Metropolitan Detroit MDONS Oncology Nursing Society

CHAPTER CAPSULE

Celebrating 30 Years

VOLUME XXVII
ISSUE 3
SUMMER 2012

Providing optimal care through promotion of professional standard, networking and development

LONG TERM COMPLICATIONS OF CANCER THERAPIES

DEBORAH OLSZEWSKI, NP, MSN, AOCN

Some years ago I cared for a young man in his twenties who had a sarcoma in his leg when he was five years old. Over the years he had chemotherapy, surgery, and radiation in an effort to control this disease. The sarcoma persisted in a few lymph nodes, but oddly enough, it did not cause any life threatening conditions. He did however suffer from numerous side effects from the therapies that affected his quality of life. He had hearing impairment from cisplatin, chronic cystitis from cytoxan, lymphadenopathy from radiation to nodal beds, and heart failure from the anthracyclines. He would have been a good candidate for a cardiac transplant, but because he had active tumor, he was not eligible. Despite all of his chronic health problems from the treatment of his cancer, he managed to graduate from a physical therapy program before succumbing to heart failure. Despite all of the challenges from his illness and the side effects of his treatments, he had the sweetest personality and everyone loved him. This article will examine the long term side effects of cancer treatment, particularly in young people.

>> INCREASED DENTAL EXAMINATIONS, SALIVA SUBSTITUTES AND AVOIDANCE OF SUGAR MAY BE IN ORDER. <<

Chemotherapy is given to children and adolescents for various tumors, most notably leukemia, lymphoma, testicular cancer, brain and spinal tumors, sarcomas, Wilm's tumor, neuroblastoma and retinoblastoma. All modalities of treatment are used, but it is the chemotherapy and radiation therapy that leave the most long term problems for a variety of organ systems.

Skin: radiation to the skin may leave the skin more sensitive to sun burn and also predisposed to skin cancer. Patients should have yearly examinations, pay particular attention to using sun block on previously radiated areas and see a dermatologist for any change or suspicious area.

Cardiac: Cardiac problems can arise after radiation to the heart, as with treatment of lymphoma. Side effects can be intensified if cardiotoxic chemotherapy agents are also delivered. Cardiotoxic agents include the anthracyclines, (doxorubicin, daunorubicin, dactinomycin), mitoxantrone, cyclophosphamide, 5FU, taxol and herceptin. Acute and chronic cardiomyopathy occurs in 1-2% of persons receiving anthracycline at total doses of 300mg/M2. The percentage increases to 6-20% after doses of 500mg/M2. Studies show that there are four times more people with non-symptomatic heart failure than those with overt dysfunction. Treatment with ACE inhibitors or beta blockers can prevent or delay the occurrence of symptomatic failure. Echocardiogram screening is recommended five years after doxorubicin treatment of 300mg/M2 or more and should continue every three to five years afterwards.

Radiation to the heart has slightly different risks, including stenosis of vessels, fibrosis of conduction pathways causing arrhythmias, valvular stenosis and atherosclerosis related to collagen deposition. Symptoms of coronary artery disease can occur 10 to 15 years after treatment. Standard guidelines for risk reduction apply, including avoidance of smoking, obesity and diabetes, management of lipids and hypertension. Baseline echocardiograms and stress tests 10 years after treatment should be done and repeated as necessary. Penicillin prophylaxis for dental or surgical procedures may apply in case of valvular disease.

Neurologic changes occur from chemotherapy, mostly in the form of paresthesias, can result in persistent numbness, hearing difficulties and balance disturbances. There is generally less awareness of the changes that can result from radiation to the young brain, especially when given with chemotherapy. Young people can have a decreased ability to learn post treatment,

Continued on page 4

WHAT'S INSIDE...

FROM THE EDITOR 2
HIGHLIGHTING A MEMBER 2
MEETING SUMMARIES 4
FROM THE PRESIDENT 7
OFFICERS AND STAFF 8

FROM THE EDITOR SANDRA REMER, RN, BS, OCN®

My nurse manager came into my office the other day and handed me a book. She told me that she had given it to my nurse colleagues at our last morning staff meeting. I had attended via a phone conference because I was at our West Bloomfield office. The book was entitled, Strength Finders 2.0. My manager told me that she would like each of us to read the book to page 30 and then take the "little test on-line". This will tell us where our strengths lie. I smiled and said thank you, thinking another gimmick. I sort of glanced through the book, but because I don't have much time at work to read, I put the book in my bag and took it home.

I was going on vacation in a couple of weeks and thought I'd take the book with me and read it then. Well, I actually did and I was intrigued by some of the initial information "Do you have the opportunity to do what you do best every day?" was the introductory sentence. "Chances are, you don't. All too often, our natural talents go untapped. We spend most of our time focusing on our weaknesses and trying to become what we are not" is what I read. I found that very strange, since I think I know what I am good at and I believe most nurses know what they do well, especially oncology nurses.

This book's introduction describes what the book is basically about and how to apply the information you have learned. It lists 34 THEMES of TALENT, such as achiever, adaptability, analytical, communication, competition, developer, empathy, individualization, learner, responsibility, and strategic to name a few. Each theme is described and examples given to help you understand how you fit into this category.

After reading the required chapters I took the test, following the instructions and answering quickly with my first reaction not concentrating on each question and then deciding what answer to pick. What I learned was, what I thought I might be was not completely accurate. I thought I would be an achiever; first, probably including empathy and harmony as themes in my strengths. Seems, I have different "strengths".

What I have gained knowledge about is that my top 5 themes are developer, empathy, harmony, relator and responsibility (in alphabetical order). How interesting I thought and my manager said "I can see this in you." So I am processing these themes and trying to learn how each of these traits makes me stand out from all of my other colleagues and how I can work with each of them using the knowledge about their themes/traits. If you'd like to find your strength, although I am not advocating this book as must read material, check it out. Strength Finders, written by Tom Rath. The book reads quickly and it can give you a whole new perspective on who you are. It could help you accent the positive and eliminate the negative in your life. We are all given so many different learning tools throughout our lives, I think I like the idea of improving strength!

What I have also observed over the years is that oncology nurses continue to hold many similar traits (theses if you will) and that is what makes us so unique. It is this special bond of traits that bring us together to provide such excellence in care. So, my question for you today is "Do you have the chance to do what you do best every day?" I do and I never realized it.

HIGHLIGHTING A MEMBER: DEBORAH HASENAU

I had the pleasure of speaking to Deborah (Debbie) Hasenau, RN, BSN, MS, OCN the other day and I'd like to share what I found out about her. Debbie has, for the last four years been a Research Nurse in the Urology Department at William Beaumont Hospital, Royal Oak. Debbie loves her job, which allows her to combine her background in research with her nursing clinical skills. Debbie is a second career nurse, with a Bachelors and Masters degree in Health Administration prior to going back to school at Wayne State University for her BSN. She worked as a research coordinator focusing on studies involving persons with traumatic brain injury (TBI) at the Detroit Medical Center, and an inpatient nurse at Karmanos Cancer Center prior to joining Beaumont Hospital.

Debbie has worked on multiple commercial clinical research studies including a pharmaceutical study to treat bladder cancer. Additionally, she is currently working on a pain study with cancer patients with Wayne State University, in which she spends five weeks working with, and educating patients and caregivers.

Debbie says she especially enjoys working directly with patients to overcome the challenges of their diseases and treatment plans. Her research has allowed her to follow patients for up to two years, getting to really know them. She loves the feeling that she has, in some small way, touched the lives of her patients.

In addition to the many contributions she makes at her work, Debbie has been an active member of the MDONS Newsletter Committee. She is also a member of the Oncology Nursing Society (ONS). She loves the opportunities these memberships present for networking, friendships, low-cost or fee education, and staying current.

The favorite night of the week for Debbie and her husband is Tuesday, when they watch their 1 year-old grand-daughter. Also, when she can find the time, Debbie likes to travel, read, and spend time with her friends and family.

When asked what advice Debbie would give to new and/or experienced nurses, she responded, "Nurses have so many opportunities and choices these days...understand your interests and talents and try to fit your career to these." Well said, indeed!

SUSAN HANSELL, RN, MBA, BSN

LONG TERM COMPLICATIONS OF CANCER THERAPIES

Continued from front page

which can be worse if hydrocephalus develops. Intrathecal chemotherapy or whole body radiation for stem cell transplants causes only mild or no deficits.

Treatment of neurologic changes includes learning assessment after treatment, psycho-educational assistance or occupational therapy in the case of severe impairment. Maintaining brain health by the avoidance of alcohol and smoking is important.

Hearing changes from cisplatin can be permanent and may require hearing aides. Radiation can lead to decreased production of curumen in which case lubricant eardrops may be necessary. Chronic otitis can occur that may need treatment with decongestants, antibiotics or tube insertion.

Visual changes can occur in many forms. 5FU can cause decreased tear production. Steroids cause decreased visual acuity and opaque lenses. Radiation damage to lens, cornea, conjunctiva, sclera and retina is possible. Treatment can include steroid drops, sunglasses for UV light protection and corrective lenses.

>> RADIATION DAMAGE TO LENS, CORNEA, CONJUNCTIVA, SCLERA AND RETINA IS POSSIBLE. <<

Dental problems can occur after chemo or radiotherapy, with malformed teeth. Salivary gland injury or prolonged narcotic use can lead to decreased saliva production which predisposes to tooth decay. Increased dental examinations, saliva substitutes and avoidance of sugar may be in order.

Pulmonary toxicity from bleomycin is well known, but it can also occur from mitomycin, carmustine, methotrexate and gemcitibine. Care after bleomycin (total doses 200-400 U/M2) must include instruction to remind anesthesiologists of its history. Pulmonary function testing every 3 to 5 years may be warranted. Of course avoidance of smoking is important along with avoiding asthmatic irritants and keeping up with vaccinations. Radiation is not generally given to the entire lung, but damage occurs to the part that is radiated and is worse with concurrent chemotherapy. Bronchiolitis obliterans can occur and lead to chronic pheumonia.

Hepatic toxicity can occur from methotrexate, 6-MP, 6-thioguanine, and actinomysin-D which can result in hepatic fibrosis and cirrhosis. Veno-occlusive disease from transplant can cause insufficiency or hepatic hypertension. Radiation to the entire liver is not usually given because of its extreme sensitivity.

Digestive problems can occur post radiation in the form of fibrosis, enteritis or stricture, and is treated with dilatation, decompression, high or low fiber diet and lysis of adhesions.

YIKES!! Still with me?!?!

Surgical or functional asplenia can also occur which requires prophylactic antibiotics for dental work, early attention to infections and immunization to meningococcus, H flu B, and strep pneumonia.

Bladder toxicity from radiation can lead to fibrosis with decreased capacity. Physical therapy can help with incontinence if it occurs. Yearly urinalysis for bladder cancer can be done. Again avoidance of smoking is important to decrease potential for bladder cancer.

Kidney damage may occur from chemotherapy, antibiotics or radiation to kidney. Periodic lab check for renal function should be done as well as avoidance of further damage from CT dye or other drugs. Dietary changes may be necessary for early renal disease or dialysis for late stage.

Thyroid radiation during any treatment to the neck can result in lifelong hypothyroidism and the need for replacement therapy. There is also an increased risk of thyroid nodules and cancer.

Growth hormone deficiency can occur from brain irradiation causing pituitary insufficiency resulting in inadequate growth. Pituitary insufficiency can also result in inadequate steroid output requiring hydrocortisone replacement or delayed puberty. Young persons should be assessed for growth and maturation and necessary replacement advised.

Fertility can of course be affected, but that is a separate article! Testosterone deficiency, early menopause and difficulty becoming pregnant or maintaining a pregnancy are common problems.

The risk of developing a second cancer is 3 to 20 times higher than the general population due to underlying genetic issues and treatment damage. For instance, breast cancer is more likely to arise after radiation to breast tissue for lymphomas and thus survivors should be screened for breast cancer.

Maybe it is good no one confronts these issues before subjecting their children to treatment, since it is the proverbial rock and hard place.... But educating our patients about the need to continue a healthy life style and do regular screening can help mitigate these problems.

Congratulations to Michelle Wallace!

Michelle was chosen for the 2012 ONS Excellence in Radiation Therapy Nursing Award. “Michelle’s dedication and determination are strongly reflected in the application.” The award was presented during the opening ceremonies of the annual ONS Congress May 3-6 2012 at the Ernest N Morial Convention Center in New Orleans, LA. She received a $250 monetary award, a plaque, plus up to $1,000 travel and one day per diem to attend the Opening Ceremony at Congress. She was also recognized through a photo display at the convention center, through press releases and on the ONS Web site.

MEETING SUMMARIES >>>>>>>>>>>>>>>>>>>>>>>>

February

UPDATES IN ONCOLOGY, 22ND ANNUAL CONFERENCE

SUMMARIZED BY SUSAN HANSELL, RN, BSN, MBA

The February MDONS Updates in Oncology, 22nd Annual Conference was attended by many members, students, and sponsors. Thanks to the dedicated work of the Conference Committee, and an interesting array of speakers, minus one (I'll explain later), it was a great success.

Attendees were welcomed by Ann Calcaterra, MDONS secretary, followed by the announcement of the winners of the Elaine Valdez Scholarship, Jill Jarvy and Kirsten D'Angelo Congratulations!

The first speaker of the day was Dr. Pranatharthi Chandrasekar, M.D. who spoke about immunizations and their use with cancer and transplant patients.

- Diseases with significant morbidity that can be prevented with vaccinations, including pneumonia, influenza, pertussis, varicella-zoster, and human papilloma virus.
- The Advisory Committee on Immunization Practices (ACIP) 2012 recommendations for healthy adults and those with at-risk conditions, such as the immunocompromised (transplant, HIV, immunosuppressive chemotherapy, chronic renal failure) and those with chronic underlying conditions can be accessed at: http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/mmwr-adult-schedule.pdf. Of note, the influenza vaccine may now be given in an intradermal form (TIV ID), which may be more accepted by patients than injectables (nasal influenza vaccines are attenuated, or live vaccines, which are contraindicated for immunocompromised patients).
- Adult pneumococcal and influenza immunizations in the United States are far below the Healthy People 2010 goals (63-69% versus goal of 90%), and rates for African Americans are even lower (56% versus 71% for Caucasians').
- Importance of vaccinations for healthcare workers and the trends towards mandatory vaccinations for selected diseases.
- Healthcare workers can increase vaccination rates and prevent avoidable diseases in our patients.

Next on the agenda was Carole Bauer, who spoke on wound care for oncology patients.

Continued on the next page

COMON UPDATE ANGELA MAYNARD, RN, MSN, OCN®, CBCN

The Advanced Practice Nurse legislation SB 481 was introduced by Senator Jansen and HB 4774 introduced by Representative Liss. The bill is now in Health Policy Committee. To check on status of bills you may go to: http://www.legislature.mi.gov/S(gr4ztjmkphybob45j1igpf45)/mileg.aspx?page=Home

Jeanette Klemczak Chief Nurse Executive of Michigan is transitioning out of her role and a successor will be selected. Currently, she is Director of the Health Care Cluster.

The following are the Task Force of Nursing Practice Recommendations:

1. **Improving Practice for Advanced Practice RNs (APRN).** This means allowing them to practice to their full extent. Did you know that 1/3 of APRN leave the state because they can not practice to full extent?
2. **Modernizing Registered Nurses Scope and Standards of Practice.** This means bringing all parts of the Public Health Code that pertain to nursing together and updating the code clearly defining scope of practice. Did you know the code has not been revised since 1978?
3. **Clarifying Delegation of Nursing Functions.** This will describe the who, what, how, and responsibilities.
4. **Protecting Licensed practical Nurses' Practice and Role.** This will define the scope of practice so they are not asked to function outside that scope.
5. **Updating Regulation of Nursing Assistive Personnel.** Further define function with nursing.
6. **Mitigating Human Factors in Patient Care Quality and Safety**
7. **Increasing Practice Efficiencies in Nursing and Healthcare.** This means practicing to full extent.
8. **Advancing Technology In Nurse Practice and Healthcare.** This not only pertains to electronic medical records but how technology contributes to quality and safety and how utilization of these technologies will impact nurses.
9. **Enabling Competition and Entrepreneurship.** There are currently codes the do not allow nurses to form healthcare business on their own.
10. **Establishing the Michigan Nursing Practice Council.** This council will be through the Department of Community Health and their role will be to convert the recommendations listed here into a work plan.

In conclusion, nurses play a pivotal role in the health of Michigan residents. If you have not heard or read the Governor's health address you can view it on www.Michigan.gov/snyder. Nurses are key to multiple prevention measures outlined in the Governor's plan and there is no better time then now for the recommendations on nursing practice move forward.

MEETING SUMMARIES >>>>>>>>>>>>>>>>>>>>

Continued from previous page

- Brief explanation of the wound & tissue repair process in the body, the factors influencing the process (nutritional status, infection, age, stress, tissue perfusion, diabetes, and the use of corticosteroids).
- Algorithm for choosing dressings was provided and explained.
- EGFR inhibitors in the form of monoclonal antibodies and tyrosine kinase inhibitors (TKI's) , often cause papulopustular eruptions (rashes) and paronychia (red, painful, swollen areas around nail). Studies are starting to show that preemptive use of moisturizer, PABA free sunscreen, topical hydrocortisone and doxycyline can be effective in minimizing the development of higher grade skin toxicities.
- Skin toxicity caused by radiation treatments - radio-dermatitis, can cause pain, limit ADL's, and delay treatments. Intensity Modulated Radiation Therapy (IMRT) has been shown to produce less skin toxicity. Studies suggest that washing with mild soap and water, and use of deoderant will not increase radiodermatitis. Topical agents calendula, hyaluronic acid, and sodium hyaluronate have shown some promise in reducing skin toxicities. Numerous other products are available, but do not have established effectiveness.
- Metastatic skin lesions - no new treatments available, goal continues to be improving quality of life by controlling bleeding, odors, and drainage.
- Pressure ulcers - PREVENT, PREVENT, PREVENT!

Linda Vanni spoke about current issues in pain management.

- Regulation of pain medications is a huge issue affecting patients, providers and drug manufacturers. MAPS is the State of Michigan's tracking system for regulated medications. REMS is a system designed to assist in risk management and evaluation of control of regulated medications.
- Many drug manufacturers are developing abuse deterrent therapies, including producing adverse, but not harmful reactions (think N/V) when drugs are crushed or dissolved.
- New therapies for post-herpatic neuralgia, e.g. Qutenza (topical Capsaicin). and Zostavax (live vaccine).
- New product for acute pain is the diclofenac epolamine patch (Flector), which is alternated with a lidocaine patch.

Mary Natschke's talk, entitled "An Integrative, Holistic Approach for Healing in Oncology" focused on holistic nursing practice. She explored the impact of stress on patients, nurses and caregivers and alternative ways to address these including aromatherapy, guided imagery, reflexology, and massage.

Dr. Cynthia Browne, MD then discussed the medical uses of vitamin D. She discussed sources of vitamin D in the body (ingested and manufactured by the body in the presence of sunlight), studies indicating appropriate levels in the body, and concludes that, in general, the U.S. population is deficient in vitamin D. The relationship between vitamin D deficiency and disease, including many cancers is being studied now. Dr. Browne indicated vitamin D3 is better than vitamin D2 as a supplement.

The final speaker, Dr. Savitha Balaraman, MD was to speak on the treatment of head and neck cancers, however, she was in a car accident on her way to the conference. Thankfully she was ok but we missed an additional great presentation.

Remember that this is an annual conference. Look for information on the web and in your email about the 2013 conference. I hope to see all of you there next year!

March

ADVANCED DIRECTIVES

PRESENTED BY KATHRYN M. SMOLINSKI MSW, JD
SUMMARIZED BY MARY WILSON BSN, RN, OCN®, CHPN

An Advanced Directive is a written or oral document that gives instructions about an individual's health care, to be followed at some future time if the individual is not able to make their own decisions. It is prepared in advance. In Michigan, it needs to be a written document.

There are two major kinds of advance directives: a Durable Power of Attorney (DPOA) for Health Care, and a Living Will. The DPOA designates who is to make the health care decisions, while the Living Will is a set of instructions on what the individual wants done , or not done, regarding health care.

The patient advocate designation (PAD) is someone that you can trust with your life. It is wise to have a secondary person designated also. The designate must be at least 18 years old, and of sound mind. They do not have to be a relative. Both the patient and the PAD must sign the document and it must be witnessed by two disinterested persons – not family or health care providers. This person will be responsible for carrying out the patient's wishes – the document goes into effect only when the patient cannot make decisions.

A Living Will consists of instructions for health care and is not legally binding in Michigan. It does help to clarify the patient's wishes and help the physician and advocate follow the patient's wishes.

The Five Wishes document is recognized in Michigan.

Wish 1 – the person I want to make care decisions for me when I cannot
Wish 2 – what kind of medical treatment and interventions I do and do not want
Wish 3 – how comfortable I want to be
Wish 4 – how I want people to treat me
Wish 5 – what I want my loved ones to know

Continued on following page

MEETING SUMMARIES >>>>>>>>>>>>>>>>>>>>>>

Continued from previous page

When any of these documents are completed, it is important to share copies with the personal physician, the patient advocate, and family members. A copy should be readily available.

When health care providers discuss these documents with patients and families, it is important to first find out what their perceptions Secondly work to dispel myths and move them toward the legal truth.

The PAD/POA document is more important than the Living Will as the Living Will is not recognized in Michigan. Barriers to establishing these documents include a lack of trust in the health care system or in family members. It is also a relinquishing of control.

Written advance directives are legal in every state, but documents prepared in one state may not be recognized in another state due to differing requirements by each state. Michigan has no reciprocity laws that would allow our documents to be recognized in other states.

Common myths include that having an Advance Directive means that you will not be treated, that you need to use a "state form", that a lawyer needs to prepare the document, and that these documents are only for "old people". These are all false.

Health care providers can assist patients in these discussions by focusing on the goals of the care versus the options, and by attempting to clarify the patient's expectations. Nursing and Social Work have a unique perspective on the situation and can take the discussions beyond focusing only on physical symptoms. We can help the patient and family focus on values, "translate" communication from the physician, and help them navigate the options. We can start this by being quiet and truly listening to what the patient and family believe and want.

April

INCONCEIVABLE, INCREDULOUS, INTRACTABLE TOTAL PAIN

PRESENTED BY VIRGINIA PAIGE MSN, NP–C, ACHPN
AND KATHLEEN OLSEN MSN, NP–C ACHPN
SUMMARIZED BY RITA DUNDON RN, MSN

This innovative presentation on the spiritual and psychological aspects of pain and suffering utilized the use of song, poetry, literature and story telling to illustrate how suffering is felt. The impending destruction of the body, the sense of self, or a change in family dynamics all cause suffering. Pain and suffering also affects cultural roles, social associations, political being and the view of the future.

In order to assess a patient's suffering the caregiver needs to ask. "How is all this affecting you?" "How tough is all this?" Suffering occurs if providers do not validate the patient's pain. The pain and suffering may be related to meaning, belief of the value of the experience, or the symptoms and the disease. It may not be confined to the physical symptoms. Suffering cannot be anticipated. One must ask about suffering. So is pain suffering? These two symptoms are closely related but are phemonomilgically different. Pain is suffering when the source of the pain is unknown, the pain is overwhelming, there is a feeling of lack of control, the meaning of the pain is dire or the pain is chronic.

Balfour Mount in 1985 identified challenges in identifying and treating pain and suffering. These challenges can include:

1. A discrepancy between the disease and the whole person
2. Caregiver assumption they are sensitive to the patient's personal needs
3. Fear of death
4. Patients' belief that they need to flatter and humor caregivers in order to receive good care

All aspects of personhood are susceptible to damage and loss that can result in suffering including: the lived past, the family's lived past, roles, culture, society, associations, relationships, the body, the mind, the unconscious mind, the political being, the secret life, the perceived future, and transcendent dimensions. Suffering is a temporal event. It may influence the person's perceptions of the future (fear is always involved). It can occur if providers do not validate the person's pain.

At times, suffering is related to meaning, beliefs or values of the experience. It is not confined to physical symptoms. It cannot be anticipated. Thus, the provider must ask about suffering and be prepared to deal with the answers provided.

Ferrell and Coyle in 2008 found that relief of suffering is at the core of nurses' work as a profession committed to the human response to illness and injury. Nurses are present at most times of suffering. Nurses are intensely involved in the whole person. They care more and often are present as people struggle with ethical and spiritual concerns during illness. Thus, the assessment and management of suffering are core to the nursing profession.

As patients are assessed for pain and suffering, the mind should not be seperated from the body. We should treat the whole person. Although suffering is something to be identified and treated, it should be recognized that suffering may result in personal growth, resilience, strength, hope and give meaning to one's life. To complete the work of dealing with suffering, it must be assigned meaning. It is a universal need to assign this meaning. It provides purpose and connection. Hope is an essential component to quality of life. It is a belief that a personal tomorrow exists. It is a belief that goes beyond the visible facts.

The presenters provided a handout illustrating the interventions

Continued on following page

FROM THE PRESIDENT MICHELLE WALLACE, BSN, RN, OCN®

I had the privilege of attending the 37th Annual Oncology Nursing Society Congress. As a first time Congress attendee, I found the educational sessions informative; the speakers dynamic; the networking opportunities exceptional; and the patient testimonials awe-inspiring. Some of the presenters at the sessions or dinner meetings, including the keynote speaker for the opening ceremony, were cancer survivors. From the stories that generated laughter to those that stimulated tears, the accounts of the patients' journey to survivorship evoked a variety of emotions. The patients and their loved ones regard oncology nurses as their lifeline as we provide care for them during the transition from diagnosis to survivorship. We are with them as they make the transition from being a newly diagnosed patient with cancer to becoming a cancer survivor through their journey to cancer survivorship.

>> WE ARE EACH OF US ANGELS WITH ONLY ONE WING, AND WE CAN ONLY FLY BY EMBRACING ONE ANOTHER. *Lucretius* <<

Throughout the conference several nurses were presented with various awards acknowledging their commitment to promoting excellence in oncology, including the CURE Magazine 2012 Extraordinary Healer Award for Oncology Nursing. Patients submitted essays to nominate their oncology nurse(s) for the prestigious Extraordinary Healer Award. The three top nominees were honored at the ceremony, and the patients who nominated them shared their essays. These heart-felt accounts validated the significance of the relationship between the patient and their nurse. Whereas each survivor's experiences were unique to their particular situation, one similar theme resonated throughout each tribute: as oncology nurses, we are not just saving lives, we are restoring lives.

"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel." Maya Angelou. As individuals, you each possess unique attributes that promote excellence in oncology nursing to ensure the delivery of safe quality care for our patients with cancer. When we share our experiences, knowledge, skill and talent, collectively, we are able to make significant contributions to the transformation of oncology care. We celebrate the triumphs of our patients' journey to survivorship, and we nurture those who succumb to their illness. Not only are we there for the patients, we support and comfort each other. The relationship between nurses is as crucial as the bond that we share with our patients. We support one another through the sharing of knowledge, experience and expertise. We embrace each other by providing encouragement and acknowledgement. So let's embrace each other for being an outstanding group of oncology nurses.

MEETING SUMMARIES >>>>>>>>>>>>>>>>>>>>>>

Continued from previous page

which promote hope and meaning for individuals experiencing pain and suffering.

1. Therapeutic communication including: compassionate presence, listening, support of patients' spiritual strength and life review.
2. Therapies such as: guided visualization, progressive relaxation, breathing techniques, referral to spiritual care providers, use of storytelling and dignity conserving therapy.
3. Self-care such as: massage, reconciliation with self and others, meditation, referral to support groups, spiritual readings or rituals, yoga, exercise, art therapy and journaling.

As oncology nurses, we have multiple opportunities to help alleviate pain and suffering if we take the opportunity to assess and address patients' needs. Simple acts such as:

- Acknowledging the privilege of treating the patient
- Acknowledging plans to care for the person not their diagnosis
- Understand the person's wishes related to outcomes e.g. what will success look like?
- Be truthful with compassion
- Acknowledge caregivers
- Listen to stories
- Encourage the search for meaning
- Tell of your concerns
- Generate hope

The presenters closed by defining what patients want from providers as a way to minimize and deal with suffering. They want to be cared for as a person, not a diagnosis. They want us to know their values. They want to be treated with dignity and respect. They want to be included in decision making, provided interventions to relieve their pain, to remain present, and provide support while they search for meaning.

ELNEC Training

The Karmanos Cancer Center is again offering the opportunity to take the Enhanced ELNEC training course here in Detroit. Monthly modules will begin September 2012 and will go through June 2013. There are two date choices offered each month to accommodate work scheduling issues. Application is being made for 22.5 CEU's that include 2.5 CEU's in pain education. The fee is $200 for the nine module course. Brochures will be available at the June MDONS meeting, or online at metrodetroit.vc.ons.org or by calling Stacy Lincoln, course coordinator, at KCC, 313-576-9283.

The Chapter Capsule

...is a publication of the Metropolitan Detroit Chapter of the Oncology Nursing Society. MDONS is devoted to improving the quality of care given to patients experiencing cancer. This newsletter is published four times a year, in spring, summer, fall and winter. Letters and articles from members are welcomed. All material is subject to editing for space and clarification. Neither the Metro Detroit Chapter nor the ONS National Office assumes responsibility for opinions expressed herein. Acceptance of manuscripts does not indicate or imply endorsement.Materials may be submitted to:

Carole Bauer, BSN, RN,OCN,CWOCN
6116 Smithfield Drive,Troy,MI 48085

Oncology Nursing Society
MDONS
Metro Detroit Chapter
ONS
Where Oncology Nurses Connect

MDONS CHAPTER CAPSULE
6116 SMITHFIELD DRIVE
TROY, MI 48085

2012 MDONS Officers

President
Michelle Wallace, mwallace@beaumonthospitals.com
President Elect
Alicia Piccolo, alicia_piccolo@yahoo.com
Past President
Sheryl Cummings, cummings_sheryl@yahoo.com
Nominating Chair
Susan Wozniak, susan.wozniak55@gmail.com
Secretary
Ann Marie Campbell, amcamp19@yahoo.com
Treasurer
Lynne Carpenter, lcarpent03@gmail.com
Newsletter Editor
Carole Bauer, carolebauer@wowway.com
Newsletter Assistant Editor
Sandy Remer, sdremer@earthlink.net

Staff

Susan Wozniak
Susan.Wozniak55@gmail.com
Theresa Benacquisto
theresab65@comcast.net
Rita Di Biase
Nancy Morrow
Nanmoro4@yahoo.com
Joan McNally
joancmcnally@aol.com
Rita Dundon
313-881-8584
Mary Wilson
MFW1311@aol.com
Loretta Biskup
edbiskup@yahoo.com
Alicia Piccolo
alicia_piccolo@yahoo.com
Deborah Hasenau
deb_and_bark@yahoo.com
Sheryl Cummings
cummings_sheryl@yahoo.com
Sabrina Richer
sabrina.richer@bms.com
Gayle Snider
gayle.snider@infusystems.com
Michelle Wallace
mwallace@beaumonthospitals.com
Angela Maynard
amaynard@beaumonthospitals.com
Susan Hansell
susan.hansell@comcast.net
Kirsten D'Angelo
kirsten.dangelo@beaumont.edu

MEMBERSHIP APPLICATION

METROPOLITAN DETROIT CHAPTER – ONS

❑ NEW ❑ RENEWAL ❑ ONE YEAR $20.00 ❑ 3 YEARS $50.00

NATIONAL ONS NUMBER (AS NOTED ON MEMBER CARDS): _____

NAME: _____

INSTITUTION NAME: _____

PROFESSIONAL POSITION: _____

BUSINESS ADDRESS:	HOME ADDRESS:
STREET: _____	STREET: _____
CITY: _____	CITY: _____
STATE/ZIP: _____	STATE/ZIP: _____
COUNTY: _____	COUNTY: _____
PHONE: _____	PHONE: _____
EMAIL: _____	EMAIL: _____

PREFERRED MAILING ADDRESS: ❑ BUSINESS ❑ HOME

MEMBERSHIP AND CORRESPONDENCE TO:
THERESA BENEQUISTO, 1844 MARKESE, LINCOLN PARK, MI 48146