ONCOLOGY NURSE ADVISOR FORUM

Our Consultants

QUESTIONS & ANSWERS

MOIST DESQUAMATION IN LARGE-CHESTED WOMEN

In my practice in radiation oncology, we see many of the larger-chested women develop moist desquamation under their breasts. We currently treat this with Domeboro solution and air exposure. Are there any better methods for treating this? — Barry A. Cochran

Large-breasted women who receive radiation have an increased chance of developing a significant skin reaction, and cosmesis may not as good as with other patients. Skin recommendations for patients receiving breast radiation include keep the skin dry and clean; use warm water and gentle soap; avoid extreme temperatures while bathing; avoid trauma to the skin and sun or wind exposure; avoid shaving the treatment area with a razor blade; avoid the use of perfumes, cosmetics, aftershave, or deodorants in the treatment area; and only use the recommended creams or lotions after daily treatment.

Some patients may still develop moist desquamation, a sunburnlike reaction with blistering and peeling of the skin. This usually occurs in the fold under the breast or in the fold between the breast and the arm and sometimes in the area where the radiation boost was given. Most patients with a limited area of moist desquamation can continue treatment without interruption. In more severe cases where radiation therapy must be stopped, the skin usually heals enough to allow radiation to be resumed within 5 to 7 days. Skin reactions usually heal completely within a few weeks of completing radiotherapy. Treatments for moist desquamation include Aquaphor (a petroleum-based product), Biafine (a topical emulsion), aloe vera, and hydrocortisone cream. Many institutions also use methods such as three-dimensional planning, modified higher energy radiation beams, the use of custom support bras during treatment, and intensity-modulated radiation therapy (IMRT) to improve the distribution of radiation throughout a large breast. All of these measures reduce the side effects of radiation in women with large or pendulous breasts. — K. Lynne Quinn, RN, MSN, CRNP, AOCNP

MEDICARE GUIDELINES FOR PROCRIT AND ARANESP

What are the new Medicare guidelines for the administration of an epoetin alfa injection (Procrit) or a darbepoetin alfa injection (Aranesp)? I have heard that the new hemoglobin (Hb) guidelines are between 10 and 12 g/dL.

The new Medicare guidelines for Procrit or Aranesp apply to treatment for chronic renal failure and chemotherapy-induced anemia. Both are based on the Hb for dosing. The guidelines state that chronic renal failure treatment with an ESA (erythropoietin-

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stimulating agent) should be initiated at a Hb level of less than 10 g/dL. The goal of treatment is resolution of anemia to a Hb level higher than 12 g/dL. Chemotherapy-induced anemia is defined as a Hb level of less than 10 g/dL. The goal in this setting also is resolution of anemia to a Hb level of at least 10 g/dL to avoid blood transfusions. However, after the dose has been increased once by 25% without response, the ESA should be discontinued in patients with chemotherapy-induced anemia. — Jiajoyce R. Conway, DNP, FNP-BC, NP-C

HYDRATION DURING CYCLOPHOSPHAMIDE ADMINISTRATION

Should hydration be administered before all doses of cyclophosphamide (Cytoxan, Neosar) or just for high-dose Cytoxan? — Ann Proctor, RN, OCN, clinical nurse educator

According to National Comprehensive Cancer Network (NCCN) guidelines, patients receiving cyclophosphamide therapy should receive 2 to 3 liters per day of both oral and IV hydration on the day chemotherapy is administered. Intravenous sodium chloride 0.9% infused at a rate of 1.5 to 3 mL/kg per hour for a total of 500 mL on the day of chemotherapy is recommended. These recommendations apply to all doses of cyclophosphamide. According to the Bethesda Handbook of Clinical Oncology, *vigorous intravenous hydration and Mesna therapy should be considered to further reduce the risk of hemorrhagic cystitis with high doses of Cytoxan. — Jiajoyce R. Conway, DNP, FNP-BC, NP-C*

DIFFERENCES BETWEEN IONIZED CALCIUM AND CALCIUM LEVELS

What is the difference between ionized calcium (iCa) and calcium levels? How does this relate to electrolyte replacement?

*About one-half of the total calcium exists in the blood in its free ionized form, and about one-half exists in its protein-bound form, mostly with albumin. Measurements of serum calcium include both of these laboratory values. Because ionized calcium is not impacted by the variability of albumin levels, measurements of ionized calcium allow for more accurate calcium replacement therapy if needed (*Mosby's Manual of Diagnostic and Laboratory Tests. *2002;146-150). — Jiajoyce R. Conway, DNP, FNP-BC, NP-C* ■

Do you have a clinical challenge to share with your colleagues?

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