April 2013 Volume 7: Issue 1

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Newsletter design and publishing:
Natalie D'Abrew

HAA 2013
Joint Annual Scientific Meeting of HSANZ/ANZBT & ASTH
Gold Coast Convention & Exhibition Centre
20-23 October 2013

Firstly a reminder that calls for abstracts and registration will be in May 2013, with abstracts due 1st July 2013.

and

Best abstract travel grants are available to members!

Conference website: www.fcconventions.com.au/HAA2013/

The nursing program is now starting to shape up nicely…with loads of help from our wonderful local organizing committee who despite the torrential rain and miserable weather have brought their bodies, brains and enthusiasm together to come up with lots of wonderful ideas, subjects and speakers that I believe will translate into another interesting and informative Nursing program at the Gold Coast HAA this year. We are bringing together much of our fantastic and inspirational local and national talent, as well as some amazing international talent to present a Nursing program that I believe will be diverse and exciting!!…Hopefully something for everyone!!

Catherine Kirk
HSANZ QLD Nursing Rep ckirk@hoca.com.au

A word or two from the President…

My name is Tracy King and I'm a #Twitter addict!

There you are, I've confessed, the beginning of my road to recovery. Having been and still remain in part, a social media sceptic – you won't find me on *facebook* (!) – I have embraced the medium in a professional capacity. After overcoming my fear of 'texting the world' via Twitter – I am finding how useful a tool it can be to get a key message out to a wider group and also to follow topics and conversations of interest as well as organisations that may be of interest.

I was lucky enough to attend a recent conference in Kyoto Japan – the International Myeloma Workshop (#IMW2013) and from there I tweeted from our local Cancer Nursing Research Unit account. Why not check it out and read some of my comments and thoughts? Twitter account: CNRU1. Be careful, it can become addictive! I'll include a report from IMW 2013 conference in the next edition of the newsletter.

We have another bumper edition of the newsletter for your reading pleasure. Of particular note is a reminder from Catherine Kirk and her local organisation committee in QLD that HAA 2013 will be held on the Gold Coast and abstracts will open very soon. I would encourage you all to get together with colleagues and think about what you have been doing over the past year that you could share with the wider Haematology nursing group. Perhaps you've been involved in a clinical audit; developing a new tool or resource in your units; improving a service or program to better meet your patient's needs? Have an idea and just can't think how to frame it – get in touch with your regional HSANZ NG representative and they would be happy to help you put something together.

Petrified of presenting in front of a group? Then a poster is a perfect way to start off – you just need to be able to stand in front of your poster, often with a glass of wine in hand, now that's not so hard is it?! In the next edition we'll include an article on how to make a conference poster… so watch this space.

Enjoy the read and remember, we're always looking for people to contribute to the newsletter so please get in touch with me directly if you have something to say.

Tracy King
President HSANZ NG
tracy.king@sswahs.nsw.gov.au

The experience of a life time!

… 2 girls, a fellowship, meeting Kathy Bates and just a little bit of shopping!

In 2012 Priscilla Gates (Advanced Practice Nurse, Peter MacCallum Cancer Centre) and I were fortunate to receive a *Department of Health, Victorian Quality Council Fellowship* to enable us to visit survivorship centres in New York City and Seattle, and attend a survivorship conference in Washington DC. The journey began 12 months before departure with a stringent application process including a written piece and panel interview. We could not believe our luck when we were short listed and then successful.

Our fellowship visit included:

- Observational visit to the Memorial Sloan Kettering Cancer Centre, NYC.
- Attendance at 6th Biennial Cancer Survivorship Research – Washington DC, Translating Science to Care conference
- Observational/clinical visit to Fred Hutchison Cancer Research Centre, Seattle.

An increasing number of patients are surviving long-term post treatment for haematological malignancies and bone marrow transplantation (BMT). This is due to significant improvements in early acute supportive care. With long term survival many patients are living with chronic illness and some experiencing late effects associated with the toxicity of prior treatment. The assessment and management of patients within a dedicated late effects clinic (LEC) is well established internationally and the increasing need is being recognised in Australia.

Our fellowship objectives were:

- To expand knowledge and skills in the development and implementation of nurse led survivorship clinics by working alongside Advanced Practice Nurses (APN)/ Nurse Practitioners (NP) at the Memorial Sloan Kettering Cancer Centre (MSKCC) and the Fred Hutchison Cancer Research Centre (FHCRC).
- To observe and gain knowledge in the development and implementation of Survivorship Care Plans.
- To observe and work along side APNs/NPs in the delivery of end of treatment consultations.
- To observe and gain knowledge about end of treatment information sessions for patients and carers, including the implementation of post treatment rehabilitation eg. Exercise programs, psychosocial support, and nutritional guidelines.
- To gain knowledge in the delivery of psychosocial screening at completion of treatment.
- To observe & gain knowledge in the assessment and management of chronic graft versus host disease.

Activities undertaken / programs initiatives observed at MSKCC:

- Overview of the survivorship program
- Establishing the nurse practitioner model of care
- Implementing an outpatient transplant program
- Patient education for cancer patients and survivors
- Nutrition for cancer survivors
- Newsletter and online resources for cancer survivors
- Psychosocial services for cancer survivors
- Nurse Practitioner provision of survivorship care
- Assessment and management of graft versus host disease
- Physical rehabilitation for cancer survivors
- Multidisciplinary clinic serving young adult survivors of paediatric cancers
- Caring for cancer survivors who underwent high-risk treatment

We were also fortunate to attend the MSKCC annual survivorship celebration. Kathy Bates was the invited speaker and described her experience of being diagnosed and treated for ovarian cancer. Priscilla and I were lucky enough to meet and have our photo taken with Kathy Bates. She was generous with her time and very excited that we were visiting from Australia.

Activities undertaken / programs initiatives observed at FHCRC:

- Clinical observation
- Discussion of chronic graft versus host disease diagnosis and management
- Discussion of long term follow up research
- Overview of survivorship services
- Implementation of survivorship services
- Discussion of survivorship research
- Overview of survivorship outreach services
- Discussion of "Exercise & Thrive" program

> *'The rationale for undertaking international investigation on survivorship initiatives at the Memorial Sloan Kettering Cancer Centre (MSKCC) and Fred Hutchison Cancer Research Centre (FHCRC) was to observe APN/NP's who specialise in the care of cancer survivors and practice within nurse led disease-specific survivorship clinics. We were given the opportunity to learn about each centres survivorship program. Each program review hundreds of patients each year and APNs and NPs have an integral role in the management of patients long term care.'*

The MSKCC and FHCRC are world renowned leaders in cancer care. They both have multi-disciplinary long term follow up clinics with APN/NPs who provide nurse led disease and treatment specific follow up care, including assessment, screening, diagnostics, early detection (physical and psychological) and pharmacological and non-pharmacological intervention. An important part of the APN/NP role is health promotion, rehabilitation, community and GP liaison and education about life long health behaviours. The APN/NPs are also proficient in the development and delivery of survivorship care plans to their patients.

The theme of the 2012 Conference was "*Cancer Survivorship Research: Translating Science to Care*" which reflects a growing consensus about the importance of translating scientific discoveries into clinical and behavioural interventions and replicating this work across diverse populations in a way that will optimise physical and psychosocial functioning and prolong the lives of cancer survivors.

The conference showcased cutting-edge research across the translational science continuum. The continuum spans basic science studies, epidemiologic research, and concept development; feasibility and efficacy testing of interventions, and measurement development; and the dissemination and implementation of survivorship interventions to practice settings and policy. Around 500 people attended the survivorship conference, though only around 30 from outside of the US. The meeting involved several plenary sessions, three concurrent preferred paper sessions and two very interactive, engaging poster sessions.

Continued from page 4

Plenary sessions included:

- Obesity in cancer care
- Mechanisms of premature again: roles of stress, telomeres and telomerase in cancer survivorship
- National cancer survivorship Initiatives
- Optimising communication and coordination during post treatment care of cancer survivors

Concurrent symposia attended:

- Cardiac injury
- Survivorship care planning
- Impact of cancer on sexuality and relationships
- Psychosocial issues in cancer survivorship

> *'The purpose of attending the Cancer Survivorship conference was to increase knowledge and expertise on current practice and research in survivorship. This meeting served as a forum for researchers, clinicians, cancer survivors, advocates, program planners, policy-makers, and public health experts to learn about current and emerging cancer survivorship research.'*

The experience, knowledge and skills gained from each visit were extremely valuable in developing our clinical practice. Our current and future goals involve implementing and disseminating the knowledge and skills we gained during our fellowship experience. We have formed relationships with the intention of pursuing collaborative projects and sharing knowledge. Each day was filled with meeting new people who were excited to share their experience of service development and implementation. They were interested in our roles and survivorship services in our organisation. Each afternoon as we walked from the Upper East Side in NYC toward 5th and Madison Ave our minds and bodies were exhausted but inspired with survivorship initiatives to bring home.

(excerpt from fellowship final report, written by Yvonne Panek-Hudson & Priscilla Gates).

Yvonne Panek-Hudson
Allograft Nurse Practitioner,
Peter MacCallum Cancer Centre, East Melbourne
Victorian representative, HSANZ Nurse Group.

Tiny blood testing laboratory gets under your skin

Scientists in Switzerland say they have developed a tiny blood-testing device that sits under the skin and gives instant results that are then transmitted to doctors via mobile phone technology. It is designed to be inserted into the interstitial tissue just beneath the skin of the abdomen, legs or arms. The researchers say it will be particularly useful for monitoring chronic conditions such as high cholesterol and diabetes as well as tracking the impact of drug treatments such as chemotherapy.

Prof De Micheli, of Ecole Polytechnique Federale de Lausanne, said: "It will allow direct and continuous monitoring based on a patient's individual tolerance, and not on age and weight charts or weekly blood tests." The device's developers hope it will be available to patients within four years.

To read the full article visit: http://www.bbc.co.uk/news/health-21841829

Written by **Louise Acret, CNRU**

Breaking News:

New opportunity for Grant-in-Aid for Supportive Care Research

OPEN NOW

Closing date for expressions of interest 3rd May, 2013

The Leukaemia Foundation is pleased to announce the call for applications for the 2014 round of the National Research Program, including a new Grant-in-Aid for Supportive Care Research.

What is supportive care?

NCI define supportive care as "Care given to improve the quality of life of patients who have a serious or life threatening disease. The goal of supportive care is to prevent or treat as early as possible the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social, and spiritual problems related to a disease or its treatment".

Projects submitted for consideration may address psychosocial, behavioural and supportive care issues in malignant haematology that have a strong rationale and methodology. Proof of concept studies including non-interventional (e.g. descriptive / observational) and interventional study designs will be considered.

For more information on this and other current funding opportunities please go to:

http://www.leukaemia.org.au/web/research/researchgrants.php

or contact jridge@leukaemia.org.au

Jacinta Ridge,
Research Executive Officer, Leukaemia Foundation

Editor's comment: *This new grant opportunity demonstrates the Leukaemia Foundations commitment to supporting research in the area of supportive care in Haematology. The new Grant in Aid focusing on supportive care complements the substantial and comprehensive program of research the Leukaemia Foundation support. I highly encourage all of you involved in undertaking research in this space, to review the full grants program and to pass it around amongst your colleagues and units.*

“You want me to do what?” …Chester Chest to the rescue!

How did you react when you had to access your first patient’s port-a-cath? What if the patient you were asked to carry out this procedure on was a very anxious 3 year old who has a fear of nurses? If any of these thoughts make you feel apprehensive and frightened you are not alone.

As the Clinical Nurse Educator I am often asked to assess a new staff member’s competence of managing central venous access devices (CVADs). In our centre, many of our patients with Haematological or Oncological conditions have CVADs. As haematology nurses we must be able to care for these devices confidently and competently. The only issue with this is that many nurses who are new to Haematology/Oncology are unfamiliar and fearful of these devices, in particular the port-a-cath. This can be a challenging clinical teaching activity as the nurse is often apprehensive of the device and how the child will react to the procedure.

In our unit we are fortunate enough to have access to a low fidelity simulation mannequin that we call ‘Chester Chest’. If you are not already familiar with Chester, it is a human torso with a central venous line in one side of his chest and a port-a-cath in the other side. On the port-a-cath side, the skin is able to be removed so that the actual port-a-cath and what it would look like inside the patient, is visible. The central line and port-a-cath are attached to a mock blood supply which allows the lines to be accessed, bled, heplocked etc, just as they would be used in real life situations.

Chester is my most valuable teaching tool as it allows me to explain the physiology of the device and demonstrate CVAD nursing skills whilst providing a safe learning environment. Nurses can experiment with the devices and gain confidence and competence through simulated procedures. A low fidelity simulation devices, like Chester, allow the components of complex nursing skills to be broken down into smaller sections to facilitate individual learning. In a paediatric setting, this approach is embraced by nurses as they can master the technical aspects of the skill before having to worry about the level of cooperativeness from the patient.

Chester is not only a valuable teaching tool for nurses, but for parents as well. As many of our patients require long term treatment they’re often given a CVAD which parents are able to use after extensive teaching sessions. We have used Chester to teach parents how to access a port-a-cath or Hickman’s line in order to administer intravenous factor medication to their own child. The option of teaching parents on a mannequin rather than on their child creates a safe and low stress environment for a parent to learn the skill. Simulation ensures that patient safety is maintained as it allows for mistakes to be made and learnt from without any potential complications to the child, which is the upmost priority of care.

Renee Gilmore
Clinical Nurse Educator
Outpatient Haematology/ Oncology Unit

16th Winter Congress

Cancer Nurses Society of Australia

25-27 July 2013
Brisbane Convention and Exhibition Centre

Invitation to Attend

The CNSA Winter Congress, to be held in Brisbane, 25 - 27 July 2013, with the theme "Connecting Cancer Care" reflects practice, education and research issues relevant to all nurses working across health providers, States and Territories and, as indicated by our presence at the International Society of Nurses in Cancer Care Conference in Prague in September 2012, our connections across continents and cultures.

The CNSA Winter Congress meeting has become the must-attend conference of the year for Australian nurses working with people affected by cancer. The Winter Congress site has all the details you will need to submit abstracts, register to attend, follow the progress of the program as it develops, book your accommodation and plan your trip to Brisbane!

The CNSA National Executive and the Local Organising Committee chaired by Jane Campbell, look forward to welcoming you to Brisbane.

www.cnsawintercongress.com.au

Diary Dates

21 January 2013	Abstract Submission Opens
20 March 2013	Abstract Submission Closes
March 2013	Registration Opens
30 May 2013	Early Bird Deadline for Registration
24 June 2013	Accommodation Bookings Close

Major Supporter Hospira

International Keynote Speaker

Professor Brenda Nevidjon

Professor and Faculty Coordinator of the Health Care Systems Instructional Area in the MSN Program, Duke University School of Nursing, North Carolina, USA

President-Elect of the International Society of Nurses in Cancer Care

What you can expect from the program

- **Pre-Congress workshops** on Thursday 25 July 2013
- **Breakfast sessions** on Friday and Saturday morning
- **Plenary Sessions**
- **Concurrent sessions** featuring abstract presentations
- **Poster presentations**
- **Social events** – Welcome Reception/Gala dinner and Farewell drinks
- **Extensive industry exhibition**

Key Topics and Themes

- Sessions developed specifically for novice and advanced practitioners
- Latest research updates
- How to publish your own work
- Leadership and mentoring
- Current clinical practices
- Psychosocial care

CNSA Membership: For information on becoming a member of CNSA, please visit the society website: **www.cnsa.org.au**

Further information: For more information please visit the congress website, **www.cnsawintercongress.com.au**

It has been a busy start to the year for the Cancer Nurses Society of Australia, with a range of activities and projects already underway. Our long awaited new website was launched in February, at www.cnsa.org.au. Keeping our members informed is the key to our vibrant society and so the CNSA has ventured into social media, launching our CNSA Facebook and Twitter accounts. Since January, the CNSA has been posting up-to-date information on our national and regional activities as well as international cancer news. Follow us at our Twitter tag: CNSA_ORG and find us on Facebook at www.facebook.com/CNSA.ORG

Planning for the 16th Winter Congress is also in full swing with registration now open. This year's congress will be in sunny Brisbane on July 25th to 27th 2013 and the theme of the meeting will be "Connecting Cancer Care". Ms Brenda Nevidjon, President Elect of the International Society of Nurses in Cancer Care, will be our international keynote speaker. Other invited speakers include Associate Professor Jane Turner from University of Queensland, Mr Dan Mellor, Deputy Director of Pharmacy at the Peter MacCallum Cancer Centre and Ms Beth Faiman, Nurse Practitioner Haematology and Medical Oncology at the Cleveland Clinic. This year's program will offer a range of workshops, plenaries and concurrent sessions for novice and advanced cancer practitioners alike.

We hope to see some of you at our Winter Congress, liking and sharing our Facebook posts and following our tweets.

Trevor Saunders
Victoria Representative
Cancer Nurses Society of Australia

Keeping 'APP' to-date on apps!

NPS Medicines List is a free, easy to use app, patients can:

- Keep a list of all the medications they are currently taking – including prescription, over the counter and complementary medicines.
- Capture important information about their medicines, including brand name, active ingredients, strength, dosage and when to take each medicine. Add/remove medicines/change dosages/ schedule.
- Set alarms to remind them when to take each medicine, (ability to turn on and off all medicine alarms or individual alarms as required).
- Add photos of medicines, packaging and dispensing labels.
- Save personal details, health professionals contact details and questions they have.
- Quickly see all medications in a list view (e.g. what's due today, tomorrow).
- Track schedule of medicines taken or any missed.
- Email a medicines list to print off copies before an appointment for review with health professionals.

Thalomid
thalidomide 50mg capsule

Cycloblastin
cyclophosphamide 50mg tablet

Dexmethsone
dexamethasone 4mg tablet

Cartia
aspirin 100mg tablet - modified release

Pramin
metoclopramide 10mg tablet

KEEP YOUR MEDICINES LIST UP TO DATE

List prepared by the patient or

MY NAME: Daniel Donovan

THIS INFO

Name of medicine Brand name and active ingredient	What is the medicine for?	How much do I use and when?	Special instructio			
Thalomid thalidomide 50mg capsule	myeloma	4 tablets, Once daily at night	take 1 hr after food			
Cycloblastin cyclophosphamide 50mg tablet	myeloma	10, Customise - weekly	take with or after			
Dexmethsone dexamethasone 4mg tablet	myeloma	5 tablets, Customise - weekly		18 March 2013	18 April 2013	ongoing
Cartia aspirin 100mg tablet - modified release	preventing clots	1 tablet, Once daily in the morning		18 January 2013	unknown	ongoing
Pramin metoclopramide 10mg tablet	if I feel sick	1 tablet, When needed	maximum 3x daily	18 March 2013	unknown	ongoing
Blackmores B12 cyanocobalamin 100mcg tablet	vitamin b deficiency	1 tablet, Once daily in the morning		01 January 2012	unknown	ongoing
Omacor omega 3 acid 840mg capsule		4 capsules, Once daily in the morning		18 March 2013	unknown	18 March 2013

For more details on the NPS medicines list iphone app go to:
http://www.nps.org.au/conditions-and-topics/topics/how-to-be-medicinewise/managing-your-medicines/iphone-medicines-list

Written by **Myfanwy Pannells**, CNRU

REPORT: Tandem BMT Meeting, Salt Lake City, February 2013

I was very fortunate to attend the Tandem BMT meetings in Salt Lake City. The Tandem meetings are a number of combined BMT meetings that run concurrently. As a registrant for the conference, the attendee is able to dip in and out of any of the meetings. The concurrent meetings included:

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

The first meeting to start was the data management meeting. The Center for International Blood and Marrow Transplant Research (CIBMTR) collects data from hundreds of transplant centres around the world and has now accumulated the data from over three hundred thousand autologous and allogeneic stem cell transplants that have been performed since the 1970's. The CIBMTR have conducted a number of retrospective observational studies about transplant outcomes and patients' quality of life – there were a few presented at this meeting.

The nursing conference had a number of very important presentations. Highlights include:

- An excellent presentation about oral complications post transplant. This gave good information about what to look out for in patients' mouths and looked at the short and long term complications (including secondary oral cancers).
- A talk about cellular therapy that, though complex in parts, was interesting and an exciting peek into where we might be heading with cellular therapy in the future. The presenter talked about using cells to treat infectious complications of transplant such as EBV post transplant lymphoproliferative disorder (PTLD) that is a rare but potentially serious complication. He also explained that cells collected from a donor could be manipulated to target particular cells that may be implicated in post transplant relapse. The use of cells in this context is still experimental but there have been some good phase I study results come through.
- An excellent talk about compassion fatigue. Compassion fatigue may be defined as: a debilitating weariness brought about by repetitive, empathic responses to the pain and suffering of others. It is multifactorial and understudied but may have a huge impact on a nurse's work and home life.

  Symptoms of compassion fatigue may include:
    - Feelings of depression, responses of negativity
    - Lethargy, little energy
    - Sadness, emotional lability or response out of context to situation severity
    - Sustained effort to subdue mounting melancholy
    - Boundary issues/overextension
    - Lack of attention to self (i.e. diet, exercise, personal enjoyment)
    - Reward substitution (i.e. food, ETOH)
    - Difficulty accepting feedback (+ or -)
    - Job transfer, turnover
    - Impatience with family or issues not deemed ‘life threatening’
    - Frustration with partner insensitivity to needs

Continued from page 10

It is something that needs to be talked about with colleagues. For those who may have worked for many years in haematology, they may have been involved with over 500 patients' deaths which may have had enormous emotional and psychosocial impact.

- There was a survivorship panel in which a 67 year old man who had MDS and the mother of a 4 year old who had a transplant at aged 6 months talked about how their treatment experience had been, their post transplant care and complications experienced. It was a very worthwhile session in which I saw that my impressions of what somebody is going through may be quite different to what they are actually experiencing.
- Transplants for elderly (over 60) patients with MDS. This presentation talked about the emerging role for allogeneic stem cell transplant in this age group. MDS is primarily a disease of those over 60 years of age and up until recent times because of the use myeloablative conditioning regimens; it has not been possible to transplant these people due to substantive transplant mortality. With the increasing use of reduced intensity and non-myeloablative conditioning regimens, this is now changing. Because of the older age of the recipients, sibling donors are also likely to be older. Comorbidities may preclude siblings being able to donate, so most allogeneic stem cell transplants performed in older MDS patients at the current time, use MUD donors.
- There was a very good talk about donor advocacy and the issues of being a stem cell donor. The presenter highlighted the fact that there hasn't been much prospective research done into the risks and benefits (both physiological and psychological) of being a stem cell donor. There are published guidelines about the education, care and treatment that donors should receive as well as the ethical obligations the medical community has in using volunteer donors. He stressed that it is very important for the donor to have their own medical team in order that the donor has an independent voice that is able to advocate on the donor's behalf.

The medical and scientific conference also had some very good presentations. Of note were sessions about:

- Post transplant complications such as VOD, GVHD and lung complications. This session provided a good overview of these complications and looked at studies being done in these areas.
- There was an excellent session about unrelated donors and donor registries - about the ambivalence many donors feel about donating stem cells even though they voluntarily signed up to the registry. There was also an excellent presentation about the finding donors who have disappeared from site of the registry and finding ways in which donors can show their commitment to being on the registry.
- Bone marrow transplant pioneer Professor E. Donnall Thomas died last year. He initially worked with dogs to prove that BMT was an option for the treatment of leukaemia and fought against many naysayers who were determined that this kind of therapy would not succeed. He won a Nobel peace prize in 1990 for his efforts. In approximately November 2012, the one millionth bone marrow transplant was performed somewhere in the world, proof that his theories and suppositions about this being a curative treatment were indeed correct. He was also a pioneer in unrelated donor transplantation. There was one session, in memory of Don Thomas, which talked about the challenges ahead for BMT around the world. Issues varied from maintaining and growing an experienced workforce, worries about resources as the numbers and indications for transplants continue to grow, equity of access for those in poorer countries as this is an expensive treatment, other finance issues, donor issues etc. It was a very interesting session and appropriate as we in NZ have an aging nursing and medical workforce like many other countries.

The mid level practitioner meeting had some excellent sessions. This meeting was for experienced nurses and physician assistants and was excellent learning with some good practical tips. There was an excellent late effects presentation which highlighted the work that had been done by transplanters around the world to develop some guidelines for screening and assessment of late effects. These guidelines were simultaneously published in several BMT and medical journals throughout the world so that the whole transplant and medical/healthcare community around the world would have access to them. The National Marrow Donor Programme has gone on to translate these into plain English guides for patients and have also developed a smart phone app for both patients and the medical fraternity. Other topics covered with excellent presentations included acute and chronic GVHD and cytogenetics in AML.

Continued from page 11

Attending this meeting has also provided reassurance that we, as a BMT centre in a small country, are providing good care to our patients and their families. I think that in NZ we often feel that we might be behind what the rest of the world is doing but in some instances, we might be ahead of what other centres are doing. One example of this was a poster by one of the leading hospitals in the USA talking about their lack of psychological support provided to patients by the mental health unit in their hospital. This lack of support was largely due to the fact that insurance companies were not prepared to pay for this service. We have very good psychological assessment and support for our transplant patients, something that we feel is an essential part of pre and post transplant care.

This has been an excellent meeting to attend. It was stimulating and thought provoking. There has been a lot of information provided that I can bring back to my colleagues and also to my patients and their support network. If anyone would like any further information about this conference, please feel free to get in touch with me.

Catherine Wood
Clinical Nurse Specialist BMT
Wellington Hospital NZ

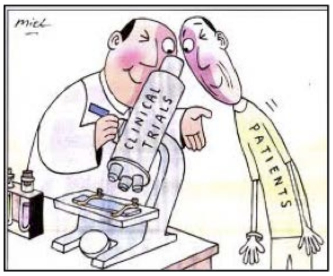
REPORT: Tandem Transplant Meeting, Salt Lake City, 2013

What is surely the premier BMT meeting internationally was held in Salt Lake City Utah from February 13 to 17. This was the best attended BMT meeting so far, with over 2800 registrants from 31 different countries and who submitted with 553 abstracts. This is a combined meeting of the Center for International Blood and Marrow Transplant Research (CIBMTR) and the American Society for Blood and Marrow Transplantation (ASBMT). In addition to the main scientific stream, the working committees of the CIBMTR do their real work here and there are also paediatric, pharmacy and BMT nursing streams. The meeting has a healthy balance of invited plenary speakers, free communications, posters and the various committees. In addition, there are daily symposia addressing specific topics and Meet the Professor sessions.

The highlight presentations are usually found in the best abstract session, which has 3 clinical papers. The first of these was a CIBMTR study of intravenous busulphan in myeloablative conditioning which demonstrated for the first time a clear survival advantage for busulphan-based regimens when compared to total body irradiation for patients with matched sibling or unrelated donors. This increase in overall survival for patients with AML, MDS and CML was observed without a change GVHD rates. A multicentre paediatric study from North America of the use of etanercept (combined with corticosteroids) in idiopathic pneumonia syndrome was equally impressive. Twenty-eight patients were studied of whom 17 were ventilated at study entry and 20 achieved a complete response. The median time to response was 10 days. Response rates were highest in non-ventilated patients.

Abstracts of all of the presented abstracts and posters are available in a supplement to the journal, Biology of Blood and Marrow Transplantation (volume 19, number 2, 2013 pages S109-392). Another issue of the journal contain excellent papers associated with the Educational Program. In 2014, the meeting (the 20th annual meeting) will be held in Dallas, Texas from February 26 - March 2.

Professor Jeff Szer
Director of Clinical Haematology and BMT Service
Royal Melbourne Hospital

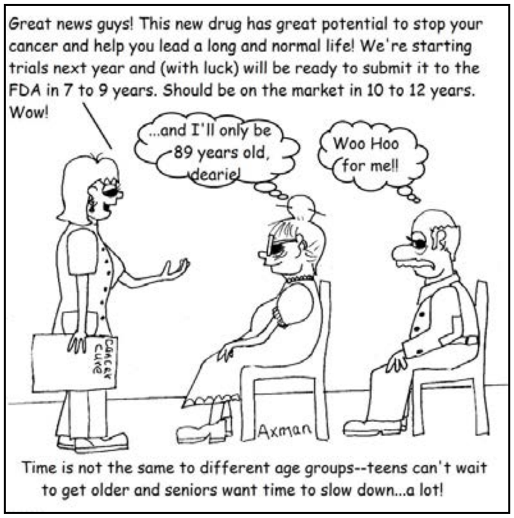


Trials Corner

Welcome to the first edition of the Trials Corner for 2013. I'm guessing that at some stage over the last few months you've caught up with friends, family and an array of new people who have not been shy in asking you questions about their ailments!

In the world of a Haematology/BMT Research Nurse, these inquiries are no different, however, many people proceed to question you on the latest scoop of what causes, and cures cancer! Similarly, it is not unusual for a Research Nurse to receive an influx of inquiries from interested parties after a 'cancer breakthrough' has been advertised.

Unfortunately, as Research Nurses can often be the first 'port of call' for information seekers, it is they, who frequently burst the bubble of drug availability; identifying that there is often a lengthy delay between laboratory breakthroughs and commercial viability. In this edition, we will explain the process undertaken by many a Research Nurse when their centre is approached to participate in a clinical trial.



Jenelle Peppin
Clinical Haematology/BMT Research Nurse
Royal Melbourne Hospital

<u>Key to diagram on page 12:</u>

- PI = Principal Investigator; the primary person in charge of the study at the institution.
- CTA = Clinical Trials Australia; a clinical trial network that is spread across multiple sites. They provide a comprehensive clinical trials service that includes the conduct of single or multisite clinical trials, ethics submissions, research governance and clinical development advisory services.
- Sponsor = a pharmaceutical company, such as Roche or Novartis; or other governing body that is primarily conducting the clinical trial.
- CTN = Clinical Trial Notification; a document which notifies the Therapeutic Goods Administration (TGA) of an institution's intent to supply an unapproved drug.
- HREC = Human Research Ethics Committee; protects the welfare and rights of participants involved in research. The HREC review research proposals for research that involve humans, monitor the conduct of research and deal with complaints that arise from research.
- Governance = the process used by institutions to ensure that they are accountable for the research conducted under their auspices. To be properly governed, research must be conducted according to established ethical principles, guidelines for responsible research conduct, relevant legislation and regulations and institutional policy.
- Indemnity = where HREC works in accordance with the National Statement, to ensure that there is an ethical duty and, in most cases involving unapproved therapeutic goods, a legal requirement, to ensure that there is adequate insurance cover for human research.
- FDA 1572 = Federal Drug Administration; an Investigator's declaration regarding their involvement in the study which is sent to the Federal Drug Administration (FDA).
- TGA = Therapeutic Goods Administration; the body responsible for regulating drugs in Australia.
- Representatives = Often pharmaceutical companies outsource their work to another company to ensure that the maintenance of study procedures and documentation is adhered to.
- Study Team = this may involve an array of people at the institution, such as pharmacy, nursing, medical and laboratory staff.

NEW CLINICAL TRIAL SUBMISSION PROCESS

Feasibility sent to PI* or CTA* from Sponsor*
(This is where the Sponsor gets an idea of numbers of people they could recruit to the study; establishing whether it is feasible for them to conduct the study at the institution. For some centres the Research Nurse may be involved in this process. In others, this process may be undertaken solely by the PI)

↓ ↑

Site Selection Visit
(This is where the Sponsor selects institutions based on the information obtained from the feasibility they conducted. Once a centre is notified that they have been chosen, all documentation associated with the study is sent to the site)

↓ ↑

Submission for Ethical Review
(Documentation such as the study Protocol; Investigator Brochure; Patient Information and Consent Form; CTN*; Patient cards/diaries; Radiation safety etc. is submitted to HREC*. This process is undertaken by either CTA or the Research Nurse allocated to the study)

↓

Receive Ethics Queries
(Once the study has been discussed at the HREC meeting, any inquiries will be relayed back to the PI directly, or via CTA or the Research Nurse allocated to the study)

↓

PI responds to the Ethics Queries
(Either directly, through CTA, or the Research Nurse)

↓

HREC Approves the Study

↓

Submission to the Governance* Office
(All study documentation – as mentioned above – along with a fully executed contract, indemnity, insurance, budget, departmental approvals, CTN etc. are submitted to the Governance Office for review)

↓

Governance Approved

↓

Send Approved Documents to the Sponsor
(These documents include the CTN, Indemnity*, and essential documents such as the FDA 1572*, Accreditation, Lab Reference Ranges, CVs etc.)

↓

Sponsor sends the CTN to the TGA* and organises drug

↓

Site Initiation Visit
(This occurs after the PI or Research Nurse has been advised by HREC that the study has been approved. The Research Nurse liaises with the Sponsor or their representatives* to conduct a visit to explain the intricacies of the study to the study team*. Unless otherwise directed, it is commonly recognised that once this visit is completed, the study is regarded as being open to accrual)

Iodine-131 Rituximab Radioimmunotherapy with BEAM Conditioning and Autologous Stem Cell Transplant Salvage Therapy for Relapsed/Refractory Aggressive Non-Hodgkin Lymphoma

Paul C. Kruger, Julian P. Cooney, and J. Harvey Turner

Abstract

A standard salvage therapy of relapsed/refractory aggressive non-Hodgkin lymphoma (NHL) comprises autologous stem cell transplantation (ASCT) after chemotherapy conditioning with carmustine, etoposide, cytarabine, and melphalan (BEAM) regimen. However, the achievement of long-term disease-free survival remains challenging. We have introduced concomitant 131I-rituximab radioimmunotherapy (RIT) in an attempt to effect the elimination of lymphoma cells. Our phase II physician-sponsored study of 16 consecutive patients with relapsed, refractory, aggressive B-cell NHL reports a median 44 month follow-up after 131I-rituximab-BEAM conditioning therapy and ASCT. Prospective personalized dosimetry performed in each patient limited the whole body radiation absorbed dose to 0.75 Gy. RIT 131I-rituximab was administered on an outpatient basis on day - 15 before ASCT. The BEAM conditioning regimen was commenced on day - 6. Evaluable engraftment data are available for 15 patients who had 16 ASCTs. Engraftment was achieved in all patients, 15 out of 16 ASCTs achieved a complete response, and 1 out of 15 ASCTs achieved a partial response. Twelve out of sixteen patients remained alive and disease free at a median of 44 months (range 4–108 months) post-ASCT.

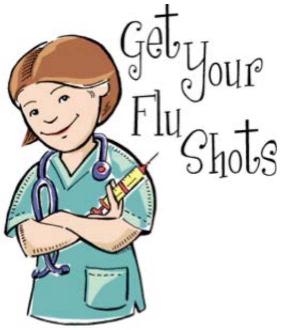
This study suggests that the addition of 131I-rituximab RIT to BEAM conditioning, before ASCT, for relapsed or primary refractory B-cell NHL improves disease eradication, compared with BEAM conditioning alone, without significant additional toxicity. In particular, there is an impression of improved disease control in the subset of patients with transformed follicular and mantle cell lymphomas.

The full published article can be accessed in
CANCER BIOTHERAPY AND RADIOPHARMACEUTICALS
2012 Volume 27 Number 9:552-560

Flu Vaccine Reminder

Autumn is here and now is the time to remind your patients to get their free flu shot. Under the National Influenza Vaccination Program free seasonal influenza vaccine is available to a number of at risk people including:

- all individuals aged 65 years and over
- all Aboriginal and Torres Strait Islander peoples aged 15 years and over
- individuals aged 6 months and over with medical conditions predisposing to severe influenza including:
- Chronic illnesses requiring regular medical follow up or hospitalisation in the previous year, including diabetes mellitus, chronic metabolic diseases, chronic renal failure, and haemoglobinopathies
- Impaired immunity, including HIV, malignancy and chronic steroid use



The CDC also recommends that people who live with or care for a person at high risk for flu-related problems get the vaccine. This means family members, caregivers, and children at home should get the flu shot, too. And finally don't forget to get your own free flu shot through your employer.

http://www.cdc.gov/cancer/flu/
http://www.health.nsw.gov.au/immunisation/Pages/seasonal_flu_vaccination.aspx

Bridging the Gap in International Haemophilia Care: *My experience working with haemophilia nurses in Vietnam*

Penny McCarthy, *Haemophilia Clinical Nurse Consultant Ronald Sawers Haemophilia Centre, Melbourne.*

"The Twinning Program of the World Federation of Hemophilia (WFH) was established more than 15 years ago. This program aims to improve hemophilia care in emerging countries through a formal, two-way partnership between two hemophilia organizations or treatment centres for a period of four years. Twinned organizations or hemophilia treatment centres work together and share information, resulting in a mutually beneficial partnership. It is a great way to transfer expertise, experience, skills, and resources." (www.wfh.org)

In October 2012 I attended my second 'twinning' visit to the National Haematology Institute for Blood Transfusion (NHIBT) in Hanoi Vietnam. The physicians at the NHIBT are well trained in western style medicine however their nurses have not had the same access to education. By building expertise within nursing, the Vietnamese health system will be able to utilize their nurses to give the patients the specialist care they require.

Our visit consisted of a team of two haematologists, a physiotherapist and myself, a haemophilia nurse consultant. We spent 5 days teaching and conducting workshops to assist this emerging Haemophilia Treatment Centre improve their diagnosis and treatment skills for people with inherited bleeding disorders.

My role, as a haemophilia nurse consultant, was to assist the nurses in preparing a program to educate their patients and families for the introduction of haemophilia 'home therapy' for those patients who could afford Factor concentrate. The aim was to give haemophilia patients access to *early* treatment which as we know, is essential in haemophilia care. The nurses needed to be confident in preparing the patient or parent for what is essentially a medical procedure to be performed by the patient at home. The education included recognising a bleed; when to commence treatment; product storage; product reconstitution; administration of the Factor concentrate and the hardest skill of all IV cannulation with a butterfly needle either to themselves or to their child.

The plan was to conduct workshops and also spend time in the wards with the nurses. This looked good on paper however, we take for granted how easy it is to be a nurse in Oz! The normal staff patient ratio on the haemophilia ward was 4 nurses to care for 30 inpatients and between 20 and 30 'outpatients' (both adults and children) all requiring treatment with either factor concentrate or cryoprecipitate. To release them from their duties was not an easy task! However they were keen and many came in from leave. The nurses had little if no English language skills. The doctors had translated the basic information on haemophilia into Vietnamese, which the nurses had learnt well, but none of it was relating to nursing practice. It was an eye opener for me the realisation that the nurses were not able to access information on the internet as most of the existing articles are in English.

I was so impressed by this group of nurses with very limited basic equipment. The patients were beautifully cared for even though many of the inpatients had spent many months in bed. These nurses were very skillful gaining IV access often using needles that were not intended for IV use as it was the only equipment available.

The patients and their families were amazing. They would spend hours and hours waiting for treatment, often sharing a bed due to overcrowding. The local Haemophilia foundation had set up a library for the children to use while they waited. There were no televisions or toys to play with other than a chess board. You can imagine their delight when we gave out red Haemophilia Foundation of Australia (HFA) balloons.

However with an interpreter, much hand waving and lots of laughter we got there! I always learn so much working in these challenging environments' and I look forward to my next visit through our twinning programme to spend more time with this wonderful team in Vietnam.

The National Cancer Nursing Education Project

NEW resources on the EdCaN site!!

Supporting Module Five – Cancer supportive care principles is now available for download from the EdCaN website. The ability to provide supportive care at an advanced level is a key domain of specialist cancer nursing practice. Key concepts within this module include:

- Definitions of supportive and palliative care.
- Screening and assessment of supportive care needs.
- Communication skills, including general principles, eliciting concerns, responding to distress, making a referral, treatment decision making (including discussion re. CAMs).
- Supportive care for specific groups – carers, children and parents, at end of life.
- Promoting self-management
- Discussing prognosis and transition to palliative care.
- Evidence based approaches to education and information provision.
- Responding to family and carer needs.

EdCaN have developed a suite of evidence summaries relating to management of key disease and treatment related effects. The ***Symptom Management: evidence summary*** reviews the aetiology and contributing factors, assessment and monitoring requirements, recommended intervention strategies and key evidence based resources for the following cancer and treatment related effects:

- Nausea and vomiting
- Distress
- Altered bowel habits
- Dyspnoea
- Peripheral neuropathy
- Adult cancer pain
- Mucositis
- Fatigue
- Lymphoedema
- Alopecia

The ***Oncological Emergencies: evidence summary*** reviews the aetiology and contributing factors, assessment and monitoring requirements, and recommended intervention strategies for the following oncological emergencies:

- Febrile neutropaenia and sepsis
- Metastatic spinal cord compression
- Disseminated intravascular coagulation
- Superior vena cava syndrome
- Hyperclcaemia
- Tumour lysis syndrome

WATCH THIS SPACE

The ***EdCaN Cancer Nursing Program (Entry to Speciality)*** will be uploaded soon…. Contact the EdCaN team for an exclusive early release of the modules, which are suitable for nurses new to specialist cancer settings.

The EdCaN and PSGC project team can be contacted via edcanpsgc@qut.edu.au for any questions or comments on the learning resources. Project resources such as factsheets, USBs, bookmarks and flyers are available for dissemination at CPD events or workshops and can be posted upon request.

Kylie Ash
Project coordinator
EdCaN & PSGC Projects
e: k.ash@qut.edu.au | p +617 3138 6128 | f +617 3138 6030 | m 0411109469 | http://www.cancerlearning.gov.au

Leukaemia Foundation national survey of people with MDS: We need your help!

Myelodysplastic Syndrome (MDS) is a rare type of haematological malignancy of the bone marrow which is incurable other than with a bone marrow transplant. It is generally more prevalent in men, with the median age at diagnosis being greater than 75.4. In Australia in 2009 there were 1185 people diagnosed with MDS. It is estimated that in 2012 this number will be greater than 1330. MDS is now one of the top 20 cancers (AIHW, 2012). Even though MDS is rare the incidence is raising across the world, particularly in Australia where we have an aging population.

There are a range of treatments to help control MDS if a bone marrow transplant is not an option. These can help control the disease for various lengths of time. There is currently only one drug PBS listed in Australia to treat MDS. This is called Azacitidine (Vidaza) but is not suitable for everyone. Access to other medications is restricted to clinical trials and depends upon the person being eligible for the clinical trial. Treatment of MDS can be complex as it is a group of disease and each subtype has its own treatment. Treatment can vary; watch and wait, supportive care, chemotherapy and Azacitidine (Vidaza). Lenalidomide is showing benefit for many people with Del (5) q type MDS in clinical trials. The effects from the disease and some of the treatments can be debilitating and have a detrimental impact physically and psychologically (Kurtin, 2012 and Pinchot, 2012).

The symptoms of MDS also vary depending on the subtype that a person may have. A person may present with anaemia, neutropaenia or thrombocytopaenia or a variety of these. Each decrease in blood cell count could present with various symptoms such as bleeding and bruising, frequent infections, increasing fatigue, loss of weight, decrease in concentration, palpitations, and increased shortness of breath. Around 30% of all people diagnosed with MDS will transform to an Acute Myeloid Leukaemia (Thomas, Crisp & Campbell, 2012)

International MDS advocacy groups are agitating about the perception that people with MDS are being discriminated against due to their age, and not being offered clinical trials or treatments already available. They believe that the medical profession have the opinion that treatments are expensive and these people have already 'had a good life', so they are not seen as a priority- **www.mdslifebeyondlimits.org/**

The Leukaemia Foundation of Australia was asked about the experience of people with MDS here in Australia. We decided that we would conduct a national survey of people with MDS, and broaden the scope of the survey to identify the major themes affecting this patient population here. This survey will give us a better understanding of what it is like to have MDS in Australia in 2013.

With the support of a range of health professionals, consumers and international MDS groups, the Foundation has now developed this National MDS survey. Ethics approval was granted by South Eastern Sydney Local Health District- Northern Sector in January 2013. This is the fourth survey in a series of national haematology disease specific surveys conducted by the Leukaemia Foundation.

The aim of this survey is to gain an understanding of the impact of having MDS has on the lives of Australians. The results of this survey may potentially assist in identifying unmet need, and will be used to help suggest improvements in health service and general support provision.

To achieve an optimal outcome from this survey, the Leukaemia Foundation seeks a minimum of 100 people with MDS to participate and complete the survey. The survey will be promoted through all Leukaemia Foundation communication channels, however, to get a broader view of the experience of people with MDS, we are seeking your assistance and support as a valuable health professional in Australia to promote the awareness of and participation in, this important survey to the MDS patient population.

The survey may be completed in a number of ways including online, in hard copy, or over the telephone with one of our trained volunteers. All participants in the survey shall remain anonymous and the results, confidential. Your patients may access the survey online at http://srnet.com.au/surveys/mds.asp. Alternatively, the contact telephone number for telephone or hard copy surveys is 1800 620 420. The survey closes on 12th May 2013.

The survey is formatted by Sweeney Research, who will also collate and analyse the results. It is intended that the survey results will be released for our inaugural National MDS Day, July 14th 2013.

References

- Kurtin, S.E. (2012). Myelodysplastic syndromes: The challenge of developing clinical guidelines and supportive care strategies for a rare disease. *Clinical Journal of Oncology Nursing, 16*(Suppl. 1)
- Pinchot, L.J (2012). The Myelodysplastic Syndromes: Challenges and Strategies for Effective Outpatient Management. *Oncology Nursing Society 37th Annual Congress,* 5-8
- Thomas, M.L, Crisp, N., & Campbell, K. (2012) The Importance of Quality of Life for Patients Living With Myelodysplastic Syndromes. *Clinical Journal Oncological Nursing*. 16 (suppl 1), 47-57
- Cancer in Australia: an overview 2012 AIHW http://www.aihw.gov.au/publication-detail/?id=60129542359

Rebecca Dring
National MDS Co-coordinator
Leukaemia Foundation
E: MDS@leukaemia.org.au

HOW DO I WRITE AN ABSTRACT?

Calls for abstracts and registration for HAA 2013 will open in May 2013 and abstracts deadline 1st July 2013. In preparation for HAA 2013 and to offer some helpful advice to those of you thinking about submitting an abstract, we are re-printing the short article below.

An abstract serves two purposes. Firstly, it allows conference organisers to select papers for various sessions at their meeting. The abstract will help the programme committee decide which presentations should be given orally and those that should be presented as posters, and in which sessions they should appear. Secondly, at the meeting itself, it allows delegates to decide which presentations interest them.

An abstract is a concise summary of your work. Mostly, abstracts are limited to 250-300 words in length so the author has to achieve as much impact as possible in a short space. As a general rule, abstracts should convey findings in ordered, brief and uncomplicated sentences. Although abstracts may very subtly, most consist of the following standard layout and design. Title, Introductory sentence, Methods, Results and Conclusions.

- **The title** should be short and give an accurate indication of what you will talk about. The reader should be able to read the title and decide if the abstract is of interest to them.
- **The introduction** provides a brief background and explains what you looked at and why you did it. In essence, use the introduction to detail why you did the work.
- **Methods**: What did you do? ese one or two sentences to explain what you did or how you tested your question.
- **Results**: What did you find? The key part of the abstract. This section provides any data obtained in its analysed form. As a rule of thumb, the layout of the results section parallels that of the methods section.
- **Conclusions**: What does it mean? The hard bit! The abstract should end with a concluding sentence / paragraph pointing out any potential significance of the findings to clinical practice or more specifically, the field of interest.

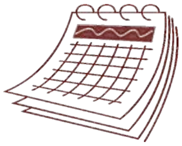
SOME FURTHER TIPS

- Make sure your abstract is clear.
- *Always read and follow* the conference abstract submission guidelines – this is what your abstract is marked against.
- Ask someone with experience to help you write your first one. Any of the committee members would be happy to help.
- Abstracts are scored by a committee of nurses using a scoring system with set criteria. Don't forget 'best abstract grants' are available to the highest scoring abstracts submitted based in set criteria.

Four criteria to think about when preparing your abstracts are:

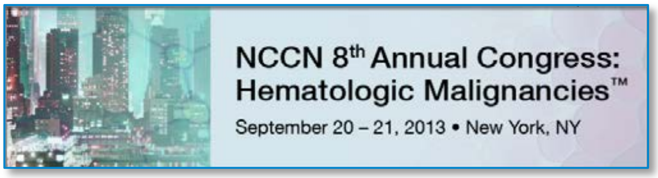
1. **Originality:** abstracts containing significant new findings or that present innovative practice will be given higher scores than those that describe updates or modifications to older findings
2. **Quality:** abstracts that contribute to the knowledge of haematology nursing practice and /or /patient 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.

Written by The Editor.



Conference Calendar

When	Conference	Details
May		
14 -17 May, 2013	**ALLG Scientific meeting – *Adelaide***  	Hilton Hotel, Adelaide For more information ⇨ http://www.allg.org.au/
June		
13-16 June, 2013	**18th Congress of European Haematology Association EHA**  	Stockholm, Sweden – in Stockholmsmässan *(Stockholm International Fairs)* For more information ⇨ http://www.ehaweb.org/ *Deadline for early registration:* **May 10th 2013**
27-29 June, 2013	**MASSC/ISOO International Symposium on Supportive Care in Cancer**  	Hotel Intercontinental, Berlin For more information ⇨ http://www.mascc.org/ *Early bird Registration Deadline:* **April 24 2013** *Regular Registration Deadline:* **June 20th 2013**

Date	Conference	Details
July		
25-27 July, 2013	**Cancer Nurses Society of Australia (CNSA), 16th Winter Congress**  	Theme: ***Connecting Cancer Care*** Brisbane Convention & Exhibition Centre For more information ⇨ http://www.cnsa.org.au/ *Deadline for early bird Registration:* **30 May, 2013**
September		
20-21 Sept, 2013	**NCCN 8th Annual Congress: Hematologic Malignancies**  	New York Marriott Marquis, New York, NY **Intended Audience:** Hematologists, oncologists, nurses, pharmacists, and other health care professionals who manage patients with hematologic malignancies. For more information ⇨ http://www.nccn.org/ *Deadline for early bird Registration:* **Friday, August 16, 2013**
October		
20-23 Oct, 2013	**HAA 2013 Annual Scientific Meeting** *Combined scientific meeting of the Haematology Society of Australia and New Zealand, Australian and New Zealand Society of Blood Transfusion, and the Australian Society of Thrombosis and Haemostasis.*  	Gold Coast Convention & Exhibition Centre, Broadbeach, Queensland For more information ⇨ www.hsanz.org.au *Registration brochure available:* **April 2013** *Due date for Abstracts:* **1 July 2013** *Early bird Registration:* **Mid Sept 2013**

Date	Conference	Details
November		
12-14 Nov, 2013	**COSA's 40th Annual Scientific Meeting 2013** ***Cancer Care Coming of Age,*** *highlighting geriatric oncology and gastro-intestinal cancers* 	Adelaide Convention Centre, Adelaide. For more information ⇨ http://www.cosa2013.org/ *Registrations & Abstract submissions are open.* *Symposium abstract submissions:* **10 July 2013** *Abstract submission Deadline:* **14 August 2013** *Early bird Registrations close:* **6 September 2013**
12-15 Nov, 2013	**ALLG Scientific meeting – *Sydney*** AUSTRALASIAN LEUKAEMIA & LYMPHOMA GROUP ALLG Australasian Leukaemia & Lymphoma Group	Novotel, Brighton Beach, Sydney For more information ⇨ http://www.allg.org.au/
December		
7-10 Dec, 2013	**2013 ASH 55th Annual Meeting and Exposition** AMERICAN SOCIETY of HEMATOLOGY *Helping hematologists conquer blood diseases worldwide* 2013 ASH Annual Meeting and Exposition	Ernest N. Morial Convention Center, New Orleans, LA. For more information ⇨ http://www.hematology.org/ *Members-only registration opens:* **24 July, 2013** *Abstract submission deadline:* **8 August. 2013**

… Missed a conference and would like to access presentations?

Catch up on last year's NCCN 7th Annual Congress: Hematologic Malignancies: Treatment of hematologic malignancies is increasingly complex. Issues relating to pathology, transplantation, and various new therapies require oncologists and haematologists to stay abreast of breakthrough advances. This Congress focuses on the new approaches that have been incorporated into patient management, including the use of drugs, biologics, and diagnostics. *Recorded presentations are available online* ***at no cost****, in the following topic areas:* http://education.nccn.org/hem2012

2013 BMT Tandem meeting*: Access abstracts from the 2013 BMT Tandem Meetings abstracts via a supplement to the Biology of Blood and Marrow Transplantation journal, February 2013 (volume 19, number 2, 2013 pages S109-392)* http://www.sciencedirect.com/science/journal/10838791/19/2/supp/S . *Recorded presentations are also available online (from $30 USD):* http://www.dcprovidersonline.com/bmt/?event_id=BMT58

2013 Survivorship Conference: *Copies of presentations available online at no cost:*

http://survivorship.asnevents.com.au

Written by **Myfanwy Pennells,** CNRU

Cancer Institute NSW Update

eviQ Haematology

The haematology reference group have a new chair and co-chair for 2013. Dr Michael Harvey and Dr Amanda Johnson have agreed to take up the respective roles for a 12 month term. The first haematology reference committee meeting will be held on the 10th May 2013 reviewing CLL treatment protocols. If you would like to attend please contact Patricia Ryan at patricia.ryan@cancerinstitute.org.au

CALGB and BFM treatment protocols for ALL have recently been published and are available on the site as has Hyper CVAD plus Imatinib for Philadelphia chromosome positive ALL. A huge amount of work has gone into these protocols (as anyone who has perused them will know) and congratulations and thanks go to all eviQ staff and reference committee members who have assisted with this.

HPCT

The HPCT reference committee is scheduled to meet this year, dates will be advised. There are many conditioning protocols up for review this year as well as a few new ones to be published. The HSOS resource document is currently under review and a resource document for Graft V Host Disease is also currently under construction.

If you would like to be a part of the HPCT reference committee, please contact us at:
Danielle.peterman@cancerinstitute.org.au or aisling.kelly@cancerinstitute.org.au

General

The CVAD documents and clinical procedures, Safe Handling of Antineoplastic Drugs and clinical procedure for Hazardous

Drug Spills have all recently been updated. The Tumour Lysis resource document is currently being reviewed.

If anyone has any feedback, is interested in participating in any of the reference committees or would like to contribute to any of the content, please don't hesitate to contact us at contactus@eviq.org.au or via the contacts page at www.eviq.org.au

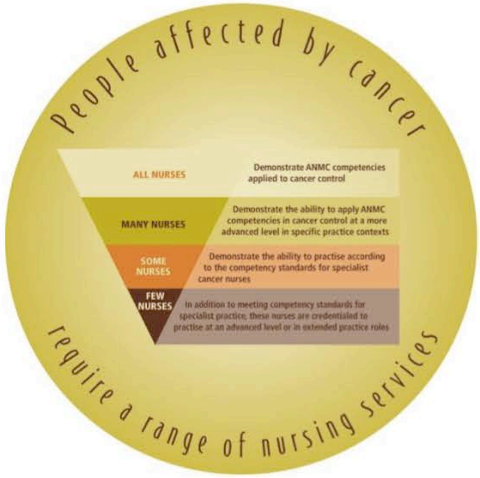
Overview of the EdCaN Cancer Nursing Program (Entry to Specialty)

Nurses can improve outcomes

There are many points across the person's cancer experience where nurses can make a significant contribution to addressing the health care needs of people at risk of or affected by cancer. The EdCaN Framework defines specific competency standards and capabilities required for nurses practicing from beginning through to advanced levels.

The EdCaN Cancer Nursing Program (Entry to Specialty) has been developed to enable nurses to meet the competency standards required of nurses new to specialist cancer settings. These competency standards define performance criteria expected of nurses practicing as a Beginning Specialist Cancer Nurse.

Professional development model for nursing in cancer control



Aims of the EdCaN Cancer Nursing Program (Entry to Specialty)

The aim of the program is to develop the capabilities of nurses new to cancer care to enable them to meet the needs of people affected by cancer. Following successful completion of the EdCaN Cancer Nursing Program (Entry to Specialty), the participant will be able to:

1. **Assess the health status of people affected by cancer to formulate an individualised plan of care**
2. **Adapt care based on the contextual influences impacting on the health status of people affected by cancer**
3. **Integrate evidence based practices in the delivery of safe and effective care for people affected by cancer**
4. **Collaborate in multidisciplinary cancer control efforts**
5. **Demonstrate a commitment to continuing professional development.**

Using the EdCaN Cancer Nursing Program (Entry to Specialty)

This suite of resources has been designed as a structured program of learning. The program includes a series of learning modules to assist those involved in facilitating transition of nurses to work effectively in specialist cancer settings. Workplace clinical educators or clinical facilitators can use these modules when designing programs to support nurses new to cancer care and to provide feedback on clinical performance.

The Entry to Cancer Nursing Practice Program:

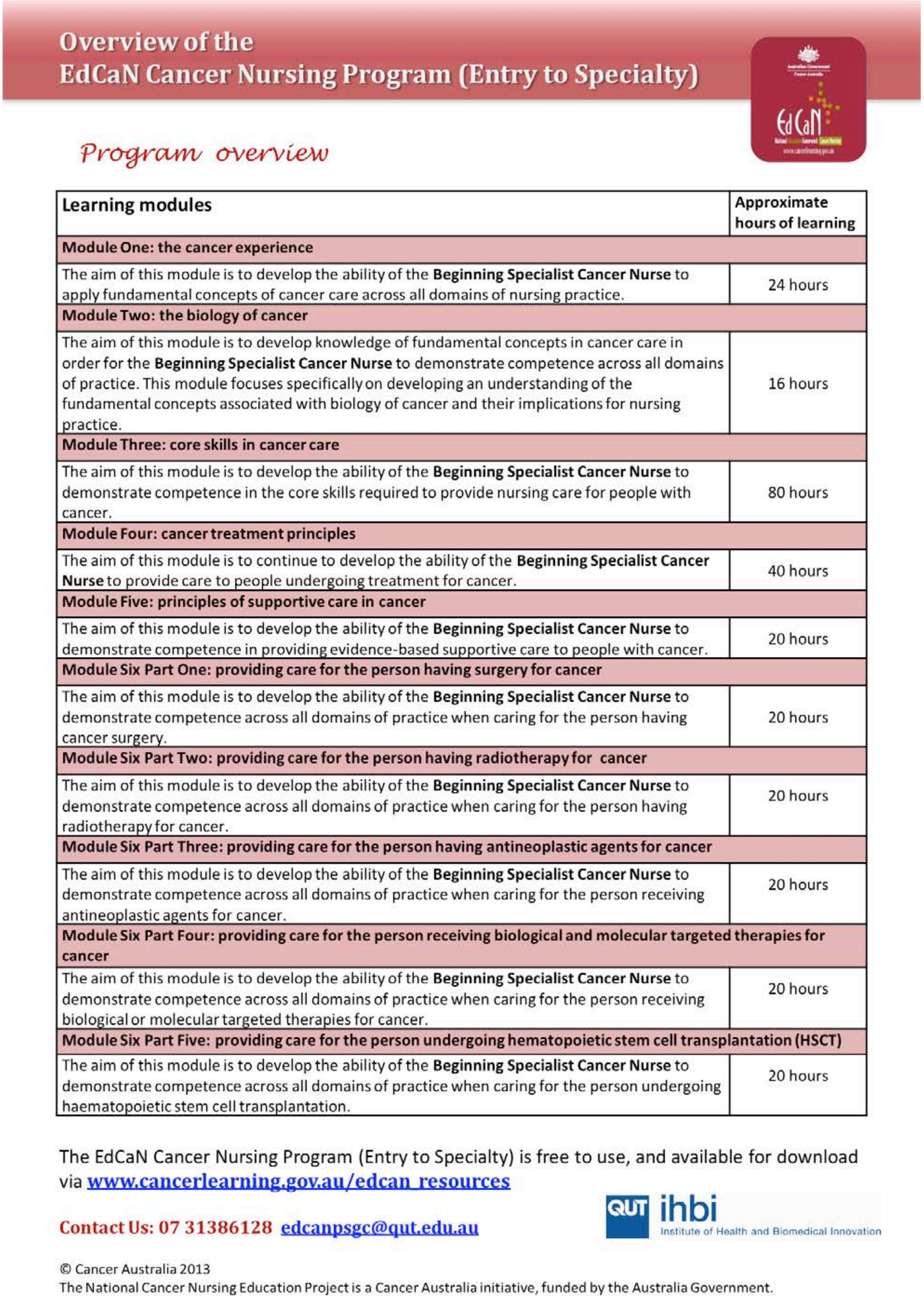
- ✓ Has a person centred focus
- ✓ Is evidence based
- ✓ Supports learning through the inclusion of clinically focussed learning activities, readings and case studies
- ✓ Can be incorporated into existing graduate nurse and professional development programs
- ✓ May enable participants to receive advanced standing towards further study (subject to approval of relevant education providers)

Thinking points

Key concepts

Case studies

Short answer Q's



Overview of the EdCaN Cancer Nursing Program (Entry to Specialty)

Program overview

Learning modules	Approximate hours of learning
Module One: the cancer experience	
The aim of this module is to develop the ability of the **Beginning Specialist Cancer Nurse** to apply fundamental concepts of cancer care across all domains of nursing practice.	24 hours
Module Two: the biology of cancer	
The aim of this module is to develop knowledge of fundamental concepts in cancer care in order for the **Beginning Specialist Cancer Nurse** to demonstrate competence across all domains of practice. This module focuses specifically on developing an understanding of the fundamental concepts associated with biology of cancer and their implications for nursing practice.	16 hours
Module Three: core skills in cancer care	
The aim of this module is to develop the ability of the **Beginning Specialist Cancer Nurse** to demonstrate competence in the core skills required to provide nursing care for people with cancer.	80 hours
Module Four: cancer treatment principles	
The aim of this module is to continue to develop the ability of the **Beginning Specialist Cancer Nurse** to provide care to people undergoing treatment for cancer.	40 hours
Module Five: principles of supportive care in cancer	
The aim of this module is to develop the ability of the **Beginning Specialist Cancer Nurse** to demonstrate competence in providing evidence-based supportive care to people with cancer.	20 hours
Module Six Part One: providing care for the person having surgery for cancer	
The aim of this module is to develop the ability of the **Beginning Specialist Cancer Nurse** to demonstrate competence across all domains of practice when caring for the person having cancer surgery.	20 hours
Module Six Part Two: providing care for the person having radiotherapy for cancer	
The aim of this module is to develop the ability of the **Beginning Specialist Cancer Nurse** to demonstrate competence across all domains of practice when caring for the person having radiotherapy for cancer.	20 hours
Module Six Part Three: providing care for the person having antineoplastic agents for cancer	
The aim of this module is to develop the ability of the **Beginning Specialist Cancer Nurse** to demonstrate competence across all domains of practice when caring for the person receiving antineoplastic agents for cancer.	20 hours
Module Six Part Four: providing care for the person receiving biological and molecular targeted therapies for cancer	
The aim of this module is to develop the ability of the **Beginning Specialist Cancer Nurse** to demonstrate competence across all domains of practice when caring for the person receiving biological or molecular targeted therapies for cancer.	20 hours
Module Six Part Five: providing care for the person undergoing hematopoietic stem cell transplantation (HSCT)	
The aim of this module is to develop the ability of the **Beginning Specialist Cancer Nurse** to demonstrate competence across all domains of practice when caring for the person undergoing haematopoietic stem cell transplantation.	20 hours

The EdCaN Cancer Nursing Program (Entry to Specialty) is free to use, and available for download via www.cancerlearning.gov.au/edcan_resources

Contact Us: 07 31386128 edcanpsgc@qut.edu.au

The National Cancer Nursing Education Project is a Cancer Australia initiative, funded by the Australia Government.

Transfusion Update 2013

Registration is now open

Transfusion Update is the annual transfusion conference run by the Australian Red Cross Blood Service which will take place Wednesday 12 to Friday 14 June at the Brisbane Convention Centre.

International speaker Prof Alan Tinmouth from the Ottawa Hospital is a lead investigator in the age of red cells and will head up a day focussing on the current debate on this topic.

He is joined by Prof Donald Silverberg from the Tel Aviv Medical Centre, who will lead us through his work on anaemia management in patients with renal, cardiac and other medical conditions.

The three day conference will focus on Patient Blood Management, transfusion medicine, age of red cells and will feature a day of streamed scientific or clinical practice content. Other sessions include topics such as clinical governance, human elements in transfusion, antibody challenges and our annual James Isbister Colloquium, which this year addresses the topic “From genetics to genomics: clarity or confusion?”

Register and pay before 30 April to take advantage of early bird rates. You can also have your accommodation arranged as part of the registration process.

Please visit our homepage www.transfusion.com.au

Lucy Bellomarino
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On World Haemophilia Day, April 17 2013, the global bleeding disorders community came together to mark 50 years of advancing the cause for treatment and care for all people with haemophilia and other inherited bleeding disorders. If you hosted or attended an activity to mark World Haemophilia Day please send in your pictures or comments and we will print them in the next edition.

Regional Round up!

HSANZ NG – regional groups are made up of nurses willing to contribute their time and energy to improve the care of those with a haematological condition within Australia and New Zealand. They do that by hosting educational meetings that not only give us all an opportunity to learn, but also to network with other like-minded nurses. These groups and meetings are only possible with the generous support of pharma but also, by the contributions, drive, and *engagement of us all*. If you have the time to contribute on a local committee, or offer some ideas for meeting topics, speakers, perhaps even present your work yourself; then we would all love to hear from you. Please take the time to get involved with your local group in some way.

North Island, New Zealand

Catherine Wood

The lower North Island has kicked of the 2013 year with its first education session being held in Wellington in February. Dr Ken Romeril gave an excellent update on Multiple Myeloma. We have five more sessions planned for the year, split between Wellington and Palmerston North.

There continues to be an enthusiastic response to these meetings with an average of around 20 attendees coming along each evening. They are popular so you need to be in quick if you want to attend! The education evenings wouldn't be possible without sponsorship. Janssen generously sponsored our first session for the year and we have support from Roche, Gilead, Bayer HealthCare and Janssen for the remainder of the meetings. Topics selected for each year are based on the evaluations and suggestions received from the previous year. Tentative dates and topics for the 2013 education evenings are as follows:

Date	Location	Topic
3rd April	Palmerston North	Haematopoietic stem cell transplantation
19th June	Wellington	How to help patients transition post treatment
21st August	Palmerston North	Haemophilia
30th October	Wellington	Sexuality and fertility issues in haematology patients
27th November	Palmerston North	AML

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

Queensland

Catherine Kirk

A big big thank you to all of the wonderful QLD nurses that travelled far and wide to attend the MM Education Day in Brisbane on Saturday 23rd March!! This day kindly sponsored by Celgene was a fabulous success. The day comprehensively covered the biology, treatment, management and supportive care of the MM patient. The turnout was amazing (around 95 attendees), with some wonderful feedback and great suggestions for future education days. Our very own Tracy King got some big wraps.... With several attendees suggesting that they "could listen to her all day"!! I do need to mention that my flashy shoes also managed a mention in the feedback forms...thus justifying my need to buy a new pair for all future education days!!! Thanks again to all the wonderful presenters who gave of their time and expertise, you made the day truly informative, engaging and successful. It truly was a wonderful day and I very much look forward to the next one.

Tasmania

Gillian Sheldon-Collins

Tasmanian membership is slowly increasing which is very pleasing. Welcome to our new members. The Leukaemia Foundation sponsored a nurses' study day on stem cell harvesting at Gibson Unit, Calvary Health Care on 19th February. This was a great opportunity for me to meet the staff as several of our patients are cared for both at Calvary and The Royal Hospital, and we collaborate in streamlining the care for patients across the public and private sectors. There will be a follow up day about transplants to be announced.

The Cancer Council sponsored a support group meeting at Franklin for the local community, and invited several cancer care coordinators/educators from the RHH to speak. We were able to give an overview of the care provided by our hospital to meet the locals and enjoy a cup of tea and scones.

We have created a **'Third Tuesday Journal Club'** to be run alternately by HSANZ and CNSA. Everyone is welcome, including non-members. Each organisation will take turns presenting a journal article for discussion. HSANZ is kicking off with the first one in May.

Planned Activities: Combined HSANZ /CNSA Journal Club: 3rd Tuesday of the month, Seminar Room 8A, Day Chemotherapy Unit, RHH 1530-1630

- HSANZ : 21st May 2013
- CNSA: 18th June 2013
- HSANZ: 16th July
- CNSA: 20th August

Keep these dates free:

- RHH Cancer Services nurses' study days, programs to be advised:
- 30th May
- 4th September
- 4th November

THING AGM and Scientific Meeting at Port Arthur 21st-22nd September. I have heard a rumour there may be a fantastic haematology nursing speaker if she's available. Program to be advised. Please feel free to contact me with any questions or suggestions for HSANZ activities. I am happy to discuss membership and help with applications.

Victoria

Yvonne Panek-Hudson

Hi from sunny, hot Melbourne! Our year has gotten off to a great start. Our first educational evening provided 'Highlights from HAA 2012' with 3 guest speakers Bianca Hopkins, Hayley King and Aaron Hill presenting their conference papers on outpatients transplants, myeloma help line and gelofusine as a sedimenting agent. Many thanks to them and our sponsors. Our next educational evening is in collaboration with CNSA on the 16th of MAY. The topic is Cancer Care in the indigenous community and we are very excited about the collaboration and the focus of the educational evening. More details will go out in the next week to mailing list members. Mid year the ANZSBT nurses will host an educational evening and our final metropolitan session will be toward the end of the year. More details to follow….

We are very excited about supporting educational opportunities for regional haematology nurses. The first regional session for the year will be in Geelong in June and then in Traralgon in August. We are also negotiating with 2 other regional centres to visit and facilitate education sessions. The Victorian group support and wish our QLD colleagues the best of luck for the HAA conference this year. We hope to once again provide conference grants to attend HAA, 2013 for successful applicants so look out for more information!! Thanks to the Victorian Haematology Nurses for their support and attendance at the educational sessions and to our guest speakers, sponsors and organising committee for making it all come together. For any information or queries regarding the Victorian group please don't hesitate to contact me on: yvonne.panek-hudson@petermac.org

Thanks and see you at the next meeting….

New South Wales

Tracy King

The new format for our meetings has received very favourable feedback from those attending. Nurses seem to appreciate a more intimate smaller group and targeted approach to content, speakers and presentations. It has been great to finally have a nurse from each Haematology unit present an update from their area. At our last meeting in Sydney we had the wonderful Cassandra Reid showcase the new Royal North Shore Hospital BMT Unit after a collaborative case study style presentation on 'Living Ethics – BMT focus' with Prof Ian Kerridge. We look forward to hearing reports from St Vincents and St Georges later on in the year.

Remaining planned meetings for the year include:

Date	Location	Topic
June 13th	Sydney	Feedback from Churchill Fellowship: BMT Units in US Speaker Gemma Dyer
August 15th	Wollongong	TBA
November 14th	Sydney	Joint with CNSA Prof Kate White speaker.

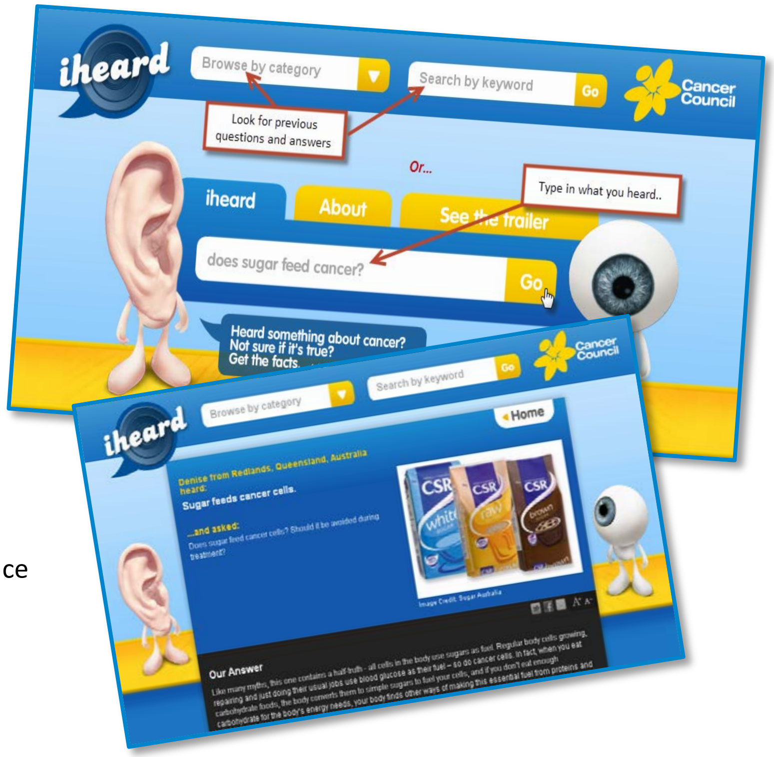
We remain committed to hosting events in regional NSW and ACT – planning underway. NSW will also have several travel grants to award to nurses to attend HAA this year. A process of application and awarding based on merit will be in place. Watch this space for further information.

Cancer is always newsworthy – sometimes with inflated or dramatic claims around causes, cures and treatments…

Is there is something you or one of your patients heard about Cancer, and you would like to know if there is any evidence to support it?

- Visit the Cancer Council's 'iheard' website: www.iheard.com.au
- Search or browse to see if your question has already been answered
- Or simply ask the question and wait for an answer
- Experts will refer to the research and post an evidence based answer

Provided by **Myfanwy Pannells**, CNRU



Denise from Redlands, Queensland, Australia heard:
Sugar feeds cancer cells.

...and asked:
Does sugar feed cancer cells? Should it be avoided during treatment?

Our Answer

Like many myths, this one contains a half-truth - all cells in the body use sugars as fuel. Regular body cells growing, repairing and just doing their usual jobs use blood glucose as their fuel – so do cancer cells. In fact, when you eat carbohydrate foods, the body converts them to simple sugars to fuel your cells, and if you don't eat enough carbohydrate for the body's energy needs, your body finds other ways of making this essential fuel from proteins and

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