We are gaining an increasing appreciation of cancer treatment induced bone loss (CTIBL), which can increase cancer patients’ risks for low impact fractures that often result in significant morbidity and increased mortality. Part I of this article discussed factors that affect bone health, particularly estrogen, aging and gender, as well as adequate dietary calcium, vitamin D, magnesium and other elements essential for healthy bones. In addition, regular weight-bearing exercise is important to improve muscle strength and balance that can decrease the risk for falls and have a modest effect on bone mineral density (BMD). Part II will review mechanisms of CTIBL, and discuss how bone health is evaluated as well as the use of antiresorptive therapies to maintain or restore normal bone mineral density.

**Effects of Cancer Therapies on Bone Health**
Bone loss is more rapid and significant in patients with CTIBL than with bone loss of aging (Guise, 2006). CTIBL may be caused by direct effects of some chemotherapy agents or long-term use (>3 months) of other drugs (i.e. corticosteroids or anticonvulsants) on bone. For instance, cyclophosphamide, ifosfamide, methotrexate, and doxorubicin are known to have direct, dose-dependent negative effects on osteoclasts, osteoblasts, or on bone mineralization (Michaud & Goodin, 2006; Schulte, Beelen, Schaefer, et al, 2000). In addition, survivors of childhood cancer may be at risk for CTIBL. Children and adolescents treated with alkylating agents or high dose methotrexate, cranial or pelvic radiation, or stem cell transplant for leukemia, lymphoma, sarcoma, or other tumors may grow to short stature, have suboptimal bone mass, and be at increased risk for premature ovarian failure, increased bone loss and greater risk for frac-

CTIBL can also occur by indirect effects secondary to the loss of sex hormones induced by particular chemotherapy or hormonal agents or secondary to surgical castration. Twenty percent to 90% of breast cancer patients treated with chemotherapy experience ovarian failure (Michaud & Goodin, 2006). High-risk factors for premature menopause are higher doses of cyclophosphamide given for a longer time and being older than 40. And adding a taxane, anthracycline, or irinotecan to the regimen increases the risk for CTIBL even more (Fornier, Modi, Panageas, et al, 2005; Tanaka, Utsunomiya, Utsunomiya, et al, 2008). Younger women are likely to have return of menstrual periods but if a woman does not have a period for a year after chemotherapy ends, they usually have experienced complete ovarian failure and menopause. Other agents including busulfan, melphalan, chlorambucil, nitrogen mustard, and procarbazine have a high risk for inducing gonadal toxicity, and paclitaxel and cisplatin have a moderate risk for affecting sex hormone production (Oktay & Sonmezer, 2008).

Most CTIBL articles are written about breast cancer patients treated with aromatase inhibitors (AIs) or prostate cancer patients treated with androgen deprivation therapy (ADT), tumors whose growth are frequently stimulated by sex hormones. Therapies to block growth of hormone-dependent breast cancers include AIs (e.g. anastrozole [Arimidex], letrozole [Femara], or exemestane [Aromasin]); a selective estrogen receptor modulator (SERM) (e.g. tamoxifen, raloxifene [Evista], or toremifene [Fareston]); or a gonadotropin-releasing hormone (GnRH) analog (e.g. goserelin [Zoladex], leuprolide [Lupron], or triptorelin [Trelstar]). These agents rapidly deplete estrogen, which leads to increased osteoclast lifespan and bone resorption alone with decreased osteoblast function and significant CTIBL (Guise, 2006).

AIs antagonize aromatase, which prevents conversion of androgens synthesized by the adrenal glands and peripheral fat to estrogen. AIs are more likely to cause bone loss, particularly in the hip and spine, than tamoxifen (Eastell, Adams, Coleman, et al, 2008). Vitamin D deficiency may exacerbate AI-associated arthralgias and is also a significant cause of secondary osteoporosis (Chlebowski, 2009). Calcidiol levels should be monitored because >33% of breast cancer patients receiving an AI develop vitamin D deficiency (Camacho, Dayal, Diaz, et al, 2008). On the other hand, tamoxifen is a mixed estrogen agonist-antagonist and has different effects on bone depending on menopausal status. Tamoxifen is an antagonist and causes bone loss in premenopausal women, but is a bone-sparing agonist in postmenopausal women (Michaud & Goodin, 2006).

Gonadotropin-releasing hormone (GnRH) analogues also cause ovarian failure with rapidly decreased estrogen levels in women and bone loss (Body, Bergmann, Boonen, et al, 2007). Elderly men with prostate cancer treated with androgen deprivation therapy (ADT) - either with a GnRH analogue or by surgical castration are also at increased risk for CTIBL. These therapies cause testosterone loss (and secondarily estrogen by aromatization), decreased BMD, and increased risk for osteoporosis and fractures (Guise, 2006; Body et al, 2007). Long duration of ADT, vitamin D deficiency, and high alcohol intake may increase bone loss in men with prostate cancer (Diamond, Higano, Smith, et al 2004).

### Evaluating Bone Health

The best procedure to evaluate bone health is dual-energy x-ray absorptiometry (DXA), which gives a two-dimensional view of the bones scanned. Peripheral DXA (pDXA) of the finger, heel, or forearm can be used to screen for low BMD, but a central DXA of the hip and spine, or total body must be done to diagnose baseline normal, low bone mass or osteoporosis (Michaud & Goodin, 2006). Serial DXA scans are done to assess changes over time, and results are reported as t-scores and z-scores, which are the number of standard deviations below the mean bone mass of the comparison group (Sweet, Sweet, Jeremiah, et al, 2009). T-scores are used to evaluate BMD in adults older than 45, and z-scores are used in children and young adults. A patient’s t-score compares their BMD to normal bone density of healthy young adults of the same gender (and ideally the same ethnicity) whereas z-scores compare a patient’s BMD to adults of the same age. The risk for hip fracture, which is inversely related to BMD, increases by 1-3-2.6 times for each one SD decrease in hip t-score (table 1). However, >50% of fractures are sustained by women with low bone mass but not osteoporosis (Khosla & Melton, 2007).

### Antiresorptive Treatment in Cancer Patients

Bisphosphonates are cornerstone
agents to prevent and manage low bone mass and osteoporosis in the general population, and also have an important role in treating CTIBL. Calcitonin, teriparatide (recombinant parathyroid hormone), and estrogen are less commonly used agents for osteoporosis and for other metabolic bone diseases, and will not be discussed. Denosumab is an investigational agent that will likely receive FDA approval in the near future for treatment (but not prevention) of osteoporosis. Denosumab has a unique mechanism of action; it is a fully human antibody that binds to receptor activator for nuclear κB (RANK) receptors on osteoclast precursors and mature osteoclasts. This prevents RANK ligand (RANKL) from binding to RANK, which normally induces osteoclast maturation and survival that subsequently increases bone lysis (Khosla, Westendorf, & Oursel, 2008). There is ongoing research about using denosumab to decrease bone metastases from breast and prostate cancer and multiple myeloma. These tumors synthesize RANKL, which has a role in signaling for tumor cell migration and osteoclastic bone metastasis (Murthy, Morrow, & Theriault, 2009).

Oral bisphosphonates (alendronate, ibandronate, and risedronate) are most commonly used for postmenopausal osteoporosis, whereas intravenous (IV) zoledronic acid (ZA) is most commonly used in cancer practice to minimize CTIBL, prevent fractures related to bone metastases, and to treat hypercalcemia. ZA 4 mg (branded as Zometa) is used in oncology practice, and ZA 5 mg IV every 12 months (rebranded as Reclast) is approved for osteoporosis. Dosing schedules of ZA also vary depending on purpose (i.e. palliative treatment of hypercalcemia, prevention of skeletal events in patients with multiple myeloma or metastatic breast, prostate, or other solid cancers). There is growing evidence for using adjuvant ZA with chemotherapy or hormone therapy to prevent CTIBL and/or bone metastases, but the optimal schedule (every three, six, or 12 months) and duration of bisphosphonate use has not been established (Body et al, 2007; Gralow, Biermann, Farooki et al, 2009; Van Denwyyngaert, Huizing, Fossion, et al, 2009).

Reaching consensus will be important because bisphosphonates are taken up and remain in bone for years to decades, and it is unknown if prolonged use and higher cumulative doses will lead to more brittle rather than stronger bones and increased risk for osteonecrosis of the jaw (ONJ) or atypical stress fractures (ASF). The occurrence of ONJ and ASF is rare, but one similarity is that both occur in areas of high bone turnover where there may be greater deposition of bisphosphonates – ONJ most commonly occurs in the mandible or maxilla (Fehm, Felsenberg, Krimmel, et al, 2009) and ASF is most common in the femoral shaft or subtrochanteric region (Schilcher & Aspenberg, 2009; Lenart, Neviaser, Lyman, et al, 2009).

Other potential, more immediate adverse effects of IV bisphosphonates including ZA are acute phase flu-like reactions and fever, and renal insufficiency. Severe nephrotoxicity can be avoided by monitoring creatinine before administering ZA, holding ZA doses for renal insufficiency, and adjusting doses for patients with renal disease (Perazella & Markowitz, 2008). Another possible adverse effect of IV ZA administered to patients with unrecognized vitamin D deficiency is calamitous hypocalcemia accompanied by exacerbated secondary hyperparathyroidism and increased serum creatinine that persists for several days after administration (Wang-Gillam, Mile, & Hutchins, 2008). These patients are also at risk for decreased BMD and increased fracture risk, so calcidiol levels should be monitored in patients receiving IV bisphosphonates.

**Nursing Implications**

RNs and APNs can identify patients at risk for primary or secondary osteoporosis – particularly those at higher risk for their age because of cancer and cancer treatment. Early identification of cancer patients at risk for CTIBL should be one goal of nursing care, so that low impact fractures and other untoward effects of low BMD can be prevented. Nurses can implement patient teaching and counseling, collaborate with prescribers regarding laboratory tests (i.e. serum calcidiol levels) and other procedures (i.e. DXA), and understand administration and other implications of pharmacologic treatment. Patient teaching focuses on healthy life-style choices that promote healthy bones such as adequate consumption of dietary or supplemental calcium, vitamin D, as discussed in part I (Wickham, 2010). Similarly, nurses who can recognize vitamin D levels indicative of insufficiency and deficiency and t-scores that reflect low bone mass or osteoporosis will be better able to teach patients about avoiding low-impact fractures and encourage moderate exercise to minimizes bone loss from disuse and improves muscle strength and balance that decrease the risk for falls (Joint Commission, 2009; National Osteoporosis Foundation, 2010). Further assessment may identify safety concerns for patients...
with poor eye sight or weakness who may need to be reminded about adequate lighting, good foot wear, avoiding throw rugs, and so forth. Although fatigue is common in persons receiving chemotherapy, nurses can help the patient explore ways to avoid excessive rest in chair or bed and plan for walking, dancing, tai chi, stair climbing, or other exercise. Nurses can also counsel and support patients who smoke to quit, especially women who have been found to lose bone more rapidly and have lower BMD than nonsmokers, as well as reach menopause earlier and have more fractures (North American Menopause Society, 2006). Finally, another important nursing action is to make certain that our patients who are to receive a bisphosphonate have their calcidiol levels checked before hand to avoid causing symptomatic hypocalcemia and worsened BMD. Such knowledge and actions will enhance nurses’ abilities to fulfill their roles as patient advocates, to safely administer therapies, to minimize adverse effects, and to maximize patients’ quality of life.

References


Table 1: DXA Evaluation of BMD and Recommendations for Cancer Patients Receiving Therapy or Surviving Cancer

<table>
<thead>
<tr>
<th>T-score</th>
<th>Diagnosis</th>
<th>↑ Fracture Risk</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>* Baseline: DXA scan to measure BMD, evaluate specific risk factors for low intensity fractures</td>
</tr>
<tr>
<td>≥ -1.0</td>
<td>Normal bone mineral density (BMD)</td>
<td>2X</td>
<td>* Normal baseline: monitor DXA every 2-5 years depending on risk factors</td>
</tr>
<tr>
<td>-2.5 to -1.0</td>
<td>low bone mass (osteopenia)</td>
<td>2-6X</td>
<td>* low bone mass or osteoporosis: DXA every 1-2 years</td>
</tr>
<tr>
<td>&lt; -2.5</td>
<td>Osteoporosis</td>
<td>&gt;6X</td>
<td>* All patients: encourage appropriate lifestyle modifications, adequate calcium and vitamin D intake</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8X</td>
<td>* Consider bisphosphonate for:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>* Patients with osteoporosis or history of low intensity fracture</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>* Low bone mass, considering severity of low bone mass and presence of other risk factors; may need subsequent bisphosphonate if DXA t-score decreases</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>* Proposed therapy:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>* Breast cancer patients receiving adjuvant Al therapy: 4mg ZA every 6 months (based on Z-FAST trial); other regimens undergoing evaluation, may be considered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>* Prostate cancer patients receiving adjuvant ADT: 4 mg ZA once yearly, or weekly alendronate</td>
</tr>
</tbody>
</table>

Information from Body et al, 2007; Gralow et al, 2009

FOCUS ON MEMBERS

On the move...
Donna Krickl is now CNS of the Cyberknife Center of Chicago at Elmhurst Memorial Hospital. Donna comments... "And I love it!"

Lynn MacMillan has taken a position as Manager of Clinical Operations of the Du Page County Health Department - sounds like a challenge. Laurel Barbour has joined the team at Advocate Christ Hospital as an advanced practice nurse. Her new position is Coordinator for Multidisciplinary Clinics. Laurel's expertise and vast knowledge base will certainly be an asset. Joseph Tariman is returning to Chicago - yeah! He is done with his coursework for his doctorate. Joseph states that he will finish his data collection at Northwestern where he will rejoin Dr. Seema Singhal in the Myeloma program. He states she is very supportive of his research study on treatment decision-making in older adults newly diagnosed with myeloma.

On the professional side...
Christa Lappin has started working towards her MSN degree at Saint Xavier along with taking on her new roles as co-chair of membership and Director at Large position. Of course, we are not mentioning the other things in her life like a full time job and taking care of family! Carole Martz participated in the Survivorship Initiatives Workshop for ONS in Pittsburgh in the Fall, 2009. Carole is an excellent resource on survivorship issues among other areas of interest.

On the personal side...
Marge Pierce survived the "Tsunami" in Hawaii while on vacation. Marge is also recovering from recent thyroid surgery and is doing well. Carol Knop is also recovering from her second inner ear reconstructive surgery done on April 19th. Please keep them both in your thoughts for speedy recoveries as they are missed.

Well, that's all the news - we know there is more out there. Please email me and tell me what's happening in your life or a fellow CCONS colleague's life.

Next deadline is July 15th.
Email-- Ann Cuvala
acuvala@aol.com
Our January CCONS meeting heightened awareness to the multicultural issues in oncology care. The speaker shared the experiences of her patient population in Arizona. The audience learned that cultural competency is important for our ability to attain optimal patient outcomes. Healthcare professionals are encouraged to explore ways to facilitate better communication with culturally diverse patients in an effort to achieve improved care.

I enjoyed reading the comments from our CCONS members in the CCONS Update winter issue. I plan to share this information with my nursing students. If you did not read your winter CCONS Update you have missed a wealth of information and resources to enhance your knowledge of cultural values, health beliefs and practices to the patient groups we serve.

A few weeks before attending the January CCONS meeting, I delivered similar information to a classroom of nursing students. As nurses we care for patients from diverse backgrounds. It is important to understand and provide care that is sensitive to these virtues. Cultural care nursing is the goal we need to strive for.

Cultural competency involves several steps, including (1) understanding your own heritage on the basis of cultural values, beliefs, attitudes, and practices relevant to health and illness, (2) identifying the meaning of health to the other person, keeping in mind that different groups may have differing definitions of health, (3) understanding the health care delivery system, (4) being knowledgeable about the social backgrounds of patients, and (5) being familiar with the language spoken by patients and the resources available to help with interpretation.

For ongoing information, please read the Transcultural Nursing Issues Special Interest Group Newsletter: http://onsopcontent.ons.org/Publications/SIGNewsletters/tni/tni18.3.html#story4

Also, check out the Oncology Nursing Forum (ONF) for interesting articles about transcultural nursing issues.

ONS Articles of Interest

- “Blending Voices of Mexican American Cancer Caregivers and Healthcare Providers to Improve Care,” by Carolyn Spence Cagle, PhD, RNC, and Elizabeth Wolff, RN, BSN (ONF, Vol. 36, pp. 555–562)
- “Breast Cancer in the Context of Intimate Partner Violence: A Qualitative Study,” by Erika Metzler Sawin, RN, MSN, Kathryn Laughon, RN, PhD, Barbara J. Parker, RN, PhD, FAAN, and Richard H. Steeves, RN, FNP, PhD, FAAN (ONF, Vol. 36, pp. 686–692)
- “Delay in Diagnostic Testing After Abnormal Mammography in Low-Income Women,” by Debra Wujcik, PhD, RN, AOCN®, Yu Shyr, PhD, Ming Li, PhD, Margaret F. Clayton, PhD, APRN-BG, Lee Ellington, PhD, Usha Menon, PhD, RN, and Kathi Mooney, PhD, RN (ONF, Vol. 36, pp. 709–715)

For access to the full-text versions of these and other ONF articles, visit the Publications area of the ONS Web site.
Healthcare reform in the US, a topic of discussion for decades, was officially signed into law March 23, 2010 with the passage of the Patient Protection and Affordable Health Care Act (PPACA). Despite the lack of bipartisan support in both the Senate and House, and complicated by the loss of the supermajority in the Senate with the election of Scott Brown, Senate and House Democrats worked to ensure that the healthcare reform agenda of the 111th Congress and Obama administration was achieved.

In the end, the House abandoned its own health reform bill, the Affordable Health Care for America Act, and instead passed the Senate’s version, the Patient Protection and Affordable Health Care Act. Using accepted, but controversial tactics, the House amended the PPACA with the Health Care and Education Reconciliation Act of 2010 that was then sent over to the Senate. The Senate passed this reconciliation bill, and returned it to the House for final passage, and the reconciliation bill was officially signed into law on March 30, 2010.

If you are still with me, I will continue. Not all aspects of the legislation will take place immediately. The plan for implementation stretches from now until 2018, with specific time frames established for enacting the key elements of the reforms. The established time frame will allow time to prepare for the different provisions of the legislation, but it will also take longer to appreciate the overall impact of the legislation on the individual and the government. The Congressional Budget Office (CBO) estimates the net effect (including the reconciliation act) will be a reduction in the federal deficit by $143 billion over the first decade. Of course the costs of these provisions will be offset by a variety of taxes, fees, and cost-saving measures.

The bill contains dates for when provisions will go into effect, some going into effect immediately, and others going into effect June 23, 2010 (90 days after enactment); September 23, 2010 (six months after enactment); and others through 2018. Interestingly, members of Congress and their staff will only be offered health care plans through the exchange or plans otherwise established by the bill instead of the Federal employees Health Benefits Program that they currently use. According to the CBO estimates, the number of uninsured residents will drop from current levels by 32 million people. This leaves 23 million residents who will still lack insurance in 2019 after the bill’s provisions have all taken effect.

Finally, organizations and lawmakers who opposed the passage of the bill threatened to take legal action against it upon its passage. The target of the threatened lawsuits were several key provisions of the bill. Opponents claimed that fining individuals for failing to buy insurance is not within the scope of Congress’s taxing powers. Less than an hour after the bill was signed into law on March 23, thirteen states filed a lawsuit in U.S. District court challenging the constitutional compact. There are some key provisions that are effective immediately upon enactment that are particularly interesting to oncology, including:

- The Food and Drug Administration is authorized to approve a generic version of biologic drugs and grant biologic manufacturers 12 years of exclusive use before generics are developed.
- The Medicaid drug rebate for brand name drugs is increased to 23% (except clotting factors and drugs for pediatric use which increases to 17%).
- Comparative Effectiveness research will be established through a non-profit Patient Centered Outcomes Research Institute
- Task forces will be established for Prevention Services and Community Preventive Services to develop, update, and disseminate evidence-based recommendations
- The Indian Health Care Improvement Act is reauthorized and amended.
- Examples of other key provisions and dates they take effect include:
  - June 21, 2010
    Adults with pre-existing conditions will be eligible to join a temporary high-risk pool, which will be superseded by the health care exchange in 2014.
  - September 23, 2010
    1. Dependent children will be permitted to remain on their parents’ insurance plan until their 26th birthday.
    2. Insurers are prohibited from discriminating against any individuals under the age of 19 based on pre-
existing medical conditions. A temporary credit program is established to encourage private investment in new therapies for disease treatment and prevention.

January 1, 2011
Insurers will be required to spend 85% of large-group and 80% of small-group plan premiums (with certain adjustments) on health care or to improve health-care quality, or return the difference to the customer as a rebate.

January 1, 2014
1. Insurers are prohibited from discriminating against or charging higher rates for any individuals based on pre-existing medical conditions.

2. Insurers are prohibited from establishing annual spending caps.

3. Offer tax credits to small businesses who have fewer than 25 employees and provide health care benefits for them.

4. Impose a $2000 per employee tax penalty on employers with over 50 employees who do not offer health insurance to their full-time workers (as amended by the reconciliation bill).

5. Chain restaurants and food vendors with 20+ or more locations are required to display caloric content of their foods on menus.

January 1, 2017
A state may apply to the Secretary of Health & Human Services for a waiver of certain sections in the law, such as the individual mandate provided that the state develops a detailed alternative that "will provide coverage that is at least as comprehensive" and "at least as affordable" for "at least a comparable number of its residents" as the waived provisions.

January 1, 2018
1. All existing health insurance plans must cover approved preventive care and checkups without co-payment.

2. A new 40% tax on high cost “Cadillac” insurance plans will be introduced.

In addition to health care reform legislation, at the state level, Illinois House Bill 5085 was introduced into the Illinois General Assembly by its chief sponsor Representative Greg Harris of Chicago. The legislation amends the State Employees Group Insurance Act of 1971 to include coverage for oral chemotherapy drugs such that "the treatment limitations applicable to such prescribed oral chemotherapy drugs is no more restrictive than the treatment limitations applied to intravenously administered or injected cancer medications and that there are no separate treatment limitations that are applicable only with respect to such prescribed orally administered cancer medications". In addition, the bill provides for coverage for cancer clinical trials that goes beyond the coverage that is provided for Medicare recipients. The bill has passed through the House and is now on its 3rd reading in the Senate and has been sent to the Senate Insurance Committee for final discussion. A coalition has been formed in support of House Bill 5085, including state chapters for the Susan G Komen organization, Leukemia and Lymphoma Society, American Cancer Society, and most recently the Oncology Nursing Society. You can follow the status of this legislation by going to the Illinois General Assembly web site and looking up House Bill 5085. There is good feeling that this state legislation will pass this year with your support and involvement. To ensure its final passage, please contact your state Representative and Senator to offer your support to HB 5085.

Feel free to contact Marnie McHale with any questions or comments at mcmarnie@aol.com or 773.620.7624.

APPLAUSE. APPLAUSE
CCONS MEMBER WINS MAJOR AWARD AT ONS CONGRESS 2010

Rita Wickham was honored at Opening Ceremonies in San Diego this year for her ongoing and extensive contributions to the nursing literature. The award was renamed this year to the Rose Mary Carroll-Johnson Distinguished Award for Consistent Contribution to the Nursing Literature. Just read our past 2 lead articles by Rita and you know why. We congratulate Rita on this prestigious award and are proud she is a member of CCONS.
Dear CCONS Members,
If you have not already heard this year is the CCONS's 30th Anniversary!!!

The 30th Anniversary Committee needs your help. For our celebration on June 16th we would like to have door prizes to raffle away to CCONS members. We would like to ask our membership to use their family and business connections to request these door prizes.

So if you know someone who works at a Chicago based business please ask them to donate a gift card, free tickets, or a basket of their products for our June 16th raffle.
Suggestions of possible give aways include:
- Cubs tickets
- Sox Tickets
- Theater tickets
- Entrance into a museum
- Carriage ride
- Restaurant gift cards from Uno’s or Fleming’s steak house or Shula’s
- Gift card from Garrett’s popcorn or American girls store

Any and all donations would be greatly appreciated!

Please bring your donations to a CCONS meeting or give to a Board member or call Dani (630-248-5546) or Paula (708-289-4772) for pick up!

Thanks for your help,
The 30th Anniversary Task Force Committee

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**Chicago Chapter Celebrates its 30th Anniversary-- A Special Campaign Fundraiser for the ONS Foundation.**

In honor of the 30th anniversary - the Chicago Chapter launched a special fundraising campaign to support the ONS Foundation. The campaign seeks to create awareness about the mission of the Foundation to improve cancer care by funding oncology nursing research and educational programs. Many of our chapter members have been recipients of this funding in the past.

The initiative for this campaign came from the leadership of our chapter to show our commitment for the Foundation’s mission. A special benefit for CCONS members is: anyone contributing a gift of $30 or more will also receive the same benefits of the "35 Reasons to Celebrate Campaign" of ONS and receive the special lapel pin.

Enclosed is this newsletter is a pledge sheet and return envelope to the Foundation for use. As a chapter, we have further pledged to match our members' contributions up to $3000.

We are hoping as you read this newsletter and take pride in CCONS you will help us attain 100% membership contribution. As we have learned, it is not the amount of the contribution that matters as much as each member contributing. We are a striving for that 100% mark.

Any questions please contact any member of the 30th Anniversary Task Force Committee and we do hope to see you at CCONS' 30th celebration meeting on June 16th at Marche Restaurant.

Committee Members: Bev Caraher, Dani Gale, Janet Golick, Paula Franson, Christa Lappin, Pam Nosse, Noreen O'Connor, Maryjo Osowski, Sandy Purl and Carol White
Imagine an oncology unit or outpatient clinic where the same team of nurses and physicians cares for oncology patients over the course of their illness. From the crisis of diagnosis to the relief of stable disease, from the disappointment of recurrence to the focus on symptom management and comfort at the end-of-life, the health care team collaborates instinctively to deliver excellent care.

Patient histories and disease trajectories are well-known to all, an accessible electronic record performs perfectly, and care is provided seamlessly, because all team members understand the goals of care and know their part in its delivery, sharing a common mental model. Patients and families revel in the holistic, patient-centered setting, and patient safety is ensured by impeccable team communication.

Nurses and physicians work side-by-side with ease, banter about the events of the day, know the names of each other's children, spouses and dogs, chat about the latest scores, and know each other well enough to inquire about favorite pastimes. When information or an order is needed, any nurse can pick up the phone without trepidation and call any physician for an immediate patient-centered solution. Communication is mutually respectful, emotions are in check, boundaries are understood, and the priority is patient care. Each member of the team respects the others' experience and competence.

If you are fortunate enough to work in such a place, then you are part of an organization that values communication and collaboration, and puts policies and strategies in place to foster good interdisciplinary relationships. But if your workplace interdisciplinary communication could use some improvement, consider some of the solutions offered below.

**Intentional Joint Rounding**

In a recent issue of the American Journal of Nursing, New Hampshire staff nurse and clinical nurse leader Kimberly Chapman reported on improved interdisciplinary communication stemming from the Transforming Care at the Bedside (TCAB) project at her hospital. Chapman describes intentional rounding (IR) as a bedside interaction engaging the nurse, the physician, and "including the patient as an active participant" (Chapman, p. 24). IR has evolved over time, according to Chapman, and now includes rolling a computer to the bedside to assure that all pertinent clinical information is available and allowing for more timely communication of test results and goals of care.

"...Making the effort to round together makes patients and families feel more comfortable knowing that their family member is being cared for by a cohesive team where teamwork is valued," Chapman said in an e-mail. "I have also learned that persistence pays off. Physicians who I used to have to chase down the hall after when they were rounding without me are now approaching me and asking if I can round with them...what a change!"

Physicians have reported fewer interruptions and phone calls and nurses on the unit have reported increased satisfaction as a result of intentional rounding. Chapman reports that these bedside communications have also been well received by patients, who appreciate the opportunity to witness interdisciplinary collaboration first-hand and to contribute to their own care in meaningful ways.

But IR is not a panacea, and time
constraints have proven to be one of the challenges to IR. "It is not abnormal for us to have multiple physicians rounding at the same time and often a physician comes to ask me round and I will already be with another physician," Chapman explains. "IR is now the standard of care for the hospitalist team. However, we are still struggling with the specialists. Generally speaking, the cardiologists and surgeons seem to be the most resistant to the change. None have voiced opposition to the initiative....(but) they are not in the practice of letting the nurse know when they are rounding on a patient. We continue to put effort in this area to show them how rounding with the nurse can make their job easier and improve patient satisfaction."

Other issues have also been identified, such as physicians who didn’t want to "bother" the nurse or physicians who believed that rounding with a nurse would take longer. But Chapman affirms the positive impact of intentional rounding on nurse-physician communication. "IR has changed the way we practice. It has increased collaboration, teamwork and I feel our patients are more satisfied knowing their nurse and physician are both on the same page," Chapman said.

**Results from an Appreciative Inquiry Initiative**

Appreciative inquiry (AI) represents an organizational development strategy which focuses on finding the existing good in an organization, rather than focusing on problems. This positive approach, using the model of "discovery, dream, design and destiny," intentionally appreciates what works well in a given setting. By valuing what is good, envisioning how this good could be leveraged, and designing the innovations to support sustaining good outcomes, AI offers a fresh approach to addressing challenges. Through the discovery of current best practice, and by dreaming about what the setting would be like if this best practice were the standard, the team is guided to design systems as they should be in the future to support best practice.

One unit used AI to enhance collaboration between nurses and physicians by conducting staff and physician guided interviews. In the physician interview, the team discovered that physicians valued nursing competence, appreciated being greeted by staff when they entered the unit, and preferred that nurses approach problems from a no-fault perspective, among other findings. The nursing staff interviews revealed a need for staff to welcome physicians to the unit, to introduce new nurses and patient care assistants to the physicians as part of the team, and to get to know the physicians better as people.

One of the strategies developed in response to the interviews included placing photographs of nursing staff members and physicians on the walls of the unit, resulting in each group becoming more familiar with the other. In addition, staff made it a practice to greet physicians when they entered the unit, wished them good morning and good evening, and became better acquainted with them. Patient satisfaction scores improved, and nurses reported feeling more respected following this process.

**Structured Communication Techniques**

Much has been written about the divergent communication skills of physicians and nurses that result from their professional training. A more descriptive style of communicating is generally attributed to nurses, while concise, fact-based communications are said to be favored by physicians. Structured communication techniques or standardized communication tools have gained popularity as a method to bridge this gap in communication preferences.

Examples of structured communication techniques include SBAR (Situation-Background-Assessment-Recommendation), ISBAR (adding "Identify" to the SBAR mnemonic), the Studer Group Communication Guidelines for Nurses, and STICC (Situation Task Intent Concern Calibrate). See the resources below for more information.

**General Suggestions for Improved Nurse-Physician Communication**

Additional strategies identified to improve nurse-physician communication include common sense solutions such as having pertinent patient information and the medical record available when interacting with the physician, presenting...
problem-focused concerns clearly with a suggested follow-up plan, limit setting, behaving professionally and not aggressively, and monitoring patient problems through resolution (Nazdam, 2009). In emergency situations, Lindeke and Sieckert (2005) emphasize the need to prioritize, stick to the germane issues and ensure currency of information.

More on Nurse-Physician Communication

Appreciative Inquiry

For more information on the Appreciative Inquiry project described above, see http://www.first-touch.org/pdf/RNMDCommunication.pdf

Joint Commission Guide to Improving Staff Communication

This document explores the role of communication as it relates to patient safety and the prevention of errors. Emphasis is placed on solutions to problems and development of a workplace culture that helps to support enhanced communication and patient care. Sample pages are available at http://www.jcrinc.com/common/Documents/SamplePages/GISC09_Sample_Pages.pdf

New York Times Blog


Professional Communication and Team Collaboration


http://www.ahrq.gov/qual/nurse-shdbk/ A chapter on professional communication and collaboration, which provides more detail on SBAR, the Studer Group Communication Guidelines and STICC is available at http://www.ahrq.gov/qual/nurse-shdbk/docs/O'DanielM_TWC.pdf

SBAR
SBAR communication tools are available for viewing at Safer HealthCare http://www.saferhealthcare.com/sbarsamples.pdf and at the Institute for Healthcare Improvement by registering at http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SBAR

SBAR Technique for Communication ASituationalBriefingModel.htm

TeamSTEPPS®

Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®) is a multi-media educational program for healthcare professionals developed at AHRQ and the Department of Defense. All materials are available at no cost, and can be downloaded from http://www.ahrq.gov/teamsteppstools/instructor/index.html

Transforming Care at the Bedside (TCAB)

TCAB is a national program coordinated by the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement which aims to improve care on medical-surgical units, to increase nurse retention, to engage patients and families in care and to improve the effectiveness of the health care team. For more information, see the Institute for Healthcare Improvement site at http://www.ihi.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm?TabId=1

References


Additional Reading

Books by Kathleen Bartholomew on communication skills for nurses include Speak Your Truth: Proven Strategies for Effective Nurse-Physician Communication and Stressed Out about Communication Skills
The U.S. Food and Drug Administration approved the use of cetuximab (Erbitux, manufactured by ImClone Systems, Inc.) March 1, 2006. Cetuximab is currently approved for use in combination with radiation therapy for patients with locally or regionally advanced squamous cell carcinoma of the head and neck and for the treatment of patients with recurrent or metastatic squamous cell carcinoma of the head and neck in which a platinum based therapy had failed.

Out of the Box
Mary Phelan Lappe

Infusion reactions, mucositis, and acne-form rash are among the most common adverse events reported. Of interest, interstitial lung disease occurred in 4 of 1570 patients in the clinical trial. With this in mind, our practice recently reported an adverse event of multiple pulmonary embolisms in one patient. To the best of our investigating and research, this was the first documented case of a pulmonary embolism while using cetuximab for treatment of a head and neck cancer patient.

Retrospectively, the patient’s clinical symptoms were very vague, mild fatigue after exertion or long distance ambulation, and were attributed by the clinical staff as very common for a patient undergoing such a grueling regime. The 49 year old patient had a performance status 0, did not smoke or drink, and reported no co-morbidities other than mild obesity. His profession was that of a school principal. The adverse event occurred at his home, eighteen days after his first cycle of cisplatin (100mg/m2) and weekly cetuximab with daily radiation therapy. The patient had received the loading dose of cetuximab the week prior to initiating Chemo/RT. He had therefore received, including the loading dose, a total of four cetuximab treatments. The adverse event was witnessed by his wife. She stated that her husband expressed a feeling of being very groggy and more sluggish than he did when ambulating. He then collapsed on the bathroom floor. He was taken via ambulance to their local hospital. A VQ scan was diagnostic for multiple pulmonary embolisms.

The outcome for the patient has been good. He has completed all his therapy, is radio graphically disease free, and currently remains on Lovenox injections.

What's in it for me??????

On April 21st, Dr. Joseph Feldman spoke on the topic of Lymphedema at Northwestern. The main reasons nursing colleagues attended this meeting were the topic, expertise of the speaker, location as well as interest in the chapter. Dr. Feldman provided a thorough review of the causes of lymphedema and management practices. He even brought along with him some of the wrappings and sleeves prescribed for patients with lymphedema.

Some of the "pearls" learned that night are: lymphedema can occur anytime even years later after surgery; even with sentinel node biopsy a patient can be at risk for lymphedema; there is no evidence for the use of diuretics for the treatment of lymphedema; obesity is an agreed upon risk factor; the importance of exercise; not to use ace bandages to wrap; and the importance of measuring and how to measure lymphedema. One statement in particular from Dr. Feldman stood out to explain why prevention was so important - "once the Genie is out of the bottle, it doesn't go back in".

The attendees felt that the presentation provided information to discuss with patients risk reduction strategies such as nail and skin care, and correct exercises for the arm. Also, to teach patients to actively seek guidance from certified lymphedema specialists for prevention strategies.

Hope to see you at the next CCONS meeting.
We are off to a great start this year. In March we met at Loyola's School of Medicine to hear Kathy Bonnefoi speak on surgery for breast cancer and Donna Krickl on radiation therapy. Both speakers provided informative updates for their specialties. Our next meeting was held at Northwestern's Robert Lurie Cancer Center. Dr. Feldman was our guest speaker and he addressed the topic of lymphedema. We had a great turn out with some new faces. Dr. Feldman gave us a good glimpse of the lifelong impact and treatment involved in managing lymphedema and he brought along many of the tools he uses with his patients.

Our next meeting was a joint meeting with the Chicago Western Suburbs Chapter. The topic was "The elephant in the room? A panel discussion on the health care reform bill and its impact on oncology practices, patients and nurses". The meeting was held May 5th at Elmhurst Memorial Center for Health/Immediate Care. There were 3 speakers: Carlton G. Brown PhD, RN, ACON; Chilakamarri Yeshwant, MD; and Sheila A. Haas, PhD, RN, FAAN. It was a meeting not to be missed and it was great collaborating with our neighboring chapter.

I would also like to wish all CCONS membership a Happy 30th Anniversary. On June 16th we will be celebrating CCONS' anniversary with Selenza Mitchell at Carnivale Restaurant in Chicago. The planning committee is busy putting together fun activities to make this anniversary even more special. RSVP is necessary.

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). As a reminder, please RSVP if planning on attending a meeting. RSVP to the e-mail or phone number supplied on the flyer by the deadline date. Again this will ensure we have adequate amounts of food and handouts. The members of the Program Committee welcome any suggestions for future speakers or programs. Please contact any of our members.

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.
With spring in the air we, the membership committee, are also doing some housekeeping! If you have received emails or letters from us we truly appreciate all of the responses you have sent back. We plan to have all our records cleaned up as we tie up the first of the year membership drive. CCONS membership is at a strong 130 members! Please remember to send us your address change if you move.

The research committee finally got together again to move along with our project on Hot Flashes. We started to review the additional articles that were found in the latest literature review. We will continue to work on these articles. We also will be pursuing the ONF research grant to cover expenses of producing the patient education materials once our project is complete. We also want to welcome Marcia Mickle as a new member. Our next meeting will be in June.

Leadership. Did you ever feel like you could make a difference, just not sure how? The leadership of CCONS welcomes all members to consider running for a leadership position within our chapter.

Not sure you're ready for a leadership position? There are many committees that are looking for new energetic ideas from YOU! This is a great way to get involved in the chapter and find out how much you have to offer.

The newsletter highlights all the committees - please reach out to a member of the committee or the chairperson to find out if a committee is right for you. Many meet via conference call, some in person. Whatever the means, it is a great way to network and build lasting nursing relationships.

You can make a difference to our chapter!

The results of the 2010 ONS election are in. - 4,100 plus members voted. The officers will begin their term of office at the close of the 35th Annual Congress in May, 2010.

Secretory: Julia Eggert
Directors-at-Large: Margaret Barton-Burke and Mary Pat Johnston
Nominating: Patricia Buchsel and Linda Person

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.

Please continue to send us news, events, photos, and job opportunities to post!
Honor Someone Special Approaches Milestone for First Anniversary
It’s hard to believe that only a year ago at the ONS Congress in San Antonio, ONS proudly introduced the Honor Someone Special recognition campaign. This unique program was created so that nurses, patients, and their families could recognize those special oncology nurses who make a difference in the lives of the patients they care for. The Honor Someone Special website recently posted its 900th nomination and we’d love to reach the 1,000th nomination by the first anniversary! Please help us to promote Honor Someone Special by encouraging your members to nominate a nurse today. It’s easy and only takes a few minutes. Visit Honor Someone Special to nominate a deserving nurse and if your nomination is the 1,000th, we’ll post this milestone nomination on our HSS home page for all to see!

Grants Available for Chapter Projects
Do you have an idea for a chapter project related to certification? Consider applying for an ONCC chapter grant. In 2010, ONCC will award up to five grants, totaling up to $5000 combined, for chapter projects to encourage, support or recognize certification of oncology nurses. Preference will be given to proposals for projects or activities that are innovative; that can be repeated or sustained over time; and to projects for which the chapter is providing matching funds. These grants are available to chapters of the Oncology Nursing Society (ONS) and the Association of Pediatric Hematology Oncology Nurses (APHON). Applications must be submitted online and are available at http://www.oncc.org/awards/chapter.shtml.

Nurses Due to Renew in 2010 Could Win Free Renewal for Life
In 2010, candidates who will be renewing their certification by Option 1 (Practice hours + Oncology Nursing Certification Points Renewal Option, or ONC-PRO) will be entered to win a lifetime of free certification renewal if their application and ONC-PRO logs are received by June 15, 2010. Five candidates will be selected from all complete renewal applications received between January 1 and June 15 to win a lifetime of free certification renewals by Option 1. Encourage your chapter colleagues to apply now - they could be among the winners! Learn more about certification renewal at http://www.oncc.org/renewal/.

Applications Due July 7 for Last Certification Tests of the Year
The last OCN®, CBCN® and CPHONTM Tests of the year will be offered November 1-30. Applications received by July 7 will save $100 on the fee. (All applications for the November tests must be received by July 21, with the full, non-discounted fee.) Test information can be found at http://www.oncc.org/getcertified/TestInformation/index.shtml.

Nurses who are interested in taking the AOCNP® or AOCNS® Test in 2010 should apply by September 1 to ensure a full 90-day testing window in 2010. Applications will be accepted after September 1, but candidates may not have a full 90-day window in which to test before the end of 2010. Information about AOCNP® and AOCNS® Tests is available at http://www.oncc.org/getcertified/TestInformation/index.shtml.

Congratulations to the Cleveland and Chicago Chapters who are celebrating 30 years.
### Chicago Chapter ONS

(meetings held 3rd Wednesday of most months)

CONTACT: Katharine Szubski  
kszubski@oncmed.net

**June 16, 2010**  
30th Anniversary Celebration  
Selenza Mitchell, RN  
The Art of Exceptional Professional Performance  
Carnivale Restaurant  
702 W. Fulton Market, Chicago  
**rsvp required**

**September 15, 2010**  
Round Table Discussions  
Loyola Stritch School of Medicine, Maywood  
Classroom 170 - 1st Floor  
**rsvp required**

### Northern Fox Valley Chapter ONS

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

CONTACT: Carol Pfeifer  
carol.pfeifer@stalexius.net

**May 18, 2010**  
Lisa Downs, RN  
Case Studies in the Proactive Management of Indolent Mantle Cell Lymphomas  
Biaggi’s Restaurant Italiano  
**rsvp required**

**June 15, 2010**  
Donna Dettman  
Bend in the Road  
Good Shepherd Fitness Center, Barrington  
**rsvp requested**

**July 20, 2010**  
Annual Vendor Fair  
Andrea Krzysko, RN  
Symptom Clusters  
Cotillion Restaurant, Palatine  
**rsvp required**

**August 17, 2010**  
TBA

### Chicago Western Suburbs Chapter ONS

(meetings held quarterly)

CONTACT: Denise Lapka  
Lapka.denise@gene.com

**May 5, 2010**  
Joint meeting with Chicago Chapter  
The Elephant in the room…Health care reform bill  
Elmhurst Memorial Center  
**rsvp required**

**Sept 1, 2010**  
Kristi Orbaugh, RN  
Hematologic Malignancies  
Edward Cancer Center - E 305, Naperville  
**rsvp required**

### Northwest Indiana Chapter ONS

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

CONTACT: Patty Robinson  
Crash7970@yahoo.com

**August 23, 2010**  
TBA
Where are you currently working and in what capacity?
I currently work as a Clinical Science Liaison for Centocor OrthoBiotech, a Johnson & Johnson Company.

What person(s) or event(s) directed you toward Oncology Nursing?
Honestly, there is no particular person or event that directed me towards Oncology Nursing, it was just my curiosity about this therapeutic area that sparked my interest- it was unfamiliar to me and I simply just wanted to explore it!

Tell us about an accomplishment you are particularly pleased about:
I set a goal for myself while an undergrad in college to obtain my Master's Degree in Nursing by the age of 30 years. Well in 2007, I was able to do just that prior to my 30 birthday!!

Is there a secret area of interest that you would like to pursue someday?
I have always been intrigued by law, so I would definitely have to say that probably being a criminal defense lawyer is and will always be a passion of mine. And according to my husband, I like to argue anyway so this is what I’d pursue in another life!!

Is there one bit of Wisdom that stays with you and directs your course?
I love quotes, and one quote that always helps me to stay focused is a Chinese Proverb: "Tell me and I’ll forget; show me and I may remember; involve me and I’ll understand." Being involved helps me stay on task because I am a diverse learner but I need hands on in order to get it- I must leave my footprints on anything that I am involved in.

Talk about someone who has touched your Heart and why:
There are so many people who have touched my heart but one person that stands out in my mind is one of my former patients, I will refer to her as Ms. A. Ms. A. had family; however her family was not involved in her life and she would always tell me about how she did not feel loved and cared for by her daughters. This weighed very heavily on my heart because Ms. A. was 70+ years of age and was like a Grandmother to me, one in which I did not have, so she and I developed a very close bond to one another.

I assumed a role in her life as an "adoptive granddaughter" and scheduled all of her MD appointments no matter if they were oncology related or not, ensured all of her prescriptions were filled. You name it, whatever she needed, I was there. We even exchanged home numbers and chatted with each other often. Ms. A did eventually die; however she made an everlasting impression on me because this experience taught me two very valuable lessons. The first lesson, was that family does not always have to be a blood relative, and second, family is extremely important. So love them and appreciate them every day because you will never know which day will be your last day on earth.

Who in your world is most proud of you?
I would have to say my Mom, because she tells me this all of the time; however, I also have a cheerleader in my corner who is always cheering me on and that is my son also known as my Motivation!!

What would you like to tell Nurses who are interested in working in Oncology?

The Multi-Faceted Oncology Nurse
Oncology nursing is such a rewarding career and there are so many opportunities in this specialty area that you will have to just try this field first to enjoy the ride and then let the exploring begin!!

What is something that helps you to relax and unwind?
A spa day in which I am scheduled to receive the works from head to toe!!

What is your idea of a perfect vacation?
Somewhere peaceful and serene in which I can bring my entire family together to reminisce about the old days and bring in new memories with them.

If you could pick anyone in the world to have dinner with, who would you select, why, and where would you go?
I will have to say, Oprah Winfrey. She and I can dine at her house whichever one she chooses. I would love to pick her brain about the keys to her success in life, and learn from her how she overcame obstacles.

What is the lasting impression you hope to make on others?
That it is always better to give than to receive. Some people say that I am too kind-hearted but I question that statement because as Winston Churchill once stated, *We make a living by what we get, but we make a life by what we give.*

Hello CCONS members,

Well, we are off to a great start this year! We have already started to meet some of our strategic goals and I want to say thank all of you who are working so diligently to make that happen! Our membership is increasing through the dedication of our Membership Co-Chairs Christa Lappin and Beth Hurter. Maggie Smith is also working with them to reach out to our non-renewals via phone and try to re-establish that commitment to CCONS. Our program committee is going above and beyond more than they normally do, being led by Katharine Szubski. They are making sure the programming needs of our chapter are met, while introducing some new ideas for programming. Our chapter is planning a very special celebration in honor of our Chapter’s 30th Anniversary. This effort is being headed by Sandy Purl and Dani Gale. Sandy is just a little over programmed as she is President-Elect, Newsletter Co-Chair, Nominating Co-Chair and on countless committees! Dani is also putting in double duty as she is coordinating our Community Outreach programs for this year. Please read about her efforts in her Director-at Large report. Our Director-at-large Ima Garcia is going to coordinate our Award and Scholarship program this year, so start looking in the coming months for some great opportunities to benefit from your CCONS membership.

Our treasurer has also been working very hard to get our financial life all in order. While so many chapters have had dwindling funds CCONS has been fortunate, for many reasons, to have money in the bank! The Board will also be working with Christa to develop our volunteer base throughout this year.

Don’t be surprised if you get a call asking to contribute your talents and gifts to CCONS in an opportunity that may be right for you! I will address the Strategic Plan progress in my next letter, so everyone has an idea of how we are meeting the goals we have set for ourselves.

On a personal note, I was married on Feb. 13, 2010 to an amazing man, Christopher Gaston. I have had my last name officially changed to Gaston and this will be the first time I will sign my married name for CCONS. Thank you to everyone who has offered their support, understanding and happy wishes during this crazy, hectic and wonderful transition in my life.

Lisa C. Gaston, MS, APN, AOCNP
sctapn@gmail.com
DIRECTOR AT LARGE REPORT

Christa Lappin

With spring thinking about arriving (and maybe staying!) I find myself surprised that 2010 is 3 months in already. The goal of my Director At Large position, bringing nurses into our organization, has been progressing. To date membership is strong at 127 active members but the goal of reaching out to younger nurses remains.

I have spoke with our APHON colleagues and we have committed to collaborating on an adult & pediatric oncology presentation for nursing schools in hopes to plant a seed for oncology early. Given the many nursing schools within the Chicagoland area, we have a unique opportunity to accomplish this goal, I am excited to get out and meet the students.

As we are out planting the seeds in our gardens this spring, I hope to be planting the love of oncology into our youth. Happy planting!

DIRECTOR AT LARGE REPORT

COMMUNITY SERVICE PROJECT

Dani Gale

CCCONS Community Service Task Force Project

This year the CCONS community service task force has met via a series of teleconferences. This "new" meeting method has proved to be a great way to meet without long meetings after work! We decided to do several projects this year instead of only one.

First, we will be working with the "Sisters Network", a national African-American breast cancer survivorship organization. There are several chapters in Chicago-land. Maggie Smith has been our contact with the organization as she had worked with them in the past. They have asked us to provide speakers on several topics.

The first topic was Lymphedema and it was presented on Saturday April 17th in Chicago and Thursday April 21st in Homewood. Barbara Fuller a Physical Therapist who specializes in Lymphedema and a breast cancer survivor presented at both meetings. Maggie Smith was the CCONS member who introduced her and represented CCONS to the Sisters Network on April 17th and Dani Gale did the same for the April 21st meeting. We have also been asked to provide a speaker on Herceptin/Tamoxifen/Femara and Christa Lappin has agreed to present on that topic. The dates will be determined soon.

The second project will involve working with the Jack Marston Melanoma Fund to provide education and help with skin cancer screenings. The dates and times will be determined soon. Look for an email blast requesting help staffing the screening. Any member can help and will be welcome. Last fall a few volunteers brought their children to help meet community service hours required by the school for graduation.

A big thanks to all the members of this group including Laurel Barbour, Paula Franson, Margaret Hanson, Mary Lappe, Christa Lappin, Pam Nosse, Marge Pierce, Terri Sims, Sandy Purl, Maggie Smith, & Mary Ellyn Witt. New members are always welcome.

If you would like to help out, please contact Dani Gale via email -- danielle.gale@mpi.com. Thanks again to all the wonderful task force members.

Barbara Fuller (Center), Physical Therapist, gathers with members of the Sisters Network at the April 17th Meeting
It's time to start thinking about scholarships and awards for 2010. Please consider nominating yourself or a colleague for one of the numerous awards our chapter sponsors. All CCONS award applications are due September 1, 2010 and are available on the virtual community. Awards include Certification Reimbursement, Career Development Awards, Nursing Education Scholarships, Undergraduate Education Scholarship, and Spirit of CCONS. Also please check ONS national website for other awards and grants that you may be eligible for.

Deadlines are quickly approaching.

If you don't apply, you can't win!!

Any questions on the awards, please contact Ima Garcia ima_garcia@hotmail.com

WALK...RUN...FUNDRAISE...DONATE

Jim Gibbons 5K Traffic Jam sponsored by the Leukemia Research Foundation and ABC Channel.

Carol's Team of Hope
Thursday, June 17th (on the Lakefront) is your opportunity to walk or run for leukemia research. I will again be fielding a team and encourage everyone to consider joining. The 5K run is a CARA sponsored event for all you runners and the 3K walk is kicked off with a "survivors' strut." It is a very moving moment for participants.

Below I will list the ways to become involved—-but if it seems too complicated, just contact me at cwhitern1@sbcglobal.net. Last year we raised over $1600. However, you DO NOT have to fundraise to join the team.

Registration: www.5Ktrafficjam.com (you can also join the team without fundraising from this site). This takes you to the Zap event website which is the official sign up for the race

FUNdraising: After registration anyone who wants to be a fundraising member of the team needs to sign up for a fundraising page at http://www.firstgiving.com/lrf

Donations: If you can't walk or run and wish to donate, contact me through my e-mail address.
EDITOR’S MESSAGE

CCONS Celebrates 30 Years
1980-2010

This May, CCONS marks a celebration of 30 years as the first local chapter of the Oncology Nursing Society organization. No matter how long each of us has been involved, either locally with the Chicago chapter or perhaps another local chapter and/or nationally with ONS, we can reflect with pride on all that we have achieved. Perhaps, our greatest accomplishment is being the first local chapter, one that has thrived for 30 years.

It has taken many volunteers and leaders to keep CCONS successful. Over the past years, countless volunteers have contributed in both large and small ways. I am struck by the incredible work our chapter has done from sponsoring scholarships for members and students to advance their education; positive community interactions such as participation in Y-ME, Lymphoma and Melanoma fundraising; providing CE’s at monthly educational meetings; to nominating countless members for local and national awards.

In the next decade we need to focus in particular on the upcoming generation of oncology nurses. We need to find ways to excite them about involvement in CCONS. This will be how we grow stronger as an organization and survive and thrive for years to come.

As CCONS celebrates its 30 year milestone, I hope you will join the Board and Committee Members in reflecting on what CCONS means to YOU and how YOU may become an active participant.

ASK YOURSELF - Where do I want to be in 5 years (in terms of CCONS)

HOW DO I GET THERE?? - Through local chapter involvement

WHO DO I CONTACT? -- CCONS past Board and Committee Chairs
Past Presidents
Those currently in office

Thanks for all YOU have done and promise to do!!
Happy 30th Anniversary Chicago!!

Sandy
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.

Oncology Nursing Month is scheduled in May. 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: Send us pictures of ways you celebrated in your practice.

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**NOMINATING CO-CHAIRS**
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www.ccons.vc.ons.org
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
after November 1st will be members as of the following year.

THE CCONS NEWSLETTER
P.O. BOX 11073
CHICAGO, ILLINOIS 60611