Cancer Treatment Induced Bone Loss
Part I: Implications of Vitamin D and Bisphosphonates

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Cancer treatment induced bone loss (CTIBL) can be significant for patients undergoing therapy as well as for survivors of pediatric or adult-onset malignancies, and may result in low bone mass (previously termed osteopenia) or osteoporosis. In addition, we are gaining an increasing appreciation of the vital roles of vitamin D in bone and muscle health, calcium and phosphorus absorption in the gut, as well as cancer itself, cancer therapies, and bisphosphonate administration.

Finally, oncology nurses are familiar with using bisphosphonates, particularly zoledronic acid (Zometa, Reclast), to treat hypercalcemia related to advanced cancer or to prevent ‘skeletal related events’ (i.e. fractures, pain, spinal cord compression) secondary to bone metastases.

Zoledronic acid has also been shown to prevent CTIBL and may be a treatment choice for osteoporosis in patients undergoing treatment and for cancer survivors. Furthermore, there is increasing evidence that bisphosphonates prevent bone metastases in some tumors and they may actually decrease the incidence of breast cancer. This article will discuss normal and altered bone health, particularly as it relates to cancer and cancer therapies, and identify modifiable and non-modifiable factors that contribute to bone health. A major focus of this article is the multiple physiologic roles of vitamin D, particularly on bone health and implications for bisphosphonate use in order to enhance oncology nurses’ understanding and ability to more effectively apply this knowledge, which will also be discussed in part 2.

Bone Health
Healthy bones are a product of normal bone remodeling, sex hormones, other factors, adequate diet, healthy life-style choices, medical problems, heredity, and age (table

WHAT’S INSIDE

Special Feature .............6
Net Nurse .................8
President’s Message ........10
Quarterly Reports ..........13
Multi-faceted Onc Nurse ....18
Focus on Members ..........21
Editor’s Message ..........22
Bone remodeling is constant over life in both outer cortical (compact) bone and inner cancellous (spongy or trabecular) bone in order to maintain bone strength and integrity, and is most frequent in the spine, hip, and long bones - sites of greatest stress (Michaud & Goodin, 2006). After full growth is attained, lysis and resorption of damaged bone by osteoclasts – bone consuming cells - is matched by bone synthesis by osteoblasts - bone building cells. That is, bone remodeling is coupled until age 30-35. After that, bone remodeling becomes uncoupled so slightly less bone is synthesized than is broken down, leading to a gradual decrease in bone mineral density (BMD) that continues into old age.

Hormones – particularly estrogen – are critical to maintaining coupled bone homeostasis. Estrogen has a negative or braking effect on osteoclasts, and a positive, stimulating effect on osteoblasts. When estrogen is lost, particularly when this occurs rapidly during natural or treatment-induced menopause, osteoclasts rapidly break greater amounts of bone down than osteoblasts can repair (Michaud & Goodin, 2006). This leads to weaker bones that have lower BMD and are more susceptible to low impact fractures (i.e. from a fall no greater than the patient’s standing height, with sneezing or coughing or abrupt movement, or spontaneously). Women, who have smaller and less dense bones than men, lose about 2% of their BMD per year during perimenopause – a period of five to 10 years (Guise, 2006). After menopause and complete ovarian failure, women (and men older than 55) lose 0.5% to 1% of their BMD per year. Both women and men have estrogen that binds to estrogen receptors on their osteoclasts and osteoblasts, and in men and post-menopausal women androgens are converted to estrogen by the aromatase.

Other Influencing Factors on Bone Health

Other influences on bone health include a diet adequate in protein, calcium and vitamin D, as well several other minerals (Palacios, 2006). For instance, phosphorus and other trace elements (i.e. zinc, fluoride, copper, manganese, boron, potassium, and iron) are essential for bone health and mineralization. Magnesium is also very important and has indirect and direct effects on bone quality, and hypomagnesemia may affect bone growth and strength, activity of osteoblasts and osteoclasts, and change calcium metabolism.

Adequate dietary calcium intake is necessary to prevent the body from stealing it from bones for neuromuscular and other body functions. Good sources of calcium are dairy products (milk, yogurt, and cheese), calcium-fortified foods, and cruciferous vegetables (broccoli, Chinese cabbage, and kale) provide some calcium. Many Americans consume calcium-deficient diets – typically about 600 mg/day – rather than 1000 mg recommended for 19 to 50 year olds and ≥1200 mg for older men and women to lessen their risk of osteoporosis (NOF, 2008). The most commonly available calcium supplements are calcium carbonate (40% calcium by weight, inexpensive, absorbed better when taken with food) and calcium citrate (21% calcium by weight, better absorbed in persons with low stomach acid, absorbed equally on an empty stomach or with food. The greater the amount of calcium ingested at one time inversely affects the proportion of the dose absorbed. Absorption is greatest with doses ≥500 mg, so supplemental doses should be divided (Office of Dietary Supplements, National Institutes of Health, 2009). Vitamin D directly enhances the absorption of dietary calcium and deficiency leads to diminished mineralization of bone with abnormal calcium-phosphorus structure formation that increases the likelihood of osteoporosis and fractures (Stechschulte, Kirsner, Federman, 2009).

Bone health is also influenced by modifiable life-style choices, other medical conditions and medications, heredity, and age (NOF, 2008). Habits detrimental to healthy bones include cigarette smoking, high, chronic alcohol consumption (considered ≥3 drinks per day), and being a ‘couch potato’ by choice or medical condition. Load-bearing (on spine, hip, and long bones) not only induces microfractures but stimulates bone remodeling, which is critical to maintaining strong bones. Conversely, prolonged inactivity (i.e., bed rest or being confined to a chair) causes calcium loss and deterioration of bone microarchitecture.

Inadequate dietary intake of important foods is not uncommon. For instance, alcoholics may have generally poor diets and many other Americans consume inadequate amounts of calcium, vitamin D, and other elements essential to healthy bones. Extremely thin individuals are at increased risk for low bone mass and osteoporosis, which is exacerbated in those with bulimia or anorexia because of dietary insufficiencies. Many medical conditions and the long-term use of some medications have also been recognized to be secondary causes of osteoporosis.
Secondary Causes of Osteoporosis

Diagnoses that may be pertinent during cancer that may increase patients risk for low bone mass and osteoporosis include primary cancer diagnosis (leukemia, multiple myeloma, or lymphoma), undergoing stem cell transplant, and having other common medical conditions (i.e. insulin-dependent diabetes, chronic obstructive pulmonary disease [COPD]) (NOF, 2008; Palacios, 2006; the Joint Commission, 2008; Sweet et al, 2009). Similarly, chronic disease often means long-term medication use that may exacerbate loss of BMD. These include tamoxifen or aromatase inhibitor [AI] for breast cancer, corticosteroid or other immunosuppressant agents, anticonvulsants, and so forth.

Finally, Asians and Caucasians are at higher risk for osteoporosis than African Americans and elderly individuals have lower BMD that may progress to primary osteoporosis than young people because of decreased gonadal function, which can be exacerbated by other factors for secondary osteoporosis.

Vitamin D in Health and Cancer

Vitamin D, which has roles in numerous body functions, is a powerful regulator of cellular growth in normal and cancer cells, acts as a hormone in the body, and is important to dietary calcium absorption, bone and calcium metabolism, and inhibition of PTH synthesis (Raisz, 2005; Stechschulte, et al, 2009). The liver converts vitamin D to calcidiol (25OHD), an intermediate metabolite that can be measured. Calcidiol is subsequently converted to its short-lived, active metabolite calcitriol (1,25(OH)2D), which is not measurable. The currently accepted ‘normal’ range of serum calcidiol is 32-100 ng/ml, and <20 ng/ml is considered vitamin D deficiency whereas 21-20 ng/ml defines vitamin D insufficiency. However, >70-80 ng/ml may actually be optimal to maximize neuromuscular health, and to muscle strength and minimize the risk for falls and osteoporotic bone fractures (Hoeck, Li, & Qvist, 2009; Stechschulte, et al, 2009).

Knowing what a patient’s vitamin D level is important because up to 50% of people in the US are vitamin D deficient – especially those living in the northern US (and during winter months) because of sun avoidance and low dietary intake of egg yolks, oily fish, and fortified foods (see table 2) (Holick & Chen, 2008; Moyad, 2008). Our diets typically provide only 150-200 IU of vitamin D per day, and the amount made in the skin by photoconversion of ultraviolet B (UVB) sunlight can vary widely depending on amount of skin exposed, genetic differences in ability to synthesize pre-vitamin D3, and using sunscreen that blocks UVB rays (Prentice, Goldberg, & Schoenmakers, 2008). There is evidence for the ‘vitamin D theory’ that our original human relatives would have absorbed the highest levels of UVB sunlight and thus pre-vitamin D3 in equatorial Africa. They developed black skin because melanin is a natural sunscreen that prevents loss of folate, an essential B vitamin (Chaplin & Jablonski, 2009). As human populations migrated north, they developed lighter skin over time in order to more effectively synthesize vitamin D in areas where UVB rays were less intense or absent for long periods (between the autumn and spring equinoxes). The migration of dark-skinned Africans to northern hemisphere countries has resulted in a higher rate of vitamin D deficiency in blacks and Hispanics (and obese persons) in North American and European countries than Caucasians and non-obese individuals (Stechschulte et al, 2009).

The current daily recommended intake of vitamin D for adults and children is 800 to 1000 IU, particularly in the absence of adequate sunlight (Holick & Chen, 2008; NOF, 2008). This recommendation may be revised upward to 2000 to 4000 IU of cholecalciferol (vitamin D3) because optimal vitamin D levels potentially may decrease the incidence and invasiveness of, and metastases from breast, colon, ovarian, endometrial, oral cavity, esophageal, renal, prostate, and perhaps other cancers, as well as negative effects on other chronic diseases (Epstein, Lindqvist, Geppert, et al, 2009; Garland, Gorham, Mohr, et al, 2009; Lipworth, Rossi, McCullough, et al, 2009; McCullough, Bostick, & Mayo, 2009; Tworoger, Gate, & Lee, 2009).

Checking vitamin D levels and calcium and vitamin D supplementation for cancer patients is not standard practice in many oncology settings and can lead to significant clinical problems. For example, a patient with undiagnosed vitamin D deficiency treated with an intravenous (IV) bisphosphonate may experience disastrous hypocalcemia, exacerbated secondary hyperparathyroidism, and increased serum creatinine up to several days after administration, as well as decreased BMD and fractures (Wang-Gillam, Miles, & Hutchins, 2008; Zuradelli, Masci, Biancofoire, et al, 2009). Hypomagnesemia may increase the risk for hypocalcemia (Chennuru, Koduri, & Baumann, 2008). Furthermore, vitamin D deficiency can result in painful osteomalacia that may be misdiagnosed (by plain radiograph or bone scan) as bone metastases in cancer patients (Khokhar, Brett, & Desai, 2009). Interestingly, patients undergoing chemotherapy for colorectal...
or breast cancer have been found to develop declining vitamin D levels, but it is not known whether this was related to chemotherapy, altered diet or dietary absorption, or a change exposure to sunlight (Fakih, Trump, Johnson, et al 2009; Santini, Galluzzo, Vincenzi, et al, 2010).

Some Nursing Implications
Oncology nurses can help patients understand their personal risks for osteoporosis – particularly factors they can alter – and support them to discontinue unhealthy habits or maintain healthy lifestyles. This is especially important for patients at risk for CTIBL. In addition, nurses who have a greater understanding about vitamin D and the high likelihood of deficiency in northern climes can collaborate with oncologists to monitor patient’s calcidiol and determine if levels are normal or deficient and to intervene appropriately. Finally, patients as well as nurses are likely to find new information about vitamin D in the lay press and on the internet, and this knowledge will provide nursing opportunities and challenges.

References

### Table 1: Risk Factors for Low Bone Mass and Osteoporosis (Primary & Secondary)

<table>
<thead>
<tr>
<th>General (Primary)</th>
<th>Life style (Primary &amp; Secondary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aging: women ≥65, men &gt;70</td>
<td>Cigarette smoking</td>
</tr>
<tr>
<td>Postmenopausal status</td>
<td>High alcohol intake (≥3 drinks per day)</td>
</tr>
<tr>
<td>Asian or Caucasian ethnicity</td>
<td>Cannot rise from a chair for extended time</td>
</tr>
<tr>
<td>Family history of osteoporosis</td>
<td>Sedentary life style; low physical activity</td>
</tr>
<tr>
<td>Maternal / parental hip fracture</td>
<td></td>
</tr>
<tr>
<td>Already experienced a low impact fracture</td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical conditions (Secondary)</strong></td>
<td><strong>Nutrition (Secondary)</strong></td>
</tr>
<tr>
<td>Amyloidosis</td>
<td>High caffeine consumption</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>Low calcium intake</td>
</tr>
<tr>
<td>Cushing's syndrome</td>
<td>Vitamin D deficiency</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Thin stature: weight &lt; 127 lbs; BMI &lt;19</td>
</tr>
<tr>
<td>Malabsorption syndrome, including gastrectomy or bariatric surgery</td>
<td>Celiac disease</td>
</tr>
<tr>
<td>Eating disorder (anorexia, bulimia)</td>
<td>Gastric bypass or gastrectomy</td>
</tr>
<tr>
<td>Hyperparathyroidism</td>
<td></td>
</tr>
<tr>
<td>Hyperthyroidism</td>
<td><strong>Medications (long-term use) (Secondary)</strong></td>
</tr>
<tr>
<td>Hypogonadism</td>
<td>Aluminum</td>
</tr>
<tr>
<td>Inflammatory bowel disease</td>
<td>Anticonvulsants (phenobarbital, phenytoin)</td>
</tr>
<tr>
<td>Insulin-dependent diabetes</td>
<td>Aromatase inhibitor for breast cancer</td>
</tr>
<tr>
<td>Leukemia/lymphoma</td>
<td>GnRH analogue for prostate cancer</td>
</tr>
<tr>
<td>Multiple myeloma</td>
<td>Immunosuppressant agents</td>
</tr>
<tr>
<td>Pernicious anemia</td>
<td>Long-term corticosteroid (5 mg prednisone per day for ≥3 months)</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>Long-term heparin use</td>
</tr>
<tr>
<td>Severe liver disease</td>
<td>Total parenteral nutrition</td>
</tr>
<tr>
<td>Solid organ or bone marrow/stem cell transplant</td>
<td>Parenteral progesterone</td>
</tr>
<tr>
<td>Thalassemia</td>
<td>Proton pump inhibitors</td>
</tr>
<tr>
<td></td>
<td>Supraphysiologic doses of thyroxine</td>
</tr>
<tr>
<td></td>
<td>Tamoxifen (premenopausal women)</td>
</tr>
</tbody>
</table>

### Table 2: Sources of Vitamin D

<table>
<thead>
<tr>
<th>Source</th>
<th>IU*/Serving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cod liver oil (1 tablespoon)</td>
<td>1360</td>
</tr>
<tr>
<td>Oysters (3 ounces)</td>
<td>545</td>
</tr>
<tr>
<td>Catfish (3 ounces)</td>
<td>425</td>
</tr>
<tr>
<td>Trout – farmed (3 ounces)</td>
<td>375</td>
</tr>
<tr>
<td>Salmon – cooked (3.5 ounces)</td>
<td>360</td>
</tr>
<tr>
<td>Sardines (1.75 ounces)</td>
<td>250</td>
</tr>
<tr>
<td>Tuna – bluefin (3 ounces)</td>
<td>170</td>
</tr>
<tr>
<td>Tuna – canned in water (3 ounces)</td>
<td>135</td>
</tr>
<tr>
<td>Orange juice – vitamin D fortified (8 ounces)</td>
<td>100</td>
</tr>
<tr>
<td>Cereal – vitamin D fortified (1 serving)</td>
<td>100</td>
</tr>
<tr>
<td>Milk – vitamin D fortified (8 ounces)</td>
<td>98</td>
</tr>
<tr>
<td>Cod (3 ounces)</td>
<td>80</td>
</tr>
<tr>
<td>Margarine – vitamin D fortified (1 tablespoon)</td>
<td>60</td>
</tr>
<tr>
<td>Sole/flounder (3 ounces)</td>
<td>50</td>
</tr>
<tr>
<td>Egg yolk (1)</td>
<td>20-25</td>
</tr>
<tr>
<td>Daily vitamin</td>
<td>400-800</td>
</tr>
</tbody>
</table>

*IU = international units
The definition of venous thromboembolism (VTE) includes the phenomena of deep vein thrombosis (DVT) as well as pulmonary embolism (PE), a complication of DVT. Twenty percent of all new VTE events occur in oncology patients; patients with cancer have nearly six times the risk of developing a VTE over a patient who does not have a cancer (Lyman and Khorana 2009). “The occurrence of VTE has been reported to increase the likelihood of death for cancer patients by 2 to 8-fold” (NCCN 2009). In addition to the increased risk of mortality, cancer patients who develop a VTE have additional serious clinical consequences including recurrence of VTE and major bleeding complications associated with anticoagulation (Lyman and Khorana 2009).

So, why are oncology patients at such a high risk for this devastating clinical problem and its significant negative consequences? Armand Trousseau first made the association between malignancy and thrombophlebitis in 1865 (Boccaccio C & Comoglio PM 2009). In the same time frame, the concept of a triad of categories of risk was developed by Rudolf Virchow and is known as “Virchow’s triad” (Boccaccio C & Comoglio PM 2009). People with a malignancy may have risk factors active and present in all 3 risk categories which are: 1) stasis of blood (for example, as a result of bed rest or vascular compression by tumor); 2) vascular injury (for example, injury caused by tumor cells within the blood vessels, drugs administered intravenously, or vascular devices such as intravenous catheters and central venous access devices); and 3) hypercoagulability (for example, from the release of cancer cell products affecting hemo- stasis, including platelet function and the clotting cascade) (Boccaccio C & Comoglio PM 2009). Cancer-related factors include the primary site of cancer. These higher risk sites include brain, pancreas, kidney, stomach, lung, gynecologic, lymphoma and myeloma. Other cancer related factors include an advanced stage of cancer, the initial period after initial diagnosis of cancer and the histologic type (Khorana AA & Connolly GC 2009). In addition to the cancer related risk factors for the development of a VTE, cancer patients may also have other contributing risk factors, such as obesity, cardiac disease, renal disease, previous VTE, poor performance status, and heritable prothrombotic mutations such as the Factor V Leiden mutation (Khorana AA & Connolly GC 2009).

There are a number of published guidelines available to review for decision making in the prophylaxis and treatment of VTE in the oncology patient. Groups who have developed the evidence-based guidelines that are most commonly referred to in the United States are listed below, in alphabetical order. American College of Chest Physicians (ACCP) American Society of Clinical Oncology (ASCO) National Comprehensive Cancer Network (NCCN). International guidelines include the Italian Association of Medical Oncology (AIOM), the European Society of Medical Oncology (ESMO), and the French National Federation of the League of Centers Against Cancer (FNCLCC) (Khorana, Streiff, et al 2009).

So, why do you need to be aware? Oncology patients are at a higher than normal risk for the development of VTE. Oncology nurses are in an ideal position to assess for risk factors, determine the extent of risk a patient may have, review and apply the guidelines as appropriate for each individual patient in order to minimize the risk of VTE as well as appropriately treat an occurrence of VTE, and to provide patient education around the signs and symptoms that should be reported immediately.

References:

OUT OF THE BOX
Mary Phelan Lappe

A serious but believed under report-ed complication of implanted venous access devices is erosion of the skin over and surrounding the portal body.

Several factors can contribute to this phenomenon of skin erosion over ports. These include: weight loss, repetitive rubbing of the port on the skin surface, accessing the septum in the exact same area, as well as poor healing after implanting the device. In the last 5 years, a new cause of skin breakdown over the port has been reported associated directly to frost bite caused by ethyl chloride spray. The use of ethyl chloride spray has been used in the oncology setting to reduce the pain associated with huber needle insertion into the skin area over an implanted venous access port. Weekly spraying over the septum with this spray, in an attempt to obtain an anesthetic effect, has been associated with skin breakdown. Frostbite or skin ulceration are unfortunate effects of using ethyl chloride spray frequently (Moureau & Zonderman, 2000).

Implanted venous access devices are used frequently in the oncology setting as a means for safe delivery of drug. All port skin erosions should be reported so the incidence and causes can be accurately identified and monitored and lead to recommendations/interventions for safe patient care.

References


America has long been described as a melting pot and a nation of immigrants. Multicultural urban areas like Chicago live up to that description by virtue of their ethnically and culturally diverse populace. The cosmopolitan city of Chicago and the surrounding area personify the human mosaic that is the United States, populated by people of every race, color, and ethnic background.

Traveling along one of Chicago’s many thoroughfares offers a pan-cultural banquet of sights, sounds and smells as the miles go by and neighborhoods are traversed. One example, Devon Avenue, from the lakefront to the western border of the city, is a microcosm of Chicago’s multihued cultural diversity. Each block exudes its own international charm, with European, Middle Eastern and Asian cultures prominently featured. The entire city boasts an eclectic array of ethnic neighborhoods rich in culture, custom and in culinary variety. As residents of this thriving and vibrant city and suburbs, we are privileged to serve patients rich in cultural diversity. And like the colorful neighborhoods and the mouth-watering cuisine, the people we serve reflect their unique diverse cultural experiences.

The Chicago area is fifth in the nation in terms of its immigrant population. Slightly more than one in ten people living in the United States are foreign-born, and nearly 20% of Americans speak a non-English language at home. Metropolitan Chicago is home to approximately 1.5 million immigrants from over 100 countries, with nearly half (47%) hailing from Latin America (South America, Central America, Mexico and the Caribbean), and about a quarter each from Europe and Asia. Most Chicago area immigrants have relocated from Mexico, Poland and India, and they are joined by people from the Philippines, Korea, China, Pakistan, Vietnam, the former Soviet Union, Ghana and Nigeria. This kaleidoscope of cultures demands a broad-based cultural competence among health care professionals and creates a variety of needs in the health care setting. For example, in order to overcome language barriers, Chicago area hospitals report using phone-based interpretation services for over two dozen different languages. Spanish and Polish represent the most prevalent languages requiring interpretation, with Arabic, Cantonese and Russian rounding out the top five in the Chicago metropolitan area.

Caring for patients and families from diverse cultural backgrounds adds an additional layer of difficulty to nursing practice, as differences in perspective, understanding, and language must be bridged.

Respecting cultural beliefs and practices, and overcoming language differences provide the foundation for delivering culturally sensitive care. Culture comprises race, gender and sexual orientation, age, differing abilities, communication patterns, language, customs, beliefs, religion, spirituality, values, familial hierarchies, and philosophies about health and healing, wellness and acceptable treatments, caregiving, and end-of-life care. Culturally competent nurses effectively deliver holistic care to patients who are diverse in social, religious, cultural and language needs.

Cultural competencies, or the behaviors, attitudes and skills that allow us to work effectively across cultures, are a set of tools that can be leveraged to address health care disparities for patients across cultures. Practicing nursing in a pluralistic community demands an awareness of the need to continually evolve as culturally competent practitioners. Culturally based behaviors, as well as socioeconomic issues such as employment and insurance, can affect every aspect of cancer care.

General Resources on Cultural Competence
Culture Clues
These excellent tools for clinicians provide key points about cultural preferences about touch, communication, decision-making, and other health care issues. Tip sheets for Albanians, American Indian/Alaska Native, Chinese, Korean, Latino, Russian, Somali, Vietnamese, as well as the deaf and the hard of hearing. [http://depts.washington.edu/pfes/CultureClues.htm](http://depts.washington.edu/pfes/CultureClues.htm)
The United States Departments of Health and Human Services Office of Minority Health

This government site provides resources to promote cultural competency in health care providers through helping to create greater self-awareness and helping to change beliefs and attitudes. Among the various resources available are several free online programs that provide continuing education contact hours.

https://www.thinkculturalhealth.org/

Ethnomed is designed to be a source of information for clinicians that can be consulted prior to patient encounters, allowing the clinician to “brush up” on a specific culture. Among the many useful pages at this site includes a section on clinical pearls.

http://ethnomed.org/clinical/pearls

Cancer-specific Cultural Competence
Read the article Ethnic Diversity and Cultural Competency in Cancer Care by Yvette Colon at accc-cancer.org/oncology_issues/articles/sep07/colon.pdf.

Intercultural Cancer Council Pocket Guide—Cultural Competence in Cancer Care: A Health Care Professional’s Passport

You Can Help Increase Nursing’s Influence on Health Care

According to a recent survey of U.S. opinion leaders commissioned by the Robert Wood Johnson Foundation, although nurses remain the most trusted professionals, they rank only seventh among stakeholders in terms of influence on many aspects of health care. Government officials, insurance executives, pharmaceutical executives, healthcare executives, doctors, and patients all were seen as having a greater impact on health care than nurses over the next 5–10 years, but the opinion leaders also wanted nurses to have greater influence.

http://natamcancer.org/

Cultural Competence and End-of-Life Issues

University of Michigan Program for Multicultural Health
This web site addresses an array of cultural issues, including a section on Competent End-of-Life Care which points to a variety of pages and links elucidating end-of-life care.

http://www.med.umich.edu/Multicultural/ccp/palliative.htm

Key Topics on End-of-Life Care for African Americans
Online compendium featuring excerpts from the Duke Institute on Care at the End of Life Initiative to Improve Palliative Care for African Americans program from The Last Miles of the Way Home conference.

http://www.iceol.duke.edu/resources/lastmiles/papers/01.html

Minority Nurse
This article from Minority Nurse discusses advanced care planning with minority patients.

http://www.minoritynurse.com/?q=legal-nurse-consultant/making-their-wishes-known
Hello CCONS members,

I want to say thank you to all of you for giving me the honor of being 2010 CCONS president. The entire board of directors and committee chairs are very excited about our past year and are looking forward to this coming year. I want to thank Paula Franson for being such a great example and acknowledge her outstanding dedication and loyalty to our chapter. This is such a great time to be a part of CCONS as we are celebrating our 30th year and we have just been honored with the ONS Chapter Excellence Award! This is such an amazing accomplishment and I want to thank every member of CCONS who has contributed to our success. It is in this spirit that I would like to personally challenge every member to take their involvement in CCONS to the next level. Simply put, we are asking members to give of their time and expertise a little more in the coming year so we can deepen our CCONS leadership and continue to serve as a role model to all other ONS chapters. I have included in this letter, an outline of our 2010 strategic plan. The board feels this plan is critical to help focus our efforts and to let members know what to expect from us this year. If you see something that is not on our strategic plan and should be, please send me your ideas with specific thoughts on how we can accomplish the item. We have also decided to organize a fundraising project with our members in honor of our 30th anniversary. The CCONS board has decided to match member donations to ONF up to $3000. Please read more about this in an article from our treasurer-elect Kathy Bonnefoi. Happy New Year to everyone and let’s get this year off to a great start!!!!!

Lisa C. Dobogai, MS, APN, AOCNP
sctapn@gmail.com

Chapter Strategic Plan 2010

**Membership**
Increase membership and current level of involvement

- Contact 5 undergraduate nursing programs in Chicago to go and speak to them about Oncology Nursing and CCONS

- Leadership outreach initiative to call current members and ask them to take their membership to the next step

**Virtual Community**
Increase Professional collaboration and networking using the VC technology

- Showcase 30 year history
- Create a task force to help support VC coordinator in this VC initiative to use the discussion board

**Program Committee**
Establish a partnership with another Professional Organization

- Partner with at least 1 other professional group for an education programming event in 2010

**Treasurer**
Have the ability to do online banking

- Transfer our money from US Bank to Fifth Third by mid year 2010

- To maintain or increase our reserves by the end of 2010

- Maintain our current awards platform

- Challenge all members to donate $30 to ONF in celebration of our 30th anniversary and CCONS will match their gift up to $3,000.00.

- Host at least 1 fundraising event for CCONS in 2010

**Community Outreach**
Identify community project and work with another organization to facilitate project

- Christmas in July

- Sponsor older adults in Skilled nursing facility
November 23, 2009
Paula J Franson RN MS AOCN®
Chicago Chapter

Dear Paula:
Congratulations! Your chapter is the recipient of the 2010 ONS Chapter Excellence Award.
Five chapters competed for this award, and I commend you not only on your wonderful chapter but also on a beautiful application. The ONS Chapter Excellence Award is a cash award of $1,333 (A check will be sent to your Chapter after the first of the year.) The use of this cash award is restricted only by the creativity of your members.

A plaque, recognizing your chapter’s achievement, will hang in the ONS Headquarters in Pittsburgh. Thank you for all you do for oncology nursing and ONS. Sit back and enjoy your well-deserved honor! I look forward to meeting you and members of your chapter at Congress.

With best wishes for continued success,

Paula T. Rieger, RN MSN AOCN® FAAN
ONS Chief Executive Officer

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December 2009
CCONS Membership,
Due to cost cutting, fundraising initiatives, and the hard work of board, committee members and membership, the financial record for 2009 is well in the black. This has led the board to look for ways to give back to the membership and ONS.

One of the ways we wish to accomplish this is through a donation matching campaign. It is important to donate to the Oncology Nursing Foundation (ONF) because they continue to support oncology nursing education and programs through grants and awards. When fundraising with corporations ONF is often asked: WHAT PERCENTAGE OF YOUR MEMBERSHIP SUPPORTS YOUR ORGANIZATION WITH DONATIONS?

Currently only about 4.9% of national membership donates. In our 30th anniversary year we would like to have 100% of our chapter donate to ONF. I know financially it is difficult to contemplate giving, but it is important to increase the percentage of members contributing, in order to increase corporate support. As this is the 30th anniversary of CCONS, it would be nice if each member could give $30. If that is difficult any amount you give will contribute to the percentage of membership donation. Of course if you can give more we will be happy to match whatever our membership gives up to a total of $3000. To help this campaign along we will have donation forms at all the meetings. Please think about donating to help support future oncology education.

Kathleen Bonnefoi RN, MS, AOCNS
Past Treasurer and Treasurer Elect
BUDGET FOR FISCAL YEAR 1/01/10 TO 12/31/10
CURRENT FUNDS AVAILABLE
CHECKING: 26,060.75
CD: 21,671.44
TOTAL: 47,732.19

PROJECTED REVENUE/EXPENSES BY COMMITTEE

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PROJECTED REVENUE/EXPENSE BY ITEMIZED

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<td>TOTAL</td>
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2010 is here. A new year and a new decade have begun. As I look back, I marvel at all the changes we have seen over the last 10 years. New technologies and drugs have been developed to provide care and treatment to our patients as well as new diagnostics and terminology for us to learn and incorporate into our practice. With all the changes we have encountered and for future ones to come in health care we need to find ways to meet the challenges. One of my very wise nurse mentors helped to put it into perspective for me by stating “we need to stay cohesive thru this time”.

One place that I have always found that cohesion was attending CCONS educational program meetings. The meetings give me a sense, no matter how my day at work was, that “I am an Oncology Nurse”. They give me a place to network to meet new colleagues or reconnect with former ones. I always get to “hang” with a great group of nurses that I can share ideas with or just get moral support. In this our 30th year as a chapter, I would ask everyone to come to at least one meeting this year to connect or reconnect. Bring a friend, colleague or someone new to help us remain a cohesive group.

The January 21st program with Kathryn Waitman presented us with information on “Multi Cultural Issues” at the Parthenon in Greek Town. She shared with us information on how various cultures can mesh with health care. Those attending left with an appreciation that cultures have regional impact on how health care is provided. We thank Pam Nosse for arranging the speaker and Lilly for providing the venue for this meeting.

There will be no meeting in February. Our next meeting will be held at Loyola Cardinal Bernardin Cancer Center in Maywood on March 24th. The topic is “Oncology Updates: Radiation and Surgery” and CCONS members Kathy Bonnefoi and Donna Krickl will be the presenters.

Our needs survey had an impressive response this year. I want to thank members who returned their survey. It was informative to the program committee to read all the suggestions and comments. The survey helped us to facilitate some changes to programs and ways we communicate with membership. The program committee is always open to member’ input -- you may contact any member throughout the year with your suggestions.

Also, we welcome anyone who is interested in joining the program committee to contact any of our program members.

Please check for all future program announcements through e-mail and on the calendar that is found on the CCONS website www.ccons.vc.ons.org. In this newsletter we have included a cardstock with future meetings and contact information for Board Directors and Committee Chairs.

As a reminder please RSVP if planning on attending a meeting. RSVP to the phone number or e-mail supplied on the flyer by the deadline date. Again this will ensure we have adequate amounts of food and handouts. Please note: this program year a nominal fee will be charged to non-members. CCONS member benefit is no charge for all meetings (exception is annual Vendor Fair).

Program Committee Members include: Carol Blendowski, Kathy Bonnefoi, Barb Kinast, Lynn MacMillan, Pam Nosse, Marge Pierce, Sandy Purl, Marc Epstein-Reeves, Katharine Szubski, Mary Szyszka, and Teresa Yang.
MEMBERSHIP COMMITTEE
Beth Hurter and Christa Lappin, Co-Chairs

Greetings from the membership committee! Membership renewals have gone out via “snail mail” this year. Please remember to fill them out completely and include ONS number and expiration date.

Incomplete applications will not be processed. Applications are also available on the virtual community. Consider printing a few out, posting them at work, discussing with colleagues what CCONS membership means to you and how you got involved. Invite them to a meeting to get a first hand look! We look forward to a great new year!

VIRTUAL COMMUNITY
Bev Caraher, Chair

Please visit our virtual community site regularly at http://ccons.vc.ons.org
If it is your first time visiting the site click on “New Users” in the top left hand corner of the page, and follow directions to register for our Virtual Community.
Thank you!

Please continue to send us news, events, photos, and job opportunities to post! There is no charge for members to post upcoming events or employment opportunities. bcaraher@amgen.com

RESEARCH COMMITTEE
Colleen O’Leary, Chair

The research committee continues to work with Patty Friend to review references for hot flash interventions that were identified in an updated literature review.

Additional grant opportunities are being researched for the project. The group re-convenes on Feb. 26 at 6:30 at Colleen O’Leary’s house. New members are always welcomed. Please join us if you would like to work on this project.
ARE YOU READY to get involved??

This is CCONS’ 30-year celebration as the first chapter of ONS and we need YOU to become involved this year.

You can start small… first by coming to at least 3 meetings a year; next step… time to join a committee. We can help you decide which one based on your interest and time.

Third, after a few years as a member of a committee…how about thinking of being a chair??

Logical next step is running for a Board Elect position – see how easy that was!!

This year Board Elect positions will include:

President Elect

Treasurer-Elect

Director at Large (2 open positions)

We welcome the chance to get you involved as an active member of this chapter – we know you will not regret it.

---------------------------------------------------------------

Register for 35th Annual Congress!

Plan now to join us in San Diego, May 13-16 for the ONS 35th Annual Congress! You’ll get the latest cancer nursing education and have a chance to connect to more than 4,000 of your nursing peers. It’s the perfect place to sharpen your skills, share ideas, and become part of the ONS community. And, if you register by April 8, you’ll save $100 off registration!
ONS BULLETIN BOARD

Resource on Chronic Iron Overload Due to Blood Transfusions
EXJADE® (deferisirox): Treatment for Chronic Iron Overload Due to Blood Transfusions provides information on a treatment method for your patients who may be at risk for chronic iron overload due to blood transfusions. If you care for patients who may receive blood transfusions, this downloadable brochure will introduce Exjade® (deferisirox), which we hope you will find valuable in your practice.

ONS Foundation Collaborative Grants
Two $10,000 grants are available to individuals, groups, foundations, institutions, and ONS Chapters interested in developing and implementing a collaborative oncology nursing education or leadership initiative in their geographic area. Applications due April 15, 2010. Please go to http://www.onsfoundation.org/funding.shtml for more information.

ONS Chemotherapy/Biotherapy Training Course in 2010
The ONS Chemotherapy and Biotherapy Course will be held March 6-7 in Atlanta, Georgia, U.S.A. Worth 13.5 contact hours, the course focuses on the knowledge you need to administer these treatments. The Chemotherapy/Biotherapy course will take place prior to the International Society for Nurses in Cancer Care (ISNCC)’s 16th International Conference on Cancer Nursing (March 7-11) in Atlanta.

All attendees will receive their own copy of the guidelines. Once you successfully complete the course and a post-test, you’ll receive a provider card indicating you have the knowledge necessary to administer these treatments.

Download Your 2010 Certification Calendar
Would you like an easy way to remember ONCC application dates and deadlines for the year? Download a copy of the ONCC calendar from http://www.oncc.org/docs/2010CertificationCalendar.pdf. A full year of deadline dates and reminders are included. Print a copy to post at your workplace, too!

Celebrate Certified Nurses Day
March 19 is Certified Nurses Day. Join ONCC in marking this day by recognizing the oncology certified nurses in your chapter or at your workplace. ONCC has ideas for celebrating at http://www.oncc.org/nursesday.shtml.

Mark Your Calendar for April 7!
Apply by April 7, 2010, for OCN®, CBCNTM, and CPHONTM Tests to be offered August 2-31, 2010, and you’ll save $100 on the fee. And if you apply via ONCC’s secure online registration system you’ll receive the lowest possible fees – certification fees are $25 lower for candidates who apply online than for candidates who submit a paper application by mail or fax. All applications for the August test dates must be received by April 21 (with the full, non-discounted fee). Find complete test information at http://www.oncc.org/getcertified/TestInformation/index.shtml. Apply early and save $100! Apply online and save even more!

San Diego Is Calling You - Invest in Your Education at ONS Congress
Come to San Diego, May 13-16, for the ONS 35th Annual Congress, where you’ll get the latest cancer nursing education and have a chance to connect to more than 4,000 of your nursing peers. And, if you register by April 8, you’ll save $100 on registration.

ONS Celebrates 35th Anniversary in 2010! CCONS Celebrates 30th Anniversary in 2010!!
That’s right! The Oncology Nursing Society got its start in 1975 and the Chicago Chapter in 1980. Stay tuned for the celebration events nationally and locally.
## Chicago Chapter ONS

(meetings held 3rd Wednesday of most months)

**CONTACT:** Katharine Szubski  
kszubski@oncmed.net

### January 20, 2010
Kathryn Waitman, RN  
Multi Cultural Issues  
Parthenon Restaurant  
rsvp required

### March 24, 2010
Kathy Bonnefoi, RN and Donna Krickl, RN  
Oncology Updates: Surgery and Radiation  
Cardinal Bernardin Cancer Center, Maywood  
rsvp requested

### April 21, 2010
Joseph Feldman, MD  
Lymphedema  
Northwestern Memorial Hospital  
(room to be announced)  
rsvp requested

### May 13-16, 2010
ONS Congress, San Diego

## Northern Fox Valley Chapter ONS

(meetings held 3rd Tuesday of each month  
March-November )

**CONTACT:** Mary Lou Sylwestrak  
mlsylwestrak@comcast.net  
Pat McLain  
Psmc9@comcast.net

### March 16, 2010
Speaker: TBA  
Targeted Therapy  
Francesca's Restaurant, Barrington  
rsvp required

### April 20, 2010
Carol Knop, RN  
Topic: TBA  
Good Shepherd Fitness Center, Barrington

### May 18, 2010
Speaker: TBA

## Chicago Western Suburbs Chapter ONS

(meetings held quarterly )

**CONTACT:** Denise Lapka  
Lapka.denise@gene.com

### February 3, 2010
Jeffrey Albaugh, RN  
Sex and Intimacy  
Edward Hospital Education Center, 3rd Floor  
rsvp required

### May 5, 2010
TBA

## Northwest Indiana Chapter ONS

(meetings held 4th Monday of each month except  
June, July)

**CONTACT:** Amber Kindt  
akindt@comhs.org  
Patty Robinson  
Crash7970@yahoo.com

### February 22, 2010
Speaker: TBA  
Renal Cell Cancer  
Café Elise, Munster, IN  
rsvp required

### April 26, 2010
Speaker/Topic: TBA  
Light House, Cedar Lake, IN  
rsvp required

### May 24, 2010
Speaker/Location: TBA  
Novel Drugs  
rsvp required
Where are you currently working and in what capacity?
I work as a staff nurse on an inpatient hematology/medical oncology unit at Loyola University Medical Center.

What person(s) or event(s) directed you toward Oncology Nursing?
Once I began working in Oncology there was no looking back. I knew it was the field of nursing I wanted to be in.

Tell us about an accomplishment you are particularly pleased about:
I have recently completed the Oncology Clinical Nurse Specialist program at Loyola. Obtaining the graduate degree was one of my greatest accomplishments so far.

Is there a secret area of interest that you would like to pursue someday?
Besides Oncology Nursing, I would like to pursue my interest in Palliative Care and Hospice.

Is there one bit of Wisdom that stays with you and directs your course?
To treat another person as I would like to be treated.

Talk about someone who has touched your heart and why:
Many people have touched my heart and it is difficult to single out just one. One of my patients touched my heart recently. He was transferred to our floor with a new diagnosis of Acute Leukemia. He was depressed and giving up even before starting the treatment. Sadly, he had almost no support system from his family or friends. With the support from our staff he began fighting for his life, and has not given up throughout the difficult times he encountered. He recently came to visit us on the floor. I am happy to say, that he is currently in remission from his Leukemia, and has a very positive outlook on his life. I know that this brave patient has touched many more hearts than just mine.

Who in your world is most proud of you?
My mom is definitely most proud of me. She has always stayed by my side encouraging me to go on when times were tough.

What would you like to tell Nurses who are interested in working in Oncology?
Oncology nursing is a fast and growing field in need of many qualified nurses. If you are interested in working in Oncology then you definitely need to try it. The experience will change your life, as you realize that you constantly make a difference in someone else’s life. Oncology nursing will provide you with an experience as no other will. It is a field of nursing that is constantly changing and expanding. It proposes many new knowledge opportunities for nurses. You will become chemotherapy certified and an expert in taking care of oncology patients, with a multidisciplinary team of healthcare providers by your side. You can advance in your career by becoming oncology certified and there are many opportunities for growth.
What is something that helps you to relax and unwind?
Prayer and music are my daily companions.

What is your idea of a perfect vacation?
I would like to travel around the World and explore as many places as possible.

If you could pick anyone in the world to have dinner with, who would you select, why, and where would you go?
I would like to meet with the Pope Benedict XVI in Rome. He is my inspiration as someone who has an ability to touch Hearts of many people.

What is the lasting impression you hope to make on others?
To be a caring person they can always rely on.

What’s In It For Me?
Submitted by
Carol Knop, Feature Editor

On November 18, 2009, the Bernardin Cancer Center at Loyola UMC hosted the Chicago Chapter meeting. Irene Stewart Haapoja, MS, RN, AOCN presented the topic “Managing Infusion Reactions”. This topic was the main reason that your oncology nursing colleagues attended this meeting. The speaker as well as the networking opportunity was also a strong draw.

Irene provided a thorough review of infusion reactions and the management of these reactions. Specifically highlighted by the participants who completed our meeting review survey were the distinguishing pathophysiology and characteristics of the different types of infusion reactions: Type I hypersensitivity and anaphylactoid reactions versus the cytokine release syndrome; the grading system for infusion reactions; an algorithm for management; the management of rigors; and a blood test that can be used to identify a true anaphylactic reaction. The attendees also benefited from a discussion in which nurses shared practices from their clinic or hospital settings.

The attendees felt that this presentation heightened their awareness of the patient at risk for an infusion reaction and would also help them to educate co workers and develop guidelines in their own practices.

The first CCONS membership meeting of 2010 was held on January 20th. The presentation was titled “Multicultural Awareness In Oncology Care” and the speaker was Kathryn Waitman, MSN, FNP-C, AOCNP. Once again, we were interested in learning what attracted our members to the event and what they learned from their experience.

Kathryn shared her experiences in caring for patients with diverse ethnic and cultural backgrounds. She provided helpful hints to help increase sensitivity and awareness when treating patients who are different from you. Several respondents mentioned they were drawn to this topic to increase their knowledge of diversity and find ways to incorporate culture sensitivity in their practice. Others commented that they will make more of an effort to utilize interpreters and will ask the interpreter to stand behind them when speaking to a patient in order to maximize their patient’s experience. Members also stated that they will try to be more patient when teaching and have made a commitment to spend more time with patients from different backgrounds.

We will look forward to your comments from our next meeting!
The first newsletter in 2010 for CCONS marks the beginning of our celebration of 30 years as a chapter. A time to reflect on all of the ways this chapter has grown in this time as well as contributed to the oncology community in our local area. Our chapter has a history consisting of dedicated, talented oncology nurses who go the extra mile for their patients. It is in the spirit of this that I am beginning this year with the goal of inviting the new generation of nurses into our organization. I have been blessed to be active in oncology for 20 years and my enthusiasm for our patients has not wavered. My plan is to provide information to our local nursing schools about our organization and our various roles within the oncology community. I would like to do this by visiting the schools and speaking directly with the nursing students. If any readers are involved in a nursing program and would like to initiate this process, please contact me at 224-234-8989 or christalappin@comcast. I look forward to working with all of you on this in the coming year and appreciate any support you can give to accomplish the goal of planting the seed of passion for oncology patients that we all have.

The Community Service Task Force is exploring several ideas for this year’s project including Christmas in July for needy children and/or elderly, or partnering with other groups for an educational event for the public. Volunteers for the task force are always needed and welcome. If you are interested in helping please call Dani Gale at 630-248-5546 or by email at danielle.gale@mpi.com.

Fundraising efforts for our chapter are vital to support the various projects, scholarships, and awards that CCONS sponsors each year. The Fundraising Task Force is looking for new members and innovative ideas to help keep our tradition of supporting local oncology nursing. Please contact Ima Garcia at 312-758-4626 or ima_garcia@hotmail.com if you are interested in participating.
On the personal side…

Here comes the bride…. **Lisa Dobogai** walked down the isle on February 13th at St Mary’s Church in Crown Point Indiana. She and her fiancé, Chris Gaston will get away from the Chicago winter and enjoy a romantic honey-moon in Maui.

Please welcome our newest CCONS member **Diane Calvillo-Sanchez**. Diane joined CCONS at our January membership meeting and is an RN who works in surgery at U of I. One day you join the chapter….then a committee…then the Board… Welcome Diane; don’t let us scare you off.

On the move… **Katharine Szubski** is moving into a new home in Prospect Heights with her husband, two children, and African Parrot!!! Stop by and say “Hi” if you’re in the neighborhood.

On the professional side… **Maggie Smith** is developing an online OCN Certification preparation course in conjunction with four other RN’s in the United States. Way to go Maggie! Just goes to prove that CCONS members are recognized as some of the best and brightest in the nation.

**Janet Golick** joined the Evidence Based Practice Committee for Outpatient Nursing at U of I. Hmmm…maybe there’s a spin off for the CCONS research committee in the works!

**Mary Szyszka** has decided to come out of retirement. OK…she’s still semi-retired, but it’s a start. Oncology nursing needs her.

Pat on the back… **Karen Daly** passed the Accredited Case Manager Certification Exam and has earned the title ACM. Congratulations Karen! (How many people know that Karen was one of the charter members of CCONS thirty years ago?!)

Where in the world is…. **Sandy Purl** returned from her trip to Egypt in pursuit of her goal to travel to every continent in the world. She only has three remaining. Maybe she’ll “Walk like an Egyptian” to Asia, Antarctica, and South America.

**Speaking of world travelers…** **Carol White** is planning a trip in March to visit her son in Amsterdam. She’s very excited to tour the Van Gogh Museum and immerse herself in the Heineken experience. How does the saying go? “What happens in Amsterdam…stays in Amsterdam.”

Well, that’s all the news that came my way. Please email me and tell me what’s happening in your life or your fellow CCONS colleagues.

Next deadline is April 15th. Email acuvala@aol.com

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**CALL FOR AUTHORS**

The newly developed Journal for the Advanced Practitioner in Oncology (JAdPrO) is targeting CNS’s, NP’s, and PA’s in oncology to be potential authors. This is a great opportunity for experienced as well as novice authors to submit review articles or shorter features.

Please contact Pamela Hallquist Viale, RN, MS, CS, ANP, AOCNP
Editor-in-Chief, Journal of the Advanced Practitioner in Oncology
p.viale@comcast.net.

Or visit the website at [http://www.advancedpractitioner.com/subscribe_jadpro.html](http://www.advancedpractitioner.com/subscribe_jadpro.html).
EDITOR’S MESSAGE

As you read through the pages of this newsletter, I’m certain that all of you have felt a sense of pride, accomplishment, and collegiality as we reflect on the last thirty years of CCONS. I would like to take this opportunity to share with you a glimpse into our history and an excerpt that was taken from the 25th CCONS Silver Anniversary Celebration.

CCONS: The Story of the First ONS Chapter

Following the 1976 ONS congress, several Chicago-based nurses recognized a need for an organized oncology nursing group within their area. Through the concerted efforts of a core group, the first meeting of the Oncology Nurses of Chicago (ONC) was held in September 1978. The goal of the ONC was to improve the quality of patient care through information exchange, education, and research.

Thirty two years ago the ONC held the first program for the membership entitled “Laetril: Political, Legal, and Nursing Implications”. Membership dues were $10.00 and we published our first newsletter called “WHATS GOING Oncology”.

On April 25, 1980 the Board of Directors of ONS met, reviewed and approved our petition for chapter charter. We became the first local chapter to be approved. Our charter was granted during the annual business meeting of The Oncology Nursing Society on May 29th, 1980 in San Diego. This date marks the official beginning of the Chicago Chapter of the Oncology Nursing Society.

Several of the original group of “pathfinder nurses” are still members of CCONS. Their leadership and innovation have set the corner stone for what CCONS is today; and I know this chapter has grown beyond their wildest expectations.

Since the chapters’ inception we have accomplished many things as an organization. We have received and awarded numerous scholarships, grants, and have remained an integral force in oncology nursing. We invite the charter members of the ONC to share their experiences with the next generation of oncology nurses as they assume their role as the future of this organization. We ask new members to take this opportunity to reflect on the achievements of the nurses who preceded us. Most importantly, we ask that all members old and new remember the past and work together for our future. The ONC is counting on us to uphold our traditions, values, and core ideas for many years to come.

-Ima
You're Always There for Your Patients
Oncology is one of the most rewarding nursing specialties. You are a caregiver, a teacher, a listener, a coach, a shoulder to lean on, and much, much more. The greatest gift you can give your patients is to be there for them, during good times and bad. It’s what you do.

The 2010 Oncology Nursing Month theme—Oncology Nurses: There When You Need Us—recognizes your dedication to your patients and your commitment to quality care.

Start Your Celebration Today With New Products to Support Oncology Nursing
Oncology Nursing Month is scheduled for May, but it’s not too early to start planning your celebrations. This year, the ONS Foundation is offering more products than ever before, to recognize cancer nurses while raising funds to support oncology nursing awards, grants, and scholarships.

Check out this year’s products, including tote bags, t-shirts, mugs, banners, umbrellas, pens, and all kinds of other fun stuff for you and your colleagues.

Get Tips and Tools to Help You Celebrate
Be sure to visit the 2010 Oncology Nursing Month website for ideas on how to celebrate, logos to use to promote your events, ways to recognize your nursing colleagues, and more.

PS: Watch your mailbox for your free Oncology Nursing Month poster, which will arrive with your April 2010 ONS Connect.
2010 CCONS MEMBERSHIP APPLICATION

ONS# (required for CCONS membership): ___________ Exp. Date(required)_________
Membership Category: ____ New Member      ____ Renewal
                        ____ Student      ____ Physically challenged
Recruited by:______________________________________________________________

MAILING ADDRESS

Name (please include all credentials):____________________________________________
Address:_____________________________________________________________________
City:_______________________________________________________________________
State:_______________________________________________________________________
Zip Code:___________________________________________________________________
Preferred Phone Number:_______________________________________________________
Email:______________________________________________________________________
Place of employment:__________________________________________________________
Specialty area:_______________________________________________________________
Change in any information from previous year:____ yes     _____ no
____ I do not want to be included in the Chapter Directory
Interested in being active in a CCONS committee: _____Program  _____ Membership
        _____Research  _____ Newsletter  _____Nominating  _____ Archives
        _____Community Outreach
        ____ I would like more information on ONStat (legislative action alerts)

Dues are $25 (student or physically challenged is $10) payable to CCONS. Mail fees to CCONS,
PO BOX 11073, Chicago, IL 60611. Membership is January through December. Persons joining
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