Leading the Way in Pain Control: A MECC-ONS Course for Oncology Nurses

What Are We Aiming At? Palliative Care in the Middle East

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The World Health Organization defines palliative as "An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."[1]

Today, we have arrived at the stage where one can start the evolution of quality measurement in palliative care practice both in hospital-based palliative care units and in hospices. It has become apparent, through surveys of healthcare professionals, seriously ill patients, and family members, that several domains were validated.[2] Nearly 70% of reviewed citations agreed on the importance of the domains of symptom palliation, emotional support, promoting shared decision-making and advance care planning, meeting the needs of patients and those who care for them, addressing grief and spirituality, and coordination of care.[3]

A useful mnemonic is the 3 Cs: high-quality care is "competent," "compassionate," and "coordinated." A competent case involves an interdisciplinary team that provides evidence-based symptom palliation and psychological support in the key domains of physical comfort: psychological support, social support, bereavement services, and life closure, including spirituality and transcendence. Too often, seriously ill people feel as though they are lost among myriad specialists focused on body organs, with no physician specifically charged with providing critical assistance and ensuring continuity and coordination of the plan of care at the stages of the disease trajectory.[3] Seriously ill patients and their families need to know whom they can call for help, what they should monitor, and when they should call; in short, there should be an orchestrated and clear plan of follow-up. Compassionate care treats the patient and family with respect, honors cultural traditions, and provides holistic care. Care is coordination across the setting of care and the disease trajectory.

Hospital-based palliative care programs often lack the extensive use of volunteers as do hospice programs use to extend their staff services. Furthermore, hospice programs are mandated to provide 12 months of bereavement follow-up to every family they serve. A high-quality hospice program is required to have an interdisciplinary team of physicians, nurses, and volunteers; bereavement services; available rehabilitative services including speech, physical, and occupational therapies; short-term in-patient care; and home health aides. A high-quality hospice program will, at the close of life, comprehensively assess patient pain to understand its cause and both pharmacologic and nonpharmacologic approaches to its management, including the appropriate use of adjuvant medications such as gabapentin for neuropathic pain. At times, palliative sedation is the only possible means of symptom relief. Furthermore, palliative care programs must manifest understanding and respect of the unique values of the patient's culture. In addition, supporting families and friends in their caregiving role is essential. Evidence of families frequently taking patients to and from the emergency department may highlight inadequate family education and lack of on-call staff to consult with and support at-home symptom management.

Be it in a hospital environment, hospice or home care setting, palliative care at the close of life needs to be patient-focused and family-centered.

This abstract is based on the excellent publication of Teno et al.[4] The authors' observations, judgment and analysis could serve as a basis for multiple new programs in developing countries eager to bring palliative care services to the best reachable levels.

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Healing Cancer Pain

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Great strides have been made in the treatment of the preponderance of cancers in recent decades, to the extent that virtually 50% of persons who develop cancer can be cured. Whether a cancer can be cured or whether one can hope only for limited remission, what the patient feels most acutely are the physical, psychosocial, and spiritual symptoms associated with the cancer and its treatment.

The prevalence of pain and inadequate control measures in patients with cancer is well documented. Pain is a huge quality of life issue. The consequences of pain are many, including depression, decreased socialization, agitation, fatigue, sleep disturbances, and more visits to the doctor and hospital.

Total pain is made up of more than just physical pain. Total pain can involve a physical component and a suffering component. Suffering involves psychologic and coping factors, social support, loss issues, fear of death, financial concerns, and spiritual, meaning of life concerns. Most patients with pain from cancer have both physical pain and suffering. Although pain has been described in the literature for centuries, and has been one of medicine's greatest mysteries, it still remains a challenge for healthcare professionals to provide the best of care for the patient and his/her family.

For pain management to be effective, a palliative care, integrative approach should be used. The palliative care, integrative approach includes the use of a nurturing, interdisciplinary team to treat both the physical pain and the suffering associated with the pain. The team includes the patient, family, physicians, nurses, social workers, spiritual ministry, pharmacists, counselors, dieticians, psychiatrists, physical therapists, occupational therapists, and volunteers. Many nonpharmacologic methods such as art, music, massage, reiki, pet therapy, relaxation, guided imagery, hypnosis, biofeedback, and spiritual counseling can help to relieve pain and suffering. It is important that all members of the care team communicate and work together to relieve and comfort the patient and improve his or her quality of life. The goal needs to be to treat mind-body-and-spirit, understanding that cure may or may not be possible but that one can always help to heal a patient. No matter what the reason for the pain, it is important for the care team to realize that they may not be able to add days to someone's life, but that they can add life to someone's days.

Neuropathic Assessment and Management Among Cancer Patients

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During my duty as a registered nurse in the outpatient chemotherapy clinics, I have frequently encountered patients who often verbalize "weird feelings" and numbness in their hands or legs. Quite often I have overheard my colleagues instructing patients to do different exercises to diffuse the tingling sensations.

The body's nervous system is divided into 2 major systems: the central nervous system and the peripheral nervous system. The peripheral nervous system is also divided into 2 major parts: the somatic nervous system and the autonomic nervous system. The somatic nervous system consists of peripheral nerve fibers that send sensory information to the central nervous system and motor nerve fibers that send signals to the skeletal muscle. The autonomic nervous system controls the smooth muscle of the viscera (internal organs) and glands (www.cancercare.com).

Peripheral neuropathy results from some type of damage to the peripheral nerves. Certain chemotherapy drugs can cause peripheral neuropathy, such as vinca alkaloids (vincristine), cisplatin, paclitaxel, and the podophyllotoxins (etoposide and tenoposide). Other drugs used to treat cancer, such as thalidomide and interferon, also can cause peripheral neuropathy (www.chemocare.com). Unfortunately, on the basis of my observation in my clinical area, many nurses know this fact since their field of expertise is in chemotherapy administration, but assessing such a complaint is almost always not considered by the nurses as a type of pain that needs proper assessment and subsequently appropriate management that should involve pharmacologic and non-pharmacologic interventions.

A proper assessment of neuropathic pain is not just grading it by a valid assessment tool for scaling. As a standard of management, it should also focus on exploring possible reasons and any underlying conditions which might be causing the pain. Any existing treatments that can have possible side effects of neuropathy should be explored. Finally, an evaluation should be made of the impact of such a complaint on the quality of life, such as sleeping, eating and other activities of daily life.

Adoption of a clear guideline that addresses a special type of pain can be very beneficial in keeping nurses on track as they realize an anticipated pathway for a predicted side effect, the mere presence of which can be an alerting sign for an existing problem that is more common that expected, and then a follow-up evaluation should be carried out to establish the effectiveness of the intervention. Nurses have a very vital role to play in being the patients' advocates, and can alleviate the problem that patients have by the following techniques[2]:

1. General history: medical, surgical, and drug use.
2. General physical examination, looking for possible reversible causes.
3. Impact of such pain on the quality of daily living and ability to perform different functions.
4. To use a valid, reliable tool that can aid nurses in scoring the baseline of the neuropathic pain and later on keep track of the effectiveness the interventions for follow-up.
5. And finally, and I would like to add this from a personal experience: raising the level of awareness among nurses with regard to the everyday words that lay people use to describe what we (health-care professionals) term as neuropathic pain. From my experience, words such as " tingling, numbness, weird or funny feelings, electrical shots, burning like chilies, and … there are ants all over my hands!) are often overlooked by many nurses as descriptive words of the nature of neuropathic pain, and an expected downside of chemotherapy treatments. All of this should be addressed through continuous education for the nurses, and later on nurses can transfer this information to patients through patient education activity to emphasize the importance of reporting such a symptom and its severity to health-care providers.

As a first step, by carrying out all of these recommendations, if executed, a proper screening of neuropathic pain can take place, and at a later stage evaluating the effectiveness of interventions for our populations according to drug availability and resources can take place, also never underestimating the contribution of non-pharmacologic interventions that can be provided by other disciplines.

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Pediatric Intensive Care Unit, King Abdullah University Hospital

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The Pediatric Intensive Care Unit (PICU) was established on September 3, 2003 on the fourth floor, wing C with potential capacity of 10 beds. Actually, it is operating now with only six beds. It is the only tertiary PICU in the north of Jordan dealing with both medical and surgical patients.

The unit received patients ranging from the age of one month to less than 13 years old. Severely ill patients are admitted based on the decision of medical personnel, or are medical and surgical cases. Patients from other hospitals as well as any unit in King Abdullah University Hospital are also received, which is inconsistent with hospital policy.

The staff and team of PICU are committed to providing all that an intensive care patient may need and holistic care to the patients and family. They provide optimal management and monitoring for all critical ill cases.

Goals:

1. Improvement in general health and well-being of patients and families who require critical sophisticated care.
2. Participation in interdisciplinary care for all specialties treated except for pediatrics.
3. Management of patient care appropriately through the acute and chronic phase of illness.
4. Establishment of a communication channel with the other health sectors regarding the cases referred.

Provision of attending and/or pediatric resident support for all the above services 24 hours a day, 7 days a week. Nursing services are available 24 hours a day, 7 days per week. The extent to which the level of care or services is provided meets the patients' needs. Staffing needs are based on the volume and acuity of the patients. The available staff are scheduled and adjusted from day to day to meet the unit demands.

On admission, the patient must be connected to a cardiac monitor and initial invasive and noninvasive hemodynamic monitoring is initiated. Then assessment of the patient is performed and planning of nursing care takes place. It depends on the current situation of the patient, by looking for the desired outcomes in a systematic way.

Standards or Guidelines For Practice:

Hospital policies and procedures.
Internal policies and procedures.
International guidelines.

Extent to Which Level of Care or Service Provided Meets the Patients Needs: At the hospital level, surveys of patients are conducted every 6 months to evaluate patient satisfaction. A patient's comments and concerns are included in future planning.

Performance Improvement Activities:

In-service education.
FOCUS-PDCA.
In-service education.

King Hussein Cancer Center: From Good to Great

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King Hussein Cancer Center (KHCC) was founded in 1997 as Al-Amal Cancer Center in Amman–Jordan, and was restructured

as KHCC at the beginning of 2003, with a total capacity of 124 beds. KHCC became one of the leading regional medical facilities in the Middle East, providing comprehensive cancer care to both adult and pediatric patients.

KHCC aims to deliver the latest in cancer treatment to patients, actively promoting awareness and educational programs for early detection and prevention of cancer, as well as training and research to decrease mortality and alleviate the suffering that results from cancer. KHCC treats over 3400 new patients yearly from Jordan and surrounding countries through the use of clinical practice guidelines. Patients are kept actively involved in treatment decisions and plan of care.

KHCC is also leading the efforts to establish the first regional Cancer Control Program. This program will work at reducing the incidence of common cancers in Jordan through public education, early detection, and primary prevention. The fully operational National Program for Breast Cancer Screening and Diagnosis established in 2006 and the Smoking Cessation Program established in 2008 are core components of this developing program. In addition to standard diagnostic and therapeutic services offered at any cancer center, KHCC elected to focus on other aspects of cancer care such as psychosocial oncology, pain management, physical therapy, nutritional services, child education, play therapy, and palliative/hospice care. These areas are often neglected, and their role is underestimated. KHCC was a pioneer in Jordan in establishing a culturally sensitive palliative and hospice care program, which included a unique home care service. It offered care to nearly 500 patients in 2008. The program focuses on managing symptoms of terminally ill cancer patients and addressing the sensitive issues of end of life care through an interdisciplinary approach (physicians, nurses, social worker, nutritionist, pharmacist, and chaplain).

KHCC earned national and international recognition by receiving Joint Commission International Accreditation including JCIA—first institution in Jordan—(February 22, 2006), Joint Commission International Disease Specific Accreditation in 2007, Hazardous Analysis and Critical Control Point Systems and Guidelines for its application in 2008, and Safety and the Occupational Health Excellence Award (Social Security Corporation-Jordan in 2008).

KHCC is a clear example of an institution steadily progressing on the path of excellence, growing from good to great and realizing that the greatest opportunity for growth and impact lies in capitalizing on individuals' natural talents and investing in them while staying committed to maintaining a clear mission and vision.

Contributions and Achievements in Pain Management Services at Sultan Qaboos University Hospital

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I come from the Sultanate of Oman. I work at Sultan Qaboos University Hospital (SQUH), which is part of the College of Medicine and Health Sciences of Sultan Qaboos University. SQUH was officially opened in February 1990. It is an educational and medical institution, and has a total bed capacity of 553. SQUH performs 5 main functions: teaching medical and nursing students, training undergraduate and postgraduate students, providing tertiary medical care, and research. The hospital was ISO-accredited in 2005, and is planning to apply for JCI accreditation in 2009. The services offered include medical, surgical, pediatrics, obstetrics, gynecology, neonatology, psychiatry, cardiothoracic, hematology, oncology, intensive care, accident and emergency, operating theaters, day care, and orthopedics. Neurology will begin in 2009. The unique services of SQUH include a bone marrow transplant unit and cord blood bank, a family and community medicine unit, clinical physiology and nuclear therapy—iodine 131.

Pain Management Service: The Pain Management Service of SQUH began in January 1993. The purpose of the service is to provide effective and continuous pain relief for hospital-referred patients. The goal is to provide 24 hour management of pain, follow up patients on a daily basis, and provide immediate care in the event of an emergency related to pain therapy.

By May 1996, we developed a 34-hour Pain Management Course for nurses. In January 1997, we formed a pain management committee with regular meetings once a month to discuss pain management concerns in the clinical areas. In January 2001, we conducted a National Pain Workshop with participation of international speakers.

Pain Management Nursing: I worked as a pain management nurse from 1993 to 2003. My role has involved the following responsibilities:

1. Making daily ward rounds to visit patients in pain to ensure effectiveness and safety of pain treatment.
2. Coordinating teaching programmes by conducting lectures, promoting causes, speaking at conferences, developing patient information booklets and giving lectures to doctors on palliative care and the use of different therapies.
3. Introducing and ensuring the safe and effective use of new methods of pain relief, such as epidurals, patient-controlled analgesia, and continuous intravenous infusion of opioids, in clinical areas.
4. Conducting pain management audits annually and researches give the results to all the concerned staff. This has led to focus on the improvement of care and patient satisfaction.
5. Developing pain management materials such as policies, procedures, guidelines, standards, and forms, and publishing guidelines for doctors, nurses, and patients. Introducing pain assessment scales to assess and evaluate the effectiveness of treatment.

Achievements: We educated approximately 300 nurses on the subject of pain management. They later became pain management liaison nurses of their allocated areas. We prepared a great deal of pain management educational material for nurses, doctors, and patients. The most important achievement is that through educating nurses and doctors we have improved the management of pain for patients with sickle cell disease, cancer, postoperative, pediatric, labor, and chronic pain at SQUH and other hospitals in Oman. Annual patient audits have indicated that the patients are satisfied with the manner in which the staff control their pain and symptoms.

MECC-ONS Conference on Pain Management: Pain Assessment Tools

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Introduction and Background: Patients vary in diagnosis, stage of disease, their responses to pain and interventions, and pain management. The pain sensed by patients with life-limiting/life-threatening conditions is a crucial issue that requires adequate management. As of now, there are a number of patients whose pain is not under control because of undertreatment resulting from inadequate pain assessment. The pain in the majority of these patients (80% to 90%) can be controlled if an extra step was taken to conduct comprehensive pain assessment by using valid and reliable tools appropriate for the patient's population being assessed.

To formulate a pain management plan of care, an assessment is paramount in identifying the pain syndrome or the cause of pain. Pain is defined by the International Association for the Study of Pain as the "unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage." To assess pain, it is very important to know what the different types of pain are.

Pain can be classified on the basis of "duration" as acute or chronic, or on "inferred pathophysiology" as nocieceptive pain (somatic or visceral) and neuropathic pain (peripherally generated or centrally generated). The pain assessment and management plan will depend on both classifications.

A comprehensive assessment addresses each type of pain and includes the following: detailed history, including an assessment of

the pain intensity and its characteristics; a physical examination with pertinent neurologic examination; a psychosocial and cultural assessment; and appropriate diagnostic workup to determine the cause of pain.

Methods: Use of extant literature review on pain assessment and management methods to explore reliable methods to assess pain comprehensively in various patient populations.

Results: The literature was reviewed thoroughly to explore the most popular and reliable pain assessment methods. It was noted and agreed upon in a number of studies that a clinical approach to pain assessment and management was recommended by the Agency for Health Care, Policy, and Research, which is currently known as the Agency for Health Care Research and Quality. The clinical approach was summarized in "ABCDE" format, highlighting the following:

1. Ask about pain regularly: Assess pain and associated symptoms systematically.
2. Believe patient and family reports of pain and what relieves the pain.
3. Choose pain-control options appropriate for the patient, family, and setting.
4. Deliver interventions in a timely, logical, coordinated manner.
5. Empower patients and their families. Enable patients to control their course as much as possible.

When conducting the assessment, the information can be gathered from observations, interviews with patient and family or significant others, review of medical data, and feedback from other healthcare providers.

Pain is a multidimensional human experience that requires comprehensive, holistic evaluation. To assess pain comprehensively, there is a need to find valid and reliable tools that will guide the pain management plan of care. Pain assessment tools are classified as unidimensional, multidimensional, and neuropathic.

Unidimensional Pain Assessment Tools: These pain assessment tools include scales that use numeric, verbal, or visual rating scales or descriptors to measure or monitor pain or pain relief. Examples include the numeric rating scale, the visual analog scale, and categorical scales.

(a) Numeric Rating Scale: The most commonly used rating scale using a 0-to-10 scale or a 0-to-5 scale, with 0 representing "no pain at all" and 5 or 10 representing "the worst imaginable pain."

(b) Visual Analog Scale: This scale consists of a numerated line, with anchors at either end: "no pain" at one end and "the worst imaginable pain" on the other end. The patient places a mark on the line, which the clinician then measures with a ruler and assigns a score indicating the patient's pain intensity.

(c) Categorical Scales: These scales provide a simple means to rate pain intensity using verbal or visual descriptors of the pain. Examples of these scales include the Faces Pain Scale for Adults and Children, and the Wong-Baker Faces Rating Scale for children.

Multidimensional Pain Assessment Tools: Multidimensional tools provide important information with regard to the pain characteristics and effects on the patient's daily life and activities. Examples include an initial pain assessment tool, a brief pain inventory, and a McGill pain questionnaire.

(a) Initial Pain Assessment Tool: This tool provides information with regard to the characteristics of the pain, the patient's expressions of pain, and the effects of the pain on the patient's life in the form of a diagram that indicates the location of pain; a scale to rate pain intensity; and a space to document additional comments and management plans.

(b) Brief Pain Inventory: This tool is easy to use and quantifies both pain intensity and associated disability. It consists of a series of questions that address aspects of the pain experienced over 24 hours.

(c) McGill Pain Questionnaire: This tool is one of the most extensively used and tested multidimensional scales, and assesses pain in 3 dimensions: sensory, affective, and evaluative, on the basis of words that patients select to describe their pain.

Neuropathic Pain Scale Assessment Tool: The recently developed Neuropathic Pain Scale provides information about the type and degree of sensations experienced by patients with neuropathic pain. It evaluates 8 common qualities of neuropathic pain (ie, sharp, dull, hot, cold, sensitive, itchy, and deep vs. surface pain). The patient rates each item on a scale from 0 to 10, with 0 for none and 10 for the "most imaginable." The choice of tool and the general approach to assessment should reflect the suffering of the patient and his/her special needs. Assessment of pain should be conducted at regular intervals to monitor any changes in pain after analgesics administration or modification of the pain management plan. The assessment should be individualized and documented in order for the entire multidisciplinary team members to have an understanding of problems associated with pain. In addition, assessment is conducted with each new report of pain.

Conclusions: In agreement with the literature reviewed, pain is considered the fifth vital sign. Proper assessment for patients suffering from pain will guide the pain management care plan for those patients. Those healthcare professionals working with patients on the frontline are responsible for identifying the most appropriate and reliable tools for conducting comprehensive and holistic assessments of pain, as well as selecting the most appropriate tool for the population being assessed, that is, elderly, cognitively impaired, or pediatric patients. Being able to do so will assure that these patients receive the best quality care resulting from comprehensive pain assessment and management.

Inauguration and Development of Pediatric Palliative Care Service at the National Cancer Institute, Cairo University, Egypt

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Introduction: Palliative care was defined by the World Health Organization in 2002 as an "approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual." The National Cancer Institute (NCI) is the largest comprehensive cancer center in Egypt. In 2008, 20,000 new patients visited NCI, including 2000 pediatric cancer patients.

Despite recent advances in cancer treatment, approximately 22% of children diagnosed with cancer eventually die of their disease, and this percentage is much higher in developing countries; this makes palliative care an expected standard of care in all cancer centers.

Design and Methods: Here we describe the palliative care activity at the Pediatric Oncology Department, NCI, Cairo University. From December 2007 to February 2009, 33 patients were referred to the clinic. All of them had been treated in the past in the same department, and the decision to discontinue active treatment was taken by 2 senior staff members. The service was first a part of the Pediatric Outpatient clinic, but with the intention to upgrade the level of care, it was moved to a larger separate room that integrated multidisciplinary specialties to offer better, faster, and more specified service. The pain management team, radiotherapist, specialized nurses, and social worker were all grouped in the new location, and different aspects of the patients' needs were taken into consideration, including physical, psychological, social, and financial demand.

Results: Thirty-three patients were referred to the clinic during the period between December 2007 and February 2009. They were 24 men and 9 women (ratio 2.6:1), their age ranged from 3 to 25 years and the original diagnosis was a solid tumor in 60% and hematologic malignancy in 40%. The most commonly encountered malignancies were neuroblastoma and acute myeloid leukemia (21% each). All patients were progressive and/or resistant to at

least 2 lines of anticancer treatment (range: 2 to 4 lines). Excluding patients who are still alive and currently being treated at the clinic, the duration of the patients' visits to the clinic ranged between 1 and 8 months with an average of 2.8 months. Medical care provided at the clinic included pain management (57%), blood and platelets transfusion (60% and 30%, respectively), infection control (63%), chemotherapy (93%), radiotherapy (27%), surgical consultation and wound care (15%), tapping of effusion (3%), and supportive measures (81%). One patient (3%) received meta-iodo-benzyl-guanidine therapy and another one underwent renal dialysis for acute renal failure. The chemotherapeutic agents used were mostly oral VP16 (54%), followed by hydroxyurea (25%), oral cyclophosphamide (12%), and a combination of vincristine, steroids, and 6 mercaptopurine (9%). Supportive care given according to the patient's condition included antipyretics, gastric protectors, antiemetics, nutritional support, vitamins, antispasmodics, antitussive, laxatives, and anticonvulsants.

Conclusions: Palliative care has become an integrated activity of the Pediatric Oncology Department of the National Cancer Institute, Egypt. Our goal is to give better support to our end of life patients, with a type of care adapted to our community.

Egyptian Nurses' Perceptions of Palliative Cancer Care and Patient Needs

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Background: Palliative care is a model of care that provides coordinated physical, emotional, and spiritual support not only for patients who have advanced and incurable disease, but also for those who require symptom relief during complications from which they will recover. It is a proactive form of care that seeks to maximize quality of life for patients and families. The perceptions and levels of experience of healthcare professionals may affect continuity of care.

Objectives: (1) To assess nurses' knowledge about palliative care; (2) to assess nurses' perceptions and attitudes with regard to palliative care; and (3) to evaluate concordance between different specialties and levels of education and experience.

Methods: A convenience sample included 50 nurses recruited from different cancer settings at the National Cancer Institute, Cairo University, Egypt, including medical and surgical oncology, critical care, and palliative care units.

Tools: (1) The questionnaire completed by nurses included demographic characteristics, knowledge with regard to the goals of palliative care, the roles of nurses and other health professionals, patients needs, types of facilities and settings needed, and problems and obstacles that may be present. (2) A checklist for recording activities performed for assigned patients.

Results: The preliminary results showed that nurses have different perceptions of palliative care. Nurses showed lack of knowledge about palliative care, and the majority expressed the opinion that shortage in staff and heavy workloads may be obstacles. In addition, there was a significant difference between the perceptions and attitudes of nurses working in palliative care settings compared with those working in other specialties.

Conclusions: Palliative care is an important specialty, and educational programs should be conducted for nurses with regard to the principles of palliative care. Guidelines should be developed to match the needs of the local setting.

The Cyprus Association of Cancer Patients and Friends Home Care Service

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The Cyprus Association of Cancer Patients and Friends (PASYKAF) is a registered charity. It was founded in 1986 by a group of cancer patients, their families, and friends. It provides services to more than 3500 cancer patients and their families every year. The Association depends on fundraising events and public donations. Its mission is to create a better quality of life for cancer patients and their families and to promote awareness with regard to cancer prevention and control.

The Association also organizes and hosts conferences and seminars. In addition, funding for postgraduate studies in the fields of cancer, palliative care, and other related subjects is also provided to its healthcare professionals.

PASYKAF has been involved in the research program DITIS, an ehealth telehomecare project, and is about to commence an evaluation of its services. A rolling audit and evaluation will commence this year with its new database, PASYKAF patient management system, allowing us to assess and audit, evaluate and continually improve services and education of staff in the particular areas required.

Our services, which are provided in the districts of Nicosia, Limassol, Paphos, Larnaca and Amochostos, are free of charge to all adults with a cancer diagnosis, at any stage of the disease, and are concerned with the care of patients and their families within the community. The staff, which totals 50, includes a full multidisciplinary team of nurses, social workers, physiotherapists, psychologists, psychotherapists, doctors, volunteers, and administration. Services include home care, psychosocial support, bus transport to main oncology hospitals, day care, breast and lymphoedema clinics, and soon to be commenced bereavement support groups.

Owing to the fact that this association was founded by cancer patients, it has always focused on psychological support, for the patients, their families and healthcare professionals. Weekly multidisciplinary meetings and monthly staff debriefings by a psychologist from another town are held. In addition, nurses are offered a extra day off monthly (in recognition of the stress that can affect them) and, in an effort to make stress-reducing improvements, a 6-monthly rolling burnout inventory is carried out to allow staff to assess their own well-being and the Association to receive feedback. Family leave to care for sick relatives is also available, thus recognizing that we need to look after our own before we look after others. Finally and very importantly, the day-to-day support of team members for each other is nurtured and encouraged.

The Cyprus Association of Cancer Patients and Friends continues to strive to improve services, and in so doing, the next step will be to try and increase hours of service to our patients and their families.

Magnitude of Cancer in Alamal Oncology Unit, Aden, Yemen

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Alamal Oncology Unit was established in December 2007 in Aden to care for cancer patients and to record their cases in the hospital-based cancer registry.

There were 526 cases registered at the Alamal Oncology Unit during the period between January 2008 and December 2008. All cases were histopathology confirmed.

Results: There were 225 men (42.8%) and 301 women (57.1%). The most common sites in both sexes were digestive organs (22.4%), breast (20.9%), lymphatic system (18.3%), head and neck (10.5%), and female genital organs (9.3%). The age group with more cancer presentation was 50 to 59 years in both sexes. Men were more affected between 50 and 69 years of age, mostly with colorectal and stomach cancers, and women between 40 and 49 years of age, mostly with breast cancers.

The mortality rate was high for acute leukemia (23/28), lung cancer (7/14), liver cancer (7/17), pancreatic cancer (5/16), nonhodgkin lymphoma (9/62), colorectal cancer (7/53), and nasopharynx cancer (7/32).

Conclusion: The gastrointestinal tract, breast and lymphatic system are the most common sites affected, and the 50-to-59 year age group is the most commonly affected.
Recommendation: Urgent approval of national cancer control strategy and improvement in the early detection of cancer and establishment of cancer centers to cover the governorates of Yemen.

Breast Cancer in Limited Resource Center

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Aim of Study: We studied breast cancer in Yemeni patients to determine the pattern of cancer, to compare the results with those from other parts of the world and to outline the experience of Alamal Oncology Unit over 1 year.
Materials and Methods: The study was carried out by using data on patients registered at Al-Amal Oncology Unit during the period between January and December 2008. The data analyzed included age, sex, type of cancer treatment and outcome.
Results: One hundred and ten patients were registered. One hundred and nine patients were female (99.1%) and 1 was male. Ninety percent of the patients presented with evidence of metastasis. The histology of the breast shows 69.1 of infiltrating ductal carcinoma. The age group most affected was 40 to 49 years, followed by 50 to 59 and 30 to 39 years. Of the 85 (93.5%) patients operated on by general surgeons, most of whom did not have operation notes and/or the histopathologic reports, and when these were available, they were often of poor quality.
Conclusions: Most breast cancer patients in Yemen are diagnosed in advanced stages because they are unaware of the disease and because of the absence of a comprehensive control program.
Recommendations: (1) Establishment of a comprehensive cancer control program and (2) The immediate establishment of Aden Cancer Centre.

Community Oncologic Nursing

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Background: Cancer patients and their families face uncertainty and chaos on a daily basis. The need has arisen to provide information and professional guidance to lessen anxiety and provide support.
Supporting patients and their families is an important and inseparable part of the nurse's role in managing chronic illness in general and cancer in particular.
Implementing the palliative model is the main approach to providing holistic care, and treating the patient and family as a unit. The approach is feasible from diagnoses until the end of life, and focuses on quality of life and prevention of suffering, in addition to providing support to patients and their families. It is possible to implement this approach in hospital and at home (community).
Rational: Nursing is an important discipline in managing chronic illness, and one of the roles of nursing is coordination between the various carers. The need for this coordination is significant with regard to cancer: patients spend considerable time looking for information about the disease, treatments, and carers, and they therefore need a coordinator who will guide and accompany them, and prevent unnecessary bureaucratic procedures.
Procedure: Approaching the physicians in clinics through a coordinator or interpreter who would explain the service and then make it possible to contact the clinic nurse. The service is provided to patients in various stages of their disease, and is adjusted to the needs identified. The nurse performs preliminary assessments, identifies problems, and plans interventions, all in collaboration with the patient and various carers.
Results: The procedure involved around 50 patients in various stages of disease.
The nurses' areas of responsibility were many, including the following:

1. Promoting procedures for ongoing diagnostics (less bureaucracy).
2. Choosing care venue according to patient's wishes, medical status, and type of care.
3. Educating the patient before treatment about characteristics and side effects, treating side effects identified by multidisciplinary team and in collaboration with the inpatient staff, and preventing unnecessary admissions.
4. Supporting the patient and family. This is a dominant factor. Symptoms such as pain and fatigue, as correlated in the literature, were important. Mental symptoms, such as anxiety and depression, could not be ignored.

Ethical issues such as truth-telling, location of death, nutrition and hydration, and ventilation surfaced in some cases.
Conclusions: Early acquaintance with the patient and family has proven to be beneficial in coping, lessening uncertainty, and improving quality of life for the patient.
Empowerment of the patient or his family members is important in achieving symptom control.
The nurse coordinator in oncology enabled physicians to be more involved in the care of oncologic patients.
Managing the care of oncologic patients by using this model achieves several goals at the same time, including proactively initiating nursing treatment, managing chronic illness, and keeping the patient, his needs and as well as his family's in the center.

Unique Treatment in the Department of Pediatric Hemato-oncology

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The Department of Pediatric Hemato-oncology is 1 of 6 departments in Meyer Children's Hospital, and includes Emergency Medicine, Pediatrics A and B, Hemato-oncology, Surgery, Neonatal Intensive Care, and Intensive Care. The Department of Hemato-oncology contains a hospitalization unit, bone marrow transplantation unit, day care unit, follow-up short-term and long-term survivor clinic, and a hostel for families. The Department diagnoses 80 new children per year, from newborn until 20 years of age, from Hadera in the center to the northern border, and treats patients from Russia and the Palestinian Authority. The Department treats children suffering from oncologic and hematologic diseases such as leukemia, thalassemia, and autoimmune deficiency. Treatment includes chemotherapy and radiotherapy according to national and international protocols. There are 14 beds in 10 rooms for hospitalization, and 4 rooms for bone marrow transplantation. The hemato-oncology multidisciplinary team includes 8 professional doctors, 2 interning doctors, physiotherapists, dieticians, and 33 registered nurses certified through an oncology course, some of whom have BA and MA degrees. There is a also coordinator nurse. At present, 3 nurses are studying for an MA. Some nurses have special training in holistic treatments such as shiatsu, healing, and reflexology. Various nurses speak Hebrew, Arabic, and Russian. There are 2 unskilled assistants, 4 social workers who speak Hebrew and Arabic, 1 psychologist, 2 art and music therapists, and 4 administrative staff. The teaching staff includes 4 teachers, a school counselor, national service staff, and volunteers.
The responsibilities of the nursing staff are as follows:

1. Giving appropriate, high-quality nursing treatment according to nursing principles.
2. Providing treatment that takes into consideration the uniqueness of the child and the adult.
3. Perceiving the child and his family as a unit.
4. Recognizing the child's right to know about his illness according to his level of understanding and perception of his illness.

5. Providing general and continuing treatment through a multidisciplinary team, taking into consideration the biopsychosocial aspects of the child and his family during diagnosis, treatment, and follow-up.
6. Enabling constant communication with the responsible bodies within the framework of the hospital and the community.
7. Providing ongoing professional development.
8. Providing ongoing training to the staff and absorbing new nurses on the ward.
9. The ward serves as a clinical field for nursing students, oncology courses, and emergency unit courses, and for research and professional upgrading.

The nursing staff underwent formal and practical training to provide treatment to the oncologic child. A number of practical areas received special attention:

(a) Enabling the treatment of a child who underwent bone marrow transplant: we designed a special role for a coordinator nurse. Her function is to escort the child and his family from admission through discharge.
(b) The palliative range: we developed a working group and chose a nurse for the palliative role.
(c) The training field, including the oncology staff and staff in other wards of the children's hospital.

In addition, we developed a class activity to enable the child to return to his educational framework. The staff accompanied the patients on excursions in the country and abroad.

My Education: RN, BA in Health Administration Management. I have 12 years of seniority in the oncology ward, working shifts, usually as a leading nurse.

My Role: Over the last 2 years, I developed a training program to upgrade the strategic treatment of the oncologic child in our ward and in all the children's wards with which we have a treatment relationship. From the first diagnosis and throughout all the oncology treatments, the child undergoes examinations in different wards and sometimes has an infection that requires hospitalization in another ward because of a lack of available beds. Consequently, we saw the opportunity to develop a training program that involves all the related wards. The exposure of the partly unskilled staff to the oncologic child and his family is defined as requiring special needs. This finding led us to build a forum that deals with the means to train the staff of the entire hospital in matters relating to the oncologic child and his family. The team is made up of 7 nurses: the head nurse of the Children's Hospital, the leading hematologic nurse, one representative from each of 4 wards, and me. At the beginning of the project, I met the head nurses from all the involved wards to identify the needs of each. According to these needs, we organized a seminar on oncology for nurses. The plan under discussion involves developing one protocol to deal with each specific activity, such as central catheters. This includes the development of methods and implications of unskilled nurses in different wards, and training them in specific activities. An oncologic classifier was created in each ward as source of specific protocols and educational material for the oncologic child's needs. The purpose of this role is continue to identify all new nurses' needs and act accordingly. We propose to assemble a protocol for the child newly diagnosed with a large malignant mass, and to prepare an internal transfer form for all children in the hospital. We expect this project to unify all the teams and serve to benefit all the children in our care.

Work of the Oncology Palliative Care Nurse Coordinator

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The Rambam Health Care Campus in Haifa, Israel is the major tertiary care hospital for Northern Israel, and serves a population of over 1.5 million people. The oncology institute of the campus was opened in 1980. Today, the institute consists of 2 in-patient units, an outpatient clinic, and a day care center.

In 2002, the palliative care service was established within the oncology institute, with a staff of one palliative care nurse coordinator and one pain care specialist physician. Over time, staff was added and today consists of a palliative care nurse coordinator, physicians (oncologists and pain care specialists), a spiritual support giver, a social worker, psychologists, a dietitian, and a secretary. Services offered included symptom control; attention at the end of life; psychological and spiritual support; referral for economic support; and follow-up of patients at home, other hospitals or in hospice settings. Subsequently, services such as dietary consultation and the integration of complementary medicine have been added.

Throughout the years, the palliative care nurse coordinator has been the leader in the development of the service. She serves as the team coordinator, and delivers hands-on patient care and follow-up and promotes staff and student education. She is available 24 hours per day to both patients and staff, often being called upon to give her expert advice during the evenings and nights. The coordinator's other responsibilities include (1) coordinating between the service and the community, (2) initiating and carrying out research projects, and (3) ongoing professional updating including active participation in local and worldwide conferences and courses.

In the future, the service hopes to establish a bereavement program and additional training programs for staff. It is hoped that a psychiatrist will be added to the staff and that communication with services offered in the community will be improved.

When Can We Teach Palliative Care at Hebron University?

Nemeh K. Manasrah. *Hebron University, West Bank.*

Introduction: Palliative care (PC) is a crucial concern in the care of oncology patients, and it becomes important for nursing students to study this area. Unfortunately, PC is not included in the general nursing curriculum in our faculty. I feel that early education in this field is valuable, on the basis of my experience at the first conference that was held by Middle East Cancer Consortium with regard to PC. As we do not work with this issue in our region, I decided to introduce PC in our nursing program, which will change many attitudes and affect our future at Hebron University.

Aim: To collect data and obtain more information by introducing the PC program into the nursing curriculum by next year, thereby increasing the level of teaching and learning among nursing students at Hebron University.

Al-Sadeel Society for Palliative Care for Cancer Patients

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Statistics revealed 8106 new cancer cases (2000 to 2005) in the West Bank (with 948 cancer cases in Bethlehem district), with 3471 deaths. This is an indicator of the problem of high mortality rates among cancer patients in Palestine, which means that most cancer patients are diagnosed at the end stage of the disease (5550 cases, representing 68% of total cases), This indicates that these patients are not diagnosed early enough and are no longer in need of curative care, but rather of palliative care to live comfortably and free of pain.

The shortage of healthcare facilities available to serve these patients and their families (1 major center in Bethlehem, 2 major centers in Jerusalem and Nablus, and 2 in Gaza); the limited services (75 beds for oncology patients in Ministry of Health hospitals, representing 2.7% of total beds, 22 of which are in the Bethlehem area) that provide only treatment of the disease, without focusing on the need for palliative care and early detection of cancer; and lack of knowledge, education and training among healthcare professionals with regard to early detection, public awareness, and palliative care for cancer patients, as well as the absence of home care services (governmental and private), indicates the need for palliative care in parallel with curative care to improve quality of life for patients and their families. The number of assigned beds to cancer patients in government hospitals in Nablus, Bethlehem, East Jerusalem, and

Gaza are limited, and encounter many obstacles and inspection barriers, especially Augusta Victoria Hospital (located in East Jerusalem).

Al-Sadeel Society is the only registered Palliative Care Society in Palestine, and dedicates its efforts to education and training programs in palliative care issues, and providing home-based palliative care services to cancer patients and their families, in addition to establishing the first nonprofit hospice center in the long term.

Al-Sadeel Society is the first and only registered Palliative Care Society in the Palestinian National Authority. The Society's vision is that life is a gift from God, and therefore it should be kept pain-free as much as possible by using updated knowledge and skills. The Society's activities aim to be free and affordable to patients who need them, and not only to those who are able to pay for them.

The mission of Al-Sadeel Society is to alleviate the pain and suffering of terminally ill cancer patients by providing professional nursing and palliative care along with care to the families by means of medical, social, emotional, and psychological approaches. In this way, we wish to provide comfort until the very end of life and to preserve the dignity of the suffering patient.

The strategic plan of Al-Sadeel Society is to create a home-based palliative care and hospice center. Moreover, the Society plans to become the leading organization in the education and training of palliative and hospice care in the Bethlehem area and the Palestinian National Authority at large.

The overall goal of the Al-Sadeel Society is to maintain quality of life for the terminally ill cancer patient within the family. This can be achieved through:

1. spreading awareness among the public with regard to the importance of early detection to decease the burden of the disease on the community;
2. training professionals and educating caregivers and the public;
3. home-based hospice and palliative care and supplies availability;
4. psychosocial and emotional support for the patient and the family through the use of support groups and survivor volunteers;
5. collaborating with other organizations in the field of cancer care;
6. developing projects related to palliative care services.

A needs assessment survey for palliative care in West Bank hospitals was conducted by the Society. Analysis proved the critical need for affordable palliative care services in all West Bank districts. We intended to begin in Bethlehem, where most of the volunteers are from. The Society conducted an initial workshop to introduce the palliative care idea in Palestine, where the recommendations were as follows:

(a) The need for better quality care for cancer patients.
(b) The need for training of health professionals in palliative care.
(c) The importance of networking and cooperation between the national nongovernmental organizations and the Ministry of Health.
(d) The need for public awareness with regard to the early detection of cancer, especially breast cancer.
(e) The need for national policy and standards for palliative care and opioids legislations.
(f) The importance of baseline data and research.
(g) The need for interdisciplinary team work on the issue of cancer.
(h) Palliative care education within the curricula of schools of health.

Pain Assessment in Children at Makassed Hospital From Health Providers Perspective

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Objectives: This study is aimed at evaluating pain assessment in children at Makassed Hospital from health providers' perspective.

Design: Self-report questionnaire consists of 11 items.

Setting: All departments that are regularly involved in the care of the pediatric age group at Makassed Hospital are Pediatric Intensive Care Unit, Neonatal Intensive Care Unit, Pediatric, Open Heart, and others.

Participants: Eighty health providers were included (60 nurses and 20 doctors) who regularly involved in the care of children at Makassed Hospital.

Results: Most health providers (75%) do not use the formal pain assessment and techniques when assessing children's pain; although on the contrary, nearly the same percentage of providers confide they assess and reassess the presence of pain in children. Sixty percent of them do not use anesthesia creams for invasive procedures, most of them include the comfort and the presence of pain in their documentation. About 87.5% give narcotics that were ordered Pro re natal, 28.9% of health care providers do not think they can control pain in children, also 24% of the sample could not judge. There is a concern about pain control in half of the sample. About 58.8% of health providers are afraid of the risk of addiction when giving medicine. In addition, 47.4% of the sample do not use nonpharmacologic approaches. About 77.2% of health providers involve parents in pain reporting and relieve measures, and 66.3% of them think they have enough information regarding drug side effect than with old medication. 62.5% Think that the presence of parents is necessary to reduce the pain in children during procedure.

Conclusions: Health providers should have knowledge about how to use suitable pain assessment tools and how to apply pharmacologic and nonpharmacologic techniques

A Glance at Ibn-Sina College of Nursing and Midwifery

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Ibn-Sina College was established in 1971. It had been offering a 3-year nursing diploma and 2-year midwifery program until 1996, the same year as the establishment of the National Palestinian Authority. It is worth mentioning that the old college consisted of 2 branches: one for female students, in Ramallah, and the other for male students, in Bethlehem. When the administrative affairs were handed over to the Palestinian Authority, both branches were merged under the supervision of Nursing Education and Training Department of the Ministry of Health. In 1997, the college program was developed to grant its students a bachelor degree in either nursing or midwifery. The college philosophy aims at improving the quality of health services in Palestine by preparing and rearing a generation of nurses and midwives who are equipped with all the latest information, recognizable skills, and required ethics to behave in a professional manner. Indeed, the administrators of our college continue to do their best to achieve the following objectives:

1. To update the educational curriculum in accordance with World Health Organization recommendations.
2. To support the infrastructure of the college to fulfill the need for training and educating students, focusing on preparing laboratories for simulation.
3. To recruit a new blood faculty and enhance its professional development by affording all possible opportunities to exchange experiences and knowledge with other colleges and universities.

By the year 1998, a program to upgrade the skills of RNs-BSNs was developed to grant a bachelor degree in nursing to its former diploma graduates (3 y) as an initial step in staff nursing development at government hospitals after finishing the required (51) credit hours.Ibn-Sina College encourages its students to achieve academic excellence and creates an inner ego supervision besides the sense of social awareness and cooperative spirit toward their clients. Incentives are offered to students to conform to Ibn-Sina College's rules and mission by offering a hostel for female students who live outside Ramallah, in addition to granting free health insurance, free transportation to all clinical sites inside Ramallah, and low tuition fees (5 JD per credit hour for those who commit to working in government hospitals postgraduation and 15 JD per credit hour if they do not commit to working in a governmental hospital following their graduation). In 2005, a new postgraduate diploma in Community Midwifery was introduced to

the college for the bachelor-registered nurses. It is 18 months long and consists of alternating blocks of classes and clinical experiences covering antenatal, normal pregnancy, complicated pregnancy, well baby and sick newborn topics. Another higher diploma program in Anesthesia Nursing (2 years)—was offered to bachelor registered nurses in 2007, under the sponsorship of the undersecretary of the Ministry of Health and General Consul of France in Jerusalem. Currently, the college is about to introduce 2 new higher diploma programs, one in mental health and the other in neonatology.

Finally, Ibn-Sina College has special laboratories both for its undergraduate program in Nursing and Midwifery and for postgraduate programs such as Anesthesia Nursing. Its library contains a wide variety of updated audio and visual educational materials provided by the Ministry of Health, WHO, UNFPA, and other benefactors.

Oncology Centre of Cumhuriyet University Hospital

Mukadder Mollaoğlu. *Department of Nursing, Cumhuriyet University, Health Sciences Faculty, Sivas, Turkey.*

Introduction: Before the establishment of the oncology center at Cumhuriyet University Hospital, patients suffering from cancer used to be hospitalized and treated in surgical units. There used to be a chemotherapy room in each surgical unit. Patients were referred to other nearby cities, in particular to Ankara, for radiotherapy. At present, however, patients are treated at the Oncology Centre of Cumhuriyet University Hospital (CCUH).

The CCUH has been providing services to patients since 2004. The center provides services to patients coming from other central Anatolian cities such as Yozgat, Tokat, and Erzincan. Five oncologists and 3 oncology nurses are on duty at the center. The CCUH includes policlinic, chemotherapy and radiotherapy units. Approximately 750 patients per year are treated at the center. Of these, 250 patients receive radiotherapy and the remainder receive chemotherapy. Five or 6 new patients apply to the center every day and approximately 15 to 20 patients require chemotherapy, whereas 25 to 30 patients receive radiotherapy on a daily basis.

Medical services and care are provided for patients during the day, after which they are sent home. The center provides services such as daycare centers. Some patients with complicated cases are hospitalized in affiliated clinics, with the cooperation of the hospital.

Palliative Care and Pain Management: The center is particularly focused on pain management in the context of palliative care. Pharmacologic treatment in pain management is applied with great attention. The World Health Organization Standard step treatment is followed as a pain management protocol. Consultation and support are required from the Algological Unit of the Anaesthesiology and Reanimation Department for the patient whose pain cannot be managed at the center.

The nurses at the center give instruction to the patients' relatives to apply the techniques that are used at the CCUH. In addition to nonpharmacologic pain management methods, the nurses also educate patients and patients' relatives on various subjects such as nausea—vomiting, oral care, and methods of coping with stress.

As a result, despite the recent deficiency of some technical devices and shortage of workers, the center provides significant services for patients in terms of better quality of life. Planning is in progress for more successful patient outcomes and removal of the above-mentioned obstacles.

Standards for Management of Postoperative Pain at Etlik Zubeyde Hanim Women's Health Training and Research Hospital, Turkey

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Pain is an unpleasant sensation that can disturb patients' comfort, sleep, emotions, normal daily activity, and quality of life. Pain is variable, and therefore the clinician must evaluate pain carefully.

The acute pain service team in our hospital consists of an anesthesiologist and a pain nurse. The team makes clinical rounds, visiting each patient twice a day, in the morning and afternoon.

After the admission of the patient to the ward, clinical rounds are repeated every 2 hours during the first 8 hours and every 4 hours thereafter. During these rounds, Visual Analogue Scores are recorded such as coughing and any other side effects associated with the medication.

The analgesic protocol has been written according to the type of surgery (Table 1). The surgical team has been informed of the protocols.

TABLE 1. Treatment Modalities

Surgical Procedure	Treatment Modalities
Major surgery	Paracetamol/NSAID + epidural local anesthetic + opioid or
Major abdominal surgery	Paracetamol/NSAID + combination or systemic opioids (patient controlled analgesia passive cutaneous anaphylaxis)
Moderate surgery	Paracetamol/NSAID + wound infiltration with local anesthetic + systemic opioids (passive cutaneous anaphylaxis)
Histerectomy	
Minor surgery	Paracetamol/NSAID + wound infiltration with local anesthetic
Gynecologic laparatomy	
Laparascopy	

NSAID indicates nonsteroidal anti-inflammatory drug.

Postoperative analgesia begins in the recovery room. The type and dose of analgesic are written in the patient's order. Table 2 shows analgesic doses.

TABLE 2. Analgesic Doses

	IV Tramadol	IV Morphine	Epidural % 0.125 Bupivacaine + 2 mg/mL Fentanyl	Epidural 10-20 mg/mL Morphine
Induction	50 mg	5 mg	5 mL	2 mg
Basal infusion	5 mg/h	0.3 mg/h	4 mL/h	0.2 mg/h
Bolus	20 mg	1 mg	6 mL	0.5 mg
Lockout time	15–30 min	15 min	15–30 min	30 min
4-h limit	200 mg	20 mg	30 mL	3 mg

IV indicates intravenous.

Patients stay in the intensive care unit for 24 hours postoperatively, where pain nurses evaluate palpitation, blood pressure, respiratory rate, O_2 saturation, sedation scale, and Visual Analogue Score. If they find an adverse effect, the anesthesiologist is called.

Effective pain treatment decreases postoperative morbidity factors such as respiratory complications, myocardial infarction, hospital stay, side effects, and cost.

The Medical Oncology Clinic of Ankara Oncology Education and Training Hospital

Pervin Yazici. *Ankara Oncology Hospital, Ankara, Turkey.*

Our clinic was first put into service in 1994 as an inpatient treatment service. Since that time we served as a single clinic and

then in February 2009, the second clinic of oncology was added into service.

The director of our clinic is the chief medical doctor (assistant professor) and the other medical staff are 2 medical oncologists, 4 fellow medical doctors, and 5 nurses.

1. Number of beds in our clinic: 18.
2. Number of hospitalized patients in our clinic in 2008: 1425.
3. Number of patients that died in our clinic in 2008: 29.
4. Educational status of our nurses: Two of them graduated from a health care professional college, 3 graduated from nurse health care high school, and 3 are certificated for chemotherapy application.
5. Topics of study in the in-service education program for nurses, 2008: maintenance of the Porth catheter, maintenance of the Hickmann catheter, communication with the patients, gastroenteritis, resistant microorganisms in hospitals and safety precautions, oral chemotherapy agents, employee safety, mucositis, and pain management in cancer patients.

In our clinic the procedures listed below are routinely applied:

(a) Adjuvant, neoadjuvant, or concomitant (with radiotherapy) or palliative care planned.
(b) Patients with neutropenia are treated intensively according to new infectious disease guidelines.
(c) Blood and blood products replacements according to the Hemotolog guidelines.
(d) Further determination of the priming cancer of unknown origin.
(e) Biopsies and arrangements of bone morrow transplantation.
(f) Best supportive care of patients has been routinely provided in our clinic.

Our clinical approach and practice for palliative patient care are:

- We give information to family and relatives of patients with poor prognosis.
- Patients' need for palliative care, taken to noiseless rooms.
- Nutrition support: If a patient is able to take orally, we give nutrition diets according to clinical dietician's suggestion. If patient cannot take food orally, we support our patient with parenteral nutrition after suggestions from the nutrition unit.
- Pain palliation: Nonsteroidal anti-inflammatory drugs are used for mild pain and we use suggestions of the pain and palliative unit's physiciansfor drastic (heavy) pain (half-opioid + adjuvants or opioid + adjuvants).

Cancer Pain Management in Palliative Care Patients

Hale Duran Tan, RN and Hülya Kafali, RN. *Pain and Palliative Care Clinic, Ankara Oncology Education and Teaching Hospital, Ankara, Turkey*.

The Pain and Palliative Care Clinic at Ankara Oncology Hospital was organized in July 2007. We have 18 patient beds in our clinic. After evaluating the patients at Pain Polyclinic and Nutrition Polyclinic, they are admitted to the clinic for further treatment. Our team includes 5 experienced anesthesiologists, 2 anesthesiology residents, 9 nurses, a dietitian, social workers, a psychologist, and physical therapist.

The mission of the clinic is to prevent or treat as early as possible the symptoms of a disease, the side effects caused by the treatment of a disease, and the psychological, social, and spiritual problems related to a disease or its treatment. Palliative care is appropriate at any stage in an illness, regardless of prognosis, and it can be delivered alongside curative treatments. Palliative care can be integrated with medical care intended to cure the disease, and is not intended to be used only when a patient has terminal disease. In fact, more patients each year are cancer survivors, but many cancer survivors suffer from chronic pain as a result of the surgery, radiation, or chemotherapy necessary to cure their cancer. These patients also can benefit from palliative care. We have one of the largest cancer rehabilitation programs in Turkey, with medical experts in medical oncology, radiation oncology, anesthesiology, physical medicine, psychology, psychiatry, and other disciplines as needed, working together to assess and manage severe cancer-related symptoms. Our clinic also provides consultation services to other clinics to adjust the treatment plans of inpatients who experience pain related to their underlying disease.

Between January 2007 and December 2008, 671 patients were admitted to the Pain and Palliative Care Clinic. Of these, only 43 patients had noncancer diseases. Among the remaining 628 cases, gastrointestinal system cancer incidence was 47%, genitourinary system cancer 14%, lung cancer 14%, head and neck cancer 10%, breast cancer 7%, and other cancers 8%. Two hundred and seventy-two patients suffered from a terminal event. Pain was the most common symptom at admission. Ninety-nine percent of the patients presented with pain.

In our service optimum pain control is achieved by:

1. Formulating an individualized treatment plan specific to each patient's needs, using a combination of pain management strategies such as nonpharmacologic methods, pharmacotherapy, nerve blocks, implants, and other procedural pain management techniques (eg, neurolytic blocks).
2. Practicing with a continuum of care approach beginning with a comprehensive assessment using frequent reassessment to adjust treatment plans when necessary, based on disease progression, side effects, and/or other factors.
3. Assessing each patient through a multidisciplinary approach involving professionals from various disciplines, including psychiatry and neurosurgery.
4. As oncology nurses, we actively involve all patients and their family caregivers in the development of a pain and palliative management plan of care and encourage open communication for the reporting of pain at all times.

Pain Management in Cancer Patients and Nurses' Responsibility

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Introduction: Many definitions of "pain" have been provided from past till today. Pain is a hard concept to comprehend. The lexical meaning of the Latin term is defined as punishment, torture, and avengement. According to McCaffery, "Pain is what the patient says it is." Whenever a patient mentions that he or she has pain, and no matter where the pain is, it exists and one is supposed to believe it without questioning. It is not the responsibility of the patient to prove that he or she has pain. It is the responsibility of the nurse to acknowledge the patient's declaration of pain. Whatever the cause of the pain, it affects the person both physiologically and psychologically. Some patients may find it hard to express their feeling of pain; finding a solution for this is the duty of the nurse. The nurse may use visual or oral scales that are developed for evaluating the patient's pain, or may seek collaboration with the patient's family and friends. A patient whose pain has been assessed appropriately is 90% healed from the pain with a simple pharmacologic treatment. For pain management, nonpharmacologic methods and pharmacologic treatment have been developed. When a patient's pain ceases, his or her quality of life will be enhanced, too. Assessment and management of pain are the duty of the nurse, who has many means of observing and evaluating the patient. Much responsibility falls on nurses, in matters of appropriate assessment, application of treatment after the assessment, and observation of the treatment's efficiency. For pain management, doctor, nurse, patient, and the patient's relatives have to collaborate. If that collaboration is achieved, pain is not an unmanageable problem.[1–7]

Conclusions: As a conclusion, we can summarize the ABC of pain management in cancer patients as follows:

1. Ask: Ask regularly about the pain.
2. Assess: Assess the pain systematically.
3. Believe: Believe the impact and intensity of a patient's pain.
4. Choose: Choose pain-control therapies that are appropriate for the patient.
5. Deliver: Deliver therapies regularly and on time.

"Pain relief is a deific art" (Hippocrates).

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Evaluating Analgesic Treatment Administered to Elderly Patients Hospitalized at a University Hospital Oncology Clinic in the Context of the "WHO Cancer Pain Relief Programme": A Retrospective Study

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Every year 6 million people are diagnosed with cancer and 4 million people die because of this illness. In addition, pain occurs in 70% of the progressive cancer cases. This ratio reaches up to 90% in the terminal phase. Three million people are estimated to complain of pain originated from cancer. On account of this reason, cancer pain is medically and socially an important problem. However, if present drug and treatment models are accurately used, much of the pain from cancer can be relieved.

The Cancer Pain Relief Program was created by the World Health Organization (WHO) to develop pain treatment in cancer patients. The aim of the program is to generalize pain treatment in cancer patients all over the world. Each step of the program consists of3 steps, including different combinations of analgesic drugs. In slight pain, first-step treatment is administered, which includes nonopioid and nonsteroidal antiinflamatuary drugs. If the severity of the pain increases, the second step is weak opioids added to the treatment. In the third step, strong opioids are used for uncontrollable severe pains. In all steps, adjuvant drugs such as neuroleptics, anticonvulsants, antidepressants, and corticosteroids can be added to the treatment.

Studies show that with this program 70% to 90% of pain in cancer patients can be relieved. This program is based on taking optimal results for the painful period of the illness and aims to prevent unnecessary and extra drug taking or to have pain that can be relieved. The relieving of pain by preventing unnecessary and extra drug taking is a feature of this programme, which is closely related to elderly patients for whom pharmacotherapy is chosen as an analgesic treatment. As pharmacotherapy can have cognitive, physiologic, and functional effects on elderly people, it is useful to know the strategies used for cancer pain relief in these people.

For this reason, analgesic treatments administered to cancer patients 60 years and older for last 1 year were reviewed and applications were evaluated based on the content of WHO Cancer Pain Relief Program. The results show that half of the pains (51.6%) were not treated and when it was treated, the treatment was not appropriate according to the WHO Cancer Pain Relief Program.

An Approach for Pain Relief in Cancer Patients

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Aim: This study was planned to specify the inefficacy and the differences between the approaches of pain control in inpatient cancer patients in Hacettepe University Hospitals by a multidisciplinary team named 'Wish Trip' therapy.

Materials and Methods: To determine the present situation for pain management, data inscription form was applied to 102 cancer patients who were hospitalized in our hospital, especially the clinics that are frequently used for these patients. In addition, 46 nurses and 31 doctors filled the questionnaire including education after graduation, the routine for using pain scale, information level for medicine, and side effects. Fifty patients having cancer pain filled another questionnaire for information, attitude, and behaviors related to pain.

Results: Fifty percent of patients of the sample group had pain in last the 24 hours. About 96.8% of the doctors and 58% of the nurses had no education after graduation. Sixty-two percent of the doctors and 61% of the nurses had no routine practice for using the pain scale. A majority (42%) of the 50 patients who had cancer pain and had used the detailed questionnaire had severe pain (Visual Analogue Scale 7 to 8), 8% of them had very severe pain (Visual Analogue Scale 9 to 10).

Conclusions and Suggestions: It is concluded that cancer patients do experience pain; there is an inefficacy in controlling cancer pain; and there are differences between the approaches for pain control. Goals were established and reason analysis applied, thus leading to suggestions for the development of solutions. It was evaluated that the primary solution would be to establish a procedure of pain control management; therefore, "The Procedure of Approach for Patients with Pain" was developed. Pain assessment was used for every patient in our hospital, and suitable procedures were designed. Two nurses were delegated to the Pain Unit. Lectures on pain management were included to the orientation programs for doctors and nurses who were going to start work at the Hacettepe University Hospitals. The brochure for cancer patients and their careers was improved.

An Experience of Palliative Care Course in the Undergraduate Nursing Education Program in Turkey

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Baskent University School of Nursing was founded in 1994 and has continued since 2000 as the Nursing and Health Services Department under the Health Sciences Faculty. Our baccalaureate nursing program is the first such program in a faculty in Turkey. The curriculum includes a 1-year preparation and 4-year baccalaureate education program and is different from traditional nursing programs. Within this system, subjects are spread out over the school years as separate modules. The subjects follow a list according the life periods, from the protection and improvement of health to the care of individuals with health problems, and from simple health problems to complex health problems. The purpose of the nursing program is to prepare students to be able to take new roles within the multidisciplinary team and continually changing health system and to develop their problem-solving and critical thinking skills.

Palliative care is a holistic and to meeting the physical, emotional, practical, and spiritual needs of patients and families coping with advanced illness. It is an important aspect of nursing because comfort and quality of life are the patient's goals. However, palliative and end-of-life care issues have traditionally not been in nursing school curricula. We have developed this as an elective course in the undergraduate program, which is the first course on this subject in Turkey.

The overall objectives of the course are:
1. Defining palliative care, related concepts, principles, and services.
2. Identifying the needs of the patient and family based on the quality-of-life concept.
3. Assessment and management of pain and common symptoms.
4. Understanding of the concepts of loss, grief, and bereavement.
5. Discussing ethical and legal issues.

This elective course has been running from 2005, for third- and fourth-year students. The content of the course is given in 14 weeks (32 h; 2 hours per week) of classroom instructions, video demonstration of a palliative care unit, and case presentations. Until now a total of 73 students have enrolled and successfully completed the course. This course is conducted by 3 faculty members who have different backgrounds and a guest who has experience with palliative care. Evaluation for the course includes midterm and final examination and also students' participation in discussions and case presentations.

Main topics are:

(a) Palliative care; definition and related concepts; principles, nursing role.
(b) End-of-life care.
(c) Multidisciplinary approach and role of team members.
(d) Individual assessment based on quality-of-life concept.
(e) Pain management.
(f) Symptom management.
(g) Preparation and care for the time of death.
(h) Loss, grief, and bereavement.
(i) Communication and cultural aspects.
(j) Ethical issues and decision making.

Students rated the course as beneficial and stated that they felt more confident with symptom assessment during their clinical practice; it helped them to recognize their attitudes regarding death and eased their fear related to care of a dying patient. We are revising our program based on students' feedback and are planning to enhance it with clinical observations at a palliative care unit. A survey for assessing the impact of the course on the student practice and their attitudes toward care of dying is being planned.

Nurses' Approach Toward Pain Assessment at Baskent University Hospital

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Introduction: Baskent University Ankara Hospital was founded in 1985, with a 60-bed capacity, and has now been expanded to a 300-bed capacity (65 of which are intensive care unit beds) and currently 330 nurses are employed. In the nursing services, the goals are to provide individualized and quality patient care in a professional setting, to have continuous quality improvement, and to provide a quality educational environment for students. The management of nursing services was restructured in 2006 and has been integrated with the Nursing School for transferring nursing research into practice.

Aim: The purpose of this study was to determine nurses' knowledge, attitude, and practices related to pain assessment and to identify the difficulties that they face.

Methods: This descriptive and observational study was conducted at Baskent University Ankara Hospital. The sample consisted of 25 nurses who worked in the medical, surgical, and pediatrics units and gave direct patient care. The nurses are grouped according to the number of working years and then selected randomly.

Data were collected using

1. A 27-item questionnaire (open-ended and multiple-choice questions related to demographics, pain knowledge and education, how they feel about their competence in pain assessment and pain control, and the difficulties they faced).
2. Pain Knowledge and Attitudes Questionnaire (developed by McCaffrey and Ferrell; translated and adapted into Turkish by Ozer et al, 2006).
3. Observation guide.

Each nurse was observed at least 3 times on different days and in different shifts; then they were interviewed after the final observation and asked to fill the questionnaires.

Results: Most of the nurses had a baccalaureate degree; received education on pain management during orientation (58%) and in-service education; and nearly all of them (95%) stated that their knowledge level was adequate. Mean nursing experience was 2.5 ± 1.9 years; the mean working experience in their clinic was 1.9 ± 1.2 years; mean number of patients per working day was 8 ± 1.9. The difficulties identified by nurses related to pain assessment included "communication problems with patients" and "explaining the scale." It was observed that the majority of the nurses asked about pain status (92%), location (84%), and severity (76%); used pain scale appropriately (76%); and 96% of them documented the results of their evaluation. However, other aspects of pain assessment such as characteristics, duration, contributing factors, and behavioral responses wererarely evaluated. According to the results obtained from the Pain knowledge and Attitudes Questionnaire; out of the 16 questions assessed, the mean number of correctly answered questions was 6.2 ± 2.1 with the range of 2 to 10, which shows a significant gap between knowledge and attitudes.

Conclusions: Although the sample size was very small and could not be generalized, these findings support the fact that nursing education and practice both need to promote knowledge of pain and pain management, and also empathy and empathic communication in relation to pain.[1–4]

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Basic Pain Education for Oncology Nurses in Turkey

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Pain in Cancer Patients: Pain is a significant symptom that affects quality of life. Untreated pain can have deleterious effects on cardiovascular, pulmonary, gastrointestinal, and immunologic functioning, which can result in delayed recovery, prolonged hospitalization, and worsening illness. The majority of patients with cancer, who are terminally ill, require pain relief. The patient has the right to appropriate management of pain. The appropriate assessment and management of pain is also a professional and ethical responsibility. The nurse has the obligation to maintain current knowledge in pain assessment and management. Beyond that, the institution has the responsibility to ensure appropriate patient care and to take measures to ensure staff competency.

Although advances in pain management have been made, there is need for improvement. Pain is still undertreated and many patients report moderate-to-severe pain. These barriers surrounding pain management may prevent the timely and appropriate education of health workers. Since January 2001, the Joint Commission on Accreditation of Healthcare Organizations pain management standards required that providers be educated in the assessment and management of pain.

The oncology nurse is most often in the best position to assess the need for pain control and management to provide comfort and support to the patients and their families. Education of the patients and their families with regard to appropriate use of medications is a major role of nursing. Therefore, the nurse must be well educated about pain assessment and management.

Several studies have demonstrated a deficiency in knowledge and attitudes regarding pain management among hospital nurses, which can directly affect the effectiveness of pain management for patients. In the United States, health care professionals lack accurate pain knowledge, and their inappropriate attitudes toward

cancer pain and use of analgesics have been recognized as major barriers to managing pain.

After realizing that insufficient knowledge of nurses plays an important role in pain management, many countries have developed pain education programs. In addition, effects of these programs on the attitudes of nurses have been investigated. Educational programs on pain have been shown to be effective in improving the pain knowledge and attitudes of nurses, and assessment and pain management in patients.[1–4]

Pain Education for Oncology Nurses in Turkey: There have been very few studies on the pain knowledge and attitudes toward pain management of nurses in Turkey. There has been only 1 study on the knowledge of oncologic pain in nurses. Kuzeyli et al[5] found that oncologic nurses had insufficient knowledge of pain.

In Turkey, education on pain and pain management is offered in undergraduate nursing programs; however, this is not enough. In fact, pain education in undergraduate nursing programs provides only general information about pain. The terms ''palliative care'' and pain management in patients who need palliative care have just started to be discussed. Sufficient education on pain management in patients who need palliative care, is not offered in undergraduate nursing programs.

There are only 2 nursing schools in Turkey offering a master's program in oncology nursing. The curricula of the master's program at these schools are directed toward cancer nursing in general. Pain education is discussed in detail. However, a limited number of students receive this education. There is no educational program for palliative care nursing or pediatric oncology and palliative care nursing. Palliative care nursing should be incorporated into the nursing curricula. Comprehensive pain management education should be offered by both undergraduate and graduate nursing programs.

Curricula of the nursing schools offering basic nursing education should include the following topics concerning pain management:

1. Physiology of pain.
2. Etiology of cancer pain.
3. Barriers to effective pain management.
4. Pain assessment.
5. Pain management.
   (a) Pharmacologic pain management.
   (b) Nonpharmacologic pain interventions: complementary and alternative medicine.
6. Management of complex pain problems.
7. Procedure-related pain management.
8. Special considerations for the dying child.
9. Ethical and cultural issues in pain management.

Nursing students should be able to follow the results of pain research after they graduate and start working and the institutions where they work should provide in-service training for most recent pain knowledge and pain management strategies and enable them to provide evidence-based care. In addition, hospitals should encourage their nursing staff to attend seminars, workshops, and congresses about pain.[6]

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Role of the Nurse in Pain Management for the Child With Cancer in End-of-life Care

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Pain in children who are dying of cancer can be complex and challenging to manage. Pain is now recognized as a significant debilitating symptom that affects the quality of life of the children and their families. Although advances in pain management have been made, there is still a need for improvement.

Effective pain management is essential in the care of any child with cancer and their families. The pediatric palliative care nurse has a vital role to provide comfort and support to the patients and their families. Pediatric palliative care nurses take care of the children who have pain by using nursing care plans. The nurse collects data, identifies expected outcomes, identifies and performs interventions, and evaluates all pain management interventions.

Nursing Care Plan for Children With Pain

Assessment: The pediatric palliative care nurse systematically and continually collects data regarding pain. Pain is both a sensory and emotional experience. For this reason, several different assessment strategies are needed to provide qualitative and quantitative information about pain. The pediatric palliative care nurse collects data that lead to the development of an appropriate care plan.

Diagnosis: The pediatric palliative care nurse analyzes assessment data for determining nursing diagnosis.

Outcome Identification: The pediatric palliative care nurse identifies expected outcomes individualized to the children and their families. Expected outcomes include the identification of appropriate methods for pain management and the child/family's ability to communicate the child's level of comfort to the health care team.

Planning: The pediatric palliative care nurse develops an individualized and holistic plan of care to attain expected outcomes. The interventions should be based on current knowledge of pain assessment and management in children.

Implementation: The pediatric palliative care nurse implements the plan of care to achieve the identified expected outcomes for the patient. The interventions are congruent with the nurse's assessment of the child's age and cognitive ability. Interventions may include the delivery of pain medications, nonpharmacologic approaches, and education of the child and family.

Evaluation: The pediatric palliative care nurse systematically and regularly evaluates the child's responses to interventions to determine progress. It is vital that the nurse evaluate all pain management interventions. The pediatric palliative care nurse uses his/her many roles when she takes care of the children and their families by using nursing care plans.

The Nurse's Role in Pain Management

Care: The pediatric palliative care nurse cares for patients continuously, 24 hours a day. The nurse takes care of the children, making sure that they are comfortable, seeing that they get enough fluids and nourishment, and helping them rest and sleep. The nurse not only takes care of the children but also gives comfort and support to the patient and his or her family. When the patient cannot recover, the nurse helps to make sure that the death is peaceful and without pain.

Treatment: The pediatric palliative care nurse carries out the treatments prescribed for the patient. The primary goal of pain management is consistent and the complete control of pain through the use of appropriate analgesic and adjuvant medications, and nonpharmacologic interventions as well. The nurse also monitors the patient's progress to make sure that recovery has no complications.

Education: Children and parents need information and education regarding all aspects of pain management at the end of life. The nurse often has a better opportunity than any other member of the health care team to spend the necessary time with patients and their

families to develop the required rapport for effective educational efforts. The information and education should be age appropriate, individualized, and given in language the child and parents can comprehend. The timing, quantity, and quality of the information must depend on the needs and desires of the child and the parents. Education includes information about pain.

Coordinate: The pediatric palliative care nurse should use strategies to make sure that pain management is a multidisciplinary concern. In taking care of patients, the nurse collaborates with other members of the health care team. The nurse works closely with the doctor, and also with other nurses, physical therapists, and any other professionals involved in the patient's care.

Research: The pediatric palliative care nurse is responsible and accountable for ensuring that the child receives appropriate evidence-based nursing assessment and intervention, which effectively treats the child's pain and meets the recognized standard of care. The nurse should be knowledgeable about pain assessment, pharmacologic and nonpharmacologic therapies, and barriers to effective pain management. Thus, the nurse has to monitor the researches and innovations on pain management.

Counseling: The pediatric palliative care nurse offers counseling that helps the child and his family to reduce pain, develop relaxation skills, manage anger more effectively, sleep better, and reduce stress.

Advocacy: This advocacy is a part of the nurse's caring and a part of the closeness and trust between nurse and child. When a child is ill and has pain he or she is more vulnerable. The nurse tries to protect the patient against anything that might be harmful and painful. The nurse protects the patient's dignity and tries to save the patient from embarrassment or shame. The nurse should demonstrate respect for the child's wishes, communicate effectively and compassionately, with him and his family and protect the patient's privacy.[1–4]

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Pediatric Oncology Clinic of Ankara Oncology Education and Training Hospital

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The Pediatric Oncology Clinic of Ankara Oncology Education and Training Hospital was founded in 1993. The clinic with 20 beds in 11 rooms is located in a separate building, apart from main building. Two rooms with single beds are reserved for isolation of patients with neutropenia. The other 9 rooms with 2 beds each are used for the medical care of patients. The director of our clinic is a professor of pediatric oncology and the other medical staff members are 2 specialists in pediatric oncology, 2 fellows, and 9 nurses. Two other people work as cleaners in our clinic.

Osteosarcoma and Ewing sarcoma constitute the majority of the cases treated in our clinic. Four hundred and fifty patients were treated in our clinic in the last year. Our pediatric oncology clinic also serves with an outpatient examination room for the follow-up of patients with an annual application number of 1380. There is an outpatient chemotherapy room with 30 special chairs for chemotherapy administration in our hospital. However, as our chemotherapy regimens are completely different for adults, we always prefer to administer chemotherapeutics in our clinic. The number of chemotherapy administrations in our clinic is 1100 per year. One hundred and forty patients with chemotherapy-related neutropenia were isolated and treated in our clinic during the last year.

A primary school was founded in our clinic in 1994 to serve the children while they were hospitalized. Three primary school teachers and 1 social worker who specialized in child growth are the staff in our school. The teaching program is in accordance with the educational level of the children, and activities such as drawing, handicrafts to improve hand skills, and computer education are taught to them. These people are also regularly involved in social activities such as cinema, theater, and picnics.

Three nurses have graduated from nursing schools of different universities and 6 from high schools of nursing. Five nurses have got a certificate in chemotherapy administration. All nurses in our clinic were given an in-hospital nursing educational program mainly on pediatric cancers, neutropenic patient and catheter care, nutrition of children with cancer, blood transfusion reactions, and mucositis care during their first year in our clinic. An educational program in the clinic is carried on with the pediatric oncologists and when the subject is related to nursing care, the nurses also attend these meetings. The nurses also attended annual National Cancer and Pediatric Oncology congresses as speakers or panelists. The nurses were also provided with information on pain, pain assessment, and pain management.

The children and their families are always evaluated on the knowledge of pain upon admission to the clinic. The relationship between social and psychologic factors of pain is also evaluated. Patients are encouraged to report to their nurse or doctor when pain occurs. Their responses about severity on a scale of 0 to 10, localization, and duration are recorded on the patient's vital signs sheet. Painful procedures such as bone marrow aspiration or intrathecal drug administration are always performed under sufficient sedation.

Patients with severe pain are evaluated by the team dealing with pain management. There is an outpatient pain management unit and palliative care service in our hospital. Six physicians from the anesthesiology department are specially involved in pain management and they also use the World Health Organization's 3-step approach. The first step is the use of acetaminophen, aspirin, or another nonsteroidal anti-inflammatory drug for mild-to-moderate pain. When pain persists or increases, an opioid such as codeine is added to the nonsteroidal anti-inflammatory drug. Opioids are often administered in combinations with acetaminophen or aspirin. When higher doses of opioid are necessary, the third step is used and the drugs are replaced with more potent opioids such as morphine and fentanyl.