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EDUCATIONAL APPROACH OF CRITICAL CARE NURSES HAVING TO MANAGE MEDICAL ANTICANCER TREATMENT IN CLINICAL TRIALS.

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Medical anticancer treatment can be administered in ICU to cancer patients for various reasons: patient at risk due to his/her medical condition; intensive chemotherapy; new drugs administration in phase I trials; therapy at risky administration such as interleukin 2 or taxol. In our practice, those patients represent 66 % of our ICU admissions, with the following rates by respective categories: 5, 12, 32 and 51 %. The majority of these treatments are performed in clinical trials.

Nurses have difficulties with this type of medical activity and a lack of understanding of the treatment to be administered might induce difficulties with physicians and patients and their families and be source of anxiety. In order to provide adequate information, we developed a standardized nursing version of the protocols with sections for treatment background, study objectives, eligibility criteria, study design, nursing considerations, prescription plan, nursing care and complications management.

This educational approach, rapidly successful, is now used routinely. Over a three year period (1990 at 1992), we managed in our ICU 26 clinical trials protocols by this nursing method, including 7 phase I trials with new drugs, 3 studies with taxol and 2 others with interleukin-2.

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Does Work in the Oncology Department Require Special Personality Qualities of the Hospital Staff

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Health care professionals in onco-hematology departments are exposed to a considerable psychic stress. They often suffer from feelings of despondence, helplessness and from emotional lability.

In a pilot study we tried to find out by means of questionnaires the level of hardness, the adaptability and the ability to cope with life's troubles. We further tried to ascertain the current state of psychic comfort or discomfort in the staff. A special questionnaire concerning psychic comfort and a test of hardness /KOBASA, ANTONOVSKY/ were administered to 20 nurses and doctors in the Department of Medicine specializing in onco-hematology. The control group was represented by 20 members of the Department of Medicine specializing in gastroenterology, where oncology patients are not treated. By comparing the two different workplaces we were able to draw up a survey of the character of subjective troubles of the staffs, as well as the level of resistance of the health care professionals to psychic burdens. Interesting results were also elicited from a comparison between the category of doctors and the category of nurses.

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SUBCUTANEOUS IMPLANTABLE INFUSIONAL DEVICES IN ONCOLOGIC PEDIATRIC PATIENTS. Armiraglio M*, Gau C*, Tatonetti M*, Zucchi F, Lanocita R, Di Tolla G and Frigerio I.F. *Pediatric Oncology and Special Radiological Procedures Dept. - Istituto Nazionale Tumori - Milano. At the Pediatric Oncology Dept. of the Istituto Nazionale Tumori di Milano the advantages of totally implantable infusional devices have been evaluated in children with malignant tumors receiving long-term systemic or intraspinal chemotherapy. A subcutaneous central venous or spinal access is always chosen in children less than 2 years of age or undergoing chemotherapy for more than 8 months, when an adequate medical or nursing assistance is not available. The implantation technique consisted in the catheterization of the subclavian or femoral vein, when the former was inaccessible. The central venous access required heparinization when not in use. A subcutaneous spinal access was used for intraspinal chemotherapy or for repeated aspirations of CSF. In 111 small children was implanted a central venous catheter connected with a subcutaneous capsule. In 6 patients with medulloblastoma a spinal port was implanted for intraspinal chemotherapy. One child had a double implantation, a spinal port and a central venous port for simultaneous systemic supportive therapy. The follow-up was 1 to 72 months. In 7 patients only the implantation was followed by pneumothorax. The complications were: mechanical (5 occlusions due to blood clots), infective (1 capsule infection). Their treatment was: Urokinase infusion through the port with complete regression, removal of the infected port. In comparison with non-implantable systems, the totally implantable subcutaneous port greatly reduces the incidence of infections, the need of external medications, at the same time allowing a greater personal care.

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HOW TO TAKE GOOD CARE OF THE PATIENT, HANDLING A PHARMACOKINETIC STUDY AS A RESEARCH NURSE IN A SMALL TEAMWORK, TESTING THE USE OF CALVERT'S FORMULA

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Usually the method for calculating the dose of chemotherapy is based on milligrams of the drug per square meter - or simply per weight.

For specific drugs, however, the dose-limiting side-effects show an individual variation, only to be explained by the influence of other factors. In 1989 Calvert et al. (UK) recommended a new formula for calculating the dose of Carboplatin used as a single agent, depending on the renal function. The formula suggested was: Dose of Carboplatin in mg = AUC x (Glomerular Filtration Rate+25).

In Denmark a young physician prepared a study to examine the relationship of dose-toxicity of Carboplatin, given in combination with Cyclophosphamide.

24 patients with ovarian cancer were given a dose of Carboplatin, randomized between 250 - 375 - 500 mg/m², and Cyclophosphamide 500 mg/m² in four courses. During the project "AUC" (Area Under the Curve) of Carboplatin was found as the result of several bloodsamples. The patients were taken care of in our small teamwork, meaning new aspects for our relationship with the patients.

As a research nurse connected to the project for three years, the author of this paper will describe her function as an oncology nurse in a pharmacokinetic study, told by daily life situations.

How to handle clinical trials in a way that makes the patient feel more secure - being responsible for almost any aspects of treatment and care during the project - as well as this research study might serve as an introduction nurses to the use of Calvert's formula for Carboplatin.

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QUALITY ASSURANCE (QA) - A TOOL IN IMPROVING INFORMATION TO PATIENTS.

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As part of a QA programme we aimed at developing a uniform set of information for patients in our ward, being made available to each patient as a hand-book. Our QA approach followed the principles formulated by Kitson. Areas of information needed for our patients were defined: a) examination, b) chemotherapy, c) radiotherapy, d) discharge. Quality standards related to *structure* dealt with written information, check lists and defined levels of knowledge among the staff members. The standards related to *process* dealt with information routines. The *outcome* standards were related to the valued results of the information efforts. In evaluating we particularly stressed the outcome criteria, e.g.: "How did you perceive the beforehand information on radiologic examination?", "Did you receive information about side-effects of chemotherapy?" The evaluation was based on a patient questionnaire with four-level scales or yes / no questions, and our criteria for success were "very good", "good" or "yes". For achieving quality standard we required 95 % rate of success. Our results, together with necessary improvement efforts, will be presented. Furthermore, the staff highly appreciated QA as working tool in the patient's hand-book project.

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The continuity of the care of the cervix cancer Patient

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At the University Hospital, Rigshospitalet, Copenhagen, Denmark, a highly well functioning and unique co-operation between surgical/ gynaecological and oncological/gynaecological departments. This contributes to a high degree of efficacy, confidence, and continuity in the treatment and care of the gynaecological cancer patient.

In our abstract we want to describe a course of treatment and care for a cervix cancer patient, from the time of diagnosis until she has finished treatment and continues with controls.

There is a special focus on the out-patient nurse regarding her participation in the course of the patient, because she is a continuous person, from the stage classification in the surgical unit to the time when information is given to the patient and at the control visits in the out-patient unit. Besides, she is the co-ordinating factor in the co-operation between the radiation unit and the bed unit.