Cancer Nurses College
NEW ZEALAND NURSES ORGANISATION

COMMUNICATING & NETWORKING FOR HAEMATOLOGY & ONCOLOGY NURSES ACROSS NEW ZEALAND

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cancernet

Editors' note

This edition of Cancernet focuses on surgery as a treatment option for cancer and explores a case study of a Māori woman with cervical cancer suffering from depression.

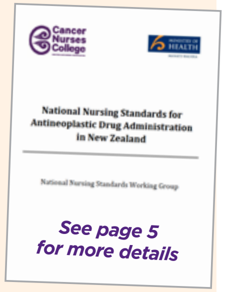
Surgery is the oldest type of cancer therapy and remains an effective treatment for many types of cancer today. Different types of surgery are used depending on the type of cancer, where it is located, and the goals of surgery. Surgery for breast, lung and colorectal cancer is looked at and discussed by clinical nurse specialists working in these cancer specific areas.

An insight into the work of a rural cancer nurse coordinator working in Otago and Southland highlights the significance of intuition "gut feeling" as an important tool and the use of formal assessment tools to identify depression.

Included also in this edition is a report on the 2016 MASCC Symposium and updates on the Cancer Nurses College Committee, National Standards for Antineoplastic Drug Administration in New Zealand, Special Interest Groups (SIG), funding and upcoming educational opportunities.

We hope you enjoy this edition and invite you to suggest topics and share your clinical practice for up and coming editions of Cancernet. Please check out the guidelines for contributing to Cancernet.

Melissa Warren and Kirstin Unahi



National Nursing Standards for Antineoplastic Drug Administration in New Zealand

National Nursing Standards Working Group

See page 5 for more details

CASE STUDY

A Māori woman with cervical cancer suffering from depression

The following case study highlights the significance of adequate assessment and use of assessment tools to identify depression in a young Māori woman with cervical cancer, living in a remote rural area in Southland.

Additionally it focuses on risk factors that are potential red flags for health care providers. Interestingly the assessment observed on this patient was not obtained using any research or evidence-based practice, rather it was a "gut feeling." Later, upon searching for evidence, support of the assessment made and subsequent actions that were taken were validated.

Care has been taken to gather consent from the patient's family to write this case study and a fictional name has been used.

Keri, a 37 year old Māori woman, was diagnosed with a cervical cancer following presentation at the emergency department with kidney failure secondary to bilateral pyelonephritis. A vaginal examination revealed a bulky ulcerated cervical tumour. Further diagnostics confirmed a stage 3B cervical cancer. It had been 14 years since Keri's last cervical smear.

Māori women are more likely to be diagnosed with cervical cancer, more likely to be diagnosed at a later disease stage and furthermore, more than twice as likely to die as a result of cervical cancer. The mortality: incidence ratio in a study on the incidence of cervical cancer in Māori was 46% for Māori and 22% for non-Māori.[1]

Keri completed curative chemo radiation and brachytherapy treatment with a good response. Unfortunately it was only a matter of months before Keri re-presented with ongoing kidney problems which lead to the discovery of an early recurrence. Palliative chemotherapy was the only option of treatment going forward.

Keri had continued support throughout her initial treatment and recurrence from the Māori cancer Kaiarahi service. However a matter of understaffing had resulted in support sought from the rural cancer nurse co-ordinator (CNC). It had been identified at a prior visit by the Kaiarahi service that Keri appeared quite low and withdrawn and concern was raised about the ability of Keri's teenage daughter to cope. Additionally, telephone conversations between Keri and the CNC had raised concerns that Keri was possibly not coping. Consultation between the supporting services was crucial at this point.

The decision to visit Keri in her home was made in order to gather a more accurate assessment of Keri's environment. Additionally, Keri was reluctant at this stage to move from her bed and had failed to attend a follow-up appointment in the gynaecology outpatients

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In this issue:

department. Reasons for non-attendance such as transport and financial issues were excluded. It was at this point that suspicion regarding a more serious level of depression was considered.

“Depression is more common in those with greater physical suffering and more advanced disease”. Clinically significant depression is “associated with poorer quality of life, more prolonged hospital stays, increased physical distress, poorer treatment compliance, a desire for hastened death and suicide.”[2]

The prevalence of depression in cancer increases toward the end of life with major depressive episodes occurring in approximately 16% of patients and sub-threshold cancers in approximately 22%.[3]

Keri and her teenage daughter lived with her parents in a remote rural town in Southland with a high deprivation index. She had formerly worked as a shearing contractor but had been unable to work since diagnosis.

The deprivation index is a tool used by the New Zealand census to measure deprivation and takes into account factors such as access to technology, room occupancy, access to transport, employment and income among other factors. The likelihood of deprivation increases with an increasing deprivation score. This provides generalised information but can indicate potential physical and psychosocial vulnerability and can be used as a tool to identify more complex patients.

Keri had received counselling through the oncology department and was continuing to communicate with the counsellor during visits to the hospital. However recent non-attendance at the hospital resulted in delays and long intervals between sessions. Keri’s rurality further inhibited the availability of services to her when she needed them most.

Confirmation of Keri’s declining mood was immediately apparent once inside her home. The house was cold and dark, Keri sat huddled under a blanket on one sofa and her father lay on the other. Both were aloof and struggled to talk or engage socially. Keri was cachexic and very frail in appearance. The television was on but muted. Keri’s mother communicated in a hopeful and positive manner with the CNC but failed to engage Keri. It was obvious that she was shouldering much of the burden and struggling to keep the family unit together. Despite the subjective nature of some of these assessment findings, they are helpful in setting the scene and would be difficult to obtain in a hospital setting.

Assessment was made of Keri’s daughter and adequate supports had already been instigated through her school and canteen. Concern about Keri’s father was not addressed at this time. However an explanation regarding his social withdrawal was given and it was considered appropriate to ignore his symptoms while addressing Keri’s.

Keri’s mood was very low. She was suffering from insomnia, decreased appetite, anhedonia and was reluctant to mobilise. Her flat effect was of most concern. A distress screening tool was not used to gather this information although the information sought fitted with that of a tool that was under development at SDHB.

The prospect of palliative chemotherapy in hospital seemed futile and impracticable. Approaching Keri for consent to visit and discuss further her low mood with her GP seemed like a daunting task. Keri willingly accepted support to seek help however. A GP voucher and prescription voucher enabled facilitation of this at no cost to Keri the following day.

According to J Holland et al “Individuals with both greater physical burden and greater psychosocial vulnerability are at most risk of becoming depressed”.[2]

Steven D Passik et al report that anhedonia can be a useful, if not the most reliable, depressive symptom to monitor as most patients maintain the ability to feel pleasure. Additionally and without doubt “feelings of hopelessness, worthlessness, and excessive guilt, loss of self-esteem, and wishes to die are also among the most diagnostically reliable symptoms of depression in cancer patients”.[4]

Adding to this is the presumption that all people with cancer are and should be depressed. Steven D Passik et al argue that this both minimises the degree of depression in patients with cancer and also promotes the under-diagnosis and under-treatment of depression.

“Health professionals may underestimate the morbidity caused by depression because they tend to believe that they, too, would feel depressed if roles were reversed. Depressive states exist on a continuum from sadness to major affective disorders. It is important for physicians to differentiate between normal sadness and abnormal levels of distress”.[4]

Keri’s visit to her GP endorsed the assessments and opinion by both the CNC and the Kaiarahi support worker. Anti-depressants were prescribed along with sleeping tablets for interim sleep issues while waiting for therapeutic effect from the anti-depressants.

Keri’s mood improved sufficiently to allow commencement of chemotherapy. Unfortunately her disease continued to progress despite chemotherapy and her treatment was ceased. She died approx 4 months later surrounded by her family and friends. Keri died with dignity and support, something she may not have had if she had continued down the disabling path of depression.

In conclusion, it seemed probable that Keri could be depressed although confusion arose around normative sadness versus depression. However, the advanced stage of her disease, which is more likely in Māori for reasons earlier explained, her rurality associated with a high deprivation index, made her vulnerable and more likely to develop depression. Using screening tools and raising awareness about depression is an important step. Of additional benefit is the ability to visit patients in their home environment to get “a sense” of how they are coping. It seems a sensible approach to target patients at greatest risk and facilitate appropriate supports to ensure depression is not an obstacle preventing access to cancer treatment.

Trudy Galer
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MASCC Symposium 2016

ADELAIDE | 23-25 JUNE 2016

The new president of MASCC Dr. Ian Olver presents the Young Investigator Award to Petra Stolz Baskett.

The Multinational Association for Supportive Care in Cancer (MASCC) was celebrating its 25th anniversary symposium this year. This brought the conference, with over 1000 attendees from fifty countries, for the first time to Australasia, usually the meeting is held alternating in a North American or a European city.

Being dear to my heart and practice, I was pleased to see that many sessions included also a geriatric oncology viewpoint. Supported by a MASCC Young Investigator Award and a Graduate Travel Fund Award from King's College in London, I was fortunate enough to not only join the international audience but present the main results from my PhD study project in the main geriatric parallel session. In addition to that, I displayed two pieces of work using the ePoster format trialled out by the conference organisers this year. Following, I summarise the pearls of knowledge and exciting new developments presented in the sessions I attended over the three-day event.

The morning sessions of the first day are usually reserved for workshops, organised by single or collaborating study groups which form the back bone of MASCC. This year, the selection included mucositis research, nutritional care throughout the advanced cancer journey, global care and local solutions to end-of-life care, cancer-related cognitive impairment and a workshop on sleep, drowsiness and fatigue.

After attending an educational meeting by MSD in Auckland earlier in the year, I realised the limitation of my understanding of bioscience knowledge in the field of immunology. Since there are revolutionary new cancer treatments available or in the pipeline in this area, I chose the workshop ***"Supportive care and immunotherapy".***

Covering first my need for a further run down on cancer immunology, the session included also several speakers outlining treatment side effects, their early recognition and possible management. Here, the data presented about oral and skin complications, such as lichenoid reactions and pemphigoid-like mucosal changes, as well as mostly self-limiting, low-grade maculopapular rashes with pruritus in 15-20% of the people receiving immunotherapeutic agents, was especially helpful to extend assessment skills.

In the afternoon, ***"Care of cancer survivors – putting evidence into practice"*** was on the agenda. Patsy Yates reported on the ***Australian TrueNTH proof of concept study*** which looks at improving supportive care for men with prostate cancer. The multi-faceted international program originates in the UK and is worth checking out:

▶ ***Check out the TrueNTH study here***

Friday morning started off with the geriatric parallel session titled ***"Geriatric assessment as a supportive care strategy".*** I could not have hoped for a more fitting lead-up to the subject of my talk around consequences experienced by informal caregivers of older cancer patients with Martine Exterman (MD Tampa, USA) first outlining the components of a geriatric assessment in the oncology context, followed by Jane Phillips (PhD RN UTS, Australia) with a brilliant case study of the nursing management of a 90-year-old man with a newly diagnosed colorectal cancer which also included a discussion of caregiver issues. Informal caregivers in this age group are often older spouses/partners, i.e. in many cases they have their own health issues or functional limitations which could affect their caregiving capacities, or indeed, the person with cancer might have looked after them before being diagnosed. Although carried out in the context of Switzerland and, therefore, maybe not transferable one-to-one to New Zealand, results from my doctoral study indicate that caregivers of people over the age of 70 years that receive ambulatory chemotherapy do have an average of three moderate to high unmet needs. An interesting novel finding identified in the qualitative phase of the mixed-methods study was that caregivers often engaged in "thinking about and planning for death and dying" as a caregiver task that is not commonly included in assessments of their responsibilities taken on.

Friday afternoon was filled with presentations focusing on dyspnoea in one session, and models of nutritional care in high-risk cancer groups in another. In the latter, a group of dietician researchers discussed initiatives and results from various projects addressing nutrition and exercise intervention in supportive care strategies within the ***"Healthy living after cancer***" program rolled out by the Australian Cancer Council.

In the session on toxicities of combined radio-chemotherapy on Saturday morning, Barbara Murphy's presentation on ***Early detection and intervention for secondary lymphedema in people undergoing radio-chemotherapy for head and neck cancer*** stood out. According to her data from n = 104 patients, 46% had external lymphedema of grade 1 or 2 and only 32% had no evidence of internal lymphedema, with over 40% presenting with moderate to severe internal lymphedema. The impact of this side effect on quality of life and functional status was shown to be considerable with swallowing, nutrition,

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Report from the chair

Welcome to this edition of Cancernet. As I start planning operations for mid-September it is also a stark realisation that the end of another year is nigh!

The CNC continues to be an active voice for cancer nurses across New Zealand. The CNC committee met in May and next meet in late August. Recent business has included rekindling links with the Cancer Nurses Society Australia. The Memorandum of Understanding between CNSA and CNC requires updating and this is currently underway. The Cancernet is now being sent to CNSA.

As members of the International Society of Nurses in Cancer Care (ISNCC), I recently attended a global teleconference. It was not well attended but this provided a great opportunity to discuss cancer nursing in NZ and also our interest in hosting an ISNCC conference here. Work in progress!

CNC continues to have nurse representation on national groups including the Medical Oncology Working Group, the Radiation Oncology Working Group, the Haematology Working Group and the recently disestablished Cancer Treatment Advisory Group. Nurse representation has been increased to two nurses per group to strengthen the nursing voice and for succession planning. We routinely invite speakers working in the specialist field of cancer care to our meetings to provide updates. This also provides us with an opportunity to update the speaker on our activities and concerns on behalf of cancer nurses in NZ.

Recently you will have received advice from the Ministry of Health on the endorsed National Nursing Standards for Antineoplastic Drug Administration in New Zealand. In June 2015, under the CNC leadership provided by Angela Knox, a national working group was formed to develop national standards for antineoplastic drug administration. The Standards will ensure that all staff administering chemotherapy has achieved a minimum level of training and education. We again thank Angela and the working group for the high standard of work. Together with the Knowledge and Skills Framework and the implementation of eviQ Anti-neoplastic Drug Administration Course (ADAC), we now have the tools. The challenge now is how to ensure they are implemented within practice and audited.

There continues to be new developments and initiatives in cancer care in New Zealand, including the announced rollout of a national bowel screening programme, a national cancer multidisciplinary meetings (MDMs) workshop as a part of the Cancer Health Information Strategy Programme, a National Faster Cancer Treatment (FCT) forum, improved access to psychological and social support services for cancer patients, ongoing development and evaluation of national cancer nurse coordinators, a refreshed governance structure for the National Cancer Programme - to highlight just a few!

Please get your applications in early to attend our conference in Christchurch next year!

I know you will find this edition of Cancernet valuable as always.

Kind regards,

Judith Warren, Chair
NZNO Cancer Nurses College

pain, voice and hearing all being associated with lymphedema severity.

The last session attended in full ***"Thinking and talking about survival time in advanced cancer"*** was a true pearl. Most of us would have thought, heard or maybe even talked about the unavailability of a crystal ball foretelling a cancer patient's prognosis? Fran Boyd's story about the crystal ball on her consultation desk that helps to invite patients to formulate what it is they like to know was delightful. After many years as an oncologist she has truly perfected the art of communication and has been at the forefront of communication courses for health professionals in the cancer field to support patients and families better to cope with the difficulties of uncertainty throughout their journey.

Two further presentations took a closer look at strategies to convey prognostic information to interested patients. Both suggested a "three scenario" approach, i.e. the information given was divided in events or time frames that were 'likely', 'possible' or 'unlikely', or based on trial data survival curves for the specific cancer/treatment modality prognostic information was given in the form of the worst case scenario (i.e. approx. ¼ of the medial survival time), the typical case (i.e. ½ to 2 x the median survival time) and the best case scenario (3 x and more of the median survival time). Belinda Kiely reports that an online tool to help clinicians with the calculation of these scenarios has been developed and evaluated, and will be shortly available for free.

This was the fourth MASCC Symposium I have attended in the past decade and as per previous conferences I encountered a thought provoking and truly multidisciplinary program in Adelaide. The bonus of well organised and entertaining social events in the breaks and the evenings left me with new contacts, reaffirmed old professional friendships and an inkling to attend the next symposium in Washington D.C. in 2017 or Vienna in 2018.

Petra Stolz Baskett, MA, RN
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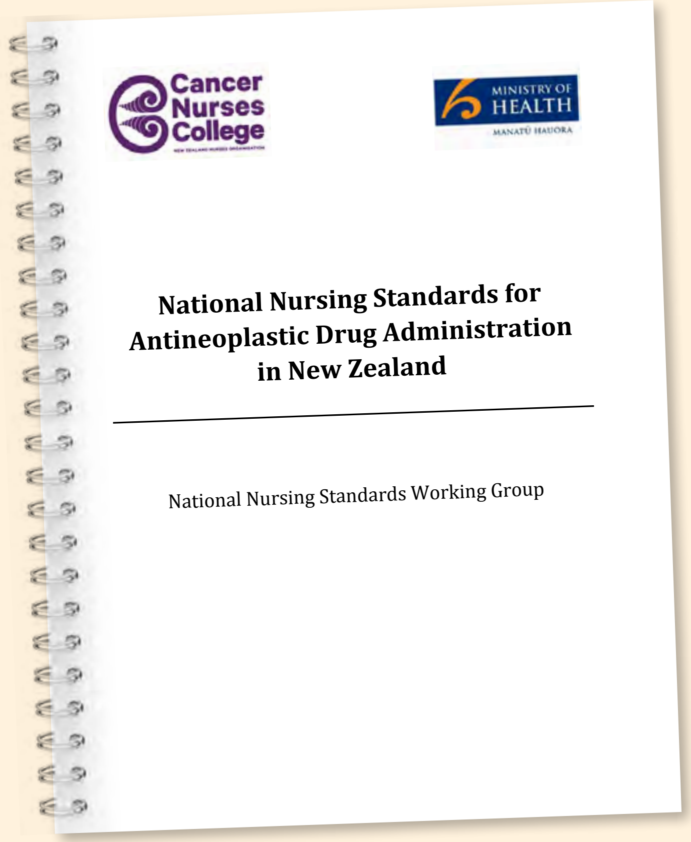
NATIONAL NURSING STANDARDS
for Antineoplastic Drug Administration in New Zealand

Developed by the National Nursing Standards Working Group



Cancer Nurses College

MINISTRY OF HEALTH
MANATŪ HAUORA

National Nursing Standards for Antineoplastic Drug Administration in New Zealand

National Nursing Standards Working Group

This an important document for cancer nurses in New Zealand providing guidance on minimum standards of care for antineoplastic drug administration and addressing the important issues of patient and nurse's safety.

We would like to encourage you to familiarise yourself with this document which represents a culmination of many hours of work on the part of the national working group. The following abbreviated excerpt has been taken directly from the Standards.

click here to view the standards

The New Zealand Nurses Organisation (NZNO) Cancer Nurses College has recognised the need to develop a national certification process for antineoplastic drug administration since 2009. In 2014, in collaboration with the Nursing in Cancer Care Collaborative Steering Group it discussed a proposal for a nationwide antineoplastic education programme for nurses with the Medical Oncology Working Group. It was acknowledged that there are difficulties in implementing a national education programme and national certification process in the absence of nationally agreed, evidenced-based practice standards for antineoplastic drug administration. In June 2015, under Cancer Nurses College leadership, a national working group was formed to develop national standards for antineoplastic drug administration.

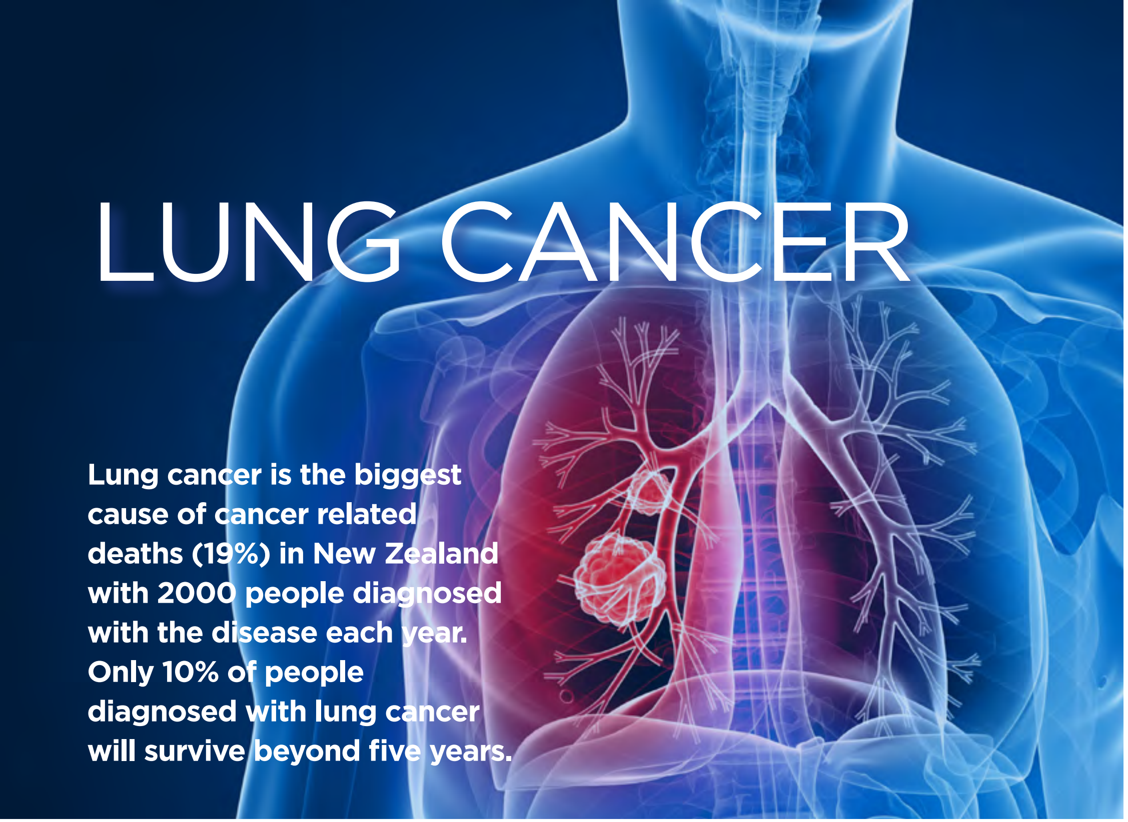
In New Zealand, nurses administer most antineoplastic drugs, with the exception of oral agents. It is essential to ensure adequate precautions are in place to protect both people administering and those receiving antineoplastic drugs.

The Standards apply to all types of antineoplastic drugs, including: cytotoxic chemotherapy; hormonal therapies; biologic therapies such as monoclonal antibodies; targeted small molecules such as kinase inhibitors; immunotherapies such as checkpoint inhibitors; antibody–drug conjugates; and radio-labelled agents.

These classes of antineoplastics vary widely in the complexity of their treatment regimen, the dose range that produces therapeutic response without having a significant adverse effect, the potential risk for patients and the recommended handling precautions. Some agents have mutagenic, teratogenic and carcinogenic properties that have the potential to cause harm to those handling and administering these drugs.

New Zealand has six tertiary cancer centres but a significant proportion of antineoplastic agents are administered in regional, rural and private centres across the country. The Standards will ensure that all staff administering antineoplastic have achieved a minimum level of training and education.

The Standards will be an overview of best and/or evidenced-based practice. They are intended to provide a tool to guide practice rather than to replace policies and procedures within each healthcare facility.



LUNG CANCER

Lung cancer is the biggest cause of cancer related deaths (19%) in New Zealand with 2000 people diagnosed with the disease each year. Only 10% of people diagnosed with lung cancer will survive beyond five years.

The chance of being a long-term survivor of lung cancer improves if the cancer is found at an early stage and the person can undergo radical treatment such as surgery or high dose radiation. This article will focus on the surgical management of early stage lung cancer. This is guided by the ***Standards of Service Provision for Lung Cancer Patients in New Zealand 2016***, which were initially developed in 2011, to improve outcomes for people with lung cancer and reduce inequalities associated with this disease.

Although smoking has been identified as the biggest contributing factor in the development of lung cancer, current trends show that more non-smokers are being diagnosed with this disease.

The majority of lung cancer at diagnosis is at an advanced stage which is due to late diagnosis. This is due to its ability to grow without being detected until it produces symptoms such as cough, a hoarse voice, repeat chest infections, haemoptysis, pain and breathlessness leading the individual to seek medical attention. Lung cancer can spread to the mediastinal lymph nodes, the contralateral lung, surrounding structures and beyond to other organs including the brain, adrenal glands, skeleton and liver.

Only a small percentage (10%) of lung cancer is detected early enough to be treated with curative intent surgery. This is often found incidentally when a person has radiographic imagining such as a chest x-ray (CXR) or computerised axial tomography scan (CT) to investigate unrelated symptoms. Further investigations are initiated often by a respiratory physician including a CT scan that includes the chest and upper abdomen, spirometry to assess lung function and the best investigation to obtain a tissue sample to determine histology.

Tissue sampling can be done via bronchoscopy where a fibre optic scope is used to visualise the area so that samples or washings can be taken. This is the best option for tumours that are located centrally near the larger airways or for those individuals that have poor pulmonary function. An alternative test is a CT guided fine needle aspiration (FNA) where a needle is introduced via the chest wall under local anaesthetic with CT assistance to locate the abnormal area. This is the test of choice when the tumour is in a more peripheral location but comes with more risks such as pneumothorax which can be a contraindication in individuals with poor pulmonary function.

There are two main types of lung cancer, small cell lung cancer (SCLC) and non-small cell lung cancer (NSCLC). This distinction is made to assist in determining the best type of treatment that is offered. NSCLC is then characterised further into adeno-carcinoma or squamous cell carcinoma. Surgery is generally only offered to individuals that have NSCLC in NZ although some international centres do perform surgery on early stage SCLC.

The offer of surgery is usually only made once further staging is completed using the TNM system to ensure that the cancer has not spread elsewhere. Best practice recommends that a positron emission tomography/ CT (PET-CT) scan is requested to look for cancer that may have spread to other parts of the body. A radioactive glucose solution is injected into the vein. Highly active cells take up the glucose and as cancer cells are highly active, they also take up the glucose, allowing them to be visualised by the scan. It takes between 30-90 minutes for the body to absorb the solution. Two scans are taken, a PET and a CT scan, and are merged so that any cancer can be identified and located. If other areas show sensitivity these need to be further investigated to see if they are involved in the lung cancer.

The PET-CT may suggest that the mediastinal nodes show ‘activity’. These would require sampling to see if they contain any cancerous cells. An endo-bronchial ultrasound (EBUS) is the investigation of choice and involves the use of ultra sound with a bronchoscope. EBUS is only available in Auckland and Christchurch within the public health system.

Often the patient has had many investigations and uncertainties throughout the diagnostic process before they are able to be referred to the surgical team for consideration of thoracic surgery. Their case is presented at a Multi-disciplinary Meeting (MDM) for a discussion involving respiratory physicians, surgeons, oncologists, nurses, radiologists and pathologists that have an interest in thoracic malignancies to decide on the most appropriate treatment for the individual patient. Those that have stage 1a or 1b would be offered curative intent treatment. Twenty five percent of these would not be surgical candidates due to patient preference, location of the tumour or existing co-morbidities such as COPD and cardiac disease.

Thoracic surgery is offered by five district health boards (DHB) in the public sector with most centres also offering

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LUNG CANCER *continued*

corresponding private surgery to both paying and DHB contract patients. The surgeons that perform the surgery are trained in both cardiac and thoracic surgery which is a recommendation in the standards. There is no specialised thoracic surgical unit within NZ therefore lung cancer surgery is fitted in around the larger numbers of cardiac surgical cases that are the majority of the thoracic surgeons work.

Success is improved with careful patient selection as many patients presenting for surgery are often of an advanced age, have poor pulmonary function due to lung disease and often have cardiovascular comorbidity. This requires an intensive multidisciplinary approach. In Canterbury the patients attend a pre assessment clinic that can take up to 4-5 hours. They are encouraged to bring a family member with them as they will be involved in the ongoing care and support once the person is discharged.

The patient's medical history is reviewed with particular interest in smoking history, respiratory and cardiac diseases and any other chronic conditions. These factors may affect the response to surgery and increase the risk of postoperative complications. Ideally the patient who currently smokes should be encouraged to quit 4-6 weeks prior to surgery as preoperative cessation of smoking prevents postoperative complications as well as an improvement in lung function. It is important that the person is supported in this process initially and also through the recovery period as well as into the future as continued smoking increases the risk of future lung cancers. The early pulmonary function tests are also relevant at this stage to determine whether the patient will have enough healthy lung tissue remaining after surgery. Any other identified conditions also need to be optimised so that the patient is in the best possible health at the time of surgery.

Instruction is given about post-operative procedures including breathing exercises and coughing techniques with the patient encouraged to practice these techniques prior to surgery. Information is also given about the expected pathway, such as analgesia, presence of intercostal drains, early ambulation and resumption of eating and drinking. Having this knowledge of what is expected as part of the surgical recovery reduces the patient's and family's anxiety. Informed consent is obtained at this time. The goal of postoperative care after lung surgery is to enable patient's to resume the normal activities of daily living, to prevent postoperative complications, reduce length of stay and increase patient satisfaction. They are encouraged to be active participants in their recovery to ensure a timely discharge and to reduce the risk of complications.

This is the time that patients require emotional and psychologic support as in addition to facing surgery, the patient may be adjusting to a new diagnosis of cancer and the possibility that surgical intervention will be only partially successful.

Within the Canterbury area if the patient lives alone or has no immediate supports available, provision is made to be discharged to one of the local rural hospitals that provide convalescence care before transitioning back to their home.

The most frequent risk factors increasing the incidence of post-operative complications include age, poor pulmonary function, cardiovascular co-morbidity, smoking status and the severity of chronic obstructive pulmonary disease (COPD).

In the ideal world high-risk patients can be optimised with preoperative cardiopulmonary rehabilitation to reduce their operative risk, frequency of complications and hospital stay. As there is often a short lead in once the decision is made to have surgery there is often limited time to complete this. Patients are encouraged to keep exercising and doing normal activities prior to surgery to optimise their fitness.

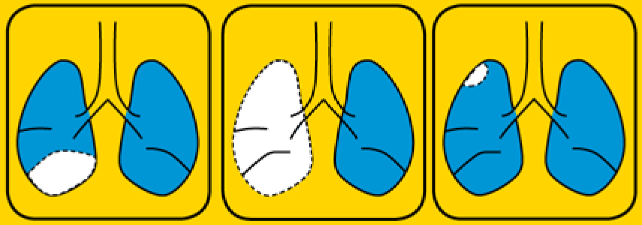
Patients are admitted on the day of surgery with the expectation that they will be discharged within 3-4 days if there are no complications. There are several types of operations that a surgeon will consider doing to remove a lung cancer.

WEDGE RESECTION – is the best option for individuals that have a reduced lung function and would be compromised if a whole lobe was removed. The area is identified and then a surgical stapler is used to cut and seal off the surgical margin.

LOBECTOMY – is the most common lung operation. The blood vessels and lymph nodes associated with the lobe containing the lung cancer will be removed as well, giving a better surgical margin.

Types of lung surgery

There are several types of lung surgery



Lobectomy: a lobe of the lung is removed

Pneumonectomy: one whole lung is removed

Wedge resection: only part of the lung, not a lobe, is removed

Reproduced, with permission, from Cancer Council Australia

PNEUMONECTOMY – is where the whole lung is removed to allow for clear surgical margins and is required due to the location of the tumour which is often close to the large airways and blood vessels.

When intubating the patient the anaesthetist will use a technique known as one lung ventilation which allows one lung to provide ventilation while the other lung can be collapsed allowing the surgeon to complete the operation.

Like abdominal surgery, thoracic surgery is now being undertaken with a form of key-hole surgery. The technique is known as video-assisted thoracoscopic surgery (VATS) and involves inflating the chest with carbon dioxide and introducing a camera and instruments through ports in the chest wall, similar to a laparoscopy in the abdomen. This is the preferred technique in early stage lung

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cancers as it reduces the incidence of postoperative pain and leads to a shorter hospital stay. It is used to carry out both wedge resections and lobectomy with a small incision required so that the surgical specimen can be removed. As a pneumonectomy results in a large surgical specimen it requires an open thoracotomy technique.

Intercostal tubes are inserted at the end of the procedure to drain any air or fluid that remains in the pleural cavity. Maintaining a patent, intact chest drainage system is vital to re-establish negative pressure within the chest cavity and allow re-expansion of the lungs. The surgical staples and the healing of the surgical bed will stop the air leak. Once the intercostal tube stops bubbling and evidence on the chest x-ray shows the lung has re-expanded the tubes are removed. Some patients have a prolonged air leak which lengthens their hospital stay and can lead to further pulmonary complications including atelectasis, pneumonia, pneumothorax and pleural effusion.

Major respiratory and cardiac complications continue to present an important source of morbidity and mortality following lung surgery. Incisional pain is a major cause of altered breathing patterns including shallow breathing and impaired coughing and can result in retention of secretions, atelectasis, hypoxaemia, hypercapnia and respiratory failure, especially in patients with pre-existing lung disease.

Adequate pain relief enhances restoration of pulmonary function, enables the patient to breathe and move about more easily, and facilitates active rehabilitation reducing post-operative complications. The patient will leave the recovery area with patient-controlled analgesia (PCA) usually for the first 24 hours. They are given oral analgesics once they are able to tolerate them, often when they resume eating and drinking normally.

Even with careful patient selection and extensive preoperative preparation there is still a risk (3-6%) of the patient dying during or soon after lung surgery. This varies with the amount of lung tissue that is removed with a pneumonectomy carrying the highest percentage of risk. The period following thoracic surgery is marked by variable changes in the structure and function of the respiratory system which can affect both the relatively healthy patients and those with pre-existing respiratory disease.

Respiratory complications include pneumonia, empyema, and prolonged postoperative air leak which are often a result of alveolar air leaks.

The most frequent cardiac complication is arrhythmia, most commonly atrial fibrillation which occurs in 10-20% of those following a lobectomy and up to 40% following a pneumonectomy. Cardiac arrhythmias are associated both with hemodynamic impairment and an increased risk of thromboembolism, stroke, myocardial infarction and heart failure.

Convalescence at home usually takes four to six weeks depending on the patient's preoperative level of fitness and health. They are encouraged to take enough analgesia so that they remain active and are able to exercise. Some people can experience post-operative surgical pain for several weeks to many months following surgery and can be at risk of developing a chronic pain syndrome.

A post-operative review including an ECG and wound check is done 6 weeks following surgery. The surgical findings are discussed at the MDM to see if further treatment such as chemotherapy will be required due to unexpected findings from the pathological review. The patient is informed of these and referred to the appropriate speciality for ongoing follow-up or further treatment.

There is insufficient evidence to recommend any particular schedule for the ongoing follow-up after lung cancer surgery so this often individualised as to the patient's needs. Patients may be seen three monthly initially, then six monthly for the first two years and then yearly for up to five years following surgery. Scans and CXR are also taken periodically.

The main objective of follow-up is to detect distance recurrence at an early stage so that treatment for any relapse can be offered and commenced. A recent audit presented at the 5th NZ Lung Cancer Conference in May 2016 demonstrated that routine follow-up of NSCLC post-curative attempt surgery did not prevent the cancer from returning. If lung cancer was to recur, it is more likely to happen in the first two years.

The longer the patient remains cancer-free, the more likely they have been cured of their lung cancer.

As lung cancer nurse specialists we are available to those patients and their families/ whanau that are on this pathway, which can often provide a lot of uncertainty and anxiety through all the investigations that may be required. Even if the person is able to proceed and complete surgery, there are some that may have ongoing effects of surgery as well as having to live with the knowledge that lung cancer may recur in the future.

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Acknowledgements:

Catherine Smith, Lung Cancer Clinical Nurse Specialist and Vicky Ray, Cardiothoracic Clinical Nurse Specialist at Canterbury DHB for their contribution to this article.

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Breast cancer surgery

A diagnosis of breast cancer is a life changing event, most women diagnosed with breast cancer experience a high level of stress and anxiety at diagnosis.

At this time they will be given options for treatment. Usually the first treatment is surgery though some patients may be advised to consider chemotherapy as the first treatment. (This is more likely for locally advanced, triple negative or HER2 positive breast cancer).

The surgical options given are wide local excision (breast conservation) or mastectomy. Following a wide local excision operation breast radiotherapy is the standard treatment to minimise the risk of local recurrence in the breast. As such women choosing this option must understand what radiotherapy involves and be willing to commit to have this treatment.

Patients advised to have a mastectomy will have the option of breast reconstruction discussed with them. Breast reconstruction can be performed as an immediate procedure at the time of the mastectomy or as delayed procedure, often once all oncological treatments have been completed.

How are decisions about breast cancer surgery made?

Traditionally surgeons told patients what surgical procedure they would have. Decision-making about breast cancer surgery is now usually a shared decision model where the surgeon will outline all suitable surgical procedures then assist the patient to decide the best surgical approach for them. Often the choice of surgery can have equivalent oncological outcome.

It is recommended that both wide local excision and mastectomy options are discussed with patients even if the surgeon gives a recommendation for a particular surgical procedure. If wide local excision is not technically possible due to size of tumour in relation to breast size or considered not adequate surgery due to tumour size and or features of the tumour for example multi focal (more than one tumour in the breast) a mastectomy is recommended. In this case breast reconstruction may be considered.

Women interested in having breast reconstruction need to be made aware that it will mean a longer operation and recovery and that there is a significantly higher risk of complications compared to standard breast cancer operations.

Any risk of delaying adjuvant treatments such as chemotherapy if there are surgical complications is an important consideration. Women opting for breast reconstruction may need to meet specific criteria (i.e. non smoker, healthy BMI) to be eligible for public funded breast reconstruction. Women can be advised against reconstruction if they have multiple co morbidities that would increase the risk of surgical complications.

What is the impact of surgery on women following breast cancer treatment?

Breast cancer surgery can impact greatly on a woman's body image and sexuality. It is generally acknowledged women treated by breast conserving surgery are less likely to have altered body image than women treated by mastectomy. While breast reconstruction promotes a healthy body image compared to no reconstruction.

The majority of women treated for breast cancer can expect a long period of disease-free survival making the long-term consequences of surgery and cancer treatments an important consideration. Psychological adjustment, fear of recurrence, satisfaction with relationships, sexuality and healthy body image are some of the complex issues to explore as they have a huge impact on a breast cancer patient's quality of life.

Each surgical option has possible risks and benefits. Patients need time and careful explanation of the surgical options including the procedure, the recovery and the expected cosmetic outcome to enable a woman to make an informed choice that suits her personality and lifestyle.

A specialist breast nurse can assist patients to adjust to a breast cancer diagnosis by acting as a point of contact, they assist women with the decision-making process by providing accurate information about breast surgery and breast cancer treatments, correcting any misconceptions, can advocate for the patient with members of the multi-disciplinary team, provide ongoing psychosocial support and referral to additional support services as necessary.

How do patients decide what breast cancer surgery to opt for?

There are many factors that govern patient choice. Women diagnosed with breast cancer may have some existing knowledge of breast cancer or strong views about cancer treatments that can influence their choice of surgery.

Wide local excision followed by breast radiotherapy has been proven safe compared to mastectomy in multiple large robust trials with long-term follow-up. However some patients will still choose to have a mastectomy as they overestimate the risk of recurrence or believe a larger operation is more likely to prevent future metastatic disease.

Factors such as age, childcare, work commitments and distance required to receive radiotherapy can influence patient decisions on surgical options. Even media coverage can influence a woman's views on their surgical options, for example since high-profile actress Angelina Jolie has disclosed she chose to have a bilateral risk-reducing mastectomy because she has the BRCA1 gene mutation. Many women attending breast clinic ask if they should be having a bilateral mastectomy and or genetic testing as part of their breast cancer treatment citing Angelina Jolie's situation.

Clinicians must consider the complex issues patients face when making decisions about breast cancer surgery. Taking time and skill to use a shared decision-making approach is the preferred approach.

Ideally the patient feels their preferences and values are included in the decision-making process, enabling them to make an informed choice that suits their requirements for evidence-based cancer treatment but also fits their values, lifestyle and futures plans.

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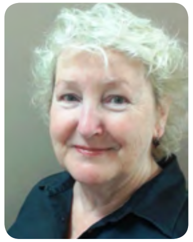
INTRODUCING OUR
2016 NEW committee members



Felicity Drumm

I have been working within oncology nursing for the past 15 years, with the last nine of these years spent in my current role as a CNS within the sub-specialty of gastro-intestinal cancers.

Working predominantly within the outpatient setting, I am based at Auckland's large Regional Cancer & Blood service, where my busy tumour stream sees approximately 650 new patients each year.

I enjoy a challenging mix of broad-based care including the provision of nurse-led clinics, and am excited to be part of a progressive environment that values and supports the expansion of senior oncology nursing roles.

Having recently completed my clinical master's degree, I am currently working towards hopefully achieving Nurse Practitioner registration.

I am pleased to have the opportunity to contribute towards the ongoing development of oncology nursing within NZ through involvement on the committee and look forward to my tenure.

My previous nursing background was largely District Nursing based, with a focus in palliative care. Over the years, I have enjoyed the opportunity to nurse both here in NZ together with England, Scotland and the Middle East.

Outside of work, life is busy with a teenage son, friends, family, and a love of the arts.

Fiona Sayer

I have worked at Thames Hospital for 25 years and in more recent times, I am the nurse co-ordinator of the Oncology/Hematology Unit in the Outpatient Department, which is part of the Waikato DHB.

Previously, I have been a blogger for the Oncology Nursing Society and have presented at the ONS congress on Oncology Nursing in New Zealand

Last year I completed my masters of nursing of which my research was on the perceptions and experiences of psychosocial distress, of patients who live rurally. This research has contributed to my learning and understanding of the challenges that our patients endure.

My passion is oncology nursing and it gives me great pleasure to be part of the Cancer Nurses College Committee.

I am looking forward to have the opportunity to contribute to the development and the challenges of oncology nursing in New Zealand.

Joseph Mundava

Clinical Nurse Specialist; Medical Oncology, South Canterbury DHB BSc Cancer and Palliative Care; Oxford Brookes University. Diploma in Adult Nursing; City University London.

It is a timely opportunity for me to be on the NZNO Cancer Nurses College Committee given the changing landscape for cancer care and cancer nursing. I look forward to being a voice for nurses, cancer patients and their whanau. The role will accord me a platform to network with other highly qualified Cancer Nurses in New Zealand and beyond influencing decisions related to practice at local and national level.

I have worked in various clinical care settings in the UK including the NHS in oncology ward with palliative care. I have also worked for Macmillan Cancer Support as a Cancer Information Specialist targeting hard to reach groups in raising cancer awareness and advocating for health equity. This was achieved through engaging communities and stake holders in providing health literature and resources tailored to meet requirements of marginalised communities. Simple health literature has remained my passion.

I have over the years gained invaluable experience which has helped me in settling in my current role focussing on patient-centred care.

Kirstin Unahi

I am a nurse practitioner working in Oncology at the Southern District Health Board, based out of Dunedin Hospital.

I have been working in Oncology since my registration 15 years ago in a number of roles including inpatient and outpatient nursing across radiation/medical oncology and haematology and as the Nurse Educator for the Oncology/Haematology service.

I qualified as a nurse practitioner in March of last year and now that I have settled into the role am thoroughly enjoying it.

I completed a Masters of Health Science (Nursing) in 2010 and have undertaken further postgraduate study since then. Having been busy juggling family, work and study commitments over the last few years, I am now looking forward to giving something back to the nursing community.

I am excited to join the College of Cancer Nurses Committee and see it as an opportunity to promote and support oncology nursing practice at a national level.

Cancer Nurses College SPECIAL INTEREST GROUPS

Do you practice in or have a special interest in an area of cancer nursing?

Do you want a forum where you can share ideas, information and expertise with others in the same cancer care subspecialty?

Do you want this forum to contribute to the objectives of NZNO Cancer Nurses College, New Zealand's recognised professional organisation for cancer nurses?

- Network with colleagues in your subspecialty within New Zealand
- Develop a newsletter for your SIG and contribute to it!
- Participate in discussions with other SIG members
- Share your expertise
- Support/mentor a colleague
- Distribute information and communications to your colleagues, eg educational opportunities, calls to action, recent advances in care, articles and research, newsletters, meeting minutes
- Contribute to the mission and objectives of NZNO and NZNO CNC
- Utilise NZNO support and resources

APPLICATIONS OPEN NOW!

Please contact the SIG coordinator for further information about how to establish a SIG and an application form at *cancernursesnz@gmail.com*

NZNOCNC provides members the means to form Special Interest Groups (SIGs). All members of NZNOCNC are eligible to belong to a Special Interest Group.

Here are just a few potential SIG examples

- *Haematology*
- *Solid tumours*
- *Clinical trials*
- *Clinical nurse specialists*
- *Prevention/ early detection*
- *Surgical oncology*
- *Survivorship*
- *Quality of life*
- *Cancer genetics*
- *Chemotherapy*
- *Radiation oncology*
- *Ethics*
- *Complementary therapies*
- *Palliative care*
- *Lymphoedema management*

Cancer Nursing NZ Under Construction

11-13 May 2017 Christchurch

NZNO Cancer Nurses College Conference 2017
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www.nznocancernursesconference2017.co.nz

The challenges and complications of COLORECTAL CANCER SURGERY

A colorectal cancer diagnosis is a very difficult, stressful and uncertain time for patients and their whānau. Investigations typically include a colonoscopy, blood tests and a staging CT scan of the chest, abdomen and pelvis. Patients with rectal tumours also require a sigmoidoscopy and a pelvic MRI. Additional imaging such as a liver MRI and a PET CT are necessary periodically.

Once the diagnosis is confirmed there is the big question of what next? Some patients require surgery, some need pre-operative long-course chemo-radiotherapy, some require neo-adjuvant chemotherapy prior to a liver resection as they are relatively asymptomatic from their primary tumour and for a small proportion the recommendation is palliative chemotherapy.

There have been articles in this forum describing the long journey around the time of diagnosis and staging for colon and in particular rectal cancer patients, therefore I shall not discuss this. I will focus on some of the more common immediate post-operative complications following surgery for the primary colorectal cancer tumour and then outline some of the optimisation measures that we utilise to improve the journey and to reduce complications.

If the patient requires surgery and agrees to this, there is the pre-admission journey to navigate. This involves anaesthetic pre-assessment clinic (APAC) and a pre-admission clinic, which shall be discussed later. They may also be invited to participate in research projects. If indicated and not already completed an iron infusion may be necessary. For some patients travel to appointments is challenging if they do not drive or if they reside in one of our rural areas. Social issues such as being their partner's caregiver create additional challenges. Significantly there is the distress of a cancer diagnosis, advising family and friends and fears and risks of surgery to consider.

POST-OPERATIVE COMPLICATIONS

For a majority of our patients and their whānau, a surgical ward is a foreign entitiy. Some feel that they need to grasp a whole new language due to the foreign terminology, as occurs with any cancer diagnosis. They see a wide variety of health professionals, support staff and students throughout their journey, but especially during an in-patient stay. Families often struggle with the wait for their loved ones to return to the ward from theatre.

The following data has been analysed from our enhanced recovery after surgery data that has been collected since October 2012. At Dunedin Hospital our range of length of stay for patients following colon cancer surgery is 3-36 days with an average of 8 days. For those with a rectal tumour the length of stay range was 4-49 days with an average of 12 days.

Post-operative complications include respiratory complications such as atelectasis, chest infection, aspiration pneumonia, pulmonary oedema and respiratory failure. This has extended the length of stay for colon patients to 10 days and for rectal patients to 13.8 days. Cardiac complications include AF, SVT, MI and arrest, which the length of stay being approximately 10 days for both groups.

A wound infection (either abdominal or perineal) can be a minor or major complication with data from both groups extending the length of stay to around 18.5 days. Approximately half of our patients with a wound complication had either a co-existing leak or ileus. Negative pressure wound therapy is utilised when indicated.

Hypotension typically delays mobilisiation, paticularly when vasopressor support is required. In our data, initial hypotension, with or without epidural use occured in a small group who then developed an ileus. This extended the average length of stay to 15 days for both groups of patients. Post-operative urinary retention resulted in an average length of stay of 9.7 days for colon patients and 8.5 days for rectal patients. Post-operative confusion was often associated with other complications such as an ileus, a leak and urinary retention, therefore this lengthened the average length of stay considerably. 11.8 days was the average length of stay for colon patients, while for rectal patients this was prolonged to 21.6 days. Excluding these cases reduced the average to 10 days in both groups. A CVA, while fortunately not common, did extend the length of stay to 16.5 days for both groups. This was also associated with an ileus in some patients. Our data indicates just one DVT which occured in a patient who had an ileus. (I have not included this in the graph).

The two most significant and bowel surgery specific complications are a paralytic ileus, typically called an ileus and an anastomotic leak. These are worth mentioning in more detail. The severity of an ileus varies from an insignificant episode which resolves after a few days of conservative treatment through to a prolonged ileus which persists for up to a couple of weeks. The most serious complication is an anastomotic leak. This can be a minor leak which is managed by CT-guided drainage and intravenous

The challenges and complications of COLORECTAL CANCER SURGERY *continued*

antibiotics through to a critical and life threatening event. Sepsis is another potentially life threatening condition. This may be secondary to an anastomotic leak, a respiratory or wound complication. Patients and their whānau experiencing these complications require increased nursing care and support. Some have their care escalated to our high dependency unit or the intensive care unit.

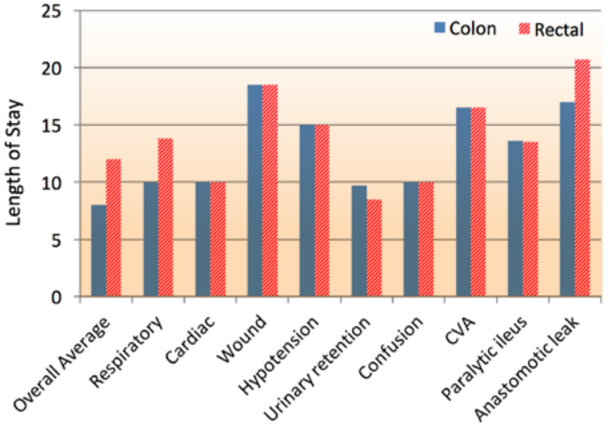
An ileus is thought to develop due to a suppression of the function of the intestinal smooth muscle due to being handled intra-operatively and pro-inflammatory responses.[1] This may occur following colorectal cancer surgery or be secondary to an anastomotic leak. The typical signs and symptoms include anorexia, nausea and vomiting, belching, hiccups, abdominal distension and discomfort and the absence of flatus/motions. At times there is a high stoma output or diarrhoea which seems incongruous. Bowel sounds are either absent or tympanic. Radiological testing can include an abdominal x-ray with dilation of the large and small bowel seen. Bloods are taken to assess electrolytes and to check inflammatory markers.

The duration of the ileus and fluid losses determine the management required. An ileus may resolve with conservative treatment after a few days, which involves maintenance intravenous fluids, being nil by mouth with or without a nasogastric tube. The nasogastric tube prevents vomiting, reduces the aspiration risk and reduces abdominal distension. Careful electrolyte and fluid balance management is required with a more prolonged ileus necessitating titration fluids to the losses, such as the nasogastric output which may be 3-4 litres plus the possible addition of a high ileostomy output. If the patient has raised inflammatory markers, is febrile or appears unwell a CT scan may be arranged to clarify if there is an anastomotic leak contributing to the ileus. Some patients require parenteral nutrition due to the duration of the episode. A small number required surgery, such as freeing of adhesions to facilitate ileus resolution. For colon patients the length of stay range was 5-41 days with an average of 13.6 days. This was similar for rectal patients with the range being 7-26 days with an average of 13.5 days.

An anastomotic leak is a breakdown in the surgical anastomosis. The signs and symptoms vary depending on the severity of the leak and typically include abdominal pain, tachycardia, fever, with raised inflammatory markers and peritonitis. As noted above there may be an ileus in conjunction with the anastomotic leak. When there is a low anastomosis, purulent discharge rectally may occur.[2] A thorough assessment by nursing and medical staff is necessary. A CT scan is required to assess the severity of the leak and to assist with treatment planning. A contrast study with a gastrograffin enema may provide additional clarity.

Treatment can range from conservative treatment with intravenous antibiotics with or without CT-guided drainage of the collection through to a requirement for parenteral feeding. Frequent rectal washouts of the anastomosis collection have been successful for some patients. Some patients required further surgery to drain the leak associated collection or abscess and repair the anastomosis. A stoma formation may be necessary. As mentioned already an escalation in care is often necessary. The length of stay range for both colon and rectal patients was 10-36 days. The average for colon patients was 17 days, while for rectal patients this was 20.7 days.

COMPLICATIONS



The other indications for re-operation were ischaemia and bleeding, but these were infrequent. The rare cases of mortality were secondary to multi-organ failure (most likely from elevated intra-abdominal pressure), respiratory failure, an arrest and following a second operation due to a leak.

I conclude from analysing our ERAS data that the length of stay is remarkably similar for both groups of patients across most of the complications. The main differences were the increase in the length of stay for rectal cancer patients who developed an anastomotic leak and respiratory complications. Interestingly the average length of stay for patients following rectal surgery was 12 days, which is slightly less than length of stay for rectal patients who developed cardiac, confusion or urinary retention related complications. It appears that the extended stays following wound, hypotensive, ileus or anastomotic leak related complications have increased the average. The graph demonstrates these statistics.

Discharge criteria include; tolerating oral food and fluids, comfortable with oral analgesia, safe mobilising short distances, self-administration of clexane which is continued for one month post-operatively and return of bowel function or independence with stoma care. Transfer to a rehabilitation ward can be necessary for ongoing stoma education or to facilitate regaining mobility.

Longer term complications associated with rectal surgery include bladder and erectile dysfunction which can be distressing. Chronic pain syndrome can require medical management. Data is not collected on these conditions in our area.

A major factor, even for those who have a smooth post-operative recovery is **post-op fatigue**. This is thought to be due to a combination of factors, such as the inflammatory cytokines stress response to surgery, weight loss secondary to diminished nutrition and a decrease in physical fitness.[3] This can be frustrating for patients and their whānau and may delay return to usual activities, including work.

The duration varies, however our surgeons advise that this typically lasts for 3 to 6 months, but possibly up to a year. This is compounded by adjuvant chemotherapy for those who require it. In a small number of cases adjuvant chemotherapy is not possible because of the time delay due to the complication or because of the risks associated with the complication directly, such as a CVA.

Optimisation

What can be done to improve timelines and reduce complication risk?

We are fortunate to have **pre-set colorectal cancer staging CT, pelvic MRI and liver MRI** appointments which enables these scans to be completed with 1-2 weeks of the request for a majority of our patients. A surge in demand intermittently extends this time frame.

Since August 2015 we arrange **iron infusions** (ferinject, 1000mg ferric carboxymaltose) for those who are anaemic or iron deficient. Prior to commencing this initiative we reviewed several articles which summarised the risks of increased incidence of complications such as thromboembolisms, sepsis, respiratory, wound and urinary, irrespective of age or sex in those with pre-operative anaemia.[4] Intravenous iron infusion produces a rapid and better haematological response with iron store replenishment, therefore is an efficient, cost effective and safe treatment for pre-operative anaemia.[5]

The anaesthetic team have initiated an **anaesthetic pre-assessment** process where paper work completed by the patient, when they are wait listed for theatre is assessed by the anaesthetic nursing staff. The patient is triaged to require a phone assessment, a clinic appointment with a nurse or a clinic appointment with an anaesthetist. Examples of their intervention include respiratory function tests, an echocardiogram, medication management or referrals to other services such as to the endocrine team to optimize diabetes management.

The **pre-admission clinic** is typically held one week pre-operatively. This is when the medical and nursing admissions are completed. The consent process details the planned operation and risks. The ERAS (enhanced recovery after surgery) programme is explained which involves pre and post-op support and education with encouragement to attain daily goals. The ERAS principles have been well documented and include minimal opioids, multi-modal analgesia, limited intravenous fluid administration, early feeding and early mobilisation.

Stomal therapy education and siting is completed for those who require this, with many patients finding the knowledge of having a stoma one of the most anxiety provoking. Referrals to other services may be initiated here or at different points along the journey; for example to our Cancer Nurse Co-ordinators, to the Māori liaison service, to our social worker, to the cancer society or to the oncology counselling service.

The Gastrointestinal multi-disciplinary team meeting **(GI MDM)** is an essential forum. Decisions regarding pre-operative care, such as pre-op short course radiotherapy or long course chemo-radiotherapy, or the management of patients who present with synchronous liver metastases and the treatment plan for post-operative patients are all discussed at the GI MDM. This recommended plan is then discussed with the patient, who can agree to the plan or occasionally choose other options.

It is generally accepted that due to an increase in life expectancy and co-morbidities that this is increasing the health needs of patients across all disciplines. This contributes to complication risks and heightens specialised care requirements.[6]

One of our colorectal surgeons is leading a trial on post-operative recovery and functional residual capacity following a supervised pre-operative high intensity interval training programme.

One of our medical oncologists is leading a co-morbidity study which is currently in the pilot phase. This study involves colorectal cancer patients with co-morbidities having a comprehensive and holistic assessment by a geriatrician to improve their health status. This may instigate medication amendments, physiotherapy referrals, social or mental health input. I am keen to see the impact of these trials on patient complications and length of stay.

My colleague and I assist with patient education, support and co-ordination of appointments around the time of diagnosis. I received a copy of a Welsh flowchart from a cancer nurse co-ordinator and subsequently designed a colorectal cancer patient journey flow chart which covers the journey from diagnosis through to surgery. We are currently trialling this and will seek feedback from patients later this year. We follow patients with clinic appointments, blood tests, surveillance CT scans and surveillance colonoscopies for five years according to our guidelines.

Thorough and compassionate nursing care with attention to early changes in vital signs, accurate fluid balance documentation and assessment of pain and cognition status along with open communication lines with the medical team are essential. This can facilitate an early diagnosis and therefore prompt treatment of post-operative complications for our colorectal cancer patients.

Acknowledgement: I appreciate my ERAS colleague sharing raw data, so that I could provide specific details on the impact of these complications on the length of stay for our colorectal cancer patients undergoing surgery for their primary tumour.

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GUIDELINES FOR

CONTRIBUTING TO CANCERNET...

Why contribute? Why publish?

- *To share knowledge*
- *To advance your field of practice*
- *To disseminate key findings or opinions*
- *To contribute to policy debates*

Introduction

Cancernet is a newsletter that is published three times a year by the New Zealand Nurses Organisation Cancer Nurses College. Cancernet aims to inform and encourage nurses managing people with cancer to share opinion, resources, clinical practice and continuing professional development.

Types of articles

All types of articles are welcomed and can include;

- *Opinion*
- *Clinical practice*
- *Case studies*
- *Continuing practice development*
- *Literature review*
- *Advanced study (e.g. BSc or MSc) write-ups*

Submitting your work

- Articles should be submitted in Microsoft Word via email to *cancernursesnz@gmail.com*
- Acknowledgement of receipt of your submission will then
- Acknowledgement of receipt of your submission will be sent by email.

Word count

Opinion articles should be between 700–1000 words long. However, clinical-based articles and literature reviews and advanced study articles, these can range from between 1,500 and 3,500 words, including references.

Illustrative and images

Authors must obtain permission for the use of illustrative material or images and ensure that this material is labeled and captioned.

Referencing

A recognised referencing system to be used. If the reference list is long, the reference list is available on request from the author.

Funding options to attend conferences or courses

Funding to attend conferences or courses is becoming increasingly hard to source. Apart from your local DHB, here are some funding options that you may not have thought of. To apply for funding you need to be organised with many groups having funding rounds and deadlines throughout the year.

- *For members, the NZNO offers several funding streams. These include NERF, Florence Nightingale, Thomas Tippet award, just to name a few. For further information including criteria and closing dates:*

  Visit the Scholarships section on the NZNO website

- *Roche provides individual "Roche Education Grants" to nurses working in the fields of Oncology and/or Haematology to support their attendance at appropriate medical education events paid for in 2016. The key goal for these grants is to support nurses in accessing continuing education opportunities in their field of expertise and to share the information gained with their colleagues.*

  Visit the Grants & Awards section on the NZNO website

- *The Genesis Oncology Trust has various award rounds throughout the year to support health professionals working within cancer care to attend courses or conferences. For further information on criteria and closing dates go to:*

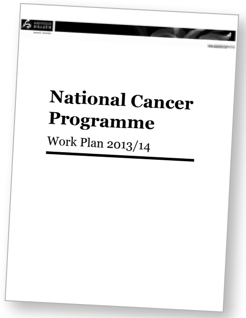
  Visit the Grant Application section on Genesis Oncology website

- *The Blood Cancer NZ and the Cancer Society offer grants for health professionals to attend conferences or courses. They usually have funding rounds. For further information contact the Cancer Society or Leukaemia and Blood Cancer NZ.*

If you are aware of other funding streams that are available and you want to publicise them, please contact us on cancernursesnz@gmail.com

National Cancer Programme update

The Ministry leads a national work programme which provides a strategic focus for cancer control and for system-wide improvements across the spectrum of cancer services.



National Cancer Programme
Work Plan 2013/14

Keep up to date on the National Cancer Programme

Online cancer learning

www.cancernursing.org

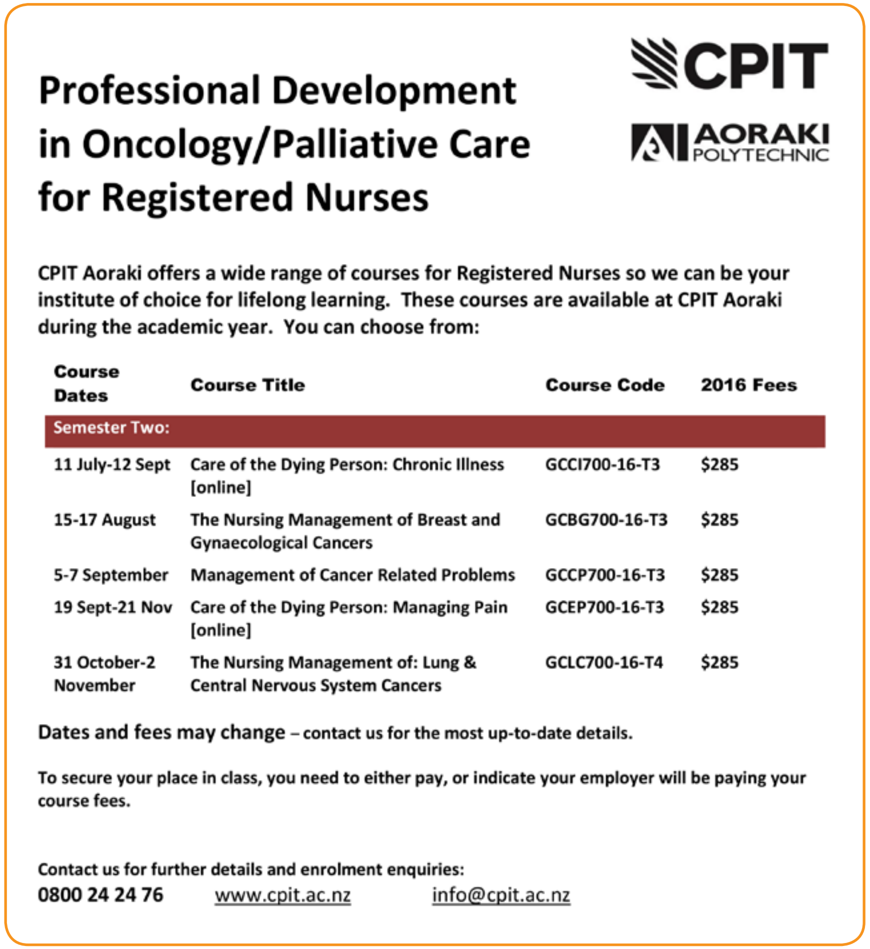
www.cancerlearning.gov.au/build/edcan_learning_resources.php

www.ons.org

www.isncc.org

www.eviq.org.au

www.nccn.org



CPIT
AORAKI POLYTECHNIC

Professional Development in Oncology/Palliative Care for Registered Nurses

CPIT Aoraki offers a wide range of courses for Registered Nurses so we can be your institute of choice for lifelong learning. These courses are available at CPIT Aoraki during the academic year. You can choose from:

Course Dates	Course Title	Course Code	2016 Fees
Semester Two:			
11 July-12 Sept	Care of the Dying Person: Chronic Illness [online]	GCCI700-16-T3	$285
15-17 August	The Nursing Management of Breast and Gynaecological Cancers	GCBG700-16-T3	$285
5-7 September	Management of Cancer Related Problems	GCCP700-16-T3	$285
19 Sept-21 Nov	Care of the Dying Person: Managing Pain [online]	GCEP700-16-T3	$285
31 October-2 November	The Nursing Management of: Lung & Central Nervous System Cancers	GCLC700-16-T4	$285

Dates and fees may change – contact us for the most up-to-date details.

To secure your place in class, you need to either pay, or indicate your employer will be paying your course fees.

Contact us for further details and enrolment enquiries:
0800 24 24 76 www.cpit.ac.nz info@cpit.ac.nz

CORRECTIONS AND CLARIFICATIONS

Cancernet acknowledges the corrections and clarifications based on the following article:

Pedal Power – Keeping up with Palliative Care 2016
April 2016 Edition of Cancernet by Jane Rollings.

The last version said - Five years on and a lot has happened in palliative care, this should read as Fifteen years. The projected deaths for New Zealand to 2068, should read as 2038. Te Ara Whakapiri: Principles and guidance for the last days of life is the correct version.

Important diary dates

23rd-24th August, 2016. Wellington
National Screening Unit hui/fono
Email for more information

4th-7th September, 2016. Hong Kong
ICCN 2016: International Conference on Cancer Nursing
Find out more information

7th-11th October 2016, Denmark
European Society for Medical Oncology
Find out more information

28th-29th October 2016, Sydney
The Australasian Melanoma Conference
Find out more information

13th-16th November 2016, Melbourne
Haematology Society of Australia & New Zealand, Australian & New Zealand Society of Blood Transfusion and the Australasian Society of Thrombosis & Haemotasis
Find out more information

23rd-25th November 2016, Wellington
4th World Congress on Integrated Care "Investing in our Future: Improving the Health of People and Communities"
Find out more information

Message

Is anyone attending the ICCN 4-7th September 2016, Hong Kong, if so please contact Moira Gillespie

moira.gillespie@hawksbaydhb.govt.nz

It would be good to meet up with cancer nursing colleagues from New Zealand.

The 2016 Cancer Nurses College COMMITTEE

L-R Back row: *Felicity Drumm, Melissa Warren, Moira Gillespie, Sharron Ellis, Kirstin Unahi.*
L-R Front row: *Joseph Mundava, Judith Warren, Fiona Sayer.*

We welcome contributions to Cancernet. Interesting stories, notices and photos relevant to our nursing community are always appreciated. Email us at

cancernursesnz@gmail.com

Cancer Nurses College badges

are now available for purchase for $8 each.

They can be purchased from CNC committee members or by emailing the committee on *cancernursesnz@gmail.com* and using internet banking.

Cancer nurses committee

cancernursesnz@gmail.com

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