

BLOOD matters APRIL 2010

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Welcome...

to the first edition of **Blood Matters in 2010**. We trust that we can build on the successes of the HAI Nurses Group again this year and are delighted to once more offer bursaries to our members for educational, clinical and travel purposes. Information and application criteria can be found inside and we would encourage you all to avail of this opportunity. Also, it would do no harm to start thinking of potential subjects for presentation at the 2010 annual conference. Susan Piggott, our externally adjudicated winner of the best oral presentation in 2009, outlines for Blood Matters how she utilised her educational bursary prize and we hope that it inspires you to get your abstract written. In fact, we're even going to help you to do it...At our Spring study day on 16th April 2010 in the Kilmainham, Dublin, amongst a wide variety of presentations, we are hosting a session on how to create a prize winning abstract, poster or oral presentation. We look forward to seeing you there - especially as the event is free to all members!

Inside this issue there is another great winning possibility. Our crossword prize was not claimed from the last edition - so it's now a rollover amounting to €200! Good luck with that. We also have articles on diverse subjects ranging from therapeutic communication to a new initiative of "dose banded" chemotherapy, current and future directions in CML management, and the Irish Blood Transfusion Service Platelet Donation Programme. We hope that these provide education and inspiration for your practice. If you have material for inclusion in the newsletter - information or innovations - please forward to me at caroline.mccaughey@qub.ac.uk. We'd be delighted to receive any contributions.

Finally I would like to thank Mary Kelly, who stepped down as Chair of the HAI Nurses Group after three years at the helm. She did a sterling job and we are delighted that she is remaining on the committee. Find out further details regarding your HAI committee inside.

Yours on behalf of the HAI nurses Committee,

CAROLINE MCCAUGHEY

Newsletter Editor and Chair
of the HAI Nurses' Group

MEMBERSHIP INFORMATION

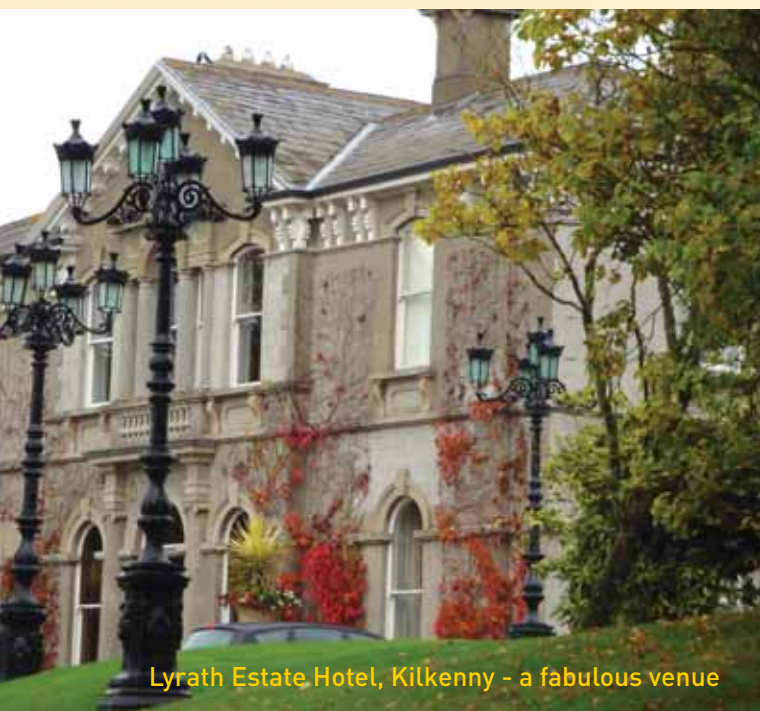
Membership of the Haematology Association of Ireland Nurses and Allied Health Professionals Group can be arranged by contacting:

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www.ncnm.ie/haing/index.asp

Haematology Association of Ireland Annual Conference

16th and 17th October 2009

I think anyone who was there would agree that HAI 2009 was one of our most successful conferences to date. It was hosted in the spectacular Lyrath Estate Hotel, Kilkenny, allowing a perfect balance of education and social relaxation.



Lyrath Estate Hotel, Kilkenny - a fabulous venue

The nurses' programme on Friday 16th commenced with a fascinating presentation by Ciara Hughes from the HARI Unit, regarding fertility preservation in haemato-oncology. This was followed by Dr Niamh O'Connell who generated much interest by her overview of novel anticoagulant agents. Sandwiched around the state of the art lecture on transplantation in adult ALL by Dr Jacob Rowe were our five oral presentations, selected from the submitted abstracts. These addressed subjects ranging from nurse managed anticoagulation services through to advanced practice nursing roles, encompassing telephone clinics, prescribing and performance of bone marrow biopsies. The external adjudicators, Marie Glackin (Queen's University, Belfast) and Patricia Fox (University College, Dublin) had a challenging job selecting the winning presentation; however Susan Piggott (Transplant Coordinator, Belfast City Hospital) inched past the rest with an original talk entitled "prescribing a can of worms". Many thanks to Schering Plough for sponsoring the €2400 educational bursary which Susan used to fund attendance at the American Society of Haematology

2009 conference in New Orleans (see article within this edition of Blood Matters).

Other presentations on day one of the conference included a well evaluated talk on modern management of CLL by Dr Patrick Thorton and an exploration of the effects of Myeloma on the kidneys by Brendan Reidy, a nephrology nurse from Tullamore. The final presentation of the day was by Dr Corrina McMahon, who got us all engaged in an interactive discussion of an unusual paediatric case of chicken pox. Poster viewing followed, and our adjudicators commented on the high standard of submissions. We were delighted to have the highest number of posters ever submitted within the nurses group and look forward to beating our new record in 2010! Imelda Whelan from the anticoagulation clinic, Naas General Hospital authored the poster which caught the eye of the adjudicators and secured her a €1000 educational bursary, kindly sponsored by Baxter.

On the second day of the conference, Dr Claire Harrison, an invited speaker from Guys and St Thomas', gave us insight into the management of a young person with a Myeloproliferative disorder. This was followed by the traditional Liam O'Connell memorial lecture, ably presented by Prof Eva Hellstrom-Lindberg, from Sweden, regarding Myelodysplastic syndromes. Lunch on Saturday was a very lively affair, as for the first time we had a combined morphology quiz, incorporating medical / scientific and nursing delegates. This was hosted by HAI's long-established "quiz mistress" Dr



Louise, Caitlin and Joanne enjoying the dinner on Friday evening

Wendy Erber who was joined by Caroline McCaughey from the nurses' committee. I suspect this format may reappear next year as the feedback was positive - at least from the winning table headed up by Dr Claire Harrison et al! The identity of the table who won the "consolation prize" for coming last will, in the interest of preserving dignity, remain anonymous!!!

The final sessions of HAI 2009 included a discussion of the importance of spiritual and Fr Gerard Fox from Belfast City Hospital chaplaincy give suggestions as to how this could be integrated into the everyday care of haematology patients. The theme then shifted to the topic of the molecular basis of haematological malignancy, which was clearly and succinctly explained by Dr Jude Fitzgibbons. Dr Paul Browne subsequently outlined the role of stem cell transplant prior to Dr Mary Cahill, the outgoing President of HAI, giving a very interesting synopsis of the highlights from the main programme.

The conference concluded with the annual general meeting where the newly configured nurses committee was voted on. Many thanks to Mary Kelly for three years of hard work and leadership as the Chair of the Nurses' Group. She is succeeded by Caroline McCaughey but as you can see, these will be hard shoes to fill!! Other changes included the nomination of three new or returning members, Ruth Thompson, Ger Walpole and Teresa Meenaghan. Lorna Storey has taken over from Susan Piggott as the treasurer, whilst Lorna handed over the office of secretary to Kathleen Beston.

And then the fun really began..... Sinead Cassidy, the HAI administrator, had used her legendary powers of persuasion to secure the very special venue of Kilkenny Castle for dinner - and had even got a guided tour of the castle thrown in! The Nurses' Group couldn't fail to mention at this point that the medical, scientific and nursing prizes were announced prior to dinner and for the first time ever, the best poster presentation in the medical/scientific category went to a nurse!! Well done to Ruth Thompson, MPD specialist nurse, Belfast City Hospital, who presented her regional Essential Thrombocythaemia audit across N. Ireland which clinched the prize.



Mary Kelly and her fabulous shoes!

Then after dinner came the entertainment and on this occasion Sinead really outdid herself! Sinead, unbeknownst to us had organised the services of the Kilkenny Gospel Choir which provided rousing renditions which as you see had just about everyone up on their feet joining in. We're not sure how Sinead is going to keep the surprises up for next year, but we're looking forward in anticipation! Sinead and her team must also be congratulated on the professionalism which they added to this year's conference administration - a job well done!



Enjoying Kilkenny Gospel Choir



The nurses committee 2009 - 2010 from left: Lorna Storey, Kathleen Beston, Ruth Thompson, Liz O'Connell, Karena Maher, Susan Piggott, Caroline McCaughey, Rosena Geoghegan, Joy Lewis, Teresa Meenaghan and Mary Kelly, (Ger Walpole missing from the photo)



Finally, many thanks to our numerous sponsors who once again contributed to the success of another very worthwhile and memorable HAI conference

HAI bursaries for Haematology Nurses and Allied Health Professionals

Applications are invited for bursaries which are aimed at supporting innovations in haematology practice and educational development. A total of €2500 is available annually; however this sum may be divided between candidates, at the discretion of the adjudicators, in the event of multiple applications. Applications will be externally evaluated by independent adjudicators and their decision is final. The following categories will be considered:

- Course fees for a haematology related qualification
- Haematology educational resources for use by nurses, AHP's or patients
- Expenses towards a research /audit project which has a haematology focus
- Expenses towards implementing an innovation in haematology practice

Eligibility criteria:

- Applicants must be current members of the HAI Nurses'/AHP group
- If ethical approval is required for a research project it must be submitted with the application
- Evidence of approval of the application by the applicant's academic lead / clinical lead must be provided with the application

Applications should contain the following detail and be no longer than 2 A4 pages (double spaced)

- Background to the proposed application
- Aims of the project / rationale for the needs of the requested resources
- Project plan and timeline
- Outline of exact costing applied for
- Anticipated benefits
- Declaration of any other sources of funding

A CV of not longer than 2A4 sides should be included with the application

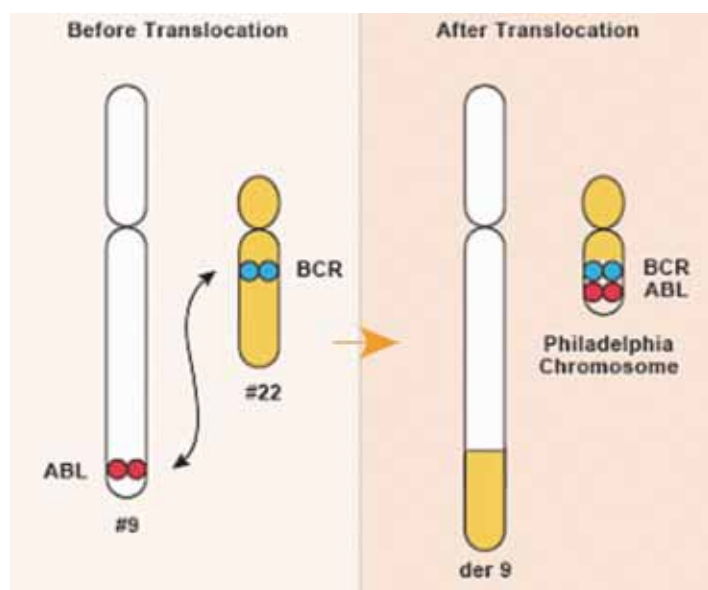
The successful applicant will be expected to present their project either at the HAI study day, annual conference or through an article in the Blood Matters newsletter within 24months of receiving the bursary.

Applications should be submitted electronically to s.cassidy@indigo.ie on or before Friday 20/08/10

Travel scholarships of up to €5000 are also available and details can be accessed at www.haematologyireland.org/scholarships.

Novel agents and current clinical trials By Lorraine McKenna, Research Nurse, Northern Ireland Cancer Clinical Trials Unit

Chronic Myeloid Leukaemia results from a reciprocal translocation between the cABL on chromosome 9 and BCR on chromosome 22. The fusion of BCR and ABL results in the production of a novel gene, BCR-ABL, which establishes tyrosine kinase activity. The consequence of this is uncontrolled cell proliferation, resistance to cell apoptosis and leukaemic development. CML follows three distinct phases; the initial chronic phase, the accelerated phase and finally the terminal blast phase. Tyrosine Kinase Inhibitors (TKI's) such as Imatinib block the activity of BCR-ABL and are now regarded as first line therapy for newly diagnosed CML, regardless of the phase. Prior to the development of TKI's, allogeneic haematopoietic stem cell transplantation was a pivotal therapeutic option, however now would be considered only in the case of eligible patients who have failed to respond to TKI's.



Currently the first line treatment of chronic phase CML is Imatinib (Glivec). With the introduction of Imatinib, the treatment of CML was revolutionised, however unfortunately approximately 30% of chronic phase patients continue to respond unsatisfactorily to Imatinib (O'Brien, 2003). With ongoing drug development in CML, many alternatives are now becoming available. New TKI's are important as despite impressive rates of complete cytogenetic response in Imatinib therapy, a minority of patients do not achieve this. This failure of treatment can be due to primary resistance whereby the patient does not attain an initial response, or secondary

resistance when the patient does not maintain their response and the CML progresses. Standard dose of Imatinib is 400mg; but the dose may be escalated to obtain maximal response. Discontinuation of Imatinib even in the context of a durable response is often associated with relapse, therefore it is an ongoing therapy for an indefinite period of time.

Dasatinib

Like Imatinib, Dasatinib is an oral targeted inhibitor of Bcr-Abl tyrosine kinase. While Dasatinib has a chemical structure that is unrelated to Imatinib, both these drugs have overlapping binding sites within the Abl kinase domain (Tokarski et al 2006), however Dasatinib will bind to both the active and inactive conformations of the protein.

Dasatinib is generally a well tolerated drug (normal dose 100mg OD), with manageable and reversible mild-moderate side effects. These adverse events appear to occur in the early stages following drug initiation. The most commonly reported side effects include cytopenia (neutropenia and thrombocytopenia), GI disturbances, pleural effusion, dyspnoea, skin rash and fatigue. Occasionally treatment interruption and dose reduction is required to allow the adverse event to resolve, enabling the patient to continue receiving the drug.

Nilotinib

Another drug designed to potentially overcome limitations of its predecessor is Nilotinib. Formerly known as AMN107, it is structurally related to Imatinib, but binds differently to the target i.e. it is more specific and selective for Bcr Abl. Preclinical studies have demonstrated that Nilotinib can achieve higher levels of intracellular concentration than Imatinib. Smaller studies conducted in the US and Italy, treating patients with 400mg twice daily, have observed 100% cytogenetic responses at 6 months. Exciting pre clinical data and ongoing studies have predicted Nilotinib to have a significant effect in the newly diagnosed chronic phase patient (Weisberg et al 2006)

Nilotinib appears to be quite well tolerated; however some adverse events have been reported including: hyperbilirubinaemia, elevation in aminotransferases, amylase and lipase, pancreatitis, myelosuppression, possible prolonged QT interval, fatigue, bone pain, loss of appetite, GI disturbances and skin rashes.

Clinical trials at Belfast City Hospital

Currently the Belfast City Hospital (BCH) site is conducting a number of clinical trials in the CML patient population. At present there is recruitment to a phase 2 study of Nilotinib in adults with newly diagnosed chronic phase CML. This treatment explores using Nilotinib 300mg BD to establish if it is as effective as 400mg BD, with potentially fewer side effects.

The BCH will also be participating in SPIRIT 2 - a phase 3 comparison of Imatinib 400mg OD v Dasatinib 100mg OD, as first line treatment in new chronic phase CML patients. The ENEST trial is presently going through the appropriate regulatory channels before opening at the Belfast City Hospital site. This trial will evaluate Nilotinib v standard Imatinib, by comparing the molecular response of CML patients with evidence of persistent leukaemia after at least 2 years of treatment with Imatinib

The future

Currently there are several other Bcr-Abl inhibitors in pre-clinical/early phase development, with the potential for greater clinical activity in CML. The novel agents currently being developed include Bosutinib and INNO-406.

Despite the success of Imatinib, Dasatinib, and now more recently Nilotinib, there are still avenues to be explored in the treatment of chronic phase CML. Possible drug combinations, covering the spectrum of Imatinib-resistant mutations are under consideration. Preliminary clinical studies combining a vaccine that targets a Bcr-Abl protein, with Imatinib, which may further reduce residual disease in the CML patient. Overall, drug development in CML represents a success story in molecular medicine. However, the ongoing aim is to continue to improve the treatment and prognosis for CML patients.

References

Milojkovic, D. and Apperley, J. (2008) State-of-the-art in the treatment of chronic myeloid leukaemia. *Current Opinion in Oncology*, 20, pp. 112-121

O'Brien SG, Guilhot F, Larson RA, et al (2003). Imatinib compared with interferon and low-dose cytarabine for newly diagnosed chronic-phase chronic myeloid leukemia. *New England Journal of Medicine*, 30, pp 994-1004

Tokarski JS, Newitt JA, Chang CV et al (2006). The structure of Dasatinib (BMS-354825) bound to activated ABL kinase domain elucidates its inhibitory activity against imatinib-resistant ABL mutants. *Cancer Research*, 66, pp 5790-5797

Weisberg E, Manley P, Mestan J, Cowan-Jacob S, Ray A and Griffin JD (2006). AMN107 (Nilotinib): a novel and selective inhibitor of BCR-ABL. *British Journal of Cancer*, 94, pp 1765-1769

Angels

Wraith - like figures down corridors of pain,
Angel's hands now soothing, like soft summer's rain,
The body is now writhing, could hell's pain be worse?
But sufferer, oh sufferer here comes this being called nurse.

Now a nurse is not all human, they are half angel and half spirit,
Soft and sheer like gossamer, their touch comes in the night,
No evil here, no evil here, nor original sin's dark curse,
For God has sent straight from above those beings that he calls nurse.

Each human heart must know its pain; each soul must know its grief,
While we seek and turn eternally, for peace and blessed relief.
Now God has brought back living, brought back life's lovely verse
By sending down those beings of light, those beings that he calls nurse.

In grateful appreciation

This poem was written by a visually impaired patient receiving chemotherapy for a haematological malignancy, who was hospitalised for a prolonged period of time.

The Introduction of Dose Banded Chemotherapy to a Haematology Service

By Stephen McNeice, Pharmacy Chemotherapy Manager, Belfast City Hospital and Claire Marshall, Team Leader, Bridgewater Suite, BCH.

Dose banded chemotherapy has been defined by Plumridge and Sewell as:

'A system whereby doses of intravenous cytotoxic drugs calculated on an individualised basis that are within defined ranges, or bands, are rounded up or down to predetermined standard doses. The maximum variation of the adjustment between the standard dose and the doses constituting each band is 5% or less. A range of pre-filled syringes or infusions, manufactured by pharmacy staff or purchased from commercial sources, can be used to administer the standard dose.'

Advantages of Dose Banding include:

- Rationalisation of doses and reduction in dose calculation errors
- Quicker dispensing using commercially prepared ready to use doses
- Reduction in waiting times for chemotherapy
- Reduces waste. Due to extended shelf life (up to 84 days), can reuse deferred doses. Can also avoid the incomplete use of the contents of a vial during preparation of individual doses
- Reduction in the risk of occupational exposure
- Free pharmacy capacity to prepare more complex regimens including items for clinical trials.

Disadvantages of Dose Banding include:

- Use of more than one syringe (potentially three or four) for some bolus doses
- Potential increase in acquisition costs
- Additional storage space required for pre-filled doses (Most products are fridge items)
- Additional pharmacy workload implications for managing of ordering, goods receipt and stock control.
- Potential supply issues from manufacturers based in mainland UK.

In Belfast City Hospital all parenteral cancer chemotherapy is prepared in the Satellite Pharmacy which is located adjacent to the Bridgewater Suite outpatient department. The pharmacy's aseptically prepared workload has continued to steadily increase and in many cases become more complex. The aim of introducing dose banded chemotherapy was to streamline the dispensing process and minimize patient waiting times. We identified drugs and regimens suitable for banding, having confirmed acceptable shelf-lives for banded products.

In Oncology the regimen FEC was chosen for the first phase of dose banding implementation. This was completed successfully by December 2008.

The two Haematology regimens chosen for second phase implementation were

- CHOP component of R-CHOP
- CVP component of R-CVP

These are the most frequently administered day case regimens in Haematology. The individualised doses based on Body Surface Area are not necessarily complex for pharmacy to aseptically prepare. However, if prepared immediately prior to administration this may result in delays and for pharmacy add a sense of pressure and urgency to the dispensing process.

As preliminary groundwork, pharmacy performed literature searches and contacted hospital pharmacies in Scotland (at the Beatson Oncology Center and Edinburgh Oncology Center) to gain an insight into their experiences with dose banding. The next step was to prepare dose banding tables for the chosen regimens. These were then approved by all relevant consultants. A procedure for use of these tables was drawn up and also approved. The range of syringes and infusion combinations needed to produce the banded doses were chosen so that the stock holding requirement in pharmacy and combinations needed to be dispensed and administered would not be excessive.

A tender specification for all products was drawn up and a regional chemotherapy dose banding contract for Northern Ireland was awarded. Pharmacists, pharmacy technicians and nurses from both the Northern Ireland Cancer Centre and Cancer Units participated in the assessment of suitability of the available products with respect to syringe sizes, shelf life, product labelling and packaging before final award of the contract was made. All syringes and infusions available on the regional contract are prepared in licensed, 'specials' production units based in mainland UK.

In practice the procedure for use of dose banding is straightforward. Prescribers continue to calculate individualised doses according to Body Surface Area. The prescriber then selects the appropriate

standardised banded dose, from tables provided, when writing or authorising the prescription. The prescription is checked by a pharmacist before being dispensed. Dose banding charts used in pharmacy specify product selection by including details of syringe size selection and quantities required for each banded dose.

Dose banding for CHOP and CVP was successfully implemented in August 2009 with many of the expected advantages quickly realised by pharmacy, nurses and patients.

Reported benefits from a nursing and patient perspective

- More rapid delivery of chemotherapy from pharmacy - it has saved approximately two hours in the process from the prescription is written until the chemotherapy arrives in the unit. This is significant for ill/frail patients awaiting treatment
- More prompt treatment initiation
- Treatments completed within scheduled outpatient department opening times rather than running late
- Capacity freed up within the department as the patient journey is expedited
- Scheduling of patient time slots can be allocated more accurately as the time when chemotherapy will be available is more predictable
- More patients are able to have both their assessment and treatment on the same day rather than having to return the following day for chemo.
- Patients have a more definite idea of the timeframe they will have to spend in the outpatient department
- Less reported dissatisfaction with waiting times or treatment delays
- Less time taken out of the patient's and carer's daily life or work.
- As the treating hospital is in the inner city, more patients can have their treatments completed prior to rush hour traffic commencing

- More predictability and control during hospital visits. A portable buzzer system is in operation so that patients can leave the department and be alerted when their blood results are confirmed and treatment is ready for administration
- More efficiency for the nurse coordinating the department including delegation of nurse/patient allocation
- Workload spread more evenly throughout the day - allowing for a more efficient use of treatment time slots
- More efficiency with transport arrangements - especially if the patient requires ambulance service
- Less interruptions of nurses by patients checking if their treatment is ready

Recommendations

Whilst this change in practice incurred no significant training issues for the staff, nurses were invited to drop-in sessions in pharmacy to familiarise themselves with the new drug packaging prior to the implementation of dose banded chemotherapy.

Future developments:

- Audit the impact of implementation of dose banding
- Assess how we can maximise the opportunity for further implementation of dose banding for other chemotherapy drugs / regimens.

Further Reading

Plumridge, R.J., Sewell, G.J. Dose-banding of cytotoxic drugs: A new concept in cancer chemotherapy. *Am J Health-Syst Pharm* 2001; 58: 1760-1764.
MacLean, F., Macintyre, J., McDade, J., Moyes, D. Dose banding of chemotherapy in the Edinburgh Cancer Centre. *Pharmaceutical Journal* 2003; 270: 691-693.
Cancer Network Pharmacists Forum - Dose banding toolkit: How to implement dose banding of chemotherapy (2008)

For further information please feel free to contact stephen.mcneice@belfasttrust.hscni.net

“A system whereby doses of intravenous cytotoxic drugs calculated on an individualised basis that are within defined ranges, or bands, are rounded up or down to predetermined standard doses.”

Irish Blood Transfusion Service Platelet Donation Programme

by Niamh Flynn, CNMII Apheresis Clinic,
Irish Blood Transfusion Service

The Irish Blood Transfusion Service, responsible for the collection of blood and blood products in Ireland, currently has two Platelet Clinics collecting platelets by apheresis donation. Like whole blood clinics, the platelet clinics operate under European Directives.

According to the World Health Organisation (WHO), safe donors are the cornerstone of a safe and adequate supply of blood and blood products. The provision of a safe blood and blood component supply is protected by a combination of measures including the use of voluntary, non-remunerated donors, careful donor selection and donor education and sensitive laboratory screening of donated blood components. There are several stages involved in the donation process, these include; donor recruitment, the selecting of eligible donors, donor education, donor vigilance and care whilst donating and infection control to ensure product quality and donor safety. A pleasant experience during platelet donation, good donor care and effective communication between clinic staff and platelet donors are all important factors for the retention of safe platelet donors.

The standards of quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components within Ireland are governed by EU Directives 2002/98/EC in Blood Collection which also encompasses the collection of platelets by a process called apheresis. Apheresis comes from the Greek word "pherese" meaning "to remove". In the Platelet Clinic the process used in platelet apheresis is called centrifugation. This involves a bowl spinning at high speed separating the blood components. Blood transfusion services began using component donation methods in the early 1970s, initially for plasma products for Factor VIII production. The technology has progressed over the years and it is now possible to collect platelet concentrate, red cells, plasma or any combination of these from each donor. At present the Irish Blood Transfusion Service collects just platelets by apheresis.

The advantages of platelet donation by apheresis are as follows:

- Recipient exposed to fewer donors
- One donation will usually produce 2 adult therapeutic doses with a possibility of a triple dose

- Several products can be collected
- Donors can donate more frequently
- Can produce HLA 'matched' donations
- No further processing necessary i.e. 'end product'

The IBTS Guidelines for donor selection by Medical Officers and Registered General Nurses are in conformance with the European Communities (Quality and Safety of Human Blood and Blood Components) regulations 2005.

Donor selection in the IBTS involves the following -
Completing a Health and Lifestyle Questionnaire, reading of Blood Safety Leaflet and Platelet Donation Information Leaflet

Donor Interview - extended for new and returning donors (i.e. those who have not donated in the last 2 years) or regular for existing donors. At this point, it is possible that a donor may be deferred from donating on a temporary or permanent basis.

Platelet screening - to ensure that the donor's platelet count is above the minimum acceptable level.

Assessment at the bedside i.e., pulse and blood pressure.

To prevent coagulation in an automated component donation, anticoagulants must be used. The anticoagulant of choice is ACD-A, (a sterile solution of citric acid, sodium citrate and dextrose) sometimes called Sodium Citrate. Once the blood containing the Sodium Citrate returns to the body, the body quickly starts to break the Citrate down releasing the calcium. Sometimes the Citrate is returned to the body quicker than the body can break it down and this leads to a condition known as Citrate Toxicity which can present as a mild tingling or numbness in the donor hands, feet, lips. If this occurs the procedure is paused to give the donor's body a chance to break down the Citrate and an isotonic drink is given to the donor to help alleviate the symptoms.

The apheresis machines are primed with the ACD-A and donor data. Gender, height, weight, blood group, haematocrit and platelet count details are entered into the machine. The optimal doses and times are offered on the screen. Triple dose donations have a 90 minute cut off for donor safety and as doses are determined on the input of individual data previously mentioned, not all donors can donate triple doses.

The average donation time is 60 minutes, producing a

double dose of platelets. The donor is monitored until the end of their first return and up-to-date platelet and haematocrit results are obtained within the first 15 minutes of donation. Donors are offered refreshments, newspapers and DVDs during their donation to enable them to have a pleasant experience.

The Irish Blood Transfusion Service is always looking to recruit new platelet donors. At present, while the IBTS collects the majority of platelets by apheresis, some are made by pooling from whole blood donations. In the long term, the goal is to collect all platelets by apheresis. There are Platelet Clinics in Dublin and in Cork where donors may attend on a monthly basis to donate. Friends and families members of patients receiving blood products are always keen to help out. All information on becoming a donor can be found on www.giveblood.ie/platelets or by calling 01 432 2833.

The Irish Blood Transfusion Service has been working for the past three years with the Irish Cancer Society to build awareness of platelet donation. If you have space to display a poster or leaflets, or if you would like a representative of the IBTS to visit you to brief staff about the Platelet Donation Programme, please contact Ann O'Leary (ann.o'leary@ibts.ie / 01 432 2717).

For information on blood donation in Northern Ireland please visit the Northern Ireland Blood transfusion website www.nibts.org or contact them at:
NIBTS, Lisburn Road, Belfast, BT9 7TS
Fax: 0044 (0)28 9043 9017
Phone: 0044 (0)28 9032 1414

FORTHCOMING events

21st - 24th March 2010

36th Meeting of the European Blood and Marrow Transplantation (EBMT). Austria Centre, Vienna.
www.congrex.ch/ebmt2010

19th April - 21st April 2010

British Society for Haematology 50th Annual Scientific Meeting, EICC, Edinburgh
www.b-s-h.org.uk/AnnualMeeting.asp

**19th May, 22nd September, 12th October,
4th November 2010**

British Society of Blood and Marrow Transplantation (BSBMT) upcoming meetings.
www.bsbmt.org/pages/10-Upcoming_Meetings

16th April 2010

Haematology Association of Ireland Nurses' Group Spring Study Day. Kilmainham Hilton Hotel, Dublin.
www.ncnm.ie/haing/index.asp
Email s.cassidy@indigo.ie FREE to HAI Nurses' Group members

June 2010

European Blood and Marrow Transplantation (EBMT) UK Nurses' Group. York.
www.ebmt.co.uk/meetings.php

19th- 26th June 2010

Myeloma awareness week. Email Brenda Drumm mymyeloma@gmail.com, visit www.mymyeloma.ie or phone Mary Kelly 0867804007

29th June 2010

Cancer Congress Update. Park Plaza Victoria, London.
www.succinctcomms.com/#/events

14th - 15th October

UKONS Annual Conference. Manchester Central, Manchester www.succinctcomms.com/#/events or www.ukons.org

15 - 17th October 2010

Haematology Association of Ireland Annual Conference. Galway Bay Hotel, Galway.
www.haematologyireland.org/meetings/default.htm
Email s.cassidy@indigo.ie

4th Thursday November 2010

UK Myeloma Forum Education Day. Royal Institute of British Architects, London.
www.ukmf.org.uk/meetings.htm

November 2010

European Blood and Marrow Transplantation (EBMT) UK Nurses' Group. Cheltenham.
www.ebmt.co.uk/meetings.php

4th - 7th December 2010

52nd American Society of Hematology (ASH) Annual Meeting. Orange County Convention Center, Orlando, Florida, USA. www.hematology.org/Calendar

American Society of Haematology (ASH) 2009 New Orleans, USA

By Susan Piggott (Winner of the educational bursary for best oral presentation - HAI 2009)

This is a report from my trip to the annual ASH meeting in early December 2009. I was only able to attend thanks to an educational bursary awarded by Schering Plough - This covered my flight, accommodation and registration costs for the meeting in New Orleans, USA.

ASH was to be held in New Orleans in 2004 but hurricane Katrina had other ideas. The Society pledged to return to New Orleans whenever it was possible to do so, and that pledge was honoured this year. Dr Cindy A Leissinger, MD, gave a presentation describing the aftermath of Katrina from the perspective of the Haematology Dept. of Tulane University Hospital caught up in the disaster. The city was buffeted by Katrina, however damage to the levees surrounding New Orleans resulted in catastrophic flooding. The people in the 'soup bowl' shaped city had been ordered to evacuate, but there were 10k people in the city who either would not or could not leave. Some had no transportation, others too old or too sick. Many were being cared for in hospitals and dependent on healthcare staff to care for them. After the flooding, all lines of communication were down - there was no telephone or web networks and no electric, food, water or sanitation for 5 days. After 5 weeks some people were allowed to return to survey the damage to their homes. Most lost everything. 1900 people lost their lives.

Lessons learned included the need to have battery operated radios available, and good back up IT systems for patient records. Some patients and healthcare staff were finally able to track each other down, but most records were lost. Many others were geographically dislocated and Dr Leissinger cited, as one example, the major difficulties faced by patients with haemophilia who required urgent treatment both within city and after evacuation. New Orleans have now switched from paper to electronic record keeping and have developed access routes for use in the event of future disasters. Food for thought.

This session at ASH was held as part of the Emergency Preparedness session. Many of us may not have spent much time considering the fact that our haematology units would be central to the care and survival of casualties in the event of a major radiation or nuclear attack within Europe.

My interest in ASH came from the perspective of a transplant co-ordinator - the transplant sessions however seemed few and far between - mainly updates on research reported in previous years rather than a focus on novel therapies. ASH, as with EBMT will over time answer important transplant related questions around best conditioning, control of immune-suppression associated complications and GvHD.

The joy of attending a conference like this though is the learning that is gained from areas outside your immediate field of expertise. A broad mix of education sessions, backed up with a comprehensive published education book, definitely sparked my interest in areas of haematology that I explore less often. A topical session by a MD from the US Centre of disease Control (CDC) demonstrated graphically the tracking systems used to monitor H1N1 influenza activity - The Advisory Committee on Vaccination guidelines are available and come with the warning that a pandemic is a multi-wave, multi-event phenomena and that we should not become complacent. The challenge for pharmaceutical companies to manufacture sufficient vaccine was cited as a current focus in planning for future pandemics.

I also learned a great deal from a historical perspective of stem cell biology - The E Donnell Thomas Lecture given by Dr John E Dick (Ontario, Canada) was a masterclass in how mice were used in the investigation of stem cell characteristics, and to track the process of stem cell engraftment; the cell doses needed and the best routes for introducing cells. This work was seminal in the evolution of the cell hierarchy, or haematopoietic tree, we all recognise today.

There is no dedicated nursing programme at ASH, and some sessions are deeply scientific but its appeal does reach to nurse specialists. In particular, the 'super Friday' Symposia, sponsored by pharmaceutical companies provide an opportunity to hear world experts speak on the state of the art in their chosen area of practice. The main ASH sessions running from Sat-Tues consist of lectures, educational sessions, plenary sessions, concurrent abstract presentations and poster sessions.

The congress centre, on the banks of the Mississippi, was absolutely massive, and navigating from one session to the other was a major headache for most people attending. Good planning along with a good map was the only way to go.

Exhibition stands by pharmaceutical companies were set up in a huge hall, but there were absolutely NO freebies - not a pen, not a piece of notepaper, a post-it nor a squirt of gel. Companies in the US are no longer able to give away anything with a company logo on it - they could not even serve a cup of coffee to an American Doctor lest it be construed as an attempt to influence their prescribing practice. The same principals will no doubt spread throughout Europe in due course. It certainly marked a change in practice from every other conference I have ever attended.

The one advantage of this was that it left more room in the suitcase for souvenir shopping. New Orleans is famed for being the birthplace of jazz - the only original art-form to have arisen from within the USA. Streetcar trolleys whizz you from the French quarter to the garden district, to downtown and wherever else you want to go. A few took the swamp tour, and apparently they all came back safely! Bourbon St. draws the tourists at night and although it can boast some great restaurants the whole area is extremely seedy and felt very unsafe for wandering. During the day the weather in December would normally be warm and balmy - perfect for dandering about - but needless to say there was a cold snap for the duration of ASH!

I had a great time though - would definitely encourage others to submit an abstract for an oral or poster presentation to HAI in the hope of winning a travel bursary. Next year ASH is in Orlando, 4-7th December; however the travel bursary can be used to cover the expenses for any other relevant Haematology conference.

The highlight for me was the ubiquitous Louisiana-style bread pudding (see recipe below) - yum - oh, you mean the highlight of ASH? Well that would be the Education session on Lymphoma; they did a superb round-up of current thinking OR maybe it was listening to Mel Greaves putting a Darwinian spin on leukaemia. His perspective on natural selection was grounded in a lifetime's work in research. All interesting stuff.

Thanks again to HAI nurses' group for the opportunity to attend.

Ps. Check out the new Disney movie "The Princess and the Frog" Out now - it's set in New Orleans!!

Bread and Butter Pudding (as they make it in New Orleans!)

12 slices of stale bread
3 tablespoons vanilla
2 large eggs, beaten
4oz cup raisins
1 pint of milk
1 tart apple, grated
12oz sugar
1 teaspoon cinnamon

Butter bread and toast in the oven until lightly browned. Tear bread into one inch pieces. Mix all ingredients in a bowl. Pour into a buttered 9 x 13 inch dish and bake for 35 - 45 mins at 180°C until the top is lightly browned. Serve with ice cream or rum sauce.

Rum Sauce

In a small saucepan melt 3 tbsp. butter, and 2 tbsp flour. Cook over a medium heat for 5 mins. Add ½ cup sugar, 1 cup of double cream, and ½ cup milk. Cook 3-5 more minutes until sauce is bubbly and has thickened. Remove from heat and add 1 tbsp, vanilla essence and 2 tbsp. rum.

yummy!!

Therapeutic communication in the cancer context (Part one of two)

By Nicola Armstrong (Post Grad Cert, Specialist Practice Cancer Pathway), Staff Nurse Bridgewater Suite Haematology, Belfast City Hospital.

This two part series will explore therapeutic communication in the cancer context. Part two, which will be published in the October 2010 edition of Blood Matters, will focus on hope and coping strategies.

According to Bowles et al. (2001) effective communication is a fundamental element of nursing and is regarded as integral to the provision of high quality patient focused nursing care. Innes and Payne (2009) highlight a cancer diagnosis may be one of the most devastating pieces of news given to a patient and their family. They state that recognising patients' information needs throughout the illness trajectory and understanding how the depth and manner of disclosure may affect subsequent well-being is crucial in providing responsive, high-quality care. Blanchard et al. (2008) highlight patients with cancer regard good communication with healthcare professionals as a high priority. They comment that ineffective communication leaves patients feeling anxious, frustrated and dissatisfied which may impair their ability to comply with treatments. Therefore it is imperative in the nurse-patient relationship that communication involves more than the transmission of information; but involves transmitting feelings, recognising these feelings and letting the patient know they have been recognised (Sheppard, 1993).

Beadsmoore et al. (2008) state that adequate information permits informed decision making by patients, and also improves coping and leads to better psychological health. According to Wilkinson (1991), there should be open two-way communication in which patients are informed about the nature of their illness and treatment and are encouraged to express their anxieties and emotions.

Breaking bad news is a complex communication task that requires expert verbal and non-verbal skills. This complexity can create serious miscommunications, such as the patient misunderstanding the prognosis of the illness or purpose of care. When bad news is delivered poorly the experience may stay in a patient's or family's mind long after the initial shock of the news has been dealt with (DOH, 2003). Barnett (2002) however informs us the reverse is also true; when

handled sensitively, patient satisfaction increases.

According to Bensing et al. (2001) two types of communicative behaviours employed by nurses seem to be important in meeting the communication needs of patients. Firstly, these include instrumental behaviours, which are of significance when informing the patient about illness, treatment and provision of medical and practical services. Secondly, they include affective behaviours, such as showing respect, giving comfort and trust. These are important in building nurse-patient relationships, in which patients feel understood and in creating a trustful atmosphere in which patients are helped to disclose information and concerns relating to the confrontation with a life-threatening disease.

McCaughan and Thompson (2000) highlight it is now extensively accepted that patients should be fully informed. Innes and Pane (2009) state frank discussion of a diagnosis is now seen as a legal and ethical imperative in most countries, in order that patients may make informed decisions. They further comment that evidence suggests there are potentially negative consequences for an individual who lacks insight into their disease stage. These include unsatisfactory management of the advanced stage of illness, such as unnecessary hospital admissions, a higher proportion of hospital deaths and a lack of, or late referral to palliative care services, poorer symptom control, less end of life planning and consequently reduced patient choice. In addition, psychological consequences include mistrust and feelings of abandonment in patients.

According to Achterberg et al. (2009) patients seldom express their concerns and emotions directly and spontaneously, instead expressing indirect cues that something is worrying them. A core skill for nurses is therefore to recognise cues of patients that are clinically relevant but not directly expressed. Picking up cues may lead to the recognition of patients who need emotional support. Leaving cues undetected may prevent patients from getting the care they require. They further comment that nurses often overlook patients' social and emotional needs. Bensing et al. (2001) comment a possible reason why nurses do not always communicate in a patient-centred way is that

they may have the necessary communication skills, but choose to use task-centred communication as a protective mechanism against emotional aspects of their work.

While all patients have the right to information, they will wish to use this right to varying degrees at different times. Therefore health professionals need to continuously assess whether each individual patient wants only limited information or whether external constraints such as language barrier, clinic organisation or the attitudes of health professionals deny them access to the information they want.

The notion that patients misinterpret or fail to absorb information is well recognised. There often exists a discrepancy between what information the professional perceived was given and what message the patient got from a conversation (Innes and Payne, 2009) According to Carlsson et al. (2002) medical information is often poorly absorbed and communication is further impeded when patients are faced with life-threatening illness. Patients are prone to misinterpret the information given to them, usually more positively than it was intended, particularly when presented with heavy use of medical terminology. Professionals engaging in prognostic discussions require a keen understanding of these influences to mitigate them as far as possible. However issues with misinterpretation may be further compounded by deliberate vagueness on behalf of professionals.

Turn over
for the
rollover!!!
€200

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Prize Winning Crossword

It's a rollover!!! €200 Prize winning crossword

As there were no correct entries for the chemotherapy crossword in the previous Blood Matters edition it's a rollover! We're offering this unique opportunity also because there was one typo the first time round which may have thrown you! This crossword is specific to **CHEMOTHERAPY** and its administration. **Closing date for competition 30/07/10.** The first randomly selected entry drawn after that date will be eligible for the prize.

CRYPTIC CLUES

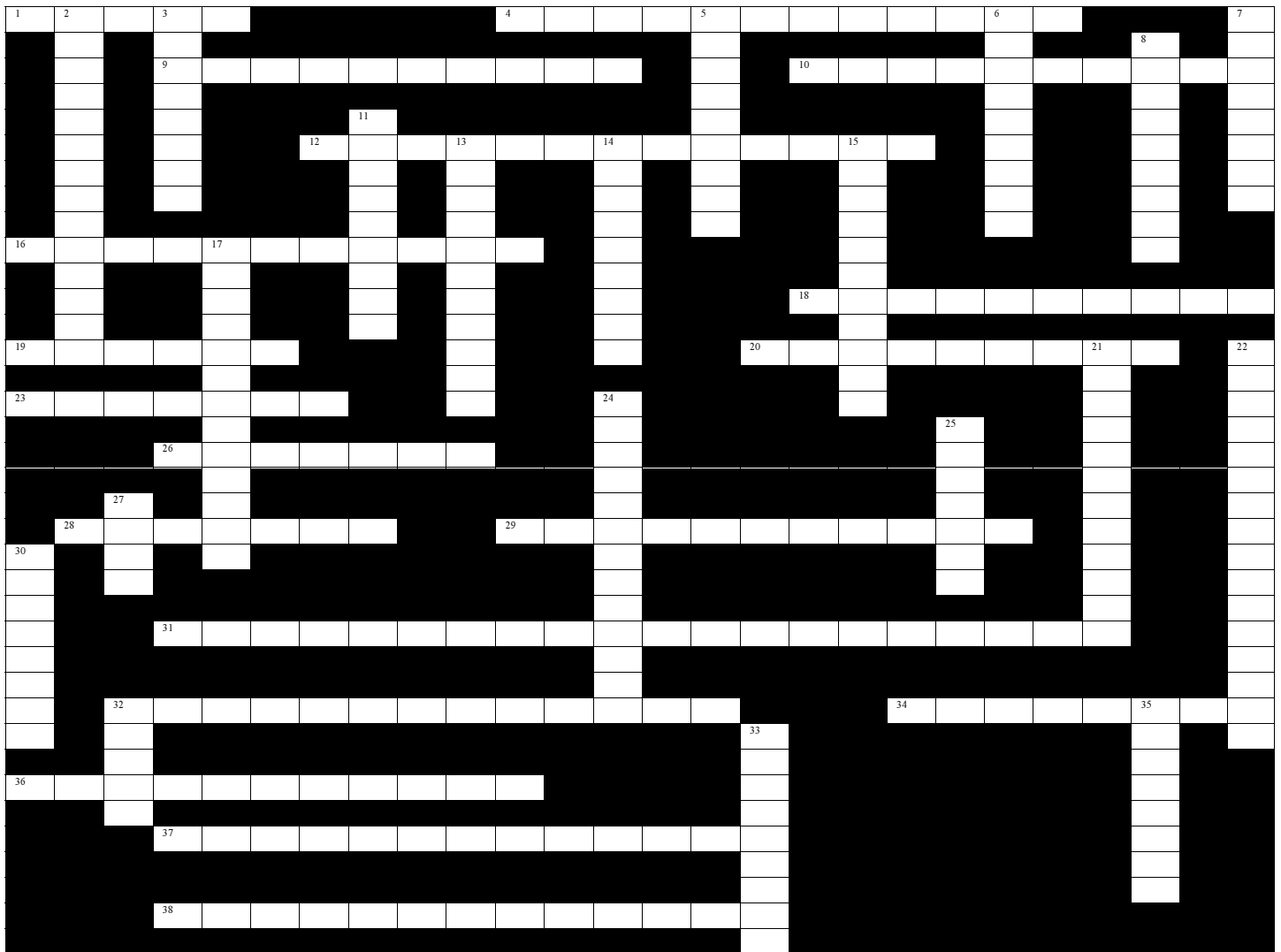
ACROSS

- 1 At a low point
- 4 Iced squash (2 words)
- 9 Opposed to chemo
- 10 Belated outcome (2 words)
- 12 Fatal, so never give i.t. (2 words)
- 16 Very vague (2 words)
- 18 White warrior
- 19 May cause a serious shock
- 20 Suicidal tendency

- 23 Wee arms
- 26 Can you sing?
- 28 Results in the birth of a daughter
- 29 Adrenaline rush
- 31 Tingle around the edges (2 words)
- 32 Restrain a tweenie
- 34 Blistering hot
- 36 Baby beware
- 37 Cold and detached hardship (2 words)
- 38 One letter from another holiday

DOWN

- 2 Resistant to a chemical breakdown
- 3 Aggravation
- 5 Heavy metal chemo
- 6 An unwanted disinfection
- 7 Auntie is becoming confused
- 8 Trade your bike (2 words)
- 11 Often joined with a chop
- 13 Chemo code
- 14 High fat chemo
- 15 Given in vain
- 17 Propagation
- 21 A provocative agent
- 22 Can be easily upset
- 24 Too much could give you a broken heart
- 25 Anger in the dark
- 27 Choose this device
- 30 Capacity to poison
- 32 Prefix to metastases, which chemo may eradicate
- 33 This chemo may make your skin radiant
- 35 May complement your chemo



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Entries should be sent to Caroline McCaughey, Graduate and Continuing Education Division, School of Nursing and Midwifery, Medical Biology Centre. 97 Lisburn Road, Belfast. BT9 7BL