

Background: The SIG N&V's primary aim is to improve the care for cancer patients with nausea and vomiting. Since its foundation in 1994 SIG N&V has focused on educating oncology nurses in the aspects of nausea and vomiting and developing national clinical standards and guidelines for nurses as well as information regarding antiemetics and self-care guidelines for patients and relatives. The SIG N&V has produced a standard with focus on the result, process and structural criteria of nausea and vomiting at cancerpatients receiving chemotherapy. The result criteria is based on literature studies. An audit was initiated in autumn 2002 to help to set realistic result criteria.

Methods: The purpose with the audit was to investigate on both patient experience and the structural factors. The investigation of patients experience was a prospective structured questionnaire of 9 questions to 144 cancerpatients. The registration of the structural criterias was based on questions to 12 wards at 6 hospitals on; annual education in nausea and vomiting; the presence of standard for antiemetic use; standards of nursing concepts; self care guidelines for the patient about how to prevent nausea and vomiting when receiving chemotherapy, or how to treat nausea and vomiting when the cancer patient actually suffers from it. Also in addition the presence of antiemetic information and a diary for selfassessment of nausea and vomiting.

Result: 50% of the patients had nausea and 28% had vomiting. 96% did get antiemetics but only 51% received information on antiemetics. 66% of those who got oral and written information were able to use it. There were standards for antiemetic use and annual education in nausea and vomiting, but only in 24% of the nursecharts the nursing care was documented. The anamnesis of nausea and vomiting was not documented in any medical journal or nursecharts. The antiemetic treatment was documented many different places causing confusion of the actual chosen antiemetic.

Conclusion: It is obvious to adjust the existing standard and to implement it as soon as possible.

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POSTER

Evidence based symptom management for patients with breast cancer: clinical pathways teach process, implementation and evaluation

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Background: Providing care based on the best available scientific evidence is essential for optimal disease management, and can be best accomplished by collaboration of all disciplines within the health care team. Clinical Pathways (CP) are tools which permit multidisciplinary collaboration in the planning and delivery of care, and the evaluation of treatment outcomes.

Materials and methods: The Breast Cancer Clinical Pathway project was undertaken in 1998 and is ongoing at the National Cancer Institute in Naples, where CPs were developed for patients undergoing breast cancer surgery, radiation therapy, and ambulatory follow up. Initial outcome measures were reported on fatigue incidence, surgical complications, and control of nausea and vomiting. As nurses gained more familiarity with the process, we identified 4 areas for providing evidence based symptom management: oral mucositis, fatigue, lymphedema and cognitive dysfunction. This process was to be used institute wide as a model for teaching evidence based practice (and some of its inherent difficulties) to nurses.

Results: Oral mucositis was selected for the large amount of existing studies spanning decades. Our guidelines were based on existing systematic reviews and including standard grading and oral care instructions. Fatigue was selected as a follow up to our previous results of its incidence in our patient population, and to show recent progress in reduction of fatigue through nursing interventions. Assessment and interventions are based on the NCCN fatigue guidelines and allow for tailored nursing interventions. Lymphedema prevention was selected for lack of evidence regarding prevention. Guidelines based on physiologic rationale and the National Lymphedema Network with standardized measurement criteria were integrated with patient education materials. Early diagnosis and prompt referral for lymphedema treatment are key outcomes measures. Cognitive dysfunction is the most recent symptom for which we routinely screen, and allows for subjective patient reports of symptoms and thresholds that prompt further investigations based on clinician findings.

Conclusion: The clinical pathway model provides a method for planning evidence based care with clear measurement and outcome criteria. The model facilitates teaching nurses the process of evaluation of evidence with its application in clinical practice.

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POSTER

Evidence based prevention and management of lymphedema in patients affected by melanoma with lymphadenectomy

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Background: Sentinel lymph node biopsy permits correct staging of patients with cutaneous melanoma, and positive biopsy is followed by subsequent radical lymph node dissection. Lymphedema is a potential morbidity of this procedure, and can profoundly impact both functional status and quality of life of affected patients.

Materials and Methods: We evaluated the current practices of prevention and management of lymphedema in melanoma patients who had undergone lymphadenectomy, and the actual incidence of lymphedema in these patients, in order to evaluate our practice and implement evidence based guidelines. Data was analysed for 209 consecutive patients admitted to our surgical oncology unit affected by cutaneous melanoma with lymphatic micrometastasis from 1997 to 2002.

Results: Of 118 patients who underwent axillary lymphadenectomy, 2.5% developed moderate lymphedema (grade II). Of 60 patients who received deep groin dissection lymphadenectomies 5% developed moderate lymphedema (grade II). Of 31 patients submitted to superficial groin dissection, 6.4% developed grade II lymphedema. No cases with modified radical neck dissection developed lymphedema of any grade. Overall incidence of lymphedema for grade II was 3.82%, and for grade III 1.43%. Standard postoperative measures for prevention of lymphedema of the extremity included: elastic compression banding of the extremity for 24 hours followed by elastic compression stocking and early mobilization. Patients who developed lymphedema were treated with sequential mechanical lymph drainage; magnetic therapy; ultrasound therapy, laser therapy and/or other drug therapy. Lymphedema grading was done at the discretion of the surgeon in follow up visits, standard measurement criteria and documentation were not used. Guidelines for patient education regarding prevention of lymphedema were lacking. We identified 3 areas where nursing could play a key role 1) developing a patient education brochure regarding risks of lymphedema and strategies for its prevention based on the National Lymphedema Network guidelines and physiologic rationale 2)adopting standardized criteria for the evaluation of lymphedema and implementing screening measures preoperatively and during follow up so early and accurate diagnosis can be made 3)collaborating with the rehabilitation department for prompt referral when lymphedema occurs.

Conclusions: Nurses can play a key role in the areas of prevention and early detection of lymphedema through evidence based guidelines, early diagnosis and prompt treatment. Clear outcome criteria will facilitate our ongoing program evaluation, and current research is focused on evaluating effectiveness of nursing interventions, compliance with guidelines and incidence of lymphedema.

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POSTER

Implementing change in a inpatient chemotherapy service

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The standard of care offered to patients receiving inpatient chemotherapy was identified as an area that required urgent attention. Problems with the quality of the service were identified by both patients and staff therefore a nursing post from the ward establishment was identified to lead on the improving the service provision to patients. This post commenced in September 2002.

The first priority was to obtain an understanding of the main problems within the chemotherapy inpatient service. Lead by the chemotherapy sister a multi-professional review of the existing service was conducted and data from an anonymous patient questionnaire was collected over a 3 months period. Collation of the information from these helped to identify areas for service improvement and development.

Key problem areas identified:

- No clear point of contact for patients having inpatient chemotherapy.
- Varying consistency in information giving
- Long waiting times for patients for their beds and treatments
- Poor documentation
- Limited time from ward nurses due to other ward demands.

From these areas the following priorities were identified and addressed:

- Patient's and multi-disciplinary members had a single point of contact
- New patients talks were consistent and given only by the chemotherapy sister