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A Simple Step to Improve Patient Adherence With Zoladex®

Zoladex® (goserelin acetate, AstraZeneca) is used routinely to induce and sustain menopause in premenopausal patients with hormone receptor-positive breast cancer (Tan & Wolff, 2007) and to reduce the production of testosterone in men with prostate cancer (Debruyne, 2002). It is a synthetic decapeptide analog of luteinizing hormone-releasing hormone, which stops the production of luteinizing hormone from the pituitary gland.

Zoladex is administered, usually by a clinical nurse, every 28 days in patients with breast cancer or every 4–12 weeks in those with prostate cancer. The implant is injected into the subcutaneous tissue of the anterior abdominal wall with a prefilled, ready-to-use syringe and large-bore (16 gauge) needle with a substantial cutting edge. Because of the size of the needle, the procedure is more akin to stabbing someone in the abdominal wall than administering an innocuous subcutaneous injection. The manufacturer makes no mention of using dermal analgesia prior to

injection. In the authors' experience, most centers use no form of dermal analgesia, expecting patients to "grin and bear it."

Painful piercing of the skin with a large-bore needle may traumatize some patients. The procedure may cause such apprehension that some patients may be inclined to delay or skip a monthly injection or forgo the treatment altogether.

Based on injecting about 50 Zoladex implants when the clinical nurse was unavailable, we observed that the whole experience is made painless by having the patient apply a local anesthetic, such as a patch containing lidocaine and prilocaine or an equivalent anesthetic ointment, 1.5 hours before the injection.

Outside the realm of closely supervised institutional protocols, what is patient compliance with monthly Zoladex injections with and without dermal analgesia? This would be an interesting research topic for an academically inclined clinical oncology nurse.

References

- Debruyne, F. (2002). Hormonal therapy of prostate cancer. *Seminars in Urologic Oncology*, 20(3, Suppl. 1), 4–9.

Corrections

The Diagnostic Reasoning column in the February 2008 issue of the *Clinical Journal of Oncology Nursing* (pp. 37–41) contained three errors.

- Figures 3–4 are pregadolinium axial T1-weighted magnetic resonance imaging (MRI) scans, and Figures 5–7 are postgadolinium axial T1-weighted MRI scans, all showing causes of increased intracranial pressure.
- The first paragraph under "Pathophysiology" should have read, "Intracra-

nial pressure is defined as the pressure exerted by the CSF within the ventricles (Hickey, 1997a)."

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Tan, S.H., & Wolff, A.C. (2007). Luteinizing hormone-releasing hormone agonists in premenopausal hormone receptor-positive breast cancer. *Clinical Breast Cancer*, 7(6), 455–464.

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Delirium Is a Common and Often Overlooked Problem

I just read "Delirium: An Under-Recognized Problem" in the December 2007 issue of the *Clinical Journal of Oncology Nursing* (pp. 805–807). The case study was well written and encompassed the all-too-many patients who show up on nursing units today. When I was still in bedside nursing, the situation became too much of a common occurrence. Unfortunately, many times, we handled it in "hurry up and let's fix this immediate problem" way and did not take the time to think about longer-term solutions.

Thanks so much for breaking it down to make it more understandable and to prompt me to search for further information based on what I found in your article.

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