ONCOLOGY NURSE ADVISOR FORUM

Our Consultants

QUESTIONS & ANSWERS

ADDRESSING CODE STATUS IN PATIENTS WITH ADVANCED CANCER

I am concerned about some of our patients with advanced cancer being full code. Is it within my scope to address this with patients, and if so, what is the best approach? — Kerstin L. McSteen, BSN, MSN, ACHPN, CNS-BC, Minneapolis, MN

Any member of the patient's health care team can discuss issues regarding code status; however, the DNR or "Do Not Resuscitate" directive needs to ultimately exist as a medical order from the health care professional legally able to initiate such medical decisions. Who can do this may vary from state to state and may include a nurse practitioner or physician assistant in addition to a physician. That person, the patient, and family members need to concur with its appropriateness. When dealing with terminally ill cancer patients and their families, I believe it is helpful to stress that "it's time to do things for *the patient and not do things* to *the patient." This shift signifies that we have arrived at the point where supportive care alone is the best management and that the health care team is not abandoning the patient.— Donald Fleming, MD*

TREATING LOW IMMUNOGLOBULIN LEVELS

When is it necessary to treat a patient with low immunoglobulin levels? — Barbara B. Rogers, CRNP, MN, AOCN, ANP-BC, Philadelphia, PA

Typically, starting IVIG replacement therapy for low immunoglobulin level correction is considered necessary when levels of IgG are less than 200 mg/dL. To provide constant protective levels, the monthly dose should be adequate to maintain a trough (measured immediately prior to the next treatment) of greater than 200 mg/dL. IVIG therapy can be justified for IgG levels greater than 200 mg/dL in patients with a significant infectious disease history and reduced IgG subtypes, such as IgG3.— Donald Fleming, MD

ISOLATION FOR RADIOIMMUNOTHERAPY

Do patients receiving radioimmunotherapy (RIT) have to be isolated? — Barbara B. Rogers, CRNP, MN, AOCN, ANP-BC, Philadelphia, PA

RIT is used primarily for B-cell non-Hodgkin's lymphoma. It is a form of targeted delivery of radiation to cancer cells by monoclonal antibodies that bind to tumor-associated antigens. Iodine I 131 tositumomab (Bexxar) and ibritumomab tiuxetan (Y-90 Zevalin) are drugs used in RIT. The half-life of tositumomab is 8.04 days, and tositumomab is a lower energy gamma and beta emitter. So depending on the

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dose, the patient may be hospitalized until radioactive levels are within the state regulations for discharge and would need isolation precautions. However, most patients are treated as outpatients. The half life of ibritumomab is 2.6 days; because ibritumomab is a high energy beta emitter, use of it does not require isolation from friends and family. However these drugs are administered, patients receive instructions to minimize exposure to others. Restrictions on patient contact with others and release from the hospital or an outpatient nuclear medicine department must follow all applicable federal, state, and institutional regulations. — K. Lynne Quinn, RN, MSN, CRNP, AOCNP

COUNSELING MALE ADOLESCENTS ABOUT SPERM BANKING

What factors should I consider when counseling my male adolescent patients regarding sperm banking before starting cancer treatment?

If your patient is to receive treatment that can impair fertility, the patient is sexually mature (at least 12 years old and at Tanner stage 3 or higher), and treatment can be delayed to allow for sperm collection, sperm banking should begin as soon as possible. Offer the opportunity for both parents and the patient to ask questions about the process. Sometimes having separate sessions with the patient and parent can decrease anxiety. Remember to consider the financial component associated with collection and storage of the sperm. Typically there is an initial consulting fee and a yearly storage fee. Is it covered by your patient's insurance? Are there outside resources that can help defray or help assist the family with costs?

If the patient decides to bank sperm, explain that if he is not able to collect sperm, this is not a failure. Given circumstances that may include pain, lack of privacy, and anxiety and stress related to his new diagnosis, collection may be difficult. Try to avoid procedures that require sedation around collection times, and allow for as much privacy as possible. The following Web sites can assist you and your patient: www.fertilehope.org; www.asrm.org; www.ihr.com/oregon/lab/process.htm; and www.cryolab.com. — Karen MacDonald, RN, BSN, CPON

URINALYSIS IN PATIENTS RECEIVING ALKYLATING AGENTS

Why are ketones present in urinalysis results when patients are receiving ifosfamide or cyclophosphamide?

These drugs are alkylating agents that increase the risk of hemorrhagic cystitis. Acrolein, the metabolized byproduct of these agents, is excreted by the kidneys into the urine. If allowed to remain in contact with the bladder mucosa, acrolein can cause irritation, inflammation, and bleeding. A urinalysis is performed to look for blood in the urine and to assess hydration status. Mesna (Mesnex) is a uroprotective agent that helps to prevent hemorrhagic cystitis. When given IV, it can be mixed with ifosfamide or cyclophosphamide and given after as IVPB. If given PO, the dose is higher and the drug is foul-tasting. Mesna is a free-sulfhydryl compound. It is these compounds that react to the ketone pad on the urine dipstick and cause the false-positive reading. Careful attention to the urinalysis is needed to check for the presence of blood and the specific gravity reading to assess the patient's hydration status. — Karen MacDonald, RN, BSN, CPON

COPING WITH COMPASSION FATIGUE

Oncology nurses are exposed every day to so much pain and suffering. Sometimes I feel overwhelmed and drained. Any suggestions? — Kerstin L. McSteen, BSN, MSN, ACHPN, CNS-BC, Minneapolis, MN

Compassion fatigue is very real. It is important to develop strategies to help yourself cope. Do particular patients trigger fatigue? Or is the fatigue generalized – an overall reaction to accumulated stress from caring for oncology patients? If particular patients are more draining, can you take a break from their care, maybe switching assignments? Activate the same coping strategies we offer to oncology patients: Comfort measures—carving out "me time." Relaxation—music, meditation, etc. Distraction—activities that allow you to forget. Draw on past experiences: what worked for you in the past? Does you hospital offer caregiver support? — Ann Brady, RN, BSN ■

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