Prostate cancer is the second-leading cause of cancer related death for men in the United States. Yet, today there is controversy surrounding screening. According to the American Cancer Society (ACS)) approximately 186,320 new cases will be diagnosed and 28,660 men will die from prostate cancer (2008). Prostate cancer is a slow growing cancer. When early prostate cancer is diagnosed the men will usually live a long time, even when they do not obtain treatment for the disease. In fact many elderly men with prostate cancer usually die from causes other than the prostate cancer. So should we continue to regularly screen for prostate cancer?

Prostate cancer screening is done with a blood test for prostate specific antigen (PSA) and by the physician performing a digital rectal exam (DRE) to manually feel the prostate for abnormalities. The two tests together can lead to a diagnosis of prostate cancer before it has begun to cause symptoms. The PSA test, which is very sensitive to early cancer, is both a blessing and a curse because when the PSA level is elevated men are faced with the decision of what to do next. Do they seek treatment which can have some significant long term side effects or wait and watch to see what happens?

At Johns Hopkins Hospital in Baltimore, an analysis was made of 300 patients who under went prostate removal. It was discovered that between 25% and 33% had such small tumors that they were potentially insignificant (Brinks, 2008). While prostate cancer treatment cure rates are as high as 80 %, some untreated prostate cancer will never pose a threat. Surgical and radiation treatment for prostate cancer is not without risks, including erectile dysfunction, urinary incontinence, bowel dysfunction and death, thus it becomes a gamble whether to receive treatment for the cancer or watch and wait. Studies are ongoing to determine which men with prostate cancer are best treated with watchful waiting and which ones will benefit from early intervention. It is uncertain whether routine screening does indeed save lives. Since the PSA screening began in the early 1990s, the prostate cancer death rates have dropped about 2.5 percent a year, but there is not any conclusive evidence linking those improved outcomes to early detection (Brinks, 2008). The National Cancer Institute (NCI) is currently conducting a research study to see if screening with the PSA and DRE can reduce the death rates from this cancer. They will also be looking at the inherent risks involved in the screening process. The results of this study will not be available until 2015 (NCI, 2007).

In August of 2008, the U.S. Preventive Services Task Force (USPSTF) made the recommendation that men 75 years of age and older should not be screened for prostate cancer (Pedersen, 2008). The consensus was that by age 75 the average life expectancy is 10 years and prostate cancer usually takes around 10 years to result in death. Thus, the risks of treatment outweigh the benefits for this group of men ((Pedersen, 2008). The USPSTF also voiced concern that the screening process

Continued on page 3
From the Editor  Sandra Remer, RN, BS, OCN®, CCRP

E-mails can be both a blessing and a nuisance; however they are often the source of good information that comes our way. The other day I received an e-mail from NSO Risk Advisor, so I thought I would take a look. NSO is the Nurses Services Organization and Nursing Center.com. This site usually has good basic information for nursing in general. The NSO has information for students, general practice RN’s and Nurse Practitioners. What I clicked on was a special report on “How to properly document to reduce your liability risk.”

Since, I do my charting electronically, for anyone and everyone who works with a patient to see, it is even more essential that the documentation be accurate and informative. I even copy and paste e-mails into the patient’s chart if he/she sends me information I believe the physicians need to know as well as letters written on the patient’s behalf per their request after the physician has reviewed and signed the letter. The days of old hand written charting are gone for the most part and JACHO is reviewing everything we do especially charting. I just thought I would send some information your way.

Some good rules for documentation the NSO recommended are:

1) Never alter a record, if you make a mistake draw a line through it indicate correction and initial/date the correction.
2) Record only the facts, only observed behaviors.
3) Do not chart critical comments or opinions.
4) Begin each entry with the time and end each entry with signature and title.

Common mistakes to avoid are 1) Failing to record pertinent health or drug information 2) Failing to record nursing actions 3) Failing to record that medications have been given 4) Recording on the wrong chart 5) Failing to document a discontinued medication 6) Failing to record drug reactions or changes in the patient condition 7) Transcribing orders improperly or transcribing improper orders and 8) Writing illegible or incomplete records. This last mistake is eliminated with electronic charting.

5) Use only abbreviations in accordance with the facility’s approved abbreviation list. Do not leave blank spaces.
6) Record all entries legibly and in ink.
7) Avoid using generalized phrased such as “the patient had a good day.”
8) Document circumstances and handling of errors.
9) Chart only for yourself.
10) Do not allow any unauthorized person access to a patient medical record.

Careful attention to our charting, being objective, specific and always remaining neutral may save the need to defend ourselves someday. I know you all are reminded about this during in-services and JACHO updates, but it was an easy reminder for me about a very important part of nursing practice. Electronic charting has it’s own ups and downs, but at least I can read what I am doing, spell check it and use Grammar and Language checks to be sure I am using the right wording and I can hold it and comeback to review it before I electronically sign it. Thanks for listening! (At least with your eyes)

Highlighting a Member: Sheryl Cummings, RN BSN OCN®,

With a little childhood inspiration and the right nurse mentor, one can aspire to being president of the Metro Detroit Oncology Nursing Society some day.

MDONS President Elect, Sheryl Cummings became a nurse in 1996 as a member of the last graduating class of Henry Ford Hospital School of Nursing. Her inspiration came many years before. “One of my early role models is my Aunt Carole. I think this is where the nursing seed got planted in me. Although she recently retired from nursing she still inspires me to become a better nurse”.

Sheryl tells us that she started her nursing career at HFH downtown on a geriatric med/surg unit. When asked why she turned to oncology, she states “ I have always been someone who works better when I have a passion for what I am doing and so I went looking for my personal niche in nursing. Oncology had always fascinated me, but my exposure to it in nursing school was brief and left me wanting more. I started working for a nursing agency and there was an opening in a private practice oncology office and I took it. There I met a nurse, Amy Putnam, who was an amazing mentor to me and realized what a little sponge I was and helped me learn all I could about oncology. After taking the temporary position I knew inside of a week or two that this was where I wanted to be. I have been in oncology ever since”.

In 2000, Sheryl joined ONS and received OCN® certification. Certification provided Sheryl with opportunities to grow in oncology, continue learning, and advance her career. Sheryl recognizes the value of ONS, “They encourage knowledge, education and support for oncology nurses. Situations come up at work that will often send me to the ONS website. When new policies or procedures need to be written I will refer to ONS, as they are the gold standard for oncology nursing. Of course the opportunity to attend the national meeting and network with other oncology nurses is just another bonus that ONS provides”.

2005 was a great year for Sheryl. She completed her BSN from Oakland University and met her husband, Matt, “the love of my life. He is a daily inspiration to me and makes me strive to be a better person and nurse”. In 2006 and 2007 they organized a cycling fundraiser (Matt’s brainchild) to benefit Gilda's Club in Royal Oak. In those two years their cycling team raised over $25,000 for Gilda's Club. Gilda's Club will always be near my heart and we will always raise money for them.”

In 2007, they married. Sheryl is the 2008 recipient of a Nightingale Award. The Nightingale Award recognizes nurses who are exceptional in their field. For more information on the nightingale award, go to: http://www2.oakland.edu/nursing/nightingale.cfm. To congratulate Sheryl and welcome her as a new MDONS board member, go to: cummings_sheryl@yahoo.com.

By Susan Woźniak, MSHS, RN, OCN®
Prostate Cancer: To Screen or Not to Screen
Continued from page 1

itself can cause pain or discomfort from the prostate biopsy and anxiety from the actual diagnosis itself. Men younger than 75 with chronic medical problems whose life expectancy is less than 10 years are also not likely to benefit from screening and treatment. The USPSTF also determined that there is not enough evidence to recommend either for or against routine screening for men younger than 75 years of age (Pedersen).

The National Cancer Institute states that screening with PSA and/or DRE may detect some prostate cancers that would never have caused important clinical problems thereby leading to some degree of over treatment for prostate cancer, and therefore they do not recommend routine testing (ACS, 2008). In fact, routine testing for prostate cancer is no longer supported by the American Cancer Society, American College of Physicians and the American Urological Association (ACS).

While the American Cancer Society (2008) also does not support routine prostate cancer testing at this time, their guidelines for early detection of prostate cancer suggest that information should be offered to all men about what is known and what is uncertain about the benefits, risks and limitations of early detection and treatment of prostate cancer so an informed decision can be made. Their guidelines recommend that the PSA blood test and DRE should be offered annually beginning at age 50 to those men who have at least a 10 year life expectancy. High risk men including African American men, and those with a strong family history, father or brothers who were diagnosed before the age of 65 should be given the option of screening by age 45 years of age. The ACS also feels that discouraging, and not offering testing is inappropriate. Since some 75 to 80 year old males have better than average health and may live longer than 10 years, they also do not believe in putting an upper age limit on the option for screening (ACS).

Recently there has been debate over the accuracy of the PSA test, since it has been shown to have up to 70% false positive rate (Pedersen, 2008). Factors that can interfere with PSA readings include benign prostatic hyperplasia, prostatitis, age, ejaculation and prostate manipulation 48 hours prior to the test, and medications such as finasteride (Proscar), and androgen receptor blockers (Holcomb, 2007). Variations of PSA screening such as free PSA, PSA density, PSA velocity, PSA slope and PSA doubling time have been proposed to improve detection. In January 2007, the National Comprehensive Cancer Network (NCCN) updated their guideline for detection and treatment of prostate cancer (Holcomb, 2007). The NCCN guidelines suggest observing the total PSA and the PSA velocity to refine the PSA readings. The PSA velocity indicates how fast the PSA level is rising over time, therefore demonstrating a greater cancer risk if the PSA velocity is rising but total PSA is not increasing (Holcomb). The NCCN guideline also gave values to consider. If the total PSA is less than or equal to 2.5 ng/mL and the PSA velocity is less than 0.75 ng/mL/year the annual PSA and DRE is all that is needed. A biopsy of the prostate gland should be considered when the total PSA is between 2.6- 4.0 ng/mL and the velocity is greater than 0.75ng/mL/year. Once the PSA reaches 4.0-10.0ng/mL biopsy should be considered and the velocity no longer needs to be monitored (Holcomb). The USPSTF on the other hand, states that evidence is lacking to support improved health outcomes with these variations of PSA testing (Pedersen, 2008).

In conclusion, whether a man gets screened for prostate cancer or not will depend upon the information he receives about the risks and benefits. Knowing about latest guidelines about prostate cancer screening and what the scientific and medical communities are endorsing can assist you in guiding your patients in their decision to have prostate screening.

 References:
Holcomb, S.S. (2007) Prostate screening an individual decision. The Nurse Practitioner, 32(8), 6-8
November

**PEP: Putting Evidence Into Practice**

Presented by Susan Wozniak, MS, RN, OCN®

Made possible through a grant from the Breast Cancer Fund of the National Philanthropic Trust to the Oncology Nursing Society, this PEP Rally was presented by Susan Wozniak, an ONS trained Outcomes Chapter Champion. The interactive evening of presentations, case studies and PEParty Game playing gave the attendees an opportunity to improve patient outcomes through the use of ONS PEP evidence-based resources.

ONS has long supported the highest quality of oncology care. They are committed to integrating evidence-based practice into oncology care and reached a new milestone with the Putting Evidence Into Practice (PEP) resource tools. The goal of these tools is to facilitate application of current evidence to everyday practice. The intent is to provide the level of evidence for interventions that could be integrated into the management of specific oncology problems. Outcomes which focus on how patients and their health care problems are affected by nursing interventions were identified and described as Nursing-Sensitive Patient Outcomes (NSPOs). Interventions for CINV, anorexia, anxiety, and more, were explored. Myths were debunked. Evidence was cited and supported.

![Evidence based practice is a concept that is integral in today’s era of healthcare accountability.](image)

Evidence based practice is a concept that is integral in today’s era of healthcare accountability. Each attendee was given a full set of PEP cards. The PEP cards have been developed by teams of oncology nursing researchers, APNs and staff nurses. For more information on PEP, go to the Research-Outcomes Resource area of the ONS website (http://www.ons.org/outcomes/)

December

The December meeting again focused on good work in the community. We collected supplies and made hygiene kits for the homeless in Detroit. Enjoy the photos of the wonderful time we all had!
The January meeting, Managing Ascites and Pleural Effusion was presented by Patricia Williams. Ms. Williams began her talk by discussing the management of ascites and then went on to discuss the management of pleural effusions. She began the evening discussing ascites. Peritoneal fluid originates from several points within the abdominal cavity and continuously washes through this cavity. It provides lubrication for the organs. This fluid consists of relatively low protein content, has a low viscosity and is pale yellow in color. Primary causes of ascites are 80% hepatic, 15% malignancies and 5% others such as cardiac, pancreatic, infections or autoimmune disorders. Cirrhotic liver also causes ascites due to lack of re-absorption of the peritoneal fluid.

Ascites accumulation causes increased abdominal girth, decreased mobility, and change in center of gravity (due to abdominal ascites). Early satiety may also be present due to fluids pushing up in the stomach. Other complications can include bowel obstruction and increased pressure on IVC which can lead to decreased venous return and right-sided heart failure. Increased portal venous pressure may also result which can cause portal hypertension.

Cancers which most commonly result in malignant ascites are ovarian, breast, lung, liver and end stage gastrointestinal cancers. It is hard to treat malignant ascites because it is uncoupled from systemic volume and it is less responsive to diuretic therapy. Patients with ascites should have diet restrictions (low sodium) and diuretics. Paracentesis are performed as needed. Long term treatment may require the use of Tanckoff catheters, peritoneo-venous shunts, peritoneal implanted ports and pleurX catheter. The most common treatments are diet and diuretics, paracentesis and pleurX catheter. Low sodium diet and diuretics such as Aldactone and Lasix are used. Aldactone is good with liver components. This treatment is less costly and non invasive to the patient.

Paracentesis can be used to drain the fluid from the abdomen by placing a needle into abdomen and connecting to suction to remove the majority of fluid. This provides temporary relief and has to be
Meeting Summaries

repeated when fluid re-accumulates. There is a risk of infection, fistula or perforation unless done under fluoroscopy. There can be a protein and electrolyte shift when fluid is drained but this is a relatively inexpensive procedure. There can be leakage from the site after the procedure. A paracentesis is usually done repeatedly if the prognosis is poor (1-4 months).

PleurX catheters are tunneled with a cuff so that the tissue can adhere to the cuff to keep the catheter in place and there are no needles. This is indicated for intermittent long term drainage of ascites that does not respond to medical management of the underlying disease. It enables palliation of symptoms related to recurrent malignant ascites. This catheter has a one way valve which diminishes leakage from the site and it is placed in the outpatient setting. Using this catheter reduces patient visits, allows for home management, ease of obtaining supplies and short learning curve for patients and families. The drawbacks include lack of Medicaid coverage for supplies, large co-pays for some patients and some insurance needs a precertification first which may result in a delay in obtaining the necessary supplies.

Ms. Williams then went on to discuss the management of malignant pleural effusions (MPE). The average adult produces between 100-200 ml of pleura fluid daily. This fluid is constantly reabsorbed through the vasculature and lymphatic system. Cancers that most often lead to malignant pleural effusion are lung, breast and lymphoma. Patients with MPE can have >1000 ml accumulate in their pleural space which can cause decreased quality of life, impaired physical activity and decreased oxygenation. This can then lead to decreased mentation, increased cardiac output and hypoxia.

There are several treatment options for MPE including pleurodesis, radiation therapy, systemic chemotherapy, thoracentesis, chest tube and PleurX catheters.

Benefits of PleurX catheter for MPE management vs. other devices include the pleurX catheter mobility in chest cavity; pleurX drops to base of cavity and migrates to areas of fluid buildup. Constant drainage of pleural effusion enables spontaneous pleurodesis. The pleurX also allows the patient and family control over MPE management without repeated hospitalizations.

Economic Stimulus Bill Aims to Improve Healthcare

On February 17, President Obama signed the economic stimulus bill (H.R. 1) into law. Included in the stimulus are provisions designed to improve healthcare quality, enhance cancer research, and address workforce shortages. Check out the ONS outline of some of these provisions at http://www.ons.org/lac/pdf/CancerandNursingInTheStimulusPackage.pdf

Read the Most Popular Articles in the Oncology Nursing Forum

A listing of the most-viewed articles in ONF is now available! At http://www.ons.org/publications/journals/ONF/mostviewed.shtml

Patients With Cancer Beware of the Peanut!

Because patients with impaired immune systems are more likely to become severely ill from a Salmonella infection than others, the National Cancer Institute developed a new fact sheet, Peanut Product Recall and Cancer Patients, to address the special concerns of cancer patients and their healthcare providers. http://www.cancer.gov/cancertopics/factsheet/Support/peanut-recall

New Article on Relative Dose Intensity in Cancer Treatment

ONSEdge and Amgen, Inc. are pleased to present you with “Increasing Awareness of Relative Dose Intensity in an Evidence-Based Practice.” The article explores the importance of RDI in the treatment of cancer and reviews the rationale for maintaining RDI. http://www.onsedge.com/pdf/amgenEBP.pdf
From the President
Susan Wozniak, MSHS, RN, OCN

This is my first From the President column and would like to use it to express my appreciation to each of you as members for making MDONS a viable organization that makes a difference in the life of its members and provides a venue to make a difference in the life of others.

The mission of the Oncology Nursing Society is to promote excellence in oncology nursing and quality cancer care. MDONS supports this mission in our community outreach activities and monthly educational member meetings. Once a year, we take a full-day to celebrate the contribution that we make to our patients’ lives and enhance our knowledge base through the MDONS annual “Updates in Oncology Care”.

Our 19th Annual MDONS conference held February 11, 2009, was a great success. I hope you all had an opportunity to attend. We extend our apology to those individuals who never made it off the waiting list. What a wonderful predicament to have. In this day and age of economic strife, when all other nursing conferences in the state are reporting decreased meeting attendance, I am proud to report that although MDONS negotiated for 150 attendees during conference planning, Andiamo’s was kind enough to accommodate 185, and yet we still disappointed many due to capacity limitations. Truly a good problem! We were blessed. The speakers were engaging and well received. (Watch this newsletter for reviews of individual presentations).

I wanted to take this newsletter space to thank the conference committee. Some MDONS members (Deb Ward) have been on the committee since the first program in 1990. Mary Mandziara and Lisa Zajac have co-chaired the conference since 2003. Margaret van der Veen submits for CE hour approval, no small task. Maryann DuCharme coordinates registration and administers accreditation paperwork. Ruth Dein coordinates vendor support. Other 2009 committee members, such as Karen Baranowski, Sheryl Cummings, Marta Metz, and Nancy Morrow, made our conference what it is today. Where you aware that their efforts, this conference and your support are what make MDONS a fiscally sound organization year round? Even though MDONS has kept the fee of the February full-day conference to $40 for members, since 2004, the program has always supported itself. More than that, it has always been and remains our only true source of income for other monthly program costs, community outreach activities and chapter scholarship funding.

You, our MDONS members, make MDONS what it is today. You promote excellence in oncology nursing and quality cancer care (ONS Mission), through Integrity-Innovation-Stewardship-Advocacy-Excellence-Inclusivelness (ONS Values), to lead the transformation of cancer care (ONS Vision).

You’re Invited! Virtual Conversation on Cancer Care

The UICC Global Cancer Control Community is hosting a virtual conversation on cancer control issues through March 31. You do not need to be a UICC member to post your comments. http://www.uicc-community.org/index.php?option=com_content&task=view&id=220&Itemid=403

Nurse Managers – Congress Has a Track for You!

Get ready to head to San Antonio, TX, April 30-May 3 to get the best education around for oncology nursing leaders. The Congress Leadership Track focuses on mentoring strategies, nursing shortage issues and more! Not a manager? Check out the other tracks Congress has to offer. http://onsopcontent.ons.org/ItineraryBuilder/conferences/SearchSessionsCustom.aspx?eId=19

Cancer Prevention and Early Detection Messages From C-Change

C-Change, a coalition of national cancer organizations, recently launched a multiyear campaign to provide cancer prevention communications to its member organizations. ONS is partnering with C-Change to promote tools that will bring consistency in how we communicate to patients and the public about prevention and survivorship. (http://www.cchangetogether.org/)
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

2009 MDONS OFFICERS
President
Susan Wozniak, susan.wozniak55@gmail.com
President Elect
Sheryl Cummings, cummings_sheryl@yahoo.com
Past President
Angela Maynard, amaynard@beaumonthospitals.com
Nominating Chair
Ruth Dein, rdein@beaumonthospitals.com
Secretary
Ann Marie Campbell, amcamp19@yahoo.com
Treasurer
Nancy Morrow, Nanmor04@yahoo.com
Newsletter Editor
Carole Bauer, carolebauer@wowway.com
Newsletter Assistant Editor
Sandy Remer, sdremer@earthlink.net

Membership Application
Metropolitan Detroit Chapter - ONS

New
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Email: ______________________ Email: ______________________

Preferred Mailing Address: Business Home

Membership and Correspondence to: Grace Marshall, 3111 Rivard Ave., Windsor, ONT N8T2J1

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