Nurses
Monday, March 27th
16:30-18:00
NG14: Abstract finalists

Hematopoietic Stem Cell Transplant (HSCT) Nurses Booklet, on behalf the French EBMT Nurses Group

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Abstract

On behalf of the GFIC-GM (French bone and marrow transplantation nurses and coordination group) and the French EBMT Nurses Group

Objective

Two nurses are talking among themselves.

Nurse 1: “Do you perform a test dose when you administer ATG?” Nurse 2: “Oh, are we supposed to do that?”


Nurse 1: “I have to administer tacrolimus. Do you know what it is?” Nurse 2: “No — maybe it’s an antifungal.”

Since these issues, which take place each day, are stressful for nurses, the GFIC-GM, nurses group of the Société Française de Greffe de Moelle osseuse et de Thérapie Cellulaire (SFGM-TC), decided to write guidelines to harmonize nursing practices in the specific management of HSCT patients.

Methods

Elaboration: Start: January 2015; Who: twelve officers of GFIC-GM; How: several working meetings per year and exchange mail between meetings

Scientific Validation: Medical, paramedical, pharmaceutical

Launch: November 2016, during SFGM-TC Meeting, Liège

Content

This booklet contains three sections: Practical advice for drug administration (antifungal agents, immunosuppressive treatment); a fact sheet about transplant (graft transfusion); and post-transplant complications support (GVHD, VOD/SOS).
The role of nurses for medication administration, drug monitoring and patient education is emphasized. There are also practical tools such as mucositis assessment and GVHD scoring.

Conclusion: This booklet will be released in paperback. It will be distributed to all French nurses working in adult and pediatric transplant centers. All comments are welcome through the GFIC-GM website to improve this guide to best meet nurses’ needs.

Disclosure of conflict of interest

None
Survivorship in ACTion — A Group Intervention to Treat Fear of Recurrence

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Abstract

Introduction: A significant and enduring late effect of cancer survivors is psychological distress driven by fear that the cancer will recur (FCR). This includes persistent anxiety, hypervigilance and catastrophic thoughts about the disease returning or progressing. This has a significant impact on quality of life. Research into FCR has been limited and there is no agreed treatment model. The author, and colleagues, developed a group intervention using acceptance and commitment therapy (ACT). ACT promotes psychological flexibility, and living with vitality alongside one’s difficulties while effectively managing pain and distress. It is useful for coping with chronic problems and uncertainty. Aims: to help participants be less preoccupied with their worry and anxiety; to increase engagement with the things that mattered to them; to improve quality of life. Methods: The group was advertised using fliers in clinics and MDTs, and mailed to patients who had completed cancer treatment ≤ 1 year. Eligible participants were adults at ≥ 3 months following completion of treatment, in remission, and without a psychiatric or neurological disorder. Intervention: Six structured 90 minute sessions, at weekly intervals, using experiential and didactic methods to convey the 6 core processes of ACT to participants: Open up to painful feelings; relate differently to thoughts; be present; observe own experience; identify what matters (values); do what matters. Outcomes were assessed using a range of validated psychological measures, implemented pre- and post- intervention. Results: 9 participants (4F, 5M) aged 33 to 64, attended. 6 attended all sessions; 3 attended 5/6. 7 underwent allogeneic SCT; 1 autologous SCT; 1 chemotherapy. Initially, some participants found the techniques uncomfortable (mindfulness), unusual (observer self) or counterintuitive (accept painful thoughts and feelings, rather than avoid them) but, ultimately, all gave positive verbal feedback about using them. 83% of participants completing all 6 sessions showed improvements on every assessment tool, including overall quality of life (Table 1). Group, mean scores for each domain of AQOL-8D questionnaire (graph 1) reflect improvements in every category other than pain. One participant’s scores worsened, but he reported subjective benefits from attending.

Table 1. Summary of Psychological Measures (for 6 participants attending all sessions)

<table>
<thead>
<tr>
<th>Tool</th>
<th>Measures</th>
<th>Range of possible scores (high score = most difficulty or distress)</th>
<th>Range of individual scores, pre-intervention</th>
<th>Range of individual scores, post-intervention</th>
<th>Mean group score pre-intervention</th>
<th>Mean group score post-intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>FCRiv4</td>
<td>Fear of recurrence (total all items)</td>
<td>0-168</td>
<td>44-129</td>
<td>45-117</td>
<td>92.4</td>
<td>84.7</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>0-27</td>
<td>5-11</td>
<td>2-11</td>
<td>7.8</td>
<td>5.5</td>
</tr>
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<tr>
<td><strong>PHQ9</strong></td>
<td>Anxiety</td>
<td>0-21</td>
<td>5-12</td>
<td>1-12</td>
<td>8.5</td>
<td>6.5</td>
</tr>
<tr>
<td><strong>GAD7</strong></td>
<td>Specific ‘ACT’ processes</td>
<td>7-49</td>
<td>15-37</td>
<td>11-33</td>
<td>27.6</td>
<td>22.8</td>
</tr>
<tr>
<td><strong>AAQ-II</strong></td>
<td>Quality of life (total all items)</td>
<td>35-176</td>
<td>81-107</td>
<td>54-95</td>
<td>89</td>
<td>74.8</td>
</tr>
</tbody>
</table>

**Graph 1: Group mean scores for AQOL-8D domains**

**Conclusion** The intervention received strongly positive endorsement from its participants, who reported that it helped them to cope with their FCR better and to begin living with more vitality. They cited ACT processes specifically as being helpful, as well as meeting others who had similar anxieties (group effect).

**Disclosure of conflict of interest**

None
Management of cytomegalovirus infection in a Home Care Unit

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Abstract

Introduction: Cytomegalovirus (CMV) infection is the most prevalent viral infection in patients undergoing allogeneic stem cell transplantation (ASCT). In clinical practice, Valganciclovir is the first-line for the outpatient treatment of CMV infection. In case of non-oral tolerance the alternative is intravenous (IV) Ganciclovir (GV), whereas when peripheral blood counts are poor and renal function is optimal the option is IV Foscarnet (FT). In most centres, to receive these intravenous treatments, patients must be readmitted. Objectives: To analyze the feasibility and the impact in the hospital resources of the domiciliary treatment of the CMV infection in a home care unit (HCU) specialized in patients with haematological malignancies. Patients and Methods: At our centre, when ASCT patients with CMV infection require IV treatment, they have the possibility of being treated at home by our HCU if they have clinical stability and home less than one hour from our centre. In patients with a peripheral venous catheter, GV was given at a dose of 5 mg/kg twice daily, with two daily visits at home for 60 minutes each of them, whereas the administration of FT (60 mg/kg/12h IV) required also two daily visits at home for about 90-120 minutes since previous IV hydration with calcium, potassium and magnesium was necessary. Patients with a central venous catheter, GV was given in a single at home visit of 15 minutes using an intermittent infusion pump (IIP) CADD-Legacy®, while the use of this device made it possible to reduce the duration of home visits to 60 minutes in patients treated with FT. In order to facilitate de central line insertion in our patients, since February 2012 we have a team of nurses trained in the placement of peripherally inserted central catheter (PICC). Results: Between November 2000 and February 2012, 108 episodes of CMV infection were treated at home in 69 patients undergoing ASCT. Median (range) age was 46 (19-71) years. GV was administered in 53 (49%) episodes and 23 (43%) of them were administered using IIP. In the rest of the episodes (n=55; 51%) FT was administered requiring two daily visits at home in all cases. Readmission was necessary in 33 (30%) of the episodes, but none related to complications of the treatment. The median duration of home treatment was 12 (1-42) days with a total number of visits by HCU of 1,485. Since we have the possibility of placing PICC, this device is a recommendation for at home IV treatment of CMV infection in our HCU. Thus, in the last two years, 38 episodes of CMV infection were treated at home, 79% of them with FT, and in all cases we use a central line type PICC to perform the treatment with a single home visit a day. Conclusions: Home treatment of CMV infection in patients undergoing ASCT is feasible and safe in an HCU with specialized nurses in the management of haematological patients of high complexity. In our experience, most episodes of CMV infection could be treated completely at home and in less than a third of them the patients required admission. Finally, having a central venous catheter, such as PICC, allows giving both GV and FT with IIP by optimizing both the number of home visits and their duration.

Disclosure of conflict of interest
None
Nursing care in gastrointestinal GVHD

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Abstract

Introduction Allogeneic hematopoietic stem cell transplant is a curative treatment for malignant hematological disease. The main complication is graft-versus-host disease (GVHD) which occurs in 40-60% of patients with skin, gut, and liver frequently involved (1). When gut is affected by GVHD, especially in grades 3 to 4 or steroid resistant GVHD, it results in nausea, vomiting, severe abdominal pain, and profuse diarrheas (> 1500 ml / 24h) which appear to be humiliating, distressing and adversely affecting patients’ quality of life (QoL), risk of fall, skin integrity and morbidity (2-3). The use of a Fecal Management System (FMS) for fecal incontinence in GVHD could improve patients’ QoL and the management of complications related to digestive disorders (4). The aim of this project was to assess the use of FMS on comfort and general condition of patients with severe and/or steroid-resistant gastrointestinal (GI)-GVHD and to evaluate the impact of this device on care quality and organization. Patients and Methods: Patients with stage 3 or 4 GI-, steroid-resistant GVHD were prospectively included from a single French Hematology Stem cell transplant unit between 2010 and 2015. During this period, fecal management device was used as a routinely care device and proposed to all patients. Results Median age of the 19 included patients was 53 years [28; 65]; 68% (n=13) were men. Median stool volume was 4.2 liter [1.5; 8.0]. All patients had an altered sleep quality due to wake up, stand up or mobilize themselves with a median frequency of 13 times per night for stools emission or changes. All patients have experimented at least one accidental fall during these nocturnal wakes up. Before the use of FMS, all patients were suffering of cutaneous lesion localized on the anal region and Performance Status, according to WHO scale, was evaluated at II, III and IV for 16% (n=3), 37% (n=7) and 47% (n=9) of the patients, respectively. Median length of stay in the unit was 93 days [73; 140] and mortality rate was 84% (n=16). Among the 19 patients included in this study, 53% (n=10) were in the FMS group and 47% (n=9) were in the standard care group. Median use duration of the FMS was 24 days [4.8; 39] and the device was regularly changed, as recommended, with a 1.5 [1; 2.8] median number of device per patient. Reasons of withdrawing the FMS were fecal leaks in 3 patient and accidental removal for another one. After the used of FMS all patients start to recover from skin lesion. Sleep quality was improved and no night accidental fall was observed in the FMS group. Nursing care was also improved with an easiest and safer way to evacuate and quantify patient’s stool, which allowed a better monitoring (exact stool volume) of the severity and the response of the GVHD to treatment. Conclusion Fecal Management System, in the context of stage 3 and 4 steroid-resistant GI-GVHD, appears to be an easy usable device which seems to improve patient’s Quality of Life by reducing skin lesion due to frequent diarrheas, avoids accidental falls down due to frequent stand up by night and finally leads to a better sleep quality for patients who are already weak and tired. This preliminary study highlights also the role of FMS on the quality of care by reducing the risk of exposure to stools for nurses and by improving the supportive care relationship between the patient and allied and healthcare professionals.
Disclosure of conflict of interest

None
HEMATOPOIETIC STEM CELL TRANSPLANT NURSE COORDINATOR’S (HSCT-NC’s) PERCEPTIONS OF RELATED DONOR CARE: A EUROPEAN SURVEY

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Abstract

Introduction: Hematopoietic stem cell related-donation raises specific clinical and ethical issues. Current practice of overlapping recipient and donor care may raise a conflict of interest within teams, underplay medical and psychosocial risks to the donor and compromise the volunteer status by a lack of confidentiality [1-5]. Our survey aimed to: describe current modalities of related-donor (RD) care; explore HSCT-NC’s perceptions of RD care. Methods: The HSCT-NCs registered with the EBMT Nurses Group and working in HSCT-adult units were sent a questionnaire by mail, focusing on: 1) professional profile; 2) HSCT unit organization regarding donors’ information, work-up, harvesting and follow up and 3) perceptions about related-donors’ care. The questionnaire was available in 6 languages (Dutsch, English, French, Italian, Portuguese, Spanish). Results: 101 HSCT-NCs from 20 countries responded to the survey and 67% confirmed that, as HSCT-physicians (HSCT-P), they care for both donors and recipients. Hematologists (55%), HSCT-NCs (22%) and HSCT-P (16%) evaluate recipients of HSC donation. Potential donors are contacted by HSCT-NCs (48%), hematologists (10%), HSCT-P (8%) and are informed about donation and transplantation before HLA tests by HSCT-P (38%), HSCT-NCs (25%) and hematologists (16%). Haematologists (25%), HSCT-NCs (39%) and HSCT-P (18%) communicate HLA test results to patients (17%), to all potential donors (25%) or to compatible donors (16%). An information interview dedicated to the compatible donor is performed either by the HSCT-P (31%) or by the HSCT-NC (28%), and sometimes by the hematologist (16%). This interview takes place when HLA results are available (35%) or at the time of pre-donation check-up (55%). Follow-up is performed by medical consultation (39%), telephone interviews (22%) or questionnaires (12%). Even if 76% of HSCT-NCs consider that the RD's needs are addressed, in their opinion the choice to donate (29%), information (33%), financial assistance (45%), psychosocial support (45%) and follow-up (36%) should be improved. Demanding situations in RD’s care have been experienced by 81% of HSCT-NCs 1-3 times (89%), 4-6 times (8%), 7-9 times (3%) in the last year. These situations are mostly linked to reluctant donors (35%), to doubts about the « free choice » of the donor (26%) and the informed consent (12%) or to conflicting family relationships (6%). In the last year, 30% of HSCT-NCs have felt to be in conflict of interest 1-3 times (89%), 4-6 times (6%), 7-9 times (1%). Lastly, 47% of respondents thought that « the only way to protect RDs’ free choice to give or not, is to organise RDs’ care by a fully independent unit ». Conclusion: Our survey shows that RD’s care organisation is not standardized and that many aspects are to be improved, notably regarding ethical aspects. Conflict of interest and RDs’ “true choice” are main issues to be considered.

References


Disclosure of conflict of interest

None