

# IRISH ASSOCIATION FOR NURSES IN ONCOLOGY



## Cancer Nursing News

# SUMMER 2002

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## EDITORIAL

Dear Members,

Welcome to the summer edition of the Cancer Nursing News. Ms Wendy Fairhas resigned her position on the National Executive Committee and the NEC would like to take this opportunity to thank her for all her hard work and her great contribution to the IANO throughout her time on the NEC. Wendy will continue to be a member of the IANO and we look forward to meeting her at our study days and meetings. Kay Leonard a college lecturer in UCD and Nurse Tutor in St. Luke's hospital has joined the NEC in Wendy's place. The updated list of all the NEC members is on page 4.

The IANO have had a busy few months to date. In February we facilitated a 'Training the Trainers' programme for 27 nurses from all over Ireland. We had a large amount of applicants for this week long programme. The overall purpose of this workshop was to introduce a Patient education programme 'Learning to live with cancer', to improve the quality of care for cancer patients and their significant others. Ursula Courtney, Director Arc House, facilitated the Course and the IANO were thrilled that Gertrude Grahn the author of the Learning to Live with cancer programme also facilitated the workshops along with Arild Stegen who has run numerous courses in Norway.

The IANO ran a half day seminar on Genetics in the Royal College of Surgeons on Thursday 7th March 2002. This was a very interesting and informative day, but was poorly attended by members.

Both the Cork and Limerick regional branches held seminars recently. The Limerick branch held an evening meeting on 'Colorectal Cancer' on the 11th April and the Cork branch had an afternoon seminar on Breast Cancer on the 18th April 2002. Both these meetings had a great turnout.

This edition of the newsletter contains an article by Suzanne Browne CNS, Breastcheck, on 'The Breast Cancer Experience', a nursing review, and a case history by Emma Nixon, St. Luke's Hospital, on a patient's experience of Breast Cancer. It also features an updated list of NEC members.

If you have any articles or case studies you would like published in future editions of the Cancer Nursing News we are always delighted to receive them, and you will receive free membership for the IANO for the following year if they are published.

Best Wishes

Paula O'Reilly NEC MEMBER



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# NATIONAL EXECUTIVE COMMITTEE MEMBERS 2002

- Eileen Furlong, President,  
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- Maura Fitzsimons, Nurse Tutor,  
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**THE BREAST CANCER  
EXPERIENCE -  
A NURSING REVIEW**

**Suzanne Browne  
April 2001**



## INTRODUCTION

Breast cancer is the most common malignancy in women (Mc Pherson et al. 2000) and in Ireland in 1997 accounted for 15.7% of all cancers (National Cancer Registry 2000). This case review will focus on the care of Mary Smith during her breast cancer experience. Mary Smith is a 63-year-old married lady. She has four children, three sons and one daughter. Her husband is a quiet man, who leaves much of the talking to Mary. Mary's daughter is the youngest of the family at 18 years. Socially, Mary enjoys swimming, holidays abroad and spending time with her family.

Mary was initially seen at the Breast Clinic following urgent referral by her General Practitioner (GP) for a clinically suspicious breast lump. At the clinic Mary was reviewed by the consultant surgeon who concluded that the lump was clinically suspicious for carcinoma. Mammography and Fine Needle Aspirate Cytology (FNAC) also confirmed this, deeming the lump code five or malignant (Walsh & O'Higgins 2000).

Treatment options were discussed with Mary and her husband on a subsequent visit to the clinic. Following this meeting, Mary decided that mastectomy would be preferable to conservative surgery, which was also an option outlined by the surgeon and breast care nurse.

The tumour was invasive ductal carcinoma, 2cm in size, stage 1, clear of margins, oestrogen receptor-positive and free from nodal involvement. Staging procedures i.e. liver ultrasound, bone scan, chest x-ray and blood tests revealed no metastatic disease. The T.N.M. classification was T.N.M. Sainsbury et al. (2000) highlighted that 5-year survival for this stage of tumour was 84%. Also highlighted in Walsh & O'Higgins (2000) is that the size of the tumour and the presence and number of lymph nodes are the most important factors in predicting the risk of relapse. As the tumour was oestrogen receptor-positive the surgery was followed by endocrine therapy.

This case review will discuss treatment modalities used; assessment of the patient, the issue of goal setting, the nursing interventions used and will finally evaluate the care given. In conclusion, within this unit, nursing care is delivered according to the systematic approach used in the nursing process (Watson and Royle 1987).



## **TREATMENT MODALITIES**

This section of the case review includes an analysis of the treatment modalities used, namely mastectomy and endocrine therapy.

As previously discussed, following consultation with the multidisciplinary team, Mary chose to have a mastectomy followed by Tamoxifen as opposed to conservative surgery and radiotherapy. This decision was respected by the multidisciplinary team. Following surgery Mary was referred to a medical oncologist who together with Mary's consent commenced endocrine therapy.

Treatment modalities used may be divided into two sections: local treatment and systemic treatment. For the purpose of this case review, the subject of local treatment shall be discussed first.

According to Susan Love (1995: 312) the aim of breast surgery is to "remove or reduce the cancer". Mary did not want the cancer to be removed by conservative means as she had a great fear of local recurrence. Even though it was explained that there were no guarantees that the cancer would not recur, Mary felt she would cope better with mastectomy. This was also reflected in Fallowfield et al. (1990) and Baum et al. (1994).

In accordance with patient preference a modified radical mastectomy with axillary clearance was carried out. This procedure was carried out in preference to the simple mastectomy, which does not involve lymph node removal. As highlighted in Goldhirsch et al. (1995) lymph node status is an important prognostic indicator and therefore was required with a view to determining postoperative course of treatment. West & Brown (1996) agree with this and also acknowledge that some surgeons consider axillary surgery a reliable treatment of axilla. It is fair to say that the best surgical option was chosen with respect for patient choice. Following local treatment for breast cancer the subject of systemic therapy shall now be addressed.

Tamoxifen is an antioestrogen drug used as adjuvant therapy in breast cancer (Fenton 1996, Backmann and Whittaker 2000). Certain factors were taken into consideration when selecting the most appropriate adjuvant therapy for Mary. These included age, lymph node status, menopausal status, oestrogen receptor status and presence of metastatic disease. Goldhirsch et al. (1995) also used similar factors in the selection of adjuvant therapy. As Mary's case data has shown, she was a suitable candidate for Tamoxifen.



Tamoxifen was primarily chosen to prevent or delay distant metastases. Follow field and Clark (1991) acknowledge that Tamoxifen is used in the majority of breast cancer patients and its benefits include delaying the onset of recurrence and thus increasing survival.

Coleman (1996), however, states that age is taken into consideration when choosing adjuvant therapy and that chemotherapy is more clearly indicated in pre-menopausal patients. It is also stated that Tamoxifen is used as preference to chemotherapy in some cases for its reduced toxicity. Baum and Schipper (2000) agree with this. On the other hand, Glick et al. (1992) show that menopausal status is not as sufficient a marker for therapy on its own. They also agreed that women who had similar tumour size and oestrogen receptor status to Mary should be treated with Tamoxifen. Hence, as the literature suggests, use of Tamoxifen was indicated in Mary's case.

However, further study continues in the use and benefits of Tamoxifen. Goldhirsch et al. (1995) portray benefits including low relapse rate within the first 10 years and reduced incidence of contralateral breast cancer. In addition, duration of treatment is recommended for 2-5 years with current trials comparing 5 and 10 years or lifetime duration. Therefore, the optimum duration of therapy remains controversial. Fenlon (1996) also adds that some studies are researching the addition of chemotherapy with Tamoxifen. Both treatments chosen for Mary were not without side effects. These shall now be highlighted.

In relation to mastectomy and axillary clearance, early side effects may be seen such as discomfort, wound infection, seroma development, haematoma formation and numbness around the breast wound radiating along the inner arm (West and Brown 1996).

Later onset of effects such as lymphoedema and arm infection present patients with the greatest problem. Other effects may result from poor range of arm movement, which include frozen shoulder and winged scapula. Tamoxifen contains side effects such as menopausal symptoms (hot flushes, vaginal dryness, vaginal discharge and weight gain). Depression may also be seen and may be more prevalent in woman who experienced pre-menstrual tension. In the long term there is an increased risk of developing deep vein thrombosis and cataracts.

The most serious effect of Tamoxifen is the increased risk of developing endometrial cancer (Buckmann and Whittaker 2000). However, some information needs to be gained on the long-term side effects of this drug.



In conclusion, the reason for choosing these treatment modalities and a review of their efficacy has been discussed. Following this discussion the assessment of actual and potential problems experienced by Mary shall now be addressed.

### **ASSESSMENT**

The main problems Mary experienced on admission to the breast unit included anxiety, alteration in body image and seroma development. Potential problems included the potential limitation of arm movement following surgery and the development of lymphoedema.

In relation to anxiety, assessment was carried out using interview technique. This problem was noted during the initial stages of diagnosis and was also noted on admission. Communication skills and listening techniques were used and Mary's fears were documented. Fears related to loss of breast, disfigurement, loss of femininity, fear of cancer and closely tied in with alteration in body image. As this problem could not be measured or confirmed by others, it was subjective rather than objective.

One of the most distressing problems for any patient who has had a mastectomy is the change in body image (Denton 1991). Coleman (1996) also acknowledges that mastectomy can cause body image problems and anxiety. Mary was not anxious to view her wound post-operatively and also showed no interest in her appearance. This problem was noted when she refused to have a temporary prosthesis fitted. However, this problem could not be measured objectively.

It is important that no patient is coerced into looking at a mastectomy scar and that nursing intervention is appropriate for each particular patient. Support and patience are paramount for the multidisciplinary team, so that each patient can progress through the steps of recovery and rehabilitation.

Seroma development occurred following drain removal, prior to Mary's discharge. The fluid was aspirated and the amount noted. This could, therefore, be measured objectively. Knowledge of this process, following drain removal, assisted nursing staff in assessing and diagnosing the problem. No tools were used in the assessment of problems in Mary's case.

Knowledge of the procedures used in treating Mary's breast cancer, resulted in assessment of potential problems. Because the multidisciplinary team were aware of problems, which could occur, they were better equipped in assessing the patient for problems.



Measuring the problems relating to lymphoedema and restriction in arm movement could be done objectively. Mary followed an arm exercise programme, was assessed doing so and was encouraged to complete this four to five times daily. In relation to lymphoedema, Mary was educated regarding skin and arm care. Also, arm measurements were recorded pre-operatively and post-operatively as baseline measurements to assess future potential swelling. Written material was given to Mary and her understanding assessed by answering simple questions relating to the problems. In conjunction with assessing Mary's actual and potential problems, goals were set to guide nursing intervention. Setting goals also gives a sense of purpose (Watson and Royle 1987).

The next section of this case review focuses on goal setting.



## **GOAL SETTING**

Goal setting is an important part of the planning phase within the nursing process. Setting goals aims towards promotion, maintenance and restoration of health (Watson and Royle 1987). These authors also state that some goals may be reached immediately whilst others are met in the long term.

It was possible to set measurable goals for Mary. In order for this to be done accurately, it was necessary for her to gain knowledge and understanding regarding the need for change. Skill and expertise within the team were paramount in conveying to Mary the importance of changing behaviour in order to meet these goals.

### **Goals set included:**

1. Looking at scar and caring for wound.
2. Maintaining wound integrity.
3. Participating fully in choosing prosthesis and bra.
4. Taking an interest in her appearance.
5. Cessation in seroma development.
6. Reduce risk of lymphoedema by early intervention.
7. Full range of arm movement.

Patient education is an important factor when setting goals and the reasoning for these goals must be communicated to the patient to ensure compliance.

Through Mary's behaviour and understanding following nursing intervention it was possible to measure these goals. However, they were not measured on a regular basis, which may have proved more useful. Continuous assessment of Mary's needs was also an important factor, which was not however carried out.

Setting goals and planning care give a sense of purpose to nursing intervention. The next section of this case review will focus on nursing intervention carried out to solve and alleviate Mary's problem.



## **INTERVENTION**

For the purpose of this case review, this section shall contain a discussion on the nursing interventions carried out to solve Mary's problems as well as a short discussion on the discharge plan.

According to West and Brown (1996) breast surgery has the ability to alter body image and, therefore, cause anxiety. To alleviate this, information regarding surgery for breast cancer was given in a clear and concise way, which Mary and her family would understand. Education material was given to reinforce what was said. One of the aims of patient teaching is to decrease fear and anxiety (Jones 1991). However, because anxiety can negatively affect attention and cognitive functioning (Lehto and Cimprich 1999) teaching was provided both verbally and with written material. Mary's knowledge was assessed by asking her to explain what she could of the surgery, following teaching.

Information and support were also given to Mary and her family in the form of Reach to Recovery (Jones 1991). Mary's needs and priorities were also assessed (West and Brown 1996) and because she was anxious not to wait a long length of time for surgery, the interval was kept to a minimum within reason, to alleviate anxiety.

Alteration in body image has been recognised as one of the most distressing factors for patients following breast cancer surgery. Viewing the mastectomy scar is seen as progress in terms of rehabilitation, however, for some women it is a terrifying experience and should not be rushed (Denton 1991). Because of this, the appearance of the wound was explained and that the wound would improve with time. Patience was used and Mary was given opportunities to view the scar in the presence of a nurse or family member.

The volunteer was a significant support for Mary and reassured her regarding fear of the unknown by reflecting on her own experience. Jones (1991) acknowledges the benefit of a suitably trained volunteer.

Some days later, Mary viewed her scar and began to show interest in her appearance when encouraged to wear a supportive bra and her own clothes (Love 1995). The fitting of a temporary prosthesis also alleviated fears relating to body image. Information regarding breast reconstruction was given should she wish to discuss it further and an approximate date for fitting a permanent prosthesis has aided Mary's self-esteem.

Seroma development can occur in patients post-operatively. Reasons for this are varied and can result from early remobilisation of the arm (Crane 1997). Mary's seroma was



drained using aseptic technique. West and Brown (1996) stress the importance of using aseptic technique. Love (1995) suggests that if there is significant fluid present it should be drained, however, numerous aspirations should be avoided to reduce the risk of infection. To reduce unnecessary fear and anxiety regarding seroma development the likelihood of its development was explained to Mary pre-operatively and reiterated post-operatively. A nursing data sheet was used to document the amount and type of fluid aspirated. Nursing intervention was also employed in order to prevent the possible limitation of arm movement and to reduce the risk of lymphoedema.

Education material was provided pre and post-operatively regarding the importance of arm movement. Mary was seen by a physiotherapist one day post-operatively. There is controversy regarding the best time to begin remobilisation of the arm. This is acknowledged by Love (1995) and she also states that only a small percentage of patients need to be seen by a physiotherapist. Sleigh (1996), however, acknowledges the importance of this role and states that patients are seen one day post-operatively.

Mary was given an exercise sheet with arm exercises printed on it. Each set of exercises were encouraged to take place four times per day. Nursing staff assessed Mary completing the exercises in the early days post-operatively to ensure she was gaining an increase in the range of arm movement. Sleigh (1996) also stresses the importance of not over-working the patient for fear of causing wound trauma.

Education was also given regarding lymphoedema. Teaching sessions took place and Mary was given education material (Badger 1996, Crane 1997) regarding skin and arm care. It is also standard practice not to use the affected arm for blood pressure monitoring and injections so as to reduce the risk of infections and ultimately lymphoedema (West and Brown 1996, Smith 1998, Coward 1999). Mary was also advised to continue her arm exercises at home and remain constant in caring for her arm as the onset of lymphoedema can be delayed by years (Love 1995).

Also within the breast unit measurements of the affected arm are recorded pre and post-operatively and at specified intervals thereafter. This practice is reflected by Denton (1991).

Mary's discharge plan commenced post-operatively. It incorporated teaching sessions described above. These teaching sessions are ongoing and are incorporated into clinic visits. Appointments were given to Mary to return to the breast nurse clinic and outpatient surgical clinic for wound assessment. Also, information regarding bras and obtaining prostheses was provided (West & Brown 1996). Mary was also given contact numbers for support agencies, volunteers and the breast care office. This practice helped to achieve continuing nursing care post discharge from the unit.



It is now necessary to evaluate these interventions with regard to assessing the improving patient care.

## **EVALUATION**

In this section of the case review the degree to which Mary's problems were alleviated/solved shall be discussed. In addition the degree of appropriateness of the interventions used shall be addressed and finally the idea as to whether another course of action would be helpful shall be examined.

Mary presented with anxiety regarding body image and reluctance to view her wound. Through nursing intervention previously discussed, the problem was solved as Mary viewed her scar and subsequently began to take an interest in her new appearance.

However, even though this problem was solved and the outcome achieved other intervention may have proved useful. A photograph of a well healed mastectomy scar and perhaps a patient who had recently had a mastectomy may have provided more reassurance and support. The photograph and patient may have provided evidence regarding what was being said and Mary may have found it easier to believe that the scar would improve with time. Even though Mary met a volunteer, she had her operation 10 years previously and was younger than Mary.

Mary's anxiety regarding the surgery and cancer diagnosis was also alleviated as her anxiety decreased. Perhaps, a more educated approach to anxiety assessment would be more helpful for women before breast surgery. This could be done in the form of routine psychological assessment by a qualified psychologist. Tait (1997) acknowledges that it is vital that nurses realise their limitations in providing psychological care and identifying patients with significant anxiety and depression. In addition, perhaps relaxation therapies such as massage and reflexology (Tait 1997) would have been beneficial in reducing Mary's anxiety pre and post-operatively.

Mary's husband may also have benefited from other support with relation to his anxiety. Outside agencies such as A.R.C. provide teaching sessions and support groups for partners of patients with cancer. This opportunity was not given to Mr Smith and perhaps, in hindsight, would have proved useful. Kilpartick et al. (1998) reflected that husband's needs are different to their wives and are often unmet.

Nursing intervention used in the problem of seroma development was appropriate in Mary's case as the problem was alleviated. However, perhaps more research into the best length of time before drains are removed would be beneficial. In this particular breast unit, drains are removed when the output is less than 50mls in 24 hours. If the drains were in place, for example, until output is less than 20mls in 24 hours would seroma



development decrease? Also, training could be provided for nurses specialising in breast care in assessing and aspirating seromas and, therefore, early intervention could be implemented during assessment, when discharged from the unit.

Two potential problems identified included limitation of arm movement and lymphoedema. With regard to the former, as Mary's arm movement was regained to full range and she encountered no problems, nursing intervention was deemed appropriate. However, exercises could be taught and implemented pre-operatively and this may help to reduce fear and anxiety post-operatively. It might also be beneficial for patients to meet the physiotherapist pre-operatively. Also, for future improvement in practice, perhaps a video demonstrating the arm exercises could be given to patients pre-operatively while they are at home. This may help them to focus on something positive.

With regard to lymphoedema, nursing intervention used was appropriate as the problem has not yet occurred. However, intervention must be reinforced at nursing clinics.

Much research needs to be carried out regarding the use of sleeves and also regarding elevating the arm at night. Also, as Love (1995) reflected, early intervention is best so nurses may have to reinforce education and teaching assessment at regular intervals. In the future, with the direction of sentinel node biopsy the need for axillary surgery will be reduced (Baum and Schipper 2000) and, therefore, so will lymphoedema.

During this section of the case review, Mary's care has been evaluated and recommendations for future practice have been made.

## **CONCLUSION**

To draw a conclusion, this case review has followed the care of Mary through the breast cancer experience. The literature has shown reasoning for the surgery undertaken. It has also proven the benefits in the role of Tamoxifen, in post-menopausal node - negative women. Problem identification was highlighted and the nursing intervention used was discussed and evaluated. Finally, recommendations for improving nursing practice were outlined in relation to pre and post-operative care of the breast cancer patient.



## References

- Badger C. (1996) The management of lymphoedema. In Breast Cancer Nursing, (Denton S.) (ed.), Chapman and Hall, London, 204-215.
- Baum M., Saunders C. and Meredith S. (1994) Breast Cancer a Guide for Every Woman. Oxford University Press, Oxford.
- Baum M. and Schipper H. (2000) Fast Facts – Breast Cancer. Health Press, Oxford.
- Buckmann R. and Whittaker T. (2000) What you Really Need to Know About Breast Cancer. Marshall Publishing, London.
- Coleman R.E. (1996) Breast Cancer. In Cancer Care in the Hospital, (Hancock B.) (ed.), Radcliffe Medical Press Limited, Oxon, United Kingdom, 80-87.
- Coward D. (1999) Lymphedema prevention and management knowledge in women treated for breast cancer. Oncology Nursing Forum 26 (6), 1047-1053.
- Crane R. (1996) Breast Cancers. In Oncology Nursing, 3rd edn. (Otto S.) (ed.), Mosby, St Louis, 81-123.
- Denton S. (1991) Nursing patients with breast cancer. In Oncology for Nurses and Health Care Professionals – Cancer Nursing 3, 2nd edn. (Tiffany R. and Borley D.) (eds.), Harper Collins, Beaconsfield, London, 309-339.
- Fallowfield L. and Clark A. (1991) Breast Cancer. (Fitzpatrick R. and Newman S.) (eds.), Tavistock/Routledge, London.
- Fallowfield L. J., Hall A., Maguire G.P. and Baum M. (1990) Psychological outcomes of different treatment policies in women with early breast cancer outside a clinical trial. British Medical Journal 301, 575-580.
- Fenlon D. (1996) Endocrine therapies for breast cancer. In Breast Cancer Nursing, (Denton S.) (ed.), Chapman and Hall, London, 104-123.
- Glick J.H., Gelber R.D., Goldhirsch A. and Senn H.J. (1992) Adjuvant therapy of primary breast cancer. Annals of Oncology 3, 801-807.
- Goldhirsch A., Wood W.C., Senn H.J., Glick J.H. and Gelber R.D. (1995) Meeting highlights, international consensus panel on the treatment of primary breast cancer. Journal of the National Cancer Institute 87 (19), 1441-1445.



- Jones E.A. (1991) Nursing patients having cancersurgery. In Oncology for Nurses and Health Care Professionals – Cancer Nursing 3, 2nd edn. (Tiffany R. and Borley D.) (eds.), Harper Collins, Beaconsfield, London, 1-37.
- Kilpatrick M.G., Kristjanson L.J., Tataryn D.J. and Fraser V.H. (1998) Information needs of husbands of women with breast cancer. Oncology Nursing Forum, **25** (9), 1595-1601.
- Lehto R.H. and Cimprich B. (1999) Anxiety and direct attention in women awaiting breast cancersurgery. Oncology Nursing Forum **26** (4), 767-772.
- Love S.M. (1995) Dr Susan Love's Breast Book. 2nd edn. Perseus Books, Indianapolis.
- Mc Pherson K., Steel C.M. and Dixon J.M. (2000) Breast Cancer– epidemiology, risk factors and genetics. In ABC of Breast Diseases, (Dixon M.) (ed.), BMJ Books, London, 26-32.
- National Cancer Registry Board (2000) Cancer in Ireland 1997 Incidence and Mortality. National Cancer Registry Board, Healy and Associates, Cork, Ireland.
- Sainsbury J.R.C., Anderson T.J. and Morgan D.A.L. (2000) Breast Cancer. In ABC of Breast Cancer Diseases, (Dixon M.) (ed.), BMJ Books, London, 38-43.
- Sleigh C. (1996) Physiotherapy and breast cancer. In Breast Cancer Nursing, (Denton S.) (ed.), Chapman and Hall, London, 186-203.
- Smith J. (1998) The practice of venepuncture in lymphoedema. European Journal of Cancer Care **7** (2), 97-98.
- Tait A. (1996) Psychological aspects of breast cancer. In Breast Cancer Nursing, (Denton S.) (ed.), Chapman and Hall, London, 15-45.
- Watson J.E. and Royle J.A. (1987) Watson's Medical-Surgical Nursing and Related Physiology. 3rd edn. Balliere Tindall, London.
- Walsh T.N. and O'Higgins N. (2000) Breast Cancer management Clinical Guidelines. Clinical guidelines committee, Royal College of Surgeons, Ireland.
- West N. and Brown H. (1996) Surgery for breast cancer. In Breast Cancer Nursing, (Denton S.) (ed.), Chapman and Hall, London, 65-76.



# **A PATIENTS EXPERIENCE OF BREAST CANCER**

**A CASE REVIEW**

**By Emma Nixon  
(St. Luke's Hospital)**



In this case review, the history of Laura O'Neill, a 52 year old separated lady with breast carcinoma, will be discussed. The history, pathology and staging of her disease will be considered alongside the treatment modalities chosen, namely surgery, chemotherapy and radiotherapy. The problems encountered by Laura including fatigue, skin reaction and altered body image, as well as their management, will be critically analysed from a nursing and a medical perspective.

Laura O'Neill had been diagnosed with non-invasive ductal carcinoma insitu (DCIS) of her left breast in 1993 and had a wide local excision performed, followed by tamoxifen therapy. Walsh & O'Higgins (2000) state that DCIS accounts for 30% of all breast cancers. According to Goldhirsch et al (1998) the incidences of DCIS have increased considerably in recent years due to refined mammography. Studies by Fisher et al (1998) cited by Goldhirsch et al (1998) have shown that radiation therapy given after a complete excision of a DCIS lesion significantly reduces the risk of subsequent invasive carcinoma. In 1993, prior to these research findings, Laura O'Neill's treatment did not include radiotherapy, perhaps because the benefits were not clearly known. The use of tamoxifen therapy to prevent subsequent invasive carcinoma following treatment of DCIS has yet to be established. Goldhirsch et al (1998) state that further research is being carried out in this area. In the case of Laura O'Neill, the tamoxifen therapy was discontinued after one year at Laura's own request, as she felt the side effects were having an adverse effect on her life, her sexuality and her relationship with her then husband. According to Aikin (1996) common side effects of tamoxifen include hot flushes, vaginitis, vaginal dryness, vaginal discharge and irregular menses. Lee (1996) states that very often, the distress caused by these side effects are undervalued by doctors.

Following her initial surgery in 1993, Laura's condition was closely monitored using mammography. Unfortunately, seven years later, another lump was discovered in the same breast. A biopsy showed infiltrating carcinoma and treatment included a left mastectomy and axillary lymph node dissection. Histology was mixed, showing both ductal carcinoma insitu and invasive lobular carcinoma. The estimated greatest dimension of tumour was 6cm, it was focally present at the deep resection margin, four out of twenty six axillary lymph nodes were positive and oestrogen receptor status was moderately positive.

Crane (1997) states that infiltrating lobular carcinoma accounts for 10% of breast cancers. She explains that when histology is mixed, showing both invasive and non-invasive carcinoma, the staging and subsequent treatment are based on the features of the invasive carcinoma. The tumour is said to be invasive when the malignant cells penetrate the tissue outside the lobes. According to Sainsbury et al (2000), once an invasive carcinoma is diagnosed, the tumour should be staged to establish the extent of the disease.



Souhami & Tobias (1998) explain that the size of the primary tumour and the number of involved axillary lymph nodes are important factors in the prognosis of breast cancer. For this reason the TNM (tumour, node, metastasis) staging system as suggested by the Union Internationale Contre le Cancer is widely used. Alexander (1997) states that this classification system assesses tumour size (T), regional nodal involvement (N) and spread of malignant cells to distant sites (M).

In the case of Laura O'Neill, the carcinoma was staged grade III T<sub>3</sub>N<sub>1</sub>M<sub>0</sub>, as the tumour was greater than 5cm, movable lymph nodes were involved but no distant metastases were found. A liver ultrasound and bone scan were carried out to ascertain the latter. According to Sainsbury et al (2000), patients with grade III disease should have bone and liver scans as the clinical management of the disease would change if these scans showed metastases. Sainsbury et al (2000) explain that breast lesions greater than 4cm generally require a mastectomy to be performed rather than breast conservation surgery. Also, grade III tumours have a much higher recurrence rate by a factor of 15 compared with grade I tumours. This clearly indicates that the decision to carry out a mastectomy on Laura rather than breast conservation surgery was a necessary one.

Seven months after her surgery, Laura was admitted to the unit to have post mastectomy radiation therapy. Prior to her admission she had commenced adjuvant combination chemotherapy as an outpatient. An overview of these two treatment modalities and why they were used will now be discussed.

Langhorne (1997 p. 550) defines chemotherapy as "the use of cytotoxic drugs in the treatment of cancer" and adjuvant chemotherapy as "the use of chemotherapy in conjunction with another treatment modality". According to Langhorne (1997) the mechanism of action of cytotoxic drugs is to interfere with the stages of the cell cycle by targeting the DNA in the cell in some manner. Unfortunately normal cells as well as cancer cells are affected thus giving rise to the side effects associated with chemotherapy. Fischer et al (1993) state that cytotoxic drugs are given in combination with one another to increase tumour cell kill thereby increasing the cure rate. Laura's chemotherapy regimen involved four cycles of doxorubicin and CMF (cyclophosphamide, methotrexate, 5 - Fluorouracil) on a three weekly basis, followed by another two cycles of CMF alone. Doxorubicin belongs to the anthracycline group of drugs, cyclophosphamide is an alkylating agent whilst methotrexate and 5 - fluorouracil are both antimetabolites (Fisher et al 1993).



The Early Breast Cancer's Trialists' Collaborative Group (1998) advocates the use of adjuvant combination chemotherapy, as it has been shown in trials, to reduce the incidences of breast cancer recurrence by 35% and mortality by 27% respectively, in women aged under 50 years. These benefits were largely unaffected by nodal status, menopausal status or tamoxifen use. Despite the fact that it was more advantageous to younger women, those aged between 50 – 69 years also benefited. According to Goldhirsch et al (1998), randomised comparisons have shown that anthracycline – containing chemotherapy regimens have greater benefits with regard to reducing breast cancer recurrence and mortality rates compared with less toxic CMF regimens. It is clear from the literature, that the adjuvant combination chemotherapy regimen used to treat Laura's disease, ensured that the best possible attempt was made to control micrometastases thereby preventing recurrence and improving overall survival.

Radiotherapy or radiation therapy is a localised treatment defined by Iwamoto (1997 p. 503) as "the use of high-energy ionizing rays or particles to treat cancer". Hilderley (1997) explains that the aim of radiation treatment is to give a therapeutic dose to the tumour while minimising damage to the surrounding healthy tissues. Walsh & O'Higgins (2000) recommend that post mastectomy radiotherapy be carried out if the risk factors for local recurrence are high. They state that having positive surgical margins for tumour and having extensive lymph node involvement, i.e. nodes > 4 positive, increase the risk of local recurrence. For these reasons, Laura O'Neill's treatment included a course of radiotherapy to her left chest wall.

In trials in Denmark, Overgaard et al (1997) cited by Goldhirsch et al (1998), found that a radiation dose of 50gy reduced the rate of local recurrence in women at increased risk, by a factor of four. Laura received this recommended radiation dose divided into daily doses. Iwamoto (1997) explains that a single, large dose of radiation is too toxic for normal tissues to recover. For this reason the total dose should be divided into daily doses known as fractions. Laura received a total of twenty five fractions i.e. five weeks of treatment. As an addition, she also received five electron boosts. The National Institutes of Health Consensus Development (1992) cited by Crane (1997) recommend that a radiation boost to the tumour site be given if surgical margins are positive.

In the case of Laura, admission to hospital for the course of radiotherapy was delayed until she had completed her four courses of doxorubicin. This was necessary, as according to Walsh & O'Higgins (2000), greater toxicity is seen when radiotherapy and chemotherapy are given concurrently rather than in sequence especially when anthracyclines are used. During her course of radiotherapy Laura completed her last two cycles of CMF.



On admission, fatigue was identified by Laura herself as a problem which she had experienced at home. This problem became gradually worse and became debilitating during her hospital stay. Ream & Richardson (1996 527) define fatigue as "a subjective, unpleasant symptom which incorporates total body feelings ranging from tiredness to exhaustion, creating an unrelenting overall condition which interferes with individual's ability to function to their normal capacity." It is important to realise that fatigue is multi-dimensional phenomenon as emphasised by Ream & Richardson (1996 p 199) when they describe it as being influenced by "a combination of biological, psychological, social and personal factors". In Laura's case, psychological and social factors were present which may have contributed to the fatigue phenomenon. These included the fact that she had separated from her husband and was currently involved in divorce proceedings. The biological factors included the effects of the treatment modalities and the disease itself.

Nail et al (1991) identifies fatigue as the most common side effect of chemotherapy which was experienced by 81% of patients in their study. It was rated as moderately severe and had the second highest mean severity rating compared with other side effects. Strohl (1988) states that fatigue is commonly reported in patients undergoing radiotherapy. It is thought to be related to the need for more energy to eliminate the waste products of cell destruction and to repair the cells destroyed by radiation. Haylock & Hart (1979) cited by Winningham et al (1994) found, in their study, that fatigue gradually increased throughout a course of radiotherapy and that it was reduced over the weekend when patients were not having radiation treatment. The latter finding was not revealed in any other study. Sitton (1997) explains that previous or concurrent chemotherapy may increase fatigue during radiation treatment. As part of the nursing care, Laura was informed that fatigue was included in the side effects of radiotherapy. She was told to expect her fatigue to increase because she was also having concurrent chemotherapy. Winningham et al (1994) recommend that patients be educated regarding the probability of experiencing fatigue because of the specific treatments. In a study, Love et al (1989) cited by Winningham et al (1994), found there was a huge gap between patient's expectations of fatigue (8%) and those who experienced it (86%). They concluded that lack of information regarding the likelihood of fatigue occurring resulted in both reduced coping strategies and effective self care activities.

Although Laura was appropriately informed of the likelihood of experiencing increased fatigue, the nursing care may be criticised for not using an assessment tool to determine her fatigue and its characteristics from the outset. Measurable goals could not be set because assessment was not carried out appropriately. According to Piper et al (1998) careful multi-dimensional assessment and measurement of fatigue is necessary not only to advance knowledge about fatigue, but also to evaluate the effectiveness of approaches used to reduce fatigue within the clinical setting.



One method of assessment that can be used is the Piper Fatigue Scale. (Appendix 1). Because this scale is so detailed, Piper et al (1998) advises that a simple rating of intensity on a scale of 0 – 10 be used to assess fatigue. She also states that the assessment tool should ascertain how fatigue affects the patient's activities of daily living, her ability to concentrate and her mood. She explains that this information empowers the nurse to begin supportive therapies and make referrals.

As Laura's treatment progressed, she tended to stay in bed for longer periods of time during the day, yet this did not seem to reduce her fatigue. Nail et al (1991) state that the most commonly used self-care activities that were reported by patients to be most effective in combating fatigue were: going to bed earlier, sleeping later and taking naps. Ream & Richardson (1999) feel that patients choose common sense approaches that they would have used prior to having cancer in order to tackle the problem. They feel that these approaches are often ineffective and for this reason, guidance and advice needs to be given by the health professional in selecting other approaches. These include light exercise, prioritisation activities and relaxation and distraction. Winningham et al (1994) recommend that a balance is achieved between restorative rest and restorative activity. This is explained by Winningham's Psychobiologic – Entrophy Hypothesis Theory (Appendix 2).

The nursing staff allowed Laura time to express how this overwhelming side effect affected her quality of life. Krishnasamy (1997) emphasises the importance of allowing patients to talk about their fatigue, as this reduces the isolation they may feel in experiencing an intangible side effect that is not easily understood by their family and friends.

Before discussing the problem of skin reaction, it is important to understand the structure of the skin and how radiation therapy can damage it. Sitton (1997) describes the structure of the skin as consisting of the epidermis and the dermis. The lowest layer of the epidermis is called the basal layer. This is a single layer of cells which is responsible for maintaining a constant cell population, balancing cell loss and cell growth. Campbell (1996) explains that radiotherapy causes damage to this basal layer resulting in no renewal of epidermis. Campbell (1996) states that there are three degrees of skin reaction identified in the literature. These are:

- (i) Erythema – The skin becomes reddened, it may tingle, a rash or inflammation may develop.
- (ii) Dry desquamation – The area becomes dry and may flake off, pruritis may develop.
- (iii) Moist desquamation – The epidermis sloughs off, leaving a painful exposed dermis that may ooze serious fluid.



Sainsburg et al (2000) explain that, nowadays, damage to the skin is minimised due to modern megavoltage machinery and the delivery of the dosage in smaller fractions. O'Rourke & Robinson (1996) list factors which may increase the chances of developing a skin reaction. These include: having concurrent chemotherapy, receiving chest wall radiation, having an electron boost as this delivers a higher dose to the skin and having skin folds in the treatment field i.e. the axilla. In the case of Laura, all these factors were present so it is hardly surprising that she developed a severe skin reaction.

Laura had been informed, on commencing radiotherapy, that she may develop a skin reaction as the treatment progressed. The goal of nursing care was to minimise any reaction and prevent infection. In an attempt to achieve this goal, nursing interventions included educating the patient on how to care for her skin. She was advised to avoid friction by rubbing the area, to avoid wearing restrictive clothing and to avoid using perfumed soaps/creams/talcs which may contain metallic elements which could result in scattering of the ionising beam. This is supported by Walker (1982). Laura was advised to wash the area with tepid water, to use a mild soap and rinse thoroughly and to avoid exposing the area to temperature extremes. Sitton (1997) supports this intervention. E45 cream was given to Laura to moisturise the skin in the chest wall area. According to Campbell (1996) this is necessary to combat the drying effect which radiotherapy has on the skin.

The problem of a skin reaction was identified easily by observing the skin area of the treatment site on a daily basis. After twenty fractions of radiotherapy Laura developed an itchy, erythematous rash. Hydrocortisone cream 1% was prescribed, which Laura was advised to use sparingly. Hilderley (1983) feels that steroid cream should not be used routinely as it can cause thinning of the skin and increase risk of injury. However, Glees (1979) cited by Walker (1982), stated that it reduced inflammation and patients found it soothing. Once Laura had commenced her electron boost, moist desquamation developed and her skin became painful. At this point, the hydrocortisone cream was discontinued and the area was kept clean and dressed with a hydrocolloid occlusive dressing (Nugel). Margolin et al (1990) conducted a small study with twenty patients using this type of dressing. It was found to be effective in the healing process and no incidences of wound infection were reported. In order to reduce Laura's pain, oral difene was commenced with good relief. This use of non-steroidal anti-inflammatories is advocated by O'Rourke and Robinson (1996). Prior to discharge, Laura's public health nurse was contacted and it was agreed that she would continue with the hydrocolloid dressings on a daily basis.

On reflection, the nursing interventions used to help prevent and alleviate the problem of a skin reaction were appropriate. The goals set were measurable and the rationales for the nursing care were based on the research currently available. There is, however, a great need for more research to be carried out on this topic.



On admission, the problem of altered body image was identified, as Laura stated that she found it difficult to cope with the adjustment of having only one breast. Carroll (1998) states that the disfigurement caused by a mastectomy results in a great deal of emotional distress for a woman. Mac Ginley (1993) emphasises the importance of nurses recognising that an alteration in body image may be related to a change in the functioning as well as the appearance of a body part. In considering the function of the breasts, it is obvious that they play a huge role in sexuality and femininity. Wassner (1982) cited by MacGinley (1993) explains that this is how breasts are viewed within our society. This correlates with the belief that body image is formed in a social context as well as a personal one and that it plays an important role in a person developing self worth within our society (Price, 1990).

In order to care for a patient with altered body image it is important for nurses to understand and recognise the stages of adjustment and patients' unconscious defence mechanisms. (MacGinley, 1993). Four stages of adjustment to altered body image are identified by Platzer (1987) cited by MacGinley (1993). These are: recognising the change, withdrawing from the loss, facing the change and re-organisation of lifestyle. Laura progressed through these responses but sometimes moved back to the previous stage.

Price (1990) devised a model for caring for patients who have altered body image. He suggests that we should view the body as consisting of three components: body reality (body as it really exists), body ideal (how we would like the body to look and perform) and body presentation (body as presented to the outside world). He proposes that nurses should use these principles whilst considering the coping strategies and social support networks, to assess, plan, implement and evaluate nursing care of a patient with altered body image. In the case of Laura O'Neill, Price's model for body image care was not officially used, yet the nursing assessment and interventions employed, reflected his ideas.

In caring for Laura, her previous body image was assessed as recommended by Price (1990). The nurses recognised that treatment with tamoxifen therapy in the past had negatively affected her sexuality and body image. Lamb (1995) states that alterations in hormonal status can result in menopausal symptoms which can affect sexual expression. Laura attributed the use of tamoxifen to one of the causes of her marital disharmony and subsequent separation. The nurses and social worker took part in active listening and allowed Laura to express the anger and sadness which she felt. MacGinley (1993) emphasises the importance of the nurse being non-judgemental and using interpersonal skills such as trust and empathy. Price (1990) feels that counselling assists the patient to re-assign value to other parts of the body that are unaltered. Laura was assisted to improve body presentation by being encouraged to dress in colourful clothes which she normally wore and liked.



Towards the end of her treatment Laura experienced severe fatigue and a skin reaction which negatively altered her view of her body. Kolb (1975) cited by Price (1990) explains that people's feelings towards their bodies are constantly changing. Rabinowitz (1997) cited by Carroll (1998) suggest that the effects of chemotherapy do little to boost the image of a woman whose body image has recently been altered by a mastectomy. At this stage, supportive actions as advocated by Price (1990), were implemented. These included encouraging Laura to look at her skin reaction while it was being dressed. MacGinley (1993) suggests that nurses should assess the level of support the patient already has and the level needed. Although Laura had no partner she had a supportive circle of friends who visited and took her out when she felt well enough. Laura was referred to the breast care nurse specialist so that she would have a resource person when discharged.

On reflection, the nursing care facilitated Laura to adjust to her altered body image. However, this could have been improved by documenting Price's model for body image care.

In conclusion, breast cancer is common in Ireland, representing 16% of all cancers in women in 1997, a total of 1715 new cases and 634 deaths in this year. (National Cancer Registry Ireland 2000). To ensure the best treatment is given to women, a number of treatment modalities are often used in combination, depending on the staging of the disease. In the case of Laura O'Neill, treatment of her invasive carcinoma adhered to current recommendations based on research. During her treatment many problems arose which had physical and psychosocial components. Alleviation of these problems using a multi-disciplinary approach, were, for the most part, successful. However, more emphasis needs to be placed on the use of assessment tools and models of care, which would improve the overall care.



## **Appendix 1: Piper Fatigue Scale**

The Piper Fatigue Scale as explained by Piper et al (1998) measures four subjective dimensions of fatigue: the timing of fatigue (temporal dimension), the emotional meaning attached to fatigue (affective dimension), the mental and physical symptoms of fatigue (sensory dimension) and the influences of fatigue on daily living (intensity/severity dimension).

## **Appendix 2: Psychobiologic - Entrophy Hypothesis Theory**

Winningham's Psychobiologic - Entrophy Hypothesis Theory (PEH) explains that fatigue arises from disease, treatments, symptoms and inactivity. These all result in more decreased activity leading to secondary fatigue, decreased functional status and disability.



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## References

- Aikin, J.L. (1996) Tamoxifen in perspective: benefits, side effects and toxicities. In *Contemporary Issues in Breast Cancer*, (Hassey – Dow, K.) (ed.), Jones & Barlett, Boston, 59 – 68.
- Campbell, J. (1996) Developing a skin – care protocol in radiotherapy, *Professional Nurse*, 12 (2), 105 – 108.
- Crane, R. (1997) Breast cancers. In *Oncology Nursing*, 3rd edn. (Otto, S.E.) (ed.), Mosby Inc., St. Louis, 81 – 123
- Carroll, S. (1998) Breast cancer part 3: psychosocial care, *Professional Nurse*, 13 (12), 877 – 883.
- Early Breast Cancer Trialists' Collaborative Group. (1998) Polychemotherapy for early breast cancer: an overview of the randomised trials, *The Lancet*, 352, (Sep 19), 930 – 941.
- Fischer, D. S., Tish – Knobf, M., Durivage, H.J. (1993) *The Cancer Chemotherapy Handbook*, 4 edn. Mosby year book, St Louis.
- Fisher, B., Dignam, J., Wolmark, N., Mamourias, E., Costantino, J., Poller, W. (1998) Lumpectomy and radiation therapy for the treatment of intraductal breast cancer: findings from National Surgical Adjuvant Breast and Bowel Project, B – 17, *Journal of Clinical Oncology*, 16 441 – 452. Cited in Goldhirsch, A., Glick, J. H., Gelber, R.D., Senn, H. J. (1998). Meeting highlights: international consensus panel on the treatment of primary breast cancer, *Journal of the National Cancer Institute*, 90 (21), 1601 – 1607.
- Glees, J., Mameghan – Zadeh Sparkes, C.G. (1979) Effectiveness of topical steroids in the control of radiation dermatitis, *Journal of Clinical Radiology*, 30 387 – 403. Cited in Walker, V. A. (1982) Skin care during radiotherapy, *Nursing Times*, Dec 8, 2068 – 2070.
- Goldhirsch, A., Glick, J.H., Gelber, R.D., Senn, H.J. (1998) Meeting highlights: international consensus panel on the treatment of primary breast cancer, *Journal of the National Cancer Institute*, 90 (21), 1601 – 1607.
- Haylock, P., Hart, L. (1979) Fatigue in patients receiving localised radiation, *Cancer Nursing*, 2, 461 – 467. Cited in Winningham, M.L., Nail, L.M., Barton – Burke, M., Brophy, L., Cimprich, B., Jones, L.S., Pickard – Holley, S., Rhodes, V., St. Pierre, B., Beck, S., Glass, E.C., Mock, V.L., Mooney, K. H., Piper, B. (1994) Fatigue and the cancer experience: the state of the knowledge, *Oncology Nursing Forum*, 21 (1) 23 – 36.



- Hilderley, L. (1983) Skin – care in radiation therapy, *Oncology Nursing Forum*, 10 (1), 51 – 56.
- Hilderley, L.J. (1997) Principles of teletherapy. In *Nursing Care in Radiation Oncology*, (Hassey – Dow, K., Dunn – Bucholtz, J., Iwamoto, R., Fieler, V., Hilderley, L.) (eds), W.B. Saunders, Philadelphia, 6 – 20.
- Iwamoto, R. (1997) Radiation therapy. In *Oncology Nursing*, 3rd edn. (Otto, S.E.) (ed.), Mosby Inc., St. Louis, 503 – 529.
- Kolb, C. (1975) Disturbances of body image. In *American Handbook of Psychiatry* Vol. 4. (Arieti, S.) (ed.). Basic Books, New York. Cited in Price, B. (1990) A model for body– image care. *Journal of Advanced Nursing*, 15, 585 – 593.
- Krishnasamy, M. (1997) Exploring the nature and impact of fatigue in advanced cancer, *International Journal of Palliative Nursing*, 3(3), 126 – 131.
- Lamb, M. (1995) Effects of cancer on the sexuality and fertility of women, *Seminars in Oncology Nursing*, 11(2), 120 – 127.
- Langhorne, M. (1997) Chemotherapy. In *Oncology Nursing*, 3rd edn. (Otto, S.E.) (ed.), Mosby Inc., St. Louis, 530 – 572.
- Lee, L. (1996) The nurse's role: facilitator of communication, *European Journal of Cancer Care*, 5 (suppl 3), 5 – 6.
- Love, R., Leventhal, H., Easterling, M., Nerenz, D. (1989) Side effects and emotional distress during cancer chemotherapy, *Cancer*, 63, 604 – 612. Cited in Winningham, N.L., Nail, L.M., Barton – Burke, M., Brophy, L., Cimprich, B., Jones, L.S., Pickard – Holley, S., Rhodes, V., St. Pierre, B., Beck, S., Glass, E.C., Mock, V.L., Mooney, K.H., Piper, B. (1994). Fatigue and the cancer experience: the state of the knowledge, *Oncology Nursing Forum*, 21 (1) 23 – 36.
- MacGinley, K.J. (1993) Nursing care of the patient with altered body image, *British Journal of Nursing*, 2(22), 1098 – 1102.
- Margolin, S.G., Breneman, J.C., Denman, D.L., La Chapelle, P., Weckbach, L., Aron, B.S. (1990) Management of radiation induced moist skin desquamation using hydrocolloid dressing, *Cancer Nursing*, 13 (2), 71 – 80.
- Nail, L.M., Jones, L.S., Greene, D., Schipper, D.L., Jensen, R. (1991) Use and perceived efficacy of self – care activities in patients receiving chemotherapy, *Oncology Nursing Forum*, 18 (5), 883 – 88



- National Cancer Registry Ireland (1997) *Cancer In Ireland: Incidence and Mortality*, Healy & Assoc, Cork.
- National Institutes of Health Consensus Development Panel (1992) Consensus Statement: treatment of early stage breast cancer, *Journal of National Cancer Institute Monogr*, 11 (1). Cited in Crane, R. (1997) *Breast cancers*. *Oncology Nursing*, 3rd edn. (Otto, S.E) (ed), Mosby Inc, St. Louis, 81 – 123.
- O'Rourke, N., Robinson, L.M. (1996) Breast cancer and the role of radiation therapy. In *Contemporary Issues in Breast Cancer*. (Hassey – Dow, K) (ed), Jones & Barlett, Boston, 43 – 58.
- Overgaard, M.H., Overgaard, J.K.C., Anderson, M., Bach, E. (1997). Postoperative radiotherapy in high – risk pre-menopausal women with breast cancer who receive adjuvant chemotherapy, *New England Journal of Medicine*, 337, 949 – 955. Cited in Goldhirsch, A., Glick, J.H., Gelber, R.D., Senn, H.J. (1998) Meeting highlights: international consensus panel on the treatment of primary breast cancer, *Journal of the National Cancer Institute*, 90 (21), 1601 – 1607.
- Piper, B.F., Dibble, S.L., Dodd, J.J., Weiss, M.C., Slaughter, R.E., Paul, S.J. (1998) The revised piper fatigue scale: psychometric evaluation in women with breast cancer, *Oncology Nursing Forum*, 25 (4) 677 – 684.
- Platzer, H. (1987) Body image – a problem for intensive care patients (part one), *Intensive Care Nursing*, 3 (2), 61 – 66. Cited in MacGinley, K.J. (1993) Nursing care of the patient with altered body image, *British Journal of Nursing*, 2 (22) 1098 – 1102.
- Price, B. (1990) A model for body – image care, *Journal of Advanced Nursing*, 15, 585 – 593.
- Rabinowitz, B.F. (1997) Two decades of psychosocial research: an overview for the practitioner. In *Textbook of Breast Diseases*, (Bonadonna, G., Hortobagyi, G., Gianni, A.M.) (eds), Dunitz, London. Cited in Carroll, S. (1998) Breast cancer part 3: psychosocial care, *Professional Nurse*, 13 (12), 877 – 883.
- Ream, E., Richardson, A. (1996 a) Fatigue: a concept analysis, *International Journal of Nursing Studies*, 33 (5), 519 – 529.
- Ream, E., Richardson, A. (1996 b) Fatigue in patients receiving chemotherapy for advanced cancer, *International Journal of Palliative Nursing*, 2 (4), 199 – 204.



- Ream, E, Richardson, A. (1999) From theory to practice: designing interventions to reduce fatigue in patients with cancer; *Oncology Nursing Forum*, 26 (8), 1295 - 1303.
- Sainsbury, J.R., Anderson, T.J., Morgan, D.A. (2000) Breast cancer; *British Medical Journal*, 321, 745 - 750.
- Sitton, E. (1997) Managing side effects of skin changes and fatigue. In *Nursing Care in Radiation Oncology*, 2nd edn. (Hassey - Dow, K, Dunn - Bucholtz, J, Iwamoto, R, Fieler, V, Hilderley, L.) (eds), W.B. Saunders, Philadelphia, 79 - 100.
- Souhami, R, Tobias, J. (1998) *Cancer and its management*, 3rd edn, Blackwell Science, Oxford.
- Strohl, R.A. (1988) The nursing role in radiation oncology: symptom management of acute and chronic reactions; *Oncology Nursing Forum*, 15 (4), 429 - 434.
- Walker, V.A. (1982) Skin care during radiotherapy; *Nursing Times*, Dec 8, 2068 - 2070.
- Walsh, T.N, O'Higgins, N. (2000) *Breast Cancer Management: Clinical Guidelines*, Royal College of Surgeons, Dublin.
- Wassner, A. (1982) The impact of mutilating surgery or trauma on body image; *Intern Nursing Review*, 29 (3), 86 - 92. Cited in MacGinley, J.J. (1993) Nursing care of the patient with altered body image; *British Journal of Nursing*, 2(22), 1098 - 1102.
- Winningham, M.L., Nail, Barton - Burke, M., Brophy, L., Cimprich, B., Jones, L.S., Pickard - Holley, S., Rhodes, V., St. Pierre, B., Beck, S., Glass, E.C., Mock, V.L., Mooney, K. H., Piper, B. (1994) Fatigue and the cancer experience: the state of the knowledge; *Oncology Nursing Forum*, 21 (1), 23 - 36.



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# PRELIMINARY NOTICE

IANO ANNUAL GENERAL MEETING

TULLAMORE  
COURT HOTEL

TULLAMORE  
CO. OFFALY

FRIDAY 4TH OCTOBER 2002 AT 6PM

*FOR FURTHER DETAILS CONTACT:-*

*MARY KENNEDY TEL:01-2310500*

*OR*

*Email:mkennedy@irishcancer.ie*

FRIDAY 4TH  
OCTOBER

TULLAMORE  
COURT HOTEL



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# PRELIMINARY NOTICE

IANO 20TH ANNUAL  
CONFERENCE  
20 YEARS OF MEETING THE  
CHALLENGES OF CANCER NURSING

TULLAMORE  
COURT HOTEL

TULLAMORE  
CO. OFFALY

SATURDAY 5TH OCTOBER 2002 AT 6PM

*SPEAKERS TO BE ANNOUNCED AT A LATER DATE*

SATURDAY 5TH  
OCTOBER

TULLAMORE  
COURT HOTEL



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## NOTES



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## NOTES



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