ONCOLOGY NURSE ADVISOR FORUM

Our Consultants

QUESTIONS & ANSWERS

A CANCER PATIENT WHO USES COCAINE

I have a patient with cancer who is actively using cocaine. We will do random urine screens on this patient. How long does cocaine remain in the urine? — Ruth C. Gholz, RN, MS, AOCN, and colleagues at the Cincinnati VA Medical Center

Once cocaine is smoked, inhaled (snorted,) or injected, it can appear as its metabolite, benzoylecgonine, and can be detected in the urine for 2 to 4 days. The actual time is difficult to determine because of the differences among individuals and in how rapidly the drug is metabolized, which depends on weight and other factors. In general, I would expect a cancer patient with significant comorbidities and overall physical deterioration to be on the longer period of detection. — Donald Fleming, MD

COPING WITH CHEMO BRAIN

What is chemo brain, and what can be done for it?

Chemo brain is a series of memory and concentration failures experienced by some patients treated with chemotherapy. Patients with chemo brain are often afraid that it means that their cancer has spread to their brain. Medical treatment with stimulants such as methylphenidate or modafinil are currently being tested. In the meantime, if chemobrain is diagnosed, the patient can do things to make life easier. For example, the patient can have standard places to keep things (such as car or house keys), work more slowly to truly concentrate on the task at hand, and keep a pen and paper at phones and bedside to write notes. But the best thing is to allow others to help out whenever possible to reduce stress and obligation for the patient. — Rosemarie A. Tucci, RN, MSN

ANEMIA IN PATIENTS WITH MDS

Managing anemia in patients with myelodysplastic syndrome (MDS) is complex. When are erythroid growth factors used as primary treatment? — Catherine Rossi, RN III, OCN, York, PA.

*Treatment for patients with MDS is multifactorial, involving age, treatment preferences, IPSS scoring, performance status, any antecedent hematologic disorders, and the availability of HLA-matched stem cell donors (*Harrison's Manual of Oncology.

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*2008;289-303). For those with low-grade MDS and anemia, low or int-1 risk, according to NCCN guidelines, therapy is guided by cytogenetic status (NCCN.org/professionals/physicians_gls/PDF/mds.pdf.). Erythroid growth factors are used as initial treatment when serum epoetin levels are 500 mU/ml or less, the patient is transfusion independent, and there are no 5q deletion or other cytogenetic alterations (*Harrison's Manual of Oncology. *2008;289-303). — Jiajoyce R. Conway, DNP, FNP-BC, NP-C*

INFUSION TIMES FOR RITUXIMAB

Other oncology nurses have mentioned to me that they infuse rituximab (Rituxan) over 90 minutes. Are there references for this? — Ruth C. Gholz, RN, MS, AOCN, and colleagues at the Cincinnati VA Medical Center

*The 5- to 6-hour infusion time utilized for rituximab has stimulated research into safely speeding up the infusion. One study involved 1,200 patients with only one Grade 3 reaction when rituximab was administered over 90 minutes (*Blood. *2007;109:4171-4173). Another study reported successful administration in 60 minutes without significant reactions (*Ann Oncol. *2006;17:1027-1028). Before attempting more rapid infusions of rituximab, strict safety monitoring algorithms should be established. Temperature, blood pressure, and heart and respiratory rates should be measured before the infusion and again at 15, 30, 60, and 90 minutes; and the patient questioned about adverse experiences. — Donald Fleming, MD*

USING METHOTREXATE IN CHILDREN

Why do children with Down syndrome who are being treated for acute lymphocytic leukemia (ALL) sometimes require oral leucovorin after intrathecal methotrexate administration?

Children with Down syndrome have between a 10- and 20-fold higher increase in developing ALL compared to the general population. Incidence peaks first in the newborn period and again at ages 3 to 6 years. During the first four stages of treatment for ALL (induction, consolidation, interim maintenance, and delayed intensification), children with Down syndrome are at particular risk to develop systemic toxicities, especially from methotrexate. Leucovorin is a methotrexate antidote administered to decrease the potential for systemic toxicity (bone marrow suppression and liver impairment). — Karen MacDonald, RN, BSN, CPON

Why is trimethoprim/sulfamethoxazole (TMP-SMX) held during methotrexate administration?

Pediatric oncology patients are typically prescribed (TMP-SMX) at a dosage of 5 mg/kg/d divided into two doses for 2 to 3 consecutive days per week during treatment and for 6 months after therapy is complete to prevent the development of Pneumocytis carinii (now renamed Pneumocystis jiroveci) infection. (TMP-SMX) should not be administered with, or close to the administration of, high-dose methotrexate (doses of 3 g/m^2 or higher). Both trimethoprim and sulfonamides have similar toxicities and can increase the risk of toxicity (such as hepatic and renal impairment) with high-dose methotrexate therapy. — Karen MacDonald, RN, BSN, CPON

PRESERVING FERTILITY IN CANCER PATIENTS

What is the determining factor for preservation of fertility? Why can some women get pregnant after treatment and others cannot or do not? Is fertility preservation based on what chemotherapy one is receiving? — Tiffany Hunter, RN, York, PA.

*Preservation of fertility in cancer patients depends on the patient's age, disease, sex, type of chemotherapeutic agents used, radiation fields, dose, dose-intensity, methods of administration (oral versus intravenous), and pretreatment fertility (*J Clin Oncol. *2006;24:2917-2931). Infertility should be discussed as early as possible with all patients as a potential risk of therapy. Fertility preservation options should be explained and patient interest ascertained before initiating treatment. Male and female infertility are highly associated with chemotherapy regimens involving alkylating agents and total body irradiation. — Jiajoyce R. Conway, DNP, FNP-BC, NP-C* ■

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