Reader Seeks Advice About Prophylactic Feeding Tubes

We have a multidisciplinary head and neck group at the cancer center where I work. We are meeting again next week and will discuss the article “Nutritional Support During Radiotherapy for Head and Neck Cancer” (December 2007 issue of the Clinical Journal of Oncology Nursing) and some of our ongoing issues related to feeding tubes. The article will help us in our discussions with some of our newer physicians about the importance of prophylactic tubes, looking at some different criteria and risk factors. I think a few have shied away after a few patients experienced some significant complications.

Presently, we also have several patients being treated with unknown primaries. Many are receiving external radiation therapy or intensity-modulated radiation therapy (IMRT) and don’t have feeding tubes. Several have needed supportive hydration and are taking liquid supplements, but one patient just had a feeding tube placed mid-treatment. He couldn’t tolerate feedings, and they changed him to a gastrostomy tube. In two days, that tube was found to be coiled. Yesterday, they had to try a weighted tube. He had a history of reflux prior to his cancer treatment. Do you have any experience noting history of gastric reflux to better determine the type of tube to be placed?

If you have patients receiving external radiation therapy only, not having a tube, will you support them with scheduled IV fluids or as needed? Our patients all are seen and followed by a dietitian, who determines the number of liquid supplements and calories, but some patients have a hard time with free water and fluids.

I enjoyed reading the article and would appreciate any comments from the author.

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The Author Responds

Thanks for your letter, and good luck trying to bring the newer physicians in your group on board with this. Although it may initially be a “hard sell” (to patients and physicians alike), in our practice at Virginia Mason we have had a better experience placing tubes early rather than waiting for people to become dehydrated. Even with IMRT plans, if you’re treating a relatively big field and/or sensitive structures (pharynx and bilateral neck), often considerable toxicity and nutritional compromise can be expected. We would probably recommend a percutaneous endoscopic gastrostomy (PEG) tube up front, or at least watch closely and try to put one in as soon as weight loss becomes apparent. At-risk patients who are reluctant to have a PEG tube placed prophylactically are educated and evaluated constantly, so we can intervene as soon as swallowing becomes a challenge, at which point patients are generally agreeable. We do not schedule patients for routine IV hydration (no need because they can accomplish this on their own with a tube). If we have to start hydrating people regularly, we recommend putting a PEG tube in (unless they continue to refuse or are very close to being done and we think they can limp through). Most patients, in retrospect, are glad they did this; they don’t like having to stay in the infusion center so long for fluids and find that using a tube for medications, etc., is preferable to struggling with swallowing (and/or dysgeusia) even if they still can swallow a bit. I have seen only the rare patient who managed to get all the way through treatment without needing a PEG tube at all (so few that I remember them clearly). If not completely dependent on it by the end of therapy, most at least use it to supplement their nutrition or for medication administration even if swallowing still is possible.

We have had some PEG complications, mostly dislodgment and infection and one or two cases of obstructive issues related to the tube (and a kink related to a misplaced suture). I am not sure about the issue of reflux and using a weighted tube, but your local gastroenterologist could probably give you some recommendations. Reflux and symptoms of dysmotility (fullness, nausea, and regurgitation) are not uncommon with enteral feedings; we place many of our patients on metoclopramide for this and advise small, frequent feedings and avoidance of recumbent positioning during and after.

Tracking how much weight your patients are losing, how many require routine IV hydration, and how many toxicity admissions you have (correlating with diagnosis, field, and dose, with or without chemotherapy and cetuximab) might be useful for understanding who
comprises your at-risk population. Once the patients are identified, a trial of early PEG tube placement (by the second or third week of treatment) and observation of subsequent outcomes may give you some institution-specific data on how to develop recommendation protocols. If the outcomes are favorable (and you're spending less time scheduling for IVF or, worse, admitting), then maybe you can start looking at expanding your screening for PEG placement as appropriate. Also keep your eye on recovery time and patient satisfaction. In our experience, patients who maintain good nutrition throughout treatment heal more quickly with fewer complications and seem to be back on their feet a little earlier. Once a patient is able to maintain his or her weight without using a PEG tube to supplement after completing treatment, it can safely be removed. This time may vary according to the patient and degree of treatment toxicity encountered. The range may be anywhere from three weeks to three months, with most patients getting the tube out around one month after treatment.

I hope that helps. Good luck—it’s a challenging issue!

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Reader Applauds Integration of Yoga in Cancer Care

It is with pleasure that I read the informative article encouraging nurses to add yoga education into their care of patients living with cancer (“Integrating Yoga Into Cancer Care” in the February 2008 issue of the Clinical Journal of Oncology Nursing). Congratulations!

As an RN and yoga instructor for 20 years, I recognize the importance of educating healthcare providers at the institution where I teach. It has been a slow and difficult process but is becoming more rewarding all the time.

One additional thing that would have been of interest in your article is information on training opportunities for nurses in this specific area.

I served on the faculty of a national teacher training program showing yoga instructors how to adapt yoga practices for people with cancer. It is the only in-depth training in this country that I am aware of, and I highly recommend it to others who already do this work and those who are interested in learning more about it. It is an excellent setting to share professional concerns and challenges of working with this patient population. Taught by Jnani Chapman, RN, from the University of California, San Francisco, and other experienced faculty, it offers nursing continuing education units through the Board of Nursing in Virginia, where the training is offered, as well as Yoga Alliance continuing education credits.

Your article adds to the growing list of published literature and in simple yet clear ways explains much of what nurses need to know. As yoga instructors, we know that the best way to impart this knowledge to healthcare providers is to give them firsthand experience of what simple breath awareness feels like, what a body scan or relaxation practice actually feels like in their bodies. Herein lies the difficulty. Having said this, you’ve done the next best thing. I wish you much success in your continuing work with patients.

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The Author Responds

Thank you for your supportive letter. I agree that providing nurses with information about yoga training for themselves is important, and I am familiar with the training program you mentioned in your letter. Prior to offering a new complementary therapy to our patients, we provide free workshops for all staff (clinical and administrative) so that they can meet the provider(s), learn about the therapy, and experience it for themselves. We also offer staff retreats to give them an opportunity to participate in the therapies for a longer duration of time. The sessions are done on “work time,” signifying support from administration and physicians (both of whom also attend the sessions and retreat). I believe that the success of our program is because of the involvement of all of our staff in providing complementary therapies such as yoga to our patients.

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Nurse Suggests That All Pain Drugs Be Converted to Oral Morphine

Thank you so much for the article “The Use of Ketamine as Adjuvant Therapy to Control Severe Pain” (February 2008 issue of the Clinical Journal of Oncology Nursing). It will definitely be logged away for future reference.

I have been an oncology nurse for 10 years and have worked from London to Los Angeles; I believe that I have something worth sharing with my colleagues. Pain control has always been a huge issue with my patients, but when I worked overseas, I had the pleasure of working with a palliative care specialist who focused on pain control. A common problem we saw then and still see now is the use of multiple opiates and opioids simultaneously with little or highly variable therapeutic effect.

The solution we sought that always seemed to work remarkably well was the conversion of all medications into oral morphine. Patients started on a four-hour regimen of oral morphine with half of the four-hour dose given hourly for breakthrough pain, and then we re-evaluated how much the patient was requiring at 12- and 24-hour intervals.

The benefits to using morphine: (a) it’s reversible if necessary; (b) there is no dosage ceiling; (c) side effects from high doses can be managed with other medications quite easily; (d) once the therapeutic 12-hour dose is found, the patient can be switched immediately to long-acting morphine; and (e) it’s cheap. The problem for healthcare providers is that stopping all pain medications at once, then switching to oral morphine, can seem very drastic. In addition, doing
so can present some challenges when multiple drugs with different half-lives are on board simultaneously. That is why it should be done only in the acute care setting.

From a nursing standpoint, I believe that the management of pain falls directly on RNs. We are the ones at the bedside and monitor the effects and outcomes of prescribed medications. I would love the Oncology Nursing Society to get involved in creating a tool for nurses and physicians to use for the management of pain. I would love even more if I could somehow be involved. Thanks again for the article; it is outstanding.

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Reader Seeks Clarification on Hand-Foot Skin Reaction

I have a question about the article on hand-foot skin reaction with sorafenib (“Sorafenib: A Promising New Targeted Therapy for Renal Cell Carcinoma” in the October 2007 issue of the Clinical Journal of Oncology Nursing). Page 653 of the article states, “Nurses need to be aware of another dermatologic reaction to sorafenib—hand-foot skin reaction, which should not be confused with the hand-foot syndrome seen among patients receiving capecitabine, fluorouracil, and doxorubicin.” Do you have a reference for this statement or any further information on how exactly the sorafenib reaction is different from the syndrome presented by the other drugs? The package insert for sorafenib and the published literature on the drug seem to use the terms interchangeably.

Marci Clark, PharmD
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The Author Responds

Your question is very valid and one that Bayer, Onyx Pharmaceuticals, and nurses involved with patients receiving sorafenib struggled with during our early work with the drug. Bayer and Onyx Pharmaceuticals tried to be proactive in using the term hand-foot skin reaction rather than syndrome to differentiate between the dermatologic toxicities with tyrosine kinase inhibitors and chemotherapy agents. I’m sure some older references used different terms for the hand-foot side effects.

The reference for the reaction is the sorafenib package insert, which uses the term hand-foot skin reaction throughout.

The differences include the mechanism, which includes a hyperkeratotic reaction, and the appearance, which is often the development of thick calluses. Rarely will you see significant desquamation with sorafenib like that seen with the chemotherapeutic agents. Calluses peel following dose interruption or discontinuation but not typically to the depth seen with other drugs.

The following Web sites provide information on the hand-foot skin reactions and other dermatologic side effects associated with sorafenib.

• www.nexavar.com/rcc_side_effects
• www.nexavar.com/rcc_downloadable_brochures

Thanks for asking; hopefully I’ve answered your question and given you resources you might not be familiar with to help clarify your questions. If I can be of further help, please let me know.

Laura S. Wood, RN, MSN, OCN®
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Nurse Asks: Must Intraperitoneal Paclitaxel Be Filtered?

I read the article “Intraperitoneal Chemotherapy for Women With Ovarian Cancer: Nursing Care and Considerations” (April 2008 issue of the Clinical Journal of Oncology Nursing) and found it to be very informative. I am an infusion nurse at Rocky Mountain Cancer Centers in Denver, CO, and wonder if you could answer a question for me. We have given intraperitoneal paclitaxel at our clinic. Some of our nurses believe it is necessary to use a filter, and some don’t. It is nearly impossible to infuse a liter of intraperitoneal paclitaxel in 30–60 minutes through a filter. Do you filter paclitaxel at your facility? If so, why? I would appreciate your response. Thanks for your time.

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The Author Responds

Thank you for your comments on the recent article on intraperitoneal chemotherapy in the Clinical Journal of Oncology Nursing.

According to the package insert from the manufacturer of Taxol® (paclitaxel, Bristol-Myers Squibb), a 0.22 micron filter with a non-polyvinyl-chloride-containing administration set must be used to deliver paclitaxel. Paclitaxel has a tendency to form microfilaments. The purpose of the filter is to prevent the microfilaments from entering circulation.

One suggestion to facilitate faster infusion yet still have paclitaxel filtered comes from the Fox Valley Chapter of the Oncology Nursing Society (please visit www.onsfoxvalley.org/Newsletter-June06%5B2%5D.doc).

Discuss with pharmacy whether it is possible to prefiltro the paclitaxel, then place the prefilled drug on non-polyvinyl-chloride-containing tubing without a filter for administration.

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