Oncology Nursing Society 2010 Advanced Practice Nursing Conference Poster Abstracts

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PROPHYLACTIC ORAL MINOCYCLINE AND TOPICAL PIMECROLIMUS ON DEMAND FOR CETUXIMAB INDUCED ACNE-LIKE RASH IN PATIENTS WITH NSCLC STAGE 3. Wilma Uyterlinde, RN, NP, Thoracic Oncology, NKI AvL, Amsterdam, Netherlands; Henk Mallo, RN, Medical Oncology, NKI AvL, Amsterdam, Netherlands; Michel M. van den Heuvel, Thoracic Oncology, NKI AvL, Amsterdam, Netherlands

Cetuximab is a chimeric monoclonal antibody that binds to the extracellular domain of the epidermal growth factor receptor (EGFR) and has demonstrated activity in patients with metastatic colorectal carcinoma and non-small cell lung cancer (NSCLC). Known toxicity of Cetuximab is acneiform rash. In 2008 a study was started in patients with locally advanced NSCLC to assess feasibility and efficacy in combining cetuximab and concurrent chemoradiation. Because of the high incidence and severity of Cetuximab induced skin toxicity a novel supportive care protocol was developed.

The purpose was to assess the efficacy of prophylactic Minocycline and therapeutic Pimecrolimus in reducing Cetuximab-induced skin toxicity.

This was an evidence based guideline protocol by the Dutch Quality Institution of healthcare.

Cetuximab was given once weekly for 6 weeks concomitant with daily dose Cisplatin and radiotherapy. During the first cohort acneiform rash was treated on demand while during the second cohort prophylactic Minocycline (100 mg q.d. for 45 days) was administered and if necessary topical pimecrolimus (1% b.i.d) was added. Toxicity was scored according to the common toxicity criteria for adverse events (CTCAE) version 3.0. In the first cohort 11 out of 12 patients developed acneiform rash grade 2 or 3. One patient discontinued treatment because of skin toxicity. In the second cohort 3 out of 14 patients developed grade 2 rash. No grade 3 was seen (P= 0.001). Side effects of minocycline and/or pimecrolimus were not reported.

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AN INSTITUTIONAL PLAN TO REDUCE SURGICAL SITE INFECTIONS. Lisa Parks, MS, RN, CNP, Surgical Oncology, James Cancer Hospital, The Ohio State University Medical Center, Columbus, OH; Meghan Routt, RN, MSN, GNP/ANP, Surgical Oncology, James Cancer Hospital, The Ohio State University Medical Center, Columbus, OH

Oncology patients are immunocompromised due to neo-adjuvant chemotherapy and radiation. These patients often have multiple comorbidities, which increase the risk of surgical site infections and poor wound healing. Medicare (CMS) guideline revisions effective October 31, 2008 stipulate that a hospitalization complicated by surgical site infection (SSI) will not be reimbursed. It is not only important for patient outcomes to decrease SSI, but also from hospital utilization stand point as well.

The goal was to develop a set of evidence based guidelines and launch a pilot program to reduce the incidence of surgical site infections (SSI) within the division of surgical oncology.

This was a quasi-experimental, time series experiment.

Chlorhexadine scrub was initiated on all patients. The scrub was started the evening prior to surgery and repeated 12 hours later the morning of surgery. Preoperative shaving was eliminated due to the microscopic cuts that can lead to bacterial proliferation. Clipping was the preferred method of hair removal. Antibiotics were delivered within one hour of surgery in order to reduce the microbial burden of intraoperative contamination. Invanz was used in order sets for all pre-gastrointestinal surgery. Modified Nickel's bowel prep was eliminated. Maintenance of blood glucose control perioperatively of less than 200mg/dl in all patients was instituted. Insulin intravenous infusions were initiated in the preoperative holding area prior to surgery. The infusion was continued throughout the procedure and postoperatively per an insulin protocol. Patients were instructed to abstain from tobacco products for at least 30 days before any elective surgery. Postoperatively, a sterile dressing covered the incision for 24 to 48 hours.

The results of the pilot program were an initial reduction at 6 months of 18.6% with an overall decrease of 19.2% over 12 months. Due to the multimodality nature of cancer treatment, oncology patients are at an increased risk for surgical site infections. Implementing evidence based practice before, during and after surgery decreased surgical site infections within this pilot program. Protocols have been revised based