

THURSDAY 18 SEPTEMBER 1997

## Proffered Papers

### Nursing diagnosis in cancer care

1496

POSTER

#### Our experience with classification of nurse's diagnoses in health care for patients in oncology (oncology patients)

Lj. Mitović, Ž. Mihajlović, D. Živković, A. Djurdjević. *Institute of Oncology and Radiology of Serbia, Belgrade, Yugoslavia*

**Introduction:** There is a growing interest for classification of nurse's diagnoses at the Institute of Oncology and Radiology of Serbia.

**Method:** The aim of this paper is to present classification of the most frequent nurse's diagnoses in health care for oncology patients. The following clinical models were used: evaluation of the most frequent nurse's diagnoses, secondary analyses of nursing anamnesis, hospital record and NANDA diagnoses.

**Analysis of Results:** Twenty nurse's diagnoses have been classified with precisely defined etiology: emotional distress, changes in comfort (pain), changes in nutrition habits (food intake less than necessary), knowledge deficiency etc. The diagnoses that were not precisely defined, collaborative problems and knowledge deficiency of health care terminology were expressed in 12 cases.

**Results:** The results point out the necessary knowledge of etiology, nurse's diagnoses, continuous education of nurses in order to enable them to use nursing diagnoses and defined terminology in health care.

### Cancer across the life span – The needs of children and older people

1497

POSTER

#### Peripheral stem cell collection (PSCC) in children. It seems to be easy: Review of the problems encountered

P.S. Beaussier, S. Vasselon, Ph. Brault, E. Benhamou, D. Valteau-Couanet, V. Lapiere, O. Hartmann. *Institut Gustave Roussy, 94805 Villejuif, France*

The arrival of new techniques to collect stem cells by cytopheresis, shows us new problems related to this type of procedure. We have studied 380 apheresis in children treated for solid tumors; we wanted to determine the incidence of complications observed in this procedure. Between June 1988 and August 1996, 141 series of stem cell collections were performed in 136 children, in the paediatric oncology department of the Gustave Roussy Institute. All were children with solid tumors and were primed with daily recombinant granulocyte colony-stimulating factor (Neupogen) alone (63.2%) or in combination with chemotherapy (36.8%). All children except one were hospitalized for the procedure. Insertion of central lines under general anaesthetic were necessary in 109 children, for the apheresis only (69.7%) or for the cytopheresis and the ABMT (30.3%). The aim of the study was to bring to the fore the most frequent problems encountered in PSCC by apheresis in order that we could draw up guide lines to improve procedure and quality of life for children. The median age at apheresis was 96 months (R8-329), weight was 26 kg (R8-77). 3 apheresis or more were performed on 91 children, 2 on 23 and only 1 on 22. The central lines were inserted by an anaesthetist; we observed some complications of insertion that will be shown later. The lines used for apheresis in 9/10 cases were Sus clavicular catheter, which is used after for Autologous Stem Cell Transplantation; it was used for prelevement or restitution. In 50% we used a femoral line. The problems that we identified (18%) for prelevement or restitution were a lower

perfusion and plugged catheter. We also observed clinical problems like shock, hypovolemia, hypocalcemia and tiredness in 12% of the collections alone or in combination. We are now able to identify the problems related to PSCC in children, we prevent them by a standardization of the procedure. In our experience, giving better information to children and their families reduces anxiety prior to the procedure. The parents become more involved, which increases the child's cooperation later.

1498

POSTER

#### Cancer in the elderly – An increasing problem with no clear solution

S. Moat, C. Campbell, R. Cropper. *North Essex Cancer Partnership, Essex County Hospital, Colchester, Essex, UK*

It is estimated that by the year 2010, cancer will have overtaken vascular disease as the commonest cause of death in adults. With the increasing elderly population this will lead to a major increase in the number of elderly patients with cancer. Physiological changes that occur with ageing and co-morbidity due to concurrent disease are potential barriers to the effective treatment of cancer in the elderly. Bias against older patients in the belief that they cannot tolerate treatment exists amongst many doctors, nurses and carers.

There are very few clinical trials to guide practice in this area.

North Essex has a disproportionately large proportion of elderly residents and we see a significantly large number of elderly patients with cancer.

We present our experience of the particular problems of treating malignancy in patients over 70 years of age. With the appropriate use of single agent cytotoxic therapy, weekly chemotherapy schedules, appropriate dose intensity and adequate anti-emetic regimes worthwhile chemotherapy can be administered to elderly patients.

Patient's expectations and attitudes to chemotherapy in this age group might be significantly different to younger patients. We present our survey of attitudes and expectations of chemotherapy in our cohort of elderly patients with cancer

1499

POSTER

#### Facilitation of children's adjustment to the terminal illness and death of a parent due to cancer

D. Hahn, E. Kaats, A. Stutterheim, C. Aalders, A. de Best, T. Vessies, J. Uiterwaal, L. van Weezel. *Social Med. Department, The Netherlands Cancer Institute, Ant. van Leeuwenhoek Hospital, The Netherlands*

**Purpose:** The death of a parent in childhood is a stressful life event that comprises children's psychosocial development (Christ et al. 1991). In our department we developed a parent-guidance model of communicating the parent's terminal illness to children, as an attempt of primary prevention before children's adjustment problems emerge.

**Method:** The parent-guidance model focuses on how parents can confront children with the stressful life event. The intervention facilitates (1) the parenting competence of the terminally ill parent and the healthy parent; (2) open family communication about the illness and expected death; (3) fostering stability in the children's environment and (4) providing assistance in the family's management of the actual death and grief process. The intervention consists of 3 hours information provision, advice and communication training to both the parents. We specially focus on different approaches according to the developmental stage of the (bereaved) children in the family, in order to facilitate healthy adjustment.

**Results:** Our first experiences with this parent-guidance model are promising. Results will be described in terms of longterm adaptation of bereaved children (clinical impressions), efficacy of the communication training and satisfaction with this care-program for parents.

**Conclusion:** Our preliminary results show the importance of a standardized intervention program for children with a terminally ill parent.