Readers Should Know About Other Positive Pressure Device

I read the informative article "Clinical Evaluation of a Positive Pressure Device to Prevent Central Venous Catheter Occlusion: Results of a Pilot Study" (*Clinical Journal of Oncology Nursing* [*CJON*], Vol. 5, No. 6, pp. 261–265) by Margaret A. Rummell, RN, MHA, OCN®, and colleagues and wanted to inform *CJON* readers that B. Braun Medical also manufacturers a positive pressure device, the Ultrasite® valve. The Ultrasite valve was the first positive pressure capless valve on the market and has demonstrated excellent quality and reliability. Our device was not mentioned in the article, and we feel that *CJON* readers should be aware of all of the positive pressure devices currently available. Thank you for presenting information that is invaluable to the practice of intravenous therapy.

Mike Brown, RN, CRNI
Marketing Manager, IV Systems
B. Braun Medical, Inc.
Bethlehem, PA

Hospital Stay Is a "Teachable Moment" for Tobacco Cessation

I read with interest the article by Eric Zack, RN, MSN, OCN®, titled "Smoking Withdrawal and Prolonged Hospitalization" in the January/February *CJON* (Vol. 6, No. 1, pp. 7–11). The article had many good suggestions for nursing management of hospitalized tobacco users.

However, I think the message that was "lost" was that the hospital stay is a "teachable moment" for tobacco cessation. I do not agree with the statement "Smoking cessation is very difficult to accomplish and is an unrealistic goal when patients require prolonged hospital stays and are placed under additional stress" (p. 10). Most hospitalized patients (75%) are interested in quitting (Emmons & Goldstein, 1992). They are away from their usual environmental cues to use tobacco, and they often are in the hospital for a tobacco-related illness, which gives them more motivation to quit.

Studies have shown that brief messages to patients from their physicians and nurses do make a difference in helping them quit using tobacco. Our hospital has had a tobacco cessation program that has been very successful in helping patients quit using tobacco. Along with brief advice and pharmacotherapy from physicians and staff nurses, the program includes a tobacco cessation counselor for patients in the hospital and follow-up with phone counseling if the patient desires additional support after discharge. Patients should be taught about the benefits of quitting, including the short-term benefits of healing more quickly, preventing respiratory complications, and tolerating treatments better. Smoking cessation also has implications for long-term health, as clearly stated in Zack's article.

Staff nurses need to know that they can make a difference and that their role is greater than enforcing the hospital smoking bans.

Karen K. Swenson, RN, MS, AOCN®
Oncology Research Manager
Park Nicollet Institute
Minneapolis, MN

Emmons, K.M., & Goldstein, M.G. (1992). Smokers who are hospitalized: A window of opportunity for cessation interventions. *Preventive Medicine, 21,* 262–269.

Erratum

In "Pacing the Standard of Nursing Practice in Radiation Oncology," by William P. Hogle, RN, BSN, OCN®, which appeared in the November/December 2001 issue of *CJON* (Vol. 5, No. 6, pp. 253–256), the units of measure in #4 of Figure 2 (p. 255) should be "Gy" (as in gray) and not "cGy." A corrected version of the figure appears below.

1. Pacemaker patients should not be treated with a betatron.
2. Pacemakers should not be placed in the direct (unshielded) therapy beam. Some accelerator beams can cause transient malfunctions.
3. The absorbed dose to be received by the pacemaker should be estimated before treatment. Estimation methods can be found in the literature.
4. If the total estimated dose to the pacemaker might exceed 2 Gy, the pacemaker function should be checked prior to therapy and possibly at the start of each following week of therapy. Since total and abrupt failure of pacemakers has been seen at cumulative doses between 10 and 30 Gy and significant functional changes have been observed between 2 and 10 Gy, early changes in pacemaker parameters could signal a failure in the 2–10 Gy region.
5. Although the transient malfunction from electromagnetic interference is unlikely from contemporary therapy accelerators and cobalt irradiators, the patient should be closely observed during the first treatment with a linear accelerator and during subsequent treatments if magnetron or klystron misfiring (sparking) occurs.
6. Studies to date have dealt with linear accelerators, betatrons, and cobalt irradiators only. Use of other radiation therapy machines should be evaluated on an individual basis and approached with caution.

FIGURE 2. MANAGEMENT OF RADIATION ONCOLOGY PATIENTS WITH IMPLANTED CARDIAC PACEMAKERS

Note. From "Management of Radiation Oncology Patients With Implanted Cardiac Pacemakers: Report of AAMP Task Group No. 34" by J.R. Marbach, M.R. Sontag, J. VanDyk, and A.B. Wolburst, 1994, *Medical Physics, 21*(1), 85–90. Copyright 1994 by American Association of Physicists in Medicine. Reprinted by permission.

Digital Object Identifier: 10.1188/02.CJON.71