“Somebody has to do something, and it's just incredibly pathetic that it has to be us.” Jerry Garcia singer, The Grateful Dead (1942-1995).

It seems to me that this quote from the late Jerry Garcia is certainly applicable to those of us who are responsible for the care of patients which includes pain management.

Since their inception in 1975, the Oncology Nursing Society's (ONS) mission has always included pain relief as an essential element in the comprehensive nursing care of oncology patients (Spross, 1993).

Were you aware that, in late 2000, as a result of the impact of undermanaged pain and its effect on the quality of life and function, the United States' Congress passed into law a provision that declared the ten-year period beginning January 1, 2001 as the decade of pain control and research.

In addition, it has already been nine years since the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) released the Pain Management Standards in 2001. These standards require organizations seeking accreditation to recognize the patient's rights to appropriate assessment and management of pain and that pain is assessed in all patients.

First, and perhaps foremost, in order to make improvements to address undertreated pain and improve pain relief, the patient's pain must be assessed. This sure sounds simple, doesn't it? Studies have found that some of the chief barriers for health care professionals to provide optimal pain relief are poor pain assessment and lack of understanding of analgescics including side effects, misconception about pain, and lack of knowledge about addiction. Also, clinician’s personal belief systems, attitudes and fears can influence the manner in which they respond to their patient's report of pain (Fink, 2000).

Think about your practice. So how is pain assessed? What are the components of pain assessment? How important is it for the clinician to assess pain? If you ask 10 clinicians to describe how to perform a pain assessment you may get 10 different responses. However it is performed, pain assessment is the cornerstone to optimal pain management. It is the foundation that the pain management plan is based upon and impacts the cycle of assessment, implementation and reassessment or evaluation. Appropriate pain assessment provides guidance for reassessing pain relief.

The most commonly cited definition for pain comes from the International Association for the Study of Pain. Pain is defined as, “an unpleasant sensory and emotional experience arising from actual or potential tissue damage. While it is unquestionably a sensation in part or parts of the body, pain is always unpleasant, and therefore, an emotional experience (APS, 2008). This definition emphasizes that pain includes multiple dimensions such as cultural, psychological, and sensory components. A broad definition first described by Margo McCaffery RN in 1968 for use in clinical practice states, “Pain is whatever the experiencing person says it is, existing whenever he says it does” (Pasero & McCaffery, 2010). Unlike other medical conditions whereby the patient relies on the experience and expertise of the health care provider, pain is subjective and pain treatment lacks objectives markers.

The patient's self report is the most reliable indicator of the presence and severity of pain. To facilitate accurate reporting a patient should be instructed on the use of a pain rating tool. The tool should be appropriate for the patient’s developmental, physical, emotional and cognitive status. The pain rating scale should be simple, easy to use and allow for quick assessment, reassessment and ease of documentation. (Ackely et al., 2008).

Pain assessment is a process that includes the clinician and the patient. Pain is more than just a number on an intensity scale. Consider the words of von Baeyer “Describing pain in terms of its intensity is like describing music only in terms of its loudness” (2006). What else can be done? The primary objective is to obtain information that will help identify the cause of the patient's pain and guide their pain management. The patient's history is an essential component of a pain assessment. One concise mnemonic device that can be used to obtain the necessary information is called "P-Q-R-S-T". Here is how it works:

- **P** – Provocative Factors: What brought on the symptoms? What provokes the pain? 
- **Q** – Quality: What does the pain feel like? Is the pain stabbing,

Continued on following page
From the Editor Sandra Remer, RN, BS, OCN®, CCRP®

As I sit looking out my home office window, I see the sun shining and the snow melting. Can Spring be far behind? Oops, it is just the middle of February, so we do have at least six more weeks of cold weather, perhaps more, after all we do live in Michigan and nothing about our weather is routine. When you least expect it something changes.

The other day, I received an e-mail from the brother of one of my brain tumor patients, who had passed away several months ago. As I read through it, I felt as though I have read those words may times before. I had, perhaps not those same word, but similar.

MJS had been diagnosed with a Meningioma, that is normally supposed to be a benign tumor. She and her family expected that everything would go well. She would continue to live a normal life except maybe with a few alterations. Her tumor however had some atypical features and that would change things. Looking back over time, I am not sure what her family expected. She had four surgeries. The second was meningioma with NO atypical features. Perhaps that changed how she and her family viewed everything. She also had several radiation treatments over time.

The purpose of the letter was to suggest how to help patients and their caregivers. He began by saying that neither he nor MJS really understood what was happening. MJS would always put pressure on herself to do better. The brother wrote that as he looked back “with guilt (he) realized that both he and his sister were also pressuring the patient to perform.” He said he was not faulting anyone, they just didn't know they were fighting a losing battle. They should have retreated to enjoy time together rather than striving for what could not be. He apologized for not really being able to express it better.

I found these words very reflective, not quite perhaps what he really was trying to say. He as the caregiver was trying hard to make sense of very difficult period of time in their lives. Looking back over time, I also wonder if my colleagues and I missed something. I do remember long conversations with them answering questions, repeating information over and over, knowing that sometimes patients and families only retain 5-10 % of what we tell them.

I remember one conversation where I spoke to the brother and sister about getting help with her care so they could go back to being a brother and sister and not continuing to be a “caregiver”. Being a caregiver is a very difficult task and can change how a family views themselves. Being a caregiver can change life for all concerned. I began to wonder if maybe we need to change what we teach patients and families as well as how we teach them. Perhaps one concept that needs to be taught is how to remain positive in an unsure world of cancer. Yet at the same time providing patients and families the tools they need to cope and work through all of the ups and downs to treatments, changes in abilities and perhaps re-establishing new goals for living.

Maybe that is the point, helping patient and families re-adjust the goals they have for living, whether it is simply adjusting to disabilities, taking more time together or considering when to stop treatments and consider quality of life. I am going to call this brother, so I can “hear” what he is really trying to tell me and see how I can help now to ease some of the guilt he is feeling.

I am sure each of you has a story, we feel their pain. How to ease it away? Perhaps that is all part of life, there are no magic words, just caring, which is what oncology nurses do best.

Promoting Excellence in Pain Management

Continued from page 1

burning, sharp? Is the pain in muscle, bone (somatic pain)? Is the pain in the organ (visceral pain)? Is the pain burning, tingling (neuropathic pain)?
• R – Radiation: Where is the pain? Does the pain go anywhere or just stay in one place?
• S – Severity: How bad is the pain? Ask the patient to rate the pain intensity on the pain rating tool?
• T – Temporal Factors: Is the pain continuous or intermittent? Ask the patient what they have already tried for treatment of the pain. What makes the pain worse? What makes the pain better?

It is also important to be alert for the other various physical and behavioral signs and symptoms associated with pain or those that may accompany pain. You may observe some of these behavioral indicators, such as restlessness, moaning, crying, clenched teeth, or protecting or guarding body parts. Asking the patient, “How does the pain effect activities of daily living?” can be an indication of the level of pain. When a patient is in pain daily activities are often either neglected or altered. Sleep can become erratic, sexual activity may decline, exercise programs can cease, playtime or hobbies are neglected, and the patient may miss more hours at work. Simply asking patients, “How does pain limit your usual daily activities?” or, “What can you no longer do because of your pain?” may elicit useful information.

When deficits in responding are present, such as dementia, mental handicap, or other cognitive impairment, the nonverbal cues of pain become most important. Though it is more difficult to assess a patient with cognitive impairment, it is not impossible. There are many behavior scales that can be used for when a patient is unable to give a self report. Every patient has the right or deserves a thorough pain assessment.

In concluding, I hope that this information will be helpful to you and your patients. A comprehensive discussion of all aspects of pain assessment and management is certainly beyond the scope of this article. However, I would like to help ensure that each and every one of us can do our part to promote excellence in pain management. Assessment is a key and critical part of the process. Pain properly assessed can result in the following positive outcome: reduced pain experience for the patient, increased comfort, improved function, and increased patient satisfaction. As a patient advocate, health care providers understand that assessment is an important part of prevention and that prevention of pain is always easier than treatment of pain.

References
American Pain Society: Decade of Pain Control and Research http://www.ampsainsoc.org/decadeofpain/
Fink, R. (2000) Pain Assessment: the cornerstone to optimal pain management. Baylor University Medical Center Proceedings, 13 (3) 236-239
Pain Assessment and Management An Organizational Approach Joint Commission on Accreditation on Healthcare Organizations 2000
November

Understanding and Managing Cardiotoxicity in Breast Cancer: Intervention Strategies for the Advanced Practice Oncology Nurse

Presented by: Patricia M. Clark MSN, RN, FNP-BC
Summarized by: Mary F. Wilson BSN, RN, OCN, CHPN

The purpose of this presentation was to facilitate the development of effective nursing care plans addressing the issue of cardiotoxicity in patients with breast cancer. Cardiotoxicity is associated with several agents used to treat breast cancer including anthracyclines, human epidermal growth factor receptor (HER) 2 inhibitors, and vascular endothelial growth factor (VEGF) inhibitors.

The most common cardiac complications associated with the anthracyclines and HER-2 inhibitors are cardiomyopathy and heart failure. VEGF inhibitors are more often associated with hypertension, emboli, and possibly CHF.

Anthracyclines are used in breast cancer treatment due to their ability to decrease disease recurrence by 30% and increase survival by 30%. They are used to shrink tumor size and increase resectability, and are not usually used in cases with metastatic disease. In cases of patients with a known history of cardiac disease, the alternate treatments are the taxanes.

Several mechanisms have been identified by which the anthracyclines cause cardiac dysfunction, and the relative risk for each patient should be considered when planning treatment. Some of the damage is reversible as cells can repair themselves after the stressors (the chemo agents) have been removed. However, some chemo agents can cause non-reversible damage. Doxorubicin is one of those. The cardiac damage starts with the first dose, is dose-related, and permanent. The quality of life issue that needs to be kept in mind is what should the threshold of symptoms be if the patient will be surviving and living with the damage?

HER-2 inhibitors have been shown to offer huge benefits to breast cancer patients. They can decrease recurrence by 50%, and decrease deaths by 33%. With metastatic disease, they have been shown to increase survival rates. HER-2 inhibitors can show cardiotoxicity through mechanical impairments - they temporarily affect contractility, but this is usually reversible within a few months after completing treatment. It is important to hold the chemo treatment until the cardiac symptoms are treated. Some damage may be permanent - when the damage reaches a certain threshold, CHF occurs.

VEGF inhibitors have been shown to decrease disease progression in breast cancers. They are used concurrently with other treatments. VEGF inhibitors are not contraindicated with hypertension, but patients should be closely monitored. Each increase in blood pressure of 20/10 doubles the risk of cardiotoxicity and mortality. It is important to educate the patient on the need to comply with anti-hypertensive therapy.

Another complication of the VEGF inhibitors is the formation of blood clots. This can be related to hypertension, vascular damage, or platelet count and viscosity. The relative risk of venous clots has been shown to be 12%, while the risk for arterial clots is 2.4%. In conclusion, baseline monitoring needs to be done to minimize the risk for cardiotoxicity in the treatment of breast cancer. A baseline echocardiogram or MUGA scan should be done prior to starting treatment and repeated every three months. Coaguability studies also need to be obtained regularly. Pre-existing cardiac conditions need to be identified and treated prior to starting treatment. The patient needs ongoing assessment and management of any cardiovascular complications using a multi-disciplinary approach to ensure the best possible patient outcomes and quality of life.

December

MDONS Holiday Party

More than 50 members turned out to attend the MDONS Holiday Party. With generous member donations of gloves, hats, and toiletries, we made more than 150 hygiene bags that were donated to Detroit Healthcare for the Homeless, Inc. Decorating the gift bags and boxing up all those bags is always the highlight of the evening.

Thanks to Active Infusion for sponsoring a great Christmas dinner at Jimmy’s Restaurant in Royal Oak. Good friends, great food, and the opportunity to help those less fortunate, what more could an oncology nurse ask for?
Multiple myeloma (MM) is a B cell malignancy of the plasma cells. Genetic and molecular defects lead to overproduction of abnormal plasma cells, associated serum proteins, and immunoglobulins (Tariman, 2011). It is the second most common hematologic malignancy; only non-Hodgkin’s lymphoma is more common. About 20,580 were diagnosed in 2009 (Tariman, 2011). MM most often affects the elderly with a median age of diagnosis of 65 years. African Americans are affected by the disease twice as often as Caucasians. It is considered incurable but highly treatable. The death rates have decreased with response to treatment from a few months to more than 10 years. According to Tariman, novel agents contribute to improved life expectancy by neutralizing the effects of some of the high risk features of MM.

MM results from clonal (lymphoid) proliferation of the plasma cells. MM is a complex interaction of malignant progenitor cells, bone marrow stroma, and bone marrow microenvironment dysregulation. Stromal dysregulation results in plasma cells adhering to the extracellular matrix and bone marrow stromal cells. Cytokines are produced that stimulate growth, survival, and migration of myeloma. In addition, upregulation factors that promote drug resistance, and stimulate bone reabsorption and tumor invasion are activated. Oncogene dysregulation in the bone marrow microenvironment is present in 40% of MM and may involve translocations that involve IgH locus on chromosome 14, deletion of 17 (inactivation of p53 the tumor suppressor gene), and deletion of chromosome 13. These pathobiological changes in myeloma have become identified targets for therapy. A brief historical perspective of therapies for MM from 1962 through 2000 on reveals multiple treatment strategies. In 1962 oral melphalan and prednisone were the treatment of choice for newly diagnosed MM. In 1984 VAD (Vincristine, Doxorubicin, Dexamethasone) or high-dose dexamethasone was quite common. Bisphosphonates were added in 1996. High dose chemo (HDC) with autologous stem cell transplant and thalidomide became the standard treatment from 1999 to date. Finally, in 2000, proteasome inhibitors (bortezomib, lenalidomide) and new thalidomide derivatives, immunomodulatory drugs (IMID) add further options in the treatment of MM. Monoclonal antibodies and histone deacetylase inhibitors (HDAC) are under study.

The most common presenting symptom of MM is bone pain (58%) and fatigue (32%). Signs and symptoms are a result of the over production of immunoglobulins. The most common clinical findings include lytic lesions (66%), anemia (73%), elevated creatinine (Cr) (19%), hypercalcemia (13%), and peripheral neuropathy (5%).

MM diagnostic evaluation includes multiple lab tests, bone marrow biopsy, and radiology evaluations. The tests help establish diagnosis, determine subtype, stage, estimate prognosis, and identify the need for immediate interventions. Lab tests may include CBC with differential and platelet count, BUN, Cr, calcium, albumin, LDH, β microglobulin, serum immunoglobulins via qualitative IgG, IgM, IgA, IgD, protein electrophoresis, and serum light chain assay (kappa, lambda). Urine testing includes 24 hour protein, protein electrophoresis and immunofixation. One new test is the sFLC or serum free light chains. Three percent of patients with MM have no detectable M protein in the urine or the serum. The sFLC assay allows detection of kappa and lambda immunoglobulins. Thus, this test is helpful in diagnosis of MM and monitoring nonsecretory MM. For more information on sFLC see: http://myeloma.org/pdfs/UnderstandingFreeLight.pdf.

Immunoglobulins are composed of two types of smaller molecules; heavy chain and light chain. There are five types of heavy chains IgG, IgA, IgM, IgD, and IgE. There are two types if light chains, kappa and lambda. Each plasma cell produces only one type of light chain. MM is classified as heavy chain, light chain or nonsecretory. Tariman (2011) classifies MM as stupid, stupidier, and stupidest. Stupid is heavy chain producer with IgG and IgA being most common, it makes too many heavy chains, and occurs in 77% of MM patients. Stupidier is the light chain (Bence Jones protein), it makes too many light chains, and occurs in 20% of MM cases. Stupidest is the nonsecretifiable immunoglobulin, it forgets to make immunoglobulins, which occurs in 1-2% of MM cases.

The disease trajectory ranges from MGUS (monoclonal gammopathy of undetermined significance) to smoldering myeloma to MM. In MGUS the patient has <3g M protein, < 10% clonal BMPC (bone marrow plasma cells), and no MM related end-organ damage. Smoldering myeloma is characterized by > 3g M protein, < 10% clonal BMPC, and no MM related organ damage. MM has > 10% clonal BMPC, M protein, and one or greater CRAB features of disease related organ damage. CRAB is Calcium elevation greater than 11.5 mg/L, renal dysfunction with serum Cr > 2mg/dl, anemia with hemoglobin < 10g/dl or 2g < normal, and bone disease such as lytic lesions or osteoporosis.

Poor prognostic findings in MM include: high risk cytogenetics, serum albumin < 3 g/dl, plasma cell labeling index > 3%, stage III hypoploidy, BMPC > 50%, β microglobulin > 4mg/L, Cr > 2 mg/dl, platelet count < 150,000, and relapse less than 12 months from transplant or first line therapy.

Treatment of MM is aimed at an early and complete sustained response because there is no known cure for MM. The treatment strategies vary among providers due to the number of options for treatment with single agents or in combination have increased in the last decade. The key principles for treatment of MM once diagnosis has been established is immediate interventions for hypercalcemia, renal failure, cord compression, pain or fracture followed by determination of transplant eligibility. Treatment selection should be individualized based on disease characteristics, individual characteristics and current evidence based treatment options. Tariman (2011) says to advocate for the patient, include patient in treatment preferences, as providers have the ability to customize treatment to the MM patient. Follow up includes consistent assessment of response to treatment.

Variable dosing and combination regimens are used in MM. Novel therapies include bortezomib (proteosome inhibitor), lenalidomide and thalidomide (immunomodulatory agents). Disease related adverse events (AE) are myelosuppression, renal, hepatic, and neuro toxicities, nausea and vomiting, constipation and diarrhea, pain, and infection. Drug specific toxicities one may encounter are:

**Bortezomib** - Neuropathy, constipation, diarrhea, hypotension, asthenia, varicella

**Lenalidomide** - Rash, puritis, diarrhea

**Thalidomide** - Neuropathy, sedation, edema, constipation

**Dexamethasone** - Hyperglycemia, muscle weakness, immunosuppression
Oncology nurses are familiar with assessment and management of many of the AE listed, but MM has several disease and treatment related events that require further knowledge to assess, monitor, and manage them. MM patients present with cytopenias at initial diagnosis as anemia (73%), leukopenia (20%), and thrombocytopenia (5%). Anemia of < 10g/dl is considered a poor risk factor at diagnosis and having leukopenia may increase the risk of atypical infections. In addition there is a 8-16% risk for grade 3-4 anemia, 13-21% risk of neutropenia, and a 4-29% risk of thrombocytopenia with novel therapies for MM.

Bone disease in MM is due to MM cells production of cytokines, increase osteoclast differentiation and suppressed osteoblast maturation that inhibits new bone growth. This process results in osteolysis, bone pain, and pathological fractures. Management of bone disease in MM involves treatment of the MM with novel therapies, radiotherapy, and orthopedic interventions. Novel therapies inhibit bone resorption and bortezomib has a stimulatory effect on bone formation. Supportive care with bisphosphonates (Aredia or Zometa) may be necessary for two years and both require monitoring for renal necrosis and osteonecrosis of the jaw. Bisphosphonates (BP) will cause flu like symptoms and patients should be prepared for these effects to last 6-24 hours after infusion. A slow rate of infusion and use of steroids or antihistamines may help reduce intensity. Patients should be taught good oral hygiene, limit use of ETOH and tobacco use, dental exams prior to starting BPs since dental procedures should be avoided once they are started. Supportive care also includes pain management, safety evaluations, spinal support, and ongoing evaluation of bone health.

Finally, development of novel agents continue for MM and refinement of toxicity management will be needed. As new novel therapies evolve so must our knowledge base. New medications and delivery methods present new side effects challenge nurses with the best way to manage them. Also, more agents are now oral with patients taking them at home and this results in a new set of monitoring issues such as, monitoring adherence and side effects. Management strategies will require the nurse’s involvement in clinical trials and educating the patient to provide the best outcomes.

References


Prostate Cancer Awareness

ONS has joined as an advocacy partner in a sports-themed campaign produced by Edge Health Initiatives, LLC. that will focus on prostate cancer awareness. “On The Line” launched on February 15 with celebrity appearances on ABC’s Good Morning America and MSNBC's Morning Joe. ESPN is the main media vehicle for this ongoing campaign that will reach across all sports seasons. Let’s share this link with our patients, family members, and colleagues to help men recognize that their health is “On The Line”! http://www.ontheline.com/
Currently the Oncology Care Clinical Director at Prime Homecare Agency in West Bloomfield, Michigan, Lynne Carpenter has traveled full circle in her MDONS career.

Starting out as a Physics and Chemistry major at Hope College, Lynne finished her BSN degree in 1974 at the University of Michigan. When St. Joseph Mercy Hospital in Pontiac opened their doors to a walk-in Nursing candidate in 1976, little did they know that they were hiring their first Oncology Nurse. Two years after working on a med-surg floor staffed with 2 RNs, 1 LPN and 1 NA for 52 patients, Lynne was offered the opportunity to work in primary care, be a Head Nurse or “Do something with Oncology.” She then began working closely with their only oncologist, Dr. Krishman, in building the foundation of their cancer program. She continued developing educational materials for the patients and staff as well as a chemotherapy course and care plans while triaging questions and answers on the phone and conducting support groups. She would seek out answers to her questions, regardless of where she had to go to get it which resulted in her ground roots efforts being supported by scholars from such facilities as UM, MD Anderson, Memorial Sloan Kettering and other facilities where oncology practices had already been formed.

After ten plus years at St. Joe’s, Lynne returned to Ann Arbor to become the clinical nurse specialist at the UM breast care center and assisted in building the concept of the multidisciplinary clinic. While there, she finished her Masters and PhD with a focus on “Dehydration and Symptom Distress during Cancer Chemotherapy”. Also, during this time, she began presenting for ONS at Congress, in cities such as Houston and San Diego starting out with an audience of 100 and progressing to 1,000 faces in a room eager to hear about her personal stories of being the only cancer nurse in a community hospital where her bedside observations led her to believe in the fact that a glass of water an hour could combat dehydration.

She then began her career in the pharmaceutical industry as a Sr. Clinical Consultant for Schering-Plough, then Oncology Nurse Consultant at Meda Pharmaceuticals, working with “new” products such as Tamoxifen and Temodar and solving patient issues across the country, from Michigan and Wisconsin through Ohio and Indiana to Alaska and Hawaii. Of the many publications Lynne has written, one that is probably seen most often is included as part of the Intron A insert, referring to combating the flu-like side effects by increasing hydration. In her spare time, besides visiting her parents in Petoskey, Lynne is interested in downhill skiing and wind surfing, reading mysteries-fantasy and sci-fi- and giving back to the community with seven builds for Habitat for Humanity (2 in New Orleans-post Katrina) and serving as an elder in her church. It’s only fitting to be highlighting Lynne this year, the 30th anniversary of MDONS. As noted in our history, once upon a time (1976-1981), our chapter was known as MONA-the Michigan Oncology Nurses Association. Lynne was one of the “core group…visionaries who all went on to make significant contributions to the discipline (oncology nursing) in many ways and continue to contribute to this very day”. Lynne’s MDONS career started as the first Treasurer, then Membership Chair, then in Ann Arbor as President of their chapter, eventually serving on the finance committee for the national ONS office along with item writing for the OCN exam. Now as our current Treasurer, Lynne has definitely come full circle hoping to encourage our newer nurses to get involved with the opportunities available and maybe even lead them to the national level. Thank you Lynne for sharing your knowledge, expertise and energy with MDONS!

Nancy Morrow, RN, BSN, OCN

---

**Book Review**

**The Emperor of all Maladies: A Biography of Cancer**

Written by Siddhartha Mukherjee

New York: Scribner, 2010

Submitted by Susan Hansell, RN, BSN, MBA

A biography is usually assumed to be the written history of a person’s life. Siddhartha Mukherjee, however, utilizes an alternate meaning; the written history of the life of an object or subject, in his recent work, The Emperor of all Maladies: A Biography of Cancer. Or does he? Mukherjee attributes cancer with human qualities and flaws, making this work feel like a biography of an undefeated foe. In this work, Mukherjee uses an effective mix of patient cases, social and political historical analysis, and historical accounts of scientific and medical discoveries to chronicle cancer from ancient Egypt to 2010. He observes that cancer was once thought to be a single disease, with the potential of a universal cure, and is now known to be discrete diseases with differing treatment plans and prognoses. Cancer, the ever changing chimera, has morphed from one to many enemies. He states, "to keep pace with this malady, you needed to keep inventing and reinventing, learning and unlearning strategies."

The book points out the barriers to major improvements in cancer prevention, and how patient advocacy has pushed some new treatments out of the research labs and into patients. Readers may find it interesting that many successful treatments have their origins in weapons development and/or the pursuit of commercial applications for newly discovered chemical compounds or processes. The author uses stories of his own patients to describe the challenges faced by patients and the difficulties care providers encounter in understanding them. Although the author mentions the importance of prevention and early detection in the successful defeat of cancer, he ends the book emphasizing the potential of future treatments. This is most likely due to his bias as an Oncologist and researcher. The Emperor of all Maladies: A Biography of Cancer is an entertaining history of man’s long battle to understand and overcome the most “relentless and insidious enemy” of mankind, and a valuable addition to the library of anyone who works with cancer patients.

---

**Register for Congress**

Registration for the 36th Annual Congress is now open! Join more than 4,000 colleagues in Boston, MA, from April 28–May 1 to get the latest in cancer nursing education. Connect with attendees before the conference to find a roommate, make dinner plans, and get in touch with those in your specialty. Register by March 24 to save $100. http://www.ons.org/CNECentral/Conferences/Congress/2011/learn
Although we experienced a wintery start in 2011, the MDONS 21st annual conference “Updates in Oncology” was a successful endeavor. Members of the program committee are to be commended for their efforts in planning, organizing, and executing this event.

As a member of MDONS, you have the opportunity to share your experience, expertise and enthusiasm by participating on a variety of committees. My goal for 2011 is to engage all of our members-to encourage active participation in MDONS. After all, MDONS is your organization. A few examples of ways to become more engaged include:

- Mentoring
- Dissemination of information
- Opportunity
- Networking
- Satisfaction

“Mentoring is a brain to pick, an ear to listen, and a push in the right direction” (John Crosby).

For some individuals, inexperience, fear, and uncertainty may be potential barriers to joining a committee or seeking a leadership role. Hence, mentoring is paramount in providing assurance that MDONS provides a safe haven to those who are willing to accept this challenge. We are fortunate to have a dynamic group of nurses who are willing to provide the support and guidance needed to foster the development of our future leaders and mentors.

“In today’s environment, hoarding knowledge ultimately erodes your power. If you know something very important, the way to power is by actually sharing it” (Joseph Badaracco).

We gain a wealth of information by attending monthly meetings, going to conferences, reading journals, and by learning from our peers. Sharing this information is another avenue to becoming an engaged member, thus empowering our organization as we spread the word about what MDONS has to offer.

“It is the responsibility of leadership to provide opportunity, and the responsibility of individuals to contribute” (William Pollard).

As a member of ONS and MDONS, you are privy to an abundance of educational and scholastic opportunities. Become engaged by recognizing a colleague as an Outstanding Oncology Nurse, or apply for one of several available scholarships.

“Coming together is a beginning. Keeping together is progress. Working together is success” (Henry Ford).

Networking is tantamount to becoming an engaged member. Assembling on a regular basis affords the opportunity for the exchange of ideas, increasing awareness of healthcare issues, enhancement of personal and professional development, and for creating a bond with others who share our passion in caring for oncology patients.

“Personal satisfaction is the most important ingredient of success” (Denis Waitley).

Engagement is more likely to occur if one finds satisfaction, value, and pride in being a MDONS member. Each member may contribute to ensure the continued success of MDONS by encouraging at least one individual to attend a meeting or to join MDONS.

“If your actions inspire others to dream more, learn more, do more and become more, you are a leader” (John Quincy Adams).

Thank you for the opportunity to serve as President for 2011. I am inspired by your commitment and dedication to our patients, and it is a privilege to be a member of this outstanding group of oncology nurses.

---

**Monthly Program Notice**

**Date:** April 13, 2011, Wednesday  •  **Time:** 5:30 pm  
**Topic:** Managing Dysphagia in Neurologic and Head and Neck Disorders  
**Speaker:** Kathy Roeder, MA, CCC  
Manager, Acute Care and Rehabilitation Unit Services - Speech and Language Pathology  
**Location:** Beaumont Hospital, Administrative Building, Royal Oak  •  **CNE credit:** 1.0

**Date:** May 10, 2011 Tuesday  •  **Time:** 5:30 pm  
**Annual Presidents’ Dinner: Tap Dancing through Life**  
Val Gokenbach DM, RN, MBA, AFP  
**Location:** (HOPEFULLY) Red Run Golf Club  •  2036 Rochester Rd. at 12 Mile Rd, Royal Oak  
**Sponsor:** MDONS chapter  •  **CNE credit:** 1.0  
Watch for invitation in the mail!!  
RSVP will be necessary!

**Date:** June 8, 2011, Wednesday  •  **Time:** 5:30 pm  
**Topic:** New Health Care Law  
**Speaker:** TBA  
**Location:** (Probably) American Cancer Society Office, 20450 Civic Center Drive, Southfield  
**Sponsor:** TBA  •  **CNE credit:** 1.0  
Check Web site for final arrangements or call Deb 313-576-8687
**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:  
- Street:  __________________________________________________________________
- City:  ___________________________________________________________________
- State/Zip:  __________________________________________________________________
- County:  __________________________________________________________________
- Phone:  __________________________  
- Email:  __________________________

Home Address:  
- Street:  __________________________________________________________________
- City:  ___________________________________________________________________
- State/Zip:  __________________________________________________________________
- County:  __________________________________________________________________
- Phone:  __________________________  
- Email:  __________________________

Preferred Mailing Address:  
- Business  
- Home

Membership and Correspondence to:  
Theresa Benequisto, 1844 Markese, Lincoln Park, MI 48146

http://metrodetroit.vc.ons.org