-12 Jun: EHA 2011, London, United Kingdom
http://eha.eurocongres.com/16th/

9-13 Dec: ASH, San Diego, USA
h ttp://www.hematology.org/Meetings/

HSANZ NG Member Survey

Last year the HSANZ Nurses Group surveyed it's members to find out a little more about them and to ascertain their education needs. We have included some of the results of the survey here to share with you. These results have provided important information about who we are and what we would like to get out of the HSANZ Nurses Group. The results of this survey are being used to guide further activities by the HSANZ NG including a haematology nursing pre HAA conference workshop as well as the development of a new journal, Haematology Nursing. If you would like to view the complete survey results, please feel free to contact Moira Stephens via email at moira.stephens@sydney.edu.au

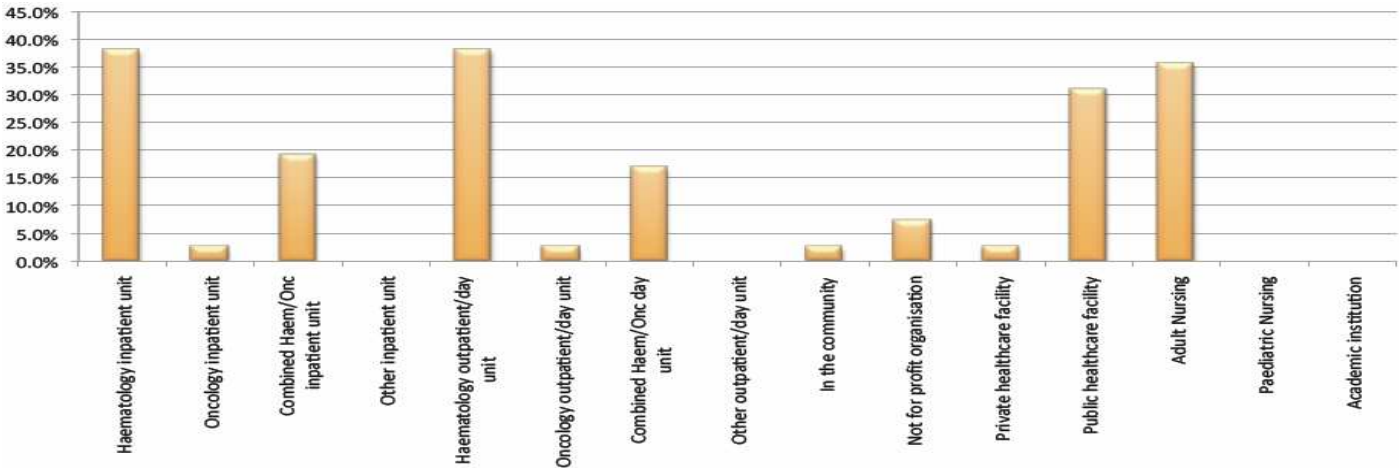


Education needs Survey Demographic

HSANZ NG Member Survey continued

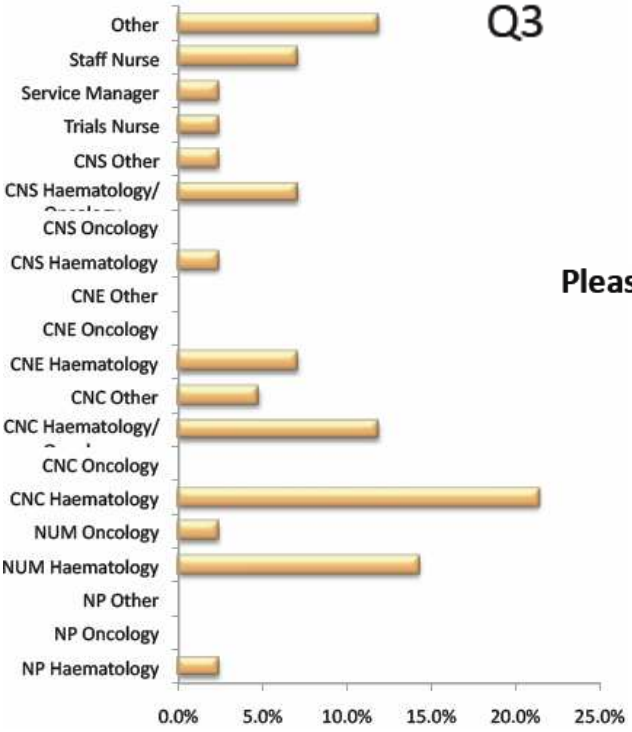
Please check the box that most accurately describes where you mostly work (you may tick more than one)

Q2



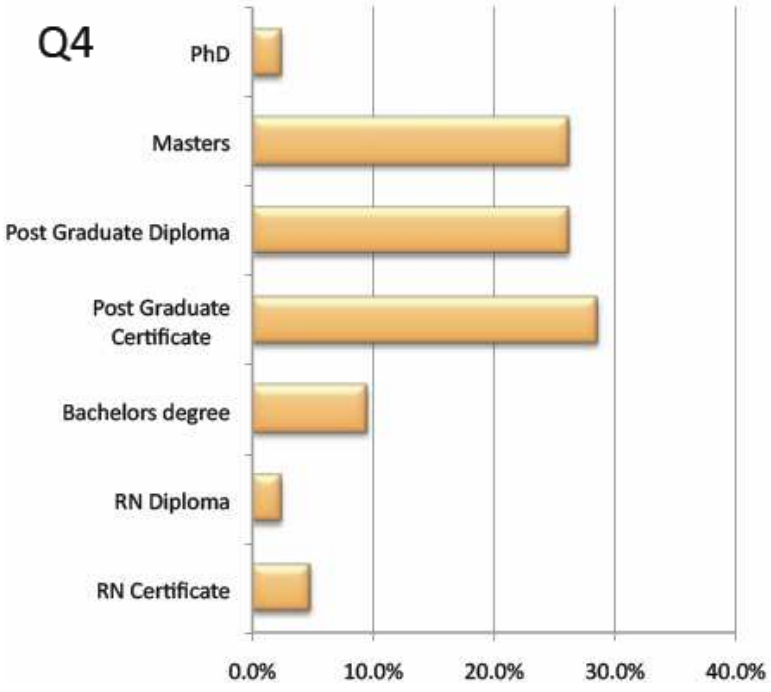
Please check the box which most accurately describes your role

Q3



Please indicate your highest level of qualification to date

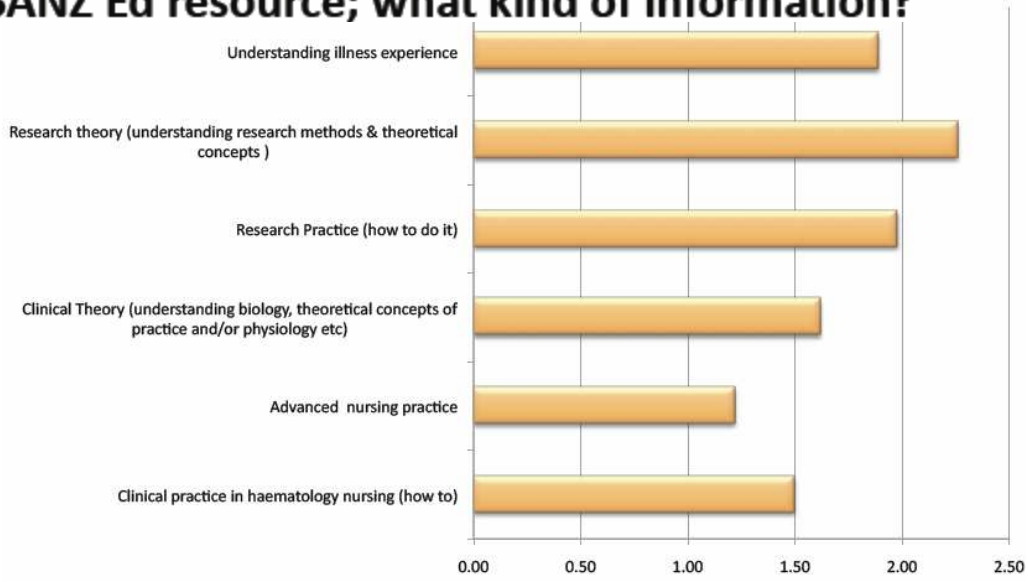
Q4



HSANZ NG Member Survey continued

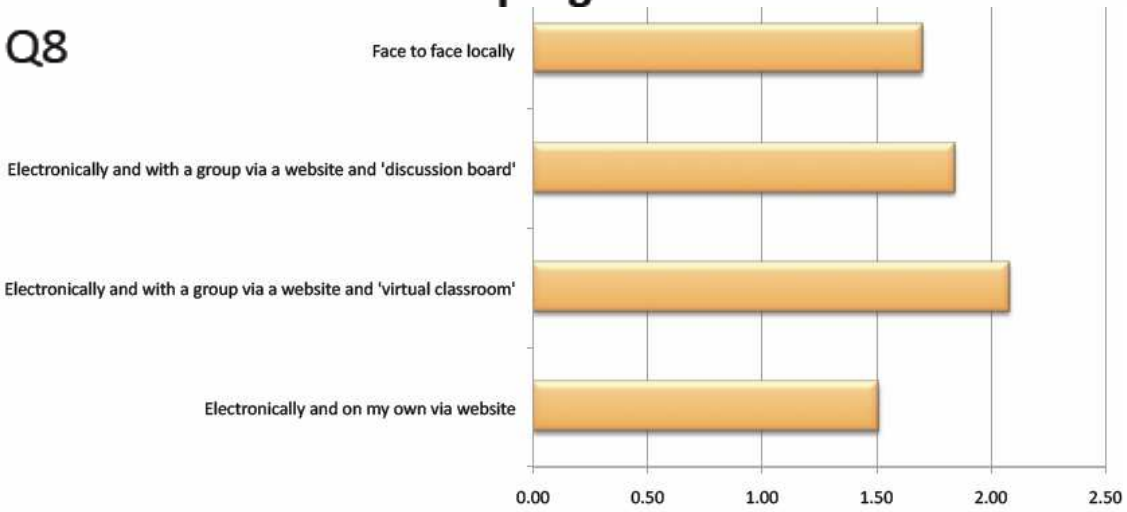
If there was an HSANZ Ed resource; what kind of information?

Q7



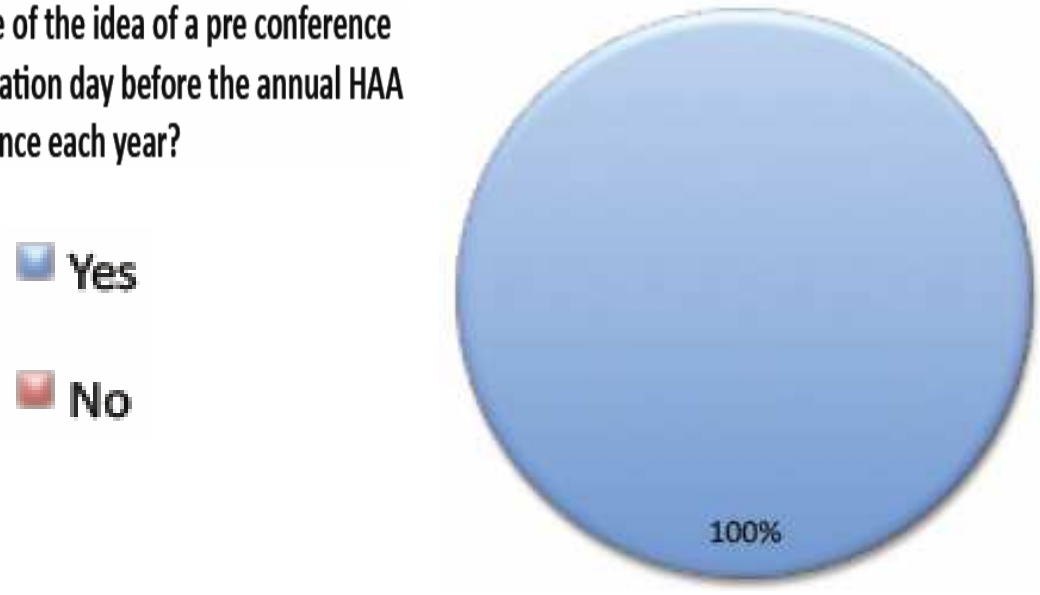
How would you like to take part in an education resource/ programme?

Q8



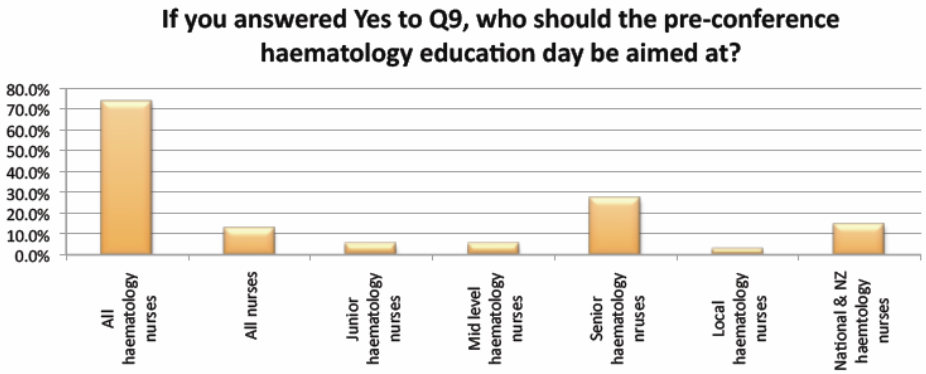
Would you be supportive of the idea of a pre conference haematology nurses education day before the annual HAA conference each year?

Q9



HSANZ NG Member Survey continued

Q10

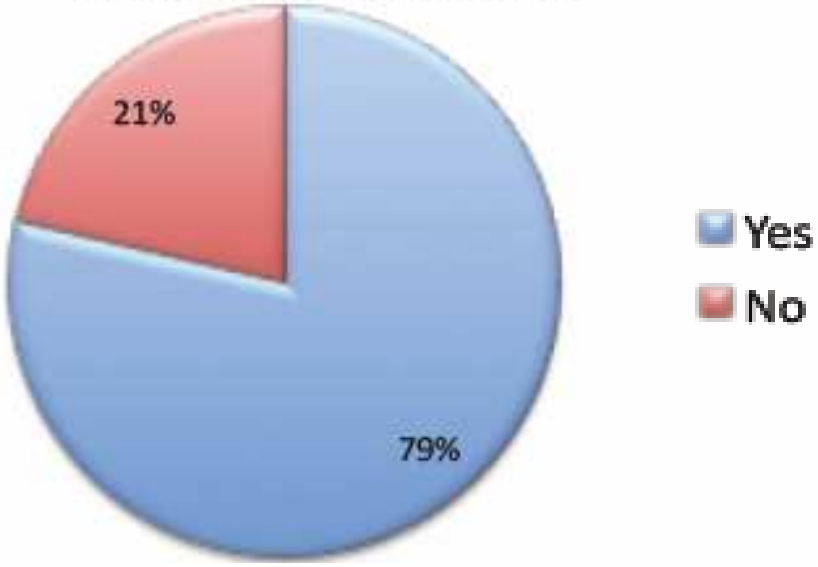


1. Some generic haematology for all with latest trends etc and then maybe a split off with some quality sessions for beginning haematology nurse and a session for advanced haem nurses
2. Being a small speciality group I don't think we should start to leave out our own IN order to achieve 'all' haematology nurses - perhaps concurrent sessions.
3. Of particular benefit to local nurses not able to attend conference.
4. There could be a variety of junior and more advanced level topics ? HSANZ nursing members (what are our current numbers)
5. Maybe a core morning with workshops in the afternoon To cater for all level of expertise and knowledge you could perhaps have concurrent sessions running for eg. novice, intermediate and advanced practice.
6. We would need to survey what the nurses needs are and address accordingly depending on the experience level of respondees and objectives of workshop.

HSANZ_NG_Membership & Education needs survey 2010

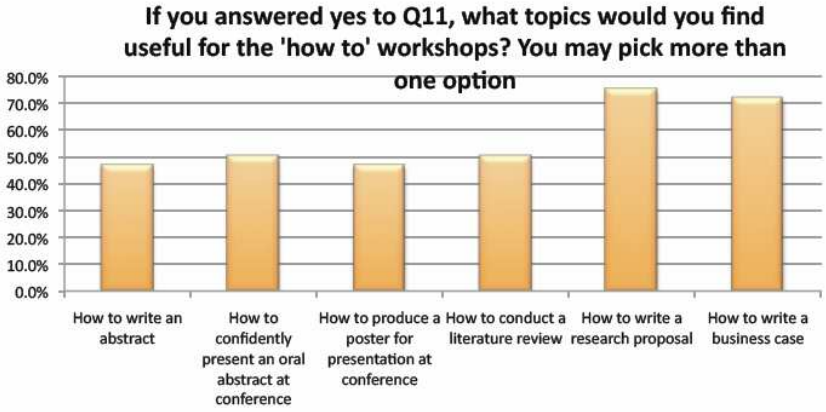
Would you find additional 'how to' workshops within the nursing stream at the annual HAA conference useful?

Q11



HSANZ NG Member Survey continued

Q12

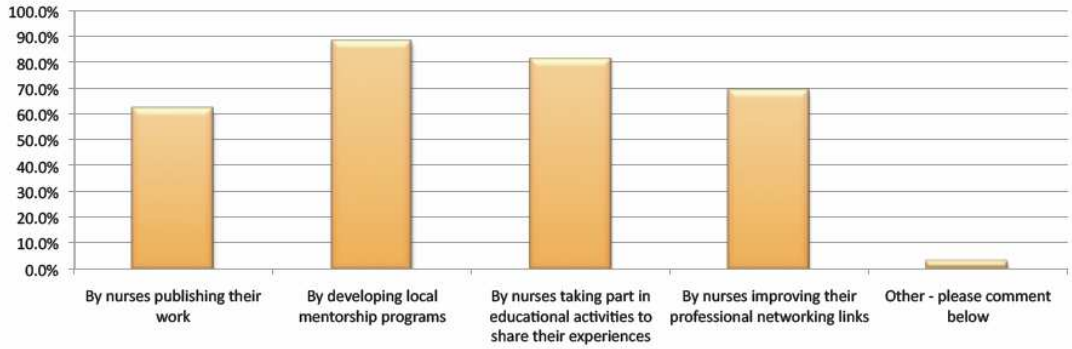


1. Key speakers that are at the conference could do something that they are an expert in- EG. Palliative care, could be anything to do with haematology/ BMT
2. how to develop stUdies within work environment and effectively report on same ALL!
3. How to set clinical indicators.
4. How to mentor effectively.
5. Microscopy, Pathology both malignant and non malignant
6. Career pathways within Haematology nursing.
7. Advanced practice nurses could present their backgrounds with suggestions for experience and education required to work in their position. I don't need these for myself but think they would be useful for junior/new to specialty nurses
8. A lot of this has been done before at previous conferences and the CNSA is also looking at running similar workshops pre-congress and regularly throughout the year in each state. Let's not re-invent the wheel!

HSANZ_NG_Membership & Education needs survey 2010

Q13

Nurses acquire an enormous amount of experience and knowledge as they develop within a specialist nursing field. How best can others gain from this knowledge and experience? You may choose more than one option

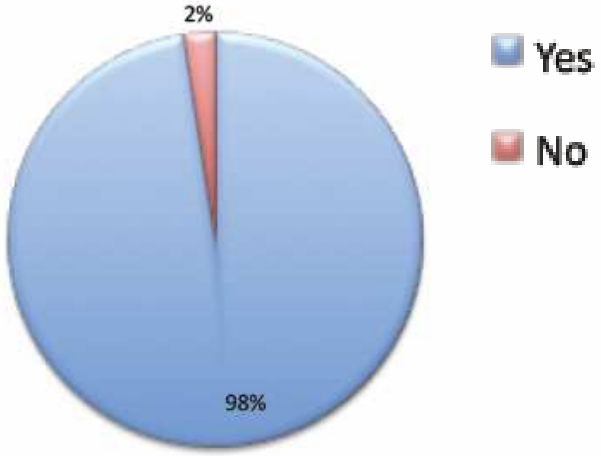


1. Mentoring might not always be practical locally but may rather need to be extended to regional and metro links etc.
2. By sharing work, ideas, protocols, activities.
3. I think that sharing and discussing experiences is an important learning tool and helps build experiential knowledge and allows for reflection on practice (praxis)
4. Being clinically visible & out there as a resource
5. Cancer nurses in Australia need to utilize the EdCaN framework and resources to plan and develop professional development activities and keep updated.
6. I think also adding pieces in relevant newsletters eg. HSANZ is useful.

HSANZ_NG_Membership & Education needs survey 2010

HSANZ NG Member Survey continued

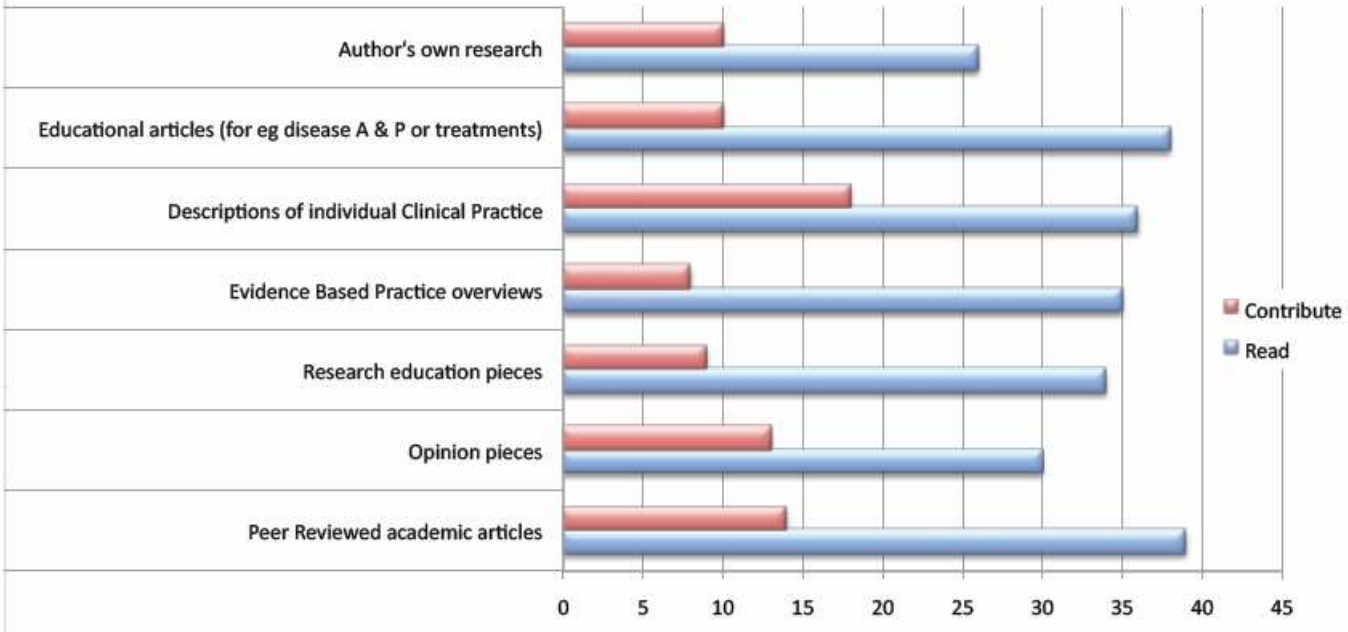
14 If HSANZ Nurses Group listed contact details for nurses with a particular specialist interest on their website, would you find this useful for networking and sharing of knowledge?



1. If able to list particular details of areas of interest, skills, knowledge and experience etc this could be a very useful tool.
2. Contact details may only be worth while if nurses willing to/have time to reply or share knowledge

HSANZ NG are intent on developing the HSANZ News into a more formal journal (such as The Australian Journal of Haematology Nursing)

Q16



Clinical Practice Corner

This is the space where you can share your practice, your bright ideas and innovative ways; everybody is at it, so why not share it?

The development of an Advanced Symptom Management System (ASyMS-H©) for the remote monitoring of patients with haematological malignancies receiving chemotherapy.

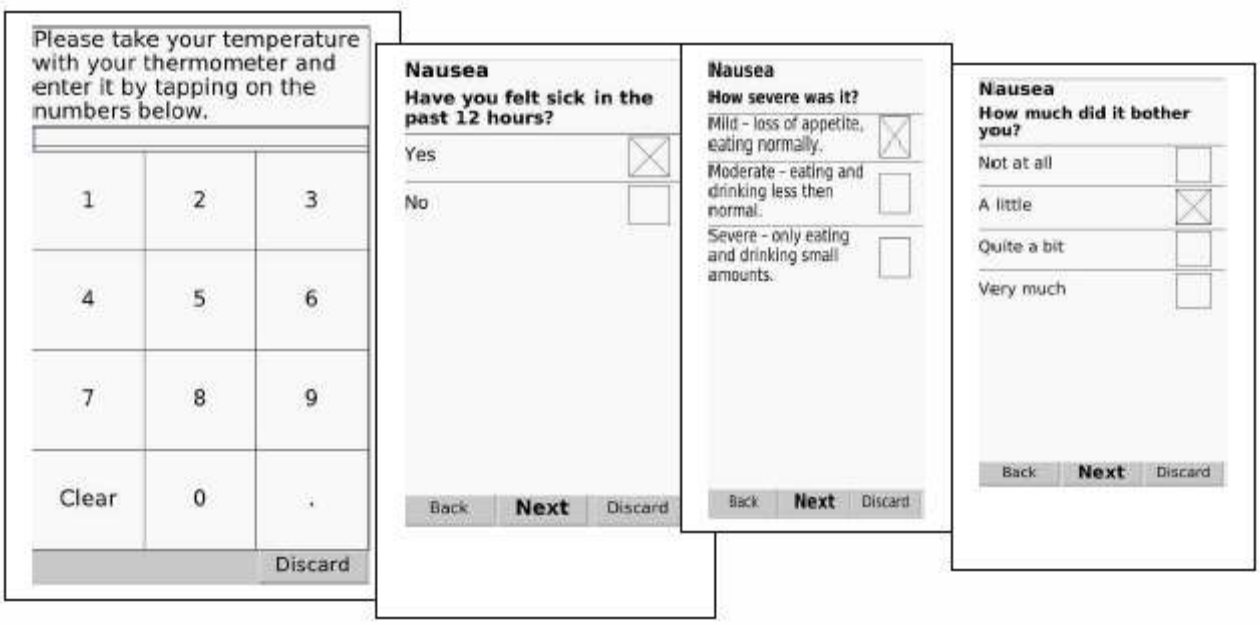
By Tracy Dryden, Travel Grant Winner HAA 2010

Earlier this year I was a fortunate recipient of a travel grant from the HSANZ-NG to attend the HAA 2010 in Auckland. Attending the conference was a great opportunity for me to meet other haematology professionals, exchange ideas and find out what is happening in other clinical settings. I also had the privilege of being able to inform colleagues about two pieces of work I have been involved in at the Peter McCallum Cancer Centre (Peter Mac) in Melbourne.

1) The development of an Advanced Symptom Management System (ASyMS-H©) for the remote monitoring of patients with haematological malignancies receiving chemotherapy.

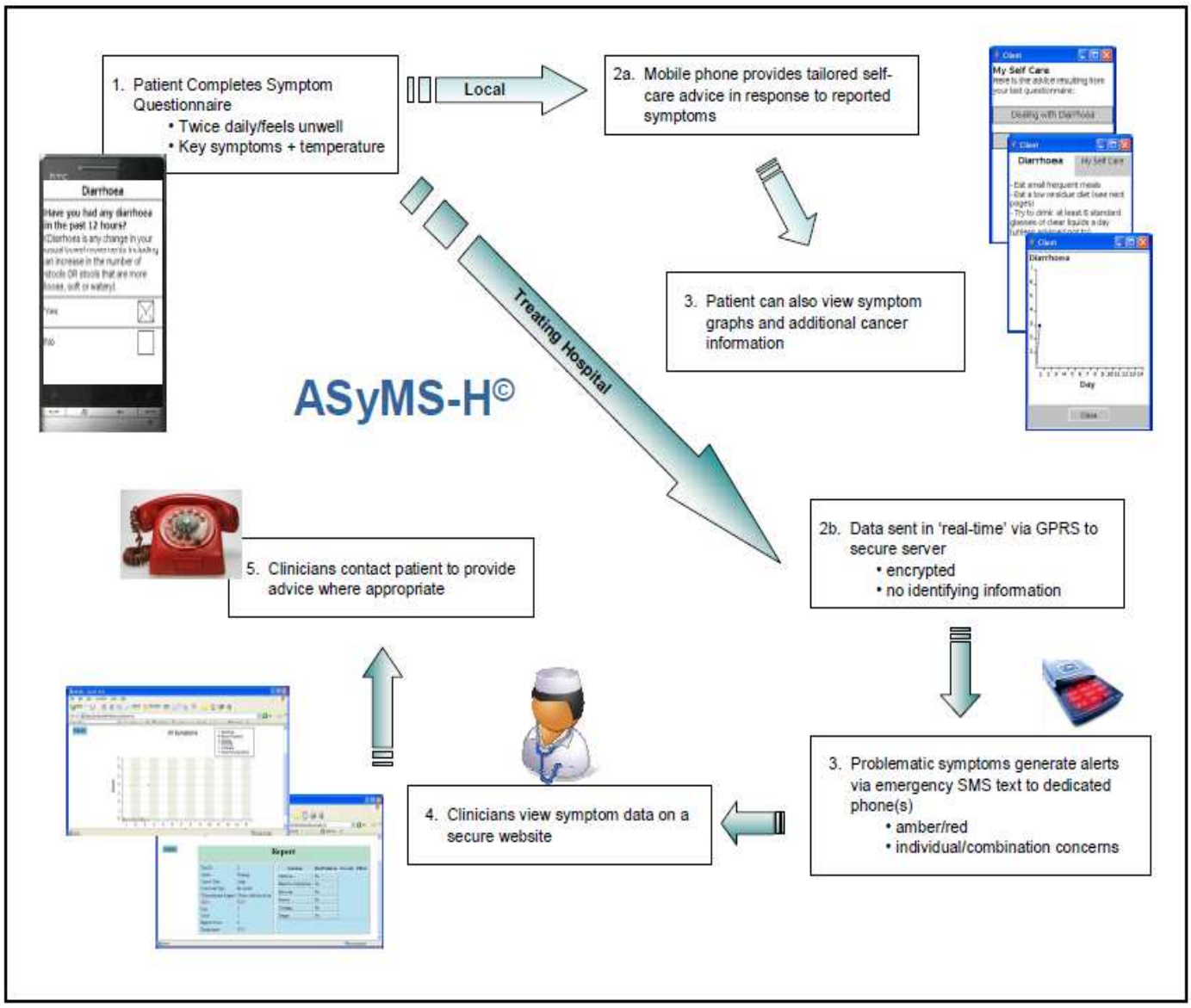
The aim of this study was to develop a mobile-phone based assessment and support system for use by patients in the community, who are often required to monitor potentially distressing or life-threatening chemotherapy toxicities at home and make difficult decisions about when to contact their healthcare professionals. Previous work conducted in the UK and USA has shown many potential benefits with phone based systems that enable real-time monitoring of chemotherapy toxicities in patients with solid tumours. These benefits include improved symptom reporting and control, provision of patient reassurance, decreased numbers of unplanned hospital admissions and length of stay, and reduced healthcare costs. Our work at Peter Mac has been conducted in collaboration with researchers in the UK, and is the first time such a system has been developed in Australia and the first time in the world that such a system has been developed for patients with haematological diseases.

In order to compile the ASyMS-H© content, semi-structured interviews were conducted with 7 haematology patients and 12 clinicians. A content analysis of the interviews was conducted and the data used to develop symptom assessment questions, self-care information and alerting algorithms for intervention from the treatment team. The ASyMS-H© was then built and a clinician website set up.



Examples of screen shots from the mobile phone-based ASyMS-H©

In brief, the ASyMS-H© monitors patients for infection, bleeding, nausea, vomiting, diarrhoea, mucositis, fatigue, constipation, peripheral neuropathy and a sudden decline in their ability to carry out activities of daily living. Patients complete the system twice a day, or if they become unwell, and the entered information is sent to the treating hospital via GPRS to a secure clinician website. Upon entry of the completed questionnaire the patient receives evidence-based self-care strategies on their handset to assist them with managing any symptoms they are experiencing. In addition, a dual alerting system has been developed for urgent (red) and less urgent (amber) interventions. Algorithms prioritise fever and severe bleeding, vomiting, diarrhoea and mucositis as potentially life-threatening and therefore generate red alerts. Moderate/sustained symptoms or symptoms that are causing the patient high distress generate amber alerts. The alerts are monitored on a mobile phone carried by a nurse in the hospital who then telephones the patient, within 15 minutes for a red alert or 8 hours for an amber alert, and provides additional interventions.



How ASyMS-H© functions

Since presenting at the HAA 2010, pilot testing of the ASyMS-H© has commenced to determine the acceptability and usefulness of the system to both patients and nurses and to trial the alerting algorithms. Whilst final analysis of this data has not yet been completed, early feedback from both patients and nurses is extremely positive.

2) Chemotherapy toxicities: the experience of patients with lymphoma

The first step to improving the patient experience is to understand it. Therefore, the aim of this study was to develop a better understanding of the 'lived experience' of lymphoma patients in relation to their chemotherapy toxicities. To our knowledge, this is the first qualitative study to investigate the overall chemotherapy toxicity experi-

Clinical Practice Corner cont'd

Data from semi-structured interviews with seven patients undergoing chemotherapy for lymphoma was content analysed, using pre-determined themes based upon Lenz et al's (1997) Theory of Unpleasant Symptoms. The themes included; quality, timing and intensity of toxicities, level of distress caused, as well as factors influencing the experience and the consequences. During the interviews, the patients discussed a number of symptoms including, fatigue (6 patients), peripheral neuropathy (6 patients), oral changes (6 patients), nausea (5 patients), constipation (5 patients), hair loss (5 patients) and fever/infection (2 patients). From the discussions it became clear that the patient experience of chemotherapy toxicities is complex and involves all aspects of the theory of unpleasant symptoms. It was also evident that whilst the patient considered none of their individual symptoms to be extremely severe, they did find the experience of multiple symptoms at one time considerably more distressing.

"Terrible, you know, once again it's [constipation] not completely debilitating but it just adds up, you know, with the nausea, with the fatigue and everything of just being not active, not being able to concentrate on things, having your mind preoccupied with something that's happening with your body. So in isolation it would be fine." [Quote from study participant 6]

This highlights the importance of nurses monitoring lymphoma patients for co-occurring multiple toxicities in order to be able to provide timely and tailored interventions to improve the patient experience. However, further research is required to identify how and when we should monitor these patients.

Another key finding from the study data was that a lack of preparation in relation to toxicities is linked to patients experiencing more distress and fear.

"I rang up about that one 'cause that one I was really concerned about, I thought that's bizarre, and it was just in the fingertips and I noticed … I got up in the shower one day, I was washing my hair and I thought what's that kind of thing, I sort of felt my fingers weren't my own a bit and I didn't know that that was a symptom or a side effect." [Quote from study participant 5 about peripheral neuropathy]

During the study, the patients also identified the use of self care strategies and having support from family and friends as important factors in improving their toxicity experience. It is clear from these findings that further research is required in when to provide timely education and information about toxicities to patients having chemotherapy for lymphoma. There is also a need for research into the development of strategies to motivate patients to use self care and to encourage the involvement of family and friends in patient care.

Once again I would like to send my sincere thanks to the HSANZ-NG for providing me with a travel grant to attend the conference and for the opportunity to present my work. The conference was a valuable and informative experience.

Tracey Dryden

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The implementation of a Nurse Practitioner model in the care of patients post Allograft.

Yvonne Panek-Hudson RN.MN. Nurse Practitioner

Yvonne.Panek-Hudson@petermac.org

Travel Grant Winner HAA 2010.

Peter MacCallum Cancer Centre (Peter Mac) is the largest referrer of patients for Allogeneic Bone Marrow Transplant (BMT) to the Royal Melbourne Hospital (RMH). In 2010 we referred 26 patients accounting for 50% of the total number of patients allografted.

The Allograft Nurse Practitioner (NP) role and model of care was developed at Peter Mac in response to an identified clinical resource issue affecting timely assessment and education, co-ordinated referral, continuity of care, and management of typical and unexpected post transplant issues and follow up. The NP role is collaborative with RMH with the NP holding an honorary appointment and attending inpatient reviews and providing weekly outpatient follow up.

Patient care is typically managed at RMH until 3 months post allograft. After this time care is transferred to Peter Mac under the management of the Allograft team which comprises a BMT physician and the Nurse Practitioner (NP). Patients are booked to the physician-led clinic or NP led clinic according to clinical care requirements and patient preference. Post transplant follow-up is provided in

two streams; post acute BMT follow up constitutes care provided in the first 2 years post transplant. After two years if appropriate, patients are referred to the NP led long term follow up clinic.

The following is a diagrammatic representation of the Allograft patient care model at Peter Mac:

The model of care and NP role within this context will be formally evaluated however the developmental goals of the role that are being met include:

- The development of a collaborative BMT service between Peter Mac and RMH fit for purpose within a world class, patient-centred cancer service delivering best possible patient outcomes
- Early identification and management of potential post transplant complications (including pharmacological and non pharmacological intervention) reducing readmission and improving patient outcomes
- Continuity of care and care delivery by the NP (releasing other members of the team to provide more complex care)
- Streamlining of care across the continuum for Peter Mac patients requiring transplantation at RMH
- Coordinated post transplant management including referral to multidisciplinary services with improved access to psycho-oncology and rehabilitation services
- Improved communication and liaison with specialist, community, RMH and GP services (including education and support to outside services)

With increasing long term survival post Allograft, the potential for advanced practice nursing roles will continue to grow. It is exciting to be part of the development of this innovative, patient centred model of care. Future directions include formal evaluation of the NP role and multidisciplinary research focusing on Allograft specific issues such as impact on sexuality, implications for carers, and socio-demographic factors and affect on morbidity.

SAFETY AND EFFICACY OF AUTOGRAFTS IN YOUNG AND OLD LYMPHOMA PATIENTS: A COMPARISON STUDY

Tuck, Deirdre, Tegg, Elizabeth, Ragg, Scott and Lowenthal, Raymond.

Statewide BMT Service, Royal Hobart Hospital, Hobart, Tasmania, Australia

Submitted by Diedre Tuck, HAA 2010 Travel Grant winner

Aim

Whilst a maximum age of 60 years has been generally regarded as safe practice for an autologous BMT, there has been an increasing tendency to utilise autologous transplants in older aged patients. This study aimed to compare the efficacy and safety of autografts of patients less than 60 years of age with those 60 years and over.

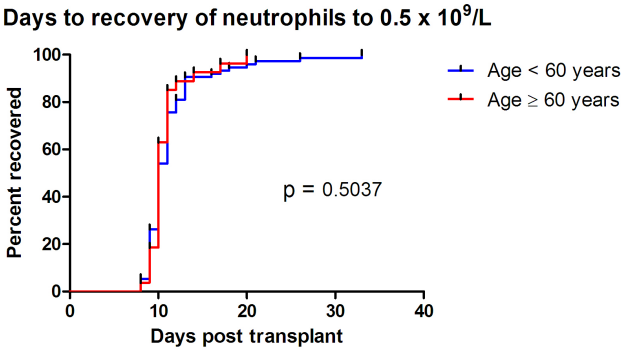
Methods

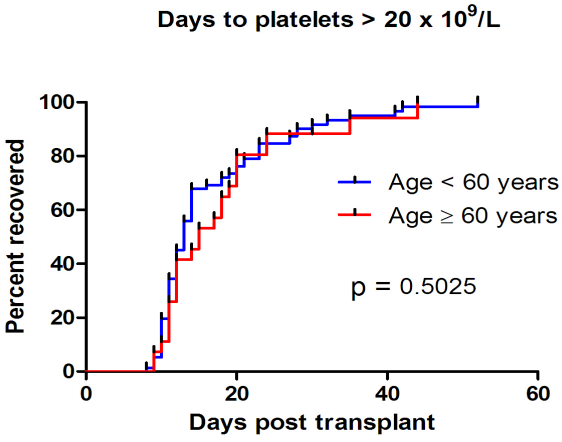
103 BM and/or PBSC first autografts for 89 non Hodgkin lymphoma (NHL) and 14 Hodgkin lymphoma (HL) between 1999 and 2008 were divided into 2 groups based on age at reinfusion, 76 patients less than 60 years (median 47 yrs) and 27 patients 60 years and older (median 63.6 yrs). Engraftment kinetics and survival curves were assessed using Log Rank (Mantel-Cox) test, with all other factors scrutinised using Students unpaired t-test.

Results Discussion

Table 1.	<60 years of age n=76	≥60 years of age n=27
Age range (years)	19 -59.9	60.3-70.2
Median Age	47*	63.6*
Sex M:F	47:29	19:8
Diagnosis		
NHL	64 (84 %)	25 (92.5%)
HL	12 (16 %)	2 (7.5 %)
Type of Autograft		
Bone Marrow	16	3
PBSC	53	23
BM/PBSC	7	1
Ablative chemotherapy		
BEAM	74 (97 %)	26 (96 %)
Others	2 (3 %)	1 (4 %)
Engraftment		
Days to Neuts ≥0.5 Range	8 - 33	8 - 20
Median	10 [ns]	10 [ns]
Days to Plat ≥20 Range	10 - 42	9 - 44
Median	13 [ns]	15 [ns]
Survival		
Alive @ 30 days	75 (98.5 %) [ns]	26 (96.3%) [ns]
Alive @ 100 days	67 (88 %) [ns]	24 (88.8 %) [ns]
Long term survival (days) Median	1407 [ns]	1039 [ns]

* significant difference ($p < 0.05$) and [ns] difference not significant between these groups





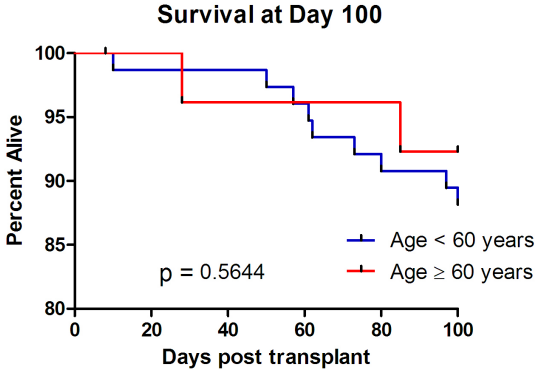


Table 1. shows the primary analysis of the patient populations. All patients achieved myeloid engraftment after reinfusion. Neutrophil and platelet engraftment was not significantly different between the two age groups (p=0.5 and 0.5 respectively). Importantly, both transplant related mortality (Survival to Day +30) and Survival to Day +100 were not significantly different (p=0.46 and p=0.56 respectively). Long term survival between the two age groups shows a non-significant (p=0.26) trend towards the younger cohort having a predictably longer post-transplant survival.

Conclusion

Successful and safe engraftment occurs after reinfusion to patients over the age of 60 years.

Where to from here?

(Adapted from an oral presentation from HAA 2010, Auckland, New Zealand)

This is a story about my ethical dilemma. This story takes us to the frequently visited cross roads of conflict in choices of duty of care. I found myself required to decide which duty should trump - my duty of non-maleficence , or, honouring my patient's choice and his autonomy. VT was a 36 year old man with severe Haemophilia A. Haemophilia A is a deficiency of factor VIII, a protein required for clotting. There are three severities of Haemophilia, severe, moderate and mild. VT has severe Haemophilia and is prone to spontaneous bleeding episodes mainly into joints such as the knee, ankle and elbow.

He presented in March 2009 with an oozing sinus in his right knee which tested positive to Staph Aureus . When he presented VT had a piece of toilet paper and a grey threadbare bandage covering the area. At this time he wanted us to refer him to the District Nursing service and surgical services which we did. Following this initial presentation, VT has not re visited us for treatment. Following his initial missed appointment, we wrote to VT to offer him another appointment. We did this to try and communicate with him and get him to clinic. Despite these efforts, the team has not been able to get VT to attend clinic appointments nor receive treatment for this sinus. This is potentially a life threatening situation, or at the very least, one which threatens him with loss of his leg through untreated infection and gangrene. He is also at risk of the developing Osteomyelitis and will have to have the infected joint replaced.

VT maintains contact with us in managing his haemophilia through his partner who is a young lady that appears very hesitant and standoffish whenever she contacts us. This is suboptimal because she will never give us feedback as to how VT is, whether he is having any bleeding events and how often he is needing to use his factor.. VT's nephew also has severe Haemophilia and is on prophylactic treatment, he has factor VIII three times a week. I have a concern that he will be made to hand over his factor VIII supply to his uncle if we do not supply VT Thus, contact with VT is on an ad hoc basis and I receive a call from his partner when he needs factor VIII delivered to his home. VT's telephone does not work and he does not answer letters despite the self addressed envelopes included with my letters, making communication and effective management all but impossible from my perspective. If my primary duty of care is is non-malefecience – how can I let this situation stand? By failing to treat his wound I am failing in my duty to 'first do no harm'. However, by calling around to his house and banging on his door or getting help to have him dragged into hospital (as I would really like to do!), I am failing in my duty to respect his choice and autonomy.

One year later, in March 2010, VT's brother called me. He said that VT was in a lot of pain and asked me to make a referral to the pain clinic on his brother's behalf. I hadn't spoken to nor seen VT for over a year and so I sent him a letter requesting his consent to make the appointment. VT contacted me and attended the clinic appointment. VT was not in any obvious pain associated with the sinus howerer he requested a script for Severdol at this appointment which we were unable to supply because he is under strict surveillance from the MOH due to his narcotic addiction. Under this surveillance VT is only allowed a limited amount of medication and this is only to be prescribed by his GP or a member of the pain service base in a single hospital. Unfortunately he left without a script and we have not heard from him since.

I wonder how we can better understand VT's illness experience. Clearly he has a different view of his health needs to those of our own and I feel that we are coming from such different directions and meeting somewhere head-on. VT either does not understand or does not want, what we consider to be best for his health and wellbeing. Similarly, we do not fully understand his needs and his lived experience with a life long and sometimes life threatening illness. How do we both enable ourselves to see into these two very different paradigms? We want VT to see our needs (to help him keep well) and , I am sure, VT wants us to see his needs (where his haemaophilia is but one issue situated within a complicated and difficult life). Ethically I struggle as to whether we are doing the best for VT, but basically apart from having him admitted and bound to a bed what other options do I have when VT seems not to want to take responsibility for his own health and wellbeing. Many could argue that we are empowering VT by giving him autonomy whereas I struggle with the ethical dilemma of balancing this with non-maleficence.

Daryl Pollock,

CNS Haemophilia/Thrombosis
Clinical Haematology
MidCentral Health
Palmerston North Hospital

daryl.pollock@midcentraldhb.govt.nz

eviQ news

eviQ Cancer Treatments Online is an Australian web-based clinical information system providing evidence based, peer reviewed point-of-care cancer treatment protocols and information

Project Officer, eviQ Primary Health Care

Duration: 16 month opportunity – can be secondment or contract period

Hours: 0.5 FTE (5 days per fortnight – flexible)

Pay Rate: Comparable to Grade 3 CNC

We are currently seeking a motivated and engaged Project Officer to join a small team of dedicated professionals. As the Project Officer, eviQ Primary Health Care you will be responsible for developing cancer treatment information for the primary health care and general practice audience, utilising an online, web-based resource.

To be considered for this role you will have appropriate tertiary qualifications or equivalent professional experience, demonstrated cancer experience in the clinical setting, and highly developed oral, written communication and computer skills. Knowledge and an understanding of the primary health care environment would be highly desirable. An understanding of the Australian health environment would be advantageous.

This Cancer Australia funded project is for 5 days per fortnight (hours/days flexible within normal working hours) on site at the Cancer Institute in Eveleigh, NSW. This position is available from late February 2011 until 30 June, 2012, and pay rate is comparable to a Grade 3 CNC.

For further information, to send your curriculum vitae, or to obtain a job description, please contact Natalie Cook on:

Ph: 02 8374 3520
Email: natalie.cook@cancerinstitute.org.au

Applications Close 18 February 2011

Haemopoietic Progenitor Cell Transplant (HPCT)

eviQ Haemopoietic Progenitor Cell Transplant conditioning protocols are evidence based and peer reviewed by the HPCT Reference Committee, which comprises of haematologists, transplant coordinators and pharmacists. Members are actively involved in developing, approving and reviewing eviQ protocols in accordance with eviQ's strict governance framework.

The development of transplant conditioning protocols has had significant input from both local and interstate transplant physicians and are therefore likely to be of interest to transplant centres around Australia.

The aim is to promote best practice, improve standards and ultimately, improve patient outcomes.

Each treatment protocol provides comprehensive information including:

- Treatment Schedule
- Patient Population
- Important Clinical Considerations
- Prophylaxis Recommendations
- Dose Modifications
- Interactions
- Post-transplant Vaccination Information
- Administering Details
- Side Effects
- Key Evidence
- Patient Information

HPCT calculator functionality includes the ability to:

- enter all relevant patient details, including all relevant serology
- export saved patient details then import back into eviQ system for completion at a later date
- manipulate the drug treatment schedule by:
  - adding or deleting drugs
  - adding a day or a rest day
  - changing the default supportive therapy to reflect individual institutional policy
- produce a PDF report of the individualised conditioning protocol

For further information, please contact:

Aisling Kelly
eviQ Content Author - Pharmacy
Aisling.Kelly@cancerinstitute.org.au
(02) 8374 5632 or 0400 316 312

Patricia Ryan
eviQ Content Author - Haematology/BMT
Patricia.Ryan@cancerinstitute.org.au
(02) 8374 3540

Also available online:

- opioid conversion calculator

1800 eviQ 00 ■ www.eviQ.org.au

News from the regional groups

New Zealand (North Island)

The lower North Island has had a successful 2010 with running education evenings. We had five in total split between Wellington and Palmerston North. Topics covered included VTE, Lymphoma, BMT, Multiple Myeloma and CLL. There has been an enthusiastic response to these meetings with an average of around 25 attendees coming along on each evening. The education evenings wouldn't be possible without sponsorship. Last year Roche Products (New Zealand) Limited, Novo Nordisk, Gilead Sciences (NZ) and Novartis New Zealand Limited very generously supported us and have pledged to do so again in 2011.
Education evenings have been mapped out for 2011 and are as follows:

Date	Location	Topic
3rd March	Palmerston North	Haemophilia
20th April	Wellington	Apheresis
22nd June	Palmerston North	Lymphoma
17th August	Wellington	AYA
19th October	Palmerston North	Palliative Care in Haematology
30th November	Wellington	Blood Transfusion

If anybody would like further information about any of these meetings or would like to attend then please feel free to get in touch with me. I can be emailed at Catherine.Wood@ccdhb.org.nz
Rosie Howard may have her arm twisted to facilitate some education sessions for the upper North Island. If anybody is willing help Rosie or has any suggestions for how these may be organised in this area, then please contact me at the above address.
Catherine Wood
BMT Coordinator Wellington Hospital
Catherine.wood@ccdhb.org.nz

Catherine Wood

New Zealand (South Island)

My name is Christine Kerr and I am taking over from Sharron Ellis as the HSANZ NG representative for South Island NZ. May I take this opportunity on behalf of the organising committee in the South Island, to thank Sharron for her fantastic efforts getting the HSANZ nurses group going in our region.

We are in the process of planning a series of four education sessions for the year ahead, with venue and topics to be announced shortly. We are also looking out for other educational opportunities during the year which promote and encourage haematology nurses.

If you would like to receive automatic updates of our events, please get in touch with me and we'll be sure to add you to our mailing list.
If you are hosting your own educational events, courses or would like to recommend a topic or event for us during 2011 then we would also love to hear from you.
I look forward to meeting many of you in the year ahead.
Christine Kerr
E: christine.kerr@leukaemia.org.nz

Christine Kerr

Western Australia

My name is Karen Taylor and I have taken over from Cassi Lawrence as HSANZ NG representative whilst she is on Maternity leave. Cassi would like to let everyone know she had a little girl in Dec 2010. May we take this opportunity to congratulate Cassi and hope she enjoys the busy maternity leave she no doubt has.

I have an extensive background in haematology / BM transplant nursing and as well as taking on the HSANZ NG WA representative role this year, I have also stepped into Cassi's job as a Cancer Nurse Specialist with the WA Cancer and Palliative Care Network.

The WA committee is meeting soon to plan ahead the educational events for 2011.The committee is on the lookout for new members, keen to get involved and help deliver Haematology educational events for nurses within the State. If you are interested, we would love to hear from you. You can contact me as per details below.

We would also like to hear from you regarding your ideas for topics to be covered in 2011 so please let us know your thoughts.
We would be happy to let you know as soon as events for 2011 are planned, so if you would like to get an automatic notification of WA activities, please get in touch.
Karen Taylor
E: Karen.taylor@health.wa.gov.au
T: +61 448 771 453

Karen Taylor

Victoria

With the success of the Victorian educational evenings in 2010 we have an interesting and exciting schedule for 2011. We have reviewed the evaluation forms and chosen topics of interest suggested by our members – so thankyou for your detailed feedback!!! The details for the first educational evening are:
Myelodysplastic Syndrome – An overview of disease and current treatment options.
Presented by: Dr Michael Dickinson
Wednesday 9th of March, 2011 – 6.30pm for a 7pm start
Venue to be confirmed
Sponsored by Pfizer, Amgen & Celgene
Please RSVP by Tuesday the 1st of March to
yvonne.panek-hudson@petermac.org

We will be circulating a formal invitation to all members on our mailing list.
Further educational evenings will be held in June, September and November – dates to be confirmed.
We are also working on coordinating an educational day in a regional centre.
I am looking forward to my second year as Victorian chairperson and to increasing our membership and further addressing our member's needs. Please don't hesitate to contact me if you have any queries.
Yvonne Panek-Hudson – Nurse Practitioner
Peter MacCallum Cancer Centre
Yvonne.Panek-Hudson@petermac.org

Yvonne Panek-Hudson

News from the regional groups

Australian Capital Territory

A local group of HSANZ Nurses Group is being established in the ACT. As a start, a small group of interested members has commenced planning of a study day to be held in late September. It will be on a Saturday, from 10am to 4pm to allow interested nurses from the surrounding areas to travel. As with all HSANZ NG educational activities, this study day will attract RCNA points. More details will be circulated as soon as they are available. If you are interested in finding out more, please don't hesitate to get in touch with me.

Angela Booth
Email: angela.booth@gsahs.health.nsw.gov.au
Mobile: +61 438435428.

Angela Booth

Tasmania

2010 was a busy and exciting year for Tasmanian Haematology Nurses and we hope that the good work will continue this year.
In 2010 the State-wide Bone Marrow Transplant Service at the Royal Hobart Hospital, in collaboration with the Launceston General Hospital was awarded a Department of Health and Human Services (DHHS) award for Innovations in Practice. The service was recognised for the innovation of implementing compliance with Quality Management Systems while ensuring that care is patient focussed with streamlined referral and follow up for patients from the three Tasmanian Area Health Services.
The Bone Marrow Transplant Service was also fortunate to be offered an educational opportunity by the Royal Melbourne Hospital. A team of health professionals including a Social Worker, physiotherapist and nurses provided education for Tasmanian nurses in both Hobart and Launceston regarding the long term care of Allogeneic Bone Marrow Transplant patients.
Tasmanians featured at the HAA conference in Aukland in all streams. Several poster and oral presentations were given by Tasmanian doctors, research scientists, stem cell scientists and nurses. It is encouraging for us all to attend conferences and benchmark our standard of care nationally and internationally and bring back ideas to develop practice.
HSANZ has engaged in discussions with CNSA in providing combined educational/social opportunities for the year ahead.
Educational opportunities
University of Tasmania (UTAS)
Graduate Certificate/ Graduate Diploma in Oncology Nursing
For information: www.snm.utas.edu.au
THING (Tasmanian Haematology Immunology and Neoplasia Group)
Please watch your email Inbox and workplace noticeboards to participate in the proud tradition of THINGs educational opportunities at scenic Tasmanian locations throughout the year.
Gill Sheldon-Collins
BMT Coordinator
Royal Hobart Hospital
Gillian.sheldoncollins@dhhs.tas.gov.au

Gill Sheldon-Collins

South Australia/Northern Territory

Our last education session for 2010 was a summary or "wrap up" of the 2010 HAA conference. More than 30 nurses attended the session and feedback was very positive. The wrap up included three different aspects of the conference reflecting the various streams available to delegates. Amanda Catherwood, Bloodsafe Transfusion Nurse Consultant, gave an overview from the perspective of the Australian and New Zealand Society of Blood Transfusion topics while Dr Simon McRae, Consultant Haematologist gave an overview of new developments in Haemostasis and Thrombosis. And lastly I provided an overview of some of the many interesting presentations from the Nurses stream .

We are looking forward to providing more educational opportunities in 2011. Our first is planned for March 29 with a non-malignant haematology focus with speakers on MDS and Thalassaemia. Also planned are sessions in August with speakers on Intragam and allotransplantation as well as another "wrap up" of the HAA 2011 in November. Following on from the success of our previous education days we will again join forces with our local CNSA group for a full study day in June. We are hoping to reach out to the NT also this year and are currently seeking support to provide an educational opportunity for Nurses in Darwin.

Our thanks again go to Amgen, Novartis, Roche and Gilead for their continued support.

Allan Hayward

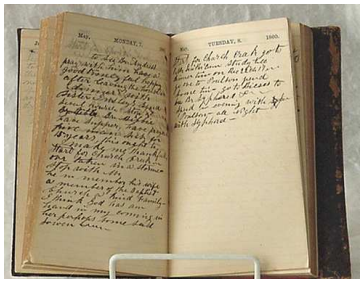
New South Wales

The local committee for NSW looks forward to a busy 2011 hosting a range of educational events around NSW. There has been recent change in the membership of the committee and we thank David Collins for his hard work in 2010 as he leaves to concentrate on other activities. Jacqui Jagger will be back on board soon for Gosford and Tracy King returns in place of Moira Stephens. Moira leaves to concentrate on those final few hundred thousand words of her PhD thesis! We wish her well in her final push to completion of her PhD.
Dates for your diary for 2011 are listed in the table below. We look forward to our first joint session with CNSA on February 17th in Sydney and also to building on the successful Haematology nurses day in Dubbo last year when we repeat the effort in Orange later this year. New this year will be a pre HAA conference nurse's study day. Preparations are underway for that day so please watch this space for more details.
For more information or to register your interest to attend any of the meetings below, please contact your NSW committee members.
Grainne Dunne: Grainne.Dunne@sesiahs.health.nsw.gov.au
Heather Mackay heather_mackay@wsahs.nsw.gov.au
Tracy King tracy.king@sswahs.nsw.gov.au
Jacqui Jagger jjagger@nsccahs.health.nsw.gov.au

Tracy King

Date	Location
17th February 2011	Sydney
14th April 2011	Gosford
16th June 2011	Sydney
18th August 2011	Wollongong
29th October 2011 Pre HAA study day	Sydney
17th November 2011	Sydney
TBA Haematology nurses day	Orange
Late September Haematology nurses day	Canberra

Research News – a short trip around some recent journals



Either Called "Chemobrain" or "Chemofog," the Long-Term Chemotherapy-Induced Cognitive Decline in Cancer Survivors Is Real

Journal of Pain and Symptom Management. 2011 Jan 1;41(1):126-139, AA Argyriou, K Assimakopoulos, G Iconomou, F Giannakopoulou, HP Kalofonos

Context: In recent years, there is growing evidence in the medical literature to support an association between administration of commonly used chemotherapeutic agents and an increased risk for cognitive impairment.

Objectives: We herein critically summarize data relating to the pathophysiological mechanisms by which chemotherapy may induce cognitive impairment in patients surviving from solid tumors. The clinical and epidemiological characteristics and the proposed management strategies to counter chemotherapy-induced cognitive impairment (CICI) also are presented.

Methods: References for this review were identified by searches of PubMed from 1995 until December 2009 with related terms.

Results: Both the pathogenetic mechanisms and the overall clinical nature of CICI remain vaguely defined. Findings indicate that CICI is a relatively common event that, in most of the cases, remains underdiagnosed, thereby adversely affecting the quality of life of patients with cancer. Effective pharmacological interventions toward the symptomatic or prophylactic management of CICI also are lacking.

Conclusion: Either called "chemobrain" or "chemofog," the long-term CICI in cancer survivors is real. The need for multidisciplinary care interventions toward a timely diagnosis and management of CICI is clearly warranted.

Infection Probability Score: a predictor of Clostridium difficile-associated disease onset in patients with haematological malignancy.

Apostolopoulou E, Raftopoulos V, Terzis K, Elefsiniotis I. University of Athens, Nursing Department, Athens, Greece. Eur J Oncol Nurs. 2010 Dec 2. [Epub ahead of print]

Purpose: to assess the predictive power of three systems: Infection Probability Score, APACHE II and KARNOFSKY score for the onset of Clostridium difficile-associated disease (CDAD) in hematology-oncology patients.

Methods and Sample: A retrospective pilot surveillance survey was conducted in the hematology unit of a general hospital in Greece. Data were collected by using an anonymous standardised case-record form. The sample consisted of 102 hospitalized patients.

Results: The majority of the patients (33.3%) suffered from acute myeloid leukemia. The cumulative incidence of CDAD was 10.8% and

Invitation to participate in research

We invite you to participate in a new research study about psychosocial care available to patients.
The study is titled: "Psychosocial Care in Cancer Settings: Assessment of Psychosocial Services and Factors Influencing Provision of Services Among Australian Cancer Nurses
The purpose of this study is to explore the current referral practices of psychosocial care referral for adults with cancer in Australia. This research will examine current practice and how it differs from the optimal practice outlined in the Clinical Practice Guidelines for the Psychosocial care of Adults with Cancer in Australia. The study aims to be able to better support nurses in ensuring psychosocial care is available in oncology settings. The study will also consider nurse burnout and stress.
Participation:
o Is voluntary, completely private and confidential
o The questionnaires will take approximately 45 minutes to complete
o In appreciation of your participation we would like to offer you a $20 Coles gift voucher upon completion of the survey.
If you would like to participate in the study please click on the link below which will forward you to the online survey. The responses will be collected using LimeSurvey.
If you would like to know more about the study please phone Dr. Catalina Lawsin or Kirsty McMillan on (02) 9114 0590.
Link to survey: https://www.psych.usyd.edu.au/limesurvey187/index.php?sid=25647&lang=en
Sincerely,
Dr. Catalina Lawsin
Lecturer of Clinical Psychology
The University of Sydney
Catalina Lawsin, Ph.D.
Lecturer
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the incidence rate of C difficile associated diarrhea was 5 per 1000 patient-days (14.2 per 1000 patient-days at risk). Patients with CDAD had twofold higher time of mean length of hospital stay compared with patients without CDAD (38.82 ± 23.88 vs 19.45 ± 14.56 days). Additionally patients with CDAD had received a greater number of different antibiotics compared to those without CDAD (5.18 ± 1.99 vs 2.54 ± 2.13), suffered from diabetes, from non Hodgkin's lymphoma, had a statistically significant higher duration of neutropenia ≥3 days and had received antifungal treatment. The best cutoff value of IPS for the prediction of CDAD was 13 with a sensitivity of 45.5% and a specificity of 82.4%.

Conclusions: IPS is an early diagnostic test for CDAD detection.

Content comparison of haemophilia specific patient-rated outcome measures with the international classification of functioning, disability and health (ICF, ICF-CY)

Silvia Riva, Monika Bullinger, Edda Amann, and Sylvia von Mackensen

Health Qual Life Outcomes. 2010; 8: 139. Published online 2010 November 25.

Background: Patient-Reported Outcomes (PROs) are considered important outcomes because they reflect the patient's experience in clinical trials. PROs have been included in the field of haemophilia only recently.

Purpose: Comparing the contents of PROs measures used in haemophilia, based on the ICF/ICF-CY as frame of reference.

Methods: Haemophilia-specific PROs for adults and children were selected on the grounds of international accessibility. The content of the selected instruments were examined by linking the concepts within the items of these instruments to the ICF/ICF-CY.

Results: Within the 5 selected instruments 365 concepts were identified, of which 283 concepts were linked to the ICF/ICF CY and mapped into 70 different categories. The most frequently used categories were "b152: Emotional functions" and "e1101: Drugs".

Conclusions: The present paper provides an overview on current PROs in haemophilia and facilitates the selection of appropriate instruments for specific purposes in clinical and research settings. This work was made possible by the grant of the European Murinet Project (Multidisciplinary Research Network on Health and Disability in Europe).

Comparison between oral and intravenous fludarabine plus cyclophosphamide regime as front-line therapy in patients affected by chronic lymphocytic leukaemia: influence of biological parameters on the clinical outcome

Luca Laurenti, *Laura De Padua*, *Michela Tarnani*, *Nicola Piccirillo*, et al. Annals of Hematology. Berlin: Jan 2011. Vol. 90, Iss. 1; pg. 59

Abstract: The fludarabine plus cyclophosphamide (FC) regimen was reported to be superior to chlorambucil or fludarabine alone in terms of complete response (CR), overall response (OR) and progression-free survival (PFS) in previously untreated patients with chronic lymphocytic leukaemia (CLL). In the present study, we compared the efficacy and toxicity of FC administered through oral and intravenous route in 65 untreated patients affected by advanced CLL. No statistical differences were noticed between the two routes of administration in terms of OR, PFS, time to retreatment (TTR) and overall survival (OS) of analysed patients. We also assessed the influence on the clinical outcome of the mutation status of the immunoglobulin variable region heavy chain (IgVH) gene, of the cytogenetic abnormalities and of the expression of ZAP70 and CD38 in patients' primary samples. Among the 58 evaluable patients, 31 (53%) achieved a CR and 18 (31%) a partial response. The median PFS was 35 months, median TTR was 42 months and median OS was not reached after 45 months (range, 1-161). A significantly lower OR rate was noticed in patients with high-risk cytogenetic abnormalities (del 17p, del 11q). In this study, high-risk cytogenetic abnormalities and unmutated IgVH genes were independent predictors of TTR. These results underline the importance of biological stratifications in front-line treatment of CLL patients. We confirm that FC is an effective regimen with mild toxicities; it could be recommended for patients with low-risk biological parameters who represent, in our experience, about 30% of the total.

Central venous catheter-associated bloodstream infection and colonisation of insertion site and catheter tip. What are the rates and risk factors in haematology patients?

Dirk Luft Claudia Schmoor, *Christine Wilson*, *Andreas F Widmer*, et al. Annals of Hematology. Dec 2010. Vol. 89, Iss. 12; pg. 1265

Abstract: Skin colonisation is an important source for central venous catheter (CVC) colonisation and infection. This study intended to identify risk factors for skin colonisation prior to CVC placement (baseline colonisation) and within 10 days after CVC insertion (subsequent colonisation), for CVC-tip colonisation and for bloodstream infection (BSI). Within a randomised clinical trial, data of 219 patients with haematological malignancies and inserted CVC (with a total of 5,501 CVC-days and 4,275 days at risk) in two university hospitals were analysed. Quantitative skin cultures were obtained from the insertion site before CVC placement and at regular intervals afterwards. CVC-tip cultures were taken on CVC removal and data collection was performed. Statistical analysis included linear and logistic regression models. Age was an independent risk factor for colonisation prior to CVC placement (baseline colonisation). Independent risk factors for subsequent colonisation were baseline colonisation and male gender. High level of subsequent skin colonisation at the insertion site was a predictor of CVC-tip colonisation, and a predictor of BSI. High level of skin colonisation predicts catheter tip colonisation and possibly subsequent infection. Sustained reduction of bacterial growth at the CVC insertion site is therefore indispensable. Male patients are at particular risk for skin colonisation and may be a target population for additional insertion-site care before and during catheterisation.

Screening, prevention and management of osteoporosis and bone loss in adult and pediatric hematopoietic cell transplant recipients.

McClune B L, Polgreen L E, Burmeister L A, Blaes A H, Mulrooney D A, Burns L J, Majhail N S. Bone Marrow Transplantation, Volume 46(1) pgs. 1-162 January 2011

Abstract: Long-term survivors of hematopoietic cell transplantation (HCT) are at risk for loss of bone mineral density (BMD) and subsequent osteoporosis. There is a lack of clear guidelines for the screening, prevention and treatment of bone loss after HCT. We reviewed the prevailing literature and provide guidelines developed by our center for the

screening and management of this complication. Bone loss occurs predominantly within the first 6-12 months after autologous and allogeneic HCT. Recovery first occurs in the lumbar spine and is followed by a slower recovery of BMD in the femoral neck. BMD may not return to baseline levels in patients with continuing exposure to corticosteroids and calcineurin inhibitors. All HCT recipients should be advised general interventions to reduce fracture risk including adequate intake of calcium and vitamin D. We recommend screening all adult allogeneic and autologous HCT recipients with dualenergy X-ray absorptiometry 1 year after transplantation. Patients at high risk for bone loss (for example, patients receiving >=5mg of prednisone equivalent daily for >3 months) can be screened earlier (for example, 3-6 months after HCT). Where indicated, bisphosphonates or other antiresorptive agents (for example, calcitonin) can be used for prevention or treatment of osteoporosis in adult HCT recipients. Pediatric HCT recipients should be referred to a pediatric endocrinologist for evaluation and treatment of bone loss. There remain several areas of uncertainty that need further research in adult and pediatric HCT recipients, such as the optimal timing and frequency of screening for loss of bone mineral density, relationship of bone loss with risk of fractures, selection of appropriate patients for pharmacologic therapy, and optimal dosing schedule and duration of therapy with anti-resorptive agents.

Tools for Assessing Nausea, Vomiting, and Retching: A Literature Review

Wood J M, Chapman K, Eilers, J. Cancer Nursing, Volume 34(1), January/February 2011, pp E14-E24

Background: Chemotherapy-induced nausea, vomiting, and retching are recognized as having an impact on patients' overall physical well-being, quality of life, and treatment decisions. Although there are many tools available to measure aspects of these symptoms, few offer a complete and concise clinical assessment.

Objective: The purpose of this article was to provide a comprehensive overview of the various instruments available for the assessment of cancer-related nausea, vomiting, and retching. Analysis included symptoms measured, period evaluated, type of questions posed, and aspects of each symptom measured.
Methods: Searches were conducted to find relevant articles using nationally recognized oncology Web sites and 4 electronic databases including PubMed, MEDLINE/CINAHL and CINAHL/EBSCO, and Cochrane.
Results: This review includes a total of 25 instruments that were identified as meeting the inclusion criteria of having been developed, or adapted, for the adult population, with an oncology focus.

Conclusion: The ideal instrument would include measurement of all 3 symptoms while remaining clear, concise, and clinically relevant.

Implications for Practice: Although only 1 instrument came close to meeting these criteria, this review provides nurses with specific information on a variety of instruments to assist providers in selecting the most appropriate instrument for their specific clinical setting. This comprehensive critique of instruments is important for nurses attempting to select a tool to guide optimum care for patients in the clinical setting.

Hematologic Patients' Clinical and Psychosocial Experiences With Implanted Long-term Central Venous Catheter: Self-management Versus Professionally Controlled Care

Møller T and Adamsen L**.** Cancer Nursing 2010 33(6), pp 426-435

Background: A significant decrease in catheter-related infections was demonstrated in our earlier randomized controlled trial of central venous catheter (CVC) care in hematologic patients.

Objective: This article focuses on patients' clinical and psychosocial experiences with CVC self-care compared with professionally controlled CVC care.

Methods: Eighty-two patients with tunneled CVCs were enrolled in the randomized controlled trial. The intervention group (n = 42) was trained to perform CVC self-care. The control group (n = 40) followed standard CVC procedure provided by nurses. Eighteen patients were selected for semistructured interviews focusing on patients' clinical and psychosocial experiences with CVCs.

Results: Methods of CVC care have different influences on the patients' clinical and psychosocial outcomes, depending on whether they were hospitalized or outpatients. Central venous catheter was viewed as important because it was the main port of treatment toward a cure, although patients constantly fear complications. Central venous catheter self-care increased patients' independence from health professionals and supported perceived self-efficacy and control. Central venous catheters cause psychosocial problems including altered body perception, sexual activity avoidance, and feeling stigmatized.

Conclusions: Patients experience increased perceived self-control and independence when individually supervised and trained in CVC self-management. Assuming ownership of CVC care can encourage patients to feel less inhibited about sexual activity and socialization.

Implications for Practice: Placement of a tunneled CVC should engage nurses to organize individualized structured and supervised patient education. Stigma originating from CVCs should be carefully considered by health professionals when maintaining CVC insertion for longer periods. Central venous catheters should be removed whenever the potential risks exceed the catheter's functional necessity.

Recombinant Infusion Therapies Indicated for Bleeding Disorders
Kauffman J Journal of Infusion Nursing Vol 34(1), January/February 2011, p 29–35

Abstract: Hemophilia is a genetic condition that causes prolonged bleeding in those affected after surgeries, dental procedures, and injuries. It has been treated with a variety of products in the modern era, with some of the treatments causing serious viral infections. The development of recombinant-factor products has led to longer life expectancy and better quality of life for those affected. The objectives of this article are to review the epidemiology and pathophysiology of hemophilia A and B and von Willebrand's disease and to outline the development of treatment products, along with the advantages and disadvantages of each product. Research on newer products is progressing at a rapid pace. The article will also discuss some of the newer products currently in development.
A comparison of international guidelines for the prevention of chemotherapy-induced neutropenia

Lyman G H, Current Opinion in Hematology

Issue: Volume 18(1), January 2011, p 1–10

Purpose of review: Clinical practice guidelines for the prevention of febrile neutropenia in patients receiving cancer chemotherapy utilizing the myeloid growth factors have been developed by several major international professional organizations. This review provides updates on the current status of these guidelines and summarizes recent reported studies currently under review by guideline panels which may alter guideline recommendations.
Summary: Current guideline recommendations for the prevention of febrile neutropenia are reviewed along with recent published results likely to alter future guideline recommendations on the use of these agents.

Natural killer cells and tumor control

Cooley, Sarah; Weisdorf, Daniel S. Current Opinion in Hematology

Issue: Volume 17(6), November 2010, p 514–521

Purpose of review: After hematopoietic cell transplantation (HCT) donor-derived natural killer (NK) cells kill tumor cells to prevent relapse and mediate other beneficial clinical effects including control of infections without inducing graft-vs.-host disease (GVHD). Understanding the determinants of NK cell alloreactivity and function will support improvements in the design of HCT and adoptive cellular therapies.

Recent findings: Refinements to the model of NK cell education or licensing have been made which will inform strategies to develop functional alloreactive NK cells for therapeutic use. Differences in NK cell function have been shown to be dependent on the nature of the stimuli. Recent advances have been made in our understanding of the role of activating NK receptors on education and outcome after HCT. The use of adoptively transferred NK cells to treat hematopoietic malignancies has been expanding. New approaches to modulate target sensitivity to NK cell-mediated killing are under development.

Summary: NK cells play an important role in the therapeutic efficacy of HCT, with effects on control of infections, GVHD, engraftment and relapse prevention. Recent advances in our understanding of NK cell biology will support improvements in our ability to exploit NK cells to treat cancer.

How I manage haematology patients with septic shock

Cohen J and Drage S. British Journal of Haematology , Volume 152, Issue 4, pages 380–391, February 2011

Abstract: Patients with a variety of haematological conditions are at risk of infection and its most serious complication: septic shock. Mortality for septic shock remains high and especially so in patients with haematological malignancy and following bone marrow transplantation. However, advances in the treatment of severe sepsis have improved mortality rates even though evidence for the management of severe sepsis in haematology patients is limited. Wherever possible this review will concentrate on evidence directly applicable to haematology patients but inevitably will have to extrapolate evidence from other patient groups. The Surviving Sepsis Guidelines 2008 provide information on best practice in the management of patients with severe sepsis and septic shock and are broadly applicable though not specific to haematology patients. This review summarizes a practical approach to the management of severe sepsis in haematology patients and highlights areas of research which may bring new treatments in the future. The review is limited to the management and initial resuscitation of septic shock in adult haematology patients and will not address the detailed intensive care management of these patients or the management of severe sepsis in children

Pre- and Post-Transplantation Risk Factors for Delirium Onset and Severity in Patients Undergoing Hematopoietic Stem-Cell Transplantation

Fann JR, Hubbard RA, Alfano CM et al

Journal of Clinical Oncoloy Published online before print January 24, 2011

Purpose To determine pre- and post-transplantation risk factors for delirium onset and severity during the acute phase of myeloablative hematopoietic stem-cell transplantation (HSCT).

Patients and Methods Ninety adult patients with malignancies admitted to the Fred Hutchinson Cancer Research Center for their first HSCT were assessed prospectively from 1 week before transplantation to 30 days after transplantation. Delirium was assessed three times per week using the Delirium Rating Scale and the Memorial Delirium Assessment Scale. Potential risk factors were assessed by patient self-report, charts, and computerized records. Multivariable analysis of time to onset of a delirium episode was undertaken using Cox proportional hazards regression with time-varying covariates. Analysis for delirium severity was carried out using a linear mixed effects model. Validation and sensitivity analyses were performed on the final models.

Results Forty-five patients (50%) experienced a delirium episode. Pretransplantation risk factors for onset and higher severity of delirium were higher mean alkaline phosphatase and blood urea nitrogen (BUN) levels. Poorer pretransplantation executive functioning was also associated with higher delirium severity. Higher doses of opioid medications were the only post-transplantation risk factor for delirium onset (hazard ratio, 1.05; 95% CI, 1.02 to 1.08). Higher opioid doses, current and prior pain, and higher BUN levels were post-transplantation risk factors for greater delirium severity (all $P < .01$).

Conclusion Pre- and post-transplantation factors can assist in identifying patients who are at risk for delirium during myeloablative HSCT and may enable clinical interventions to prevent delirium onset or decrease delirium symptoms.

Immunosuppressive therapies in the management of immune-mediated marrow failures in adults: where we stand and where we are going.

Risitano A M, British Journal of Haematology 152(2):127-140, January 2011.

Abstract: Immunosuppression is a key treatment strategy for aplastic anaemia (AA) and the related immune-mediated bone marrow failure syndromes (BMFS). For the last 20 years the standard immunosuppressive regimen for AA patients has been anti-thymocyte globulin (ATG) plus ciclosporin A (CyA), which results in response rates ranging between 50% and 70%, and even higher overall survival. However, primary and secondary failures after immunosuppressive therapy remain frequent, and to date all attempts aiming to overcome this problem have been unfruitful. This article reviews the state of the art of current immunosuppressive therapies for AA, focusing on open questions linked to standard immunosuppressive treatment, and on experimental immunosuppressive strategies which could lead to future improvement of current treatments. Specific immunosuppressive strategies employed for other BMFS, such as lineage-restricted marrow failures, myelodysplastic syndromes and large granular lymphocyte leukaemia-associated cytopenias, are also briefly discussed.

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