Lung Cancer in Delaware: Nurses Serving Together

Since 2015 the challenge was to develop and implement a statewide lung cancer screening program based on the United States Preventive Task Force (USPSTF) recommendations. Delaware’s citizens continue to be impacted by lung cancer. The recent incidence and mortality report shows little change for men and women. This edition of the DNA Reporter was the idea of several oncology nurses who have watched this disease take many loved ones, from our family and friends. Because of the importance and the many aspects of lung health and cancer, oncology nurses took action and coordinated DNA’s efforts.

The Role of Smoking Cessation

Trina M. Turner, MSN, RN-BC, LNC

DNA is a nurse advocacy organization. Its legislative mission is to strengthen the voice of nursing through legislative activities and to establish working and collaborative relationships with legislators and key stakeholders. Throughout the summer, DNA has been busy working to support this mission by attending events that provide information on pending healthcare and nursing issues as well as bring visibility to the association. DNA attended: ANA Membership Assembly; bill signings for House Bill 58 – Delaware Nursing Incentive Program and House Bill 79 – Default Beverages in Children’s Meals in Restaurants, Future of Nursing Townhall Meeting, ANA Lobbyist Meeting, DHSS Drug Overdose Mortality Survey Report meeting, and Senator Coons’ Addressing Delaware’s Opioid Crisis event.

Information sharing from these events as well as determining the DNA legislative agenda are done at the DNA Advocacy Committee meetings. Advocacy is about getting involved, sharing expertise, and engaging stakeholders to make a change in bettering a position or improving a situation. The word ‘advocacy’ comes from the Latin ‘advocare’ and literally means to call out for support. DNA calls out to all its members to get involved in this important work.

The Advocacy Committee meetings are open to all DNA members and welcome the sharing of ideas and expertise. Meetings are generally held the third Monday of the month in the DNA office. Though the General Assembly is not in session until January, there is still work to be done in planning the DNA legislative agenda and events. One event that is in the works is a DNA bus trip to Washington DC to attend the ANA Hill Day. This is a great opportunity to meet nurses from around the country and to join them in bringing the nursing voice to our nation’s Capitol. This event will take place in the middle of June 2020. The final date has yet to be announced by ANA. Please be sure to check the DNA website for meeting and event dates.

Finally, DNA has worked with Delaware Today magazine to improve the Top Nurse program. Explanation of the voting process, category descriptions, and voting can be done on the DNA website. If you have any questions or comments, please send them to contactdna@denurses.org. This program is not limited to DNA members and is also open to licensed practical nurses. Please take a few minutes to vote for a nurse colleague that represents excellence in nursing.

Guest Editor continued on page 2

Nora C. Katurakes, MSN, RN, OCN®

Nora Katurakes earned her BSN from the University of Delaware and her MSN from the University of Texas Health Science Center – Houston. She is a Certified Oncology Nurse. Nora worked as the manager of the Community Health Outreach and Education Program at the Helen F. Graham Cancer Center & Research Institute, Christiana Care Health System for over 20 years. Previously has worked in oncology at MD Anderson, National Institutes of Health, Visiting Nurse Association and Salick HealthCare. She is currently a manager for the Community Health Outreach and Education program at Christiana Care and serves on the Practice Council. She is involved in community work including Co-chair of the Wilmington Health Planning Council, member of the Early Detection and Prevention Committee for the Delaware Cancer Consortium and member of the American Cancer Society Leadership Council. Nora can be reached by email at nkaturakes@christianacare.org or her office at (302) 623-4628.
I will be brief to conserve space for this condensed edition of the Reporter. My thanks to our editors and all of our contributors.

This is a reminder of our redoubled efforts to increase DNA’s focus upon advocacy. Please be on the look-out for some new and interesting endeavors and initiatives that our Advocacy Committee has in store for you this fall and into the coming year.

A heartfelt thank you to the folks at Delaware Today magazine for working with DNA to improve the selection and recognition of Delaware’s top nurses. We expect that the planned changes will greatly improve this program. When the time comes please participate by nominating your favorite top nurse!

Congratulations to Penny Short, RN on her ascension to President of Nanticoke Hospital. It is quite impressive to see an RN in this position in one of Delaware’s seven acute-care hospitals.

Lastly, I encourage all of you to consider becoming more active in DNA. Opportunities abound for participation especially in the areas of advocacy and educational programs. As with any volunteer organization, participation waxes and wanes but the key to sustainability is a constant influx of new people with new ideas! Please come to the meetings and programs and please encourage your colleagues to join. We are all stronger together!

Thank you.

Gary W. Alderson

Guest Editor continued from page 1

this edition to share with other nurses. They intentionally wanted this to be a themed edition during November which is traditionally Lung Cancer Awareness Month. This theme was meant to draw attention during Lung Cancer Awareness Month and to highlight the expertise of the statewide nurse advocates who are delivering care across the lung health and cancer continuum. By sharing information in the areas of prevention, lung screening, care management, treatment, clinical trials and nurse navigation we will inform and educate our nurses statewide and bring more awareness to this cancer. Included in this edition are resources for access to programs such as the Delaware Quitline for smoking cessation, the Lung cancer screening programs statewide, the Screening for Life Program, the Delaware Cancer Treatment program, how to find clinical trials and the emerging role of immunotherapy. A dynamic speaker at a recent conference stated that if Delaware were to focus on the 30% mortality from lung cancer deaths it would impact the overall cancer ranking and further drop Delaware’s position in the rankings. As I began my career here in Delaware, we ranked third in the nation for cancer deaths. In twenty years, Delaware has dropped to 16 and recently to 18. Can you imagine a community with no lung cancer? Or more individuals who are living cured of lung cancer because it was found early? Or where new treatments like immunotherapy made a difference and clinical trials advanced the treatment for lung cancer? I hope that this edition energizes you to use this information for your family, friends and in your workplace. Let’s change the face of Lung Cancer in Delaware. It is time to end lung cancer. I have heard it said…if any state can do it… Delaware can.

Did you know the DNA Reporter goes to all registered nurses in Delaware for free?

Arthur L. Davis Publishing does a great job of contacting advertisers, who support the publication of our newsletter. Without Arthur L. Davis Publishing and advertising support, DNA would not be able to provide the newsletter to all the nurses in Delaware.

Now that you know that, did you know receiving the DNA Reporter does not automatically provide membership to the Delaware Nurses Association?

DNA needs you! The Delaware Nurses Association works for the nursing profession as a whole in Delaware. Without the financial and volunteer support of our members, our work would not be possible. Even if you cannot give your time, your membership dollars work for you and members of the profession both at the state and national levels. The DNA works hard to bring the voice of nursing to Legislative Hall, advocate for the profession on regulatory committees, protect the nurse practice act, and provide educational programs that support your required continuing nursing education.

At the national level, the American Nurses Association (ANA) advocates and educates about the nursing profession to national legislators/regulators, supports continuing education and provides a unified nationwide network for the voice of nurses.

Now is the time! Now is the time to join your state nurses association! Visit www.denurses.org to join or call (302) 733-5880.
DNA in Action

ANA Membership Assembly

Future of Nursing Town Hall Meeting

House Bill 79 Signing

2019 Membership Assembly
American Nurses Association

13-07

Drug Overdose Mortality Surveillance Report
Delaware 2017

Delaware Health and Social Services
Division of Public Health
and above all – did the patient understand what might be required to manage them and the patient’s false positive and negative findings) and methods that the patient, in their own words, might be found by the scan (including development of lung cancer, what this test entails, and the patient’s perspective can be an issue. Evidence from the National Lung Screening Trial (NSLT) showed that a low-dose chest CT (LDCT) performed annually among high-risk patients for lung cancer screening found lung cancer earlier and resulted in a 20% reduction in mortality secondary to lung cancer. High-risk has been defined as patients aged 55-74 years, current or former smokers who quit within 15 years and has a 30+ pack-year history of smoking who are asymptomatic (Aberle et al., 2011).

Shared decision making is defined as a thorough discussion of benefits and harms that should happen between a physician/nurse practitioner and their patients with regards to any test or procedure. In the case of the Lung Screening CT scan, some discussion items should include the patient’s level of risk for the development of lung cancer, what this test entails, an explanation of the options if the scan is not done, pros and cons of what might be found by the scan (including false positive and negative findings) and methods that might be required to manage them and the patient’s willingness to undergo additional scans and treatments and above all – did the patient understand what was discussed? This is so important that the Centers for Medicare and Medicaid Services (CMS) now requires documentation of this decision-making discussion and is willing to pay for a separate appointment for this payment to take place. Additionally, clinicians should query the patient on smoking cessation if they are current smokers and have information available on support systems for quitting (cms.gov/Medicare-coverage-database). If this is what is being questioned, it is the Medicare website for payment coverage. All of this information must be documented in the patient record for CMS to cover the cost of the scans. While this is not mandatory for other insurers at this time, it may come – so it is best practice to make sure this documentation is completed on all patients’ records before the order is written.

While shared decision making is fundamentally a communication activity involving clinicians and patients, decision making tools alone are not sufficient to ensure the process progresses appropriately. There are many caregivers who state that there are barriers to discussing LDCT for screening that include competing health issues of the patient, discussions taking up too much time, and the patient’s literacy levels along with a lack of decision making aids.

Patient support tools should be created in multiple formats and used to add to the decision making discussion. The Agency for Healthcare Research and Quality (AHRQ) has developed many tools that patients and their families can access to initiate conversations with their caregivers or to update themselves on the how and why this scan should be done. Among the tools are: “Is Lung Screening Right for Me? A Patient Tool.” “Is Lung Screening Right for Me? A Healthcare Professional Tool.” “Lung Cancer Screening: A Summary Guide for Primary CarePhysicians,” and “Lung Cancer Screening: A Guide to Screening for Lung Cancer.” Once these issues are discussed, a written order for LDCT lung cancer screening must be given to the patient or electronically sent for scheduling.

But where do we as nurses fit into this scenario? Whether nurses see these patients in the navigation role, as a bedside or chairside caregiver, from the doctor’s offices to in-patient hospital care, the nursing role has always been one of bridging the gap between patient and physician. Nurses in general, and oncology nurses specifically, have always been in the position to hear what patients and families are saying – especially since many patients still feel that they “don't want to tie up the doctors time with questions.” Nurses have allowed patients to verbalize their needs and concerns and validate what is being communicated. They can then reflect back to the patient the need to communicate with the entire healthcare team to better facilitate understanding and shared decision making. Nurses can provide information to patients and family members. Nurses can ensure patients and family members understand the information provided. But most importantly, nurses can assist patients in the discussion of testing with their physicians.

What nurses need to know about payment of the testing is that CMS (Medicare) pays for the testing as long as the patient meets criteria and State Medicaid programs are not required to cover the cost of screening or offer only partial payment (UPI, Health News, 2019). In the state of Delaware, the Lung Screening CT is covered by Medicaid under the Department of Health’s (DPH) Screening for Life program. ‘All Delawareans, especially current or former smokers, should talk to their healthcare providers about getting low-dose CT scans, said DHSS Secretary Dr. Kara Odom Walker (news.delaware.gov/2019). For more information regarding the cancer prevention and control program, visit https://www.dhss.delaware.gov/dhss/dph/cancer.htm or (news.delaware.gov/2019/04/17/dph-urges-delawarans-at-high-risk-of-lung-cancer-or-offer-only-partial-payment). It is difficult to keep up with all programs’ information. Encourage your patient to discuss with the physicians’ office staff for pre-certifying coverage before scheduling the scan and/or have the patient call their insurance company directly to determine coverage.

References
Tobacco use plays a significant role in the number of newly diagnosed lung cancer cases. Smoking and tobacco use have been deemed the leading cause of lung cancer (American Lung Association [ALA], 2018). In the state of Delaware, the smoking rate is currently 17.4 percent, which is slightly higher than the national average of 16.8 percent. Having the ability to quit using tobacco products is vital to the overall health of the community. Tobacco use affects every major body system (i.e., cardiovascular, pulmonary, and renal); however, tobacco cessation is imperative to reduce the risk of developing cancer.

Research has shown that while smoking and tobacco use quit rates and quit attempt rates are relatively high shortly after a cancer diagnosis, the relapse rates are also high (Karam-Hage, Cinciripini, & Gritz, 2014). Among cancer patients and survivors, it is essential for healthcare providers to screen, treat, and prevent the patients from returning to tobacco use. Over the years, research has proven that when used in combination, pharmacologic and behavioral interventions achieve the highest smoking cessation rates. With a recent emphasis on individualized treatment as the most promising approach (Karam-Hage, et al., 2014). Among health care systems, challenges exist that have slowed significantly the process in getting patients screened for tobacco cessation. Some of the issues include, but are not limited to: the lack of appropriate training, the resources needed to develop, sustain, and achieve a deliverable program that meets the needs of the community. It is recommended that when oncology providers are screening their patients for tobacco use, the patient should be referred to specialized treatment programs, such as those who provide integrated smoking cessation services (Karam-Hage, et al., 2014). Quit line providers may take the training to support tobacco cessation services (Fucito et al., 2016). Tobacco use and cessation for cancer survivors: Ann overview for clinicians. CA: A Cancer Journal for Clinicians, 64(4), 272–290. doi:10.3322/caac.21231

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Trina M. Turner
Trina M. Turner earned her BSN and MSN (with a concentration in Adult Gerontology Nurse Practitioner) from Wilmington University in New Castle, Delaware. She is a board-certified Progressive Care Nurse who has worked in critical care, interventional radiology, and ambulatory surgery as a circulating nurse and nursing supervisor for 25 years. She is currently a lung and colorectal nurse navigator at Bayhealth Medical Center, Kent and Sussex Campuses. Working with patients to educate, provide community outreach, and assist with lung and colorectal screenings. Part of her position is in collaboration with the Delaware Department of Health and Social Services, providing patients with resources such as Screening for Life, a program that offers uninsured or underinsured patients free or low cost health screenings. Additionally, she has created Delaware’s “Tobacco Cessation Face-to-Face Coach with the Delaware Quit Line. Trina is a member of Bayhealth’s Community Outreach Task Force and a member of the Sussex County Health Coalition, and the IMPACT Delaware Tobacco Prevention Coalition. Trina can be reached by email at Trina_Turner@Bayhealth.org or at her office at (302) 744-6831.
The FDA does not regulate the content of the “e-juices,” so not everyone is aware that there is nicotine in most e-cigarettes in varying amounts. Some people contain as much nicotine as one pack of cigarettes (Truth Initiative, 2019). The sleek shapes and appealing flavors make e-cigarettes attractive to younger consumers, and strawberry have made e-cigarettes especially enticing to youth.

Youth use of cigarettes has surpassed youth use of regular combustible cigarettes in Delaware. According to the 2017 Delaware Youth Risk Behavior Survey (YRBS) of public high school students conducted by University of Delaware on behalf of Delaware Health and Social Services, 13.6 percent of students had used e-cigarettes in the past month. This is an increase from the percent smoked regular combustible cigarettes. Approximately 38 percent of Delaware high school students reported ever trying an electronic vapor product (University of Delaware, n.d.). Although e-cigarettes don’t contain all of the chemicals as cigarettes, there are still health risks from using them especially for youth. According to CDC (2018), e-cigarettes risks include the following:

- Nicotine is highly addictive, and can harm adolescent brain development, which continues into the early to mid-20s.
- E-cigarettes can contain other harmful substances besides nicotine.
- Many young people who use e-cigarettes also smoke cigarettes. There is some evidence that young people who use e-cigarettes may be more likely to smoke cigarettes in the future.
- Some of the ingredients in e-cigarette aerosol could also be harmful to the lungs in the long-term. For example, some e-cigarette flavorings may be safe to eat but not to inhale because the gut can process more substances than the lungs.
- Defective e-cigarette batteries have caused fires and explosions, some of which have resulted in serious injuries.

Experimentation with e-cigarettes is also catching on with adults. According to the 2017 Behavior Risk Factor Survey (BRFS) conducted by Delaware Health and Social Services, 4.8 percent of Delaware adults currently use e-cigarettes, roughly the same reported in the 2016 survey. However, within the adult demographic, 12.7 percent of 18-24-year-old adults and 21.3 percent of males, ages 18-24 are ‘current users’ of e-cigarettes (Delaware Health and Social Services, n.d.).

Health care providers can screen for tobacco use and advise patients to quit if they do use tobacco products. Providers can refer tobacco users 18 years and older to the Delaware Quitline (1-866-409-1858) for free help in quitting tobacco products. For providers that participate in the Quitline fax referral program, with patient consent, the Quitline will call patients directly. For patients under 18 years, providers should educate them on the dangers of tobacco use, especially e-cigarettes. According to the United States Department of Health and Human Services (2019), teenagers are more likely to get information on health issues from their parents than from peers through the internet, or social media. Tobacco users under 18 years can be referred to the American Lung Association in Delaware to connect them with a student wellness center that has staff trained in Not on Tobacco (NOT). There is also a national text campaign by the TRUTH Initiative to help teens quit e-cigarettes called “This is Quitting.”

Delaware has taken a comprehensive approach in combating e-cigarette use as well as tobacco use in general. Tobacco use is still the leading preventable cause of death in Delaware and the United States. Since 95% of adult smokers begin smoking before they turn 21, one of the steps that Delaware took was to raise the age to purchase tobacco products from 18 years to 21 years. This law took effect in July 2019. Other policies that have shown to reduce tobacco use initiation and prevalence are increases to tobacco excise taxes. The Division of Public Health conducted focus groups with youths and used their input to develop multi-media campaigns on e-cigarettes. Delaware Kick Butts Generation and Delawareans Against Nicotine and Tobacco Exposure (a youth led and young adult led groups) educate their peers on the hazards of e-cigarettes and other tobacco products.

There are several resources that can be used to learn more about the Delaware Tobacco Prevention and Control Program

https://www.dhss.delaware.gov/dhss/dph/dpc/Tobacco2017brfs.html

The Dirty Truth

http://www.thedirtytruth.com/

Health Delaware

https://www.healthycdhss.delaware.gov/Healthcare-Providers/Tobacco-Cessation

Suicide Prevention Health Care Professional E-cigarette Guide

https://e-cigarettes.surgeongeneral.gov/documents/SGR_E-Cig_Helping Care PROVIDER_Card.pdf

Centers for Disease Control and Prevention

https://www.cdc.gov/tobacco/basic_information/e-cigarettes/about-e-cigarettes.html

Campaigns for Tobacco Free Kids

http://www.tobaccofreekids.org/assets/factsheets/0379.pdf

Delaware has made great strides in preventing initiation of combustible cigarettes, as youth smoking rates are at an all time low (University of Delaware, n.d.). However, youth are becoming increasingly addicted to e-cigarettes and as new information emerges on the dangers of these products. Respecting, education and raising awareness about the risks. Health care professionals can play a large role in helping to curtail e-cigarette use by providing credible information to their patients.

References


How Health Care Providers Can Address E-Cigarette Use

Lisa Moore, MPA and Nora C. Katurakes, MSN, RN, OCN®

Lisa Moore received her BA in Psychology and Masters of Public Administration from the University of Delaware. Lisa has worked within the Delaware Division of Public Health for twenty years and currently manages the Tobacco Prevention and Control Program. She is a certified Quality Improvement Associate through the American Society of Quality. Lisa also facilitates an online course for the University of Phoenix, Health Care Quality Management and Outcome Analysis. Lisa can be reached at lisa.m.moore@delaware.gov or 302-744-1010.

See the bio & photo for Nora C. Katurakes, MSN, RN, OCN® on page 1.
diagnosis, or soon thereafter, in a multidisciplinary clinic setting or in an advocate for them to assist with psychosocial support and help with a trusting relationship with the lung cancer patient, the ONN becomes invaluable to the cancer care continuum. By building a relationship with the lung cancer patient, these symptoms can be tackled quicker as the ONN is in constant communication with the patient and the oncologists, as they follow them through treatment. Despite being an overwhelming time for the patient and their family, studies on navigation programs have shown that connecting the patient with an oncology nurse navigator from the beginning improves the timeliness of their care (Wagner et al., 2013). The partnership and support that the ONN provides will make sure that the patient does not “fall through the cracks.” In summary, the ONN offers individualized patient care for each lung cancer patient with the goal of supporting the individual and their family through the cancer care continuum. This continuity of care from the ONN and the lung cancer patient allows optimization of cancer care delivery, which will improve the patient’s experience and outcome of their treatment (Collett et al., 2019). The partnership and support that the ONN provides to the lung cancer patient helps improve their experience with cancer care and reduces the burden of symptoms. This results in an increase in patient satisfaction with the care they have received and improvement in their overall health status (Lee et al., 2011). For lung cancer patients and their families, the ONN is an instrumental part of their cancer care team to help provide and support best outcomes of lung cancer treatment physically, mentally, and emotionally.

References:

From the early 1900s, navigation has proven to play an important role in decreasing time to care when a patient is diagnosed with a medical condition (Strusowski, Sein, & Johnston, 2017). When a patient receives the diagnosis of lung cancer their lives can quickly turn to chaos, and fear of the unknown can be overpowering and frightening. During the time of diagnosis, Psychology from Albert College Nursing Diploma from Reading Hospital School of Health Sciences, and BSN from Chamberlain College of Nursing. She is currently enrolled in Wilmington University for her MSN. Ginny is certified in oncology nursing. Ginny has worked in various oncology positions. She has worked as an intake oncology nurse on an oncology medical/surgical unit and as a staff nurse in an outpatient radiation oncology department. She is currently employed as an oncology nurse navigator at Helen F. Graham Cancer Center and Research Institute at Christiana Care Health Systems where she coordinates care for the head/neck & GU patient population from the time of diagnosis throughout the cancer continuum. Ginny also serves as the Chair of the Helen F. Graham Oncology Practice Council where she leads interdisciplinary initiatives for the cancer center and various oncology clinicians. Ginny can be reached by email at gpugh@christianacare.org or by phone at (302) 623-4753.

Making an impact in the lives of Others... Every Day we work as One.

Ginny Pugh, BSN, RN, OCN

Ginny Pugh earned her Bachelor of Science degree in Psychology from Albert College Nursing Diploma from Reading Hospital School of Health Sciences, and BSN from Chamberlain College of Nursing. She is currently enrolled in Wilmington University for her MSN. Ginny is certified in oncology nursing. Ginny has worked in various oncology positions. She has worked as an intake oncology nurse on an oncology medical/surgical unit and as a staff nurse in an outpatient radiation oncology department. She is currently employed as an oncology nurse navigator at Helen F. Graham Cancer Center and Research Institute at Christiana Care Health Systems where she coordinates care for the head/neck & GU patient population from the time of diagnosis throughout the cancer continuum. Ginny also serves as the Chair of the Helen F. Graham Oncology Practice Council where she leads interdisciplinary initiatives for the cancer center and various oncology clinicians. Ginny can be reached by email at gpugh@christianacare.org or by phone at (302) 623-4753.

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Since the earliest days of chemotherapy clinical trials in the 1960s, oncology nurses have been involved with clinical research. The oncology nurse role has evolved over the years and includes different variations of title, all of which may include clinical nursing practice, study management, coordination and continuity of care, human subject protection (i.e., conducting the informed consent process), and contributing to the science of clinical research by being part of the research team and following the research protocol(s) and/or by coming up with new ideas and innovations for research (Schmotzer & Ness, 2016). Research Nurse Coordinators at the Christiana Care Health System (CCCHS) are responsible for verifying patient eligibility at study entry and the overall management of the patient while they remain on a clinical trial. Research Nurse Coordinators assess for compliance, efficiency, safety, and welfare of participants while they are on a trial. Research Nurse Coordinators are another set of eyes for the patient as they are going through this journey.

CCCHS has its own research nurse for over fifty years. The oncology program has been federally funded from the National Cancer Institute (NCI) Community Oncology Research Program (NCORP) which is only awarded to 46 sites in the United States. In May 2002, the Helen F. Graham Cancer Center and Research Institute (HFGCC&RI) opened as the fifth member site. Up to this point, the research program primarily consisted of a center providing coordinated care to patients in the tri-state area. In 2001, HFGCC 4R began developing a relationship with the pharmaceutical industry, which has provided further access to research nurse coordinators facilitate day to day requirements of each trial. Each trial varies with the complexity of requirements and may include significant input from research nurse coordinators. In addition to standard dose chemoradiotherapy and cetuximab, and that cetuximab (Erbitux) offers additional benefit for these patients (Bradley et al., 2016).

An important trial that CCHS contributed to, which revealed a change in how patients are treated for non-small-cell lung cancer (NSCLC). In this trial, 616 patients with stage IIIB disease, non-squamous histology, sensitizing ALK or EGFR mutations who had not received treatment for metastatic disease plus pembrolizumab or placebo every three weeks for four cycles followed by pembrolizumab or placebo for up to five years. Of the patients, 42% were medical fit to undergo thoracic surgery.

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Immunotherapy and Lung Cancer

Constance Hill earned her BSN and MSN from Wilmington College in New Castle, DE. She is an Advanced Oncology Certified Nurse Practitioner and is certified as a Family Nurse Practitioner. Constance worked as an oncology Nurse Practitioner in various hospitals and has practiced within the oncology field for nine years. She then joined a different practice at the Helen F. Graham Cancer Center & Research Institute in 2018. Previously she worked in oncology as an LPN and then an RN starting in 1975. Constance has worked in various roles within the oncology field in Northern California as a travel nurse for five years. She also worked as a consultant speaking nationally for Genentech, Novartis and Celgene and as a Panel Advisor for the National Cancer Institute. Constance is currently an oncology hematologist hospitalist nurse practitioner at ChristianaCare. She is a member of the ASCO, NSCO, and the Delaware Diamond Chapter of the Oncology Nursing Society. She served as chapter president and newsletter writer for the Delaware chapter. Information on practice can be reached by email at Constance.Hill@christianacare.org or her office at (302) 731-7782.

Oncology nurses have been waiting for many years for new therapies for lung cancer. Immunotherapy, also referred to as Immune Checkpoint Inhibitor therapy, is an exciting treatment option for the control of lung cancer. It has arrived and is here to stay! Nurses are an integral part of the multidisciplinary health care team, and the best way for nurses to understand why this new immunotherapy treatment may involve one or more of the body’s systems. The toxicity is directly related to over-activation of the immune system and can have a delayed onset and last for months after withdrawal of the agent (Kottschade, 2018). Why is this important for nurses to understand? Immune–related adverse events need to be recognized early and treated quickly to prevent mortality. The lung cancer patient receiving immunotherapy may seek treatment in a dermatology office, an endocrine office, a medical office, or even an emergency department. Nurses and families even with previous teaching, they do not have the understanding that they must call their oncologist when the immune related adverse event occurs.


The role of Supportive and Palliative Care (SPC) is to provide an extra layer of support for patients with a chronic or serious illness. For patients with lung cancer, palliative care is appropriate at all stages of the illness; from initial diagnosis until end of life. The SPC team are specialists who are trained in having difficult conversations with patients and loved ones to discuss their illness and prognosis. They assist patients and families in understanding their treatment options and goals of care by facilitating family meetings to ensure all members of the patient’s primary team are collaborating, educating, and listening to the patient and families concerns are in alignment with patient’s goals.

The World Health Organization (WHO) defines palliative care as:

An approach which improves the quality of life when patients and families are facing life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual. (WHO, 2010).

When chemotherapy is discontinued, or the doses are reduced, the side effects generally resolve on their own. The immune-related adverse events of immunotherapy treatment may involve one or more of the body’s systems. The toxicity is directly related to over-activation of the immune system and can have a delayed onset and last for months after withdrawal of the agent (Kottschade, 2018). Why is this important for nurses to understand? Immune–related adverse events need to be recognized early and treated quickly to prevent mortality. The lung cancer patient receiving immunotherapy may seek treatment in a dermatology office, an endocrine office, a medical office, or even an emergency department. Nurses and families even with previous teaching, they do not have the understanding that they must call their oncologist when the immune related adverse event occurs.


In this study, it was noted that a significant number of individuals who are receiving immunotherapy to alert non-oncology clinicians of the most common side effects and management strategies of these new medications. There is a need for prompt intervention with treatment to prevent or mitigate adverse effects of treatment.

References


Lung cancer treatment has come a long way from the days of standard chemotherapy and radiation. Immunotherapy is truly amazing, but the adverse events associated with it are unique. All nurses should understand what immune-related adverse events are and how to manage them. Nurses and families need to understand that there are actions and measures that can be taken to prevent, mitigate, and treat these adverse events.

Supportive and Palliative Care in Lung Cancer

Constance Hill

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LaTonya E. Mann, DNP, FNP-BC, OCN®

Dr. Mann earned her Licensed Practical Nurse degree from Salem Community College, Associate Degree in Nursing from Gloucester County College, Bachelors in Nursing from Immaculata University, Master’s Degree of University of Delaware, and Doctorate in Nursing from William University. She is board certified as a Family Nurse Practitioner. LaTonya serves as Past President for Delaware Chapter of Oncology Nursing Society and is also a member of the Delaware Nurses Association. Delaware Coalition of Nurse Practitioners, and Sigma Theta Tau International Honor Society of Nursing. LaTonya brings over 30 years of experience in various settings of nursing including medical surgical, intensive care, home infusion therapy, and oncology nursing. She presently works as a Nurse Practitioner with the Supportive and Palliative Care Team at Christiana Care Health System. LaTonya can be reached by email at lamann@christianacare.org or at (302) 733-4186.

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Treatment for lung cancer may include surgery, radiation, chemotherapy and/or immunotherapy. Each of these treatment options have side effects which the SPC team can help by providing recommendations for medications and referrals to other supportive services such as rehabilitation and nutrition. Common symptoms that can be improved through the support of SPC include pain, shortness of breath, fatigue, nausea, constipation, loss of appetite, problems with sleep, anxiety, and depression. After lung cancer treatment it is likely that the patient will continue to experience several symptoms as they recover requiring continued support from the SPC team.

Increased symptom burden from advanced lung cancer treatment is associated with poor quality of life (Iyer, Rongley, Rider and Taylor-Smith, 2014). Symptom burdens are subjective cancer symptoms that produce negative physical and emotional responses for the patient. Iyer et al (2014) performed a study to evaluate symptom burden in advanced non-small cell lung cancer (NSCLC), and how it impacts a patient’s quality of life (QOL) as well as the perception of severity of symptoms between physicians and patients. In this study, it was noted that a significant number of patients experienced lung cancer symptoms including fatigue, shortness of breath, cough, pain, and blood in sputum and that symptom burden had a negative effect on the QOL in patients with advanced stage NSCLC.

Obtaining support from an early referral to the SPC team from the primary team and specialists for symptom management is key. Referral rates are much higher when there is the convenience of a palliative provider or team. Further research is needed on the importance of referral to SPC for psychological and emotional support to include complex emotional states of grief, sadness, fear of pain, death, anxiety, and loss versus solely for disease and symptom management (Johnson, Girgis, Paul, & Currrow, 2011).

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Results of multiple studies suggest that early palliative care improves quality of life. Temel et al. (2011) conducted a randomized control trial to examine the effects of early palliative care referrals for patients with metastatic stage NSCLC and to explore perceptions of prognosis and goals of care. Patients who were newly diagnosed with metastatic NSCLC received either early palliative care integrated with standard oncology care or standard oncology care alone. Of the 151 participants who enrolled in the study, one third of them reported that their cancer was curable at baseline, and a majority endorsed getting rid of all of cancer as a goal of therapy. The researchers discovered there was a substantial improvement in the patients’ understanding of prognosis and decision-making with early implementation of palliative care (Temel et al., 2011). In another study, Jacobsen et al. (2011) described a clinical practice that provided early palliative care consultation, which improved the quality of life, mood, and survival. There was a total of seven palliative care providers who made a consultation for 67 patients. The focus of the referral was symptom management, patient and family coping, and illness understanding and education (Jacobsen et al., 2011).

There is research that reflects referral rates are compromised by physicians concerns that patients and families would be alarmed about a referral to the SPC team. It is extremely important for the patient’s primary team to educate the patient and family on the role and benefit of having the support of the SPC team. There are misconceptions that a referral would mean that treatment was ineffective, that they must stop treatment, or that the patient is giving up. Some patients and families believe that a referral to palliative care is the same as a referral to hospice care.

The ability to focus on the patient as a whole is a primary focus of the SPC team, by not only utilizing the role of the provider, but also the chaplain, social worker, and other disciplines. The focus is not primarily on managing their physical but also spiritual distress, poor self-concept, and distress from their cancer diagnosis and prognosis. The chaplain on the team adds the expertise of identifying and addressing spiritual distress and suffering through history taking and assessment. Patients with advanced lung cancer often express feelings of emotional distress such as helplessness and hopelessness. The social worker on the team has a unique and instrumental role in addressing anxiety, fear, and depression of patients and loved ones dealing with lung cancer by providing additional support. They also work very closely with the discharge planner to help facilitate discharge planning. Providing oversight of the SPC team is the Nurse Navigator who identifies potential barriers and facilitates appropriate referrals for the team. Understanding the role of SPC is extremely important for nurses as they have the expertise to understand the complex needs of patients and families dealing with a lung cancer diagnosis and play an essential role to advocate for this vulnerable population.

In conclusion, the SPC team contributes to the patient’s quality of life through the use of a holistic approach which provide diverse capabilities of a supportive team with the mutual goal to exceed the expectation of patients and families. The intention is not to replace the patient’s primary oncology team, but rather to add an extra layer of support. Nurses can provide education to patients and families about the role and benefit of SPC which will increase referral and decrease symptom burden in patients with lung cancer thereby improving their QOL.

References
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**Mail** Delaware Nurses Association, 4765 Ogletown-Stanton Rd, Suite L10, Newark, Delaware 19713

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### Essential Information

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### Professional Information

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- Current Position Title: (ie: staff nurse) ____________________________
- Type of Work Setting: (ie: hospital) ____________________________
- Practice Area: (ie: pediatrics) ____________________________
- Currently Employment Status: (ie: full-time nurse) ____________________________
- Currently Employment Status: (ie: part-time nurse) ____________________________
- Currently Employment Status: (ie: not currently working in nursing) ____________________________
- Currently Employment Status: (ie: retired) ____________________________
- Currently Employment Status: (ie: student) ____________________________
- Currently Employment Status: (ie: other) ____________________________
- Currently Employment Status: (ie: not employed) ____________________________
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<td>Price: $159/annually or $13.75/monthly, electronically</td>
<td>$247/annually or $21.09/monthly, electronically</td>
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### Ways to Pay Annual Payment

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