100 POSTER

A comparison of the neurological toxicities of cisplatin-paclitaxel (PT) and cisplatin-cyclophosphamide (PC)

M. Bacon[1], B. Zee, K. James, G. Stuart, D. Soroka, W. Walsh, E. Bacon. [1]*National Cancer Institute of Canada, Clinical Trials Group, Kingston, Ontario, Canada*

PT is known to be neurotoxic initially but there is little data on toxicity after completion of treatment. The objective of this study is to assess both the acute and delayed toxicities in PT.

Methods: This study was based on data prior to disease-progression on 160 Canadian patients from an international trial (Proc. ASCO 17.361a #1394). Standard NCIC CTG Common Toxicity Criteria (tox) and patient self-administered QOL (qol) questionnaire (EORTC QLQ-C30 + 3) on sensory, motor, hearing and insomnia toxicities were compared during two periods: chemotherapy delivery (<9 cycles) [acute toxicity (A)] and from the end of chemotherapy to disease progression [delayed toxicity (D)]. The number of occasions when a particular toxicity was observed was taken as a surrogate measure of its duration. The average durations observed with PT were compared to PC.

Results: The incidence of mild insomnia (tox) in A was higher with PT (10.1 v 1.4, $p = 0.035$) and this is confirmed by insomnia (qol) (19.0 v 2.7, $p = 0.002$). There were no differences in D. Hearing (tox) showed no difference in A but, although over the whole of D the cumulative incidences did not quite differ significantly (7.0 v 18.9, $p = 0.055$), at the 3-month post-chemotherapy point PC was worse (2.8 v 17.0, $p = 0.009$) and the duration indicated that hearing (tox) lasts longer with PC (2.1 v 10.6, $p = 0.036$). Motor (tox) was not different between the two arms in either A or D but motor (qol) was worse with PT in A (44.3 v 6.9 $p < 0.001$) but not in D. Sensory (tox) was more common with PT in A (88.6 v 46.6 $p < 0.001$) and this was confirmed by sensory (qol) (79.8 v 34.3 $p < 0.001$). Also, the duration was longer with PT during A (52.4 v 17.5 $p < 0.001$) compatible with the earlier rise in incidence of sensory (tox). During D, only mild sensory (tox) remained different (85.9 v 58.5, $p = 0.0008$) and the duration was longer with PT (69.6 v 45.5, $p = 0.005$). Sensory (qol) showed no significant difference.

Conclusion: There is a greater incidence of mild insomnia, sensory toxicity of earlier onset and patient-reported motor toxicity with PT during A. In contrast, during D, only mild sensory toxicity with no difference being detectable by questionnaire, was more frequent and lasted longer in PT. Post-treatment impairment of hearing was probably worse with PC.

101 POSTER

Cold-cap – Keeps the head cold and help some women avoiding alopecia through chemotherapy treatment for ovarian cancer

A.K. Tronstad, A.C. Hanshus, K. Skogsfjord, E. Støring. *Department of Gynecology, Norwegian Radium Hospital, Montebello, 0310 Oslo, Norway*

Purpose: We had noticed that loosing the hair through chemotherapy treatment was a hard struck to womens self-image. By using cold cap during chemotherapy treatment we hoped to find that alopecia would be reduced.

Method: In 1996/97 we had a little project with 26 patients reciving Taxol and Cisplatin/Doxorubicin treatment. We used photo and a questionnaire as documentation. The first patients had not cold enough cold-caps, but when we got the right temprature, we started to see effect.

Results: We had 6 patients with the right teprature, and none of them had to use the wig. One recived 12 courses without any hairloss. Today cold-cap is used as an offer for women who wants to try to avoid alopecia.

Conclusion: Alopecia is a side effect to chemotherapy that does something with the women's self image. Using cold-cap through chemotherapy treatment will help some avoiding alopecia, and reduce the experience of having cancer.

102 POSTER

Scalp cooling for chemotherapy induced alopecia: Devising and implementing a unified trust policy

D. Brewer, L. Mans. *Guy's and St. Thomas' Hospital Trust, Cancer Directorate, London, United Kingdom*

Scalp-cooling has become an increasingly effective method of preventing hair loss as a result of chemotherapy with specific cytotoxic agents. The efficacy of scalp-cooling is demonstrated in a number of published studies, using a variety of scalp-cooling systems.

Purpose: Our aim was to devise a workable Trust policy which would enable an equitable service to both in- and out-patients who would benefit from the available scalp-cooling facilities.

Method: A literature review was conducted and other cancer centres were contacted by telephone to ascertain current practice. We also undertook a systematic review of current equipment and practices within the cancer centre that enabled us to devise a policy which could be utilised by all departments within the Trust in which cytotoxic agents are administered Having purchased two systems with comparable efficacy ratings, a comprehensive teaching programme was initiated for all grades of nursing staff, Using the policy, staff were easily able to select the most appropriate system for their patients and use it competently. This review also assisted the forward planning for an equipment replacement programme.

Conclusion: In the light of current literature pertaining to chemotherapy induced alopecia and the increasingly encouraging results utilising scalp-cooling, a workable policy was devised in an attempt to unify current practice within a large hospital Trust across two sites. Implementation of the policy resulted in a radical change in clinical practice and all patients now have Suitable access to appropriate scalp-cooling facilities and competent nursing expertise.

103 POSTER

Prevention of lymphoedema: A booklet for Greek women with breast cancer

D. Pappa[1], E. Patiraki[2], V. Chrysanthou[1]. [1]*Ag. Anargiri Oncology Hospital, Athens;* [2]*Department of Nursing Studies, University of Athens, Greece*

The development of lymphoedema following surgery and radiotherapy for breast cancer isn't an uncommon problem and may develop early or late.

Lymphoedema is a chronic condition which, if untreated, progressively becomes worse. For those affected however, it can mean pain and discomfort, reduce mobility, problems obraining clothing and serves as a constant reminder of their disease (Benington. G, 1991).

Lymphoedema can't be physically cured, but it can be monitored treated and maintained to give the patient a relatively normal quality of life (Barret. J, 1977).

Prevention of cosmetic deformity, emotional distress, functional impairment, infection and discomfort are the goals (Otto S, 1997).

At Ag. Anargiri Oncology Hospital-Athens, a booklet have been developed by nurses. This booklet, listis, specific arm care precautions for all patients to prevent trauma and infection in the arm on the operative side.

104 POSTER

Skin and nail disorders: One of the specific non-hematological side effects of docetaxel (taxotere)

Liliane De Gucht. *A.Z. Maria Middelares, Ghent, Belgium*

Skin and nail disorders are frequent and disturbing side-effects of Taxotere treatment.

These side-effects can often be prevented.

It is important to give the right information to the patient.

The role of the nurse is indispensable.

To be able to give the correct preventive advice she should be aware of:

– the characteristics, symptoms and timing of these different side-effects.

– the possible nursing measures.

– certain practical advices to be given to the patient at the start of the treatment (prevention and self-care).

105 POSTER

Clinical experience of ketamine for intractable neuropathic cancer pain

C. Mula, R. Penfold, W.P. Makin, E. Smith. *Palliative Care Team, Christie Hospital NHS Trust, Wilmslow Road, Withington, Manchester, M20 4BX, United Kingdom*

Purpose: To reflect on clinical experience of ketamine for neuropathic pain, when strong opioids and adjuvant therapies are not providing adequate pain relief. To analyse the efficacy, doses and side effect profile of subcutaneous us and oral ketamine To address the incidence and management of side effects. To examine the usefulness of this pharmacological approach for treatment of neuropathic pain.

Method: More than 1,000 patients per annum are referred to the Palliative Care Support Team at this regional cancer centre. Service provision for difficult pain problems include opioid rotation, non-pharmacological interventions, intrathecal/epidural techniques and nerve blocks. 10 patients who received ketamine were randomly selected to be included in the retrospective evaluation during March 1997–February 1999. All of this patient group had advanced cancer.

Results: Approximately half the patients experienced side effects some of which were manageable (details outlined in the poster). However, for two patients the burdens of this treatment outweigh the benefits and the ketamine was discontinued. Specific details will be given with regards to the route of administration, the dose range and the duration of treatment. The patient group included those on oral ketamine discharged home, as well as those approaching the terminal phase of their illness.

Conclusion: Sub-cutaneous and oral ketamine can be effective when combined with more conventional methods of pain control for neuropathic pain. There are implications for the patient and staff in hospital and community settings.

Good clinical practice

106 ORAL

Multi-professional core care planning: A model to ensure evidence based practice

H. Porter[1]. [1]*University Hospital Birmingham NHS Trust, Nursing, Birmingham, United Kingdom*

The Policy Framework for Commissioning Cancer Service (Calman Hine 1995) states that 'all patients should have access to a uniformly high quality of care wherever they live'. This statement can be applied to the provision of care within a large organisation where patients with cancer are to be found on many wards and departments. The implementation of Clinical Effectiveness initiatives promote evidence based care within nursing and other disciplines. In order to ensure clinical effectiveness and evidence based care the nurse needs to base decision making on the best evidence available.

The development of multi-professional, evidence based, core care plans ensures that care for patients throughout the hospital is evidence based, provides an easy form of references for nurses unfamiliar with the management of patients with cancer and identifies best practice. They also enable expertise within the hospital to be explored and disseminated and provides a philosophical basis on which to plan care.

This paper will discuss the process used to develop a comprehensive manual of multi-professional core care plans covering all aspects of the management of the patient with cancer. This will include the method, problems, acheivements, audit framework and plans for the future together with examples of the 108 core care plans developed.

107 ORAL

The information needs of women contemplating breast reconstruction after a diagnosis of breast cancer: A pilot study

H. Dryden. *Ninewells Hospital, Plastic Surgery Dept., Dundee, United Kingdom*

Cancer of the breast affects over 3,000 women annually in Scotland (Scottish Needs Assessment Programme 1996). Between 5–10% of women opt for breast reconstruction postmastectomy, although the figure could be as high as 50% for women offered immediate breast reconstruction (Antony 1995). The information needs of women contemplating breast reconstruction after a diagnosis of breast cancer has not been investigated in any depth. Therefore this qualitative study aimed to investigate this important topic, particularly from the perspective of the women concerned. Seven women were interviewed prior to their consultation with the plastic surgeon; two had previously undergone mastectomy and five women were contemplating mastectomy/reconstruction as a simultaneous procedure (immediate breast reconstruction). Data was analysed using the "Framework" method (Ritchie & Spencer 1994). The findings indicated that women welcomed discussion regarding breast reconstruction at the time of diagnosis and that their preferred source of information would be the breast care nurse. All women identified information needs relating to: breast cancer, available methods of reconstruction and possible complications of surgery. All women voiced concerns relating to the silicone controversy. Although partners were generally supportive regarding possible breast reconstruction, some women had received overt criticism from other family members. As treatment options diversify, it is essential that women receive tailored information relating to their needs at the optimum time. Implications for nursing practice are discussed

108 ORAL

After mastectomy: The nurse's counselling role in breast reconstruction

Regina Ferrario. *With collaboration of Nurses of Plastic Surgery Department, Istituto Nazionale Tumori, Milano, Italy*

Breast cancer is one of the most serious health threats facing women. Even in today's age of liberation a woman's physical attractiveness determines her status and security rather than her skills interests and values. The treatment of breast cancer is particularly emotionally charged because it requires partial or total removal of an organ that is tied intimately to self-image, self-esteem, sense of actractiveness, femininity, sexuality and reproductive and nurturing capacity. Understanding the impact of mastectomy as a distortion of the woman's body image, enhances the nurses ability to promote patient and family adaptation to this disfiguring operation. Response to loss of a body part will be related to: 1) the visibility of the loss 2) the functional loss 3) the emotional investment in, or the significance to the patient of the part affected. Of course, the nurse who has continuous contact with the patient is a powerful force in the patient's early efforts to adapt to the experience. Nursing intervention must be carried out in three areas: 1) the patient's perceptions of the event 2) the patient's coping strategies 3) the situational support available to the patient. So specific nursing counselling intervention falls into three main categories. 1) expression and exploration of feeling 2) inclusion of partner or significant others 3) rehabilitation. The emotional support provided by expert nursing staff, well informed about women's needs for rieducation, reassurance and understanding makes the several days' hospitalization conforting. All women agree that breast removal would lead to a loss of their sense of being a woman, this loss of self-esteem may result in decreased sexual satisfaction following mastectomy. Nowaday that breast conservaion and reconstruction procedures are more widely performed, it is important that women who must undergo a mastectomy are given realistic information about reconstruction which is an important point in the process of physical and psychological reahbilitation. The degree of satisfaction with the results is strictly related to expectation. A good acceptance of reconstruction is a balanced and realistic attitude which avoids the disappointment of idealization. For the nurse it is necessary to give correct information and to thorough by explore the woman's motivations and expectation. 84% of 38 patients who replied to a follow-up satisfation-evaluation questionnaire said they would not hesitate to recommend reconstruction to other mastectomized women.

109 ORAL

How safe are the patients in your care? The nurses's responsibility for equipment safety-selection, purchasing, maintenance, training and the millennium issues

Shelley Dolan. *Clinical Nurse Specialist Critical Care, Royal Marsden NHS Trust, London, United Kingdom*

As the 21st Century approaches our dependence on a variety of mechanical devices is growing. As the number of devices grows so too does the number of adverse incidents reported to the department of Health in the UK. Indeed not only has the number of incidents increased but also the number resulting in death or serious injury. It is when the incident is concerned with high risk devices such as infusion pumps or anaesthetic/critical care equipment that the risk of death is heightened.

As the treatment for cancer becomes ever more aggressive our patient's dependence on 'high risk' equipment is increased. More of our patients are also being treated in their own homes utilising equipment from community agencies or the cancer centre.

It is therefore imperative that every practising nurse is able to ensure that the device used is:

- appropriate to the clinical situation; conforms to European standards
- is well maintained and serviced; staff who are using it have been trained.

This paper will set out guidelines to manage these 4 issues utilising recommendations from the Medical Devices Agency and the Health and Safety Executive of the Department of Health, UK and the greater European directive.